SANTA BARBARA COUNTY
BOARD AGENDA LETTER

Clerk of the Board of Supervisors
105 E. Anapamu Street, Suite 407
Santa Barbara, CA 93101
(805) 568-2240

Agenda Number:	
Prepared on:	08/31/2006
Department Name:	Alcohol, Drug & Mental Health
Department No.:	043
Agenda Date:	9/12/06
Placement:	Administrative
Estimate Time:	1 Hour on 9/26/06
Continued Item:	NO
If Yes, date from:	

TO:	Board of Supervisors
FROM:	James L. Broderick, Ph.D Director, Alcohol, Drug & Mental Health Services
STAFF CONTACT:	Marianne Garrity, ADMHS Assistant Director, Administration 805-681-4092
SUBJECT:	Request for Hearing Implementation of the Mental Health Services Act (MHSA)

Recommendation(s):

That the Board of Supervisors set September 26, 2006 as the date to consider the following recommendations:

A. Approve $5.1 million from the State Department of Mental Health for implementation and operation of the MHSA programs for Fiscal Year 06-07.
B. Direct the Auditor-Controller to create a separate Special Revenue Fund for the purpose of segregating MHSA funding, expenditures and designations.
C. Adopt one resolution, effective September 26, 2006 adding:
   - One (.75 FTE) Psychiatrist I/II, (Class 6165/6166), Ranges 7290/7510 ($11,235-$11,235/$12,538-$12,538)
   - One (.5 FTE) Psychiatrist I/II, (Class 6165/6166), Ranges 7290/7510 ($11,235-$11,235/$12,538-$12,538)
   - One (1.0 FTE) Clinical Psychologist I/II, (Class 1758/1759), Ranges 5866/6066 ($4,524-$5,523/$4,998-$6,102)
   - Five (1.0 FTE) Psychiatric Nurse I/II, (Class 6147/6148), Ranges 5926/6026 ($4,661-$5,690/$4,900-$5,981)
   - Six (1.0 FTE) ADMHS Recovery Assistant, (Class 5160), Range 4446 ($2,228-$2,720)

- Eight (1.0 FTE) ADMHS Practitioner Intern/I/II, (Class 5190/5191/5192), Ranges 5286/5486/5576 ($3,387-$4,135/$3,743-$4,569/$3,914-$4,779)
- One (1.0 FTE) Accountant III, (Class 0016), Range 5726 ($4,219-$5,150)

D. Approve the Budget Revision Request to establish the budget for MHSA funding and associated revenues and expenditures of $5.1 million.

Alignment with Board Strategic Plan:

The recommendation(s) are primarily aligned with Goal No. 2, A Safe and Healthy Community in Which to Live, Work and Visit.

Background:

In November of 2004, the voters of California approved the MHSA, also known as Proposition 63. This act increased funding to expand mental health services to children, youth, adults and older adults who have severe mental illnesses. Program funding for counties will be divided into five separate categories: 1) Community Services and Support; 2) Prevention and Early Intervention; 3) Capital Facilities and Technology; 4) Education and Training; and 5) Innovation. All counties are currently in the Community Services and Support portion of the MHSA, which required extensive planning, collaboration, and community input, resulting in a three-year program plan.

Executive Summary and Discussion:

When the plan was approved by the BOS in November 2005, the Board was made aware that State approval would generate approximately twenty additional civil service positions to provide MHSA services. ADMHS reviewed the possibility of filling existing vacant positions; however, MHSA funds cannot be used to supplant existing positions or services and therefore require the creation of these new positions. As MHSA funds are to be kept separate from current Department funds, it is requested that the Board of Supervisors direct the Auditor-Controller's office to create a separate Special Revenue Fund for the purpose of segregating MHSA-related funding, expenditures and designations (Auditor-Controller concurs).

To procure the funds, the Department was required to develop an inclusive community planning process. The planning process included a 3-day summit with 150 participants. This process provided opportunities for consumers, families, Community Based Organizations, County Agencies, and other stakeholders to develop and create the 3-year program plan. The State Department of Mental Health approved Santa Barbara County's MHSA Plan on June 30, 2006. The plan calls for the implementation of 10 new programs developed by key community stakeholders. $3.9 million will be allocated annually to support these programs, as well as $1.2 million for one-time start-up costs and other program expenses.

MHSA's five funding categories are an innovative attempt to transform the Mental Health System of California. The Act has particular requirements related to consumer/family involvement, outreach to underserved communities and cultural competency, all of which set a new direction for the mental health system. This process has already created a growing and powerful consumer and family movement in our county, which has assisted in the development of programs for MHSA.

Our county has also convened a Latino Advisory Group that is assisting the department in establishing standards in areas related to service delivery, and to cultural and linguistic competency. Since March 2006, 33% of all new ADMHS staff hired have been bilingual/bicultural. The Alcohol & Drug Program has made the most impressive gains in this area, filling 45% of their current positions with qualified bilingual/bicultural (Spanish/English) staff.

The majority of the MHSA programs will be provided by Community-Based Organizations through a competitive RFP process; the quality of service delivery will be balanced with cost effectiveness, performance and outcomes. ADMHS is projecting that 46.5 CBO positions will be created through this process. Santa Barbara County's MHSA programs generally fall below the number of civil service/MHSA positions when compared to other counties of similar size (i.e. Ventura County (32), San Luis Obispo (14), and Monterey County (47)). The Board is asked to approve 22.25 new MHSA positions. Approved by the State Department of Mental Health, these positions will ensure that mentally ill residents throughout Santa Barbara County will receive MHSA services. Also, many of the positions are medical staff, or "safety net" staff that provide consistency to both County and CBO Programs. These positions will be fully supported by MHSA funding and will not require General Fund support. However, a number of these programs will provide support to county agencies that receive extensive General Fund support; for example, the CARES and Justice Alliance programs will benefit law enforcement agencies by ensuring that crisis situations are diverted from the jail and law enforcement personnel.

For a Detail of Positions by Program See Attachment I

MHSA will serve approximately 4,000 clients (***see Attachment I***). In addition, programs are required to meet approximately 77 outcome measures ***(see Attachment II).*** The final client numbers associated with the outcomes will be determined at a later date when the programs become operational. Our Full Service Partnership Programs (Vida Nueva, OARRS, and SPIRIT) will allow us to provide a high level of service to our most needy and un-served clients. Other projects such as New Heights and Connections will permit the department to outreach to children and adolescents, including very vulnerable transition aged youth who are exiting foster care and probation. Partners in Hope, Bridge to Care, and Justice Alliance will assist in serving adults in the community through existing service providers, or via the courts. Our final project, CARES Mobile Crisis, will improve 24/7 crisis assistance throughout the county and will be key in our efforts to decrease the number of clients who, in times of crisis, may burden other systems such as hospitals and the jail.

Mandates and Service Levels:

No mandates require Counties to procure MHSA Funding. However, this is one of the most significant reforms for individuals with mental illness since the passage of the Short Doyle Act in the 1960's. Additionally, pursuant to DMH Letter No. 05-04, MHSA funding cannot supplant existing state or county funds utilized to provide mental health services. Furthermore, item 3 of Letter 05-04 indicates that "MHSA funds must be used to expand mental health services beyond services that were provided or funded at the time of enactment of the MHSA (November 2, 2004)". In addition there are extensive state mandates requiring the oversight of MHSA related to fiscal, human resource, and outcome/data collection.

Fiscal and Facilities Impacts:

No General Fund support is required for the implementation of MHSA programs.

FY0607 MHSA funding of $5.1 million will support FY0607 MHSA one-time costs of $1.2 million and program and administrative costs totaling $3.9 million. The fiscal impact of FY0607 MHSA funding and associated expenditures is further detailed in a Budget Revision Request included with this Board Letter. Ongoing MHSA program funding of $3.9 million annually (in combination with MediCal and other revenue sources) will fully support program costs in future years.

Any increased facilities requirements resulting from the implementation of MHSA will be MHSA-funded.

Attachments:

Attachment 1: Detail of Positions by Program
Attachment 2: Outcome Measures
Attachment 3: MHSA Program Information

Concurrence:

Bob Geis, Auditor-Controller
Sue Paul, Human Resources

CC:

Mental Health Commission

Attachment I

State Approved Programs and Positions

- **Vida Nueva/Vida Nueva for Transition Aged Youth (Serving 140 Clients)**

  This is a Full Service Partnership program (ACT model design) to serve severely mentally ill adults, older adults, and Transition Aged Youth (ages 18 to 24) in Lompoc who are at risk of homelessness or who are homeless. ACT model programs are composed of multi-disciplinary teams with staff trained in psychiatry, psychology, social work, nursing, substance abuse, and vocational rehabilitation. The ACT team provides these necessary services 24 hours a day, seven days a week. Individuals with co-occurring substance abuse issues are eligible for this program. This program is one component of a complete Vida Nueva program.

  Requested County Position
  1 FTE Psychiatric Nurse, .75 FTE Psychiatrist

  CBO Positions
  1 FTE ADP Specialist, 1.5 FTE ADMH Practitioner, 5 FTE Personal Services Coordinators, 6 FTE Peer Recovery Assistants, 1 FTE Program Manager, .5 FTE Employment Specialist, .5 FTE Independent Living Coach, 2 FTE Peer Coaches, 2 FTE Support Staff

- **Spirit (Serving 75 Clients)**
  Spirit is designed for children, youth and families and is countywide in scope: It develops culturally competent wraparound teams at all ADMHS children's service sites by expanding existing staff resources, adding youth and/or parent partners hired as staff and licensed mental health professionals.

  Requested County Position
  2 FTE ADMHS Practitioner, 1 Psychologist, 3 ADMHS Recovery Assistants

  CBO Positions
  None

- **Crisis and Recovery Emergency Services (CARES) (Serving 2,880 Clients)**
  This program is designed to serve all age groups throughout the entire County. This program establishes a 24/7 Mobile Crisis Response in connection with CARES and coordination with the Mental Health Assessment Team (MHAT).

  Requested County Positions
  3 FTE Mental Health Practitioner, 4 FTE Psychiatric Nurse, .5 FTE Psychiatrist

  CBO Positions
  None

- **OARRS (Serving 100 Clients)**
  This is a Full Service Partnership program, ACT model design, to serve severely mentally ill older adults in Santa Barbara and Santa Maria. Individuals with co-occurring substance abuse issues are eligible for this program.

  Requested County Positions
  None

  CBO Positions
  1 FTE Mental Health Practitioner, 2 FTE Office Assistants, 3 FTE Psychiatric Nurses, 1 FTE Psychiatrist, 4 FTE Recovery Assistants

- **New Heights (Serving 200 Clients)**
  This program is designed to serve transition-age youth who have aged out of systems such as CWS and Probation and who are at risk for homelessness or incarceration. This program creates a drop-in center to help young adults live in ways that are productive and interdependent by providing opportunities to develop meaningful relationships, vocational skills, stable housing, greater independence and leadership skills.

  Requested County Positions
  None

  CBO Positions
  1 FTE ADP Specialist, .5 FTE Mental Health Practitioner, 1 FTE Office Assistant, 1 FTE Peer Coach, 1 FTE Program Manager

- **Partners in Hope (Serving 75 Clients)**
  This project will ensure that family partners and peers in recovery will be hired to augment existing service delivery teams, providing recovery activities to strengthen peer and family member services. The goal will empower consumers and families to provide mutual and natural support and will lessen the dependency on county services. In addition, a peer supervisor will also work with transition aged youth and staff in the development of countywide youth leadership activities. Warm line staff will also make up this consumer and family operated program.

  Requested County Positions
  3 FTE Recovery Assistants

  CBO Positions
  1 FTE Peer Supervisor, 2 FTE Family Advocates, 1.5 FTE Warm Line Staff

- **Connections (Serving 500 Clients)**
  Using peer staff, family partner staff and mental health staff, Connections will provide culturally competent outreach to children and families in natural community settings. Connections staff will be located on sites of local schools, primary care clinics and other community sites still to be determined. Staff will connect with families and children with emotional or behavioral

problems and/or substance abuse. Support groups, advocacy, outreach and celebrations will draw community member

Requested County Position
None

CBO Positions
3 FTE Mental Health Assistants, 3 FTE Mental Health Practitioners

- **Justice Alliance (Serving 75 Clients)**
  This program will serve adults involved in the justice system throughout the county: Alcohol, drug and mental health specialists will facilitate quick linkage for incarcerated mentally ill people and/or people with mental illness and addiction to appropriate care to reduce recidivism in the justice system.

  Requested County Positions
  3 FTE ADMHS Practitioners

  CBO Positions
  None

- **Bridge to Care (Serving 100 Clients)**
  This program provides CBO's providing alcohol and other drug treatment services with the resources to contract for physician services in order to ensure quick and appropriate medication evaluation and monitoring for clients with co-occurring substance use and mental illness, thus diverting such clients from over-taxed ADMHS' outpatient clinics or providing timely medication support pending client admission into ADMHS clinic services.

  Requested County Positions
  None

  CBO Positions
  1 FTE Psychiatrist

- **MHSA Program Oversight**
  As explained previously, counties will be asked to implement MHSA programs via involvement in a five-stage process. We are currently in the middle of the first phase of this process. Consequently, the extensive state mandates, require additional MHSA staffing to assist in the oversight of issues related to fiscal, human resource, and outcome/data collection.

  Requested County Position
  1 FTE MHSA Accountant III

  CBO Positions
  None

Attachment 2

Mental Health Services Act (MHSA) Program Goals and Outcomes

Overall MHSA Outcomes

- ✓ Outreach to and engagement in services of unserved/underserved communities
- ✓ Outreach to and engagement in services of youth, adults and older adults that are homeless or at-risk for homelessness
- ✓ Improve ADMHS ability to provide services that address the cultural and linguistic needs of the community

Vida Nueva		
Program Goals	**Outcomes**	**Measure/Data Elements**
❖ Extend the 24/7 wraparound services level of care in Lompoc to support these individuals recovery from mental illness	✓ Enroll previously unserved/underserved populations (e.g., ethnic groups, gender groups, geographic regions) in services ✓ Engagement in and/or maintenance of mental health treatment activities	➢ Number of unserved and underserved clients enrolled; communities served ➢ Participation in recovery-based meetings (e.g., clinical services, support groups, AA, NA)
❖ Reduce involuntary care utilization	✓ Decrease number of incarceration days ✓ Decrease number of inpatient/acute care days and length of hospital stay	➢ Number of incarceration days ➢ Number of hospital admissions; length of hospital stay; reduction in hospitalization costs
❖ Increase client ability to live independently in the community	✓ Increase number of days in stable/permanent housing ✓ Increased success in establishing and maintaining meaningful social activities and relationships ✓ Increase skills needed to maintain success in vocational and educational activities	➢ Number of days in stable/permanent housing ➢ Participation in healthy social activities and relationships at least one time per week ➢ Number of clients employed, in school or training, or volunteering
❖ Enhance the foundation of clients and family members working in the recovery-oriented system of care	✓ Increased number of client and family members hired in system ✓ Increased number of bilingual/bi-cultural staff in system ✓ Increase service provision by consumers and family members	➢ Number of peer and family staff hired ➢ Number of bi-lingual/bi-cultural staff ➢ Number of peer mentoring and client-provided services

Attachment 2

OARRS		
Program Goals	**Outcomes**	**Measure/Data Elements**
❖ Provide culturally competent, age-specific mental health services to Older Adults	✓ Enroll previously unserved/underserved populations (e.g., ethnic groups, gender groups, geographic regions) in services ✓ Increased number of older adults receiving the full range of services needed for mental health and co-occurring disorders	➢ Number of unserved and underserved clients enrolled; communities served ➢ Number of Older Adults identified as having co-occurring disorders ➢ Number of linkages to system- and community-based services
❖ Stabilize Older Adults with mental health problems in the community	✓ Decreased number of Older Adults receiving higher levels of care and/or being placed out of the community for long term care ✓ Increased accessibility and quality of medication support services	➢ Number Older Adults returning to community from long-term psychiatric care ➢ Number returning to acute care ➢ Number of medication support services provided ➢ Number of medication accidents
❖ Reduce utilization of involuntary care and emergency rooms for mental health and physical health problems	✓ Decreased number of psychiatric hospitalization, emergency room visits, and/or placed in out-of-home/long-term psychiatric care settings	➢ Number of psychiatric hospitalizations ➢ Number of emergency room visits for physical and/or psychiatric care ➢ Number of out-of-home/long-term care placements
❖ To prevent mental health symptom recurrence and suicide, engage Older Adult in treatment and supportive activities	✓ Engagement in and/or maintenance of mental health treatment activities ✓ Increased number of older adults involved in some meaningful activities (work, volunteer, social, etc.).	➢ Number of services provided in community to decrease symptoms ➢ Number engaged in meaningful activity (work, volunteer, social) ➢ Number of Older Adult suicides

Attachment 2

Bridge to Care		
Program Goals	**Outcomes**	**Measure/Data Elements**
❖ Stabilize clients in alcohol and drug treatment who have co-occurring conditions	✓ Enroll previously unserved/underserved populations (e.g., ethnic groups, gender groups, geographic regions) in services ✓ Mental illness symptom reduction ✓ Reduced trauma related symptoms Increased engagement in substance abuse treatment	➢ Number of unserved and underserved clients enrolled; communities served ➢ Number of psychiatric and medication evaluations ➢ Mental illness symptom reduction and trauma-related symptom reduction or management ➢ Attendance and participation in substance abuse treatment program
❖ Reduce utilization of involuntary care	✓ Decreased hospitalizations and substance abuse relapse	➢ Number of hospital admissions ➢ Length of hospital stay ➢ Number of substance abuse relapses ➢ Number of incarceration days
❖ To support clients in their recovery from mental illness and addiction and prevent relapse, engage clients in mental health treatment services	✓ Reduction in unnecessary referrals to mental health services ✓ Reduced length of time between referral, assessment and first appointment for mental health services ✓ Reduction in positive drug tests for alcohol or illicit drugs	➢ Number of clients admitted to and retained in substance use treatment ➢ Link to and engagement in mental health services within 30 calendar days of referral from substance abuse treatment ➢ Participation in substance abuse outpatient treatment ➢ Number of negative urinalysis samples

Attachment 2

Connections		
Program Goals	**Outcomes**	**Measure/Data Elements**
❖ Provide outreach and access to mental health services for children and their families who are presently unserved and who need services	<u>Individuals:</u> ✓ Enroll previously unserved/underserved populations (e.g., ethnic groups, gender groups, geographic regions) in services ✓ Increased ability of educators and community members to identify youth and families in need of mental health services <u>System of Care:</u> ✓ Increased number of peer, client and family members hired in system ✓ Increased number of bilingual/bi-cultural staff in system ✓ Increase service provision by peers, clients and family members	<u>Individuals:</u> ➢ Number of unserved and underserved clients enrolled; communities served ➢ Number/type of services provided by what type of provider ➢ Number of community settings, schools and educators receiving education ➢ Number of assessments and referrals into system of care <u>System of Care:</u> ➢ Number of peer and family staff ➢ Number of bi-lingual/bi-cultural staff ➢ Number of peer mentoring and client-provided services
❖ Decrease stigma and increase knowledge about mental illness	✓ Increased community knowledge about the relationship between mental health, parenting and child development ✓ Increased community knowledge about accessing system- and community based services ✓ Increase social support/network for children and families coping with mental illness	➢ Number of community educational events ➢ Number of individuals served ➢ Knowledge acquisition survey ➢ Referrals and linkages to community-based support services

Attachment 2

New Heights		
Program Goals	**Outcomes**	**Measure/Data Elements**
❖ Provide a welcoming, supportive drop-in center for Transitional Age Youth in Lompoc	<u>Individuals:</u> ✓ Enroll previously unserved/underserved populations (e.g., ethnic groups, gender groups, geographic regions) in services ✓ Involvement of TAY in leadership and mentoring roles at the Center and in the community <u>System of Care:</u> ✓ Increased number of TAY client and family members hired in system ✓ Increased number of bilingual/bi-cultural staff in system ✓ Increase service provision by consumers and family members	<u>Individuals:</u> ➢ Number of unserved and underserved clients enrolled; communities served ➢ Number of youth served at center; types of services provided ➢ Number of youth in leadership and mentoring roles <u>System of Care:</u> ➢ Number of TAY peer and family staff ➢ Number of bi-lingual/bi-cultural staff ➢ Number of peer mentoring and TAY client-provided services ➢ Establishment of a Peer & Family Advisory Council
❖ Support Transitional Age Youth in their mental health recovery process	✓ Engagement in and/or maintenance of mental health treatment activities ✓ Reduced number of days in juvenile hall/jail/bookings ✓ Reduced number of acute care episodes and reduced number of hospitalization days per episode	➢ Participation in recovery-based activities (e.g., clinical services, support groups, AA, NA) ➢ Number of jail days and/or bookings ➢ Number of hospitalizations and length of stay
❖ Assist Transitional Age Youth with developing the skills necessary to lead health and productive lives	✓ Increased number of days in stable/permanent housing ✓ Increased skill and success in vocational and educational activities ✓ Increased social support network	➢ Number of days in stable/permanent housing ➢ Number engaged in educational activities, employment/employment seeking; volunteer activities ➢ Participation in healthy social activities and relationships at least one time per week

Attachment 2

Partners in Hope		
Program Goals	**Outcomes**	**Measure/Data Elements**
❖ Enhance the existing recovery-based model by involving people in recovery at every level in the system of care, policy to service delivery	✓ Integration of clients and family members into existing service delivery teams ✓ Increased number of bilingual/bi-cultural staff in system ✓ Increase service provision by peers, clients and family members	➢ Number of clients and family members hired and located with a team ➢ Number of bi-lingual/bi-cultural staff ➢ Number of peer mentoring and client-provided services ➢ Number of clients and family members involved in management and advisory roles
❖ Integrate additional recovery-based activities as a main component of services at every service site provided by clients and family members	✓ Enroll previously unserved/underserved populations (e.g., ethnic groups, gender groups, geographic regions) in services ✓ Increased outreach and service provision by clients and family members ✓ Increased sense of empowerment, hope and wellness in clients and family members employed as well as those that are enrolled	➢ Number of unserved and underserved clients enrolled; communities served ➢ Number and type of WRAP and other recovery-based services provided ➢ Client and family member employee and enrollee empowerment survey ➢ Number of clients and family members attending weekly team meetings
❖ Develop system of workplace support for client and family members to promote professional development and symptom/stress management	✓ Retention, participation and promotion of client and family member staff ✓ Expansion of paid and volunteer roles for clients and family members throughout the system of care	➢ Participation of client and family member staff in support activities for self-care ➢ Participation in professional development activities ➢ Retention and promotion rates ➢ Number of paid and volunteer positions designated for clients and family members

Attachment 2

CARES		
Program Goals	**Outcomes**	**Measure/Data Elements**
❖ Crisis stabilization and link to services	✓ Provide face-to-face crisis intervention services to 100 North County and 300 South County community members per month. ✓ Link 75 North County and 240 South County community members per month to brief or ongoing mental health, alcohol or drug treatment programs. ✓ Ensure that a second face-to-face service contact occurs within 10 calendar days after initial service contact with CARES.	➢ Number of clients receiving services ➢ Length of CARES stay; symptom reduction/level of acuity at entry & exit; types of services provided ➢ Number of referrals given ➢ Number of linkages to services made from referrals ➢ Number of follow-up care events within 3 days of crisis episode ➢ Number of follow-up contacts with CARES clients within 10 days ➢ Number of clients seen ongoing at least once per month in long-term care
❖ Decrease hospitalizations and shift funds to long-term care treatment services	✓ Reduce the number of local and out-of-county psychiatric hospital admissions by 15% from an average of 105 per month to 89 per month. ✓ To increase medication compliance, establish a baseline of scheduled and kept medication appointments for clients open to CARES	➢ Number of North & South hospital admissions ➢ Length of hospital stay ➢ Reduction in hospitalization costs ➢ Number of scheduled medication appointments ➢ Number of kept med appointments ➢ Number of “no shows”
❖ Avert incarceration for clients with mental illness and/or substance abuse problems	✓ To reduce incarceration of individuals with mental illness and/or addiction problems, provide services to those at-risk for incarceration, as evidenced by law enforcement referrals to CARES. ✓ Ensure continuity of care following CARES service delivery to reduce contact with local law enforcement for 90 days after receiving crisis services.	➢ Number of clients referred to and brought to CARES by criminal justice and law enforcement systems rather than incarcerated each month ➢ Number of jail days and contacts with criminal justice and law enforcement systems since crisis service delivery

Attachment 2

CARES (cont.)		
Program Goals	**Outcomes**	**Measure/Data Elements**
❖ Increase community safety and access to services	✓ Community members endorse an increased sense of security from and knowledge about resources for help with mental illness and addiction.	➢ Community satisfaction survey

SPIRIT		
Program Goals	**Outcomes**	**Measure/Data Elements**
❖ Provide 24/7 mental health and substance abuse services for children and their families in order to prevent out-of-home and out-of-county placements	✓ Enroll previously unserved/underserved populations (e.g., ethnic groups, gender groups, geographic regions) in services ✓ Maintain children in their homes or community ✓ Return children placed out-of-home and out-of-county to the most appropriate, safe and stable living environment	➢ Number of unserved and underserved clients enrolled; communities served ➢ Number of interventions; number/types of services provided ➢ Number of out-of-home placements (county and out-of-county)
❖ Assist children in their mental health recovery process and with developing the skills necessary to lead healthy and productive lives	✓ Improve quality of life for children ✓ Engagement in and/or maintenance of mental health treatment activities ✓ Reduced number of days in juvenile hall/jail/bookings ✓ Reduced number of crisis and acute care episodes ✓ Reduced number of hospitalization days per episode ✓ Increased number of days in stable/permanent housing ✓ Increased skill and success in vocational and educational activities ✓ Increased social support network	➢ Academic performance (GPA) ➢ Number of days in classroom ➢ If applicable, employment status ➢ Hospital admissions; length of hospital stay; reduction in hospitalization costs ➢ Number of days in juvenile hall and bookings ➢ Number of days in stable/permanent housing ➢ Participation in recovery-based activities (e.g., clinical services, support groups, AA, NA) ➢ Participation in extracurricular activities ➢ Participation in healthy social activities and relationships at least one time per week

SPIRIT (cont.)		
Program Goals	**Outcomes**	**Measure/Data Elements**
❖ Assist families with building a family structure that will support the recovery process for both the child and family	✓ Improve quality of life for family members ✓ Increased ability of families to provide a stable and safe environment for their children ✓ Increase access to and utilization of community-based support resources	➢ Parent/guardian/family quality of life, system knowledge/utilization and parenting skills survey ➢ Attendance at mental illness educational and supportive activities (e.g., support groups, parenting classes, mental illness psychoeducational forums, family counseling)
❖ Enhance the foundation of culturally competent staff, clients and family members working in the recovery-oriented system of care	✓ Increased number of client and family members hired in system ✓ Increased number of bilingual/bi-cultural staff in system ✓ Increase service provision by consumers and family members	➢ Number of peer and family staff hired ➢ Number of bi-lingual/bi-cultural staff ➢ Number of peer mentoring and client-provided services

Justice Alliance		
Program Goals	**Outcomes**	**Measure/Data Elements**
❖ Provide treatment for persons with mental illness and addiction in order to avert incarceration	✓ Enroll previously unserved/underserved populations (e.g., ethnic groups, gender groups, geographic regions) in services ✓ Reduction in the number of mentally ill and/or substance abusers in criminal justice system	➢ Number of unserved and underserved clients enrolled; communities served ➢ Number of clients averted from criminal justice system ➢ Number of jail days, bookings, sanctions ➢ Number of clients volunteering, employed, or engaged in meaningful activity ➢ Cost to community (cost of incarceration versus mental health services)
❖ Strengthened communication between ADMHS and criminal justice system	✓ Increased assessment and access to mental health and substance abuse treatment services	➢ Number of psychiatric assessments ➢ Number of clients engaged in ongoing outpatient treatment

Santa Barbara County Department of
Alcohol, Drug & Mental Health Services

MHSA Mental Health Services Act

Transforming Mental Health Services in Santa Barbara County

In November 2004, the voters of California approved Proposition 63, the Mental Health Services Act (MHSA). Revenues from a one percent tax on incomes exceeding $1 million will be used to expand mental health care for children, youth, adults, and seniors. Following an intensive 11-month community planning process, in December 2005 the Santa Barbara County Board of Supervisors unanimously approved a three-year plan that funds 10 new programs summarized here:

►*Vida Nueva for Adults and Older Adults:* Assertive Community Treatment (ACT) model programs have proven to be one of the most effective, evidence-based approaches for creating interventions for people with severe mental illness who are often also dependent on alcohol or drugs. ACT programs deploy multidisciplinary teams that are responsible for all service coordination.

Vida Nueva will become the first ACT program in **Lompoc**, serving 95 adults and five older adults with severe mental illness who are homeless or at risk of homelessness**.** Clients will be offered intensive wraparound services twenty-four hours a day, seven days a week. The treatment team typically provides all client services using a highly integrated approach to care. Vida Nueva will help people in recovery remain independent.

Peer support staff and family member staff will be added to an ACT Team in Santa Maria to extend services to **Guadalupe**. Staff will also be added to existing teams in Santa Barbara. In addition, services will be extended to **Carpinteria**, an under-served community in South County.

Services will include housing assistance; supported employment and education; vocational skills enhancement; medication support; counseling support; peer support; and social skills development.

►*Vida Nueva for Transition-Age Youth* includes intensive wraparound services 24/7 for transition-age youth. An integrated multidisciplinary team will provide comprehensive mental health, social, cultural, physical health, substance abuse and trauma assessments.

Specialized Personal Service Coordinators for transition-age youth will serve as long-term, consistent mentors for young adults during their years of transition.

►*SPIRIT* will provide a family-centered, community oriented, strength-based, highly individualized planning process to help people meet unmet needs both within and outside of formal human services systems while they remain in their neighborhoods and homes whenever possible.

Three culturally competent wraparound teams will be established, one at each of the three regional ADMHS Children's service sites. Existing staff resources will be reallocated at each site. Teams will be enhanced by adding parent partners who reflect the culture and language of those being served and mental health professionals to each team.

SPIRIT Personal Service Coordinators will ensure that care is available 24/7 to families to keep youth and families stable and safe.

►**Older Adult Response and Recovery Service (OARRS)** creates an essential specialized system of care specifically designed for the older adult population. This is extremely timely, due to the state-wide closure of many acute care facilities for older adults. OARRS will be staffed by coordinating resources from several other agencies including Social Services, Adult Protective Services, and the Public Health Geriatric Assessment Team. Regional teams will be created in Santa Barbara and Santa Maria. Additional support services will be provided by community-based organizations.

►*CARES Mobile Crisis Team:* Adding a mobile crisis team to the ADMHS CARES program (Crisis and Recovery Emergency Services) will provide clients in crisis appropriate alternatives to hospitalization. Mobile crisis response teams will collaborate with law enforcement crisis calls that in the past have typically resulted in incarceration or involuntary care. The goal will be to increase access to care by extending comprehensive crisis services to under-served individuals.

More on page 2.

Guiding Principles:

Community collaboration: individuals, families, agencies, and businesses work together to accomplish a shared vision.

Cultural competence: adopting behaviors, attitudes and policies that enable providers to work effectively in cross-cultural situations.

Client– and family-driven system of care: adult clients and families of children and youth identify needs and preferences that result in the most effective services and supports.

Focus on wellness, including recovery and resilience: people diagnosed with a mental illness are able to live, work, learn and participate fully in their communities.

Integrated service experiences: services for clients and families are "seamless" — so they do not have to negotiate with multiple agencies and funding sources to get their needs met.

For more information:

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New MHSA Programs (continued from page 1)

►*New Heights* will serve as a one-stop, warm and welcoming drop-in center specifically for transition-age youth in Lompoc. This outreach and engagement program will feature a multicultural, multi-disciplinary center of support, services and social connection for young adults.

The program is designed to help young adults in recovery find their place in the world. The center will help young adults by providing opportunities to develop meaningful relationships, vocational skills, stable housing, greater independence and leadership skills.

►*Partners in Hope:* Additional family partners and peer recovery staff will be hired to provide outreach, linkage to care and recovery-oriented activities at ADMHS adult service delivery sites in the Lompoc, Santa Maria, and Santa Barbara. The newly hired staff will work join existing service delivery teams under the coordination of the existing Client and Family Member Services Coordinator.

►*The Justice Alliance* will emphasize treatment, not punishment, for people with mental illness in the justice system. Treatment and services will be wellness- and recovery-oriented. The work of the Justice Alliance will be carried out by hiring liaisons who are licensed mental health professionals.

A focus will be placed on freedom from incarceration, substance abuse and the debilitating symptoms of mental illness through assessment and linkage to appropriate community treatment services.

►*Connections: Each One, Reach One:* Using peer staff, family partner staff and mental health staff, Connections: Each One Reach One will provide culturally competent outreach to children and families in natural community settings. Connections staff will be located on sites of local schools, primary care clinics and other community sites still to be determined. Staff will connect with families and children with emotional or behavioral problems and/or substance abuse. Support groups, advocacy, outreach and celebrations will draw community members to these services.

►*Bridge to Care* will provide psychiatric medication evaluation, prescriptions and medication monitoring to stabilize people in treatment with drug and alcohol programs who have co-occurring serious mental illnesses or trauma. Psychiatrists will be hired by alcohol and drug providers to serve as a medication "bridge" for people in the recovery programs awaiting assessment and intake at the mental health service delivery sites.

Two Key Terms

✓**ACT program** — Assertive Community Treatment programs use a team-based approach to the provision of treatment, rehabilitation, and support services. ACT models of treatment use multidisciplinary teams that serve as the point of responsibility for all care for a fixed group of clients.

✓**Wraparound services:** A family centered, community-oriented, strengths-based, individualized planning process to help people achieve important outcomes by meeting their unmet needs both within and outside of formal human services systems while they remain in their neighborhoods and homes, whenever possible.