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

MENTAL HEALTH SERVICES ACT

2022-2023

DRAFT ANNUAL MHSA PLAN UPDATE
FISCAL YEARS 2022-2023

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Executive Summary

In the Fiscal Year (FY) 2020-23 Mental Health Services Act (MHSA) Three Year Plan, the Department of Behavioral Wellness (Department) committed to focusing on the continued enhancement and evolution of the many MHSA programs and initiatives launched in the past few years, while also outlining new proposals within Santa Barbara County MHSA programming. The FY 2022-23 MHSA Plan Update highlights progress achieved in the past year and plans for achieving new goals.

Over the last year, our Department continued to be impacted by the COVID-19 pandemic in a variety of ways:

- We had staffing shortages throughout our clinics and contracted providers as well as having to close our Psychiatric Hospital Facility to admissions for several weeks

- Our mental health facilities were impacted by either outbreaks or staffing shortages as well and the Department had difficulty finding placement for individuals needing inpatient care with the continued need to provide services via telehealth

- Isla Vista had a growing homeless encampment with many people using illicit substances and living in close quarters during the COVID-19 pandemic which posed health and safety risks for individuals and the community

- In response to the COVID-19 pandemic, shelters were set up for homeless individuals who tested positive for COVID-19 and The Department provided support for this effort including transporting individuals, providing mental health services, and assisting with other needed tasks

- The Department also lead a county-wide survey to assess the mental health and substance use needs resulting from COVID-19 and is helping to develop a plan to implement strategies to address identified priority service areas.

Additionally, after 6 years of services with Behavioral Wellness, Alice Gleghorn left the Department in June of 2021 and we welcomed Toni Navarro as new director in December of 2021. In light of these recent changes, the Department is thankful for our stakeholders who have been supporting us to ensure we deliver these necessary services and providing input on solutions to any barriers, such as staffing shortages from outbreaks, or virtual support groups when people couldn't meet in person.

We have had a multitude of significant changes and accomplishments over the last year:

- We continued to roll out and provide additional technology in order to maintain all needed services throughout the pandemic

- Homeless Outreach staff, along with ADP Care Coordinators, worked in a larger County initiative to link homeless encampment residents into Pallet Houses/transitional housing and to services
- Initiated of the Quality Improvement component for Katie A. as a part of the Family First Prevention Services Act
- The Cultural Competency Manager and Patients' Rights Advocate completed a series of Spanish-language radio station outreach spots on 6/3/21, 6/29/21, and 10/27/21 to promote how to access Behavioral Wellness's mental health and substance use disorder treatment services
- Implemented the Family Urgent Response System
- Opened our first housing site funded utilizing No Place Like Home (NPLH) funding in Santa Maria, providing thirteen units of permanent supportive housing
- Launched the Mental Health Student Services Act Program, partnering with our local schools in North County
- Launched new Headspace Project in order to increase access to mental health care, support wellness, promote the early detection of mental illness and allow early intervention
- Launched the Jail Discharge Pilot Program with the goal of providing basic resources and linkage to services for individuals being released from the jail
- Expanded Co-Response with a 5th team partnering with Santa Maria Police Department
- The Department began meeting with our Santa Barbara Public Health Department and CenCal in a monthly meeting to focus on coordinating care and implementing CalAIM initiatives
- Merged our Access Line team with our Crisis teams in order to provide better coverage for both teams
- Developed and implemented a Crisis Triage Data Smartsheet in order to better collect crisis timeline data and improve system flows
- Implemented Programmatic Monitoring for our mental health providers in order to continue to build relationships and support staff in maintaining compliance
- Applied for a variety of new housing projects in the last three years and met our goal of creating fifty new permanent supportive housing units for our unhoused populations with a serious mental illness with newly awarded NPLH grant funds, Homekey funds and MHSA Housing funds.

The Department has continued to focus on developing fiscally sustainable programming as MHSA revenues have surged in FY 2020/21 and FY 21/22, after a significant shortfall due to COVID-19 in FY 2019/20. While the significant shortfall in revenues required the department to draw down all MHSA operating reserves in FY 2019/20, the revenue surge in FY 2020/21 allowed the department to replenish depleted reserves. The continued proliferation of revenue growth into FY 2021/22 has allowed the department to accommodate the significant COVID-19 and inflation related cost increases across the spectrum. The department continues to closely monitor the historically volatile MHSA revenue trends, and if it is clear that revenues are stabilizing at higher levels, program expansions may be possible.

Beginning in July 2019, the Department commenced a robust MHSA Planning process for the new FY 2020- 2023 Three-Year Plan. The Behavioral Wellness Commission supported creation of a planning group made of Commissioners, Department staff, Access Ambassadors, Peers, Family members, and Youth in the community. A UCSB student intern served as MHSA intern in development of the FY 2022-23 Plan Update, including assisting with communication ideas, drafting the plan and coordinating stakeholder meetings. Additionally, the Planning team held fourteen meetings throughout the County virtually and in person, and marketed the public events on a variety of social media platforms. The support from the community was overwhelmingly positive and feedback was received in various formats such as surveys, emails, public comments and written comment cards.

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

1. Implementation of expanded Youth-Focused Care and Youth-Driven Initiatives,

2. Increased utilization of Peer Services and integration of Peer Philosophies in the Department,

3. Expansion of Housing Developments and Support Services for those experiencing Homelessness; and

4. Integrating Whole Person Care practices throughout Outpatient programming.

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

About the Mental Health Services Act

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

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 which is provided in this document.

County plans are to contribute to achieving the following goals:

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

Santa Barbara County Department of Behavioral Wellness is applying MHSA funds in following proportion for FY 22-23:

1. Community Services and Supports (CSS); 80.4% in FY 22-23
2. Prevention and Early Intervention (PEI); 13.5% in FY 22-23
3. Workforce Education and Training (WET); .27% in FY 22-23

4. Capital Facilities (Buildings) and Technological Needs (CF/TN); 0.0% in FY 22-23

5. Innovation; 5.4% FY 22-23

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 19 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.

Although funding was originally allocated for Housing under MHSA, funding for housing development is now a separate funding stream. The "No Place Like Home" initiative established a new stream of funding for housing projects with implementation plans that have been completed throughout FY 2021-22 and upcoming years. Ongoing MHSA funding for Santa Barbara was diverted to the State, and Santa Barbara County was awarded $2.56 million in non-competitive No Place Like Home funding. Santa Barbara County has used the NPLH noncompetitive funding to fund housing units for people with a serious mental illness who are experiencing homelessness. These non-competitive funds have funded 13 units in Santa Maria at West Cox Cottages, 3 units in Santa Barbara at Hollister II in development, and are anticipated to fund 14 units in Lompoc at Cypress Studios.

Additionally, Santa Barbara County Housing Authority, in conjunction with the Department of Behavioral Wellness, has been awarded Competitive NPLH funding for a 16-unit housing project, Hollister Lofts, in Santa Barbara. Funding is available through competitive applications for housing at the State level through FY 2021-22, and the Department is awaiting determination on several competitive applications.

Community Program Planning Process for FY 2022-23 Plan Update

Community Program Planning 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. This 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 Planning Process provides a structured process that the County uses in partnership with stakeholders in determining how best to improve existing programs and to utilize funds that may become available for the MHSA components.

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

The first step to creating a 1-year Plan Update is to solicit feedback from stakeholders throughout the County of Santa Barbara on what to include in the initial draft of the plan. Feedback is gathered through Department Action Team meetings on specific programs/needs, at hosted regional community stakeholder forums, and in attendance of local community organization meetings with an awareness of mental health needs and engagement with regional key informants. In light of the COVID-19 Pandemic, feedback was obtained both through online, virtual meetings and in-person events. A Survey Monkey was distributed to meeting attendees and interested community members who were unable to attend virtually.

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, 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 an "issue" on the Department's website for anonymous input.

Once the 30-day period is complete, the plan is presented to the Behavioral Wellness Commission at a public hearing on the proposed plan. This allows for public comment, testimony, and presentation. To enhance the transparency of the plan and aid the accessibility needs of the public, the Behavioral Wellness Commission has encouraged allowing the meeting to take place in a public building that is "less intimidating" for the public to join. Due to COVID-19, a virtual hearing is anticipated.

After a hearing and review by the Behavioral Wellness Commission, the Commission then votes on presenting the plan for adoption by the County Board of Supervisors. 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.

Santa Barbara County's FY 2022-2023 MHSA Community Program Planning

More than 800 individual stakeholders were invited to participate in the county-wide stakeholder meetings. A total of at least 313 individuals participated in the fourteen stakeholder meetings, including representatives from the Santa Barbara County Sheriffs, National Alliance on Mental Illness (NAMI), Peer Resource Learning Centers, Santa Barbara County Housing Authority, Santa Barbara County Public Defenders, Justice Reform Advocates, Pacific Pride, Just Communities, What Is Love, Santa Barbara Education Office, Lompoc Education Office, Santa Maria Education Office, YouthWell, the Youth Action Board, Channel Islands YMCA, Project Heal of Santa Barbara, Casa Pacifica, Cottage Hospitals, Crestwood, Transitions Mental Health Association Santa Maria

and Lompoc, Good Samaritan Shelter, Community Health Center, Community Action Commission and many more.

Our unserved and underserved populations include: LatinX populations; People in Crisis; People who are homeless or at risk of homelessness; People with mental health and substance use disorders; Adults with severe mental illness who are involved with the justice system, out of custody, on probation, or at risk of being in custody; Children ages 6-15 who have a serious emotional disturbance; Youth ages 16-25 experiencing serious emotional conditions or severe mental illness; Trauma exposed individuals; Individuals experiencing onset of Serious Psychiatric Illness; Children and Youth at Risk for School Failure; Children and Youth at Risk of/or Experiencing Juvenile Justice Involvement; Underserved Cultural Populations; Children and Youth at risk for substance use disorders.

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; Mixteco communities; Homeless and At-Risk of Homeless Populations; LGBTQIA+ populations; TAY populations; College and High School students; staff and tenants at Supportive Housing sites; School counselors and Psychologists; Justice involved populations; and Older Populations. Additionally, this year, Project Heal coordinated a listening session with African-American and Religious community members.

We ensured participation of our unserved and underserved populations by offering all stakeholder events online, so that no transportation was required in order to participate, we ensured participation by offering stakeholder events in both Spanish and English, and offering live translation to anyone who requested it. Mostly, we tried to ensure participation of our unserved and underserved populations by meeting them where they were: we held events at public libraries, Peer resource Learning Centers, Consumer and Family Member Action Team Meetings, Justice Alliance Action Team meetings and events for religious community members, and other places where we anticipated unserved and underserved populations might attend.

A Survey Monkey was disseminated to all Department email distribution lists and at all meetings for community feedback for those unable to attend meetings or wishing to provide online feedback. Over sixty-three people completed the survey in Spanish or English. The survey was completed by stakeholders from March to May 2022. Survey results showed enthusiastic support for proposed projects for our four key proposals, and survey responders had many additional ideas for our key proposals and addressed areas needing improvement.

Robust conversations ensued at all public stakeholder events. Extensive notes were taken of all public comments and every public comment is recorded in Attachment 5 of this plan, but the comments fell into the areas and topics highlighted below:

Main Themes: Constituent Desires Regarding the MHSA Three Year Plan Update

Improved Drop-In Centers

- "Drop in Youth Center in North County is needed"
- "Drop in center that's closer (want and need in SB)

Increased Peer Support Services

- "Is there a Peer Certification training specifically for youth"
- "In our own system we should create a "program" that is a training of youth for peer services, thereby promoting future workforce
- "Peer support program for the peers that work"

Increased Housing Options and Resources

- "Have a county/state care BNB platform for engaging landlords/tenants" Potentially increase housing options
- "Have a housing navigator"
- All housing tenants need many services available because they are vulnerable

Increased Coordination with Local Non-Profits

- "Less data collection and more community involvement"
- "Have expectation that behavioral wellness staff are assigned to local groups (assign everyone to a non-profit) collaboration and cross pollination = better data"

Whole Person Care Need for Field Trips

- "Field trips (lotus land)"
- "Increase or gain access to MTD bus tokens"
- Money for/to tickets to the theatre (plays), provide discounts to provide entertainment

Improved Community Education

- "Community needs to be supportive"
- "Teachers and admin staff aren't aware of CSEC risk factors"
- "In Lompoc, LGBTQ+ population doesn't have much support"

Increased Training

- "Drop in Youth Center in North County is needed"
- "Need to provide calm and consistent care"
- "Contracts needed to mandate trainings for housing staff to get a better understanding of client care"

Improvements in Peer Documentation

- "We need more time for Documentation"
- "We need another in person Documentation training for peers, it has been two years at least"

Supports for Those Dropping Out of Systems

- "Transition youth fall out of the system"
- "Outreach for people who fall out of system (check in on them)"
- "More follow up on kids out of TAY"
- "housing for transitional youth so they aren't homeless"

Expanding ACT

- "Add peer employees to ACT/AOT teams"
- "Need increase in staff in ACT/AOT programs"
- "AOT and ACT programs are eligible for whole person care, want an increase in programs"

Improved Co-Response Teams

- "Outreach to CPS, social workers to provide outreach, co-response, grief counselors"
- "Security and safety @ depot and homekey"

Outreach to African American Communities

- "community groups that receive little outreach are the African American community and the Black Caribbean Community."
- "Project Heal is the only African American mental health services group"

Santa Barbara County's FY 2022-23 Community Planning Process Schedule

The 30-day review process was conducted from May 14th- June 13th in partnership with the local Behavioral Wellness Commission. Additionally, the draft Mental Health Services Act FY 2022-2023 One-Year Plan Update was emailed to nearly 800 stakeholders. It was available by postal mail on request, posted online and available in the Director's Report. The Behavioral Wellness Commission will be hosting a Public Hearing, and a Board of Supervisors' hearing is anticipated on June 28th. Finally, the Final plan update will be posted to the Department of Behavioral Wellness website and announced in the Director's Report.

For more information about the Community Planning Process or if you missed the opportunity to share input at any of 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
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Fiscal Years 2022-2023 MHSA Community Program Planning Process Schedule	
MHSA Planning Workgroup Meeting	
BWell Communications Team	03/05/2022
Client Family Member Action Team	03/17/2022
BWell Peer Employee Forum	03/17/2022
MHSA CPPP Sessions – Stakeholder Focus Groups Meetings	
BWell Peer Employee Forum- Peer Focused	3/17/2022
BWell Peer Employee Forum-Peer Focused	3/28/2022
General Community Listening Session on MHSA Planning and Updates- Lompoc Region	3/29/2022
BWell All Staff Meeting MHSA Planning and Updates	3/30/2022
General Community Listening Session on MHSA Planning and Updates- Santa Barbara Region	4/6/2022
Homeless Youth Action Board-TAY focused	4/12/2022
Housing Empowerment Action and Recovery Team (HEART)- Housing and Homeless Service Focus	4/13/2022
General Community Listening Session on MHSA Planning and Updates- Santa Maria Region	4/14/2022
Client and Family Member Action Team- Peer Focused	4/19/2022
Project Heal of Santa Barbara – Africa-American Community Outreach- Whole Person Care Focused	4/22/2022
Justice Alliance Action Team—Whole Person Care Focused	4/27/2022
Cultural Competence and Diversity Action Team—Whole Person Care Focused	5/13/2022
General Community Listening Session on MHSA Updates-in Spanish	4/4/2022
General Community Listening Session on MHSA Updates-in Spanish	4/28/2022
Survey Monkey – Virtual MHSA Feedback Survey	
Disseminated at all Stakeholder Sessions and to the Department distribution list.	March-May 2022

Performance Data Description

This year's plan update, where available, includes program performance reports using data collected by the Department for Fiscal Year 2020-21. As part of the plan update, the Department has committed to collect and report this data, and intends to continue to expand data collection in upcoming years.

There were a few expansions to the performance metrics last year, and the methods of calculation remain consistent this year:

(1) ***Incarceration***. Incarceration data was derived by using a jail in/out report shared by the Sheriff's Department; thus, this only captures stays in Santa Barbara County Jail. Clients were matched to the jail census data through name and date of birth; therefore, it is likely a slight underreport due to names variations across systems. This data does not include juvenile hall stays, so it will underreport criminal justice involvement for transitional-age youth programs where some of their clients are under 18. We hope to be able to provide juvenile hall outcome data in the future.

(2) ***Crisis Services***. Crisis Services data was derived in the same way as inpatient psychiatric hospital admissions data; by cross-referencing the crisis services billed during a clients' admission to a program.

(3) ***Child and Adolescent Needs and Strengths (CANS)***. In moving to the new CANS version, the Department also changed how it examined clinical change on the CANS. See below for a more detailed description.

The outcomes reported depend on the type of program. Psychiatric hospital admissions during program admission are reported for all programs. Higher intensity programs, such as Full-Service Partnership (FSP) programs, have more detailed outcomes. The CANS and MORS continue to be administered as a way to monitor clinical acuity, needs, and strengths. Below is a description of each of the measurement tools used to determine outcomes in the children and adult systems of care.

Child and Adolescent Needs and Strengths (CANS)

The CANS is a multi-purpose tool developed for children's service professionals to identify current needs and strengths of the child and family, to support treatment planning, facilitate quality improvement and to monitor outcomes. Implementation of the CANS began mid-year FY14/15. Due to a state mandated change, Santa Barbara County began using a new version of the CANS (CANS-50) in July 2018. This change in instrumentation made all existing CANS reports (such as compliance and outcomes) obsolete. In addition to changing versions, the CANS age range was also extended to age 20. This means that more transitional-age youth clients will receive a CANS.

The CANS-50 is organized into six primary domains (domains have changed slightly from the previous version of the CANS): *Life Functioning*, *Behavioral/Emotional Needs*, *Risk Behaviors*,

Cultural Factors, *Caregiver Resources and Needs*, and *Child Strengths*. The Department did not present *Caregiver Resources and Needs* for these analyses because caregivers that are entered in the Caregiver A section often change across timepoints and are not currently tracked to allow for a matched comparison.

This year, the Department also examined CANS clinical change differently than in previous years. The data provided shows the percent change in the average number of *actionable needs* within a particular domain. On each item in the CANS, clients are rated a 0-3 on a Likert scale, with higher ratings indicating more serious problems, and a rating of 2 or 3 on an item to be considered an *actionable need*: 0 = no evidence; 1 = history or suspicion, monitor; 2 = interferes with functioning, action needed; 3 = disabling, dangerous; immediate or intensive action needed. Therefore, improvement on the CANS is evidenced by a decrease in scores. Further, looking at the number of actionable needs over time is a meaningful measure of change.

As an example of this analytic method: At intake, the clients in a program had an average of three actionable needs per client in the 11-item *Life Functioning* domain. At six months, that matched group has an average of two actionable needs per client. This difference corresponds to a 33.3% decrease in their number of actionable needs in that domain. This method of analysis is more meaningful when there are more items in the domains and ratings are more normally distributed. Some scales, such as Cultural Factors, experience large percent differences between time points because the average number of actionable needs are so low that the average actionable needs have positive skew and a floor effect.

Milestones of Recovery Scale (MORS)

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

MHSA Department Action Teams

Department Action Teams are continuous community planning and feedback meetings focused on topics of interest for stakeholders. The meetings are public and held regularly for ongoing collaboration with partners in Santa Barbara. Each team is highlighted below reflecting on activities from the year and contact information for those interested in participating in MHSA activities by attending these meetings.

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

The Justice Involved Action Team Meeting seeks to connect a wide variety of leaders and stakeholders invested in cross-sector collaboration and ongoing systemic enhancements for services provided to criminal justice-involved juveniles and adults. Meetings occur monthly on the 4th Wednesday of each month from 1:30 P.M. – 3:30 P.M. (via Zoom)

Throughout 2021 and into 2022, the Justice Involved Action Team has been meeting monthly to discuss the Proposition 47 Jail Diversion grant, which offers law enforcement the option to divert intoxicated individuals from incarceration to a safe and therapeutic setting where they may be linked to substance abuse and/or mental health services, and the Assembly Bill 1810 Department of State Hospitals Felony Diversion grants, which promotes stabilization of individuals within their community rather than being sent to a state hospital. New COVID-19 laws regarding the early jail release process required a discussion about positive teamwork between Probation, Sheriff's Office, Public Defender, and Behavioral Wellness and changes that have been made in response to the COVID-19 health crisis. Partner updates regarding this health crisis were presented by the Behavioral Wellness Justice Services Manager, whose mission is to provide individualized intensive treatment for adults involved in the criminal justice system.

Meetings were well-attended and many included lively roundtables with a diverse group of stakeholders and forensic partners regarding the successes and challenges of Prop 47 and AB1810 and implemented programs such as: 1) Jail Based Competency Treatment program in the

jail; 2) Discharge Planning and placement upon jail release; 3) Addressing homelessness and providing mental health treatment; 4) Veterans justice services and linking veterans to services; 5) Prop 47 data; 6) Opioid Recovery Network; 7) Navigation Centers; 8) Thrive SBC application – a grant through the Santa Barbara Public Defender to make supportive programs and resources accessible to justice-impacted residents to improve the quality of their lives and reduce recidivism; 9) Access Line changes allowing for direct screenings by ADP providers; and 10) Cannabis school grants

This year ended with discussions regarding 2021 highlights and successes and visionary goals for 2022, including growing youth system of care services from physical health, mental health, substance use, and other community supports – linking systems together to support interventions; and to continue to reduce the jail population and identify individuals who can receive treatment in the community. For more information you can contact Celeste Andersen at candersen@sbcbwell.org

Housing, Empowerment, Action and Recovery Team (HEART) was chartered to address the present and expanding housing and treatment crisis facing clients and potential participants of the Department of Behavioral Wellness in Santa Barbara County. The team has produced policies, launched MHSA programs such as No Place Like Home, and produced capital recommendations for incorporation into the budget and programs of Behavioral Wellness. This action team is currently co-chaired by Deputy Chief of In-patient and housing Services Laura Zeitz and MHSA Manager Natalia Rossi.

Throughout the fiscal year, HEART members planned and discussed the multitude of Housing programs that utilize MHSA funding including, but not limited to, the No Place Like Home (NPLH) Initiative, the Homeless Emergency Assistance Program (HEAP), the Community Corrections Partnership (CCP) Housing (MHRC), and the Project Homekey State limited term program.

Funding was secured for NPLH, making it possible to open West Cox Cottages in Santa Maria to provide 13 units of housing for homeless and mentally ill individuals. HEART's current focus under NPLH includes applying for non-competitive funding for a 14-unit development in Lompoc, and HEART supported the Department's submission of three competitive NPLH funding applications for projects in South County.

HEART also supported the community's efforts to disperse 256 Emergency housing Vouchers. Over 95% of vouchers resulted in housing placement, and as a result of this success rate, both the County and City Housing Authorities were granted additional vouchers.

For more information contact Laura Zeitz at lzeitz@sbcbwell.org or Natalia Rossi at nrossi@sbcbwell.org; or, you can call the department at (805) 681-5220.

Cultural Competency and Diversity Action Team (CCDAT) seeks to increase access to services for under-served populations, particularly in high poverty areas; increase the capacity of staff to work effectively with diverse cultural and linguistic populations; revise or develop policies on cultural competency and disparities to ensure relevance and consistency; develop strategies to address issues of cultural competency regarding staff preparation and client engagement; and improve the accuracy of clinical assessments for diverse clients. This action team serves as a platform to host and guide all MHSA programs. This action team is currently chaired by Equity Services and Consumer Empowerment Manager Maria Arteaga.

Throughout the 2021-2022 fiscal year, the CCDAT continued to work on meeting central goals relating to language access services, outreach and engagement, cultural competence training, stigma reduction, and the Alcohol and Drug Program (ADP). All CCDAT members joined one of four subgroups focusing on these goals. The Language Access Services group assisted in the development of the translation policy and the language assistance survey for those who received interpretation services. The Outreach and Engagement group worked on constructing the current Outreach Plan by incorporating outreach strategies communities' members have used to engage unserved, underserved, and marginalized populations. Lastly, the ADP workgroup worked on incorporating the Cultural formulation Interview within their treatment plan. In addition to these subgroups, members also participated in providing feedback and recommendations to MHSA programming, Psychiatric Health Facility Process Improvement Project, Help@Hand Project, and the Office of Health Equity and Diversity. There were various presentations on providing culturally appropriate services specific to cultural and ethnic groups, including individuals with disabilities. Furthermore, other topics that were discussed during these meetings include stigma, examining institutional racism, barriers to accessing care, the technology divide that impacts access to care, accessibility technology: Compliance with American Disability Act, and the CalAIM Initiative.

Overall, during the fiscal year 2021-2022, we continued to work on strategies to reduce behavioral disparities and provide culturally and linguistically appropriate and high-quality care services to unserved, underserved, and marginalized communities.

For more information contact Maria Arteaga at: marteaga@sbcbwell.org or contact the department at (805) 681-5220

Crisis Action Team seeks to improve timeliness to psychiatrist visits for adults in crisis; increase the quality and availability of transportation to support the quality and availability of transportation to support voluntary admissions to out-of-county LPS facilities; improve the continuum of crisis response services for children; ensure consistent awareness of the rights of individuals in psychiatric crises; and increase public awareness of psychiatric crisis services needs in Santa Barbara County. Crisis Action Team hosts discussions on MHSA-funded programs that are built to serve people in crisis. This action team is currently chaired by Crisis Services Manager Careena Robb.

Crisis Action Team meets monthly to problem solve barriers to client access to crisis services and ensure timely access. The team focuses on collaboration between Behavioral Wellness staff, local hospitals, and community members. Crisis Action Team members work to stay abreast of current and changing regulations and discuss how innovations can be brought to Santa Barbara County. A recent meeting focused on changing regulations around community members with non-typical diagnosis accessing crisis services. For example: the mental health community is considering expanding LPS hospitalization as an option for clients that have primary Dementia or Alzheimer's and need inpatient level of care. Challenges to timely access to care have been closures of LPS facilities across the state, leading to difficulty placing clients needing hospitalization.

For more information contact Careena Robb at crobb@sbcbwell.org or you can contact the department at (805) 681-5220.

The Consumer and Family Member Action Team (CFMAT) is a community-wide group composed of consumers, family members, and peers. Its mission is to broaden information exchange within the Behavioral Wellness Department (BeWell), as well as sustain ongoing Consumer and Family Member input and achieve system change and the best quality of care for consumers. The aim is to strengthen the consumer and family involvement within Behavioral Wellness, ensure stakeholder participation, destigmatize mental illness, and inspire hope that recovery is possible. This action team is currently chaired by Equity services and Consumer Empowerment Manager Maria Arteaga.

This action team serves as an advisory committee to the MHSA Community Program Planning Process and the Office of Health Equity and Diversity to ensure that MHSA programs are community and client-driven. Monthly meetings are held where members participate in sharing information regarding community resources and upcoming community events. In addition, they provide input on MHSA programming and quality improvement, together with members participating in various departmental and community initiatives.

For information on attending contact Maria Arteaga by email at: marteaga@sbcbwell.org or call the department at (805) 681-5220.

Children System of Care (CSOC) provides information to schools, agencies, and the community on trauma-informed services available in the community with hosted discussions on MHSA-funded initiatives about prevention and early intervention. This action team is currently chaired by Deputy Chief of Clinical Services John Winckler.

During the year, meeting members continued to meet in sub-groups to discuss Access to Care & Engagement, Safety & Resilience, Criteria for Services, and Youth of Color. Each sub-group identified numerous gaps, concerns and areas of improvement that they worked to create solutions for. In addition, the meeting had several presenters including Lindsay Walter who presented on the MHSA planning sessions, Josh Woody who presented on SUD services for TAY

age youth, and Jordan Killebrew from the Santa Barbara Foundation who presented on the work he is doing to address stigma, racism and trauma in the community. Most importantly, this year saw the passing of Tony Hollenback, Lompoc Regional Manager and the leader of the CSOC meeting for the past several years. Tony brought a wealth of enthusiasm, compassion and great ideas to not only CSOC, but the department as a whole as well as the community. Tony will be very much missed by all.

For information on attending contact Deputy Chief of Clinical Services John Winckler at jwinckler@ sbcbwell.org or call the department at: (805) 681-5220.

Change Agent sought to improve the quality of care through continuous quality of care activities. This Action Team was chaired by Assistant Director Pamela Fisher and will no longer continue to meet in the 2022-23 Fiscal Year.

The Change Agent meetings this year saw quite a few new PDSA (Plan, Do, Study, Act) projects in our clinics and programs. Several clinics worked on lobby beautification projects – pre-improvement surveys were given to clients asking them to rate their impression of the lobbies in relation to cleanliness, welcoming and inviting environment, level of comfort, etc. Fresh paint, pictures/paintings, new furniture, rugs, etc. were used to help improve lobbies. Clients were very appreciative of the changes. Other PDSA's included efforts to increase Zoom appointment attendance in one of our Adult outpatient programs, providing group debriefing sessions in our Homeless Services program to reduce staff burnout related to on the job exposure to traumatic events, doing ASAM screenings on all youth entering Los Prietos Boys Camp or the Juvenile Justice Center to ensure all youth with potential substance use disorder issues are being referred for treatment, and increasing clients use of community resources to support their recovery as the pandemic lifted and previously unavailable resources started to become available again.

Santa Barbara County Demographics and Target Populations

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

(Retrieved 4-18-2022 from Wikipedia)

Quick Facts Santa Barbara County the United States Census

Population	
Population Estimates, July 1 2021, (V2021)	446,475
Population estimates base, April 1, 2020, (V2021)	448,229
Population, percent change - April 1, 2020 (estimates base) to July 1, 2021, (V2021)	-0.4%
Population, Census, April 1, 2020	448,229
Population, Census, April 1, 2010	423,895
Age and Sex	
Persons under 5 years, percent	6.1%
Persons under 18 years, percent	22.1%
Persons 65 years and over, percent	15.7%
Female persons, percent	50.0%
Race and Hispanic Origin	
White alone, percent	85.4%
Black or African American alone, percent	2.4%

American Indian and Alaska Native alone, percent	2.1%
Asian alone, percent	6.0%
Native Hawaiian and Other Pacific Islander alone, percent	0.3%
Two or More Races, percent	3.8%
Hispanic or Latino, percent	46.0%
White alone, not Hispanic or Latino, percent	43.8%
Population Characteristics	
Veterans, 2016-2020	19,824
Foreign born persons, percent, 2016-2020	22.7%
Housing	
Housing units, July 1, 2019, (V2019)	159,246
Owner-occupied housing unit rate, 2016-2020	52.3%
Median value of owner-occupied housing units, 2016-2020	$610,300
Median selected monthly owner costs -with a mortgage, 2016-2020	$2,447
Median selected monthly owner costs -without a mortgage, 2016-2020	$662
Median gross rent, 2016-2020	$1,697
Building permits, 2020	1,027
Families & Living Arrangements	
Households, 2016-2020	148,309
Persons per household, 2016-2020	2.86
Living in same house 1 year ago, percent of persons age 1 year+, 2016-2020	81.6%
Language other than English spoken at home, percent of persons age 5 years+, 2016-2020	40.1%
Computer and Internet Use	
Households with a computer, percent, 2016-2020	94.2%
Households with a broadband Internet subscription, percent, 2016-2020	89.7%

Education	
High school graduate or higher, percent of persons age 25 years+, 2016-2020	81.8%
Bachelor's degree or higher, percent of persons age 25 years+, 2016-2020	35.0%
Health	
With a disability, under age 65 years, percent, 2016-2020	6.5%
Persons without health insurance, under age 65 years, percent	12.0%
Economy	
In civilian labor force, total, percent of population age 16 years+, 2016-2020	63.1%
In civilian labor force, female, percent of population age 16 years+, 2016-2020	58.1%
Total accommodation and food services sales, 2012 ($1,000)	1,428,929
Total health care and social assistance receipts/revenue, 2012 ($1,000)	2,637,280
Total manufacturers' shipments, 2012 ($1,000)	4,157,565
Total retail sales, 2012 ($1,000)	4,853,808
Total retail sales per capita, 2012	$11,255
Transportation	
Mean travel time to work (minutes), workers age 16 years+, 2016-2020	20.6
Income & Poverty	
Median household income (in 2020 dollars), 2016-2020	$78,925
Per capita income in past 12 months (in 2020 dollars), 2016-2020	$38,141
Persons in poverty, percent	10.5%

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

Community Planning Process and Prioritized Targeted Population Programming:

The planning process resulted in stakeholders identifying all six populations as priorities:

1. Trauma Exposed Individuals
2. Individuals Experiencing Onset of Serious Psychiatric Illness
3. Children and Youth in Stressed Families
4. Children and Youth at Risk for School Failure
5. Children and Youth at Risk of/or Experiencing Juvenile Justice Involvement
6. Underserved Cultural Populations
7. Children and Youth at risk for substance use disorders

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

1) Those community members in geographically isolated areas (such as Carpinteria, New Cuyama, Guadalupe, Santa Ynez), and

2) Those experiencing homelessness as the new Ten-Year County Homeless Plan prepared for No Place Like Home Initiative indicates increases in this population county-wide and a large contingent of these individuals have underlying behavioral health issues.

Additionally, Santa Barbara County completes the Network Adequacy Certification Tool (NACT) annually, as directed by Information Notice 18-011 and Information Notice 20-012. The NACT is used to determine if the County has enough outpatient Specialty Mental Health Services (SMHS) providers to serve the anticipated need of the County. This information is provided to the Department of Health Care Services (DHCS) which reviews and approves the NACT 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,
- Adult (21+) Psychiatry 1 provider to 524 clients and Children (0-20),
- Children (0-20) SMHS 1 provider to 43 clients, and
- Psychiatry 1 provider to 323 clients.

Santa Barbara County has collected data from both our Behavioral Wellness Programs as well as our Contracted Providers to determine our anticipated need as well as our current staffing. The NACT's submitted for January 2021 and April 2021 show that Santa Barbara has successfully met the ratios provided by DHCS and has an adequate network of outpatient SMHS providers to meet the anticipated need for services of our county. Overall, the County strives to ensure a complete network of care for all outpatient services, which are primarily funded in MHSA. This plan will outline each program and those targeted age group populations to ensure our network remains adequate and there is focus toward the unserved and underserved in our Community.

Program Updates

Community Services and Supports and General System Development

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

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

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

Crisis Services

Provider:	**Behavioral Wellness**
Estimated Funding FY 2022/23:	
Estimated Total Mental Health Expenditures	$7,165,779
Estimated CSS Funding	$2,337,603
Estimated Medi-Cal FFP	$2,699,676
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$2,128,500
Average Cost Per Consumer	$2,298.93
Estimated Total of Consumers Served	3117
Target Population Demographics Served	Children, TAY, Adults, Older Adults

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

1. Respond to all Access urgent calls. Crisis Services staff can respond in the field to urgent calls coming into the Access line, or the callers can be directed to come into the Crisis Services offices for services in the three regions.
2. Respond to law enforcement requests for outreach. Crisis Services staff build strong relationships with law enforcement and assist them in outreach to individuals in the community who appear to be struggling with severe mental health issues and are frequently calling 911 or being contacted by law enforcement in the field.
3. Respond to requests for services when an individual is evaluated for a 5150 but a hold is not written. Crisis Services staff work closely with the client to provide urgent follow-up services for these individuals with severe mental health issues who are not meeting criteria for a hold.
4. Assist current outpatient program clients when they are rapidly decompensating and are at risk of hospitalization. Crisis Services staff step in to provide very brief, intensive treatment, medication support and case management for core outpatient clinic clients when needed to prevent hospitalization.
5. Act as an access point for walk-in clients new to Behavioral Wellness or returning clients who are not currently open and can have more difficulty with engagement into services. Crisis Services staff are available to provide an initial assessment to determine if clients meet medical necessity for SPMI services and determine appropriate level of care in the system. The Crisis services staff outreach the clients and the Clients needing intensive stabilization will be served by Crisis Services staff for a short period of time (up to 30 days) before being transferred to an appropriate level of care.
6. Provide hospital discharge services to individuals being discharged from the Psychiatric Health Facility (PHF), Crisis Stabilization Unit (CSU), Telecare & Crestwood Behavioral Health CRT (Crisis Residential Facility), or out-of-county LPS facilities, to individuals who are new to Behavioral Wellness or to returning clients who are not currently linked to services.

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

Program Challenges and Solutions

The crisis and Access teams were merged to provide better communication and collaboration between the staff. This increases the ease and timeliness for clients to access routine and crisis services. Santa Barbara County opened a new jail in Santa Maria and much of the population of inmates with mental health needs has shifted from Santa Barbara to Santa Maria. This requires North County Crisis teams to support those inmates for 5150 valuation or to support them upon release. To aid in this transition, crisis staff received a tour of the facility and crisis leadership has had regular meetings with mental health leadership in the jail system. Co-Response teams continue to respond to mental health crises in the community. There are currently five teams: two clinicians paired with a Sheriff Deputy and one clinician paired with Santa Barbara Police Department in South county and one clinician paired with a Sheriff Deputy and one Mental Health Case Worker paired with a Santa Maria Police Officer in North County.

Crisis Services Data

Program Performance (FY 20-21)

Crisis Services

Unique Clients Served					
	Adult Crisis Services*			**Youth Crisis Services (SAFTY)^**	
	North	**South**	**West**	**North**	**South**
Age Group					
0-15	32	34	19	325	176
16-25	148	200	90	242	119
26-59	486	648	299	0	0
60+	105	145	49	0	0
Missing DOB	0	0	0	0	0
Total	**771**	**1,027**	**457**	**567**	**295**
Gender					
Female	364	444	227	348	181
Male	396	580	229	218	114
Missing/Other	11	3	1	1	0
Race					
American Indian or Alaska Native	8	10	5	6	0
Asian	17	16	9	7	5
Black or African American	19	50	20	10	7
Mixed Race	20	155	17	10	9
Native Hawaiian or Pacific Islander	0	2	0	3	0
White	601	702	369	376	185
Other	18	6	10	11	4
Unknown/Not Reported	88	86	27	144	85

Hispanic or Latino					
Hispanic or Latino	331	263	160	261	125
Not Hispanic or Latino	331	605	246	101	55
Unknown/Not Reported	109	159	51	205	115

**Mobile Crisis and Crisis Triage still provided separately in Lompoc have been combined under West County Crisis Services for easier comparison and counting of unique clients.*

^SAFTY is funded and described in detail in PEI programs but is included here to display all outpatient crisis services together.

Client Outcomes (Adult Crisis Services*)

Higher Levels of Care	% during program admission in FY 20-21		
	North	South	West
Incarcerations	2%	16%	2%
Crisis Services	N/A	N/A	N/A
Psychiatric Inpatient Care	10%	12%	13%

**Note. Youth outcomes (SAFTY) described under PEI section.*

A goal of the crisis service program is to stabilize clients in the community with safety planning and other supportive services in order to avoid admitting clients to a psychiatric hospital. The table above shows the demographics of the unique clients who encountered crisis services.

The client outcomes table displays the percent of unique clients who experienced a higher level of care during an admission to the program (adult crisis services) in the 20-21 fiscal year. Youth outcomes for the SAFTY program are described in the PEI section. The source of incarceration data is the Santa Barbara Jail and therefore only includes adults; clients were matched from the county electronic health record to the FY 20-21 jail roster. The source of psychiatric inpatient data is the electronic health record. Two percent of clients in North County, 16% of clients in South County, and 2% of clients in West County experienced a jail stay during their admission. Crisis Services as an outcome does not apply for this program because all services provided are crisis services. Ten percent of clients in North County, 12% of clients in South County, and 13% of clients in West County experienced hospitalization during their program admission. Clients' admissions to crisis services may not be closed out immediately after the crisis team intervention, so if a client is subsequently hospitalized following the encounter with crisis services then the hospitalization is counted as within the admission.

Partners in Hope

Provider:	Mental Wellness Center, Transitions Mental Health Association and Behavioral Wellness
Estimated Funding FY 2021/22:	
Estimated Total Mental Health Expenditures	$1,018,600
Estimated CSS Funding	$977,700
Estimated Medi-Cal FFP	$40,900
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	
Average Cost Per Consumer/Families	$581
Estimated Total of Consumers/Families Served	1753
Target Population Demographics Served	Children, TAY, Adults, Older Adults

Peer Support Services at the Recovery Learning Centers

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

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

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

Santa Barbara Services: Mental Wellness Center

In Santa Barbara, the Mental Wellness Center, a community-based nonprofit organization, works with consumers to improve their mental wellbeing. By utilizing their peer staff, the Mental Wellness Center provides for basic needs, resources, family support and advocacy, mental health education and support groups to consumers, families and community.
Staffing at the Mental Wellness Center's Recovery Learning Center (RLC) consists of all peer providers that reflect the ethnic distribution of the RLC membership. This includes the program staff, a kitchen crew that provides 60-90 lunches daily, and computer laboratory, music room and art room facilitators. Over the last two years during the COVID pandemic restrictions, the RLC adapted and continued services by utilizing our 5000 square foot outdoor patio to offer daily support, updated community resource information and a "lunch to go" program. Computer and phone stations were set up outdoors for client use and Partner community agencies were invited to access the outdoor patio space in a safe, socially distanced manner to offer resources to clients who came by the RLC for food and resources. Doctors Without Walls, free Government issued cellular phone programs, and homeless outreach teams have utilized this space and coordination of service. The RLC staff collaborated on a local Vaccination Equity Project to provide information and access to increase vaccinations to our clients. Vaccination Clinics are being offered at the RLC.

The Santa Barbara RLC has developed multiple supported employment positions, especially around a Clothing Care Closet that has many benefits, including retail and stocking positions for RLC members to learn and practice employment skills that are in high demand in the community. The Closet provides gently used clothing and hygiene items, which are particularly useful for consumers who are homeless.

Besides creating greater employment access both through in-house peer staff positions and through supported training opportunities, the Santa Barbara RLC also promotes physical and mental health learning. Using groups and one-to-one dyads, Peer Specialists and RLC member volunteers meet with club members to recognize and manage symptoms, learn self-care, and engage in recreational and social activities that are beneficial to their health. The Santa Barbara RLC schedules more than ten group activities per week. During the last two years COVID pandemic restrictions, all support groups and education program activities were adapted to Zoom. We are now providing most groups and activities both in person and virtually. Participation and utilization of services increased and new groups were formed to address the needs, including monolingual Spanish support groups for parents of teens who live with a mental health diagnosis and a Spanish language men's support group.

In Santa Barbara, the Family Advocate connects with both Spanish and English-speaking audiences. The Family Advocate meets with consumers and family members in small groups or individually to address questions about resources and systems navigation on behalf of family members who often have a serious mental illness. The Family Advocate presents current and accurate information that is hard to obtain in the community, and also demonstrates and

encourages coping skills for family members. The Family Advocate models effective strategies that he or she has learned through lived experience as a family member.

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

Program Challenges and Solutions

The cost of services, for both staffing and program expenses have greatly increased. The Mental Wellness Center has always supplemented the MHSA funded portion of the RLC with grants and private donations. In 2021 the MWC was awarded a Peer Workforce Initiative grant to increase staffing and services.

In February 2022 the club re-opened for indoor use and in-person services. The challenges include monitoring for vaccine status as well as any symptoms related to COVID for members and staff on a daily basis. Stringent procedures have been adapted to effectively monitor both staff and members and guidelines are strictly adhered to. Recovery from the COVID pandemic is going to be multi-faceted and monitored over the coming months, so that any emerging needs may be responded to.

This program population has changed from thirty percent of homeless clients to fifty percent; This increase has created challenges in adapting services to the increased number of people experiencing homelessness being served. During the last two years programming has developed to meet the needs of the homeless population that include connection to outreach workers and community services directly providing resources such as doctors without walls, visiting nurses, showers of blessings, food insecurity and hygiene education and supplies. Transportation vouchers are provided to the homeless in our community to attend medical appointments. Services have expanded with the reopening to strengthen and increase the resources for the homeless in our community.

All peer staff recently attend an eighty-hour peer certification training that will be invaluable in helping and supporting staff in the challenging work ahead as the Mental Wellness Center looks at the needs of all members and adapts programming from the peer perspective.

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

Transitions Mental Health Association (TMHA) is a non-profit organization serving San Luis Obispo and North Santa Barbara Counties. The agency is committed to eliminating stigma, promoting recovery and wellness for people who live with mental illness, and fighting against all forms of discrimination. TMHA operates over 40 programs with a wide variety of services to assist individuals and family members in their recovery journey. These services include housing, family support, work, community, and clinical services. In addition, TMHA hosts events and educational events throughout the year such as Journey of Hope and the Alliance for Mental Wellness Mental Health Forums.

The Santa Maria Recovery Learning Community and Helping Hands Recovery Learning Community in Lompoc are 100% client-designed and client-led recovery centers. All leadership, operational decisions, program design, and advocacy efforts are made by the membership, all of whom are individuals with lived experience in mental health. The Recovery Learning Communities (RLCs) provide a safe, welcoming, and supportive meeting place where people with mental illness engage in educational, vocational and recreational activities, support groups, meaningful interactions and, above all, receive the support of their peers. The program promotes independence and revitalization through self-governed activities as members work toward recovery. The RLCs also provide dedicated outreach to the local Latino community through bilingual Mental Health Advocates. In FY 2021-2022, the two RLCS provided services to 489 unique individuals and 5,332 duplicated clients YTD.

Program Challenges and Solutions

TMHA hired its first Family Advocate to work with family members in North Santa Barbara County in 1997, and that program expanded into Partners in Hope in 2007. Our Family Support Specialists work directly with families to help them navigate the mental health and judicial systems by offering resources and referrals. In addition, they facilitate family support groups, trainings, classes and educational events. These services are offered in both English and Spanish. In FY 2021-2022, Partners in Hope served 676 unduplicated family members and had 2956 duplicated contacts YTD. TMHA's Family Support Specialists are bilingual, bicultural and have longstanding ties and involvement in their respective communities.

The impact of COVID continued during Fiscal Year 2021-2022. This impact included a significant need for mental health services from our community and flexibility with service delivery from our program staff. Safety protocols such as wearing masks, COVID testing, temperature checks and social distancing remained in place. However, our services changed as we opened our doors for more in-person services. We continued to utilize a hybrid model of service delivery as we have learned that some of our members and families preferred or required remote access in order to participate. During times of COVID surges, it became necessary to discontinue in-person support temporarily for staff and community member safety. All services provided remain in place but with the added flexibility of accessing services both in-person and remotely.

The biggest challenges faced this fiscal year is adequate office space for staff and program services. The RLC was pleased to expand their team with additional staffing. They also welcomed the addition of our Family Services (formerly known as Partners in Hope) on site. However, there is not adequate office space to house all the staff comfortably and safely while providing the normal programming. Our teams strategized how to offer family services programming independent of RLC services. However, the overwhelming feedback from our families in both Santa Maria and Lompoc is that they do not want to engage in programming at the centers where their loved ones receive services. They have opted to meet outside in a public location or only receive services remotely. This creates a significant strain on both our staff and our families due to lack of adequate and private meeting space for all the services we are able to provide. These services include training, classes, support groups and other educational events. Another challenge was integrating technology and Help@Hand programming. Our RLC staff continue to offer computer lab support, teach computer classes, tech clinics, and digital literacy independently without the support or attendance of Help@Hand staff. To strengthen the technology opportunities and integration of the use of Wellness Applications more guidance is needed from the Help@Hand Project.

Partners in Hope Data

Program Performance (FY 20-21)

Partners in Hope

	Activities			
	North & West^		South	
	RLC	Family Advocate	RLC	Family Advocate
Unduplicated clients	421	805	273	254
Client visits	6,872	3,655	13,980	0
Support Groups	*	*	*	39
Support Group Meetings	*	205	*	296
Classes	53	*	1	*
Outings, Educational Events	48	565	*	11
Unique clients provided services in Spanish	*	454	*	5
Underserved population	421	805	273	393
Linked to additional services	167	713	290	254

^ = Data for North and West RLCs were combined this year; Family Advocate is shared between sites.

** = not reported, not applicable, or not recorded.*

North and West County data is provided combined this year. In North and West County, the RLC served 421 clients from underserved populations who had almost 8,000 visits. RLCs provided 53 computer classes and 48 outings and educational events. They linked nearly 167 clients with additional services. The Family Advocate served both North and West County and served over 805 unique clients across 3,655 visits, led 205 support groups, and attended over 500 outings and educational events. The Family Advocate linked 713 clients to additional services and provided over half of client services in Spanish.

In South County, the RLC served 273 clients from underserved populations who had almost 14,000 visits. They made nearly three hundred linkages to additional services. The Family Advocate in South County served 254 unique clients from underserved populations, led nearly 300 support group meetings and 39 support groups, attended 11 outings and educational events, and linked 254 clients to additional services. Five clients were provided services in Spanish.

Homeless Outreach Services – Behavioral Wellness, Good Samaritan

Provider:	**Behavioral Wellness, Good Samaritan, PATH, Housing Authorities of the City and County, Salvation Army**
Estimated Funding FY 2022/23:	
Estimated Total Mental Health Expenditures	$3,562,855
Estimated CSS Funding	$368,555
Estimated Medi-Cal FFP	$624,800
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$2,569,500
Average Cost Per Consumer	$12,371(costs include grants and specialized projects)
Estimated Total of Consumers Served	288
Target Population Demographics Served	TAY, Adults, Older Adults

The Department of Behavioral Wellness Homeless Services program provides outreach and engagement to those experiencing homelessness, or at imminent risk of homelessness, and also experiencing serious, persistent mental illness and/or chronic substance abuse in Santa Barbara County. 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. These services aim to enhance the mental health of the general population, prevent the onset of mental health problems in individuals and communities, and assist those persons experiencing distress, who are not reached by traditional mental health treatment services, to obtain a more adaptive level of functioning.

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

Meeting the needs of people experiencing both homelessness and behavioral health challenges is an important priority for Santa Barbara County Department of Behavioral Wellness. Outreach teams have adopted strategies that meet the specific needs of homeless populations in each region of the county (North, West, and South). Historically, Homeless Outreach Services have been centralized in South Santa Barbara County and there were no stand-alone Behavioral Wellness Homeless Outreach Services in Lompoc or Santa Maria. In FY 2021-22, Behavioral Wellness augmented this initiative by securing additional funding to expand Homeless Outreach Services into both the North, West and South regions of the County. This was accomplished through the utilization of one-time Homeless Emergency Solution Grant (ESG) funds. The funding has allowed for the hiring of a full time Behavioral Wellness Caseworker and a psychiatric nurse who works 36 hours a week in the south county region of Santa Barbara County. The addition of both the Behavioral Wellness Caseworker and Psychiatric Nurse has allowed our clients to have access to needed community resources. It has also allowed us to 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 ESG grant allows for the hiring of an Extra Help Behavioral Wellness Caseworker in the Lompoc region. The position was filled and later became vacant after the staff departed. The recruitment to fill this position is ongoing, given the pandemic and staffing shortages, recruitment has been challenging. Homeless Services staff countywide receive ongoing training in trauma-informed care, motivational interviewing, harm reduction, client engagement, strategies for connecting clients to mainstream resources, and interventions which aim to facilitate housing stability and retention. The expansion of these services has successfully enhanced the mental health system's ability to respond to long-term needs of persons with severe mental illness, who are homeless, or at risk of homelessness, and who are not receiving adequate mental health services.

Critical to the Homeless Services ability to successfully outreach and engage some of our community's most vulnerable is the teams' ability to readily access available, low-threshold shelter beds in various regions of the county. The Department of Behavioral Wellness provides for approximately 37 shelter beds throughout the county. There are 22 contracted mental health beds at the PATH shelter; Homeless Services works closely with PATH program staff to support residents with engagement in the Coordinated Entry System, while helping residents to

become “document-ready” for housing. Clients are also provided with frequent on-site supportive services provided by Behavioral Wellness staff to support their continued engagement in behavioral health services and connection to mainstream resources. Homeless Services uses a similar model to provide a total of five mental health beds at a Salvation Army shelter in Santa Barbara. Santa Barbara County Department of Behavioral Wellness provides funding for additional five contracted beds at the Good Samaritan Shelter in Santa Maria, and two contracted shelter beds at the Bridge House Shelter in Lompoc.

The outreach vans that were delivered to the department in May 2021 have provided a significant benefit to outreach efforts of Homeless Services staff. The vans provide privacy and a safe place for individuals to access both physical health care and mental health services. The vans provide convenience in storing outreach items needed to engage individuals experiencing homelessness. The vans have been well received by the communities in both Santa Barbara and Santa Maria region where the vans are located and operated by Homeless Services staff.

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

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

The Homeless Services program has experienced successful outcomes in FY 2021-2022. A total of 13 Behavioral Wellness clients successfully moved into the West Cox Cottages located in Santa Maria. Homeless Services staff located in Santa Maria kept clients engaged as the clients experienced numerous delays and postponements of the scheduled move in date. The clients living at West Cox Cottages have support of a part time caseworker employed by Good Samaritan Shelter.

In FY 2021-2022, Santa Barbara County was provided an opportunity to receive Emergency Housing Vouchers (EHV) that would allow for our clients to access housing opportunities offered by landlords who were willing to accept the Emergency Housing Vouchers. The Homeless Services team, in collaboration with our community partners with the City of Santa Barbara Housing Authority, Santa Barbara County Housing Community Development, County of Santa Barbara Housing Authority, City Net and Good Samaritan, successfully housed a total of twelve clients in Santa Barbara County.

The Santa Barbara County Housing Authority continues to provide updates on housing opportunities for our clients at our identified No Place Like Home housing programs at the following locations: Depot Street and Rancho Hermosa in Santa Maria, Home Base on G Street and Homekey studios in Lompoc, and Pescadero Lofts in Isla Vista.

Program Challenges and Solutions

Santa Barbara County continues to have a large gap between its supply of affordable housing and the demand for affordable housing. To increase residents' access to safe, affordable housing, the County will use No Place Like Home (NPLH) funding to build and rehabilitate affordable housing units. The Department of Behavioral Wellness has been working closely with the Housing Authority of the County of Santa Barbara to link children/family, transitional age youth (TAY), and adults/older adults who are homeless, or at risk of homelessness, and have a serious mental health condition to the Residences at Depot Street in Santa Maria. To ensure that MHSA eligible tenants have access to ongoing mental health support, Homeless Services continues to provide 20 hours per week of onsite support. The clinician assigned to this location will have expertise in interventions aimed at promoting housing stability and will act as a liaison to the larger mental health system of care and the County of Santa Barbara Housing authority. The Residences at Depot Street have experienced challenges during COVID-19 including lack of a sense of community with other residents due to social distancing and no access to the community room to celebrate holidays and other activities. A few residents, though they were chosen from the Coordinated Entry System, exhibited behaviors that indicate that they were not ready for independent living and require a great deal of support to maintain their apartment.

The pandemic has contributed to significant difficulty in the recruitment of qualified applicants and individuals willing to work part time in Homeless Services. The Extra Help Behavioral Wellness Caseworker position in Lompoc has remained vacant for most of FY 2021-2022 which has resulted in diminished capacity to link clients to needed community resources and services.

The Behavioral Wellness Practitioner position in Lompoc became vacant in early March 2022 due to a staff's departure making the Lompoc region a difficult region to recruit and retain staff. The Santa Barbara County region experienced the departure of an Extra Help Caseworker in Spring 2022. The position remains vacant and has been difficult to recruit and interview for the position. A factor contributing to these challenges are other homeless outreach programs who are offering candidates full time employment with benefits. Also, because of COVID exposure and infections among staff, isolation and quarantine times have resulted in staff not being available to meet with clients in-person and to provide outreach and support.

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

Homeless Outreach Services – Behavioral Wellness, Good Samaritan, United Way Data

Program Performance (FY 20-21)

Homeless Services

	Unique Clients Served		
	North	**South**	**West**
Age Group			
0-15	0	0	0
16-25	9	6	4
26-59	75	92	53
60+	5	37	7
Missing DOB	0	0	0
Total	**89**	**135**	**64**
Gender			
Female	64	47	47
Male	25	88	17
Unknown	0	0	0
Ethnicity			
American Indian or Alaska Native	2	5	3
Asian	0	3	0
Black or African American	3	15	8
Mixed Race	2	28	1
Native Hawaiian or Pacific Islander	0	0	0
White	72	83	50

Other	4	1	2
Unknown/Not Reported	6	0	0
Hispanic or Latino			
Hispanic or Latino	45	27	32
Not Hispanic or Latino	41	106	32
Unknown/Not Reported	3	2	0

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

Homeless Services All Contacts

Unique Clients Served				
	PATH South County Street Outreach	**PATH South County Supportive Services**	**HEAP Street Outreach & Supportive Services (All Regions)**	
0-17	0	0	0-17	0
18-23	0	2	18-24	7
24-30	2	4	25-34	19
31-40	5	8	35-44	27
41-50	5	12	45-54	32
51-61	8	8	55-61	12
62+	7	1	62+	11
Missing DOB	0	0	1	
Total contacted by PATH	**74**	**58**	**109 (total served)**	
Total open to PATH	**27**	**35**	**N/A**	
Total new enrollments to PATH	**22**	**27**	**N/A**	
Total entered mental health services	**10**	**9**	**N/A**	
Gender				
Female	10	8	51	
Male	17	27	53	
No Single Gender	0	0	1	
Questioning	0	0	0	
Transgender	0	0	3	
Not collected	0	0	1	
Total	**27**	**35**	**109**	
Race (Multiracial individuals counted in all categories)				
White	24	28	77	
Black, African American, or African	1	6	14	
Asian or Asian American	0	1	1	
Native Hawaiian or Other Pacific Islander	0	0	0	

American Indian, Alaska Native, or Indigenous	2	4	4
Multiple Races	N/A	N/A	10
Other/Not Reported	1	1	3
Total	**28**	**40**	**109**
Ethnicity			
Hispanic/Latino	6	14	36
Non-Hispanic/Latino	21	21	72
Not collected	0	0	1
Total	**27**	**35**	**109**
Veteran			
Yes	1	0	6
No	25	33	101
Not collected or N/A	1	0	2
Total	**27**	**35**	**109**
Co-Occurring Disorder			
Co-occurring substance use disorder	21	22	N/A
No co-occurring substance use disorder	6	12	N/A
Mental Health problem	N/A	N/A	90
Alcohol and/or Drug Use Disorder	N/A	N/A	52
Unknown	0	1	0
Total	**27**	**35**	**N/A**

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

Client Outcomes

Milestones of Recovery Scale (MORS) Age: 18+		
	Initial to 6 months (n = 171)	**6 to 12 months (n = 128)**
Showed improvement^	30%	34%
Remained stable^	43%	47%
Living Situation (combined across programs)	**Entry (n = 170)**	**Exit* (n = 107)**
Place not meant for habitation	91	11
Emergency Shelter	37	9
Transitional Housing for Homeless	0	0
Institution (e.g. Jail, hospital, psych facility, AOD treatment)	29	2
Transitional (with family/friends or hotel/motel)	12	2
Permanent	0	26

Other	0	19
Unknown	1	24
Deceased	N/A	1
Still active at report end date	N/A	13

Higher Levels of Care	**% during program admission in FY 20-21**		
	North	**South**	**West**
Incarcerations	1%	14%	5%
Crisis Services	4%	6%	8%
Psychiatric Inpatient Care	1%	4%	0%

^Note. "Showed Improvement" and "Remained Stable" reflects the percent of clients whose MORS scores improved or stayed the same between time periods.
**Note. Forty-five clients were still active at the end of the fiscal year so their living situation at exit is missing*.

Because the Homeless Services provides outreach services, they have many contacts with clients that are not captured in Clinician's Gateway. Outreach programs provide services to individuals experiencing homelessness living in a situation not meant for human habitation. Homeless Supportive Services provides support to clients experiencing homelessness who are living in transitional living situations and need support in accessing community resources and learning skills to help them gain and maintain housing.

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

(1) A contact with the program that results in entry into HMIS (n = 241 individuals contacted by PATH or HEAP in FY 20-21; n = 62 new clients opened to PATH in FY 20-21);

(2) A contact with the program that results in entry into HMIS, and consent to enroll in PATH (n = 49 clients enrolled in FY 20-21); and

(3) A contact with the program that results in enrollment in mental health services through Behavioral Wellness (n = 288); services recorded through EHR (Sharecare/Clinician's Gateway).

In the 2020-21 fiscal year, clients in Homeless Outreach Services had initial, 6-month and 12-month MORS data. In the first six months of engagement, 30% of clients improved, while 43% remained stable. In the second six months, a third of clients improved and almost half remained stable. Taken together, in the first year in the program, about three quarters of clients either improved or remained stable.

Examining housing status at Program entry and exit, it is important to note that some clients included in this count had only one contact with Behavioral Wellness and were not seen again. Of the clients who had exited the program by the end of the fiscal year, one quarter (n = 26) of clients had transitioned to permanent housing.

The client outcomes table displays the percent of unique clients who experienced a higher level of care during their admission to Homeless Services in the 20-21 fiscal year. The source of incarceration data is the Santa Barbara Jail and therefore only includes adults; clients were matched from the county electronic health record to the FY 20-21 jail roster. The source of psychiatric inpatient and crisis services data is the electronic health record. One percent of clients in North County, 14% of clients in South County, and 5% of clients in West County experienced a jail stay during their admission. Four percent of clients in North County, 6% of clients in South County, and 8% of clients in West County had crisis services contact during their program admission. One percent of clients in North County, 4% of clients in South County, and 0% of clients in West County experienced hospitalization during their program admission.

Co-Occurring Mental and Substance Use Outpatient Teams

Provider:	**Behavioral Wellness**
Estimated Funding FY 2022/23:	
Estimated Total Mental Health Expenditures	$3,898,877
Estimated CSS Funding	$ 1,991,887
Estimated Medi-Cal FFP	$1,907,000
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	
Average Cost Per Consumer	$9,579
Estimated Total of Consumers Served	407
Target Population Demographics Served	TAY, Adults, Older Adults

The Co-Occurring Outpatient Teams offer consumer-driven services and customized services based on individual needs. Specialized outpatient Co-Occurring Teams are based in North, West and South County, and designed for adults 18 and older. Consumers diagnosed with a severe mental illness and a co-occurring substance use disorder (SUD) are identified for this specialized level of service. More specifically, this may include consumers who 1) have SUD-related legal issues, 2) have been recently discharged from a detoxification program, or 3) have a history of substance use.

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

The Department of Behavioral Wellness continues to offer telephone, telehealth, and in-person appointments to assist clients in successfully meeting treatment plan goals. Certain clinic locations have a designated room setup with audio and video for those without access to technology. Groups meet outside while socially distanced (adhering to CDC guidelines) and via Zoom since the beginning of the COVID 19 pandemic.

Program Challenges and Solutions

The Drug Medi-Cal Organized Delivery System (DMC-ODS) has expanded covered benefits over the past three years. Drug Medi-Cal beneficiaries now have a full range of inpatient and outpatient services to address all areas of client health and functioning. County BEWELL has decentralized the screening process for outpatient treatment services, allowing clients to access treatment directly rather than through a centralized access point, thus removing a barrier. Nonetheless, the Substance Use Disorder (SUD) continuum of care still faces challenges that need to be addressed. Youth, adolescents especially, have difficulty accessing early intervention and treatment services. Outreach into schools and other community areas is indicated but cannot be funded with current Alcohol and Drug Program (ADP) funds. More housing options are needed for clients in outpatient services who neither meet nor want residential (inpatient) treatment services. ADP has begun building Recovery Residence (RR) capacity but scarcity of available ADP funds will limit the amounts of RR beds we can purchase.

Mental Health (MH) staff need to be more proficient in screening, assessing, and referring clients with SUD into our current system of care. Recent and future changes within specialty mental health services cover initial assessment and treatment of all clients coming into the MH clinics, regardless of MH, SUD or Co-Occurring Disorder (COD) symptoms or potential diagnoses. This "no wrong door" mandate demands that all MH clinicians have practical skills in differential diagnosis, motivational interviewing and co-occurring disorders (COD) theory and practice at least. Additionally, MH staff need to have a solid theoretical understanding of medication assisted treatment (MAT) and the American Society of Addiction Medicine (ASAM) Treatment Criteria. Currently, each adult MH adult clinic co-locates Alcohol and Drug Service Specialists (ADSS), creating a basic and cumbersome MH/SUD integration system that is and will continue to be insufficient and clinically contraindicated for client care. There is a need in the Mental Health Clinics for an increase in case management and care coordination services so that there is a cohesive link for clients with SUD or COD to community-based SUD treatment providers.

Co-Occurring Mental Health and Substance Use Outpatient Teams Data

Program Performance (FY 20-21)

Behavioral Wellness: Adult Co-Occurring Teams

	Unique Clients Served		
	North	**South**	**West**
Age Group			
0-15	0	0	0
16-25	20	1	4
26-59	161	122	57
60+	12	26	4
Missing DOB	0	0	0
Total	**193**	**149**	**65**
Gender			
Female	87	51	41
Male	106	98	24
Unknown	0	0	0
Ethnicity			
American Indian or Alaska Native	5	5	0
Asian	1	1	1
Black or African American	7	11	6
Mixed Race	4	19	2
Native Hawaiian or Pacific Islander	0	0	2
White	173	109	54
Other	2	3	0
Unknown/Not Reported	1	1	0
Hispanic or Latino			
Hispanic or Latino	100	47	22
Not Hispanic or Latino	91	94	43
Unknown/Not Reported	2	8	0

Client Outcomes

Milestones of Recovery Scale (MORS) Age: 18+			
		Initial to 6 months (n = 354)	6 to 12 months (n = 305)
Showed improvement^		34%	29%
Remained stable^		45%	46%
Higher Levels of Care	**% during program admission in FY 20-21**		
	North	**South**	**West**
Incarcerations	5%	7%	4%
Crisis Services	15%	3%	4%
Psychiatric Inpatient Care	2%	0%	3%

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

In the 2020-21 fiscal year, clients in the Adult Co-Occurring Teams had initial, 6-month and 12-month MORS data. In the first six months of engagement, over a third of clients improved, while 45% remained stable, and in the second six months, 29% of clients improved and 46% remained stable. Taken together, in the first year in the program, three-quarters of clients either improved or remained stable.

The client outcomes table displays the percent of unique clients who experienced a higher level of care during their admission to Adult Co-Occurring Teams in the 20-21 fiscal year. The source of incarceration data is the Santa Barbara Jail and therefore only includes adults; clients were matched from the county electronic health record to the FY 20-21 jail roster. The source of psychiatric inpatient and crisis services data is the electronic health record. 5% of clients in North County, 7% of clients in South County, and 4% of clients in West County experienced a jail stay during their admission. 15% of clients in North County, 3% of clients in South County, and 4% of clients in West County had crisis services contact during their program admission. Two percent of clients in North County, 0% of clients in South County, and 3% of clients in West County experienced hospitalization during their program admission.

Children Wellness, Recovery and Resiliency (WRR) Teams

Provider:	Behavioral Wellness
Estimated Funding FY 2022/23:	
Estimated Total Mental Health Expenditures	$5,844,523
Estimated CSS Funding	
Estimated Medi-Cal FFP	$3,321,224
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$2,523,300
Average Cost Per Consumer	$5,149
Estimated Total of Consumers Served	1,135
Target Population Demographics Served	Children, TAY

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

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

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

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

A specialized service provided within the WRR program is "Katie-A" treatment that 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 a contracted Community Based Organization, which varies per region), and those Katie-A children requiring a higher level-of-care are connected to more intensive services, such as the clinic's Full Service Partnership (FSP) SPIRIT Program, Intensive Home Based Services (IHBS), Therapeutic Based Services (TBS) and/or Wrap-163. As indicated in the Core Practice Model Guide, developed by the California Department of Health Care Services (DHCS), Katie-A services are provided within a cross-sector, team environment to build a culturally relevant and trauma-informed system of support and services that is responsive to the strengths and underlying needs of each child and family. Katie-A services include Intensive Care Coordination and Intensive Home-Based Services when a client is requiring a higher level-of-care, in addition to Child and Family Team (CFT) meetings to bring all supportive parties together for the benefit of the child and family. For team consultation related to Wrap-163 and residential treatment referral recommendations, the Interagency Placement Committee (IPC) was implemented in October 2018 to include Behavioral Wellness, Social Services and Probation as the voting representatives. This Committee focuses on streamlining and tracking all children in placement or at risk of placement in partnership with the Department of Social Services, Probation, schools, and the Regional Center. The overarching goal is to further implement the Continuum of Care Reform (CCR) for children across systems.

The Department of Behavioral Wellness continues to offer telehealth services and in-person appointments 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. Groups meet outside while socially distanced (adhering to CDC guidelines) and via Zoom since the beginning of the COVID 19 pandemic.

Program Challenges and Solutions

One major change that is impacting the cross section of services in the Wellness, Recovery and Resiliency Teams is the lack of case management support that was transferred to TAY FSP versus replacing key rehab/case management services. The recovery of the family unit is crucial to the healing of the identified child(ren) in the household thus connecting them and supporting them to effectively navigate the myriad of complex county services. 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. In addition, 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.

A challenge experienced at the state level is the lack of mental health practitioners; in the rural area of Lompoc, it has been nearly impossible to fill the position of an assessor for the Access

and Assessment Roles in the Prevention Early Intervention Program (PEI), thus overloading the current three practitioners carrying the load of four plus the load of the vacant PEI position.

10% of the Wellness, Recovery and Resiliency caseload is accounted for as monolingual Spanish where one staff is now fully responsible for the clinic services. This staff member's cultural and bilingual skills draw parents and single parents to engage with the minor in treatment. The recent relocation of a rehab specialist has handicapped this process and will affect the number of monolingual families we are able to serve.

Children's Wellness, Recovery and Resiliency (WRR) Teams Data

Program Performance (FY 20-21)

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

	Unique Clients Served		
	North	**South**	**West**
Age Group			
0-15	352	154	193
16-25	199	152	76
26-59	5	4	0
60+	0	0	0
Missing DOB	0	0	0
Total	**556**	**310**	**269**
Gender			
Female	339	174	151
Male	216	136	118
Missing	1	0	0
Ethnicity			
American Indian or Alaska Native	4	4	7
Asian	2	2	2
Black or African American	22	17	10
Mixed Race	5	12	8
Native Hawaiian or Pacific Islander	1	2	1
White	504	251	233
Other	9	12	3
Unknown/Not Reported	9	10	5
Hispanic or Latino			
Hispanic or Latino	396	201	183
Not Hispanic or Latino	133	91	69
Unknown/Not Reported	27	18	17

Client Outcomes

Child & Adolescent Needs & Strengths Assessment (CANS-50) Age: 6-20 years	Percent Improvement*	
	Initial to 6 months (n = 214)	6 to 12 months (n = 116)
Life Functioning (e.g., ability to communicate and interact with families, communication, social functioning and health status)	-25.9%	-48.1%
Behavioral/Emotional Needs (e.g., symptoms of depression, anxiety, psychosis and other conditions)	-15.6%	-49.1%
Risk Behaviors (e.g., self-injury, suicidal behavior, bullying, and running away)	-10.8%	-53.0%
Cultural Factors (e.g., language, traditions, stress)	-18.8%	-53.8%
Strengths (e.g., optimism, talents/interests, relationship permanence, and involvement in treatment)	-8.1%	-44.2%

Higher Levels of Care	% during program admission in FY 20-21		
	North	South	West
Juvenile Hall	--	--	--
Crisis Services	11%	8%	7%
Psychiatric Inpatient Care	2%	3%	1%

**Note. On the CANS-50, a higher the score indicates more actionable needs (greater problems). A negative percent change indicates that client scores are improving because they have fewer actionable needs.*

Due to a state mandated change, Santa Barbara County began using a new version of the CANS (CANS-50) in July 2018. In addition to changing items and domains, the CANS age range was extended to age 20. This means that more TAY-aged clients now receive a CANS. *Cultural Factors* is a new 3-item domain. We did not present *Caregiver Resources and Needs* for these analyses because caregivers that are entered in the Caregiver A section often change across timepoints and are not currently tracked to allow for a matched comparison.

The CANS data provided shows the percent change in the average number of *actionable needs* within a particular domain. On each item in the CANS, clients are rated a 0-3 on a Likert scale, with higher ratings indicating more serious problems, and a rating of 2 or 3 on an item to be considered an *actionable need*: 0 = no evidence; 1 = history or suspicion, monitor; 2 = interferes with functioning, action needed; 3 = disabling, dangerous; immediate or intensive action needed. For example: at intake, the clients in a program had an average of three actionable needs per client in the 11-item *Life Functioning* domain. At six months, that matched group has an average of two actionable needs per client. This difference corresponds to a 33.3% decrease in their number of actionable needs in that domain. This method of analysis is more meaningful when there are more items in the domains and ratings are more normally distributed. Some scales, such as Cultural Factors, experience large percent differences because the average number of actionable needs are so low that the average actionable needs have positive skew and a floor effect; in other words, it is rare for many clients to be rated as having actionable needs in the *Cultural Factors* domain.

Clients in the Children's Wellness, Recovery and Resiliency program saw reductions in the number of actionable needs across all 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 = 116) saw greater reductions in their number of actionable needs than the larger group (n = 214) seen from intake to six months. In the second six months of treatment, clients averaged about a 50% reduction in actionable needs; in other words, clients had half as many needs rated a 2 or 3 at 12 months than at 6 months.

The client outcomes table displays the percent of unique clients who experienced a higher level of care during their admission to Children's Wellness, Recovery and Resiliency Teams in the 20-21 fiscal year. Juvenile hall data were unavailable this year and we are unable to report on these metrics. The source of psychiatric inpatient and crisis services data is the electronic health record. Eleven percent of clients in North County, 8% of clients in South County, and 7% of clients in West County had crisis services contact during their program admission. Two percent of clients in North County, 3% of clients in South County, and 1% of clients in West County experienced hospitalization during their program admission.

Adult Wellness and Recovery Outpatient (WRR) Teams

Provider:	**Behavioral Wellness**
Estimated Funding FY 2022/23:	
Estimated Total Mental Health Expenditures	$7,165,779
Estimated CSS Funding	$2,337,603
Estimated Medi-Cal FFP	$2,699,676
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$0
Average Cost Per Consumer	$11,483
Estimated Total of Consumers Served	624
Target Population Demographics Served	TAY, Adult, Older Adult

The Wellness and Recovery (WRR) teams provide services to adults in a clinic setting that are a lower level of care. All staff have been trained in relevant 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. Other groups introduced during the pandemic are Anger Management, a Technology group in order to support clients in accessing virtual services, Grief and Loss, Budgeting and learning to manage Anxiety. Clients are also linked with services provided by the Department of Rehabilitation (D.O.R.) by referral from the WRR program and are eligible to participate in a specialized D.O.R. Co-Op program where the client receives specialized supports in achieving their vocational goals. 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. In Lompoc those clients that are in WRR and are stable are being linked to the Recovery Learning Center (RLC) medication support services. This new service provides medication support and links clients to the RLC within the RLC site. At the RLC site clients are engaged in peer support services where clients are not required to participate in the Adult Behavioral Wellness clinic. The goal is to expand similar services in North and South County in the upcoming year. The RLC in South County was launched in November of 2019 in collaboration with the Mental Wellness Center (MWC). The RLC pilot includes participants who are in the Maintenance Phase of treatment, having met their identified treatment plan goals and would be candidates for medication support services at MWC. Medication support services are provided by a psychiatrist based at MWC two days per week, bi-weekly for 8 hours per day and would provide services to approximately 8 - 10 clients.

In response to the COVID-19 Pandemic 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. Groups meet outside while socially distanced (adhering to Center of Disease Control (CDC) guidelines) and via Zoom since the beginning of the COVID 19 pandemic.

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, especially if the consumer has Medicare or Medicare/Medi-Cal insurance. Consumers who likely can step down remain at the clinic receiving services as a consequence of the lack of other treatment options. The result of this barrier is that the WRR teams are comprised of consumers with a wide variety of diagnoses and treatment needs that stretches staff resources and impacts good consumer care. The 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.

The WRR program remains as was initially designed to serve consumers who are lower need and will be appropriate for step-down to a lower level of care. This program continues to experience a bottle neck of clients that are functioning at different levels of care for a variety of reasons including a consistent lack of step-down options available in the community and the lack of community-based psychiatry and or Primary care physicians that are comfortable prescribing psychotropic medications. Clients who likely can step down or need to be referred to a higher level of care remain at the clinic receiving moderate to severe level of services as a consequence of the lack of these other treatment options, staffing vacancies and wait lists from the receiving provider causing long delays in transition of referrals completed. The effects of the pandemic continue to not only impact service delivery and capacity within the WRR program, but also with contracted providers. The lack of staffing includes Licensed Mental Health Professionals, Nursing staff, Case Workers and Rehabilitation Specialists which has resulted in fragmented teams not being fully staffed.

Some solutions to these challenges have been that the core clinic continues to have complex capable teams which has alleviated some of the impacts to staffing shortages wherein staff across programs have been able to step in and assist in providing services to clients across programs. The core clinic continues to have an augmented lower level of care with the RLC program in South County where clients receive medication support services and has seen some success with clients graduating from this program to independent functioning within their community. As a result of the Pandemic Behavioral Wellness successfully transitioned to providing a mix of both in person and telehealth services. This successfully enabled clinic programs to offer services that were more tailored to clients preference and needs resulting in minimal service disruption to clients who were unable to come to the clinic or for clients that preferred in person services.

Adult Wellness, Recovery, and Resilience (WRR) Teams Data

Program Performance (FY 20-21)

Behavioral Wellness: Adult Wellness, Recovery & Resilience Teams

	Unique Clients Served		
	North	**South**	**West**
Age Group			
0-15	3	0	0
16-25	24	4	9
26-59	171	149	147
60+	19	58	40
Missing DOB	0	0	0
Total	**217**	**211**	**196**
Gender			
Female	121	107	118
Male	96	104	78

Unknown	0	0	0
Ethnicity			
American Indian or Alaska Native	1	3	2
Asian	7	10	6
Black or African American	6	12	17
Mixed Race	1	18	2
Native Hawaiian or Pacific Islander	0	0	0
White	199	160	164
Other	3	6	3
Unknown/Not Reported	0	2	2
Hispanic or Latino			
Hispanic or Latino	119	66	58
Not Hispanic or Latino	98	132	138
Unknown/Not Reported	0	13	0

Client Outcomes

Milestones of Recovery Scale (MORS) Age: 18+			
		Initial to 6 months (n = 583)	**6 to 12 months (n = 530)**
Showed improvement^		30%	25%
Remained stable^		48%	52%
Higher Levels of Care	**% during program admission in FY 20-21**		
	North	**South**	**West**
Incarcerations	1%	1%	2%
Crisis Services	10%	2%	4%
Psychiatric Inpatient Care	2%	1%	1%

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

In the 2020-21 fiscal year, clients in the Adult Wellness, Recovery, and Resilience Teams had initial, 6-month and 12-month MORS data. In the first six months of engagement, 30% of clients improved, while nearly half remained stable. In the second six months, a quarter of clients improved and over half remained stable. Taken together, in the first year in the program, almost 80% of clients either improved or remained stable.

The client outcomes table displays the percent of unique clients who experienced a higher level of care during their admission to Adult Wellness, Recovery & Resilience Teams in the 20-21 fiscal year. The source of incarceration data is the Santa Barbara Jail and therefore only includes adults; clients were matched from the county electronic health record to the FY 20-21 jail roster. The source of psychiatric inpatient and crisis services data is the electronic health record. One percent of clients in North County, 1% of clients in South County, and 2% of clients in West County experienced a jail stay during their admission. Ten percent of clients in North County, 2% of clients in South County, and 4% of clients in West County had crisis services contact during their program admission. Two percent of clients in North County, 1% of clients in South County, and 1% of clients in West County experienced hospitalization during their program admission.

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

Provider:	**CALM, Family Service Agency**
Estimated Funding FY 2022/23:	
Estimated Total Mental Health Expenditures	$714,000
Estimated CSS Funding	
Estimated Medi-Cal FFP	$175,800
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$538,200
Average Cost Per Consumer	$4250
Estimated Total of Consumers Served	168
Target Population Demographics Served	Children, TAY

The Pathways to Wellbeing 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 Holman Group or private insurance providers making it difficult to track services and monitor at-risk Katie-A children that may later need to be re-referred. Currently, all Katie-A children are referred by Social Services through 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.

Program Challenges and Solutions

Throughout the pandemic, CALM has continued to provide Katie A children 0-5 with timely assessments. CALM and FSA have continued to provide children 0-21 with on-going specialty mental health services with no disruption. During the second year of the pandemic, CALM saw a decrease in Pathways to Wellbeing referrals from Behavioral Wellness in both the Santa Barbara and Lompoc regions. CALM has not had any wait time for providing services to Pathways to Wellbeing clients, and in fact the contract does not allow for wait times. Pre-pandemic, if there were ever a situation where CALM was unable, due to staffing, to provide Pathways services to a client, the client was referred back to Behavioral Wellness. FSA saw a significant increase in Pathways to Wellbeing referrals in the Santa Maria region in this same time frame. Due to reaching capacity in FSA's Pathways to Wellbeing program, some referrals have been referred back to Behavioral Wellness.

During the past year, the Department was awarded the Mental Health Services Student Services Act (MHSSA) grant which is a collaboration with the Santa Barbara County Education Office and local school districts to increase access and linkage to care for all students, focusing on those vulnerable in the school system. This grant funds additional health navigators, a manager, and practitioners who can assess all students and attempt to link them to their health care networks and coordinate support and education to families and educators about behavioral health. Additionally, the Alcohol and Drug Program (ADP) received a grant to open a youth center in Lompoc and enhance school outreach regarding opioid use using navigators in North County. As the Department expands its outreach and engagement in these areas, it is intended to create community activism and enhance services to youth across the continuum.

Pathways to Well Being (Formerly "HOPE" Program: CALM, Family Service Agency) Data

Program Performance (FY 20-21)

Pathways to Well Being

	Unique Clients Served		
	North	**South**	**West**
Age Group			
0-15	64	26	64
16-25	5	4	5
26-59	0	0	0
60+	0	0	0
Missing DOB	0	0	0
Total	**69**	**30**	**69**
Gender			
Female	40	16	44
Male	29	14	25
Unknown	0	0	0
Ethnicity			
American Indian or Alaska Native	0	0	1
Asian	2	1	0
Black or African American	1	0	6
Mixed Race	1	0	0
Native Hawaiian or Pacific Islander	0	0	0
White	65	27	62
Other	0	2	0
Unknown/Not Reported	0	0	0
Hispanic or Latino			
Hispanic or Latino	55	15	48
Not Hispanic or Latino	13	12	20
Unknown/Not Reported	1	3	1

Client Outcomes

Child & Adolescent Needs & Strengths Assessment (CANS-50) Age: 6-20 years	**Percent Improvement***	
	Initial to 6 months (n = 54)	**6 to 12 months (n = 28)**
Life Functioning (e.g., ability to communicate and interact with families, communication, social functioning and health status)	-17.6%	-49.2%
Behavioral/Emotional Needs (e.g., symptoms of depression, anxiety, psychosis and other conditions)	-3.4%	-59.5%
Risk Behaviors (e.g., self-injury, suicidal behavior, bullying, and running away)	0.0%	50.0%
Cultural Factors (e.g., language, traditions, stress)	0.0%	-100.0%
Strengths (e.g., optimism, talents/interests, relationship permanence, and involvement in treatment)	-6.5%	-49.1%
Other Outcomes	**Average per quarter**	
	North (FSA)	**South & West (CALM)**
Out of Primary Home Placement	7%	2%
Stable/Permanent Housing	99%	100%
Purposeful Activity (employed, school, volunteer)	100%	99%
Discharged to Higher Level of Care	13%	13%
Discharged to Lower Level of Care	87%	87%
Higher Levels of Care	**% during program admission in FY 20-21**	
	North (FSA)	**South & West (CALM)**
Juvenile Hall	0%	0%
Crisis Services	1%	2%
Psychiatric Inpatient Care	0%	1%

**Note. On the CANS-50, a higher score indicates more actionable needs (greater problems). A negative percent change indicates that client scores are improving because they have fewer actionable needs.*

Due to a state mandated change, Santa Barbara County began using a new version of the CANS (CANS-50) in July 2018. In addition to changing items and domains, the CANS age range was extended to age 20. This means that more TAY-aged clients now receive a CANS. *Cultural Factors* is a new 3-item domain. We did not present *Caregiver Resources and Needs* for these analyses because caregivers that are entered in the Caregiver A section often change across timepoints and are not currently tracked to allow for a matched comparison.

The CANS data provided shows the percent change in the average number of *actionable needs* within a particular domain. On each item in the CANS, clients are rated a 0-3 on a Likert scale, with higher ratings indicating more serious problems, and a rating of 2 or 3 on an item to be considered an *actionable need*: 0 = no evidence; 1 = history or suspicion, monitor; 2 = interferes with functioning, action needed; 3 = disabling, dangerous; immediate or intensive action needed.

For example: at intake, the clients in a program had an average of three actionable needs per client in the 11-item *Life Functioning* domain. At six months, that matched group has an average of two actionable needs per client. This difference corresponds to a 33.3% decrease in their number of actionable needs in that domain. This method of analysis is more meaningful when there are more items in the domains and ratings are more normally distributed. Some scales, such as Cultural Factors, experience large percent differences because the average number of actionable needs are so low that the average actionable needs have positive skew and a floor effect; in other words, it is rare for many clients to be rated as having actionable needs in the *Cultural Factors* domain.

Clients in Pathways to Well Being saw reductions in the number of actionable needs across most domains, with the exception of the *Cultural Factors* and *Risk Behaviors* domains. Both of these domains had very low averages of actionable needs (average = 0.00 in *Cultural Factors* and 0.04 in *Risk Behaviors*), which amplified any small changes over time and should therefore be interpreted with caution. On the other three domains (Behavioral/Emotional Needs, Life Domain Functioning, and Strengths), 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 = 28) saw greater reductions in their number of actionable needs than the larger group seen from intake to six months (n = 54). For these domains, clients experienced half as many actionable needs at 12 months than 6 months.

Most outcomes are tracked and reported quarterly by the program. In the 2020-2120 fiscal year, clients in the Pathways to Well Being Program had quite positive outcomes. Seven percent experienced in North County and 2% in South and West County experienced out-of-primary-home placement. In all regions, nearly all clients were engaged in purposeful activities and had stable housing. In all regions, 87% of clients were discharged to a lower level of care while the remaining 13% transitioned to a higher level of care.

The client outcomes table displays the percent of unique clients who experienced a higher level of care during their admission to the program in the 20-21 fiscal year. Juvenile hall data were reported in quarterly reports by providers. The source of psychiatric inpatient and crisis services data is the electronic health record. No clients experienced juvenile hall stays. One percent of clients in North County and 2% of clients in South and West County had crisis services contact during their program admission. No clients in North County and 1% of clients in South and West County experienced hospitalization during their program admission.

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

Provider:	Crestwood, Telecare, Behavioral Wellness
Estimated Funding FY 2022/23:	
Estimated Total Mental Health Expenditures	$5,070,345
Estimated CSS Funding	$3,069,445
Estimated Medi-Cal FFP	$1,730,900
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$ 270,000
Average Cost Per Consumer	$17,483
Estimated Total of Consumers Served	290
Target Population Demographics Served	TAY, Adult, Older Adult

The Department of Behavioral Wellness offers voluntary residential recovery programs to clients in crisis in both North (Santa Maria and Agnes) and South (Santa Barbara) County. These facilities were operated by Anka Behavioral Health (Anka) until May 2019. During the 30-day FY 19-20 MHSA posting period, Anka filed bankruptcy and new contracts for the services were authorized for Crestwood and Telecare for July 2019 to December 2020. As a result of COVID-19, these contracts were extended until December 2020 and a Request for Proposals was issued in 2021 for the long-term service provision. The three locations offer 30-32 residential treatment beds on any given day to consumers in the County.

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.

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. Clients consistently experience significantly less homelessness at discharge than intake as a result of coordinating and planning discharge activities during their residential treatment time at the CRT.

Crisis Residential Services North/South Data

Program Performance (FY 20-21)

Crisis Residential

Client Outcomes

Higher Levels of Care	% during program admission in FY 20-21	
	North	South
Incarcerations	9%	6%
Crisis Services	14%	5%
Psychiatric Inpatient Care	0%	1%

The client outcomes table displays the percent of unique clients who experienced a higher level of care during their admission to Crisis Residential in the 20-21 fiscal year. The source of incarceration data is the Santa Barbara Jail and therefore only includes adults; clients were matched from the county electronic health record to the FY 20-21 jail roster. The source of psychiatric inpatient and crisis services data is the electronic health record. Nine percent of clients in North County and 6% of clients in South County experienced a jail stay during their admission. Fourteen percent of clients in North County and 5% of clients in South County had crisis services contact during their program admission. Zero percent of clients in North County and 1% of clients in South County experienced hospitalization during their program admission.

Medical Integration Program

Provider:	Behavioral Wellness
Estimated Funding FY 2022/23:	
Estimated Total Mental Health Expenditures	$2,392,397
Estimated CSS Funding	$1,475,297
Estimated Medi-Cal FFP	$917,100
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	
Average Cost Per Consumer	$18,124
Estimated Total of Consumers Served	132
Target Population Demographics Served	TAY, Adult, Older Adult

The specialized Medical Integration teams in each region of the County serve persons with severe mental illness who also experience serious medical problems, including individuals who are 60

years of age and over. Teams address the complex needs of this population, including multiple medication management and the prevalence of significant physical and mental health conditions. With ongoing evaluation and program development the Teams learned that age alone was not a clinically appropriate determination for assignment to this Program. Each consumer is now being assigned based on the existence of complex medical needs to ensure individualized treatment.

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

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

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

The Department of Behavioral Wellness continues to offer telehealth services and in-person appointments 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. Groups meet outside while socially distanced (adhering to CDC guidelines) and via Zoom since the beginning of the COVID 19 pandemic.

Program Challenges and Solutions

This program was originally developed to serve older adults and now serves consumers with complex medical needs of all ages. The services have evolved to being a specialized area that requires a lot of collaboration with primary care and ongoing education and collaboration. This population requires intensive field based medical and case worker services that exceed the allocated staffing patterns. To address this issue, the Medical Integration Teams were trained in team-based care so that responsibility for consumer care could be shifted away from individual caseloads to multi-disciplinary teams who could assist with multiple consumers. The teams have been very successful in integrating a team-based approach and have successfully adopted

consumers into their new teams. However, ongoing refinement to this approach requires evolving levels of care that include medical integration at all levels, being mindful that each program level will require a different level of coordination and services. A 3-4-50 Health Program Manual and trainings have been developed and implemented including groups such as Rethink your Drink, movement, pain management, healthy eating, yoga, and walking to assist consumers with improving physical concerns which impact their mental health. Staff turnover and continued staffing allocation patterns remain a challenge in providing these specialized services to clients. This last year has proven especially challenging with the lack of nursing staff in our communities, increased demands for nurses throughout Santa Barbara County and clients presenting with further complicating medical issues which were exacerbated by the COVID 19 pandemic.

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

management to their primary care providers. Although some community based medical organizations/agencies have been hesitant to manage mental health medications, medical staff continue to outreach in the community to develop relationships with primary care providers. This remains an ongoing effort as there remains limited availability of psychiatrists and community-based providers who are comfortable with managing mental health medications.

During FY 2021-22, The Genoa Pharmacy completed construction in the adult outpatient clinic in South County Santa Barbara and is in the certification process. Multiple team integration meetings have been held with pharmacy and clinic staff to coordinate integration of services as one collaborative team. Clinic staff have already begun transitioning clients to this onsite pharmacy that will also, once fully certified, will not only be able to provide onsite pharmaceutical services but can also mail medications to clients with mobility challenges, reduce the number of clinic visits to clients by having all services available at one location and also deliver medications to other clinics and programs versus sending clients to various pharmacies to refill medications. It is expected that with this onsite pharmacy resource there will be a minimization of gaps in medication refills, more consistent adherence to medication regimens thus leading to an increase of ongoing stabilization while allowing for Behavioral Wellness's nursing staff to focus more on

direct care nursing support services to clients. This has already been an effective resource for those that have transitioned to the onsite pharmacy and is projected to be tremendously helpful to those clients with limited mobility and/or incapacities due to health conditions in this program.

An additional challenge for the MIOA program is the continued lack of placement options for clients that have complex co-occurring mental health and medical needs. Crestwood Crisis Residential Treatment in Santa Barbara is licensed as a Social Model Rehab Facility since they opened in 2015 and accepts clients ages 18 -59 years old. They are able to accept clients up to age 65 by exception only with additional supplemental paperwork required and reviewed. Some of these restrictions / guidelines are related to Community Care Licensing requirements that have to do with considering mobility, medication considerations, fire clearances, medical issues etc. which has caused many difficulties with placing these clients locally thereby allowing them to keep their established mental health treatment team. There are other types of facilities licensed as RCFE's (Residential Care Facility for the Elderly) for older clients that have specific criteria that have proven difficult to place MIOA clients in. The lack of options have resulted in some cases needing to be placed out of county for their particular care needs causing significant geographical barriers to mental health services. Telehealth options have provided some relief in overcoming geographical distances resulting from out of county placements in addition to staff working to transition care to the local county mental health providers.

The Santa Maria region attempted to have these as separate teams however that was not successful and led to a lot of client movement within the system and clients separating from known treatment providers. The clinic reintegrated the teams and everyone is complex capable and trauma informed in the teams. There is no difference in the approach as each service is delivered with client needs focus first. Clients served have a secondary diagnosis.

Medical Integration Program Data

Program Performance (FY 20-21)

Behavioral Wellness: Medical Integration and Older Adult Teams

	Unique Clients Served		
	North	**South**	**West**
Age Group			
0-15	0	0	0
16-25	0	1	0
26-59	21	14	16
60+	33	33	14
Missing DOB	0	0	0
Total	**54**	**48**	**30**
Gender			
Female	35	30	20

Male	19	18	10
Unknown	0	0	0
Race			
American Indian or Alaska Native	1	1	0
Asian	1	2	0
Black or African American	5	1	4
Mixed Race	0	5	0
Native Hawaiian or Pacific Islander	0	0	1
White	47	36	25
Other	0	2	0
Unknown/Not Reported	0	1	0
Hispanic or Latino			
Hispanic or Latino	16	16	6
Not Hispanic or Latino	37	27	24
Unknown/Not Reported	1	5	0

Client Outcomes

Milestones of Recovery Scale (MORS) Age: 18+			
		Initial to 6 months (n = 124)	**6 to 12 months (n = 117)**
Showed improvement^		30%	17%
Remained stable^		55%	63%
Higher Levels of Care	**% during program admission in FY 20-21**		
	North	**South**	**West**
Incarcerations	0%	0%	0%
Crisis Services	3%	2%	0%
Psychiatric Inpatient Care	1%	1%	0%

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

In the 2020-2120 fiscal year, clients in the Medical Integration and Older Adult Program had initial, 6-month and 12-month MORS data. In the first six months of engagement, 30% of clients improved and over half were stabilized, and in the second six months, 17% of clients improved and nearly two-thirds were stabilized. Examined another way, over the year, 80% or more of clients were either stable or made improvements.

The client outcomes table displays the percent of unique clients who experienced a higher level of care during their admission to Medical Integration and Older Adult Teams in the 20-21 fiscal year. The source of incarceration data is the Santa Barbara Jail and therefore only includes adults; clients were matched from the county electronic health record to the FY 20-21 jail roster. The source of psychiatric inpatient and crisis services data is the electronic health record. Zero percent of clients in all regions experienced a jail stay during their admission. Three percent of clients in North County, 2% of clients in South County, and 0% of clients in West County had crisis services contact during their program admission. One percent of clients in North County, 1% of clients in South County, and 0% of clients in West County experienced hospitalization during their program admission.

Adult Housing Support Services

Provider:	**Behavioral Wellness, Psynergy, Pathpoint, Telecare, Mental Wellness Center, Good Samaritan**
Estimated Funding FY 2022/23:	
Estimated Total Mental Health Expenditures	$4,041,533
Estimated CSS Funding	$1,560,033
Estimated Medi-Cal FFP	$873,500
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$ 1,608,000
Average Cost Per Consumer	$26,415 (Some provider's support services, others all housing costs, each provider is varied in MHSA support)
Estimated Total of Consumers Served	153
Target Population Demographics Served	TAY, Adult, Older Adult

During prior years' stakeholder forums, additional housing continues to be raised as an issue. This year, the Department opened a 13-unit No Place Like Home (NPLH) funded housing project in Santa Maria (West Cox Cottages). This site, and Homekey Studios, have an onsite supportive services staff. In FY 22-23, the Department plans to begin construction on a 3-unit NPLH-funded housing project located at Sanctuary Centers in Santa Barbara, and a 14-unit NPLH Housing in Lompoc. The Department is awaiting notice for three NPLH applications submitted in January. All three applications submitted were for Housing Projects in South County. The Department will continue to review and modify the types of adult housing supports, such as rental subsidies, based on funding available.

Included in this program is mental health support services for:

- *Depot Street Housing:* Opened Fall 2020 for 34 MHSA-eligible families. The Department will be providing onsite supportive services to all MHSA tenants, including a case worker onsite to provide supportive services and help coordinate additional services.

• *Heath House*: Opened Winter 2021 for Women experiencing homelessness. The Department provides case workers to support tenants with independent living skills and connects them to County and community-based organizations as needs arise.

• *West Cox Cottages*: Construction was completed on this project in November of 2021. There are 13 NPLH-funded units for persons with a serious mental illness who are experiencing homelessness. This project will have an MHSA funded caseworker onsite to provide supportive services and help coordinate additional services.

• *Hollister Lofts:* The Department has been awarded funding for over 4 million dollars in NPLH competitive funding for a 16-unit housing project for persons with a serious mental illness who are experiencing homelessness. It is anticipated that construction will begin on this project in 2022. Once complete, this project will have a full-time caseworker onsite to provide supportive services and help coordinate additional services.

Hollister II: The Department has been awarded non-competitive NPLH funding for 3 Single Room Occupancies at a Sanctuary Centers site in Santa Barbara, construction is anticipated to begin this year

• *Cypress and 7th:* The Department applied for our remaining non-competitive NPLH funding for a 14-unit Housing Project in Lompoc entirely dedicated to persons with a serious mental illness who are experiencing homelessness. Construction is anticipated to begin in FY 23-24

For the above programs, initially State grant funding would provide the support services for the multidisciplinary support services provided. Adult Housing Supports or Homeless Outreach Services would provide the ongoing behavioral health support to residents and those sheltering on a long-term basis should MHSA funding be available.

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

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

• **Pathpoint** which offers residential board and care at Phoenix and Mountain House Adult Housing Supports. This program design includes MHSA principles, peer services, and enhanced focus on case management and support group activities. PathPoint operates two residential programs. Also supported are other Pathpoint residential scattered site community locations that serve MHSA clients.

• **Mental Wellness Center's (MWC)** manages Intensive Residential Programs and extended peer services and group support. The intent of the Programs is to coordinate housing for adults primarily served through the MHSA. Mental Wellness Center will provide twenty-four (24) hours per day, seven (7) days per week psychiatric rehabilitation, residential care and room and board services in four locations and several apartments in the community. The Department is looking to also perhaps partner with MWC to add more beds within MHSA.

- **Telecare** offers McMillan Ranch in Santa Maria which is an intensive residential program with support from the Santa Maria full services partnership teams.

- **The Residences at Depot Street** has an onsite case manager at a minimum of 20 hours per week funded by MHSA

- **West Cox Cottages** has an onsite case manager at a minimum of 20 hours per week funded by MHSA.

Program Challenges and Solutions

The Department continues to work towards building adequate infrastructure, and adding to the housing continuum while acknowledging that additional components may be needed as the demand for housing increases and the type of housing desired varies depending on region. Along with the No Place Like Home initiative, establishment of additional crisis residential locations, and flexible housing assistance, such as: short-term shelters, rental subsidies, security deposits, utility deposits will be explored to the extent available.

Behavioral Wellness has also applied for, and been awarded various grants to provide funding for onsite supportive services. The Department will continue to creatively pursue State and Federal funding opportunities to fund out onsite supportive services. Behavioral Wellness will attempt to seek providers interested in master leasing and housing services management in FY 22-23 in order to ensure an enhanced support network when housing opportunities of funding become available.

Ongoing housing support services are critical and MHSA is a stable source for this as new housing options are created, however, community support and leveraging MHSA funds is necessary for sustainability of these housing support and step-down service options. The Department is anticipating applying for an Innovations MHSA grant to provide wraparound services at our new housing sites, to create a Housing Retention Team.

Adult Housing Support Services Data

Program Performance (FY 20-21)

Adult Housing Support Services

	Unique Clients Served							
Provider	**Pathpoint**		**MWC**	**Psynergy**	**Telecare**	**Pathpoint Residential Support Services**		
Site	**Mountain House**	**Phoenix House**	**Polly's House**	**Psynergy**	**McMillan Ranch**	**Artisan Court**	**Bradley Studios**	**El Carrillo**
Age Group								
0-15	0	0	0	0	0	0	0	0
16-25	0	1	0	0	0	0	0	0
26-59	12	14	8	15	9	5	1	10
60+	2	1	5	7	4	3	1	8
Missing DOB	0	0	0	0	0	0	0	0
Total	***14***	***16***	***13***	***22***	***13***	***8***	***2***	***18***
Gender								
Female	4	6	5	15	8	4	0	6
Male	10	10	8	7	5	4	2	12
Unknown	0	0	0	0	0	0	0	0
Race								
American Indian or Alaska Native	0	0	0	0	0	0	0	0
Asian	0	0	0	0	1	0	0	0
Black or African American	2	1	2	1	0	1	0	2
Mixed Race	0	2	0	0	1	1	0	2
Native Hawaiian or Pacific Islander	0	0	0	0	0	0	0	0
White	12	12	11	21	11	5	2	14
Other	0	1	0	0	0	0	0	0
Unknown/Not Reported	0	0	0	0	0	1	0	0
Hispanic or Latino								
Hispanic or Latino	1	5	2	6	4	2	0	2
Not Hispanic or Latino	13	11	11	16	9	6	2	16
Unknown/Not Reported	0	0	0	0	0	0	0	0

Program Outcomes

Other Outcomes	Average per Quarter							
	Mountain House	Phoenix House	Polly's House	Psynergy^	McMillan Ranch	Artisan Court	Bradley Studios	El Carrillo
Physical Health Hospitalization	0%	0%	2%	2%	5%	4%		
Physical Health Emergency Care	5%	0%	5%	0%	15%	9%		
Stable/Permanent Housing	100%	98%	93%	--	100%	100%		
Purposeful Activity (employed, school, volunteer)	41%	64%	3%	--	100%	26%		
Discharged to Higher Level of Care	N/A	33%	0%	33%	50%	50%		
Discharged to Lower Level of Care	N/A	67%	100%	67%	50%	25%		
Higher Levels of Care	**% during program admission in FY 20-21**							
	Mountain House Support Services	Phoenix House Support Services	Polly's House	Psynergy	McMillan Ranch	Artisan Court	Bradley Studios	El Carrillo
Incarcerations	0%	0%	0%	0%	0%	0%	0%	0%
Crisis Services	0%	6%	8%	0%	15%	0%	0%	0%
Psychiatric Inpatient Care	0%	6%	8%	0%	8%	0%	0%	0%

^ = Reflects three of four quarters of data

Most outcomes are tracked and reported quarterly by the program; all data in the first half of the Program Outcomes table reflects the average per quarter. Not many clients across all programs experienced physical health hospitalizations (2-5%), though generally more clients experienced physical health emergency care (0-15%). Almost all clients had stable/permanent housing (expected, given that these are housing programs) and between 3% and 100% of clients across programs were engaged in purposeful activity. Programs also report on the level of care that clients went upon discharge; depending on the program, between 25-100% of clients who were discharged transitioned to a lower level of care while less than half transitioned to higher levels of care.

The client outcomes table displays the percent of unique clients who experienced a higher level of care during their admission to Housing Support Services in the 20-21 fiscal year. The source of incarceration data is the Santa Barbara Jail and therefore only includes adults; clients were

matched from the county electronic health record to the FY 20-21 jail roster. The source of psychiatric inpatient and crisis services data is the electronic health record. No clients experienced a jail stay during their admission. Between 0-15% of clients had crisis services contact during their program admission, and 0-8% of clients in West County experienced hospitalization during their program admission.

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.

New Heights Transitional Age Youth (TAY) FSP

Provider:	**Behavioral Wellness, CommUnify (formerly Community Action Commission, Department of Rehabilitation**
Estimated Funding FY 2022/23	
Estimated Total Mental Health Expenditures	$3,333,590
Estimated CSS Funding	$1,597,490
Estimated Medi-Cal FFP	$915,300
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	
Average Cost Per Consumer	$26,668
Estimated Total of Consumers Served	125
Target Population Demographics Served	Children, TAY, Adults (as they age within TAY continuum)

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

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

Program Challenges and Solutions

In the past year we completed the transition of our SM TAY program to a new location on Skyway Dr. This is the first time the department has set up a separate, stand-alone clinic for TAY age clients. This allows us to set up lobbies, treatment rooms and group rooms that are more TAY friendly. The biggest challenge we faced this year in New Heights TAY was the overall staffing crisis across the department. The department saw a significant wave of staff leaving for other opportunities made available in the community due to telehealth expansion, additional funding for MH services in the schools, or just choosing not to work at all during the pandemic. In addition, recruitments are bringing in fewer candidates than in the past, so we have had more vacancies. These vacancies have gone unfilled for longer than they have in the past. Staffing shortages have led to increased caseloads for staff, staff needing to see clients in multiple programs versus just seeing clients in the program they are assigned to. This staffing crisis has also impacted our CBO's.

We have also seen a reduction in Commercial Sexual Exploitation of Children (CSEC) referrals. While Behavioral Wellness continues to participate in the county-wide multidisciplinary team meetings related to CSEC, we no longer have the RISE program that was able to do much of the screening, outreach and engagement to identify and bring CSEC youth into treatment. The RISE program also did a lot of outreach to the community providing education on CSEC awareness and keeping CSEC on the forefront of folks' minds. The department is looking at ways to reinvigorate CSEC awareness and services.

FSP New Heights (General System Development) – Behavioral Wellness, Community Action Commission and Department of Rehabilitation (DOR) [Augment to Full Service Partnership in FY 20-21] Data

Program Performance (FY 20-21)

FSP New Heights – Transitional Age Youth

Unique Clients Served			
	North	**South**	**West**
Age Group			
0-15	2	1	1
16-25	50	41	30
26-59	0	0	0
60+	0	0	0
Missing DOB	0	0	0
Total	**52**	**42**	**31**
Gender			
Female	27	17	20
Male	25	25	11
Unknown	0	0	0
Ethnicity			
American Indian or Alaska Native	0	1	0
Asian	2	1	2
Black or African American	2	2	3
Mixed Race	0	6	1
Native Hawaiian or Pacific Islander	0	0	0
White	48	31	23
Other	0	1	2
Unknown/Not Reported	0	0	0
Hispanic or Latino			
Hispanic or Latino	33	20	17
Not Hispanic or Latino	14	18	13
Not Reported	5	4	1

Client Outcomes

Child & Adolescent Needs & Strengths Assessment (CANS-50) Age: 6-20 years		**Percent Improvement***	
		Initial to 6 months (n = 5)	**6 to 12 months (n = 3)**
Life Functioning (e.g., ability to communicate and interact with families, communication, social functioning and health status)		*	*
Behavioral/Emotional Needs (e.g., symptoms of depression, anxiety, psychosis and other conditions)		*	*
Risk Behaviors (e.g., self-injury, suicidal behavior, bullying, and running away)		*	*
Cultural Factors (e.g., language, traditions, stress)		*	*
Strengths (e.g., optimism, talents/interests, relationship permanence, and involvement in treatment)		*	*
Milestones of Recovery Scale (MORS) Age: 18+			
		Initial to 6 months (n = 50)	**6 to 12 months (n = 44)**
Showed Improvement^		36%	39%
Remained Stable^		40%	43%
Other Outcomes		**Average per Quarter**	
	North	**South**	**West**
Out of Primary Home Placement	2%	1%	3%
Stable/Permanent Housing	94%	85%	95%
Purposeful Activity (employed, school, volunteer)	63%	60%	46%
Discharged to Higher Level of Care	0%	17%	13%
Discharged to Lower Level of Care	100%	83%	87%
Higher Levels of Care	**% during program admission in FY 20-21**		
	North	**South**	**West**
Incarcerations	2%	12%	0%
Crisis Services	15%	30%	16%
Psychiatric Inpatient Care	7%	12%	0%

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

**Note. On the CANS-50, a higher score indicates more actionable needs (greater problems). A negative percent change indicates that client scores are improving because they have fewer actionable needs. CANS analyses are not included for this program because of the low n per group (see text below).*

Due to a state mandated change, Santa Barbara County began using a new version of the CANS (CANS-50) in July 2018. In addition to changing items and domains, the CANS age range was extended to age 20. This means that more TAY-aged clients now receive a CANS. *Cultural Factors* is a new 3-item domain. We did not present *Caregiver Resources and Needs* for these analyses because caregivers that are entered in the Caregiver A section often change across timepoints and are not currently tracked to allow for a matched comparison.

The CANS data provided shows the percent change in the average number of *actionable needs* within a particular domain. On each item in the CANS, clients are rated a 0-3 on a Likert scale, with higher ratings indicating more serious problems, and a rating of 2 or 3 on an item to be considered an *actionable need*: 0 = no evidence; 1 = history or suspicion, monitor; 2 = interferes with functioning, action needed; 3 = disabling, dangerous; immediate or intensive action needed. For example: at intake, the clients in a program had an average of three actionable needs per client in the 11-item *Life Functioning* domain. At six months, that matched group has an average of two actionable needs per client. This difference corresponds to a 33.3% decrease in their number of actionable needs in that domain. This method of analysis is more meaningful when there are more items in the domains and ratings are more normally distributed. Some scales, such as Cultural Factors, experience large percent differences because the average number of actionable needs are so low that the average actionable needs have positive skew and a floor effect; in other words, it is rare for many clients to be rated as having actionable needs in the *Cultural Factors* domain.

It should also be noted that for transitional-age youth, many clients switch from the CANS to the MORS mid-treatment (when they turn 21). This change in assessment tool reduces the number of CANS comparisons that are available because clients often “age out” of the CANS while still in treatment. As a result, the low Ns (n = 5 intake to six months; n = 3 six to twelve months) from the CANS analyses cannot be considered representative of overall program data and is not provided.

On the MORS, in the first six months of engagement over one third of clients improved, and in the second six months, almost 40% of clients improved. Further, over both time periods at least 40% of clients were stable, suggesting that even when not improving, a large portion of FSP New Heights clients are not deteriorating. At a time when mental illness symptoms often worsen and risk-taking behaviors escalate, keeping TAY stable is especially critical. Note that because the TAY New Heights program transitioned to the FSP at the beginning of the fiscal year, the number of clients captured in these two clinical outcome tools may be slightly lower as many clients experienced administrative transfers from the former non-FSP New Heights TAY program to the new FSP program. As a result, their initial CANS or MORS scores would have been captured under the old program.

Most outcomes are tracked and reported quarterly by the program; all data provided except inpatient admissions reflects the average per quarter. Housing stability was similar for clients in all regions and the vast majority experienced stability (85-95%). One to three percent of clients experienced a placement out of their primary home. About half of TAY served were engaged in

purposeful activities (46-63%). Opportunities for purposeful activity engagement were significantly impacted by COVID social and physical restrictions; client activity engagement may also have been limited by access to activities or technology. The majority of clients in all regions graduated to lower levels of care (83-100%).

The client outcomes table displays the percent of unique clients who experienced a higher level of care during their admission to FSP New Heights TAY in the 20-21 fiscal year. The source of incarceration data is the Santa Barbara Jail and therefore only includes adults; clients were matched from the county electronic health record to the FY 20-21 jail roster. Juvenile hall data were unavailable this year and we are unable to report on these metrics. The source of psychiatric inpatient and crisis services data is the electronic health record. Two percent of clients in North County, 12% of clients in South County, and 0% of clients in West County experienced a jail stay during their admission. Fifteen percent of clients in North County, 30% of clients in South County, and 16% of clients in West County had crisis services contact during their program admission. Seven percent of clients in North County, 12% of clients in South County, and no clients in West County experienced hospitalization during their program admission.

Assertive Community Treatment (ACT) / Assisted Outpatient Treatment (AOT): Santa Barbara, Lompoc and Santa Maria

Adult Assertive Community Treatment (ACT) Programs for adults include Santa Maria ACT FSP (Provider: Telecare; estimated 100 slots), Santa Barbara ACT FSP (Provider: Behavioral Wellness; estimated 100 slots); Lompoc ACT FSP (Provider: Transitions Mental Health Association/Merakey Allos; estimated 85 slots). Each of these teams encompass Assisted Outpatient Treatment (AOT), which practices a model of care similar to “Laura’s Law.”

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

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

Santa Barbara ACT FSP – Behavioral Wellness

Provider:	Behavioral Wellness
Estimated Funding FY 2022/23:	
Estimated Total Mental Health Expenditures	$3,751,916
Estimated CSS Funding	$1,793,516
Estimated Medi-Cal FFP	$1,985,400
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	
Average Cost Per Consumer	$28,210
Estimated Total of Consumers Served	133
Target Population Demographics Served	Adult, Older Adult

Santa Barbara ACT/AOT functions as a multi-disciplinary team. Teamwork ensures that the ACT multi-disciplinary staff delivers intensive and continuous community-based treatment, rehabilitation, and support services to adults with severe and persistent mental illnesses. The ACT/AOT team is composed of Mental Health Practitioners, Nurses, Case Managers, Psychiatrists, an Alcohol and Drug Specialist, and Recovery Assistants.

SB ACT utilizes a recovery-based, client-centered approach. Care coordinators work with clients to create individualized treatment plans to help them reach their recovery and personal goals. The team empowers 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, psychiatrist services, outreach, advocacy, and housing support.

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

homelessness, hospitalizations, incarcerations, and focuses on providing all services using a recovery-based, client-centered approach.

The Assisted Outpatient Treatment (AOT) Program is incorporated into the ACT program. The AOT program outreaches to individuals who have been referred for mental health services and would benefit, but are not voluntarily willing to accept treatment. When a referral is received and it is determined the client meets criteria, the AOT outreach worker will begin outreaching to the individual. The goal is to build rapport with clients and provide them with education on the program and the benefits of treatment through consistent outreach efforts.

The outreach worker will attempt to engage AOT candidates at least three times a week. Outreach workers utilize the same recovery-based, client-centered approach used in ACT. The program does not pressure clients to accept services, but will continue to outreach to the client with the goal of having them gain insight into the benefits of mental health treatment and accept it willingly. More often than not, clients do end up agreeing to receive treatment on a voluntary basis.

Having said that, after three months of outreach efforts, if a client continues to refuse services, but still meets criteria for AOT, a petition will be submitted to the Courts to try and get the client court-ordered for treatment. The AOT outreach worker will continue to support the client through the Court process. Hopefully the client will agree to engage treatment on a voluntary basis under the Court's supervision. Even if they do not agree, the Court can order the client into treatment if they feel the client meets criteria after hearing testimony. Regardless of how a client enters AOT treatment, either voluntarily or court-order, they will be provided ACT services.

When the AOT client enters the ACT/AOT program, the outreach worker will work with ACT staff to conduct a warm hand-off. The outreach worker will also continue to provide the ACT team with valuable insight into the client and provide support as needed. The ACT team and AOT outreach worker are in the same office, which allows for consultation and support for ACT/AOT clients.

Program Challenges and Solutions

The SB ACT/AOT team continues to struggle with staffing shortages. The team was able to fill a number of positions during the year, but had a number of staff resign during the COVID-19 period. The ACT/AOT program was able to fill its program manager position, but has not been able to fill the team supervisor position due to a lack of qualified applicants.

The staffing vacancies cause existing ACT staff to have higher than typical caseloads and has impacted the ability for the program to run to true fidelity. Despite the staff shortages, the program continues to maintain its stated maximum caseload of 100 clients. Compounding the staffing vacancies, the COVID pandemic caused staff to take time off intermittently due to either testing positive for COVID or being exposed and needing to quarantine. Also due to COVID, all clinics reduced in-clinic staffing to minimum levels to reduce the risk of COVID exposure. The

team developed a rotation of staff working in the clinic or telecommuting who worked together to ensure all clients received adequate treatment and support. Psychiatric Nurses, however, continued to come to the clinic each day and provided daily medical support to clients at the clinic and in the field.

In addition to staffing shortages, another challenge has been the difficulty to graduate clients to a lower level of care when they are ready to do so. When other programs do not have openings for clients, the ACT program has to keep clients in the program longer than needed. As a result, this impacts the ACT program's ability to admit new clients since the program is at or near capacity at all times. However, programs and leadership are working on ways to create more flow between programs to ensure all clients get to the appropriate level of care in a timely manner.

One final challenge has been the increased medical needs of older adult clients. As clients begin to age, many require additional medical attention, resulting in more medical appointments to adequately address their needs. This has posed a challenge to staff to be available for all their clients if they have a client on their caseload who has frequent medical appointments and needs. However, ACT staff have come together to support one another and ensure all clients are adequately served if a staff member needs to take a client to an appointment, which can sometimes take several hours. The ACT program nurses have also supported case workers with taking clients to appointments when they have the time to do so.

Lompoc ACT FSP – Merakey Allos

Provider:	**Merakey Allos in FY 2022-23 / Behavioral Wellness**
Estimated Funding FY 2022/23:	
Estimated Total Mental Health Expenditures	$1,970,703
Estimated CSS Funding	$1,237,403
Estimated Medi-Cal FFP	$733,300
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	
Average Cost Per Consumer	$21,897
Estimated Total of Consumers Served	90
Target Population Demographics Served	Adult, Older Adult

On July 1, 2021, Merakey began providing Assertive Community Treatment (ACT) services in the Lompoc region of Santa Barbara County, California. Merakey submitted responses to the County's Request for Proposal (RFP) on February 2, 2021 and received Notice of Intent to Award on April 2, 2021. Between April 2 and July 1, Merakey worked with Santa Barbara County Department of Behavioral Wellness (BeWell) to contract and transition Lompoc ACT from the previous provider, TMHA, to Merakey.

Merakey offered TMHA Lompoc ACT staff equivalent positions within Merakey. These staff began employment with Merakey effective July 1, 2021. The following positions transferred from TMHA to Merakey: Team Leader, Physician Assistant/Prescriber, Registered Nurse, Vocational Specialist, Rehabilitation Specialist, and 2 Substance Abuse Specialists. Merakey provided staff with immediate access to Merakey benefits and perks starting on Day 1 of employment.

Merakey assumed care and treatment for all 76 clients served by the Lompoc ACT team on July 1, 2021. Clients were provided information on Merakey's evidence-based approach to delivering ACT services in accordance with a high-fidelity model. In August 2021, Merakey began admitting new clients to the Lompoc ACT team. Referrals and admissions were on hold during the transition period. Lompoc Adult Clinic is the primary source of referrals to the Merakey Lompoc ACT team, though any county provider can submit a referral for services. Each week, Merakey participates in a collaborative meeting with representatives from programs across Santa Barbara County to discuss referrals and continuity of care.

Program Challenges and Solutions

The COVID-19 pandemic continues to be the biggest challenge facing the Lompoc ACT team. Merakey began providing ACT services in Lompoc during the spread of the highly contagious Delta variant. This requires an adaptive approach to balancing the absolute need for direct client interaction with preventing spread of the disease to a population prone to chronic illness and disparate access to preventive health care services. Merakey leadership continues to evaluate local disease rates and follow CDC and other health authority guidance.

Merakey continues to recruit additional candidates for vacant positions on the ACT team. Vacancies include the Lead Mental Health Clinician and Registered Nurse.

Merakey has identified challenges with clients enrolled in the AOT program. These clients are difficult to engage and are resistant to treatment. Combined with a higher rate of homelessness and hospitalizations, these clients present a challenge to the team's efforts to engage and encourage treatment adherence. Merakey staff continue to work with these clients to highlight the benefits of treatment for clients involved with the justice system.

Santa Maria ACT FSP – Telecare

Provider:	Telecare / Behavioral Wellness
Estimated Funding FY 2022/23:	
Estimated Total Mental Health Expenditures	$1,918,000
Estimated CSS Funding	$1,013,700
Estimated Medi-Cal FFP	$904,300
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	
Average Cost Per Consumer	$17,759.26
Estimated Total of Consumers Served	108
Target Population Demographics Served	TAY, Adult, Older Adult

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

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

   Consumers interface with employment and co-occurring staff when this is a focus of treatment and/or is a barrier to the "hope and dream" for the consumer. Consumers involved with forensic systems are supported in Mental Health/Drug Court as well as Probation obligations. Each consumer is assisted in the areas of medical and psychological health, housing, education, vocational readiness, interpersonal skills development, substance use, and family interactions as identified in a "problems" list. Goals, both short and long term, are prioritized by the consumer. Stages of recovery are addressed by the team to assist consumers in identifying barriers which the consumer may not connect to past or current failures in reaching their own hopes and dreams.

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

C. 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 consumer drives recovery through staff support in the awakening of hopes and dreams. The recovery process involves gaining the knowledge to reclaim one's power and achieve one's desires by learning to make choices that bring strength rather than harm. Recovery involves living a meaningful life with the capacity to love and be loved.

D. 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.

E. 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.

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

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

Program Challenges and Solutions

Santa Maria ACT continued to provide services in the community throughout the pandemic. Engagement in services was more challenging for most clients due to COVID related restrictions. To respond to these challenges, the team increased the use of telehealth for psychiatric appointments, medication support and case management visits and meeting clients in suitable settings in the community.

Stable housing has been found for most clients enrolled in the ACT program in the past year. Challenges emerged when clients were evicted, and new housing options had to be found. Housing continues to be very limited in the Santa Maria region. 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 ACT 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 SNF has been crucial in the placement of these clients.

Staffing issues were a significant concern for the program in the past year. Recruiting qualified candidates can be difficult due to the small pool of candidates in Santa Maria and surrounding areas. The competitive market for job seekers also contributed to difficulties recruiting and retaining new talents. Telecare has implemented innovative strategies company-wide to improve staffing in programs. Weekly meetings take place on a weekly basis to monitor progress

of recruitment efforts and address any concerns. Hiring has improved significantly due to the strategies.

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

Program Performance (FY 20-21)

Assertive Community Treatment (ACT)

	Unique Clients Served		
	North	**South**	**West**
Age Group			
0-15	0	0	0
16-25	7	4	12
26-59	73	87	58
60+	28	42	20
Missing DOB	0	0	0
Total	**108**	**133**	**90**
Gender			
Female	45	53	53
Male	63	80	37
Unknown	0	0	0
Ethnicity			
American Indian or Alaska Native	0	3	2
Asian	5	1	3
Black or African American	7	11	8
Mixed Race	2	9	1
Native Hawaiian or Pacific Islander	0	0	0
White	92	108	75
Other	2	1	1
Unknown/Not Reported	0	0	0
Hispanic or Latino			
Hispanic or Latino	39	35	35
Not Hispanic or Latino	69	97	55
Unknown/Not Reported	0	1	0

Client Outcomes

Milestones of Recovery Scale (MORS) Age: 18+		ACT	
		Initial to 12 months (n = 305)	12 to 18 months (n = 285)
Showed improvement^		30%	22%
Remained stable^		42%	56%
Other Outcomes	**Average per Quarter**		
	North	**South**	**West**
Physical Health Hospitalization	2%	7%	4%
Physical Health Emergency Care	6%	7%	13%
Stable/Permanent Housing	95%	92%	89%
Purposeful Activity (employed, school, volunteer)	67%	*	49%
Discharged to Higher Level of Care	21%	32%	11%
Discharged to Lower Level of Care	5%	9%	50%
Higher Levels of Care	**% during program admission in FY 20-21**		
	North	**South**	**West**
Incarcerations	3%	8%	5%
Crisis Services	12%	4%	22%
Psychiatric Inpatient Care	5%	6%	12%

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

In the 2020-21 fiscal year, clients in ACT had initial, 12-month and 18-month MORS data. In the first year, 30% of clients improved while 40% stabilized. In the next six months, one-fifth improved while 56% stabilized. Clients who remained in treatment for over a year overall saw increased levels of stability compared to those in their first year.

Most outcomes are tracked and reported quarterly by the program. Rates of physical health hospitalization were similar in all regions (2-7%). Physical health emergency care ranges from 6-13%. Most clients had stable/permanent housing (89-95%). An average of a half of clients in West County and two-thirds in North County engaged in purposeful activities; this information was not available for South County. Following their enrollment in ACT, 11-32% of discharged clients transitioned to a higher level of care, while 5-50% of clients graduated to a lower level of care. Circumstances that comprise the group of clients who did not have a change in level of care at discharge were typically that they were discharged because they moved or discontinued their FSP partnership, they transferred to a similar level of care, or were deceased.

The client outcomes table displays the percent of unique clients who experienced a higher level of care during their admission to Assertive Community Treatment in the 20-21 fiscal year. The source of incarceration data is the Santa Barbara Jail and therefore only includes adults; clients were matched from the county electronic health record to the FY 20-21 jail roster. The source of psychiatric inpatient and crisis services data is the electronic health record. Three percent of clients in North County, 8% of clients in South County, and 5% of clients in West County experienced a jail stay during their admission. Twelve percent of clients in North County, 4% of clients in South County, and 22% of clients in West County had crisis services contact during their program admission. Five percent of clients in North County, 6% of clients in South County, and 12% of clients in West County experienced hospitalization during their program admission.

Supported Community Services FSP Summary

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

Supported Community Services South - (Santa Barbara) – PathPoint

Provider:	**PathPoint**
Estimated Funding FY 2022/23:	
Estimated Total Mental Health Expenditures	$1,490,264
Estimated CSS Funding	$ 569,164
Estimated Medi-Cal FFP	$ 921,100
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	
Average Cost Per Consumer	$11,827
Estimated Total of Consumers Served	126
Target Population Demographics Served	TAY, Adult, Older Adult

Pathpoint connects with clients in the Southern region of Santa Barbara County at various housing locations through the supportive services mental health model. PathPoint also provides Residential Support Services (RSS). RSS provides mental health case management services to residents of the El Carrillo, Artisan Court, and Bradley Studios apartments in Santa Barbara. They provide treatment, rehabilitative and supportive services with the goal of helping clients obtain and maintain independent living. PathPoint also provides housing and supports at 2 Adult residential facilities, Phoenix and Mountain Houses.

Program Challenges and Solutions

The program was issued a request for proposal in winter of 2021 which Pathpoint was awarded. PathPoint continues to focus on creating flow (transitioning clients who are ready for a lower level of care). This focus, and increased communication between the other programs (Outpatient clinics, ACT, Crisis, etc.) led to an improvement in the program's ability to accept referrals into their program without having to wait until another staff person is hired. This has been identified as an issue by the programs in the past, so this is good to see and assists the entire system of care in meeting the needs of clients. This shift has also led to the staff working more closely with clients on opportunities to graduate down to a lower level of care, including to community-based services, utilizing warm handoffs throughout all transitions. Another concern expressed by PathPoint is when they admit clients without current treatment plans or assessments, which impacts their ability to adequately document and bill for services provided. The treatment planning process is a focus of the Department and a goal to ensure it runs smoothly in the upcoming year as collaboration by Pathpoint and Behavioral Wellness quality assurance and clinical staff is occurring for timing and completeness of the treatment plans.

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

Provider:	**Transitions Mental Health Association**
Estimated Funding FY 2022/23:	
Estimated Total Mental Health Expenditures	$1,096,841
Estimated CSS Funding	$ 319,341
Estimated Medi-Cal FFP	$ 777,500
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	
Average Cost Per Consumer	$10,968
Estimated Total of Consumers Served	100
Target Population Demographics Served	TAY, Adult, Older Adult

Santa Maria Supported Community Services 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. Additional Master's level clinical staff have been recruited, and more therapeutic groups and individual therapy opportunities have been offered

to consumers. Groups have focused on healthy relationships, self-care, stress management, coping skills, art therapy, co-occurring disorder support, and laughter therapy. Supportive Community Services has provided care for 92 unique individuals YTD in FY 2021-2022.

Program Challenges and Solutions

An inevitable challenge for a program that continues to increase in scope and size is the need for more adequate office space. The program recently relocated to a new building temporarily for staff and client comfort and safety. The space is not ideal and has drawbacks, but due to the high commercial real estate costs, this new location was the most affordable. The team continues to wait on adequate rent funds to locate and secure a long-term space.

The "Great Resignation" has had a negative impact on the Supportive Community Services program. The increase in CPI is over 8%, the highest in decades. The need for increased contract funds to adequately pay staff and address staff concerns regarding on-call pay is a priority. Hourly staff are not compensated in a way that is commensurate with other programs, and salaried staff are not compensated at all for on-call duties. As staff are finding it more and more difficult to balance work and home life in a healthy way, on-call duties have been more burdensome. Due to the changing environment and the impact that isolation, financial stress, and health concerns have had on our staff, it is imperative that we find ways of retaining team members. Turnover and long-term vacancies contribute to staff burnout and have a negative impact on our clients, who have had long-term connections with our staff.

Supported Community Services FSP: PathPoint in Santa Barbara and Transitions Mental Health Association in Santa Maria Data

Program Performance (FY 20-21)

Supportive Community Services (*formerly Supported Housing*)

	Unique Clients Served	
	North	**South**
Age Group		
0-15	0	0
16-25	4	0
26-59	64	79
60+	32	47
Missing DOB	0	0
Total	**100**	**126**
Gender		
Female	49	57
Male	51	69

Unknown	0	0
Ethnicity		
American Indian or Alaska Native	0	1
Asian	9	3
Black or African American	2	10
Mixed Race	0	9
Native Hawaiian or Pacific Islander	0	1
White	87	99
Other	2	2
Unknown/Not Reported	0	1
Hispanic or Latino		
Hispanic or Latino	44	22
Not Hispanic or Latino	55	104
Unknown/Not Reported	1	0

Client Outcomes

Milestones of Recovery Scale (MORS) Age: 18+		
	Initial to 12 months (n = 222)	**12 to 18 months (n = 210)**
Showed improvement^	33%	18%
Remained stable^	45%	63%
Other Outcomes	**Average per Quarter**	
	North	**South**
Physical Health Hospitalization	4%	5%
Physical Health Emergency Care	6%	13%
Stable/Permanent Housing	96%	93%
Purposeful Activity (employed, school, volunteer)	12%	73%
Discharged to Higher Level of Care	18%	47%
Discharged to Lower Level of Care	24%	53%
Higher Levels of Care	**% during program admission in FY 20-21**	
	North	**South**
Incarcerations	2%	1%
Crisis Services	3%	2%
Psychiatric Inpatient Care	2%	2%

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

In the 2020-21 fiscal year, client progress in Supportive Community Services (SCS) were compared using initial, 12-month and 18-month MORS data. Similar to last year, about twice as many clients showed improvement in the first year than in the following six months, and it appears that these clients then stabilized after a year. In fact, 45% of clients in the first year were stable and two-thirds stabilized from 12-18 months, suggesting that program longevity is particularly important in stabilizing clients' mental health.

Most outcomes are tracked and reported quarterly by the program; all data provided except inpatient admissions reflects the average per quarter. Clients in North and South County experienced similar levels of physical health hospitalization (4-5%) while twice as many clients in South County experienced physical health emergency care (13% in South; 6% in North County). Housing stability was also similar for clients in North and South County and the vast majority experienced stability (93-96%). Only 12% of clients in North County were engaged in purposeful activity while 73% of clients in South County were. Opportunities for purposeful activity engagement were significantly impacted by COVID social and physical restrictions; client activity engagement may also have been limited by access to technology and technology literacy. The majority of clients in South County graduated to lower levels of care.

The client outcomes table displays the percent of unique clients who experienced a higher level of care during their admission to Supportive Community Services in the 20-21 fiscal year. The source of incarceration data is the Santa Barbara Jail and therefore only includes adults; clients were matched from the county electronic health record to the FY 20-21 jail roster. The source of psychiatric inpatient and crisis services data is the electronic health record. Two percent of clients in North County and 1% of clients in South County experienced a jail stay during their admission. Three percent of clients in North County and 2% of clients in South County had crisis services contact during their program admission. Two percent of clients in both North County and South County experienced hospitalization during their program admission.

SPIRIT FSP Wraparound Services

Provider:	**Behavioral Wellness, CALM, Casa Pacifica**
Estimated Funding FY 2022/23:	
Estimated Total Mental Health Expenditures	$2,510,910
Estimated CSS Funding	$1,274,910
Estimated Medi-Cal FFP	$1,201,000
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$35,000
Average Cost Per Consumer	$26,711
Estimated Total of Consumers Served	94
Target Population Demographics Served	Children, TAY

The SPIRIT Full Service Partnership (FSP) Wraparound program for children ages 6-15 and their families is an evidenced-based, intensive treatment model designed around the following MHSA

core principles: children and family involvement and empowerment, culturally competent and appropriate services, integration into existing systems, increasing informal supports, collaboration and partnership and wellness and recovery.
The SPIRIT program operates in all three regions of the County as a specialized team that provides intensive, high frequency services to a disenfranchised, underserved population of children and families that have limited resources, have failed to thrive with conventional treatment, and whose children are at risk for placement in out-of-county, high-level group home facilities due to emotional and behavioral issues.

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

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.

Program Challenges and Solutions

The SPIRIT team services are designed to provide high-frequency, intensive services within the home and/or community to both the child and family members, in which regular attempts to outreach 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. Secondly, it is not uncommon for SPIRIT children and families to have limited resources and complex socio-economic barriers, thus at times they struggle with transitioning out of SPIRIT's intensive, supportive 24/7 wraparound care. Resolutions to these problems have included expanded collaboration with community based organizational partners, community resources, school teams, and informal supports, in order to assist families in transitioning to a lower level-of-care as their circumstances improve.

Since July 2019, Behavioral Wellness implemented an enhanced staffing structure for the SPIRIT program, in which the Parent Partner is employed by CALM (a community-based organization) and is taking a lead role in engaging parents/caregivers, providing urgent parent response and de-escalation to sustain families, while further promoting that parents collaborate with their children's school teams. Additionally, the changes in the SPIRIT team structure offer increased support outside regular business hours to ensure that parent partners can offer extensive

assistance as in alignment with wraparound program model ideals. 2021/2022: Due to low staffing, CALM has been unable to maintain a Parent Partner in the Santa Maria region for the majority of the year which has increased the needs that are required from the remainder of the Spirit team.

The Spirit program regularly and more consistently sees clients in-person while following all safety guidelines such as the use of masks and social distancing. CALM transitioned back to in-person service by September 2021.

SPIRIT FSP Wraparound Services (SPIRIT) – Behavioral Wellness/CALM Data

Program Performance (FY 20-21)

SPIRIT

	Unique Clients Served		
	North	**South**	**West**
Age Group			
0-15	31	22	23
16-25	4	11	3
26-59	0	0	0
60+	0	0	0
Missing DOB	0	0	0
Total	**35**	**33**	**26**
Gender			
Female	15	24	18
Male	20	9	8
Unknown	0	0	0
Ethnicity			
American Indian or Alaska Native	0	0	0
Asian	0	0	0
Black or African American	1	2	3
Mixed Race	0	1	1
Native Hawaiian or Pacific Islander	0	0	0
White	32	29	20
Other	1	1	1
Unknown/Not Reported	1	0	1
Hispanic or Latino			
Hispanic or Latino	23	26	21
Not Hispanic or Latino	10	7	4
Not Reported	2	0	1

Client Outcomes

Child & Adolescent Needs & Strengths Assessment (CANS-50) Age: 6-20 years	Percent Improvement*	
	Initial to 6 months (n = 4)	6 to 12 months (n = 2)
Life Functioning (e.g., ability to communicate and interact with families, communication, social functioning and health status)	*	*
Behavioral/Emotional Needs (e.g., symptoms of depression, anxiety, psychosis and other conditions)	*	*
Risk Behaviors (e.g., self-injury, suicidal behavior, bullying, and running away)	*	*
Cultural Factors (e.g., language, traditions, stress)	*	*
Strengths (e.g., optimism, talents/interests, relationship permanence, and involvement in treatment)	*	*
Other Outcomes	**Average per quarter**	
	All Regions	
Out of Primary Home Placement	1%	
Stable/Permanent Housing	98%	
Purposeful Activity (employed, school, volunteer)	98%	
Discharged to Higher Level of Care	10%	
Discharged to Lower Level of Care	90%	
Higher Levels of Care	**% during program admission in FY 20-21**	
	All Regions	
Juvenile Hall (average per quarter)	1%	
Crisis Services	13%	
Psychiatric Inpatient Care	3%	

**Note. On the CANS-50, a higher score indicates more actionable needs (greater problems). A negative percent change indicates that client scores are improving because they have fewer actionable needs. CANS analyses are not included for this program because of the low n per group (see text below).*

Due to a state mandated change, Santa Barbara County began using a new version of the CANS (CANS-50) in July 2018. In addition to changing items and domains, the CANS age range was extended to age 20. This means that more TAY-aged clients now receive a CANS. *Cultural Factors* is a new 3-item domain. We did not present *Caregiver Resources and Needs* for these analyses because caregivers that are entered in the Caregiver A section often change across timepoints and are not currently tracked to allow for a matched comparison.

The CANS data provided shows the percent change in the average number of *actionable needs* within a particular domain. On each item in the CANS, clients are rated a 0-3 on a Likert scale, with higher ratings indicating more serious problems, and a rating of 2 or 3 on an item to be considered an *actionable need*: 0 = no evidence; 1 = history or suspicion, monitor; 2 = interferes with functioning, action needed; 3 = disabling, dangerous; immediate or intensive action needed. For example: at intake, the clients in a program had an average of three actionable needs per

client in the 11-item *Life Functioning* domain. At six months, that matched group has an average of two actionable needs per client. This difference corresponds to a 33.3% decrease in their number of actionable needs in that domain. This method of analysis is more meaningful when there are more items in the domains and ratings are more normally distributed. Some scales, such as Cultural Factors, experience large percent differences because the average number of actionable needs are so low that the average actionable needs have positive skew and a floor effect; in other words, it is rare for many clients to be rated as having actionable needs in the *Cultural Factors* domain.

Unfortunately, the number of SPIRIT clients who had at least two CANS during the 20-21 fiscal year was very low (Intake to 6 months: n = 4; 6 to 12 months: n = 2). Upon review of the data, it appears that the main challenge was that clients were not open to programs within the same admission long enough for multiple CANS to be matched. Further review showed that many clients experienced administrative errors whereby admissions were discharged and re-opened the next day, which impacted pre-post analyses because CANS are analyzed based on program admission dates. While a client would not experience an interruption in service and would be administered CANS according to the same schedule, our analytic software looks for two or more CANS within the same admission. Therefore, a second CANS administration during a new admission would appear to our pre-post analyses like two initial CANS measures for two different admissions. As a result, the data from the CANS analyses cannot be considered representative of overall program data and is not provided. We have addressed these administrative errors so data analyses are not impacted in the future.

Most outcomes are tracked and reported quarterly by the program; all data provided except crisis services and inpatient admissions reflects the average per quarter. In the 2020-2120 fiscal year, clients in the SPIRIT Program had quite positive outcomes. Nearly all SPIRIT clients experienced residential stability (98%) and were engaged in purposeful activity (98%). A quarterly average of 1% experienced out of primary home placement and of the clients who were discharged, 90% discharged to a lower level of care.

The client outcomes table displays the percent of unique clients who experienced a higher level of care during their admission to SPIRIT in the 20-21 fiscal year. The source of juvenile hall data is quarterly reports while psychiatric inpatient and crisis services data are from the electronic health record. Across all regions, 3% experienced juvenile hall stays, 13% of SPIRIT clients had crisis services contact during their program admission, and 3% of SPIRIT clients experienced hospitalization.

Justice Alliance FSP

Provider:	Behavioral Wellness, Good Samaritan
Estimated Funding FY 2022/23:	
Estimated Total Mental Health Expenditures	$2,464,964
Estimated CSS Funding	$2,257,864
Estimated Medi-Cal FFP	$ 207,100
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	
Average Cost Per Consumer	$19,409
Estimated Total of Consumers Served	127
Target Population Demographics Served	TAY, Adult, Older Adult

The Justice Alliance countywide program is a time-limited, outreach and engagement, specialized Full-Service Partnership (FSP) program that seeks to provide transitional, supportive services and linkage to individuals with mental health needs, who are criminal justice-involved. The Justice Alliance program was designed to remove barriers to accessing treatment, while assisting individuals with navigating both the criminal justice and behavioral health systems. The Justice Alliance team provides services that promote stabilization, reintegration in the community and reduced recidivism with the goal of linking them to longer-term care, such as the Assertive Community Treatment (ACT) program or an outpatient clinic. The individuals served often have co-occurring substance abuse disorders. Many of the individuals assessed are underserved or unserved members of ethnically diverse populations in need of integrated, customized, mental health and/or substance abuse treatment.

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, facilitate access and linkage to treatment. Justice Alliance also provides ongoing progress reports to the Court supporting client's reintegration with the goal being to prevent 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.

In addition, Justice Alliance psychologists provide competency restoration services to misdemeanants found to be Incompetent to Stand Trial (IST) in both the inpatient Psychiatric Hospital Facility (PHF), Crisis Residential Treatment (CRT) and board and care placement settings. When providing restoration services, the team utilizes various residential resources such board and care facilities and crisis residential treatment programs.

Program Challenges and Solutions

The Justice Alliance (JA) team has had some ongoing staffing challenges at both the line staff and leadership levels. During much of the year, the team functioned without an assigned Team Supervisor or Manager despite recruitment efforts. Division Chief of Clinical Operations stepped in to assist on an interim basis. Despite vacancies, the team has continued to meet all service requirements of the program while also managing to maintain services during COVID interruptions. Happy to announce that April saw the onboarding of a Forensic Manager to oversee the JA program.

Due to COVID, direct access to JA clients has been limited as visitors to the jail, PHF and CRT's were not allowed in an effort to prevent spread of the virus. The JA team has managed to provide a fast majority of services remotely. In addition, with intermittent closure of some facilities due to COVID including PHF, CRT's Residential SUD programs and shelters, the JA team has had to become agile and creative in providing secure living arrangements for clients.

Midway through the year there was a change in misdemeanor legislation moving away from restoration and to a community diversion model. The JA team worked closely with county Judges, Probation and the Public Defender's office to pivot and adapt to the changing legislation. County Probation, Public Defenders and BWELL have also been meeting on a new pre-arraignment diversion model to more quickly get individuals with severe mental illness out of the jails quickly so they can access needed mental health services in the community.

Forensic FSP Justice Alliance Data

Program Performance (FY 20-21)

Justice Alliance

	Unique Clients Served		
	North	**South**	**West**
Age Group			
0-15	0	0	0
16-25	10	6	2
26-59	31	64	2
60+	2	10	0
Missing DOB	0	0	0
Total	***43***	***80***	***4***
Gender			
Female	6	18	3
Male	37	62	1
Unknown	0	0	0

Ethnicity			
American Indian or Alaska Native	1	2	0
Asian	1	0	1
Black or African American	0	7	0
Mixed Race	3	21	0
Native Hawaiian or Pacific Islander	0	1	0
White	38	48	3
Other	0	0	0
Unknown/Not Reported	0	1	0
Hispanic or Latino			
Hispanic or Latino	26	25	2
Not Hispanic or Latino	16	50	2
Not Reported	1	5	0

Client Outcomes

Milestones of Recovery Scale (MORS) Age: 18+			
		Initial to 6 months (n = 89)	**6 to 12 Months (n = 78)**
Showed improvement^		40%	28%
Remained stable^		27%	50%
Higher Levels of Care	**% during program admission in FY 20-21**		
	North	**South**	**West**
Incarcerations	33%	38%	50%
Crisis Services	10%	11%	0%
Psychiatric Inpatient Care	2%	6%	0%

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

In the 2020-21 fiscal year, clients in the Justice Alliance had initial, 6-month and 12-month MORS data. Over the first six months, two-thirds were either stable or made improvements; over the second six months, over three-quarters were either stable or made improvements. Similar to patterns in other programs, more clients improved in the first six months (40% improved and 27% stabilized), while in the latter six months more clients stabilized (28% improved while 50% stabilized).

The client outcomes table displays the percent of unique clients who experienced a higher level of care during their admission to Justice Alliance in the 20-21 fiscal year. The source of

incarceration data is the Santa Barbara Jail and therefore only includes adults; clients were matched from the county electronic health record to the FY 20-21 jail roster. The source of psychiatric inpatient and crisis services data is the electronic health record. Thirty-three percent of clients in North County, 38% of clients in South County, and 50% of clients in West County experienced a jail stay during their admission. These high percentages make sense in light of the work that Justice Alliance staff do; both because the target population is justice-involved and because the staff work with clients in the jail. Ten percent of clients in North County, 11% of clients in South County, and no clients in West County had crisis services contact during their program admission. Two percent of clients in North County, 6% of clients in South County, and no clients in West County experienced hospitalization during their program admission. Somewhat higher psychiatric hospitalization rates would also make sense for this program as clients served by Justice Alliance are often transitioning from hospitalization to the community to be restored to competency, and may even begin services with Justice Alliance staff prior to their release from an inpatient hospital. In particular, clients who are deemed Incompetent to Stand Trial (IST) are typically unable to consent to treatment in the community and may require extended inpatient services prior to outpatient services. Note that West County percentages are also impacted by the low number of clients open in that region.

Crisis Stabilization Unit (CSU) South and North

Provider:	**Behavioral Wellness; New unit in Santa Maria with Dignity Health and Vituity in FY 2021-22 with MHSA Funding in FY 2022-23**
Estimated Funding FY 2022/23:	
Estimated Total Mental Health Expenditures	$4,539,145 (budget in FY 2022/23 only reflects South Unit)
Estimated CSS Funding	$1,129,145
Estimated Medi-Cal FFP	$1,831,600
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$1,578,400
Average Cost Per Consumer	$15,598
Estimated Total of Consumers Served	291
Target Population Demographics Served	TAY, Adult, Older Adult

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

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

Program Challenges and Solutions

The CSU continues to struggle with adequate referrals and utilization of beds. Law Enforcement drop-offs that were instituted helped initially but then dropped off. The CSU did see increased usage with the addition of the CREDO 47 Stabilization Center and doing screening for them as the center is located in the Crisis Hub of South County.

The biggest challenges this year have been related to the COVID Pandemic. In the initial phases of the Pandemic, and in an effort to keep the unit safe, operational and minimize the risk of COVID exposure the CSU made required physical changes to the unit (plexi-glass barriers, 6ft spacing signage posted, etc.) as well as COVID screening for all people entering the CSU. Public Health required weekly COVID testing/tracking/reporting of all staff. And the CSU began COVID testing direct referrals to avoid the need of an emergency room (ER) visit. As ER's began to fill to capacity, the CSU agreed to admit individuals on 5150 holds on a limited basis, mostly for individuals on grave disability holds that were not a danger to themselves or the public.

Staffing issues related to the pandemic were also a challenge. The greatest staffing challenges occurred at our Psychiatric Health Facility which saw frequent staff shortages due to COVID related absences. In order to keep the PHF open at all costs, we began floating staff from our CSU to the PHF so it could maintain minimum staffing levels. This floating of staff in turn caused the CSU to need to close at times. In order to keep the CSU open even when floating the majority of their staff to the PHF, the department quickly trained all available outpatient nursing staff and Peer Recovery Assistants to work at the CSU. As CSU staff were pulled to the PHF to cover vacancies there, outpatient staff were pulled from their duties in the clinics and assigned to the CSU so CSU could remain open. We hope that in the upcoming year, as COVID impacts are reduced, operations will be at full capacity.

Additionally, MHSA will be funding a new Crisis Stabilization Unit with Dignity Health at Marian Hospital in Santa Maria beginning in FY 2022-23. The new CSU anticipates opening Summer 2022 as a three-year pilot with initial funding from Medi-Cal and General Funds for the first year and MHSA and Medi-Cal in years two and three. This was an initiative as a result of ongoing feedback regarding Hospital Innovations in the MHSA Stakeholder Process, and described in the plan under Innovations.

Opportunities of creating CSUs for improvement of current barriers and challenges:

South County CSU

In January 2016 the Department opened the County's first CSU in South Santa Barbara County. The County CSU was partly funded through Senate Bill 82. Senate Bill 82 "Investment in Mental Wellness" was a State grant that financed the development of CSUs across California. Santa Barbara County was awarded $1,500,000 which provided rehabilitation of a County owned building for the South County CSU. The actual cost of renovations totaled $499,644, and the balance of funds was reallocated to purchase and rehabilitate a Crisis Residential Treatment facility in Santa Maria.

In FY 2021-22, CSU has experienced staffing challenges. Licensed medical staff positions have been difficult to fill and there have been times when the CSU staff have had to fill in shifts at our Psychiatric Health Facility and close CSU. However, CSU now has an onsite provider, Peter Barnett, PA. This has enabled CSU to serve clients with mild to moderate medical conditions.

The North location is NEW in MHSA in 2022, opening Summer 2022 with other funds.

Need for North County CSU

In order to reduce the length of time Clients in a psychiatric emergency or mental health crisis who present at Marian's Emergency Department (ED) remain in the ED, and provide timely mental health crisis stabilization services, Marian will medically clear and transfer these Clients to its newly constructed 8 bed CSU for crisis stabilization services lasting less than 24 hours, in accordance with C.C.R., Title 9, Section 1810.210. Marian will be fully responsible for all services. Marian funded the construction of the CSU.

Additionally, this proposed agreement is for three years in order to evaluate the program's effectiveness and impact on the overall system of care. As a pilot program, the program goals are aligned with the Mental Health Services Act (MHSA) as the program will be monitored and reported on to stakeholders as part of the MHSA 2020-2023 Three Year Plan and Yearly Updates. If MHSA growth funds are available, the program will be sustained by MHSA funds and Medi-Cal reimbursements in subsequent years.

The maximum contract amount was established based on a 1.6 County Medi-Cal Client census per service day totaling $1,600,000 per year. It is estimated that the maximum contract amount will be funded equally from Medi-Cal reimbursements and County matching funds. The census estimates were provided by Marian during the development process. Marian's CSU has capacity to serve 8 patients. Marian will also be accepting privately insured patients in addition to County Clients.

Program Goals of the North CSU

The goals of the Program are to:

- Increase Clients' access to mental health crisis stabilization services by providing timely access to such services;

- Improve the efficacy and integration of medical and mental health crisis services;
- Reduce Marian's ED length of stay for Clients requiring mental health crisis stabilization;
- Reduce unnecessary psychiatric hospitalizations;
- Provide rapid treatment and resolve mental health crisis in the least restrictive setting;
- Reduce use of more restrictive measures for treatment for Clients undergoing mental health crisis;
- Ensure services are individualized, person-centered, recovery-based, and trauma informed in order to build upon strengths and promote stabilization in the community;
- Improve Clients' level of functioning and refer them to an appropriate community resource for Clients returning to the community; and
- Increase coordination to continuity of care plan for Client linkage to mental health and alcohol and drug treatment services.

Five-Year Project Development

The proposed Marian CSU agreement is the result of ongoing discussions between the County and Marian since approximately 2016. In 2021, a program implementation team comprised of Marian representatives (CEO, ED physician, hospital administrator and legal counsel) and County staff (Assistant CEO, BWELL's Director and Assistant Directors, CFO, Contract Manager and program staff subject matter experts, along with County Counsel) was established to work out the details of establishing a North County CSU through Marian. This workgroup met regularly to develop the agreement. During that process, staff conducted extensive reviews of regulations, policies and procedures utilized in other similar units in the State, and information provided by the Department of Health Care Services and the California Behavioral Health Directors Association.

Medi-Cal Site Certification

Per CCR Title 9 Section 1810.435, the Mental Health Plan (MHP) must certify that a provider other than the MHP meets the criteria set forth in the regulations governing Specialty Mental Health Services. This site certification, to be completed by BWELL staff, includes verification of a County contract, verification of a valid fire clearance, verification that the head of service is a licensed mental health professional, and an on-site visit which initially occurred on April 22, 2021. The on-site review consisted of ensuring that the facility is clean, sanitary, and in good repair; that safety policies and procedures are in place; that the client records meet the requirements of all applicable state and federal standards; that medications are stored and dispensed according to all state and federal standards; and that patient's rights are being accommodated. Due to delays with DHCS approval of the subcontract and CDPH licensing approval, the MHP will conduct an additional on-site visit on May 6th, 2022 to ensure that the facility continues to meet requirements for Medi-Cal Site Certification.

The information collected prior to and during the site visit will be submitted to DHCS for approval. Following the initial site certification, BWELL will complete an additional annual site visit to ensure that all policies, procedures, and regulations are being followed and that Medi-Cal site certification can be maintained. Thereafter, Medi-Cal recertification occurs every two years and

follows the same procedure as the initial site certification. The Department looks forward to the opportunity of offering CSU services in North County in the Summer of 2022.

Crisis Stabilization Unit South- Behavioral Wellness Data

Program Performance (FY 20-21)

Crisis Stabilization Unit (CSU)

Unique Clients Served	
	CSU
	South
Age Group	
0-15	0
16-25	41
26-59	227
60+	23
Missing DOB	0
Total	***291***
Gender	
Female	110
Male	181
Unknown	0
Race/Ethnicity	
American Indian or Alaska Native	3
Asian	3
Black or African American	23
Mixed Race	32
Native Hawaiian or Pacific Islander	0
White	230
Other/Not Reported	0
Hispanic or Latino	
Hispanic or Latino	101
Not Hispanic or Latino	190
Not Reported	0

Client Outcomes

To evaluate CSU Program utilization, admissions and discharge data was obtained from the CSU. Note that the total admissions in the table below is 373; this is a duplicated count of all admissions so it is not expected to match the unique count displayed above in the demographics table.

CSU Admissions and discharges (N = 373)	Admission	Discharge
Hospital/Residential Treatment	61%	7%
Crisis Services	18%	0%
Outpatient (Mental Health or Medical)	6%	1%
Justice	10%	0%
Shelter, Supported/Sober Living, Board and Care	1%	17%
Self / Home	2%	52%
CRT	0%	21%
CREDO47 Center	2%	2%

Three-fifths of clients served by the CSU were referred by hospitals (61%). A quarter of clients were referred by crisis services and outpatient programs (24% combined). Ten percent were referred by justice programs and partners. Upon discharge from the CSU, a fifth of clients were admitted to a CRT (21%). Some clients were discharged to home or "self" because they did not meet 5150 criteria to hold, but did not want linkage to another program (self; 52%). Many clients were also discharged to sober living, board and care, or other supported living environment or shelter (17%). Only 7% of clients were discharged to the hospital or a residential treatment facility, suggesting that clients from the CSU are typically stepping down in terms of service intensity.

Higher Level of Care	% with any admissions			
	within 24 hours of discharge	within 7 days of discharge	within 15 days of discharge	within 30 days of discharge
Psychiatric Inpatient Care	4%	8%	9%	11%

Psychiatric Hospitalizations

The client outcomes table displays the percent of clients who experienced an inpatient psychiatric hospitalization within 1, 7, 15, and 30 days following their admission to the CSU in the 20-21 fiscal year. Over the first month following a CSU stay, hospitalization rates rose incrementally as would be expected, though overall the CSU was effective in helping clients avoid inpatient treatment.

Senate Bill 82 (S.B. 82)

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

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

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

- Mobile Crisis Services West Team (funded by SB 82) through January 2020; now in Crisis Services CSS
- Crisis Stabilization Unit Santa Barbara (funded by SB 82), funded in CSS now
- Crisis Stabilization Unit Santa Maria (New, will be funded by CSS or other MHSA funds in FY 2022-23)
- Crisis Residential Facility Santa Barbara and Santa Maria Agnes (funded by SB 82), funded in CSS now
- North Crisis Residential Facility (funded by MHSA CSS)
- Access and Assessment teams, Santa Maria, Lompoc, Santa Barbara (funded by MHSA PEI)
- Children's Crisis Triage (funded by Children's Crisis Triage Grant with SB82, extended additional year to FY 2022-23)

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

Children's Crisis Triage Program

Provider:	Behavioral Wellness
Estimated Funding FY 2022/23:	
Estimated Total Mental Health Expenditures	$482,712
Estimated CSS Funding	$205,412
Estimated Medi-Cal FFP	$157,300
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$120,000
Average Cost Per Consumer	$3,218
Estimated Total of Consumers Served	150
Target Population Demographics Served	Children and TAY (Age 21 and under per grant)

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

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

Program Challenges and Solutions

The upcoming goals of the CCTP include:

- Providing assessment to 70 youth clients presenting at the EDs annually in program years 1, 2, and 3.
- Providing on-going reassessments of youth in the ED on 5150/5585 holds of 80% of youth presenting at the ED in program years 1, 2, and 3.

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

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

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

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

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

Data will be reported as available in the upcoming plan based on grant evaluation. The grant was anticipated to end in October 2021, but has been extended for another year, which will end in FY 2022-23. The services have been supported greatly with Medi-Cal funds and it is anticipated the grant services will be sustained with MHSA and Medi-Cal once the grant concludes.

In FY 22-23, Children's Triage has experienced staffing challenges. The Santa Barbara practitioner position remains open. However, the North County team is fully staffed with a clinician and parent partner. The Children's Triage team continues to work with youth at risk of hospitalization and has been vital in working with the families to support them in linking to ongoing mental health services.

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

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

Children's Crisis Triage Grant
Client Satisfaction Survey Results, FY 19/20 Q1-Q4

Parent/Adult Crisis Triage (N=83)

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

1. Overall, I am satisfied with the services my child and/or family received. 98.8% ≥3
   97.6% Agree/Strongly Agree; 1.2% Neutral

2. The services my child received were right for them. 98.8% ≥3
   97.6% Agree/Strongly Agree; 1.2% Neutral

3. My family got the help we wanted for my child. 97.6% ≥3
   94% Agree/Strongly Agree; 3.6% Neutral

4. As a result of the services my child received…
   My child is better at handling daily life. 97.6% ≥3
   75.9% Agree/Strongly Agree; 21.7% Neutral

5. As a result of the services my child received…
   My child is better able to cope when things go wrong. 97.5% ≥3
   61.4% Agree/Strongly Agree; 36.1% Neutral

Demographics

6. Age Range
   a. 18-24 — 2.4%
   b. 25-59 — 91.6%
   c. 60+ — 4.8%
7. Gender (select all that apply)
   a. Male — 32.5%
   b. Female — 67.5%
   c. Transgender — 0%
   d. Gender non-conforming — 0%
8. Ethnicity (*2 missing responses)
   a. Hispanic/Latino — 43.4%
      (Mexican/Mexican-American, Central American, South American)
   b. Not Hispanic/Latino — 54.2%
      (African, Asian Indian/South Asian, European, Filipino, Middle Eastern, Mixteco, Non-Hispanic Caribbean, Vietnamese)
9. Race (*1 missing response)
   a. American Indian/Alaskan Native — 1.2%
   b. Asian — 2.4%
   c. Black/African-American — 6.0%
   d. Native Hawaiian/Pacific Islander — 0%
   e. White — 72.3%
   f. More than one race — 12%
   g. Decline to state — 4.8%

Survey launched May, 2019.

Prevention and Early Intervention (PEI)

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

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

Mental Health Education and Support to Culturally Underserved Communities

Provider:	**Community Health Centers of the Central Coast (CHCCC), Santa Ynez Tribal Health Clinic (SYNTHC)**
Estimated Funding FY 2022/23:	
Estimated Total Mental Health Expenditures	$ 170,600
Estimated PEI Funding	$ 170,600
Estimated Medi-Cal FFP	
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	
Average Cost Per Consumer/Families	$42
Estimated Total of Consumers/Families Served	Families 2,426 – Participants 4,878
Target Population Demographics Served	Children, TAY, Adult, Older Adult

Community Health Centers of the Central Coast, Inc.

Community Health Centers of the Central Coast, Inc. (CHCCC) is a contracted community partner that provides community-based mental health prevention and early intervention services to the most marginalized populations in Northern Santa Barbara County which includes: Indigenous, Latinx, limited English proficiency individuals, migrants, agricultural farmworkers, the unhoused, LGBTQ+ individuals, rural residents, as well as low-income individuals. 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 Maria, Guadalupe, New Cuyama, Los Alamos, and Lompoc regions of the County. The Mental Health Outreach teams' programmatic focus is the mitigation of the negative social and cultural impacts of immigration as well as

intergenerational trauma to improve the mental, physical and behavioral outcomes of these populations. The "whole-person" approach to population engagement is driven by community-based participatory activities and interventions. The goal of the mental health education and outreach activities is to empower newly bridged members of special populations such as monolingual or 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.

This includes timely access to prevention and early intervention treatment and coordination of care through digital navigators to further reduce mental health stigma and barriers to care.
CHCCC's Mental Health Outreach team addresses the community's lack of knowledge and understanding of mental wellness by providing linguistically accessible, culturally relevant, and evidence-based mental health education. CHCCC create safe health space through trauma-informed, network-wide community circles and groups that foster trust between members of these special populations and the larger systems of care. As a result of CHC's behavioral health integration initiatives, empowered community members have challenged social norms and cultural roles which previously impeded their ability to access mental health services. Through these pointed outreach efforts, CHC'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.

Memorandums of Understanding have been developed and established with local low-income housing programs to provide on-site support groups to predominant monolingual Spanish and limited English proficiency speaking communities. This approach brings the services directly to under-resourced and subsequently underserved community members that otherwise would not seek or attend support groups due to stigma, childcare issues, and transportation barriers.
Furthermore, CHCCC has been successful in developing partnerships with local agricultural employers to gain access to migrant workers at their worksites and has partnered with local Spanish and Mixtec-language radio stations to bring free lunches to workers while providing mental health education. These lunchtime "meet and greets" allow agricultural workers to interact with CHCCC outreach staff informally and build a personal connection that over time facilitates access and linkage to services. CHCCC also conducts ongoing radio and television outreach, education, and anti-stigma efforts and has sponsored and staffed an annual health fair for migrant farmworkers. CHCCC's health outreach fairs focus on health and mental health education, resources, and linkage to services.

Program Challenges and Solutions

As the healthcare industry continues to expand telehealth platforms, CHCCC has found that limited English proficiency, poor health literacy, and subsequent digital illiteracy among vulnerable populations have resulted in gaps in care and in perceived poor patient engagement. In an effort to bridge treatment and services for the Spanish, Mixtec-speaking, and patients with limited English proficiency, CHCCC mental health educators have broadened outreach platforms

to include text messaging campaigns, telehealth consultation, telephonic care coordination, remote patient monitoring, virtual community engagement, and digital adaptation of services. CHCCC's mental health and behavioral health prevention and direct services include care coordination, relevant resource linkage, emergency department utilization follow-up, and language access.

Further, CHCCC's mental health outreach activities include quick, effective, evidence-based interventions from The Trauma Resource Institute's Community Resiliency Model which can be taught to anyone in any setting, language, or culture to reset the nervous system. All the outlined activities and services form a hybrid model of virtual, telephonic, in-clinic, and in-neighborhood services that creates access for our diverse special population and mitigates the disruption of services. Virtual services have enabled CHCCC to reach more individuals with transportation and childcare barriers as well as young patients including transitional age youth.

During the FY 2020-2023 MHSA Planning process, CHCCC partnered with the Santa Barbara County Behavioral Wellness Department staff and hosted MHSA planning events at local schools and housing complexes. This collaborative stakeholder process led to the inclusion of three languages (English, Spanish, and Mixteco) in one event and to the learning and contribution from members of the community to future MHSA programming. As a result, the Department hopes to continue this partnership and outreach strategy in the upcoming planning years.

As the MHSA partnership continues, CHCCC would like to sustain the care coordination services and expand the direct clinical services that are being provided by their clinical social workers, primary care providers, psychiatrists, interpreters, nurses, and allied health professionals to the most vulnerable community members. In alignment with the mission and vision as a network of safety-net community health centers, CHCCC provides "whole-person" fully integrated behavioral health services regardless of an individual's ability to pay and will continue to link clients from the Department to their organization.

Santa Ynez Tribal Health Clinic

The Santa Ynez Tribal Health Clinic (SYTHC) is dedicated to providing comprehensive medical, dental, and behavioral health services. It is located on the Santa Ynez Band of Chumash Indians reservation, federally recognized since 1901. The SYTHC is an Indian Health Federally Qualified Health Center (FQHC) look-alike and receives funding through various sources, including the federal Indian Health Service (IHS), 3rd party revenue and grant sources. The core mission of SYTHC is to serve Native Americans living in Santa Barbara County; however, the clinic serves the public, providing sliding fees based on income and accepts Medicare, Medi-Cal, and most major insurance plans. The services that the Santa Ynez Tribal Health Clinic offers are expansive: including primary medical, dental and behavioral health services to include family practice, pediatrics, general dentistry, individual and family psychotherapy, psychiatry and substance abuse services. Specialty services include chiropractic, nutrition and podiatry. The

clinic provides over 20,000 patient visits per year with an active patient population of more than 7,400.

Program Challenges and Solutions

During the 2021-2022 fiscal year, the Santa Ynez Tribal Health Clinic transitioned from virtual to in-person sweat lodge support groups. Due to the importance of this practice for cultural and spiritual healing, we have seen a much higher rate of attendees. SYTHC hosted community workshops addressing various parts of physical, mental, emotional, and spiritual wellness. SYTHC met with community leaders including CommUnify, Santa Ynez High School Wellness Program, Community Health Centers of the Central Coast, Native Like Water, and 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.

Mental Health Education and Support to Culturally Underserved Communities (Promotora Program) - La Casa de la Raza, Community Health Centers of the Central Coast, Santa Ynez Tribal Health Clinic Data

Program Performance (FY 20-21)

Outreach Events			
PROGRAM	**LCDLR***	**SYTHC**	**CHCCC**
TOTAL # EVENTS	**88**	**119**	**167**
TOTAL # PARTICIPANTS	**2,186 (contacts)**	**621 (contacts)**	**4,878 (unique) 34,729 (contacts)**
TOTAL # FAMILIES SERVED	**755**	**NR**	**1,589**
EVENT TYPE			
Outreach	3	3	39
Training	7	22	24
Forum	6	44	37
Support Group	72	50	67
PRIMARY LANGUAGE OF EVENT			
English	0	119	44
Spanish	88	0	123
Other or both English and Spanish	0	0	0

**only three quarters of data reported*

NR = Not Reported

Note. This data reflects a compilation of Vertical Change data and/or quarterly reports. Therefore, it does not always correspond to the data in the pivot tables collected in Vertical Change.

More detailed information required for PEI reporting is also provided in the PEI Summary (Attachment 1). Each program provided various outreach events, trainings, forums, and support groups to their communities. CHCCC served almost 5,000 unique individuals in North County through outreach events, trainings, and support groups with their total contacts reaching nearly 35,000. Santa Ynez Tribal Health Clinic served West County, had over 600 contacts through their outreach events, trainings, forums, and support groups. La Casa de La Raza served Spanish-speaking individuals in South County and in three quarters (fourth quarter data was not submitted), they had over 2,000 contacts across 88 events and support groups.

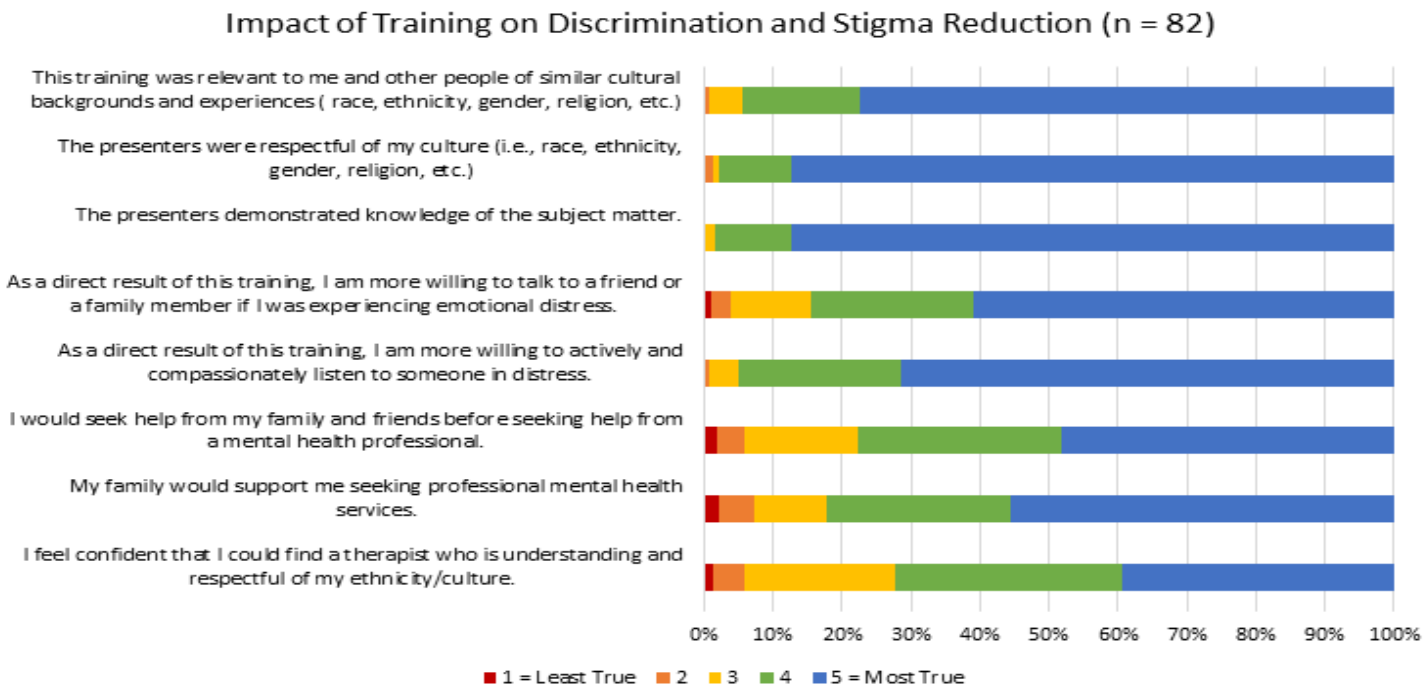
Stigma and Discrimination Reduction - La Casa de la Raza, Santa Ynez Tribal Health Clinic

Program Performance

Stigma and Discrimination Reduction		
PROGRAM	**LCDLR***	**SYTHC**
TOTAL # TRAININGS	**7**	**4**
TOTAL # PARTICIPANTS	**NR**	**82**

*only three quarters of data reported

Santa Ynez Tribal Health Clinic provided four community trainings focused on reducing stigma and discrimination related to mental illness. Following each training, they assessed the impact of their training on the audience using items from *Attitudes toward Mental Health Treatment Scale – Depression* (Brown et al, 2010). See results in the chart below.



For the majority of questions, on average 88% of the audience endorsed fours and fives ("most true"), suggesting that the trainings are effective in achieving their goals. The most highly endorsed questions were, "*the presenters demonstrated knowledge of the subject matter*" and "*the presenters were respectful of my culture (i.e., race, ethnicity, gender, religion, etc.)"* (both were 98% fours and fives). The question that received the lowest agreement was: "*I feel confident that I could find a therapist who is understanding and respectful of my ethnicity/culture*" (72% fours and fives), suggesting that there is still more work to be done both to increase cultural competence among mental health professionals as well as community perceptions that they can find a culturally competent therapist.

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

Provider:	**CALM, Santa Ynez Valley People Helping People (SYVPHP)**
Estimated Funding FY 2021/22:	
Estimated Total Mental Health Expenditures	**$1,517,500**
Estimated PEI Funding	**$591,300**
Estimated Medi-Cal FFP	**$926,200**
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	
Average Cost Per Consumer	**$2,662**
Estimated Total of Consumers Served	**570**
Target Population Demographics Served	**Children, TAY, Adult**

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

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

There are two Programs funded under this initiative:

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

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

During the COVID-19 pandemic, CALM continued to provide uninterrupted mental health services and education. At the beginning of the pandemic, services were largely provided via telehealth platforms to ensure the safety and well-being of clients and staff. Last fall we were able to return to mostly in-person services while following all safety guidelines such as the use of masks and social distancing. We have been able to respond quickly to surges (I.e. Omicron) by returning to tele-health temporarily and then shifting back to in-person services when it was deemed safe to do so. We look forward to maintaining the ability to continue to provide services via tele-health whenever that is clinically indicated, though our staff believe that most families greatly benefit from in-person services when it is safe to engage this way.

CALM continues to use community outreach via on-line platforms during COVID-19 to share knowledge of child development and intervention strategies with the public and other community organizations. Some of these outreach engagements include: providing information to the community at Noah's Anchorage, Boys and Girls Club, CADA, Family Day in the Park – YMCA, the Safe Sleep Awareness Campaign, training Carpinteria parents on Protective Factors and ACES, participation in the Lompoc Public Health Department Meetings and the NICU reunion. Staff have participated in outreach with local community schools, the Carpinteria Health Fair, and the Wilderness Youth project. CALM is also affiliated with the following community groups: Early Childhood Family Wellness Coalition, Child Abuse Prevention Coalition (CAPC), and Medically Vulnerable Population Care Coordination.

Staff receive ongoing clinical training and case consultation at weekly clinical staff meetings as well as individual and group clinical supervision as needed. Supervision has been provided mostly in-person this year, while clinical trainings have been provided via on-line platforms such as Zoom. Clinical supervisors attended a training on Clinical Supervision Guidelines. Additionally, staff attended trainings on Healthy Families of America, Partners for a Healthy Baby Curriculum, Cultural Sensitivity training, Suicide Risk Assessment, Parent-Child Care (PC-CARE), Interpersonal psychotherapy, Parent Child Interaction Therapy (PCIT), Trauma-Focused Cognitive Behavioral Therapy, Reflective Practice, and Play Therapy.

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

This Program provides services to low-income monolingual Spanish speaking children and families in the Santa Ynez Valley in Central County. Services are based at four school sites. Parents may access services in their neighborhood and in their homes. This component provides needed services in an area of the Central County where program resources are limited. Key goals include providing education and support services to children and families that promote positive parenting by conducting at least three groups a year with cohorts of at least 8-10 parents. In order to assist children and families in their mental health recovery by developing skills needed to lead healthy and productive lives, People Helping People aims to screen and assess at least 80 families that present with mental health issues, provide 45 children with developmental screenings, and provide least 60 referrals to family service coordinators who provide case management and linkages to other needed services in the community. People Helping People exceeded these goals in FY 19-20.

Program Challenges and Solutions

In addition to the impacts of COVID-19, Cencal, the Health Authority in Santa Barbara County, has additional funding for Medi-Cal beneficiaries for family therapy and behavioral health support to parents or their children who need services based on a new service benefit in their Health Plan. This new benefit requires coordination and linkage to services between the Department, Community Based Organizations, and Cencal providers. As a result, the Department will be working with Cencal on the best design, helping create a well-resourced program for their system, and monitoring how this is delivered within MHSA to ensure funding is appropriately aligned and the system's resources are well-allocated for the parents and youth. Many more parents are requesting individual counseling and support while they navigate parenthood, separation and divorce, domestic violence, addiction, unemployment, illness and other challenges. It has been difficult to meet the needs of all clients referred due to full caseloads. However, when the school term ends any waitlisted clients will receive services right away, as some students will choose to conclude or suspend their services during the summer months.

PEI Early Childhood Mental Health (ECMH) – CALM, Santa Ynez Valley People Helping People Data

Program Performance

CALM ECMH (Prevention – Great Beginnings)

Unique Clients Served	
	All Regions
Age Group	
0-15	73
16-25	0
26-59	4
60+	0
Missing DOB	0
Total	**77**
Gender	
Female	42
Male	35
Unknown	0
Ethnicity	
American Indian or Alaska Native	0
Asian	0
Black or African American	2
Mixed Race	0
Native Hawaiian or Pacific Islander	0
White	59
Other	16
Unknown/Not Reported	0
Hispanic or Latino	
Hispanic or Latino	61
Not Hispanic or Latino	16
Not Reported	0

SYVPHP ECMH (Prevention)

Unique Clients Served	
	SYVPHP
Age Group	
0-15	71
16-25	13
26-59	12
60+	0
Missing DOB	0
Total	**96**
Gender	
Female	51
Male	45
Unknown	0
Ethnicity	
American Indian or Alaska Native	0
Asian	0
Black or African American	4
Mixed Race	12
Native Hawaiian or Pacific Islander	0
White	80
Other/Not Reported	0
Hispanic or Latino	
Hispanic or Latino	46
Not Hispanic or Latino	50
Not Reported	0

CALM ECSMH (Early Intervention – Specialty Mental Health Services)

	Unique Clients Served		
	North	**South**	**West**
Age Group			
0-15	233	148	112
16-25	0	0	0
26-59	0	0	0
60+	0	0	0
Missing DOB	0	0	0
Total	**233**	**148**	**112**

Gender			
Female	109	64	53
Male	123	84	55
Unknown	1	0	4
Ethnicity			
American Indian or Alaska Native	4	0	0
Asian	2	0	1
Black or African American	10	0	6
Mixed Race	0	5	1
Native Hawaiian or Pacific Islander	2	0	0
White	206	128	80
Other	2	4	1
Unknown/Not Reported	7	11	23
Hispanic or Latino			
Hispanic or Latino	168	113	48
Not Hispanic or Latino	47	25	17
Not Reported	18	10	47

Client Outcomes

Child & Adolescent Needs & Strengths Assessment (CANS-50) Age: 6-20 years		
	Early Intervention CALM ECSMH Specialty Mental Health Percent Improvement*	
	Initial to 6 months (n = 76)	**6 to 12 months** (n = 41)
Life Functioning (e.g., ability to communicate and interact with families, communication, social functioning and health status)	-28.9%	-72.5%
Behavioral/Emotional Needs (e.g., symptoms of depression, anxiety, psychosis and other conditions)	-42.3%	-65.8%
Risk Behaviors (e.g., self-injury, suicidal behavior, bullying, and running away)	0.0%	-100.0%
Cultural Factors (e.g., language, traditions, stress)	0.0%	-100.0%
Strengths (e.g., optimism, talents/interests, relationship permanence, and involvement in treatment)	-13.7%	-54.8%

Child Behavior Checklist & Parenting Stress Index		
	Prevention CALM ECMH Great Beginnings	**Early Intervention CALM ECSMH Specialty Mental Health**
At least 65% of children/youth scoring in the Clinical range of **Internalizing Behavior** at intake will be in the Non-Clinical range at most recent follow up, as measured by the *Child Behavior Checklist*.	50%	49%
At least 65% of children/youth scoring in the Clinical range of **Externalizing Behavior** at intake will be in the Non-Clinical range at most recent follow up, as measured by the *Child Behavior Checklist*.	33%	61%
At least 65% of parents scoring in the Clinical range of **Total Parenting Stress** at intake will be in the Non-Clinical range at most recent follow up, as measured by the *Parenting Stress Index*.	No follow-up data due to early termination	60%
Increased knowledge of child development (care, nutrition, discipline)	100%	100%
Increased knowledge of resources	100%	100%
Families linked to services	100%	100%
Other Outcomes		
	Average per quarter	**Average per quarter**
Out of Primary Home Placement	0%	0%
Stable/Permanent Housing	96%	99%
Purposeful Activity (employed, school, volunteer)	99%	100%
Discharged to Higher Level of Care	4%	3%
Discharged to Lower Level of Care	96%	97%
Higher Levels of Care		
	% with any admissions over FY 20-21	**% with any admissions over FY 20-21**
Juvenile Hall	--	--
Crisis Services	0%	0%
Psychiatric Inpatient Care	0%	0%

**Note.* On the CANS-50, a higher the score indicates more actionable needs (greater problems). A negative percent change indicates that client scores are improving because they have fewer actionable needs.

Activities	SYVPHP
Provide 30 parenting education and support groups to families/Parents	24 (80%)
Provide 80 screenings and assessments to families presenting with mental health issues	178 (223%)
Provide developmental screenings to 45 children	10 (22%)
Provide 60 referrals to Family Services Coordinators for case management and linkages/referrals to other needed services	612 (1,020%)

Due to a state mandated change, Santa Barbara County began using a new version of the CANS (CANS-50) in July 2018. In addition to changing items and domains, the CANS age range was extended to age 20. This means that more TAY-aged clients now receive a CANS. *Cultural Factors* is a new 3-item domain. We did not present *Caregiver Resources and Needs* for these analyses because caregivers that are entered in the Caregiver A section often change across timepoints and are not currently tracked to allow for a matched comparison.

The CANS data provided shows the percent change in the average number of *actionable needs* within a particular domain. On each item in the CANS, clients are rated a 0-3 on a Likert scale, with higher ratings indicating more serious problems, and a rating of 2 or 3 on an item to be considered an *actionable need*: 0 = no evidence; 1 = history or suspicion, monitor; 2 = interferes with functioning, action needed; 3 = disabling, dangerous; immediate or intensive action needed. For example: at intake, the clients in a program had an average of three actionable needs per client in the 11-item *Life Functioning* domain. At six months, that matched group has an average of two actionable needs per client. This difference corresponds to a 33.3% decrease in their number of actionable needs in that domain. This method of analysis is more meaningful when there are more items in the domains and ratings are more normally distributed. Some scales, such as Cultural Factors, experience large percent differences because the average number of actionable needs are so low that the average actionable needs have positive skew and a floor effect; in other words, it is rare for many clients to be rated as having actionable needs in the *Cultural Factors* domain.

Clients in the ECSMH Specialty Mental Health program saw reductions in the number of actionable needs across all CANS domains with the exception of *Risk Behaviors* and *Cultural Factors* from intake to six months. Both of these domains had very low averages of actionable needs (a floor effect and positive skew), which amplified any small changes over time and should therefore be interpreted with caution. While children saw a reduction in actionable needs in the other three domains in both time period comparisons, the group of clients that had a CANS administered at six and twelve months (n = 41) saw greater reductions in their number of actionable needs than the larger group seen from intake to six months. The group

assessed from six to twelve month saw between 55-73% reduction in actionable needs, suggesting significant progress for children and families who persist in treatment for longer periods.

More detailed information required for PEI reporting is also provided in the PEI Summary (Attachment 1). Note that in the ECMH Great Beginnings Program, there are a few clients who fall outside the age range of 0-6 years old; this is because pregnant women are able to start services in the prenatal period. After giving birth, services are transferred to their child. Therefore, while the baby is always the client, services are initially captured under the parent. During fiscal year 2020-2120, CALM's Great Beginnings program (ECMH Prevention) served 77 families. No clients had new out-of-primary home placements and 96% had stable or permanent housing. After six months in treatment, 50% of children who fell in the clinical range for internalizing behaviors at intake were in the non-clinical range at follow up, and 33% of the children who fell in the clinical range for externalizing behaviors were in the non-clinical range at follow up. All parents who participated in the program experienced increased knowledge of children development and resources, as well as linkage to appropriate services.

CALM's Specialty Mental Health program (ECSMH Early Intervention) served 493 children and their families across the county in fiscal year 2020-2120. Similar to the Great Beginnings program, no clients had new out-of-primary home placements and almost all (99%) had stable or permanent housing. After six months in treatment, about half (49%) of children who fell in the clinical range for internalizing behaviors at intake were in the non-clinical range at follow up, and 61% of the children who fell in the clinical range for externalizing behaviors were in the non-clinical range at follow up. Furthermore, 60% of parents who were in the clinical range for parenting stress at intake were in the non-clinical range at follow-up. All parents who participated in the program experienced increased knowledge of children development and resources, as well as linkage to appropriate services.

The client outcomes table displays the percent of clients who experienced an inpatient psychiatric hospitalization during their admission to the program in the 20-21 fiscal year. In all regions, no clients in either ECMH or ECSMH program experienced hospitalization or contact with crisis services. Note that these outcomes would be quite rare due to the age of the children served. Juvenile hall data were unavailable this year and we are unable to report on these metrics, though this is similarly an unlikely occurrence for this age group.

People Helping People served 96 individuals over the 2020-2120 fiscal year. Their performance objectives relate to their program goals of providing education, screenings, and linkage/referrals. They provided 24 parenting education and support groups (Nurturing

Parenting curriculum), 178 screenings and assessments, 10 developmental screenings to children, and 612 referrals and linkage for additional services. It should be noted that in-person services such as parenting education and support groups and developmental screenings were lower than last year because of the impacts of COVID. No groups or screenings occurred from July to December 2020; these activities resumed in 2021. However, throughout the year, People Helping People continued to screen and assess families presenting with mental health concerns and link them to services.

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

Provider:	**Family Services Agency, Council on Alcoholism and Drug Abuse**
Estimated Funding FY 2022/23:	
Estimated Total Mental Health Expenditures	$502,600
Estimated PEI Funding	$332,500
Estimated Medi-Cal FFP	$170,100
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	
Average Cost Per Consumer	$4,053
Estimated Total of Consumers Served	124
Target Population Demographics Served	Children, Transitional Age Youth (TAY)

The START (Support, Treatment, Advocacy and Referral Team) Program is a partnership between Family Service Agency (FSA), the Council on Alcoholism and Drug Abuse (CADA),), 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.

Program Challenges and Solutions

The 2021-2022 START Team included only one returning part-time therapist, so this has been a rebuilding school year for the START program. The new START Therapists needed time to become familiar with Medi-Cal protocols and procedures and build their caseloads. In addition, one of the new therapists resigned her position half-way through this school year, which created the challenge of hiring a new qualified clinician during a time when the demand for mental health professionals appears to be much higher than the supply. Luckily, one of our staff members was able to provide part-time coverage temporarily while we searched for a permanent replacement. By the end of March, we were back to a full staff roster. In addition to staffing challenges, the START Team faced challenges posed by the COVID-19 pandemic; in particular, the Omicron surge in January and early February disrupted the consistent delivery of START services. During this surge, some therapy sessions needed to be canceled due to client or therapist illness and necessary quarantines. Despite these challenges, the START team demonstrated persistence and dedication as they gradually increased their productivity levels and continued to admit more clients during each quarter. Overall, it has been the START therapists' resilience and strong work ethic which has helped the program recover and overcome these challenges. Also, the collaborative nature of the START team's relationship with school staff has been another source of strength. The START Therapists supported the launch of the S.O.S (Signs of Suicide) program in the Carpinteria School District in February. Although this was the first time that the school district provided this curriculum to their middle and high school students, the program was a success. The school staff continues to seek out support and collaboration from the START Team, and school district leadership has expressed a desire for school-based services to be extended past the end of the school year and through the summer vacation. This new development demonstrates the school district's confidence in the START team and the strength of the partnership between Family Service Agency and school staff.

For Casa Pacifica, the biggest challenge for FY 21/22 has been hiring qualified staff (LPHAs) to work at the START program. A huge deficit in qualified candidates has meant that positions were left unfilled until February 2022. For CADA, this meant that one part time therapist (who also serves as program manager) was serving 3 school sites. This caused a reduction in the number of clients served and the number of services provided. CADA is pleased to now have 100% staffing and a growing caseload and hopes that by the end of FY 21/22 we will again be at full capacity.

School-Based Prevention/Early Intervention Services for Children and TAY (START) - Family Service Agency, Council on Alcoholism and Drug Abuse Data

Program Performance (FY 20-21)

School-Based Prevention/Early Intervention Services (START)

	Unique Clients Served		
	START South (FSA & CADA)	**School-based South (FSA)**	**School-based West (FSA)**
Age Group			
0-15	42	21	34
16-25	9	13	5
26-59	0	0	0
60+	0	0	0
Missing DOB	0	0	0
Total	**51**	**34**	**39**
Gender			
Female	25	26	21
Male	26	8	18
Unknown	0	0	0
Ethnicity			
American Indian or Alaska Native	0	1	2
Asian	0	0	1
Black or African American	0	0	1
Mixed Race	0	0	1
Native Hawaiian or Pacific Islander	0	0	1
White	49	29	32
Other	0	0	1
Unknown/Not Reported	2	4	0
Hispanic or Latino			
Hispanic or Latino	43	33	29
Not Hispanic or Latino	8	1	10
Not Reported	0	0	0

Client Outcomes

Child & Adolescent Needs & Strengths Assessment (CANS-50) Age: 6-20 years	Percent Improvement*	
	Initial to 6 months (n = 50)	**6 to 12 months (n = 38)**
Life Functioning (e.g., ability to communicate and interact with families, communication, social functioning and health status)	-26.7%	-56.3%
Behavioral/Emotional Needs (e.g., symptoms of depression, anxiety, psychosis and other conditions)	-37.8%	-41.9%
Risk Behaviors (e.g., self-injury, suicidal behavior, bullying, and running away)	-83.3%	-100.0%
Cultural Factors (e.g., language, traditions, stress)	-50.0%	-100.0%
Strengths (e.g., optimism, talents/interests, relationship permanence, and involvement in treatment)	-6.7%	-21.4%

Other Outcomes	Average per quarter		
	START South (CADA)	**START South (FSA)**	**School-based South & West (FSA)**
Out of Primary Home Placement	0%	0%	1%
Stable/Permanent Housing	98%	100%	100%
Purposeful Activity (employed, school, volunteer)	100%	100%	100%
Discharged to Higher Level of Care	3%	0%	8%
Discharged to Lower Level of Care	97%	85%	60%
Higher Levels of Care	**% with any admissions over FY 20-21**		
	START South (CADA)	**START South (FSA)**	**School-based South & West (FSA)**
Juvenile Hall	0%	0%	0%
Crisis Services	3%	0%	3%
Psychiatric Inpatient Care	0%	0%	1%

**Note. On the CANS-50, a higher score indicates more actionable needs (greater problems). A negative percent change indicates that client scores are improving because they have fewer actionable needs.*

Due to a state mandated change, Santa Barbara County began using a new version of the CANS (CANS-50) in July 2018. In addition to changing items and domains, the CANS age range was extended to age 20. This means that more TAY-aged clients now receive a CANS. *Cultural Factors* is a new 3-item domain. We did not present *Caregiver Resources and Needs* for these analyses because caregivers that are entered in the Caregiver A section often change across timepoints and are not currently tracked to allow for a matched comparison.

The CANS data provided shows the percent change in the average number of *actionable needs* within a particular domain. On each item in the CANS, clients are rated a 0-3 on a Likert scale,

with higher ratings indicating more serious problems, and a rating of 2 or 3 on an item to be considered an *actionable need*: 0 = no evidence; 1 = history or suspicion, monitor; 2 = interferes with functioning, action needed; 3 = disabling, dangerous; immediate or intensive action needed. For example: at intake, the clients in a program had an average of three actionable needs per client in the 11-item *Life Functioning* domain. At six months, that matched group has an average of two actionable needs per client. This difference corresponds to a 33.3% decrease in their number of actionable needs in that domain. This method of analysis is more meaningful when there are more items in the domains and ratings are more normally distributed. Some scales, such as Cultural Factors, experience large percent differences because the average number of actionable needs are so low that the average actionable needs have positive skew and a floor effect; in other words, it is rare for many clients to be rated as having actionable needs in the *Cultural Factors* domain.

Clients in START and School-based Counseling saw reductions in the number of actionable needs across all 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.

During fiscal year 2020-2120, START and School-Based Counseling Programs served a combined 124 clients. No clients had new out-of-primary home placements, all were engaged in purposeful activity, and nearly all had stable or permanent housing. The vast majority of clients were discharged to lower levels of care; 0-8% of clients transitioned to a higher level of care. The client outcomes table also displays the percent of unique clients who experienced a higher level of care during their admission to START or School-based Counseling in the 20-21 fiscal year. Juvenile hall data were reported by programs in their quarterly reports. The source of psychiatric inpatient and crisis services data is the electronic health record. Across all regions, zero percent of clients had a stay in juvenile hall. Less than 3% of clients had crisis services contact during their program admission. No clients in START and 1% of clients in School-based Counseling experienced hospitalization during their program admission.

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

Provider:	Behavioral Wellness
Estimated Funding FY 2022/23:	
Estimated Total Mental Health Expenditures	$1,129,298
Estimated PEI Funding	$124,398
Estimated Medi-Cal FFP	$1,004,900
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	
Average Cost Per Consumer	$5,482
Estimated Total of Consumers Served	206
Target Population Demographics Served	Children, TAY, Adult (if aging into age 25)

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

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

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

The staffing involves Psychiatrist, Psychiatric Technician, practitioners, case workers and extra help TAY peers.

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

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. Recreational funds will be set aside in the new FY to assist with the planning and creation of social activities for both PEI and New Heights FSP TAY population. We will be providing training for all staff working in the PEI program to implement use of the Coordinated specialty care model (CSC). CSC programs include peer and family advocacy and support, substance abuse management and cognitive behavioral therapy for psychosis.

The PEI teams will be encouraged to use CSC teams to use a family- oriented approach even for the adult clients in which all aspects of an individual support network are engaged at every level of care. An effective and stable support network is the key to wellness for our clients.

The gold-standard clinical and functional assessments will be implemented to measure and ensure accurate and reliable diagnosis of mental health conditions. The staff will be trained in the structural clinical interview for DSM 5 and the structured interview for Prodromal syndromes, functioning outcome measures and the Columbia suicide severity rating scale to ensure ongoing reliability in utilizing assessment instruments.
The Santa Maria TAY clinic moved into a new building. The department is working on expanding services, creating drop in centers, outreach, family support with the implementation of more caseworkers and peers to the programs.

Program Challenges and Solutions

One major change that is impacting the cross section of services in the Wellness, Recovery and Resiliency Teams is the lack of case management support that was transferred to TAY FSP versus replacing key rehab/case management services. The recovery of the family unit is crucial to the healing of the identified child(ren) in the household, thus connecting them and supporting them to effectively navigate the myriad of complex county services. A large percentage of this population meets the 200% threshold of living in poverty, and navigating the county managed welfare system requires persistence, literacy and advocacy at a level most families are not capable of. In addition, 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.

A challenge experienced at the state level is the lack of mental health practitioners. In the rural area of Lompoc, it has been nearly impossible to fill the position of an assessor for the Access and Assessment Roles in the Prevention Early Intervention Program (PEI), thus overloading the current three practitioners carrying the load of four plus the load of the vacant PEI position.

10% of the Wellness, Recovery and Resiliency caseload is accounted for as monolingual Spanish where one staff is fully responsible for the clinic services. His cultural and bilingual skills draw parents to engage with the minor in treatment. The recent relocation of a rehab specialist has handicapped this process and affects the number of monolingual families we served.

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

Program Performance (FY 20-21)

PEI Early Detection & Intervention

Unique Clients Served			
	North	**South**	**West**
Age Group			
0-15	0	0	4
16-25	59	55	88
26-59	0	0	0
60+	0	0	0
Missing DOB	0	0	0
Total	**59**	**55**	**92**
Gender			
Female	27	32	60
Male	32	23	32
Unknown	0	0	0
Ethnicity			
American Indian or Alaska Native	0	0	0
Asian	0	2	4
Black or African American	4	2	3
Mixed Race	1	4	5
Native Hawaiian or Pacific Islander	0	0	2
White	52	40	71
Other	1	4	3
Unknown/Not Reported	1	3	4
Hispanic or Latino			
Hispanic or Latino	48	36	50
Not Hispanic or Latino	9	16	36

Not Reported	2	3	6

Client Outcomes

Child & Adolescent Needs & Strengths Assessment (CANS-50) Age: 6-20 years	**Percent Improvement***	
	Initial to 6 months (n = 41)	**6 to 12 months (n = 32)**
Life Functioning (e.g., ability to communicate and interact with families, communication, social functioning and health status)	-51.2%	-6.8%
Behavioral/Emotional Needs (e.g., symptoms of depression, anxiety, psychosis and other conditions)	-29.1%	-32.1%
Risk Behaviors (e.g., self-injury, suicidal behavior, bullying, and running away)	-50.0%	-70.0%
Cultural Factors (e.g., language, traditions, stress)	-28.6%	120.0%
Strengths (e.g., optimism, talents/interests, relationship permanence, and involvement in treatment)	-25.6%	-23.5%
Milestones of Recovery Scale (MORS) Age: 18+		
	Initial to 6 months (n = 89)	**6 to 12 months (n = 73)**
Showed improvement^	47%	36%
Remained stable^	35%	47%

Higher Levels of Care	**% with any admissions over FY 20-21**		
	North	**South**	**West**
Incarcerations	2%	5%	3%
Crisis Services	5%	5%	9%
Psychiatric Inpatient Care	2%	5%	2%

**Note. On the CANS-50, a higher score indicates more actionable needs (greater problems). A negative percent change indicates that client scores are improving because they have fewer actionable needs.*
^Note. "Showed Improvement" and "Remained Stable" reflects the percent of clients whose MORS scores improved or stayed the same between time periods.

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Clients in the PEI Early Detection and Intervention TAY program saw reductions in the number of actionable needs across all CANS domains with the exception of the *Cultural Factors* domain from six to twelve months. Because average actionable needs scores in this domain experienced positive skew and a floor effect, with a very low average of actionable needs, these relatively small changes corresponded to a fairly large percent change (120.0%).

Looking at the MORS, which the majority of clients completed, over 80% of clients in the first year of treatment were either stable or made improvements. In fact, almost half showed improvement in the first half of the year, and over a third showed improvement in the latter half of the year. Conversely, a third were stable in the first half of the year while almost half were stable in the second half of the year.

The client outcomes table displays the percent of unique clients who experienced a higher level of care during their admission to PEI TAY in the 20-21 fiscal year. The source of incarceration data is the Santa Barbara Jail and therefore only includes adults; clients were matched from the county electronic health record to the FY 20-21 jail roster. Juvenile hall data were unavailable this year and we are unable to report on these metrics. The source of psychiatric inpatient and crisis services data is the electronic health record. Two percent of clients in North County, 5% of clients in South County, and 3% of clients in West County experienced a jail stay during their admission. Five percent of clients in North County, 5% of clients in South County, and 9% of clients in West County had crisis services contact during their program admission. Two percent of clients in North County, 5% of clients in South County, and 2% of clients in West County experienced hospitalization during their program admission.

Safe Alternatives for Children and Youth (SAFTY) Crisis Services

Provider:	Casa Pacifica
Estimated Funding FY 2022/23:	
Estimated Total Mental Health Expenditures	$1,091,300
Estimated PEI Funding	$660,200
Estimated Medi-Cal FFP	$431,100
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	
Average Cost Per Consumer	$1,266
Estimated Total of Consumers Served	862
Target Population Demographics Served	Children, TAY

Crisis services for children and youth were provided by Casa Pacifica through the Safe Alternatives for Treating Youth (SAFTY) Mobile Crisis Response Program. SAFTY is a mobile crisis response and hotline service available to all Santa Barbara County youth aged 20 and under. The SAFTY team provides services 8:00 AM- 8:00 PM, 7 days a week. The other hours of the week are covered by Behavioral Wellness Crisis Services. 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 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 Medical 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.

Program Challenges and Solutions

Staffing has been the greatest challenge for the SAFTY program. The shortage of labor throughout our society – including the mental health crisis field – is a significant problem. SAFTY has been consistently understaffed for several years and has experienced a high turnover rate. Being

understaffed as a crisis team coupled with high demands from the community due to the Pandemic resulted in long hours and stress for the staff. Staffing a crisis line is very crucial as the crisis line must be on daily from 8am to 8pm. Staffing challenges increased during the Pandemic as staff who had significant exposure to COVID or had positive COVID tests (or were sick) could not come to the office or respond to crises in person. This placed an increased burden on the staff who were working in person. Additionally, the labor shortage during the pandemic resulted in very few applicants applying to the SAFTY program, coupled with current staff requesting their pay be increased due to the increased workload, as well as increased opportunities for higher pay outside the SAFTY program.

Some solutions SAFTY implemented included supporting staff members individually, listening to their personal and work issues, and trying to find a solution. Our staff tell us flexibility is the key. Additionally, in order to retain current staff and onboard new staff, we increased the hourly rate of pay (which creates concerns around budget constraints with Santa Barbara County). SAFTY received a grant from the Women's Fund of Santa Barbara to pay for an extra SAFTY staff in the past fiscal year, and we would like to obtain this grant again; however, there is no guarantee. To assist with reducing travel time when short staffed while working to reduce exposure to Covid during surges, Casa Pacifica worked to arrange telehealth capabilities with both Marian Medical Center and Lompoc Valley Medical Center.

Recent CDC data indicated that suicide was the second leading cause of death for youth aged 10-14 in 2020, and 44% of high school students in 2021 felt persistently sad or hopeless. Research shows hospitalization is more costly and less successful than community-based interventions like SAFTY in addressing suicidal behaviors of children/adolescents. The availability of a specialized mobile crisis program results in significant decrease of acute psychiatric hospitalizations (as further evidenced by the 0.0% hospitalization rate with our SAFTY pro-active clients), detainment in juvenile halls, and visits to hospital emergency rooms. An ongoing challenge for families with a youth in crisis in Santa Barbara County is there are no short-term, interim crisis services. Currently, California's legislature is considering a bill (AB-226 Children's crisis psychiatric residential treatment facilities) addressing this need across the state. Additionally, while the County provides crisis stabilization services for adults in a 23-hour program, the same type of services would also benefit youth. We are grateful to hear that Marian Hospital intends to open such a program for youth at its facility, though at this point their plans could change.

Safe Alternatives for Children and Youth (SAFTY) (Crisis Services) Casa Pacifica Data

Program Performance (FY 20-21)

SAFTY

	Unique Clients Served	
	North	**South**
Age Group		
0-15	325	176
16-25	242	119
26-59	0	0
60+	0	0
Missing DOB	0	0
Total	**567**	**295**
Gender		
Female	348	181
Male	218	114
Missing/Other	1	0
Ethnicity		
American Indian or Alaska Native	6	0
Asian	7	5
Black or African American	10	7
Mixed Race	10	9
Native Hawaiian or Pacific Islander	3	0
White	376	185
Other	11	4
Unknown/Not Reported	144	85
Hispanic or Latino		
Hispanic or Latino	261	125
Not Hispanic or Latino	101	55
Not Reported	205	115

Client Outcomes

Call Outcomes	Total
Contact Type	
Total Calls	1,956
Crisis Calls	1,563
Non-crisis Calls	393
Face to Face	518
Reason for Calls	
Aggression Towards Others	103
Increase in Mental Health Symptoms	130
Oppositional Behavior	25
Peer/Family Conflict	38
Anxiety/Panic Attack	20
Resources/Access to Service	240
Substance Use/Abuse	5
Homicidal Ideation	24
Depressive Symptoms	18
Self Harm Thoughts	23
Suicide Attempt	73
Suicidal Ideation	527
Self-Injurious Behaviors	90
Psychotic Symptoms	18
Running Away/AWOL	16
In-Person Follow Up Request	47
5150/5585	80
5150/5585 Re-Assessment / Bed Search	341
Nightly Check In Request	34
Other	104
Hospitalization	
Hospitalization Rate on Calls (non-crisis excluded)	8%

In the 2020-2120 fiscal year, SAFTY reported that the program received a total of 1,956 calls, 518 of which had an in-person response. The most common reason for a call was Suicidal Ideation; these accounted for just over one-quarter (27%) of all calls. The next most common reasons were 5150/5585 Reassessment or Bed Search (17%), Resources and Access to Service (12%), Increase in Mental Health Symptoms (7%), and Aggression towards Others (5%). *Hospitalization Rate on Calls* examines calls that were designated as crisis, which were 80% of all calls. Eight percent of crisis calls led to hospitalization. It is important to note that this data includes a portion of the shut down due to COVID-19 and schools being in virtual learning.

Access and Assessment Teams & ACCESS Line Program

Provider:	Behavioral Wellness
Estimated Funding FY 2022/23:	
Estimated Total Mental Health Expenditures	$3,039,978
Estimated PEI Funding	$2,238,679
Estimated Medi-Cal FFP	$801,300
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	
Average Cost Per Consumer	$2,477
Estimated Total of Consumers Served	1,227(based on Access service, no Access Line target
Target Population Demographics Served	Children, TAY, Adult, Older Adult

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

The Department has restructured its operations to a centralized access approach, and an Access call center continues to be expanded and improved. Access screeners handle 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.

Assessments and referrals are customized to ensure that appropriate cultural and linguistic needs of each consumer are identified and accommodated. Furthermore, each team includes staff members who are bicultural and bilingual in the primary threshold language (Spanish) and all staff are trained in how to access and utilize our multiple Interpreter Service contractors.

Program Challenges and Solutions

Behavioral Wellness centralized the Access call center within the Quality Care Management Division by routing all Access calls to one place. Staff dedicated to this function were hired and trained to screen all calls coming into the Access Line and connecting them to the most appropriate level of care. In December of 2018, Behavioral Wellness launched centralized Access for the Drug Medi-Cal Organized Delivery System (DMC-ODS) to screen and refer all beneficiaries seeking substance use disorder (SUD) treatment. Since the launch, calls into the Access Line have doubled, increasing average wait times and abandoned calls. In response, Behavioral Wellness started and completed a Performance Improvement Project (PIP) with target goals to decrease average wait times and decrease abandoned calls. Over the last year interventions included increasing full time staff on the Access Team and a comprehensive all-staff training targeted at increasing efficiencies of screenings. At the end of calendar year 2020 the program examined the years' worth of data, concluding our PIP after reaching our goals. Despite a stressful year with unforeseen staffing issues due to COVID-19, the program decreased average wait times from a baseline of 4 minutes and 30 seconds down to 1 minute and 23 seconds. Additionally, the abandoned call rates went down from a baseline of 25.6% to 8.2%. of all calls. The program will continue to monitor these indicators through our Quality Improvement Committee Work Plan to ensure it continues to keep these measures low, ensuring beneficiaries are able to have consistent access to be screened for mental health and substance use disorder treatment services in a timely manner.

As the Access Line is a toll-free number for people experiencing mental health crises and to be screened and referred to routine and urgent mental health and SUD services, staffing is always a challenge. As the line receives calls 24 hours a day, 7 days a week there is a team who screens and refers Monday through Friday during business hours and historically contracted with a provider, ProtoCall to cover nights and weekends. ProtoCall staff are trained at safety planning with callers in crisis and connecting them with our Mobile Crisis staff. Over the last year, the program successfully cross-trained all Mobile Crisis staff to be able to answer the Access Line when they are not out on crisis calls. Now calls can be answered by County Crisis staff to be screened and referred to needed services after hours. The Department continues to contract with ProtoCall and calls will continue to roll over after hours if all Crisis Staff are in the field attending to crises in the community.

While most of the services are centralized, there is availability at many of our outpatient clinics for walk-ins of consumers. For Mental Health Plan (MHP) services, the clinics continue to accept walk-ins in our regional Children's, Adult, and Crisis Clinics. Most services through the DMC-ODS require calling the Access Line with the exception of Opioid Treatment Programs who can accept walk-ins into their clinics. In addition, in August and September 2021, the CBOs providing outpatient SUD services were trained on the Access Template & Screening, so that a client can walk into an outpatient SUD provider and receive a screening on the spot without needing to go through the Access Line.

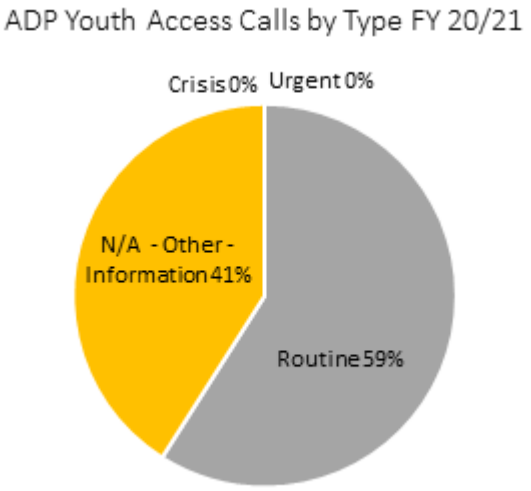
And lastly, Access has moved from being under the QCM Department to now being under the Crisis Department. The transition for Access to move from QCM to Crisis was a long transition and Department goal and many steps were taken over the course of 2 years including training, hiring of a Crisis Manager, Team Supervisors, etc. Officially, the change of Supervisors for the Access Team Supervisor from QCM manager to Crisis Manager went into effect on 1/10/2022.

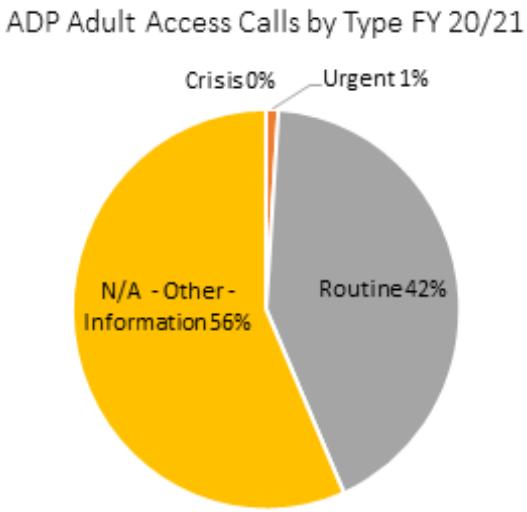
Access Line and Access and Assessment Teams – Behavioral Wellness

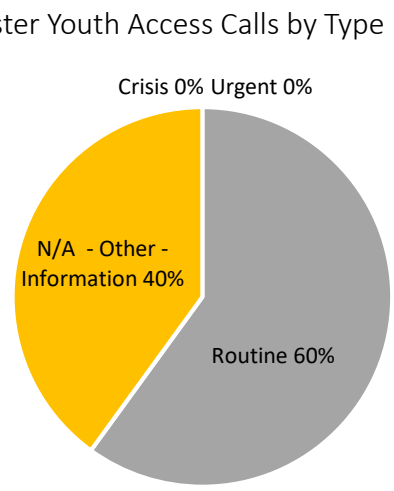
Access Line Program Performance (FY 20-21)

Alcohol and Drug Access Calls

During FY 20-21 there were 5,719 Substance Use (SU) Access calls. The majority of adult and youth calls were requests for information; the remaining were almost entirely routine calls.

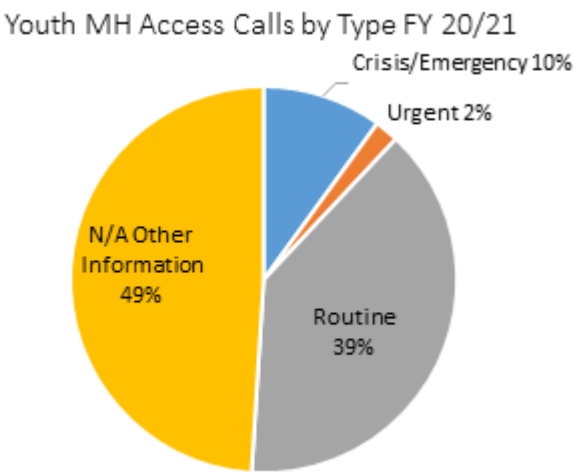


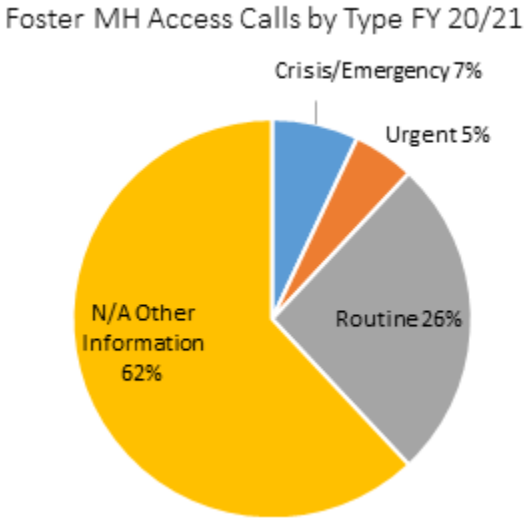


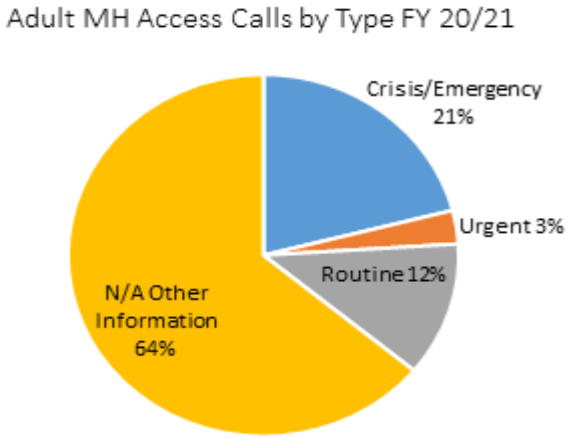


Mental Health Access Calls

During FY 20-21 there were 11,400 Mental Health (MH) calls received, an average of 950 per month. These numbers are higher than FY 19/20. Requests for information or "other" were the most common type of call across groups; they accounted for about two-thirds of adult and foster youth calls and about half of youth calls. Routine calls, where the caller or client should be offered an appointment within ten business days, accounted for just 12% of adult calls and 39% of youth calls, and about one-quarter of foster youth calls. Approximately one-fifth (21%) of adult calls were classified as crisis/emergencies while 10% of youth calls and 7% of foster youth calls were for crisis/emergency. Three percent of adults, 2% of youth, and 5% of foster youth calls were designated as urgent. Calls are displayed below by age and type.







Alcohol and Drug Program Timeliness

There were 5,719 calls during FY 20/21; of those, over half (3,306) were for information/other and no appointment was requested nor offered. The average number of days from Access call to offered appointment is calculated based on the remaining 2,413 adult and youth callers, which includes routine, urgent, and crisis calls. There were few (61) urgent calls during this time frame (small N) – 10% of urgent clients had contact with a care coordinator in the same or next day following their access call. Responding to urgent ADP calls is a Quality Improvement work plan goal in FY 21/22.

ADP Access Timeliness, FY 20-21			
		Adult	**Youth**
Routine	Offered an appointment within 10 business days	82%	87%
Urgent	Offered an appointment within same/next day	57%	N/A
Crisis	Offered an appointment within same/next day	100%	N/A

Mental Health Timeliness

During FY 20/21 of routine *calls*, 95% were offered an appointment within 10 business days for adults (increase from 92% from FY 19/20) and 93% for youth (increase from 91% FY 19/20). For *urgent calls*, 97% were offered an appointment within two business days, which is comparable to FY 19/20. Almost 90% of urgent youth calls and foster youth calls were offered an appointment within the same/next day. Finally, of the calls designated as *crisis,* 100% were offered an appointment within the same/next day for adults, 99% for youth and 100% for foster youth (comparable to FY 19/20).

Mental Health Access Timeliness, FY 20-21				
		Adult	**Youth**	**Foster**
Routine	Offered an appointment within 10 business days	95%	93%	97%
Urgent	Offered an appointment within same/next day	97%	86%	88%
Crisis	Offered an appointment within same/next day	100%	99%	100%

Access and Assessment Program Performance (FY 20-21)

Unique Clients Served						
	Access & Assessment ADULT			Access & Assessment YOUTH		
	North	South	West	North	South	West
Age Group						
0-15	0	0	0	176	148	NA
16-25	67	12	12	90	103	NA
26-59	296	140	107	0	0	NA
60+	37	26	13	0	0	NA
Missing DOB	0	0	0	0	0	NA
Total	***400***	***178***	***132***	***266***	***251***	NA
Gender						
Female	204	69	70	167	141	NA
Male	191	108	61	99	110	NA
Unknown	5	1	1	0	0	NA
Ethnicity						
American Indian or Alaska Native	6	9	1	1	2	NA
Asian	10	1	1	3	5	NA
Black or African American	7	12	13	6	7	NA
Mixed Race	7	19	3	2	5	NA
Native Hawaiian or Pacific Islander	0	0	2	1	0	NA
White	360	119	104	246	217	NA
Other	2	13	3	3	4	NA
Unknown/Not Reported	8	5	5	4	11	NA
Hispanic or Latino						
Hispanic or Latino	237	56	56	198	174	NA
Not Hispanic or Latino	148	70	92	60	70	NA
Unknown/Not Reported	15	6	30	8	7	NA

Access and Assessment Client Outcomes

	Access & Assessment ADULT			Access & Assessment YOUTH		
Higher Levels of Care	**North**	**South**	**West**	**North**	**South**	**West**
Incarcerations	1%	5%	0%	--	--	NA
Crisis Services	5%	4%	1%	6%	12%	NA
Psychiatric Inpatient Care	2%	1%	0%	1%	2%	NA

In the 2020-21 fiscal year, the Access and Assessment Team in North County saw 2-3 times as many clients as the teams in West and South County. To understand this variation, it is important to understand that clients have the choice to either complete an initial assessment on the phone with an Access screener or in-person as a walk-in to one of these clinics. Clients may choose, and

clients in North County may prefer to speak with someone face-to-face rather than on the phone. Further, North County has a higher portion of their population on Medi-Cal, and therefore may screen more Medi-Cal clients who are then ultimately referred to Holman or the community for a lower level of service intensity. A similar trend was observed in the data last year.

The client outcomes table displays the percent of unique clients who experienced a higher level of care during their admission to the Access and Assessment program in the 20-21 fiscal year. The source of incarceration data is the Santa Barbara Jail and therefore only includes adults; clients were matched from the county electronic health record to the FY 20-21 jail roster. Juvenile hall data were unavailable this year and we are unable to report on these metrics. The source of psychiatric inpatient and crisis services data is the electronic health record. In the adult program, 1% of clients in North County, 5% of clients in South County, and no clients in West County experienced a jail stay during their admission. Five percent of clients in North County, 4% of clients in South County, and 1% of clients in West County had crisis services contact during their program admission. Two percent of clients in North County, 1% of clients in South County, and no clients in West County experienced hospitalization during their program admission. In the child program, 6% of clients in North County and 12% of clients in South County had crisis services contact during their program admission while 1% of clients in North County and 2% of clients in South County experienced hospitalization during their program admission.

NEW: PEI Mental Health Student Services Act (MHSSA) Grant

Provider:	**Behavioral Wellness, Santa Barbara County Education Office (SBCEO) – Health Linkages, Community Partners**
Estimated Funding FY 2022/23:	
Estimated Total Mental Health Expenditures	$986,136
Estimated PEI Funding	
Estimated Medi-Cal FFP	
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	$986,136 (MHSSA Grant Funds)
Average Cost Per Consumer	
Estimated Total of Consumers Served	To be determined with Grantor
Target Population Demographics Served	Children, TAY

This is a new collaborative grant with Behavioral Wellness, Santa Barbara County Education Office (SBCEO) – Health Linkages, and Community Partners such as YouthWell and Mental Wellness Center.

The target population demographics to be served are school-aged youth PK through 12th grade with a focus on high-risk youth including foster, homelessness, LGBTQ and students who have been removed from the school environment through suspension and/or expulsion.

In July 2020, Behavioral Wellness was awarded a Mental Health Student Services Act grant to bring mental health and substance use resources to the Santa Barbara County schools. The Department collaborated with Santa Barbara County Education Office, Mental Wellness Center and YouthWell to develop the plan which provides participating schools with Navigators and Clinicians to help connect students and families with mental health resources and make direct referrals to community-based organizations and County resources. MHSSA programming focuses on providing education, prevention and early intervention in order to decrease the need for higher levels of care. It will also create additional referral pathways for higher levels of care while collaborating with additional partners to increase access to services.

Activities will include suicide awareness and prevention, drop-out prevention and outreach to high-risk youth including foster, homelessness, LGBTQ and students who have been removed from the school environment through suspension and/or expulsions. Outreach and educational opportunities for students, teachers, administrators, other school staff, parents and community members will include training around Youth Mental Health First Aid, mental health awareness and stigma reduction, substance use issues and suicide prevention training. Additional professional development opportunities will also be extended to increase awareness of MHSSA funded activities while increasing staff capacity to identify and address emerging mental health and/or substance use issues.

Funding includes hiring Behavioral Health Clinicians (1.5 FTE) and contracting with a community-based organization for Service Navigators (4.0 FTE) to provide direct services and linkages to students and their families. Additional personnel include a .25 FTE Evaluator to assist with data collection, analysis, and grant reporting and a 1.0 FTE Project Manager to coordinate grant programming along with ensuring the goals of the MHSSA Grant are met.

Performance Measurement for the grant:

1. Preventing mental illness from becoming severe and disabling,
2. Improving timely access to services for underserved populations,
3. Providing outreach to families, employers, primary health care providers, and other to recognize the early signs of potentially severe and disabling mental illness,
4. Reducing the stigma associated with the diagnosis of a mental illness or seeking mental health services,
5. Reducing discrimination against people with mental illness, and
6. Preventing negative outcomes in the targeted population, including, but not limited to:
    a. Suicide and attempted suicide
    b. Incarceration
    c. School failure and dropout
    d. Unemployment
    e. Prolonged suffering
    f. Homelessness
    g. Removal of children from their homes, and
    h. Involuntary mental health detentions.

Program Challenges and Solutions

The collaboration between the Santa Barbara County of Education Office (SBCEO) and Behavioral Wellness (BWell) for the MHSSA Grant program has been a great unified collaboration effort thus far. The greater part of this past year has been spent hiring staff, developing policy, protocols, procedures, and assessing the school districts' needs as we develop the program and learn how to work together as two different entities for one project. Program challenges over this first year of implementation have been hiring the .5 clinician for BWell due to the clinician shortage within the clinics and within our county. A second challenge has been that the number of Health Navigators originally written into the grant proposal budget by SBCEO was not possible; therefore, the number of navigators reduced to about 4.0 FTE for the entire county. This greatly reduces the amount of population we can serve. We have attempted to combat that, as SBCEO applied for additional grant funding through the California of Education Office. They were able to obtain a two-year grant for up to three Health Navigators to focus on homelessness within our schools. The MHSOAC informed the collaboration that we could utilize these additional positions within the MHSSA program; however, we are not allowed to count the funds or positions at this time until the MHSOAC provides further direction. Some additional challenges in general were starting a program from scratch to develop tracking/data collection systems, forms, policies and procedures, MOU's between MHSSA and the schools, and training of the Navigators who are new to the mental health field. An ongoing challenge will be making sure all aspects of the grant are being addressed as there are many goals for this grant given a small budget for capacity.

NEW: Early Psychosis Intervention Grant Project

Provider:	**Behavioral Wellness**
Estimated Funding FY 2022/23:	
Estimated Total Mental Health Expenditures	$618,371
Estimated PEI Funding	
Estimated Medi-Cal FFP	$233,700
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	
Average Cost Per Consumer	*
Estimated Total of Consumers Served	**
Target Population Demographics Served	TAY

**This grant has focused on hiring program staff and training of staff on screening and evidence-based programs, not serving consumers.*
**To meet the program requirements, we agreed to join the LHCN network last year to gather the same information across programs. Once the LHCN is launched, the program will begin serving consumers.*

In August 2020, Behavioral Wellness was awarded by the Mental Health Oversight and Accountability Commission, an Early Psychosis Intervention grant, to implement Coordinated Specialty Care (CSC), a high-quality, evidenced based program focused on treating transitional-

aged youth who are currently or have recently experienced a First Episode Psychosis. Program components include case management, recovery-oriented psychotherapy and relapse prevention, family psychoeducation and psychotherapy, educational and vocational support, and pharmacotherapy and primary care coordination. The CSC model seeks to improve the lives of transitional-aged youth with mental health needs before escalation of symptoms to the level of severe or disability while decreasing the duration of untreated psychosis and mood disorders. Targeted population is youth ages 16-24.

A key strategy for positive outcomes includes reduction of time between onset of symptoms and receiving treatment. Therefore, access to early intervention mental health services within a comprehensive, integrated system of care is essential to achieving improved outcomes for youth experiencing episodes of psychosis or mood disorder. CSC staff will identify and address the unique needs of each participant through a shared decision-making approach. Individuals and their families will be supported through a team-based structure of support which provides a full continuum of services to assist in their recovery. By implementing this whole person approach, clients and their support systems will be engaged throughout the treatment process leading to an increase in long-term positive outcomes, including allowing clients to obtain life goals they set before experiencing mental health challenges.

Program Challenges and Solutions

Staffing challenges throughout the department have created challenges with fully implementing this grant. There have been many unfilled clinical positions in the TAY and Children's clinics. This has left the clinics short staffed and unable to manage current caseloads while also meeting the demands of the extensive training requirement that is part of the grant. The Team Lead that was hired in late December 2020 has retired in March, 2022, from the Department, leaving the lead position now open as well as other clinic positions that are still vacant. One of the successes to report is that 3 part time Peer Recovery Assistant positions have been transitioned to full time civil service positions and those three positions have been filled. On another positive note, the TAY clinic in North County has been expanded to accommodate the expansion of staff for the TAY-focused services. General Services has completed the facility improvements and the program now has adequate office space to accommodate the increase in staffing positions.

This grant funding includes Technical Assistance through University of California, Davis. While the quality of the training has been excellent, it has been difficult to meet all of the expectations of the Technical Assistance team. Staff did not have sufficient time in the summer months of 2021 to attend some of the training as the department was not given adequate notice and scheduling time to prepare for this. During the rest of this year, the training has been slowly available and the team is still waiting for a couple significant training components to be available in order to adequately implement the full CSC model. The grant manager has been meeting with the TA team and providing feedback and working to streamline some of the training so it can be completed and yet still manageable.

Innovations

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

Provider:	Behavioral Wellness
Estimated Funding FY 2022/23:	
Estimated Total Mental Health Expenditures	$ 909,153
Estimated INN Funding	$ 909,153
Estimated Medi-Cal FFP	
Estimated 1991 Realignment	
Estimated Behavioral Health Subaccount	
Estimated Other Funding	
Average Cost Per Consumer	$2,951
Estimated Total of Consumers Served	308
Target Population Demographics Served	Children, TAY, Adult, Older Adult

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 use innovative methods in accomplishing the state-wide goal of acknowledging and destigmatizing mental health by improving access to care and service delivery.

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 based on if a project 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:

1. *Did participating Cities/Counties learn something proportionate to the investment they made in the project?*
2. *Have other Cities/Counties learned from what participants have done and implemented the elements that are valuable to that City/County?*

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

Local Santa Barbara Project Overview

Santa Barbara County Target Populations

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

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

The latest Mental Health Services Act Innovation Technology Suite Evaluation Report can be located at:
Mental Health Services Act | Santa Barbara County, CA - Official Website (countyofsb.org)

FY 2021-22

During the 2021-22 fiscal year, the Help@Hand team worked to expand digital access to mental health care within the sphere of public behavioral health systems. Help@Hand provided community support by increasing access to technology along with improving digital literacy within crisis resident facilities and recovery learning centers. Digital Literacy Workshops were held at these facilities and run by Help@Hand team members. These workshops taught consumers about mental health services, how to use computer applications like Gmail and Zoom, and the benefits of using technology to support their wellness. Moreover, members of

Help@Hand also facilitated technology and wellness groups at psychiatric health facilities. While there, the Help@Hand team was involved in a process improvement project to assist in warm handoffs to the out-patient clinics.

To improve upon community access to technology, the Help@Hand team connected members of the community with smartphones that had data and WIFI plans. The Help@Hand project also provided unhoused consumers currently receiving services at the in-patient Psychiatric Health Facility with prepaid phones through TracPhones. By providing community members with smartphones that have access to data and WIFI, community members were better able to access mobile wellness applications, such as Headspace.

From June 2021 through September 2021, the Help@Hand team conducted a Headspace Application Pilot study. The purpose was to understand the participant's perception of the Headspace mobile application, as well as the feasibility of using the application to meet the needs of Santa Barbara's target populations (e.g., those receiving crisis services, clients living in geographically isolated communities, Transitional Age Youth). Approximately 60 people took part in the Headspace Pilot study. Participants included Behavioral Wellness clients (Transition Age Youth, Crisis Residential Treatment), Peer Empowerment Conference attendees, and Staff. Participants were provided licenses to Headspace that they could access via their personal cell phone, county-issued iPhone, county-issued Android, or desktop computer. Of the 60 pilot participants, a total of 19 participants completed the survey (~32.7%). Participants were consistent in endorsing Headspace, describing it as easy to use (94.4% somewhat or strongly agree) and stating that they would recommend Headspace to a friend (94.7% somewhat or strongly agree). Participants were more mixed in their assessment of whether Headspace met their mental and wellness needs, provided support when they were feeling stressed, or respected cultural differences. However, even within these questions, the majority of participants agreed that Headspace was useful in these regards or had these qualities. As such, these results support the promise of Headspace, while also noting some areas where participants expressed less enthusiasm.

Shortly after launch, Help@Hand presented Headspace at the Youth Empowerment Summit. The presentation was intended to educate attendees on strategies to leverage technology for wellness. It also addressed the Eight Dimensions of Wellness and how mindfulness applications, like Headspace, are helpful in connecting with these dimensions.

On October 01, 2021, the Help@Hand Project launched the Headspace mobile application, offering licenses at no cost to community members of Santa Barbara County. Headspace is a technology application created with one mission in mind: to improve the health and happiness of the world. The Headspace mobile application offers meditation and mindfulness techniques that can benefit its users in many ways, such as relief from stress and anxiety, relaxation techniques, and increasing focus on the present moment. The Help@Hand team members assisted with providing education on using Headspace and how to enroll in the application. The

Teams focused on providing whole-person-care within the digital platform to empower individuals, and support for wellness and recovery efforts through technology.

Furthermore, the Help@Hand team continues to provide presentations on the benefits of using digital therapeutic technology to consumers of community-based organizations, Behavioral Wellness staff and clients, and those receiving services at psychiatric health facilities in Headspace. The team utilizes the *Guide to Wellness App Brochure,* a guide created in collaboration with Painted Brain, to enhance the conversation about utilizing wellness applications for mental health wellbeing. Technology and Your Wellness groups are held at the in-patient Psychiatric Health Facility (PHF), Crisis Residential Treatment facilities in Santa Barbara, Santa Maria, and throughout the community led by the local Help@Hand team. Lastly, the Help@Hand project continues to create in-person and virtual educational sessions leveraging the expertise of the Painted Brain organization to improve the application's outreach and engagement amongst the community.

Program Challenges and Solutions

1) Access to Technology

Continuously, consumers' and stakeholders' sessions have identified that there is a digital divide that prevents individuals from utilizing mobile applications for emotional wellness. Some consumers do not have smartphones that have data and WIFI plans. In addition, some consumers do not have the natural support system to assist the consumer in obtaining a smartphone with internet access. To meet this need, the Help@Hand team members work with an authorized Lifeline vendor to provide individuals with smartphones that have a data and WIFI plan. The Help@Hand project also provides unhoused consumers who are currently receiving services within the in-patient Psychiatric Health Facility with prepaid phones through TracPhones.

2.) Increasing Digital Literacy

Continuous stakeholder sessions have identified the need to increase digital literacy with consumers of mental health services and the BWell System of Care providers. To meet the need, the project has partnered with the Santa Maria Library and Painted Brain to provide digital literacy workshops for adults and youth. Some of the training topics include, but are not limited to, Online Safety & Privacy, Email Maintenance, Zoom Teleconferencing and Telehealth Etiquette, and How to Build Your Online Social Network. Every topic will include one of the Eight Dimensions of Wellness.

3.) Deploying Technology Wellness Application
Currently, Help@Hand is promoting the Headspace application. Stakeholders have expressed other mobile applications that they would like the Help@Hand project to explore. In Fiscal Year 2022-2023, the project will be piloting other mobile applications.

Program Performance (FY 20-21)

Outreach Events	
PROGRAM	**Tech Suite**
TOTAL # EVENTS	**19**
TOTAL # PARTICIPANTS	**215**
TOTAL # FAMILIES SERVED	**NR**
EVENT TYPE	
Outreach (Health Fairs, Other Outreach)	0
Training (Trainings, Workshops)	3
Forum (Meetings w/ Community Leaders)	16
Support Group	0
PRIMARY LANGUAGE OF EVENT	
English	16
Spanish	3
Other or both English and Spanish	0
TRANSLATION PROVIDED	
Translation to English at Spanish event	3
Translation to Spanish at English event	15
Other or both English and Spanish	0
PARTICIPANT AGE	
0-15	0
16-25	35
26-59	111
60+	14
Missing DOB	55
PARTICIPANT GENDER	
Female	94
Male	66
Unknown/Decline	55
PARTICIPANT VETERAN	
Yes	0
No	0
Unknown/Decline	215
PARTICIPANT RACE	
American Indian/ Alaska Native	1
Asian	4
Black/African American	14
Native Hawaiian/ Pacific Islander	0
White	53
Other	88
More than one	0
Unknown/Decline	55
PARTICIPANT ETHNICITY	
Latino	49
Non-Latino	53
Unknown/Decline	113

Proposed Hospital Collaboration Project Ideas

Where are we today?

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

Community Services and Supports (CSS) Funded:

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

Senate Bill 82 and CSS Funded:

- Children's' Crisis Triage Teams in North, South, and West

Prevention and Early Intervention (PEI) Funded:

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

Other Non-MHSA Funded:

- Crisis Stabilization Sobering Center for Substance Use Disorders [Prop 47 Grant]
- Crisis Stabilization North with Dignity Health [NEW: General Funds in 22-23 and then MHSA in 23-24]

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

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

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

Stakeholder feedback from the Crisis Action Team during the planning period and from other stakeholder meetings was focused on a variety of crisis elements. Feedback included interest in focus on how to provide crisis residential or stabilization services to Youth and TAY, ensuring capacity for new CSU's since current CSU underutilized, review of current CSU design and location

which could be changed if new CSU's at hospitals, review if MHSA could fund a CSU that is involuntary and if so, possibly setting these up as Involuntary units.

Future goals and ideas for Collaboration with Hospitals Project?

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

NEW: Hospital Collaboration Project Proposal Idea?

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

A continued partnership with the County to collaborate on expansion of services by development of additional Crisis Stabilization Units at or near hospitals has been proposed. This would be an innovative proposal that the collaborative partners would create and submit for approval to the Mental Health Oversight and Accountability Commission after the stakeholder input process. In order to utilize Innovation funding, the availability of funding is key. As a result of the pandemic, the projection of these funds and rules regarding usage of this funding source are not clear. The Department will be monitoring status of these funds availability and policies on utilization of funds.

Program Challenges and Solutions

Behavioral Wellness plans to open a Crisis Stabilization Unit in partnership with Dignity Health at Marian Regional Medical Center. The County agreement will support Marian's new CSU unit for voluntary outpatient Crisis Stabilization services for Santa Barbara County Medi-Cal beneficiaries who are experiencing a psychiatric emergency or mental health crisis. It will be located in Santa Maria as the first North County CSU. Due to delays in DHCS approval and CDPH licensing approval, the Department anticipates requesting Board of Supervisor's approval of a pilot agreement for three years and opening in Summer 2022. The Medi-Cal operation is estimated to be $1,600,000 per year from Medi-Cal and matching funds for an average of 1.6 slots per service day. Initially, the matching funds will be general funds and in future years, MHSA will be an option if there is funding available as a result of growth. The funding streams likely will be Community Services and Supports (CSS) although Innovations could be an alternative pending MHSOAC approval if

the project contained innovative elements. The new CSU is designed for 8 slots per day. The County has been collaborating with all three local hospitals and the Hospital Association for additional projects in this continuum of care and will continue discussions regarding crisis services in the upcoming year.

Dignity Health CSU Grand Opening- article image from Santa Barbara KEYT News Channel

Housing

The Department has worked to create a final housing development with these funds in partnership with local housing stakeholders. The MHSA Housing Program has supported major housing projects in each of the three largest cities in Santa Barbara County. The Depot Street project was finalized last year and added 34 new Permanent supported housing units in Santa Maria. In addition, a state funding source HomeKey was leveraged to create 14 units of housing for MHSA-eligible homeless populations, and we opened our first NPLH site in Santa Maria, with 13 units for homeless persons with a serious mental illness.

MHSA Housing Projects:

- **Garden Street Apartments, Santa Barbara**

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

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

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

- **Rancho Hermosa, Santa Maria**

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

- **Residences at Depot Street, Santa Maria**

MHSA funds support 34 units, including family units, for persons with mental illness including studios, one- and two-bedroom units.

Homekey Housing Projects:

- **Homekey Studios, Lompoc**

  Homekey funds support 14 studio units for persons with a mental illness and experiencing homelessness

No Place Like Home Housing Projects:

- **West Cox Cottages, Santa Maria**

  No Place Like Home funding supports 13 one-bedroom units for person with a serious mental illness and experiencing homelessness

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

The "No Place like Home" Initiative

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

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

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

1) **West Cox Cottages**: The Department jointly applied with the Housing Authority for the County of Santa Barbara and was awarded $1.5 million in non-competitive NPLH funds. This housing site opened in November 2021 and funds 13 one-bedroom units exclusively for persons with a serious mental illness experiencing homelessness. This was one of the first No Place Like Home sites in the state to be fully occupied and was highlighted at a No Place Like Home State Advisory Board Meeting.

2) **Hollister Lofts:** The Department jointly applied with the Housing Authority for the County of Santa Barbara and was awarded $4,822,998 in NPLH competitive funds to build 16 units exclusively for persons with a serious mental illness in South County.

3) **Hollister II:** The Department has jointly applied with Sanctuary Center of Santa Barbara for both competitive and non-competitive funding for 16 Single Residency Units to be used exclusively for persons with a serious mental illness experiencing homelessness. The Project was awarded $456,000 in non-competitive funding for three studio units. The Development will be located in downtown Santa Barbara. At this moment, we are awaiting determination of a possible competitive funding award.

4) **Cypress and 7th:** The Department jointly applied with the Housing Authority for the County of Santa Barbara for $650,000 in NPLH non-competitive funding for 14 units exclusively for persons with a serious mental illness in mid-County. The Department is awaiting notification of funding award.

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.

In FY 2021-22, the Department continues to fund part of the peer empowerment manager position, part-time Recovery Assistant positions in the Department, a WET Coordinator position, and two additional support training staff to support workforce development projects. Through wise and prudent spending of the Southern Counties Regional Partnership (SCRP) funds, the Department is continuing to utilize SCRP funding from prior years and has committed additional funds this year to the new WET SCRP grant opportunity through the State. Santa Barbara County Behavioral Wellness continues to act as the fiscal agent for the SCRP and assists in managing the new WET grant that was awarded to the SCRP. These existing and new WET funding sources will be utilized to sustain employment through education, training, and recruitment opportunities created through workforce education and training programs.

Internships and Training Programs:

During FY 2021-22 the Manager of Clinical Training and Special Projects has continued to build the infrastructure for internship programs within the department. The Student Support Agreement (SSA) is the Memorandum of Understanding (MOU) used by the department to establish contracts with various educational institutions. Over the years, this document has been updated and revised adding addendums for each of the different disciplines in order to support new internship programs. This revised MOU creates a template to be used to create defined training opportunities for psychologists, marriage and family therapists, clinical social workers, psychiatric mental health nurse practitioners, nurses, and case workers. During FY 2021-22, the Manager of Clinical Training and Special projects has worked to develop new or renew relationships with Cal Poly San Luis Obispo, University of California Santa Barbara, Antioch University Santa Barbara, Alan Hancock College, and UMASS Global (formally known as Brandman University). The manager has attended several placement fairs or been in contact with faculty for recruiting students from these educational institutions.

In a continued effort to build our department's infrastructure for training of graduate students, clinical supervision training has been provided again to prepare licensed staff to engage in the role of a clinical supervisor. This will expand the capacity for student interns/trainees and to assist in the mission of a recruiting pathway from the educational institutions.

Program Challenges and Solutions:

The current staffing of the department is very challenged with hard-to-fill positions remaining unfilled over an extended period of time. The staffing challenges also include extended time involved in filling open positions or promoting existing staff and difficulties with retention of current staff. This continues to create a strained staffing infrastructure and thus limits the number of internship positions that can be offered to students. Activities such as training new supervisors, encouraging the recruitment from the clinical programs at local educational institutions, and encouraging workforce development programs to support existing staff will assist in addressing these challenges in FY 2022-23 in order to grow the internship program.

Staff Training

During FY 2021-22, 95 training events were offered to the department and CBO staff. These included a combination of department organized and funded training, contracted training utilizing the SCRP grant funding, and externally offered training provided by outside agencies and organizations. Training opportunities included a variety of topics such as training that was focused on Peer staff development, alcohol and drug counseling topics, general professional development information, cultural competency and increasing staff ability to work with diverse populations, and a variety of training required by the department for core competencies related to job duties. Additional details are included in Table 1 (Training Attendance)

	Total Hours	Total Number of BWell Staff
Total Number of Training Events	95	477
Total Number of Cultural Competency Topics	14	45.5
Total Number Alcohol and Drug Program Topics	15	42
Total Number of Peer-Focused Topics	5	132.5
Total Number of Required Trainings for Core Job Duties	14	42.5

Satisfaction Evaluations

Following each training provided directly by the Behavioral Wellness department, attendees completed an evaluation of the training. The evaluation includes a variety of inquiries such as effectiveness of the instructor, inclusion of diversity and cultural factors, and the overall satisfaction and value of the training. Attendees assign a score on a 5-point Likert scale with the following values:

Evaluation Questions	Training/Scores				
	1 Strongly Disagree	2 Disagree	3 Neutral	4 Agree	5 Strongly Agree
The instructor's teaching methods were effective.					
The course content was consistent with stated objectives.					
The course was inclusive of topics related to diversity and culture.					
Accommodations were provided as needed					
The course content was appropriate for the intended audience.					
The course information enhanced my professional knowledge and/or skills					
I was satisfied with the educational experience					

Department of Healthcare Access and Information: Southern Counties Regional Partnership

The 2020-2025 Workforce Education and Training (WET) program addresses the shortage of mental health practitioners in the public mental health system (PMHS) through a framework that supports individuals through pipeline development, undergraduate scholarships, education stipends, and educational loan repayment programs and staff retention. This five-year WET Plan originally developed by the Office of Statewide Health Planning and Development (OSHPD) engages regional partnerships across the State to administer various workforce development programs in these five areas. The regional partnership activities are to support the mission of MHSA-WET in outreach to multicultural communities, increasing the diversity of the mental health workforce, enhancing the competency of staff in providing data driven and culturally sensitive services, reducing stigma associated with mental illness, and promoting various workforce development projects. Five Regional Partnerships have been formed under WET throughout the State. Santa Barbara County is a member and acting fiscal agent of the Southern Counties Regional Partnership (SCRP) which contains 10 counties in the southern part of the state (Imperial, Kern, Riverside, Orange, San Diego, San Bernardino, San Luis Obispo, Santa Barbara, Tri-Cities, and Ventura).

On December 2, 2014, our Department became the fiscal and administrative agent for SCRP activities. The initial funding helped to implement the Five-Year Plan goals established by OSHPD for FY 2014-2019. Although Behavioral Wellness has received full payment of the SCRP funds, as of June 2022, there remains available funds from the original distribution. As of October 1, 2017, The SCRP Memorandum of Understanding was scheduled to automatically renew on an annual basis, subject to funding or termination for convenience by members.

In 2020, the SCRP applied for and was awarded a new Regional WET grant by the Office of Statewide Health Planning and Development (OSHPD), now known as Department of Healthcare Access and Information (HCAI). During the initial year, this required the SCRP to revise the current MOU with each of the member counties to accept these funds and to establish Participation agreements with CalMHSA to collect the matching funds from each of the 10 counties which was a requirement of the grant. This process of contracting with the 10 counties, accessing approval by each county's Board of Supervisors and with CalMHSA took the majority of the FY20-21.

Southern Counties Regional Partnership

Provider:	Behavioral Wellness
Estimated Funding FY 2022/23:	
Estimated Total Mental Health Expenditures:	$129,520
Estimated WET Funding:	

In Fiscal Year 21-22, existing SCRP funds were used to fund the SCRP annual conference. During the pandemic in FY 2019-20, this conference had to be canceled, but it was able to be reinstated in November of 2021. This conference is typically an annual event focused on person-centered engagement strategies for the partnership staff. This is the fifth year that the SCRP has offered this conference. All ten counties participate in this two-day conference with approximately 10-15 attendees from each county. An additional conference is scheduled for the fall of 2022 to make up for the canceled conference in 2020. The focus of this conference will be on Diversity, Equity, and Inclusivity topics and we expect to host approximately 200 staff.

The original SCRP funding was also used to provide a series of Trauma-Informed Care trainings, including a new curriculum on Homelessness. Each county chose up to four trainings on different aspects of providing Trauma-Informed Care, and these trainings have been very well attended throughout the partnership. Other training provided through this funding was a series of training on Suicide Assessment, Treatment and Prevention to all ten counties.

Program Challenges and Solutions
The only main challenge that has occurred with this original funding was the impact of the Coronavirus Pandemic. It was necessary to shift training formats to virtual methods and had to restructure the conference during this period of time. These challenges created an initial delay in the delivery of the training and staff had to adjust to participating in a virtual format for training.

OSHPD Southern Counties Regional Partnership

Provider:	Behavioral Wellness
Estimated Funding FY 2022/23:	
Estimated Total Mental Health Expenditures:	$3,615,146
Estimated WET Funding:	

As explained above, the SCRP received a new state WET grant. The Southern Counties Regional Partnership (SCRP) membership will implement programs for educational stipends, loan repayment, pipeline development, and staff retention as outlined in the plan that was submitted. Each county was required to provide matching funds to the grant with Santa Barbara committing $130,337 for match purposes. The entire funding for the SCRP from 2020-2025 is $15,340,829.

As the fiscal agent, Santa Barbara will administer the grant funds for the entire ten counties, ensuring that the Partnership has adequate funds for the programs that they deem most necessary for the continued recruitment, education, and training of our workforce.

During FY 21-22, the Santa Barbara WET staff initiated a number of contracts to begin the projects funded by this new grant. A contact was established with Phillips Graduate Institute of Campbellsville University to facilitate the graduate student and peer stipend programs providing $6,000 for each awarded student that is participating in a traineeship or internship at an SCRP member placement. A contract was initiated with CalMHSA to facilitate the staff loan repayment program. This program provides up to $10,000 in loan repayment to existing staff in hard to fill or retain positions that have existing student loans related to their employment. Contracts were established with CIBHS and National Council of Behavioral Health for various training programs.

Program Challenges and Solutions:

Due to the multiple counties involved in the SCRP, there are a variety of workforce needs across the partnership and a variety conflicting pressures or demands on workforce development. It has been challenging to navigate the logistics of the county agreements such as the SCRP MOU in addition to the individual participation agreements with the entity that is collecting and verifying the individual county matching funds. It has been necessary to have many planning meetings to clarify how the new grant funding will be employed, how each county will have a benefit in proportion to their matching fund requirement, and to meet the individual county workforce needs with regional programs. It has also been challenging to navigate the fiscal process of establishing contracts for certain programs such as the loan assumption program and the stipend program. This process has required creating an RFP and reviewing those applications and to then move into the contract process. Now that many of those steps have been completed the SCRP anticipates a smoother process in implementing the projects within the plan.

Peer Training (WET)

Provider:	**Behavioral Wellness**
Estimated Funding FY 2022/23:	
Estimated Total Mental Health Expenditures:	$272,684
Estimated CSS Funding to WET:	$272,684
Target Population Demographic Served	CHILDREN, TAY, ADULT, OLDER ADULT

The peer empowerment manager position and part-time employment opportunities for peers continue to be partially funded by WET, sustained by a transfer from CSS through FY 2021-22. The part-time employment opportunities are intended for peers who have completed the Workforce and Education Training (WET) Peer Specialist training as Peer Expert Pool Staff.

Ongoing training for Peer Expert Pool Staff is provided through the Quarterly Peer Employee Forum. In addition to peer employment as a Recovery Assistant, peers have also been employed through the Help@Hand Innovation project. This is described in the updated section on Innovation plans.

The Peer Empowerment Manager and the Manager of Internships and Special Projects have participated in a variety of focus groups, informational sessions, and advisory group meetings during the year regarding the Peer Certification Bill that was signed into law in 2020. After receiving final guidance from the Department of Health Care Services, the department will move forward with finalizing plans to implement the peer certification Medi-Cal benefit within the department. During FY 2021-22, the Peer Empowerment Manager was selected to be on the California Mental Health Services Authority (CalMHSA) Stakeholder Advisory Council. The purpose of this council is to provide program recommendations for the implementation of the Medi-Cal Peer Support Specialist Certification. In addition, the Department continued to provide Peer Support Specialist training to staff and non-staff members, with the aim to increase the quality of care in the delivery of Peer Support Services and to increase the peer workforce. This training is provided by Crestwood Behavioral Health. Additionally, the department continues to work on implementing a peer support specialist internship program in collaboration with Crestwood Behavioral Health. This internship opportunity will provide training and development activities for peers that are new to this profession and interested in both a career pathway as a Peer Support Specialist, and in completing the Medi-Cal Peer Support Specialist Certification process. Training will be enhanced in FY 2022-23 to meet the specifications of the Medi-Cal Peer Support Specialist Certification requirements and to support any new peers in the internship program.

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

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

Various presentations were given throughout the 2021-22 fiscal year, including a Patient's Rights Advocacy Training, Senate Bill 803 Peer Certification, updates from the recovery learning centers, CalAIM, and Mental Health Services Act programming updates. Furthermore, members provided recommendations regarding the Headspace mobile application, consumer perception surveys, complaints and grievances process, and Psychiatric Facility Process Improvement Project. Lindsay Walter, MHSA Coordinator, facilitated lively discussions regarding the MHSA Community Planning Process and many CFMAT members provided feedback and volunteered to lead on peer initiatives. These initiatives include expanded Youth Focused and Youth-Driven Initiatives, Increasing utilization of Peer Services, and integration of whole Person Care philosophies throughout the delivery of services.

Moreover, during the fiscal year 2021-22, members continued to plan the annual Peer Empowerment Conference, participated as a stakeholder in Peer Certification stakeholder sessions, and provided updates to members at CFMAT's monthly meetings. During this time period, members continued their production and distribution of the quarterly newsletter "Together in Our Journey". This consumer lead newsletter features inspiring storytelling and promotes wellness, resiliency, and recovery. It includes art and poetry, community resources, and lists upcoming events.

Peer Workforce

Throughout FY 2021-2022, the peer workforce continued to receive training at the quarterly Peer Employee Forums, Behavioral Wellness training department, and the Relias Learning Platform to enhance their skill set to ensure the appropriate delivery of peer support services. The Peer Employee Forum is a Peer Support Specialist training platform and Peer Employee Stakeholder forum. During this period, peer staff continued to participate in discussions regarding the MHSA Community Planning Program Process, EQRO, and the implementation of the Peer Certification Program. The focus of these discussions with peer staff was to provide input/feedback for system change, peer programming, implementation of the Medi-Cal Peer Support Specialist Certification Program, and the Process Improvement Project- Psychiatric Health Facility Discharge project (warm-handoff).

A highlight during this fiscal year was peer support staff and community-based organization peer support staff continued to be trained in the practice of Peer Support Services by Crestwood Behavioral Health, through a grant from the Office of Statewide Health Planning and Development. It is estimated that by the end of the fiscal year 2022, more than fifty Peers will have participated in the Crestwood Behavioral Health Peer Personnel Training Program. This will allow participants to apply for the Medi-Cal Peer Support Specialist Certification. Another accomplishment during this period was that peer staff who were Wellness and Recovery Action Plan (WRAP) facilitators received a five-day refresher course in order to obtain WRAP recertification. This will continue to enhance and strengthen their knowledge in facilitating WRAP groups. WRAP helps clients with serious mental illnesses develop plans for their wellness and recovery by making them a part of their therapeutic process. Furthermore, the peer workforce received training that is consistent with the core competencies of peer support services. These core competencies for peer support workers center on principles and values that are recovery-oriented, person-centered, voluntary, relationship-focused, and trauma-informed. In addition to focusing on these foundational principles and values, training has been aimed at meeting the training curriculum, as listed in the Department of Health Care Services Informational Notice number 21-041. The information below highlights some of the training our peer workforce has received during the fiscal year 2021-2022 at the Peer Employee Forums:

- Essential Interviewing Skills
- Peer Recovery Services Documentation Standards
- Telling Your Story
- Employment Preparation-Application and Resume development
- Peer Support Ethics
- Refresher Wellness Recovery Action Plan Facilitator Training

Program Challenges and Solutions

An area of continued focus is ensuring that the peer roles/responsibilities are consistent in the delivery of peer support services throughout department programs. The Department intends to establish an additional career pathway with a peer supervisor that oversees the peer providing services within the clinics.

With the passage of Senate Bill 803, the Peer Empowerment Manager will continue to work with various State administrators, training managers, department managers/supervisors, peer staff, and various stakeholders to implement the Peer Certification Program. In collaboration with the Human Services Department, the Peer Empowerment Manager will be working on the Peer Support Specialist's new job classifications (entry-level position, certified Peer Support Specialist, Supervisor of Peer Support Specialist).

Current and future focus will continue to be the following:

- Establish new Peer job classifications
- Implement a Peer Internship Program
- Implement a pipeline for hiring Peers utilizing the Southern California Regional Partnership Grant
- Increase Peer Support groups within Behavioral Wellness and in the community
- Establish a Peer Speaker Bureau
- Increase a diverse Peer Workforce
- Support Peer Staff to obtain the Medi-Cal Peer Support Specialist Certification

Cultural Competency Plan and Achievements/ Cultural Competency and Diversity

Our commitment to serving unserved, underserved, and marginalized communities has remained our central focus in ensuring access to services and providing culturally and linguistically responsive care. During the fiscal year 2021-2022, an area of attention was given to increasing the service delivery penetration rates for LatinX county residents by working closely with our outreach and engagement contract providers. Language access services for the Limited English Proficient and those with disabilities, ensuring stakeholder involvement, and reducing behavioral health stigma were also focused on during this fiscal period.

As part of our community outreach and engagement efforts, the Department worked closely with the Behavioral Wellness' Cultural Competency Subcommittee, Building Resilient Communities (BRC). The Building Resilient Communities Subcommittee serves as a bridge to close the gaps regarding the availability of mental health, substance use, and wellness resources for all diverse communities of Santa Barbara County. This network of community leaders assists in ensuring all residents of the county of Santa Barbara are aware of the behavioral health services and community resources that are accessible to them.

Within the BRC, representatives from Community Health of Central Coast were able to assist to secure local radio station interviews (June to December 2021) for the Cultural Competency and Diversity/Peer Empowerment Manager. The purpose of these radio station interviews was to bring awareness on accessing behavioral health services (i.e., mental health, alcohol, and drug services) to the community of Santa Barbara County. Additionally, during these radio broadcasts, we expanded the conversations to include the importance of mental health, Wellness, and stigma reduction. Furthermore, in collaboration with Health Linkages, Promotora Network, Community Health Center of Central Coast, University State University, Northridge and the University of Santa Barbara, and the Cultural Competency and the Diversity/Ethnic Services/Peer Empowerment Manager facilitated a mental wellness conference titled "*Wellness within Reach-Bienestar a Tu Alcance*" in Spanish. There were seventy Spanish-speaking community members.

Another project that the Building Resilient Communities subcommittee has been working on in the past year is the development of a culturally and linguistically responsive measuring tool and a psychoeducation mental health toolkit. This project is a collaboration between California State University, Northridge's P.U.E.N.T.E (Promoting the Use of Evidence-based practices, Narrowing the Treatment Engagement gap) lab, and the Department. The goal of this collaboration is to understand the perspectives of community providers on the strengths, challenges, and areas of need when administering existing mental health measures with community clients in Santa Barbara. The information obtained will be used to create questionnaires on mental health literacy, stigma, and help-seeking that are tailored more for underserved communities in our county.

An area of focus over the past year has been providing various Cultural Competency Trainings to staff and our contracted community-based organizations. Cultural competence training is an excellent tool for skill development and practice, which in turn, is a necessary step in reducing health disparities. Due to the pandemic, cultural competency training was offered via Relias Learning Platform, as well as through virtual learning opportunities by departmental sponsored events and various organizations, such as, The Department National Hispanic and Latino Prevention Technology Transfer Center, CBHDA CCESJC, and LGBTQ+ Workgroup, California Institute for Behavioral Health Solutions and other state-recognized mental health organizations. The Department utilizes the "Relias Training Management Platform", to assign, track and report training quickly and efficiently. Cultural competency training is announced via email, with reminders sent periodically. The following are some of the cultural competency training that were provided to staff and our community-based organizations:

- The Art of Understanding the Cultural Complexities of the Latinx Community on September 16, 2021
- Providing Responsive Care to Immigrant Families
- Cultural and Linguistic Factors to Consider when working with Migrant Farm Workers in Santa Barbara County
- Cultural Formulation Interview Training
- Emerging Best Practices for Communities of Color: Prevention and Treatment Modalities
- Chumash History and Culture
- Cultural Humility
- Engagement, Treatment, and Retention for Spanish Speaking Clients and their Families: Culturally and Linguistic Appropriate Services

Additionally, another area of continued focus is assessing clients' language needs. In July of 2021, the Department conducted a language capacity survey. The survey was distributed to 419 Behavioral Wellness staff. Hundred eighty-eight responded to the survey, and of those participants, 53.59% indicated speaking a language other than English. For those 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. Additionally, during this time the office developed a smartsheet to track translation services.

Throughout the 2021-2022 fiscal year, the CCDAT continued to work on meeting central goals relating to language access services, outreach and engagement, cultural competence training, stigma reduction, and the Alcohol and Drug Program (ADP). All CCDAT members joined one of four subgroups focusing on these goals. The Language Access Services group assisted in the development of the translation policy and the language assistance survey for those who received interpretation services. The Outreach and Engagement group worked on constructing the current Outreach Plan by incorporating outreach strategies communities' members have used to engage unserved, underserved, and marginalized populations. Lastly, the ADP workgroup worked on incorporating the Cultural formulation Interview within their treatment plan. In addition to these subgroups, members also participated in providing feedback and recommendations to MHSA programming, Psychiatric Health Facility Process Improvement Project, Help@Hand project, and the Office of Health Equity and Diversity. There were various presentations on providing culturally appropriate services specific to cultural and ethnic groups, including individuals with disabilities. Furthermore, other topics that were discussed during these meetings include stigma, examining institutional racism, barriers to accessing care, the technology divide that impacts access to care, accessibility technology: Compliance with American Disability Act, and the CalAIM Initiative.

Overall, during the fiscal year 2021-2022, we continued to work on strategies to reduce behavioral disparities and provide culturally and linguistically appropriate and high-quality care services to unserved, underserved, and marginalized communities.

Capital Facilities and Technological Needs (CF/TN)

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

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

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

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

Electronic Health Records and Outpatient Electronic Health Record

Electronic Health Records – Capital Facilities and Technological Needs	
Provider:	**Behavioral Wellness**
Estimated Funding FY 2021/22:	
Estimated Total Mental Health Expenditures:	$800
Estimated CSS Funding to CFTN:	$800

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

Behavioral Wellness will be engaging a new Electronic Health Record model for inpatient and outpatient services in 2022-23. The Department is planning a Request for Proposal (RFP) process to identify a vendor that is capable of scaling our inpatient and outpatient space.

The Department has been striving to be part of the modern healthcare infrastructure IT systems. Behavioral Wellness was awarded twelve Telehealth grants in 2020-21 in order to respond to the COVID-19 Pandemic. The Department spent $135,000 to continue deployment of laptops and docking stations, upgrading conference rooms for social distancing with telehealth capabilities for group and individual sessions, and supporting services being delivered by Zoom or other telephonic means.

Additionally, the new CalAim Medi-Cal initiative will require more modern electronic systems. In order to enhance the Electronic Health Records for MHSA outpatient services that align with Medi-Cal standards, funding will be transferred from CSS to CFTN as available, to ensure the electronic infrastructure is sufficient in future years to provide sufficient medical records for all consumers.

As we move toward providing our consumers with modernized outpatient facilities that align with Medi-Cal standards, funding may be transferred from CSS to CFTN as available, to meet our Capital Facilities' needs. The Department has applied for Behavioral Health Continuum Infrastructure Program Grant, and if awarded, MHSA funding may be used for the matching funds to complete this new mental health facility in our system of care.

Update for Proposals Included in FY 2020-2023 Three-Year Plan

These proposals were introduced to Stakeholders for feedback and program development input during the Stakeholder public forums.

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

As a result of feedback received and trends from community voices in the planning process, progress and updates to the Three-Year Plan proposals for the FY 2021-2022 Update are:

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

This proposal focuses on the creation of Youth-Led Leadership and the assistance of Youth in the development of those skills. Potential avenues identified include establishing a Youth designated position on the Behavioral Wellness Commission, promoting and marketing youth involvement at each Department Action Team meeting, and inviting youth subject matter experts to work with youth on their topics of interest.

Other goals include increased prevention activities using digital solutions, such as connection with MHSA Innovations Help@Hand project, formerly known as Technology Suite. Additionally, this proposal supports Advocacy and Support Youth Community Initiatives that are youth-designed and/or youth-led. This encompasses the development of ideas and grant applications, such as Youth-Designed Treatment Plans, Peer-Run Centers with creative technology spaces,

Mental Health First Aid Training for Youth and their Support Systems, and a Youth Drop in Center. This proposal also aims to expand community programming and access around Early Psychosis Intervention, and Transitional Age Youth Department of Rehabilitation services.

Update

During FY 21/22, the Behavioral Wellness Commission outreached to fill newly-created Transitional Age Youth (TAY) positions on the Commission, successfully filling one TAY commissioner position in September 2022. The TAY Help@Hand Team continues to support and expand advocacy and youth community initiatives by creating peer digital literacy training, youth gaming listening sessions, and digital peer support groups focused on LBGTQ and meditation. In June of 2021, YOR Place opened, the result of a grant awarded in collaboration with Family Services Agency funded for the creation of a Youth Center in Lompoc. This Youth Center focused on Substance Use with a link to MHSA mental health services. Our Early Psychosis Grant award from MHSOAC, funded three peer positions at our TAY clinic in Santa Maria, and our MHSSA School Navigator and Prevention Grant award in collaboration with SBCEO, YouthWell, and the Mental Wellness Center funded onsite promoters and mental health practitioners at two school districts in North County.

Plan for FY 22-23

From the Santa Barbara County MHSA 2022-2023 Planning the Virtual Survey, the department gathered feedback from stakeholders on department activities in relation to Youth-Focused Care and Youth-Driven Initiatives. 85% of respondents either agreed or strongly agreed that the department's activities aligned with the goals outlined in this proposal. Additional input and ideas on how to further achieve Youth-Focused Care and Youth-Driven Initiatives include:

- Advocacy and Support Youth Community Initiatives that are youth-designed and/or youth led
- Development of ideas and grant applications, such as Youth-Designed Treatment Plan
- Peer-Run Centers with creative technology spaces
- Youth Drop in Center
- Expand community programming and access around Early Psychosis Intervention

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

This proposal aimed to increase Peer staff capacity in order to provide every mental health program with the opportunity to have a peer support specialist on the clinic team. This encompasses an increase in Peer Lead Wellness Support Groups and specialist groups (LGBTQ+, TAY, Older Adult groups, etc.), an increase in Peer Navigators to ensure consumers connect with clinics and sustain treatment, and hiring multi-lingual/multi-cultural peers for peer support services programming.

Goals for this proposal also includes an ongoing Peer training program that may lead to later employment opportunities, highlighting the knowledge and practice of Peer Support Services by engaging trusted, Subject Matter Experts to provide training to peers, as well as mentorship, internship and workforce skill opportunities for peers. Additionally, noted was the need for increased peer run community wellness and recovery outreach fair activities, as well as access to Peer Certification programs.

Update

During FY 21/22, the Department added peer casework leaders with TAY and expanded peer recovery assistants for Early Psychosis services. To increase the capacity toward building a diverse Peer Workforce and creating employment opportunities, the Department established a partnership with Crestwood Behavioral Health. Crestwood provided peer training to over fifty individuals who wish to become peer support specialists. Additionally, during this fiscal year, Help@Hand hired extra help Transitional Age Youth staff to aid in increased outreach and engagement with our youth population. Also, the expansion of community activities and peer led support groups included new curriculum development, Mental Health Awareness campaigns during COVID, and participation with the PHF Discharge Planning Group and digital literacy support groups. This community presence has led to strengthening advocacy initiatives within the community and systems of care have promoted partners' trainings/groups. Subsequently, it has fostered additional community partnerships that assisted in co-developing the Consumer Family Member's "Together Our Journey" Quarterly Peer Newsletters. Finally, in May 2021, the first MHSA Peer Advocacy and Empowerment Conference. The Department is committed to providing consumers with the Medi-Cal Peer Certification benefit and continues to and will actively participate in State planning and consulting with Santa Barbara consumers and peers on this process.

Plan for FY 22-23

From the Santa Barbara County MHSA 2022-2023 Planning the Virtual Survey, the Department gathered feedback from stakeholders on department activities in relation to Youth-Focused Care and Youth-Driven Initiatives. 86% of respondents either agreed or strongly agreed that the department's activities aligned with the goals outlined in this proposal. Additional input and ideas on how to further achieve Increased Utilization of Peer Services and Integration of Peer Philosophies in the Department and Contracted Services include:

- Peer training for State accredited Peer Certification
- Engaging trusted, Subject Matter Experts to provide consultation services for peers on documentation
- Funding more peer run community wellness and recovery outreach activities
- Funding more peer "field trips" through the Resource Learning Centers
- Hosting an annual Peer Empowerment Conference to engage and support our communities
- Establish a Behavioral Wellness Peer Speaker Bureau that will focus on Adult outpatient system of care, Transitional Age Youth and Housing

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

The goal was to increase housing units by creating a minimum of 50 new permanent supportive housing units in County, and development locations included regions in Lompoc, Santa Maria, and Santa Barbara. Utilizing No Place Like Home funding rounds was identified as essential in achieving this goal. Additionally, supportive services for these housing units and others within the County was desired. Proposed models for supportive services included utilizing MHSA and rental income, along with other State Homeless funding as available.

In developing this proposal, prior feedback from stakeholders on what is important when developing housing options and services included: promoting harm reduction philosophies at housing units with a Housing First approach, utilizing "Tiny Home" modeled housing communities, creating Peer-run supportive programming at housing complexes, providing Credit repair and legal aid support for people facing evictions or unable to gain housing outside of these opportunities, establishing a Navigation Hub with lockers and phone charging stations to help those who are in the initial steps of getting resources, increasing workforce opportunities within BWELL for people experiencing homelessness, and assisting with Department of Motor Vehicle tags for those who prefer living in cars and/or non-traditional settings.

Update

During FY 21/22, over 50 new housing units were completed with support from No Place Like Home, Homekey COVID funding, MHSA Housing, and HEAP grants. 28 units were funded in Lompoc, 54 units in Santa Maria, and 9 units in Santa Barbara. Behavioral support services were created for a variety of locations across the three target areas. Due to the impacts of using the Coordinated Entry System, and this influx of people new to permanent supportive housing, the goal for FY 22/23 will focus on developing an Innovation grant to fund a Housing Retention Team. This team will provide wraparound services to those entering our MHSA, Homekey and No Place Like Home funded sites, and also provide peer support services at housing locations, tenant's advocacy and flex funding for basic housing needs like transportation and food.

Plan for FY 22-23

From the Santa Barbara County MHSA 2022-2023 Planning the Virtual Survey, the Department gathered feedback from stakeholders on department activities in relation to our proposed Innovations Funded Housing Retention Team. 80% of respondents either agreed or strongly agreed that the department's proposed activities aligned with the goals outlined in this proposal.

The Proposed Innovations Plan approved by stakeholders includes:

- Housing Manager: oversees Housing Retention Team and Tenant Selection Process
- "Good Tenant" curriculum for new tenants and those awaiting housing
- Three case managers to provide intensive services to new tenants

- Three peer recovery assistants to provide onsite peer supports and tenant advocacy
- One Patients' Rights Advocate to act as a tenant advocate with Housing Management
- Three SOAR-trained case workers to provide benefits counseling and advocacy
- Flex funding for transportation, furniture, food, and other tenant needs

Proposal Four: Integrating Whole Person Care philosophies throughout Outpatient services

Whole person care seeks to study, understand and promote the role of health care in relieving suffering and promoting healing in acute and chronic illness. Whole Person Care Ideas from the Santa Barbara community are to facilitate development of trainings, support group curriculum, and outreach materials with Unserved and Underserved groups regarding whole person care practices that resonate within their communities. Programming tools should be modeled after the Eight Dimensions of Wellness.

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

Targeted Populations identified from stakeholders

- Native American Community
- LatinX Community
- Mixteco Community
- LGBTQ Community
- Asian Community
- Foster Youth and Underserved Communities
- Parents of Young Children
- Those who suffer from co-occurring mental health and substance use disorders
- Geographically Isolated Communities

Update

During FY 21/22, the Department of Behavioral Wellness coordinated with the Public Health department to implement substance use care coordinators, linking individuals with all appropriate resources based upon their needs. Peer-run holistic approaches included COVID friendly drum circles, Help@Hand digital literacy training, and youth listening sessions. Additionally, the expansion of Tele-Health availability led to an increase from 2% to 85% of

services over the past year, ensuring that consumers could receive care in their own safe space. The Department anticipates engaging in specialized focus areas in the Cultural Competency and Diversity Action Team.

Plan for FY 22-23

From the Santa Barbara County MHSA 2022-2023 Planning the Virtual Survey, the Department gathered feedback from stakeholders on department activities in relation to our proposed Whole Person Care Program Activities. 85% of respondents either agreed or strongly agreed that the department's proposed activities aligned with the goals outlined in this proposal. The Proposed Whole Person Care Activities approved by stakeholders include:

- A robust mental health and Substance Use Disorder anti-stigma campaign to reach Youth, Transitional Age Youth, Adult, unserved and underserved populations
- A Population Needs Assessment conducted to discover unmet mental health/substance use disorder needs in our community
- Creation of Whole Person Care curriculum for peers and clinicians to use when engaging consumers
- A Cultural Competency Needs Assessment conducted to determine where our organization needs to improve in our delivery of services

Supporting Materials

Attachment 1: Prevention Early Intervention (PEI) Data Report

Attachment 1: Prevention Early Intervention (PEI) FY 2020-2120 Data Report

The following are the PEI programs and providers from FY 2020-2021 for each MHSA Category. Tables of client demographics, provider events, and referrals follow.

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

DEMOGRAPHICS (ALL PROGRAMS)

Unique Clients Served											
	OUTREACH			PREVENTION & EARLY INTERVENTION				UNDERSERVED			ACCESS & LINKAGE
	& STIGMA			PREVENTION		EARLY INT.					
PROGRAM	LCDLR^	SYTHC	CHCCC	CALM	SYVPHP	TAY	CALM	CADA	FSA	CP	A & A
TOTAL CLIENTS	**35**	**38**	**259**	**77**	**96**	**206**	**480**	**35**	**73**	**867**	**1,227**
AGE											
0-15	0	0	3	73	71	4	480	34	55	498	324
16-25	0	0	8	0	13	202	0	1	18	363	284
26-59	35	38	1	4	12	0	0	0	0	5	543
60+	0	0	1	0	0	0	0	0	0	1	76
Unknown/Decline	0	0	246	0	0	0	0	0	0	0	0
SEX AT BIRTH											
Female	0	0	76	42	51	119	230	15	47	526	651
Male	0	0	19	35	45	87	249	20	26	336	569
Unknown/Decline	35	38	164	0	0	0	1	0	0	5	7
CURRENT GENDER IDENTITY (if over 12 years)											
Male	0	0	19	n/a	*	*	n/a	*	*	69	*
Female	0	0	76	n/a	*	*	n/a	*	*	95	*
Transgender	0	0	0	n/a	*	*	n/a	*	*	9	*
Genderqueer	0	0	0	n/a	*	*	n/a	*	*	5	*
Questioning	0	0	0	n/a	*	*	n/a	*	*	5	*
Another	0	0	0	n/a	*	*	n/a	*	*	0	*
Unknown/Decline	35	38	164	n/a	*	*	n/a	*	*	410	*
SEXUAL ORIENTATION (if over 12 years)											
Gay/Lesbian	0	0	1	n/a	*	*	n/a	*	*	7	*
Heterosexual	0	0	91	n/a	*	*	n/a	*	*	58	*
Bisexual	0	0	2	n/a	*	*	n/a	*	*	20	*
Questioning/ Unsure	0	0	0	n/a	*	*	n/a	*	*	4	*
Queer	0	0	0	n/a	*	*	n/a	*	*	2	*
Another	0	0	0	n/a	*	*	n/a	*	*	0	*
Unknown/Decline	35	38	165	n/a	*	*	n/a	*	*	593	*
PRIMARY LANGUAGE											
English	0	38	27	52	76	*	367	*	*	681	*
Spanish	35	0	220	25	20	*	104	*	*	171	*
Other	0	0	7	0	0	*	1	*	*	2	*
Unknown/Decline	0	0	169	0	0	*	8	*	*	13	*
VETERAN (if over 12 years)											
Yes	0	0	1	n/a	*	*	n/a	0	0	0	*
No	0	0	72	n/a	*	*	n/a	35	73	684	*
Unknown/Decline	35	38	186	n/a	*	*	n/a	0	0	183	*

(cont.)	OUTREACH			PREVENTION & EARLY INTERVENTION				UNDERSERVED			ACCESS & LINKAGE
	& STIGMA			PREVENTION		EARLY INT.					
PROGRAM	LCDLR^	SYTHC	CHCCC	CALM	SYVPHP	TAY	CALM	CADA	FSA	CP	A & A
RACE											
American Indian/ Alaska Native	0	0	0	0	0	0	3	0	3	6	19
Asian	0	0	0	0	0	6	0	0	1	13	20
Black/ African American	0	0	1	2	4	9	12	0	1	14	45
Native Hawaiian/ Pacific Islander	0	0	0	0	0	2	3	0	1	1	3
White	0	0	233	59	80	163	328	35	61	550	1,046
Other	0	0	17	11	0	8	75	0	1	100	25
More than one	0	0	0	5	12	10	20	0	1	0	36
Unknown/Decline	35	38	8	0	0	8	39	0	4	183	33
ETHNICITY: LATINO											
Caribbean	0	0	0	0	0	1	0	0	0	0	2
Central American	0	0	2	0	0	0	0	0	0	0	0
Mexican/Mex. Amer./ Chicano	0	0	237	0	46	83	20	23	43	171	472
Puerto Rican	0	0	0	0	0	0	1	0	0	0	3
South American	0	0	1	0	0	0	0	0	0	0	0
Other Latino	35*	0	1	61*	0	50	308	6	19	203	244
Unknown/Decline	0	38	1	0	0	11	75	0	0	0	66
ETHNICITY: NON-LATINO											
African	0	0	1	*	*	9	*	0	1	*	45
Asian Indian/ South Asian	0	0	0	*	*	1	*	0	0	*	18
Cambodian	0	0	0	*	*	0	*	0	0	*	0
Chinese	0	0	0	*	*	0	*	0	0	*	0
Eastern European	0	0	0	*	*	*	*	0	*	*	*
European	0	0	0	*	*	*	*	0	*	109	*
Filipino	0	0	0	*	*	3	*	0	0	*	8
Japanese	0	0	0	*	*	0	*	0	0	*	2
Korean	0	0	0	*	*	1	*	0	1	*	2
Middle Eastern	0	0	0	*	*	0	*	0	*	*	*
Vietnamese	0	0	0	*	*	1	*	0	0	*	3
Other	0	0	0	*	*	10	*	0	2	86	26
Unknown/Decline	35	38	10	*	*	8	*	35	4	275	33
More than one	0	0	0	*	*	10	*	0	1	*	*

(cont.)	OUTREACH			PREVENTION & EARLY INTERVENTION				UNDERSERVED			ACCESS & LINKAGE
	& STIGMA			PREVENTION		EARLY INT.					
PROGRAM	LCDLR^	SYTHC	CHCCC	CALM	SYVPHP	TAY	CALM	CADA	FSA	CP	A & A
DISABILITY											
Difficulty Seeing	0	0	0	0	*	*	2	*	*	0	*
Difficulty Hearing / Having Speech Understood	0	0	0	5	*	*	26	*	*	0	*
Physical/Mobility	0	0	0	3	*	*	7	*	*	0	*
Chronic Health Condition/Pain	0	0	0	0	*	*	*	*	*	0	*
Other Mental Disability not Related to Mental Illness	0	0	0	2	*	*	1	*	*	0	*
Other	0	0	0	0	*	*	7	*	*	0	*
Unknown/Decline	35	38	184	3	*	*	190	*	*	0	*
FAMILY											
# Family Members in Program	NR	0	159	0	*	*	87	*	*	0	*

*Note. Asterisks indicate categories that were either not available as options or not selected. For a few programs, Hispanic/Latino was grouped together but not identified by specific region.
^only three quarters of data available

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

ORANGE data sourced from Vertical Change and quarterly reports
BLUE data sourced from EHR; some demographic data is not available on PEI categories
GREEN data sourced from provider's EHR; some demographic data is not available on PEI categories

OUTREACH EVENTS

Outreach Events			
PROGRAM	**LCDLR**	**SYTHC**	**CHCCC**
TOTAL # EVENTS	**88**	**119**	**167**
TOTAL # PARTICIPANTS	**2,186**	**621**	**4,878 (unique) 34,729 (contacts)**
TOTAL # FAMILIES SERVED	**755**	**NR**	**1,589**
EVENT TYPE			
Outreach (Health Fairs, Other Outreach)	3	3	39
Training (Trainings, Workshops)	7	22	24
Forum (Meetings w/ Community Leaders)	6	44	37
Support Group	72	50	67
PRIMARY LANGUAGE OF EVENT			
English	0	119	44
Spanish	88	0	123
Other or both English and Spanish	0	0	0
TRANSLATION PROVIDED			
Translation to English at Spanish event	NR	0	1
Translation to Spanish at English event	NR	0	22
Other or both English and Spanish	NR	0	35
PARTICIPANT AGE			
0-15	NR	7	10,046
16-25	NR	83	7,460
26-59	NR	15	16,176
60+	NR	0	1,081
Missing DOB	NR	10	0
PARTICIPANT GENDER			
Female	NR	90	17,727
Male	NR	15	16,971
Unknown/Decline	NR	10	0
PARTICIPANT VETERAN			
Yes	NR	0	0
No	NR	38	0
Unknown/Decline	NR	17	34,725
PARTICIPANT RACE			
American Indian/ Alaska Native	NR	50	28
Asian	NR	0	125
Black/African American	NR	0	129
Native Hawaiian/ Pacific Islander	NR	0	0
White	NR	0	572
Other	NR	0	7,010
More than one	NR	0	0
Unknown/Decline	NR	14	0
PARTICIPANT ETHNICITY			
Latino	NR	0	33,895
Non-Latino	NR	0	803
Unknown/Decline	NR	12	0

NR = Not Reported (blank).

*(cont.) *Note that this data reflects a compilation of Vertical Change data and/or quarterly reports. Therefore, it does not always correspond to the data in the pivot tables collected in Vertical Change.*

Unique Clients Referred										
	OUTREACH & STIGMA			**PREVENTION & EARLY INTERVENTION**			**UNDERSERVED**			**ACCESS & LINK-AGE**
PROGRAM	LCDLR	SYTHC	CHCCC	CALM	SYVPHP	TAY	CADA	FSA	CP	A & A
TYPE (TOTAL #)										
CBO Referral to Behavioral Wellness	40	4	8	N/A	NR	N/A	N/A	N/A	NR	N/A
Intake to Behavioral Wellness										N/A
Behavioral Wellness Referral Out										N/A
MENTAL/BEHAVIORAL HEALTH SYMPTOMS PRIOR TO REFERRAL / INTAKE										
Yes	40	4	2	N/A	NR	N/A	N/A	N/A	NR	N/A
If yes, date is completed	NR	NR	NR	N/A	NR	N/A	N/A	N/A	NR	N/A
No	0	0	2	N/A	NR	N/A	N/A	N/A	NR	N/A
If no, average duration of sxs	N/A	N/A	N/A	N/A	NR	N/A	N/A	N/A	NR	N/A
Unable to Determine	N/A	N/A	4	N/A	NR	N/A	N/A	N/A	NR	N/A
ARE YOU CONCERNED THE MENTAL/BEHAVIORAL HEALTH SYMPTOMS REPORTED INDICATE A POSSIBLE SEVERE MENTAL ILLNESS?										
Yes	0	0	0	N/A	NR	N/A	N/A	N/A	NR	N/A
No	0	0	1	N/A	NR	N/A	N/A	N/A	NR	N/A
Unable to Determine	40	4	7	N/A	NR	N/A	N/A	N/A	NR	N/A
WAYS REFERRING PARTY ENCOURAGED CLIENT TO ACCESS SERVICES AND FOLLOW THROUGH ON REFERRAL										
Called	NR	NR	7	N/A	NR	N/A	N/A	N/A	NR	N/A
Emailed	NR	NR	NR	N/A	NR	N/A	N/A	N/A	NR	N/A
Arranged Transport	NR	NR	NR	N/A	NR	N/A	N/A	N/A	NR	N/A
Arranged Appointment	NR	NR	1	N/A	NR	N/A	N/A	N/A	NR	N/A
Other	NR	NR	3	N/A	NR	N/A	N/A	N/A	NR	N/A

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

Attachment 2: Prevention Early Intervention (PEI) Priorities Table

Program & MHSA Category	Category of PEI	Relevant Stakeholder Input
Santa Ynez Tribal Health Clinic Prevention and Early Intervention Program	Culturally competent & linguistically appropriate prevention & intervention	Native BWELL liaison to best engage with SYTHC. There is a disconnect and a lack of trust. BWELL does not communicate with Elders in a manner that Elders see as respectful. Treatment need to include of cultural preferences. SYTHC is struggling to fill staff positions and executive positions.
Community Health Centers of the Central Coast Prevention and Early Intervention Program	Culturally competent & linguistically appropriate prevention & intervention	Need to increase staffing to best reach community. Promotoras have minimal funding, would like increased. Especially with the loss of Casa de la Raza, we need more funding for our staff to provide outreach.
Santa Ynez Valley People Helping People Prevention and Early Intervention Program	Childhood trauma prevention & early intervention, & mood disorder & suicide prevention programming that occurs across the lifespan; Early identification programming of mental health symptoms & disorders, including but not limited to, anxiety, depression and psychosis Early Childhood Mental Health	Native community holds cultural traditions that need to be respected. Parents of children may have mistrust of BWELL clinicians. BWELL clinicians need trainings on cultural norms of Native people. Clinicians minimize preferred cultural healing practices and look down on the belief of power in “sweat lodges” “sage cleanses”; suggest enhance cultural competency trainings.

CALM ECMH Great Beginnings Prevention and Early Intervention Program	Childhood trauma prevention & early intervention, & mood disorder & suicide prevention programming that occurs across the lifespan; Early identification programming of mental health symptoms & disorders, including but not limited to, anxiety, depression and psychosis	Need coordinated comprehensive community outreach programming. A Cultural Competency Needs Assessment could help identify where we can improve in delivery of services.
CALM ECMHS Special Needs	Early identification programming of mental health symptoms & disorders, including but not limited to, anxiety, depression and psychosis	BWELL needs to invite disability organizations to the table and create an outreach event with disability organizations and advocates present. This should include children programming.
County Early Detection & Intervention Early Intervention Program	Childhood trauma prevention & early intervention, & mood disorder & suicide prevention programming that occurs across the lifespan;	Need to enhance program with the state of CA new suicide prevention plan. Educational series maybe created with guest speakers (peers). Prevention and early intervention for children is key.

School-Based Counseling Council on Alcohol and Drug Abuse Early Intervention Program	Youth outreach & engagement strategies that target secondary school & transition age youth, w/ a priority on partnership w college mental health programs; Early identification programming of mental health symptoms & disorders, including but not limited to, anxiety, depression and psychosis	Interactive programming would help for families to understand how to assist child's outcomes through empowering children to learn about wellness plans. More programming on what is mental illness/what are mood disorders/ Peer speakers. Many resources at schools are desired as students are captive audience. Great need for suicide awareness trainings for staff, students and parents.
School-Based Counseling Family Service Agency Early Intervention Program	Youth outreach & engagement strategies that target secondary school & transition age youth, w/ a priority on partnership w college mental health programs; Early identification programming of mental health symptoms & disorders, including but not limited to, anxiety, depression and psychosis	Create programming allowing for youth to help create programming. Include youth while receiving services to help with programming materials.
County Access & Assessment and Access Line Program Early Intervention Program	Early identification programming of mental health symptoms & disorders, including but not limited to, anxiety, depression and psychosis	Need more people answering calls. Wait times may aggravate symptoms. Request better hold system while people wait with calming sounds or soothing information talking about referrals sources or talk down recording while people wait to speak to assessor.

Attachment 3: MHSA Budget Summaries

FY 2021-22 Through FY 2023-24 Three-Year Mental Health Services Act Expenditure Plan
Funding Summary

County: Santa Barbara County Date: 3/11/22

	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 2021/22 Funding						2,023,113
1. Estimated Unspent Funds from Prior Fiscal Years	12,825,759	5,397,869	1,601,465	0	0	
2. Estimated New FY2021/22 Funding	26,957,000	6,739,300	1,773,500			
3. Transfer in FY2021/22[a/]	(6,237,660)			84,300	6,153,360	0
4. Access Local Prudent Reserve in FY2021/22	0	0				0
5. Estimated Available Funding for FY2021/22	33,545,099	12,137,169	3,374,965	84,300	6,153,360	
B. Estimated FY2021/22 MHSA Expenditures	20,559,900	4,532,200	738,400	84,300	135,000	
C. Estimated FY2022/23 Funding						2,023,113
1. Estimated Unspent Funds from Prior Fiscal Years	12,985,199	7,607,671	2,895,937	0	0	
2. Estimated New FY2022/23 Funding	28,512,100	6,681,800	1,713,200			
3. Transfer in FY2022/23[a/]	(273,484)			272,684	800	0
4. Access Local Prudent Reserve in FY2022/23		0				0
5. Estimated Available Funding for FY2022/23	41,223,815	14,289,471	4,609,137	272,684	800	
D. Estimated FY2022/23 Expenditures	29,900,889	4,996,377	1,964,707	272,684	800	
E. Estimated FY2023/24 Funding						2,023,113
1. Estimated Unspent Funds from Prior Fiscal Years	11,322,926	9,293,095	2,644,430	0	0	
2. Estimated New FY2023/24 Funding	28,512,100	6,681,800	1,713,200			
3. Transfer in FY2023/24[a/]	(278,938)			278,138	800	0
4. Access Local Prudent Reserve in FY2023/24	0					0
5. Estimated Available Funding for FY2023/24	39,556,088	15,974,895	4,357,630	278,138	800	
F. Estimated FY2023/24 Expenditures	30,530,820	5,151,002	2,003,907	278,138	800	
G. Estimated FY2023/24 Unspent Fund Balance	9,025,269	10,823,893	2,353,724	0	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2021	2,023,113
2. Contributions to the Local Prudent Reserve in FY 2021/22	0
3. Distributions from the Local Prudent Reserve in FY 2021/22	0
4. Estimated Local Prudent Reserve Balance on June 30, 2022	2,023,113
5. Contributions to the Local Prudent Reserve in FY 2022/23	0
6. Distributions from the Local Prudent Reserve in FY 2022/23	0
7. Estimated Local Prudent Reserve Balance on June 30, 2023	2,023,113
8. Contributions to the Local Prudent Reserve in FY 2023/24	0
9. Distributions from the Local Prudent Reserve in FY 2023/24	0
10. Estimated Local Prudent Reserve Balance on June 30, 2024	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 2021-22 Through 2023-24 MHSA Plan Update
Community Services and Supports (CSS) Component Worksheet

County: Santa Barbara County

Date: 3/9/22

	Fiscal Year 2021/22			
	A	B	C	D
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi Cal FFP	Estimated Realignment & Other Funding
FSP Programs				
1. SPIRIT FSP Wraparound Services	2,621,500	1,367,800	1,218,700	35,000
2. Lompoc ACT FSP	2,227,400	1,441,000	786,400	0
3. Santa Maria ACT FSP	1,914,600	1,132,800	781,800	0
4. Santa Barbara ACT FSP	3,523,900	1,463,300	2,060,600	0
5. Supported Community Services North	1,046,600	234,100	812,500	0
6. Supported Community Services South	1,382,800	408,800	974,000	0
7. Forensic FSP (Justice Alliance)	1,903,200	1,677,300	225,900	0
8. New Heights TAY FSP	2,825,500	1,277,800	983,300	564,400
9.	0			
10.	0			
Non-FSP Programs				
1. Crisis Services	5,697,300	1,003,500	2,407,600	2,286,200
2. Adult Wellness and Recovery Outpatient (WR) Teams	4,705,300	601,700	4,103,600	0
3. Co-Occurring Mental Health and Substance Use Outpatient Tea	3,579,000	448,600	3,130,400	0
4. Partners in Hope	939,200	895,600	43,600	0
5. Children Wellness, Recovery and Resiliency (WRR) Teams	5,369,100	0	2,871,100	2,498,000
6. Pathways to Well Being	714,000	0	175,800	538,200
7. Crisis Residential Services North/South	4,730,600	2,618,700	1,841,900	270,000
8. Adult Housing Support Services	3,641,700	75,400	936,100	2,630,200
9. Crisis Stabilization Unit South	3,270,800	1,381,000	1,077,600	812,200
10. Homeless Outreach Services	1,926,100	398,300	661,300	866,500
11. Medical Integration	2,057,500	1,086,900	970,600	0
12. Childrens Crisis Triage Teams	278,400	0	38,400	240,000
13.	0	0	0	0
CSS Administration	9,078,800	3,047,300	5,663,000	368,500
CSS MHSA Housing Program Assigned Funds	0			
Total CSS Program Estimated Expenditures	63,433,300	20,559,900	31,764,200	11,109,200
FSP Programs as Percent of Total	51.4%			

	Fiscal Year 2022/23			
	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	2,510,910	1,274,910	1,201,000	35,000
2. Lompoc ACT FSP	1,970,703	1,237,403	733,300	0
3. Santa Maria ACT FSP	1,918,000	1,013,700	904,300	0
4. Santa Barbara ACT FSP	3,751,916	1,793,516	1,958,400	0
5. Supported Community Services: North/Santa Maria	1,096,841	319,341	777,500	0
6. Supported Community Services: South/Santa Barbara	1,490,264	569,164	921,100	0
7. Forensic FSP Justice Alliance	2,464,964	2,257,864	207,100	0
8. New Heights TAY FSP	3,333,590	1,597,490	915,300	820,800
9.				
10.				
Non-FSP Programs				
1. Crisis Services	7,165,779	2,337,603	2,699,676	2,128,500
2. Adult Wellness and Recovery Outpatient (WR) Teams	5,646,261	1,774,461	3,871,800	0
3. Co-Occurring Mental Health and Substance Use Outpatient Tea	3,898,887	1,991,887	1,907,000	0
4. Partners in Hope	1,018,600	977,700	40,900	0
5. Children Wellness, Recovery and Resiliency (WRR) Teams	5,844,524	0	3,321,224	2,523,300
6. Pathways to Well Being	714,000	0	175,800	538,200
7. Crisis Residential Services North/South	5,070,345	3,069,445	1,730,900	270,000
8. Adult Housing Support Services	4,041,533	1,560,033	873,500	1,608,000
9. Crisis Stabilization Unit South	4,539,145	1,129,145	1,831,600	1,578,400
10. Homeless Outreach Services	3,562,855	368,555	624,800	2,569,500
11. Medical Integration	2,392,397	1,475,297	917,100	0
12. Childrens Crisis Triage Teams	482,712	205,412	157,300	120,000
13.		0		0
14.		0		
	0			
CSS Administration	10,455,862	4,947,962	5,045,500	462,400
CSS MHSA Housing Program Assigned Funds	0			
Total CSS Program Estimated Expenditures	73,370,089	29,900,889	30,815,100	12,654,100
FSP Programs as Percent of Total	40.3%			

	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	2,561,128	1,301,108	1,225,020	35,000
2. Lompoc ACT FSP	2,010,117	1,262,151	747,966	0
3. Santa Maria ACT FSP	1,956,360	1,033,974	922,386	0
4. Santa Barbara ACT FSP	3,826,954	1,829,386	1,997,568	0
5. Supported Community Services: North/Santa Maria	1,118,778	325,728	793,050	0
6. Supported Community Services: South/Santa Barbara	1,520,069	580,547	939,522	0
7. Forensic FSP Justice Alliance	2,514,264	2,303,022	211,242	0

8. New Heights TAY FSP	3,400,261	1,645,855	933,606	820,800
9.				
10.				
Non-FSP Programs				
1. Crisis Services	7,309,095	2,426,925	2,753,670	2,128,500
2. Adult Wellness and Recovery Outpatient (WR) Teams	5,759,186	1,809,950	3,949,236	0
3. Co-Occurring Mental Health and Substance Use Outpatient Tea	3,976,865	2,031,725	1,945,140	0
4. Partners in Hope	1,038,972	997,254	41,718	0
5. Children Wellness, Recovery and Resiliency (WRR) Teams	5,961,414	50,466	3,387,648	2,523,300
6. Pathways to Well Being	728,280	10,764	179,316	538,200
7. Crisis Residential Services North/South	5,171,752	3,136,234	1,765,518	270,000
8. Adult Housing Support Services	4,122,364	1,623,394	890,970	1,608,000
9. Crisis Stabilization Unit South	4,629,928	1,183,296	1,868,232	1,578,400
10. Homeless Outreach Services	3,634,113	427,317	637,296	2,569,500
11. Medical Integration	2,440,245	1,504,803	935,442	0
12.		0		0
13.	0		0	
14.	0	0	0	0
CSS Administration	10,664,979	5,046,921	5,146,410	471,648
CSS MHSA Housing Program Assigned Funds	0			
Total CSS Program Estimated Expenditures	74,345,124	30,530,820	31,270,956	12,543,348
FSP Programs as Percent of Total	40.3%			

FY 2021-22 Through 2023-24 MHSA Plan Update
Prevention and Early Intervention (PEI) Component Worksheet

County: Santa Barbara County 3/9/22

	Fiscal Year 2021/22			
	A	B	C	D
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated Other Funding
PEI Programs - Prevention				
1. Mental Health Education	170,000	170,000	0	0
2. Early Childhood Mental Health (ECMH)	383,700	383,700	0	0
3.	0			
4.	0			
5.	0			
6.	0			
7.	0			
8.	0			
9.	0			
10.	0			

PEI Programs - Early Intervention				
11. Early Childhood Mental Health	1,517,500	662,700	854,800	0
12. PEI Early Detection and Intervention Teams for TAY	947,400	0	947,400	
13. School-Based Prevention/Early Intervention Services	458,100	317,100	141,000	0
14. Access and Assessment Teams/ACCESS Line	2,610,000	1,753,800	856,200	
15. Safe Alternatives for Children and Youth Crisis Servic	1,072,800	614,800	458,000	
16. Mental Health Student Services Act	488,600	0		488,600
17. Early Psychosis Intervention Grant	179,500	179,500		0
18.	0			
19.	0			
20.	0			
PEI Administration	450,600	450,600	0	
PEI Assigned Funds				
Total PEI Program Estimated Expenditures	8,278,200	4,532,200	3,257,400	488,600

	Fiscal Year 2022/23			
	A	**B**	**C**	**D**
	Estimated Total Mental Health Expenditures	**Estimated PEI Funding**	**Estimated Medi-Cal FFP**	**Estimated Other Funding**
PEI Programs - Prevention				
1. Mental Health Education	170,600	170,600	0	0
2. Early Childhood Mental Health (ECMH)	428,100	428,100	0	0
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
PEI Programs - Early Intervention				
11. Early Childhood Mental Health	1,517,500	591,300	926,200	0
12. Early Detection and Intervention Teams for TAY	1,129,298	124,398	1,004,900	0
13. School-Based Prevention/Early Intervention Services	502,600	332,500	170,100	0
14. Access and Assessment Teams/ACCESS Line	3,039,979	2,238,679	801,300	0
15. Safe Alternatives for Children and Youth Crisis Servic	1,091,300	660,200	431,100	0
16. Mental Health Student Services Act	986,136			986,136
17. Early Psychosis Intervention Grant	618,371		233,700	
18.	0			

19.	0			
20.	0			
PEI Administration	450,600	450,600	0	
PEI Assigned Funds	0			
Total PEI Program Estimated Expenditures	9,934,483	4,996,377	3,567,300	986,136

	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. Mental Health Education	170,600	170,600		
2. Early Childhood Mental Health (ECMH)	428,100	428,100		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
PEI Programs - Early Intervention				
11. Early Childhood Mental Health	1,547,850	621,650	926,200	0
12. Early Detection and Intervention Teams for TAY	1,151,884	146,984	1,004,900	0
13. School-Based Prevention/Early Intervention Services	512,652	342,552	170,100	0
14. Access and Assessment Teams/ACCESS Line	3,100,778	2,299,478	801,300	0
15. Safe Alternatives for Children and Youth Crisis Servic	1,113,126	682,026	431,100	0
16. Mental Health Student Services Act	1,005,859			1,005,859
17. Early Psychosis Intervention Grant	630,738			630,738
18.				
19.				
20.				
PEI Administration	459,612	459,612	0	
PEI Assigned Funds	0			
Total PEI Program Estimated Expenditures	10,121,199	5,151,002	3,333,600	1,636,597

FY 2021-22 Through 2023-24 MHSA Plan
Update Innovations (INN) Component
Worksheet

County: Santa Barbara County

	Fiscal Year 2021/22			
	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	726,800	726,800	0	0
2.	0	0	0	0
3.	0	0	0	0
4.	0			
INN Administration	11,600	11,600	0	
Total INN Program Estimated Expenditures	738,400	738,400	0	0

	Fiscal Year 2022/23			
	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	909,153	909,153		0
2. Housing Retention and Benefit Acquisition Team	1,050,853	1,050,853		
3.				
4.				
INN Administration	4,700	4,700	0	
Total INN Program Estimated Expenditures	1,964,707	1,964,707	0	0

	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	927,336	927,336	0	0
2. Housing Retention and Benefit Acquisition Team	1,071,870	1,071,870		
3.				
4.				
INN Administration	4,700	4,700		
Total INN Program Estimated Expenditures	2,003,907	2,003,907	0	0

FY 2021-22 Through 2023-24 MHSA Plan Update
Workforce, Education and Training (WET) Component Worksheet

County: Santa Barbara County

	Fiscal Year 2021/22			
	A	B	C	D
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated Other Funding
WET Programs				
1. Peer Training	84,300	84,300	0	0
2. Southern Counties Regional Partnership	295,200	0	0	295,200
3. OSHPD Southern Counties Regional Partnership	3,481,100			3,481,100
4.	0			
WET Administration		0		
Total WET Program Estimated Expenditures	3,860,600	84,300	0	3,776,300

	Fiscal Year 2022/23			
	A	B	C	D
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated Other Funding
WET Programs				
1. Peer Training	272,684	272,684	0	0
2. Southern Counties Regional Partnership	129,520	0	0	129,520
3. OSHPD Southern Counties Regional Partnership	3,615,146			3,615,146
4.	0			
WET Administration	0	0		
Total WET Program Estimated Expenditures	4,017,350	272,684	0	3,744,666

	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	278,138	278,138		
2. Southern Counties Regional Partnership	132,111	0		132,111
3. OSHPD Southern Counties Regional Partnership	3,687,448			3,687,448
4.	0			

WET Administration	0	0		
Total WET Program Estimated Expenditures	4,097,697	278,138	0	3,819,559

FY 2021-22 Through 2023-24 MHSA Plan Update
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Santa Barbara County

	Fiscal Year 2021/22			
	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)	135,000	135,000	0	0
12.	0			
CFTN Administration	0			
Total CFTN Program Estimated Expenditures	135,000	135,000	0	0

	Fiscal Year 2022/23			
	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)	800	800	0	0
12.	0			
CFTN Administration	0			
Total CFTN Program Estimated Expenditures	800	800	0	0

	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.	0			
2.	0			

CFTN Programs - Technological Needs Projects				
11. Capital Information Technology (CIT)	800	800		
12.	0			
CFTN Administration	0			
Total CFTN Program Estimated Expenditures	800	800	0	0

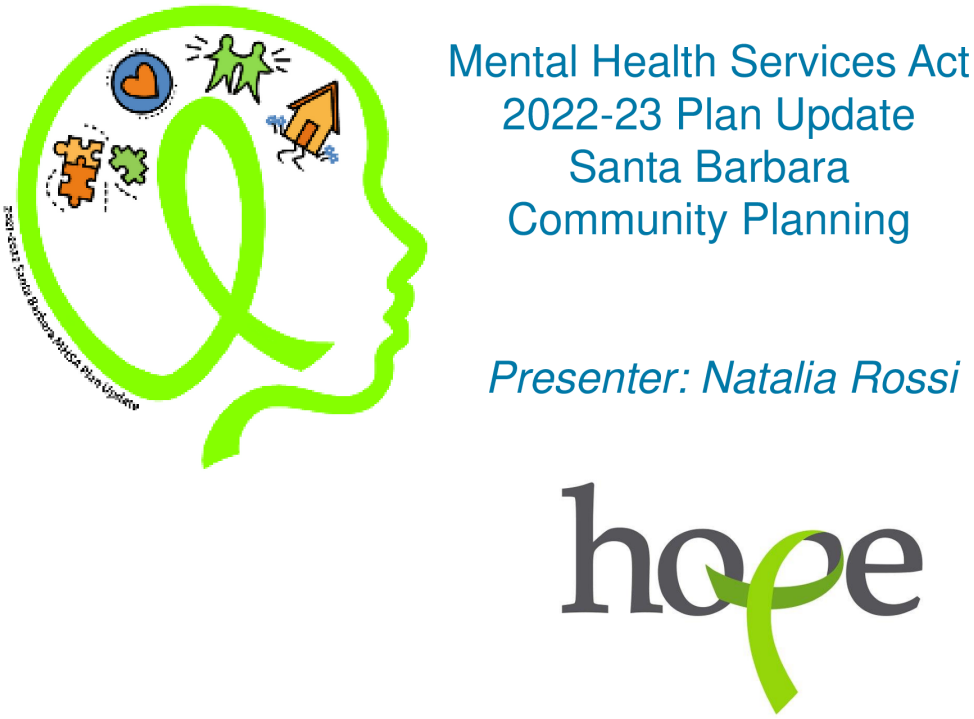
Attachment 4: MHSA Fiscal Three-Year Community Planning Process Program PowerPoint

Mental Health Services Act Fiscal Years 2022-2023 One-Year Community Planning Process Program PowerPoints were shared virtually, regionally, and translated into Spanish with Mixtec live interpretation available throughout the county.

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

The PowerPoints included the Mental Health Services Act Overview; Annual Percentage of MHSA Funding and MHSA General Standards Three-Year MHSA Community Planning Process; Current Funded MHSA Programs; FY 2021-22 Focus Topics Feedback gathered throughout FY2020-23; and Open Discussions.

Examples of PowerPoint:



About me, your new Mental Health Services Act Person

- Licensed attorney
- Worked as coordinator for Southern California Regional Partnership (SCRP), a regional Workforce Education and Training (WET) grant to 10 counties in Southern California
- Previously BWELL's Training Coordinator
- Previously BWELL's Housing and Homeless Services Coordinator

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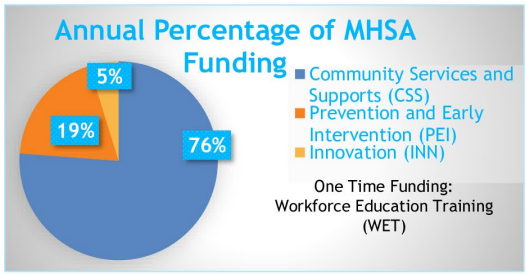
Mental Health Services Act (MHSA) Overview

On November 2004, voters in the State of California passed Proposition 63, the Mental Health Services Act (MHSA), which was designed to expand and transform California's county mental health service system. The MHSA is funded by imposing an additional one percent tax on individual, but not corporate, taxable income in excess of 1 million dollars.

To accomplish its objectives MHSA applies a specific portion of funding to each of six system-building components:



MHSA General Standards:

1. Community Collaboration (9 CCR § 3200.060)
2. Cultural Competence (9 CCR § 3200.100)
3. Client Driven (9 CCR § 3200.050)
4. Family Driven (9 CCR § 3200.120)
5. Wellness, Recovery, and Resilience Focused (WIC § 5813.5(d))
6. Integrated Service Experience (9 CCR § 3200.190)

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MHSA Community Collaboration

MHSA Community Collaboration (9 CCR § 3200.060)

"Community Collaboration" means a process by which clients and/or families receiving services, other community members, agencies, organizations, and businesses work together to share information and resources in order to fulfill a shared vision and goals.

Note: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5830(a)(3) and 5866, Welfare and Institutions Code.

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Current Funded MHSA Programs

Community Services and Supports (CSS)
General System Development
Crisis Services
New Heights
Partners In Hope
Homeless Outreach Services
Co-Occurring Mental and Substance Use Outpatient Teams
Children Wellness, Recovery and Resiliency (WRR) Teams
Adult Wellness and Recovery Outpatient (WR) Teams

Pathways to Well Being (Formerly "HOPE" Program) Teams
Crisis Residential Services North, South, and Agnes
Medical Integration Program
Adult Housing Support Services
Crisis Stabilization Unit South
Kids Triage Program

Full Service Partnerships (FSPs)
Assertive Community Treatment (ACT)
Lompoc ACT FSP
Santa Maria ACT FSP
Santa Barbara ACT FSP
Supported Community Services South
Supported Community Services North
SPIRIT FSP Wraparound Services
Forensic FSP Justice Alliance
Lompoc TAY FSP
Santa Maria TAY FSP
Santa Barbara TAY FSP

Prevention and Early Intervention (PEI)
Mental Health Education and Support to Culturally Underserved Communities (Promotora Program)
PEI Early Childhood Mental Health (ECMH)
School-Based Prevention/Early Intervention Services for Children and TAY (START)
PEI Early Detection and Intervention Teams for Children for Transition-Age Youth (TAY)
Safe Alternatives for Children and Youth (SAFTY)(Crisis Services)
Access and Assessment Teams – Kids, TAY, Adults

Innovations
Technology Suite Project: Technology Advancing to Access and Recovery FY 2019-24
Proposed: Housing Retention Team for FY 2022-2027

Housing
Completed MHSA-funded Projects
The "No Place Like Home" Initiative

Workforce Education and Training (WET)
Consumer Empowerment and Peer Employment

Capital Facilities and Technological Needs (CF/TN)
Electronic Health Records

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5

MHSA Community Planning Process

Community Planning Process

Spring Planning Stakeholder Meetings

MHSA Community/Workgroups

Draft MHSA Annual Plan Update

BeWell Commission Public Hearing

Approval and Adoption

Mental Health Services Act Planning Process

Every three years, we engage stakeholders and develop a three-year plan

We are in the final year of the 2020-23 Three Year Plan

At the beginning of this plan, there were four new initiatives identified by stakeholders

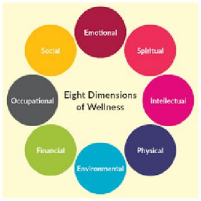
I am here now to get feedback on programs we can start or continue to meet the goals of these four initiatives

Fiscal Years 2020-23 Proposals

Implementation of expanded
Youth-Focused Care and Youth-Driven Initiatives

Increased utilization of Peer Services and
integration of Peer Philosophies in Department and Contract Services

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



Integrating Whole Person Care
philosophies throughout Outpatient services

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

- Creation of Youth Led Leadership
- Assistance of Youth in the development of Leadership skills
- Establishing a Youth designated position on the Behavioral Wellness Commission
- Promoting and marketing youth involvement at each Department Action Team meeting
- Inviting youth subject matter experts to work with youth on their topics of interest

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Youth Initiatives in 2020-21 : A Visual of Activities

Channels

Mental health services move online as social isolation changes norms

The Channels • April 17, 2020 • https://www.thechannels.org/news/2020/04/17/mental-health-services-move-online-as-social-isolation-changes-norms/

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Youth Driven and Youth Led Initiatives in 2021-22

- Supported outreach and planning for Behavioral Wellness Transitional Age Youth Commission Members with 4 applicants as of March 2021
- Awarded Early Psychosis Grant from MHSOAC, to start spring and summer 2021
- Awarded School Navigator and Prevention Grant in collaboration with SBCEO, Youth' l Wellness Center
- Created YOR Place in Lompoc focused on Substance Use with link to MHSA mental health services. Grant award March 2021 with collaboration with Family Services Agency, opened June 2021
- Transitional Age Youth Help@Hand Team created Peer Digital Literacy Training, Youth Appy Hour and Gaming Listening Sessions, Digital Zoom Peer Support Groups focused on LBGTQ and Meditation
- Continued workplace opportunities with our writing internship program with UCSB students, including drafting the MHSA Plan
- Transitioned RISE Innovations program into TAY Full Service Partnership and PEI programs including converting Santa Maria clinic into a TAY location

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Proposed Youth Driven Initiatives for 2022-23

- Advocacy and Support Youth Community Initiatives that are youth-designed and/or youth led
- Development of ideas and grant applications, such as Youth-Designed Treatment Plans, Peer-Run Centers with creative technology spaces
- Mental Health First Aid Training for Youth and their Support Systems
- Youth Drop in Center
- Expand community programming and access around Early Psychosis Intervention

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Let's Discuss….

Barriers to services?

Opportunities?

Experiences?

Key Things to think about?

Highlights?

What is going well?

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

- Increase Peer staff capacity in order to provide every mental health program with the opportunity to have a peer support specialist on the clinic team
- Increase in Peer Lead Wellness Support Groups and specialist groups (LGBTQ+, TAY, Older Adult groups, etc.)
- Increase in Peer Navigators to ensure consumers connect with clinics and sustain treatment
- Hiring multi-lingual/multi-cultural peers for peer support services programming.

Peer Support Initiatives in 2021-22

- Access to Peer Certifications and State Peer Certification Legislation:

  -Peer Certification – Participation in State Planning and Implementation as discussed over past Peer CFMAT and Employee Forum meetings for past, present, future.

- Capacity for Peer Employment/Services:

  -Mental Health Early Psychosis (EPI) Grant Award – Adding peer caseworker leadership role with TAY and expanding peer recovery assistants for EPI services.

  -Help@Hand TAY Team – Expanded hiring TAY peers for digital application program.

  -Expanded Community Activities and Peer Led Support groups including curriculum development, Mental Health Awareness Campaign during COVID, PHF discharge and digital literacy support groups, meditation support group training, etc.

- Training and Advocacy for Peers in Community and Within Systems of Care:

  -Promoted partners' trainings/groups including distribution of Quarterly Peer Newsletter.

  -Appointment to Behavioral Wellness Commission of first Youth Commissioner

Peer Support Initiative Proposals for 2022-2023

- Peer training for State accredited Peer Certification
- Engaging trusted, Subject Matter Experts to provide training to peers, as well as mentorship, internship and workforce skill development opportunities for peers.
- Funding more peer run community wellness and recovery outreach activities,
- Hosting an annual Peer Empowerment Conference to engage and support our communities
- Establish a Behavioral Wellness Peer Speaker Bureau that will focus on Adult outpatient system of care, Transitional Age Youth and Housing

Let's Discuss....

Barriers to services?

Opportunities?

Experiences?

Key Things to think about?

Highlights?

What is going well?

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

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

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

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

- Creating Peer-run supportive programming at housing complexes.

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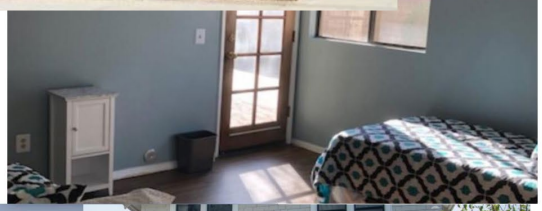
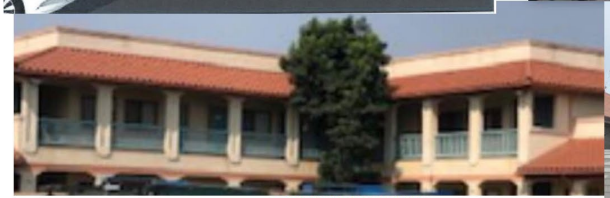
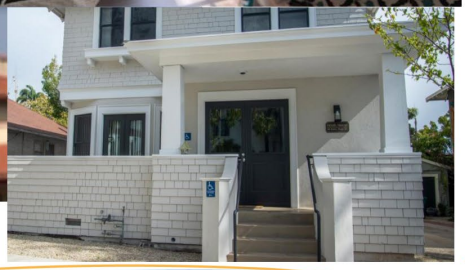
Housing and Homelessness Initiatives in 2022-23 – A Visual of Activities







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Housing and Homelessness Initiatives in 2021-22

- Established over 50 new housing opportunities with No Place Like Home (NPLH), HomeKey COVID funding, MHSA Housing and HEAP grants.

- Opened 34 MHSA-funded units in Santa Maria at Depot Street (2020)
- Opened 14 Homekey-funded units in Lompoc at Homekey Studios (2021)
- Opened 13 No Place Like Home-funded units in Santa Maria at West Cox Cottages (2021)
- NLPH awarded 3 units in Santa Barbara at Sanctuary Centers (not built yet)
- NPLH awarded 18 units in Santa Barbara at Hollister Lofts (not built yet)
- NPLH awarded 14 units in Lompoc at Cypress & 7th (not built yet)

Behavioral Support Services created for a variety of locations.

West Cox: 20 hours/week
Homekey Studios: 20+ hours/week
Sanctuary Centers: 20 hours/ week-proposed
Cypress: 20 hours/week-proposed
Hollister Lofts: 40 hours/week-proposed
Depot Street: 20 hours/week

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Proposed Housing Services Innovations Project for 2022-27

Creation of Housing Retention team funded as Innovations Project, including:

- Housing Manager: oversees Housing Retention Team and Tenant Selection Process
- "Good Tenant" curriculum for new tenants and those awaiting housing
- Three case managers to provide intensive services to new tenants
- Three peer recovery assistants to provide onsite peer supports and tenant advocacy
- Three SOAR-trained case workers to provide benefits counselling and advocacy
- Flex funding for transportation, furniture, food, and other tenant needs

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

Let's Discuss….

Barriers to services?

Opportunities?

Experiences?

Key Things to think about?

Highlights?

What is going well?

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

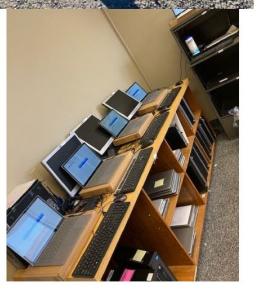
Proposal Four: Integrating Whole Person Care philosophies throughout Outpatient services

- Promote the role of health care in relieving suffering and promoting healing in acute and chronic illness
- Focus is on the whole person -- physical, emotional, social, and spiritual
- Empower consumers to attempt to self-manage their health by being fully empowered to play an active role in their health
- Remove feelings of helplessness and encourage hopefulness
- Engage clinicians, coaches, and peers to motivate consumers to improve their overall health

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

Whole Person Initiatives in 2021-22

- Public Health and BWell Coordination of Care
- Substance Use Care Coordinators to link individuals to all resources based on their needs
- Drum Circles – COVID Friendly
- Tele-Health – in your own safe place and increased availability and access to care, 2% to 85% of outpatient services in past year are Tele-Health
- Early Psychosis Grant
- School Navigator and Prevention Grant
- Help@Hand Digital Literacy Training, Youth Listening Sessions, and Psychiatric Unit Homeless Fanny Packs and Discharge Connections (solar chargers, phones, guide)



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MHSA GENERAL & INN PLANNING SURVEY – PLEASE FILL OUT!

In English:

https://www.surveymonkey.com/r/ZV5YHXS

In Spanish:

https://www.surveymonkey.com/r/NY362SY

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

WELLNESS • RECOVERY • RESILIENCE

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Here's the QR Code for English Survey

SANTA BARBARA COUNTY DEPARTMENT OF Behavioral Wellness
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28

…And the QR Code for the Spanish Survey

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What Do You Think? What Are Current Barriers? Input?

This is your time to share your input, thoughts or feedback for Santa Barbara
Please follow the link below if you have any suggestions!

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Mental Health Services Act Person

Please feel free to reach out with questions, comments and ideas!

Thank You,
Natalia Rossi, JD
MHSA Manager
nrossi@sbcbwell.org

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DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery

MENTAL HEALTH SERVICES ACT · CALIFORNIA · PROPOSITION 63
WELLNESS • RECOVERY • RESILIENCE

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

Public Comments regarding the MHSA Annual Plan Update in May 2021 were gathered. Feedback from Public Stakeholder meetings, surveys, emails sent in, and calls received are below.

Public comments regarding the MHSA Annual Plan Update were gathered at Department Action Meetings, Public Stakeholder Community Meetings, and throughout the region. Below is feedback gathered through different methods ensuring it was inclusive and reflective of the needs of the community.

Comments from Public Stakeholder Forum at Housing Assistance Action Team Meeting April 13th 2022

MHSA Manager Natalia Rossi held an MHSA Plan Update presentation for attendees representing Behavioral Wellness with a focus on housing services. She started by introducing the allocation of funding and the general standards MHSA must follow including community collaboration, cultural competence, and integrated service experience, among others. She went through the currently funded MHSA programs and proposals for fiscal years 2022-23.

Comments from attendees and discussion with presenters included:

Comment: 8 years ago, we had a great training funded through WET. It was two weeks of peer-to-peer training. Is there a way to increase WET funding to cover training like that again?

Comment: Path point used to provide onsite housing services, for the INN proposed plan, have you reached out to them for feedback?

Comment: That contact is now handled by citinet, you should get their feedback on what has worked/what hasn't worked

Comment: Expand ACT/AOT programs. ACT staffing shortages have been around for years

Comment: For whole person care, we need more alternatives to talk therapy. Things like meditation, movement, field trips to Lotus land, museums, the Getty, whale watching. Offering art classes.

Behavioral Wellness All Staff Meeting- March 30th 2022

MHSA Manager Natalia Rossi held an MHSA Plan Update presentation for attendees representing Behavioral Wellness. Comments from attendees are listed below.

Comment: Drop in Youth Center in North County is needed

Comment: Is there a Peer Certification training specifically for youth? Under 18? TAY? It would be great to have integrated Youth Drop-In centers to serve both MH and SUD in one location

Comment: The certification regulations require you to be 18 years old

Comment: In our own system we should create a "program" that is a training of youth for peer services, thereby promoting future workforce

Comment: Offering training for the onsite housing managers would be a great idea. A pattern that has been observed in that the onsite managers are not trained on how to work with our clients and a lot of problems come up as a result of this. Also having a training on Opioid Overdose Prevention Training for Housing Managers would be beneficial.

Comment: Having and outdoor/indoor 12 step meetings for youth at the children's clinic

Comment: ADP arena has providers that specialize in youth empowerment

Comment: Have a county/state care BNB platform for engaging landlords/tenants. Potentially increase housing options.

Comment: Can we launch one needs assessment and gather both cultural competence and community needs at once?

Comment: Need to include substance using/abusing clients in the anti-stigma campaign

Comment: Need people trained in CBT for depression and response prevention therapy for anxiety

Comment: If you are looking for whole-person care- include SUD as a part of the anti-stigma campaign

Comment: consider merging population and cultural competency into one needs assessment

Comment: ADP and MHSA need to integrate in regards to youth services

Comment: Integrate social activities and connection into interventions

MHSA Presentation Feedback YAB and TAY Meeting- April 12th 2022

MHSA Manager Natalia Rossi provided an overview of MHSA funding and how it helps to develop and expand mental health services as well as a presentation of current and future goals. Natalia discussed the specific principles MHSA must embody including community collaboration, cultural competency, resiliency, and the integration of services. One of MHSA's current goals is to further integrate mental health services with substance abuse services, resulting in one integrated program as opposed to having separate programs. Eventually, physical health will be integrated, creating the Whole-Person Care plan that encompasses all three of these aspects of wellness. She then introduced currently funded programs including the "No Place Like Home" initiative and youth-focused initiatives. A need for more youth-driven voices was addressed by opening up the BWELL Commission to TAY, holding listening sessions at UCSB and for the TAY community to understand their wellness needs, hiring more youth within the county system, and focusing on housing needs within the TAY population. Natalia concluded her presentation by asking for feedback and providing a survey.

Comments from attendees and discussion with presenters included:

Comment: What are youth community initiatives?

Comment: Having a job program that could help one keep a job, learn about budget spending, and how to create and maintain a savings account.

Comment: Having a youth drop-in center

Comment: Harm reduction and usage reduction. Narcan distribution, needle exchange

Comment: Peer support services, Peer management

Comment: Access hotline can be difficult to access. Need to make it an easier way to connect youth to mental health services (in-person) also a shorter wait on the access line. Need a faster way to bypass the referral process in regards to feedback and calls on the access line

Comment: Drop in centers. Also, have drop in centers do assessments that can be done there quickly by mental health staff

Comment: Have trainings on how to approach peers while on the street/in public and how to share with them access to services

Comments for MHSA Plan Update: Peer Employee Forum- March 17th 2022

Summary: A brief overview of MHSA and training in MHSA was presented by Natalia Rossi, followed by an in-depth discussion of Proposal Two of the MHSA Plan Update for FY 22-23: Increased utilization of Peer Services and integration of Peer Philosophies in Department and Contract Services.

Public Comments:

Comment: Documentation in Clinicians Gateway is too hard

Comment: We need more Peer-oriented training for Clinician's Gateway

Comment: We need a liaison for Peer Documentation

Comment: How about funding for peers to use Grammarly, an app that has really helped me with my written communication skills

Comment: Productivity is too stressful, we need to make it easier

Comment: How can I write a good note when there is constant change about what my notes should look like?

Comment: We need more time for Documentation, at the end of the day I don't have time, I've been seeing people all day.

Comment: You should invest in software that works better than Sharecare

Comment: Clinic cultures are very different now

Comment: There is confusion about note writing

Comment: We need another in person Documentation training for peers, it has been two years at least

Comment: We need a group mentorship/coaching for old to new peers on Documentation

Comment: We need more peer support

Comment: There needs to be more objectivity in Note Review, it changes from Supervisor to supervisor

Comment: Let's have one whole day as Documentation Day

Mental Wellness Center Stakeholder Feedback- April 6th 2022

MHSA Manager Natalia Rossi led a stakeholder presentation describing the objective of the Community Program Planning Process (CPP) and the importance of the Mental Health Services Act in utilizing funding for Behavioral Wellness programs. She explained how feedback gathered from stakeholders in the community allows MHSA funding to be used for necessary and needed resources and services. Natalia informed attendees of the 2022-23 update to the MHSA Plan including an expanded budget. To determine where funding will be utilized in the future, feedback will be gathered through more virtual and in person stakeholder sessions as well as through an online and in-person survey after each event.

Comments and discussion on Youth- Focused Care and Youth-Driven Innovations are as followed:

Comment: What is currently working?

Comment: Your place in Lompoc and ADP

Comment: How are they different from recovery centers? They differ by ages 18-25 and substance abuse specific

Comment: They have early psychosis program on trial/ experimental medications

Comment: Behavioral Wellness and community support needed in year 3 from Anne Marie's program

Comment: ALLCOVE: integrated care for young people

Comment: Physical care, employment help, substance abuse model based in Australia and now in Canada, Stanford partnered with MHSA

Comment: Early onset prevention is the goal

Comment: Evidence-based practice

Comment: Concern plan now for sustainable / long term or permanent solution for when grant money runs out

Comment: Drop in center that's closer (want and need in SB)

Comment: Advocate for TAY drop in center 18-25 feel like they don't have a place to go

Comment: Safe space where people aren't using drugs and are sober and where mental health services are provided

Comment: Peer-to-peer is initial contact in youth

Comment: Train youth for peer to peer skills like: First line of connection, Educate and prevention, Youth can notice the early signs, Lack of awareness on what's available in school

Comments and discussion of Peer Support Initiatives/ Peer Philosophies are as followed:

Comment: Co-host RLC w/ peer empowerment conference

Comment: What is our 22/23 budget? -Announced by CFO

Comment: The more peer involvement the better within our system

Comment: Peer support program for the peers that work

Comment: Have a drop-in room

Comment: Have staff for them

Comment: Have peer support specialists

Comment: Have housing availability

Comment: Add peer employees to ACT/AOT teams

Comment: Have a housing navigator

Comment: How can outcomes be measured? -Quality care management teams and Research and evaluation teams

Comment: Each program in plan has detailed information regarding outcomes

Comments and discussion of Housing Development/ Support are as followed:

Comment: People who live in apartments aren't required to come to meetings

Comment: All housing tenants need many services available because they are vulnerable

Comment: Involvement of advocacy at the beginning of stay

Comment: Cannot use regular MHSA funding for food, furniture, or transportation

Comment: Don't hire the manager, hire the peer

Comment: High speed internet access at all locations (use flex funding)

Comment: Get a peer navigator at housing that isn't built yet

Comment: Explanation of what supportive housing is (housing navigator)

Comment: Who should clients talk to, connect with, who/where do they go to when trying to apply?

Comment: Housing coordination

Comment: Peer navigators to get into the system

Comment: Have a homeless outreach team

Comment: Coordinated entry system that has documentation and applications. They don't have peer navigators in this

Comment: Keeping in touch with space on waitlists

Comment: Curriculum for aging in place

Comment: More outreach workers in the community

Comment: More housing for homeless

Comment: Transition youth fall out of the system

Comment: Outreach for people who fall out of system (check in on them)

Comment: Advocating housing for couples, people with pets, families

Comment: Using ACT model for housing teams

Comment: Good tenant curriculum

Comments and discussion of Whole Person Care are as followed:

Comment: What's the difference between whole person care vs. integrated care?

Comment: Whole: spiritual

Comment: Integrated: physical

Comment: Where is the staff and what are the resources?

Comment: Need increase in staff in ACT/AOT programs

Comment: Have college campus tours for youth = motivation

Comment: Availability of psychiatrists would lead to

- Support with awareness of medications
- How to store a 3-month supply of meds (a locker?)
- Medication management
- Education on what to do if meds get stolen/lost

Comment: What are efforts to partner with nonprofits in the community?

- Dignity moves
- CSUA site

Comment: Increase coordination with local non-profits

Comment: Less data collection and more community involvement

Comment: Have expectation that behavioral wellness staff are assigned to local groups (assign everyone to a non-profit) collaboration and cross pollination = better data

Comment: Retreat, drum circles, alumni (whole person) for staff and consumers

Comment: High school to college/ leaving home, moving out (TAY) support

Comment: Equitable access to holistic services (yoga, meditation, dance movement, art, outdoor walks

- RLC- will have yoga

Comment: More follow up on kids out of TAY

Comment: More follow up on kids who are leaving foster care

Comment: Different apps that share services

Comment: Funding for physical classes (recreation centers)

Comment: Field trips (lotus land)

Comment: Department of rehabilitation

Comment: Job application help

Comment: Job skills training/ workforce

- Peer workforce
- Housing sites

Comment: Exposure to different career opportunities (zookeeper, firefighter)

- Especially job careers that peers have gone into

Comment: Whole person care needed and usually for those most in poverty

- Need access

Comment: People in physical pain (whole person) healing

- Acute and chronic care through
  - Yoga
  - Meditation
  - Outdoor walks

Comment: Increase transportation for consumers

Comment: Increase Spanish speaking services/staff/translation

Comment: Increase or gain access to MTD bus tokens

Lompoc Library MHSA Stakeholder Event- March 29th 2022

4 proposals

1. Youth- Focused Care, Youth-Driven Innovations
2. Peer Support Initiatives/ Peer Philosophies
3. Housing Development/ Support
4. Whole Person Care

<u>Comments and discussion on Youth- Focused Care and Youth-Driven Innovations are as followed:</u>

Comment: In Lompoc, LGBTQ+ population doesn't have much support

Comment: Is youth led support possible?

Comment: Hospital beds are County funded

Comment: Misunderstanding from community

Comment: Community needs more educations

Comment: Fine line from access to services

Comment: Transitioning from foster care

- Community needs to be supportive
- Combined approach to educate on
  - Domestic violence
  - Sexual assault
  - Preventative care
  - Lompoc= county wide
  - CSEC training
  - CSEC surviving peer
  - STESA, PD, Child Welfare, probation

Comment: Teachers and admin staff aren't aware of CSEC risk factors

- running away
- substance abuse
- truancy at school

<u>Comments and discussion of Peer Support Initiatives/ Peer Philosophies are as followed:</u>

Comment: More training on documentation

Comment: Have a coordinator to help with peer documentation

Comment: peer certification through the state?

- Peer recovery assistance
- Trying to make trainings available

Comment: WRAP certified

Comment: Peer employee space

Comment: Advocate (trusted) needed for safe space and safe person (go without losing their job)

- Share resources and support one another
- Having a peer in the clinic @ TAY, staff and patients

Comment: "what can a peer do?"

- Scope of practice for you and them

Comment: Short term pain internships

Comment: 350k grant pays for paid internships

Comment: PEER WORK INVESTMENT GRANT

- Test waters with different programs

- Don’t work for THMA
- THMA wants them to strive
- Other components in the grant
- Peer support
- Trainings
- Main focus -> internships
- Scholarships?
    - For continued education?

Comment: Lompoc doesn’t have a co-response team

- If outside of the city, Sheriff’s office gets involved

Comment: Priority with NAMI; getting Co-Response Teams

Comment: Santa Maria not up and running well either BUT MOUs are in place

Comment: Holistic defense: echo need for countywide co-response

- Has to call law enforcement because there are no co-response teams

Comment: Need to expand mobile crisis co-response team

Comment: Lompoc only city without this

Comment: Santa Maria is included in grant, not Lompoc

Comments and discussion of Housing Development/ Support are as followed:

Comment: Lack of knowledge in trauma enforced learning

Comment: Need to provide calm and consistent care

Comment: Contracts needed to mandate trainings for housing staff to get a better understanding of client care

Comment: Regular trainings on

- patient rights
- Trauma informed learning

Comment: Unity shoppe

Comment: SSI, general relief; not consistent recovery or consistent work

Comment: Need cleaning supplies, housing supplies, toiletries

Comment: Youth/foster care systems: housing for transitional youth so they aren’t homeless

- Can’t get support after aging out of the system

Comment: Security and safety @ depot and homekey

- Car break ins

- Bikes stolen
- People hopping the fence
- Harassment of tenants/ stalking
- Tenants have keys
- Residents steal laundry stuff
- Things that are suggested are already in place
- Housing doesn't like bikes in unit

Comment: Peer advocate

Comment: Clients have social anxiety and don't file reports

- Build sense of community on site

Comment: Class on what to do when xyz happens (ex: bike stolen)

- Have guest speakers

<u>Comments and discussion of Whole Person Care are as followed:</u>

Comment: Love all of the ideas listed in PPT

Comment: Access education

Comment: Paid clinical internships

Comment: AOT and ACT programs are eligible for whole person care

- Want an increase in programs

Comment: Retainment of staff needs to be focused on

- Expanding CBOs
- Increase contacts with CBOs to increase staff at other agencies (because of long waitlists)

Santa Maria Public Library MHSA Stakeholder Event- April 14th 2022

MHSA Manager Natalia Rossi held a presentation discussing an overview of the Mental Health Services Act (MHSA) Plan and the Community Planning Process (CPP). The CPP is a requirement of MHSA to ensure stakeholders, including consumers, personal advocacy groups, law enforcement, community groups, and health agencies, are involved in the MHSA program plans and annual updates. Natalia then informed attendees of the tentative MHSA Plan Update timeline and process including holding CFMAT planning meetings, hosting public input in person and zoom meetings, and providing online and in person surveys for stakeholders to give feedback. Natalia asked attendees for their input on how best to implement this next year's funding.

<u>Comments and discussion on Youth- Focused Care and Youth-Driven Innovations are as followed:</u>

Comment: Transitional aged youth should get first priority on the Behavioral Wellness commission

Comment: How should we recruit young people to the commission?

- Reach out to leadership senior classes at local high schools
- Connect with those with lived experiences or interests in subjects related to mental health services, policy, and community leadership/ outreach
- Application needed to apply in each district to behavioral wellness commission
- Reach out to high school AVID classes and high school counselors
- Outreach to family members of those who have mentally ill parents/ caretakers of family members with mental health disparities
- Mental Health student Grant
- Peer led outreach
- Must be 18 years old to hold behavioral wellness commission spot

Comment: More family members than clients were on commission

Comment: Need more consumers

Comment: Outreach to CPS, social workers to provide outreach, co-response, grief counselors

Comment: START program

Comment: Youth well

<u>Comments and discussion of Peer Support Initiatives/ Peer Philosophies are as followed:</u>

Comment: Need more money to have/keep/help <u>transitional positions</u>: clients who are entering back into the workforce at RLC previously known as "hosts"

- Work 5 hours a week

Comment: Carmen Lane needs to be more inclusive to the CSU, w/ transitioning into community

- Needs to be more flexible

<u>Comments and discussion of Housing Development/ Support are as followed:</u>

Comment: Never enough feedback

Comment: Finding people to get into the units isn't a problem, the problem is getting people to live comfortably in units

Comment: Phone services and computer learning advocates

Comment: Housing corporation services to help integrate a plan

Comment: good tenant certificate

Comment: Need training for staff where families and children are living in units

Comment: Need bigger community space

Comment: Housing authority and housing managers NEED more trainings

Comment: Want to provide inclusive services

- Flex housing for food, transportation and furniture

Comment: Community center needed for the community

- Provide and have artwork and supplies
- Social gatherings/activities
- Safe place to talk about experiences
- Field trips

Comment: Drop in center RLC

Comments and discussion of Whole Person Care are as followed:

Comment: Field trips

- Ex: Getty museum, zoo, art exhibits, (healing)
- Money for/to
  - Tickets to the theatre (plays)
  - Provide discounts
  - To provide entertainment
  - Pools
  - Outreach to churches
  - food

Comment: Need for one stop shop like in Santa Barbara

- Community center

Comment: Support group partnered with food bank

- Took place at church (she went to them rather than them coming to her)
- Provided
  - Prevention services
  - Self-care services

Comment: Connection to local services

Consumer Family Member Action Team Meeting Feedback- March 17th 2022

MHSA Manager Natalia Rossi held a presentation discussing an overview of the Mental Health Services Act (MHSA) Plan and the Community Planning Process (CPP). The CPP is a requirement of MHSA to ensure stakeholders, including consumers, personal advocacy groups, law enforcement, community groups, and health agencies, are involved in the MHSA program plans and annual updates. Natalia then informed attendees of the tentative MHSA Plan Update timeline and process including holding CFMAT planning meetings, hosting public input in person and zoom meetings, and providing online and in person surveys for stakeholders to give feedback. Natalia asked attendees for their input on how best to implement this next year's funding.

Comment: Have events in Spanish

Comment: Have good food at events

Comment: stakeholder input is vital

Comment: Lindsay and Vanessa were universally loved

Comment: Contact Project Heal

Comment: call Chuck

Comment: had a stakeholder event at Foster Road, do that again!

Comment: mail Darlene the info

Comment: reach out to the Jewish community

Comment: Reach out to Asian American and Pacific Islander community

Comments: Lindsay Winter & Vanessa Ramos stakeholder events = popular

Comment: Need food at events, and Spanish translation at events because stakeholder input is vital

Comment: Need to include Asian American population and Jewish communities

Comment: Hmong community in Lompoc

Comment: Santa Maria public library's last event no one showed up. Staff went to individuals in the library and offered them food. This led to a group discussion

Comment: Recovery Learning Center: Santa Maria Members have been coming together and gathering more because they are feeling more comfortable with one another due to gatherings making a positive difference

Comment: Will peers have to find their own transportation to the stakeholder events? -Yes

Comments: Activities that help include, music, song writing, chess, hearing voices club

Comment: Treatment is key

Comment: Gang rape issues in tri counties

Comment: SM RLC 7-day testing if not boosted/have shots

Comment: Workshops help vulnerable populations like children and adults

Comment: Project Heal SB is recruiting new members (everyone's voice matters)

Comment: New navigation site is looking for volunteers

MHSA Peer Employee Stakeholder Session 3.24.22

<u>Comments regarding the concerns about peer certification</u>

Comment: Taking away from client care while in training
Comment: We need to hire more peers so that they can be more effective.
Comment: Have support for the exam. For example, study guides or some training before the test.
Comment: Form a study guide via Zoom
Comment: Follow-up question: How many times can you take the test and what time in between taking the test?

Suggestions on Peer Steps for Advancement
Comment: Entry Level
Comment: Peer Supervisor
Comment: Peer Manager
Comment: The opportunity of becoming a clinician.

Comments Regarding Expanding Workforce
More Peer-Led Groups
For Peers to be able to support clients in ERs while on holds.
For Peers to be a part of the CIT program.
For Peers to be offered any open positions at different sites in case they want to change where they are working from.

Comments on Initiatives
Unique clothing to identify peers.

Comments on Training
Conflict Resolution
Motivational Interviewing
Writing Skills
Headspace
Create a chat room for Peers like in Teams

What skills or background peer supervisors should have?
Lived Experiences
Haves some time in recovery (3 plus years)
Have experience in working as a peer assistance
Someone stable and understands the support system
Someone with integrity, candid, inclusive that can support other peers
A good communicator and be honest in their communication style
Work well under pressure and be flexible
Someone you can trust and be candid about situations
Be able to communicate when there's an issue, so things don't get worse.
Someone with empathy and transparency.

Consumer Family Member Action Team Meeting- April 21st 2022

Comments and discussion on Youth- Focused Care and Youth-Driven Innovations are as followed:

Likes the idea of youth drop in center for SB, SM and Lompoc. They need to provide:

- Food
- Mental health, physical health, emotional health, job support (like ALLCOVE plan)
- Counseling for individuals and family
- Have these drop-in centers not near local gang meet up locations (like your place)
    - Has led to fights breaking out

Comment: Helping hands in Lompoc- no services like this in place there

Comment: Your place is just for substance use

Comment: Co-facilitate with Almonado, Paige Youth Center, Boys and Girls club since they are already available, well-known, built and local

- Talk to FSA or clinics on how to get in
- This will save funds
- Provide food
- Partner with RLC and CBOs to start youth drop in centers

Comment: Need for specific clinics for TAY

Comment: Partner or reach out to probation to gather targeted youth who are involved

Comments and discussion of Peer Support Initiatives/ Peer Philosophies are as followed:

Comment: Needed in Housing

Comment: Mental wellness center art exhibit at de la Guerra plaza

- Great opportunity for peers to get involved, have a voice, and possible opportunity to make $

Comment: Have field trip to art exhibit in SB

- MHSA can provide $ more gas

Comment: Have a peer advocate

- Patient rights trained
- Can provide direct and trusted relationship with tenants and housing corp/ managers

Comment: Artwork at housing

Comment: Have speaker from homeboy industries in LA come talk to youth to help motivate them in regards to sharing similar experiences like

- Dual diagnosis
- Inter-generational mental health issues and experiences

Comments and discussion of Housing Development/ Support are as followed:

Comment: Need a tenant closet so supplies can be given out

Comment: Get donations from HomeGoods

Comment: Need vehicle for case managers at housing sites to pick up food and furniture

Comment: Cal-fresh or certain food banks to drop offs but only to large housing sites

- We NEED this for small housing sites which leads to the need of a van

Comment: 1 full time or part time patients' rights advocate for these issues

Comments and discussion of Whole Person Care are as followed:

Comment: Project Heal

- Spiritual, mind and body holistic whole person and body care
- Partner and reach out to her for these services

Comment: Anti-stigma campaigns

Comment: Agree with public assessment

Comment: Reach out to high schools and high school seniors

- Wellness connection in sb
- Some outreach in N County of Santa Barbara

Comment: MWC has curriculum with 6th graders and 9th graders to promote and discuss mental health and mental health first aid

Comment: Lompoc has no resources and a need for them is urgent (many recent deaths of kids) need for advocacy for mental health services and awareness

Comment: Help TAY youth and high schoolers for early prevention and awareness so they know they aren't alone

- Need for outreach to help them

Virtual MHSA Stakeholder Event: Whole Person Care Live Listening Session- April 23rd 2022

MHSA Manager Natalia Rossi introduced MHSA and how community planning and collaboration helps support the programs currently funded. Participants included Behavioral Wellness staff, a Behavioral Wellness Youth Commissioner, staff from Project Heal, and a Peer Advocate. She discussed 2022-2023 plan proposals, specifically the Whole Person Care Initiative to better integrate a variety of services related to emotional, physical, social, and spiritual healing. Ideas for curriculum include dance, meditation, and nutritional cooking as well as integration of tele-health and additional wellness services such as Employment services, Legal Aid, Educational Services, Alcohol and Drug Programs, Public Health, and Social Services. Implementation of digital literacy to improve mental wellness and increase access to services is also a current key-focus. The target population discussed during this event include the African American community in Santa Barbara, peer staff, and the Hmong community in Lompoc. A survey was shared to be filled out and returned for feedback.

<u>Comments and discussion of Whole Person Care are as followed:</u>

Comment: Initiatives listed are loved by group

Comment: One of the biggest issues faced by the African American community is the anti-stigma campaign, community groups that receive little outreach are the African American community and the Black Caribbean Community. No inclusion of colored individuals on brochures that are passed out. Need educational materials tailored to them. This makes these communities not want to be involved or receive services because they feel excluded and that they do not have a voice/ person to speak to who is related to them. Having a clergy in the community specific to this community would be beneficial. Black community needs their own resources. Funding goes elsewhere and not directly to the African American community. They feel like they are neglected. Project Heal is the only African American mental health

services group. Other races within the community get priority which leads to black community losing trust with agency. Outreach includes- surveys, needs assessment, create or have input on services in community, agencies come to them, not them go to agency, talk to SBCC and UCSB African American students, have African American clinicians and practitioners in Santa Barbara because right now consumers have to travel to LA, Ventura, or Lompoc.

Comment: When individuals are kicked out of a session or meeting for having a bad day or are not on their meds is not inclusive of whole-person care procedure. Individuals have been dropped or kicked out of programs when they are most vulnerable and need services the most. A solution would be to put them on probation but they should not be kicked out forever because who knows where they will end up.

Comment: Building Resilient Community that is an anti-stigma community is mainly for LatinX community. They must include other races to gain more inclusion for all

Comments regarding Peer Support Services are as followed:

Comment: No peer support staff. The peer support staff member needs a trusted support group as well. San Francisco clinician would work specifically with peer staff and it has had a great impact. They feel supported, and are able to facilitate groups within their own teams which allows them to feel a sense of independence. We should look at their models rather than starting from scratch. Peer extra help staff needed for simple services. The focus of change should be from staff who have dealt with the issues first hand because peers do not feel like they are in a safe space.

Comment: Have peers and volunteers who are of color if you want that population to be included.

Comment: Management needs to be more compassionate towards staff who have their own struggles. Need a peer advocate that includes implementation of peer empowerment, has close ties to administrative power/duties by reporting directly to director

Comment: The peer support manager needs their own support and must have lived experience. Possible separate sections- “circle one or the other” (are you a family peer? OR are you a peer with direct lived experience?)

Comment: Peers are someone who has lived or is living in the same (situation, traumas, experiences, etc.). Parents, and caregivers can be peers and they need support too.

Justice Alliance Action Team Virtual Meeting- April 27th 2022

MHSA Manager Natalia Rossi held a presentation discussing an overview of the Mental Health Services Act (MHSA) Plan and the Community Planning Process (CPP). The CPP is a requirement of MHSA to ensure stakeholders, including consumers, personal advocacy groups, law enforcement, community groups, and health agencies, are involved in the MHSA program plans and annual updates. Natalia then informed attendees of the tentative MHSA Plan Update timeline and process. Natalia asked attendees for their input on how best to implement this next year’s funding regarding Housing Development and Support only.

Comments and discussion of Housing Development/ Support are as followed:

Comment: Need more housing opportunities for individuals who need intensive care

- Board and care
- Homeless clients want more options

Comment: Life house individuals need a higher level of support through board and care

Comment: like housing support initiative, but HOW? Not all onsite services aren't being used or outreach to those who need it most

Comment: how do we get people to use these services?

Comment: NEED flex funding!!!

Comment: QIC goal: more support for folks going into housing opportunities

Comment: patient's rights advocates

Comment: use services of those already in place (ACT/AOT)

Comment: housing retention team, Liaison, patient's rights advocate

Comment: Misdemeanor diversion from jail- lots of beds. Coordination and cohesive plan

Comment: Jail based competency training

Comment: pile up program

Comment: Need for more beds and case management

Comment: community-based treatment

Pubic Comments from Behavioral Wellness Commission Meeting 6/15/22

- She wanted to find out who is heading up the LGBT digital literacy. She received a grant to do outreach to TAY in the LGBT community, she wants to connect and collaborate.
  - Natalia will put her in connection, this is being done through Help@hand, will put her in contact with Maria Arteaga
  - Rivas will email Maria directly
- There were a few hires for AOT, not sure if also ACT, he was wondering if these are funded by MHSA or if they can be

        - Natalia: MHSA provides the majority of funding for FSPs, including the staff, so she assumes so
    - Wants to know if there were new hires in both
        - Yes
    - Were they funded by MHSA?
        - Yes
    - All in the July 1 budget, going through recruitment
    - Is there a total of 6 positions?
        - 2 AOT, 2 ACT, 4 intensive outreach and engagement
    - Very kind words about Natalia's incredible work, especially on substance use
    - Thanks new leadership for responding to needs and budget negotiations

Thanks the community partners and expresses gratitude

Attachment Six: MHSA Planning Survey Feedback

Survey results from the Santa Barbara County MHSA 2022-2023 Planning Survey. This survey solicited feedback from stakeholders on Department activities in relation to the new proposals identified in the initial 2020-2023 MHSA plan. The survey was disseminated to key stakeholder--including individuals who experience or have experienced mental health challenges and/or their family members, individuals who use or have used mental-health services or supports, and providers of or administrators in mental-health services—and was promoted during department action team meetings and community program planning meetings. During this feedback process, the MHSA Manager Natalia Rossi worked to ensure that the voice of the community was heard and key informants throughout the community were spoken to. The MHSA Evaluation team prepared the survey to align with MHSA required data elements and managed collating the data.

The MHSA Planning Survey was distributed in person and electronically via SurveyMonkey in English and Spanish, and was completed by stakeholders from March to May 2022. Fifty nine people responded to the survey; .05% of respondents took the Spanish survey. The English version took respondents just over 3 minutes to complete and had an 100% completion rate. The Spanish version took respondents on average, 9 minutes and 40 seconds to complete and had a 100% completion rate.

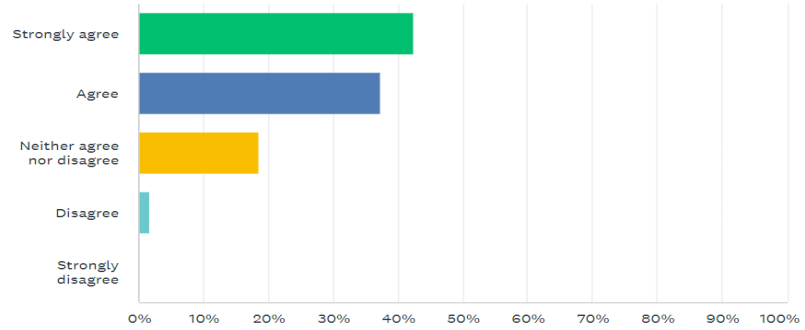
Question 1: To what extent do you agree that these activities align with Youth-Focused Care and Youth-Driven Initiatives?

Q1

Customize Save as

To what extent do you agree that these activities align with Youth-Focused Care and Youth-Driven Initiatives?

Answered: 59 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strongly agree	42.37%	25
Agree	37.29%	22
Neither agree nor disagree	18.64%	11
Disagree	1.69%	1
Strongly disagree	0.00%	0
TOTAL		59

Question 2: If you have any suggestions related to these activities, what additional input or ideas do you have to achieve Youth-Focused care and Youth-Driven Initiatives?

Q2

Save as

If you have any suggestions related to these activities, what additional input or ideas do you have to achieve Youth-Focused care and Youth-Driven Initiatives?

Answered: 33 Skipped: 26

RESPONSES (33) WORD CLOUD TAGS (0)

Cloud View List View

Search responses

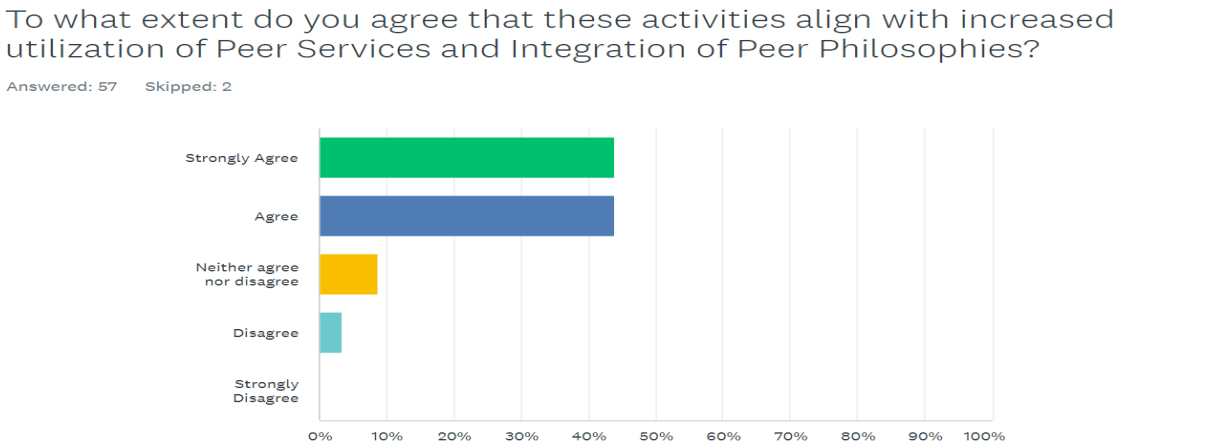
Customize

n schools none focus SUD Lompoc need community services involved youth support TAY group programs students peer high drop center system

Showing 20 words

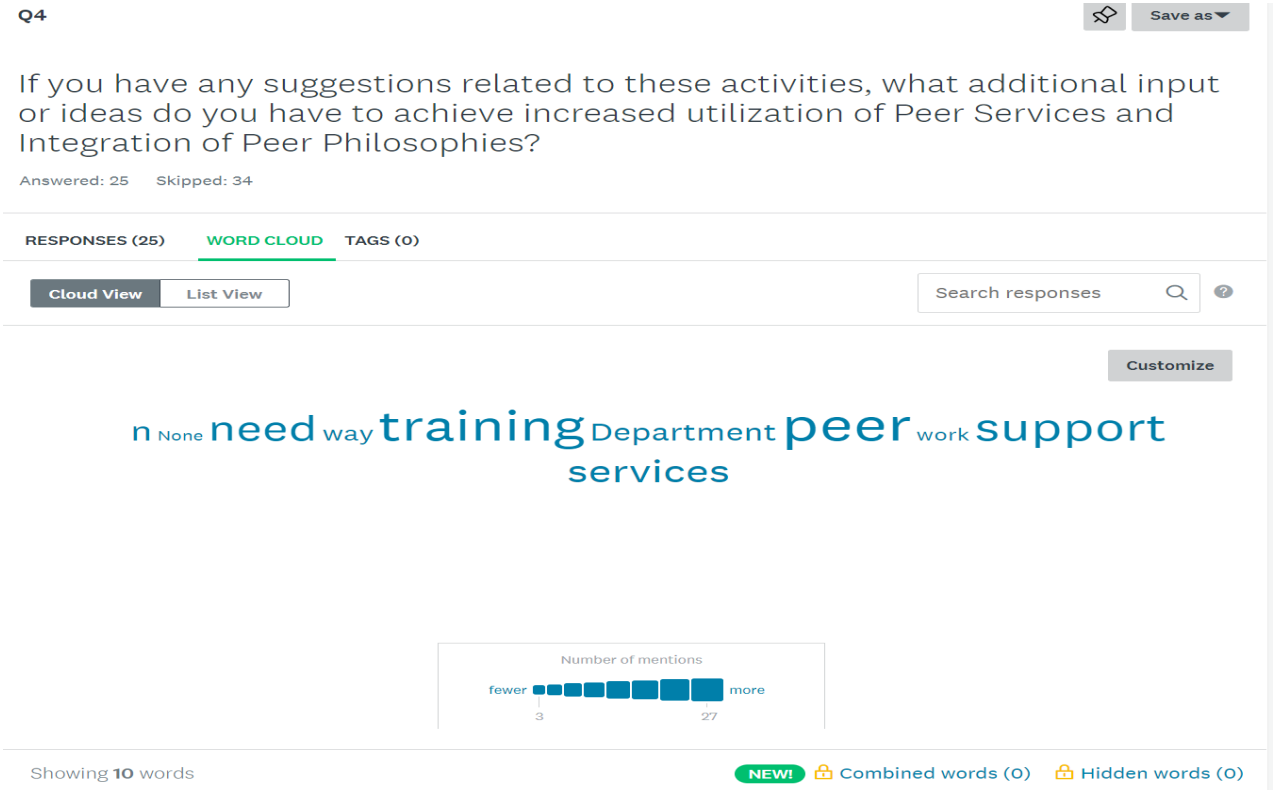
NEW! Combined words (0) Hidden words (0)

Question 3: To what extent do you agree that these activities align with increased utilization of Peer Services and Integration of Peer Philosophies?



ANSWER CHOICES	RESPONSES	
Strongly Agree	43.86%	25
Agree	43.86%	25
Neither agree nor disagree	8.77%	5
Disagree	3.51%	2
Strongly Disagree	0.00%	0
TOTAL		57

Question 4: If you have any suggestions related to these activities, what additional input or ideas do you have to achieve increased utilization of Peer Services and Integration of Peer Philosophies



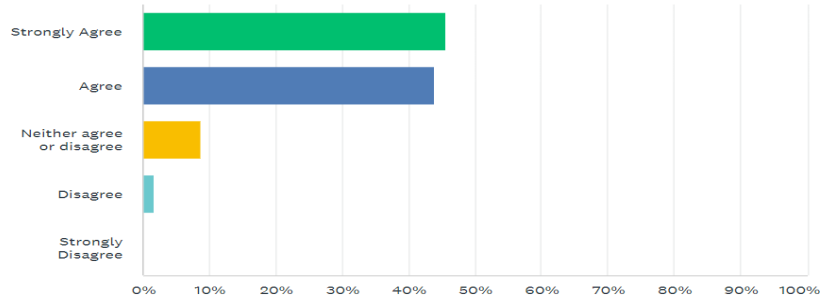
Question 5: To what extent do you agree that these activities align with Expansion of Housing Developments and Housing Support Services for those at risk, or experiencing, Homelessness??

Q5

Customize Save as

To what extent do you agree that these activities align with Expansion of Housing Developments and Housing Support Services for those at risk, or experiencing, Homelessness?

Answered: 57 Skipped: 2



ANSWER CHOICES	RESPONSES	
Strongly Agree	45.61%	26
Agree	43.86%	25
Neither agree or disagree	8.77%	5
Disagree	1.75%	1
Strongly Disagree	0.00%	0
TOTAL		57

Question 6: If you have any suggestions related to these activities, what additional input or ideas do you have to achieve Expansion of Housing Developments and Housing Support Services for those at risk, or experiencing, Homelessness?

Q6

Save as

If you have any suggestions related to these activities, what additional input or ideas do you have to achieve Expansion of Housing Developments and Housing Support Services for those at risk, or experiencing, Homelessness?

Answered: 29 Skipped: 30

RESPONSES (29) WORD CLOUD TAGS (0)

Cloud View List View Search responses

Customize

housing program sites provide homeless tenant Manager need Retention housing funding support help Training peer mental health

Number of mentions

fewer more

3 21

Showing 15 words NEW! Combined words (0) Hidden words (0)

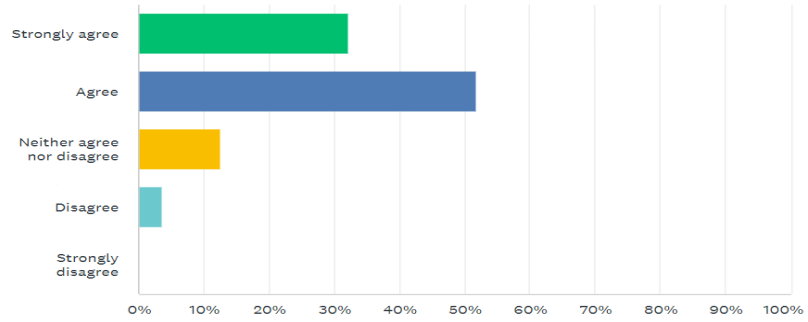
Question 7: To what extent do you agree that these activities align with Integrating Whole Person Care Philosophies throughout Outpatient services?

Q7

Customize Save as

To what extent do you agree that these activities align with Integrating Whole Person Care Philosophies throughout Outpatient services?

Answered: 56 Skipped: 3



ANSWER CHOICES	RESPONSES	
Strongly agree	32.14%	18
Agree	51.79%	29
Neither agree nor disagree	12.50%	7
Disagree	3.57%	2
Strongly disagree	0.00%	0
TOTAL		56

Question 8: If you have any suggestions related to these activities, what additional input or ideas do you have to achieve Integrating Whole Person Care Philosophies throughout Outpatient Services?

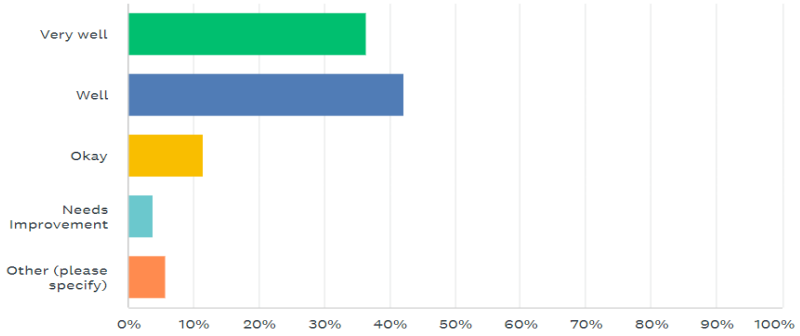
Question 9: To what extent does the proposed MHSA Innovations Plan align with the established goals for our MHSA Plan for FY 2020-2023?

Q9

Customize Save as

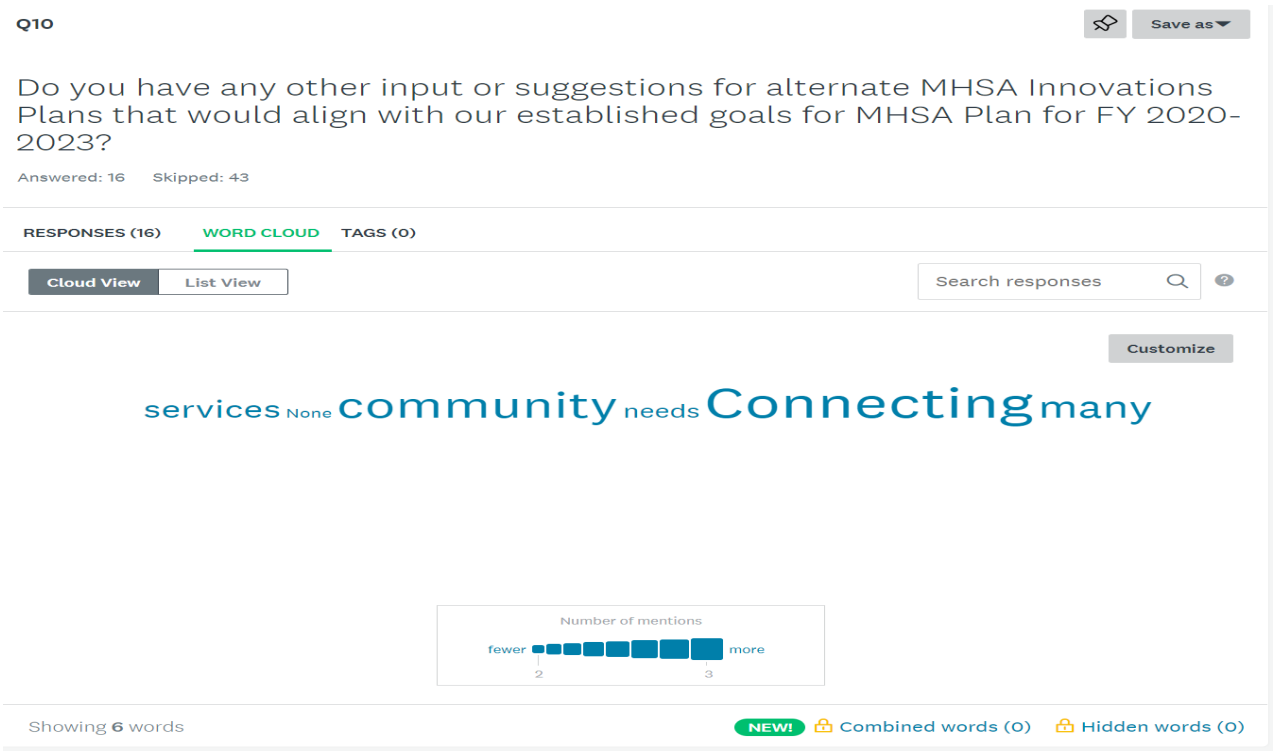
To what extent does the proposed MHSA Innovations Plan align with the established goals for our MHSA Plan for FY 2020-2023?

Answered: 52 Skipped: 7

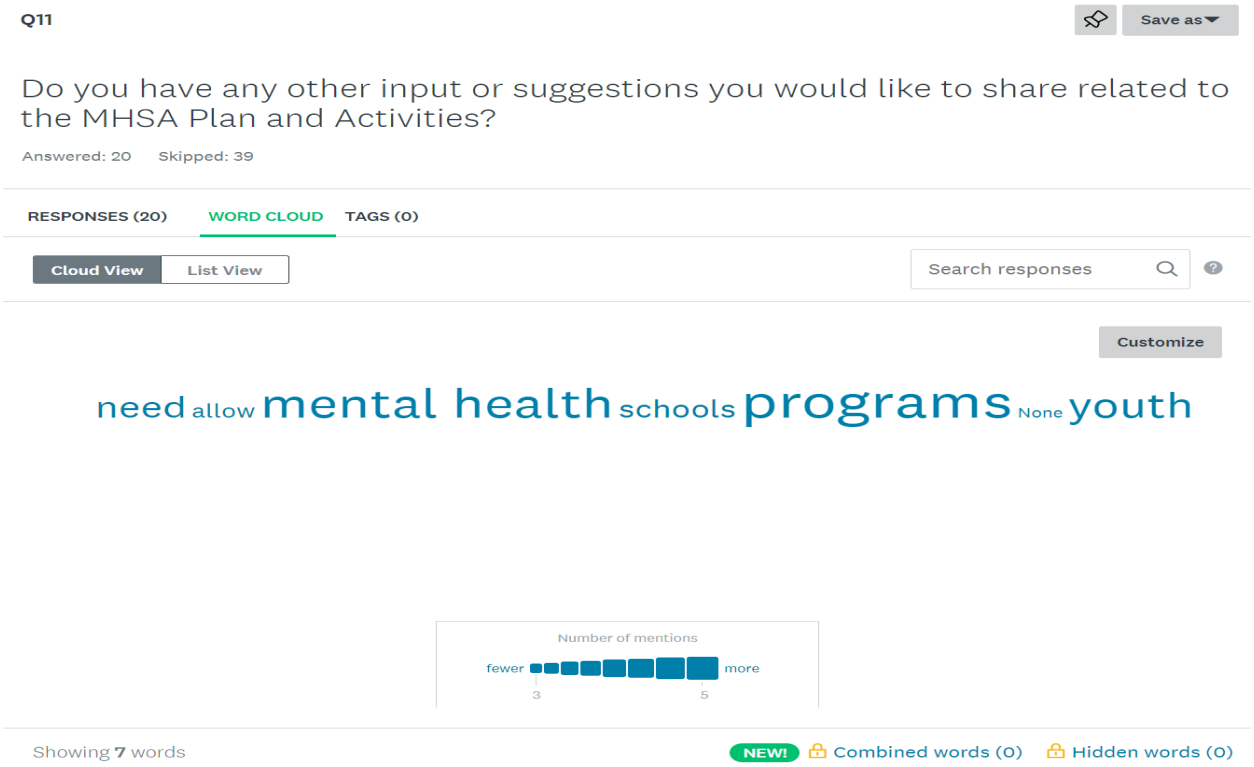


ANSWER CHOICES		RESPONSES	
Very well		36.54%	19
Well		42.31%	22
Okay		11.54%	6
Needs Improvement		3.85%	2
Other (please specify)	Responses	5.77%	3
TOTAL			52

Question 10: Do you have any other input or suggestions for alternate MHSA Innovations Plans that would align with our established goals for MHSA Plan for FY 2020-2023?



Question 11: Do you have any other input or suggestions you would like to share related to the MHSA Plan and Activities?



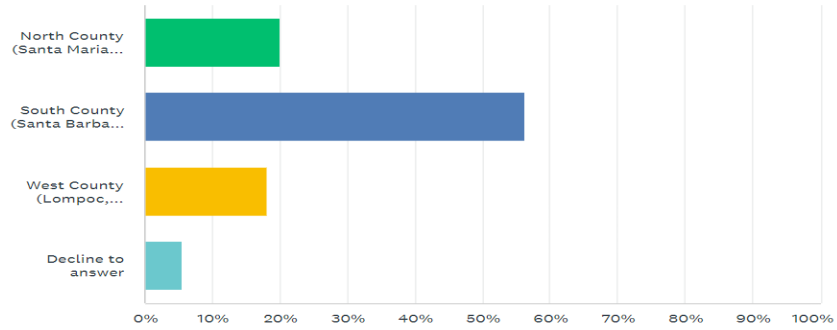
Question 12: In which region of the county do you live or represent/work?

Q12

Customize Save as

In which region of the county do you live or represent/work?

Answered: 55 Skipped: 4

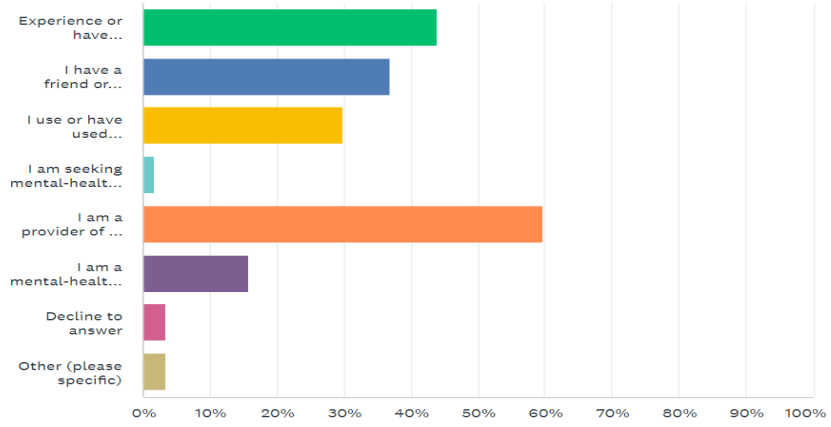


ANSWER CHOICES	RESPONSES	
North County (Santa Maria, Guadalupe, New Cuyama)	20.00%	11
South County (Santa Barbara, Goleta, Carpinteria)	56.36%	31
West County (Lompoc, Buellton, Santa Ynez)	18.18%	10
Decline to answer	5.45%	3
TOTAL		55

Question 13: Which of the following describes you? (Check all that apply)

Which of the following describes you? (Check all that apply)

Answered: 57 Skipped: 2



ANSWER CHOICES	RESPONSES	
Experience or have experienced mental-health challenges	43.86%	25
I have a friend or family member who experiences or has experienced mental-health challenges	36.84%	21
I use or have used mental-health services or supports	29.82%	17
I am seeking mental-health services or supports	1.75%	1
I am a provider of or administrator in mental health services	59.65%	34
I am a mental-health advocate representing a specific racial/ethnic, cultural, or other group	15.79%	9
Decline to answer	3.51%	2
Other (please specific)	3.51%	2
Total Respondents: 57		

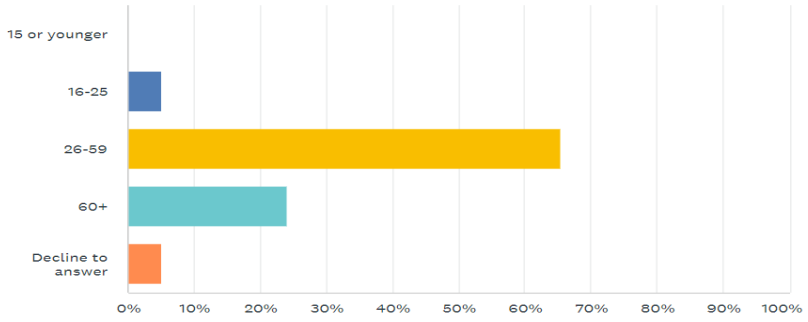
Question 14: How old are you?

Q14

Customize Save as

How old are you?

Answered: 58 Skipped: 1

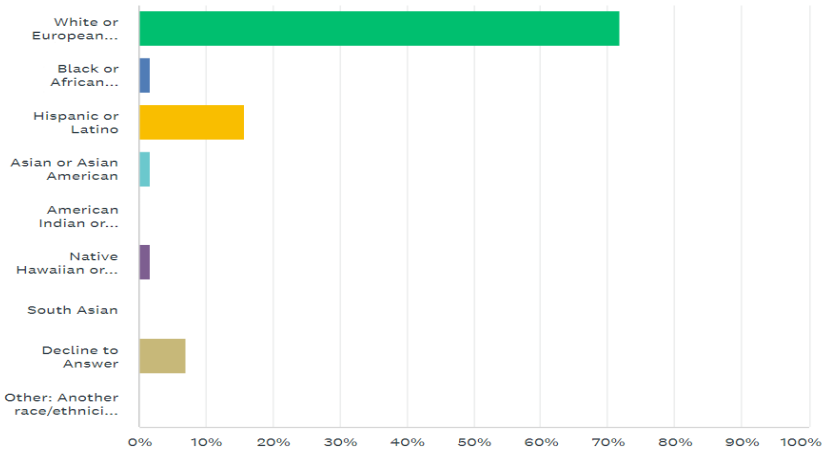


ANSWER CHOICES	RESPONSES	
15 or younger	0.00%	0
16-25	5.17%	3
26-59	65.52%	38
60+	24.14%	14
Decline to answer	5.17%	3
TOTAL		58

Question 15: What is your race/ethnicity?

What is your race/ethnicity?

Answered: 57 Skipped: 2



ANSWER CHOICES	RESPONSES	
White or European American	71.93%	41
Black or African American	1.75%	1
Hispanic or Latino	15.79%	9
Asian or Asian American	1.75%	1
American Indian or Alaska Native	0.00%	0
Native Hawaiian or other Pacific Islander	1.75%	1
South Asian	0.00%	0
Decline to Answer	7.02%	4

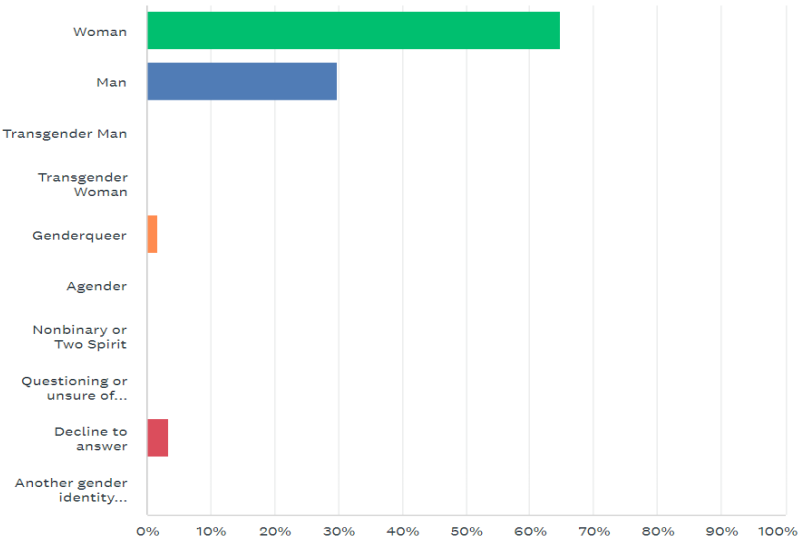
Question 16: What is your gender identity?

Q16

Customize Save as

What is your gender identity?

Answered: 57 Skipped: 2



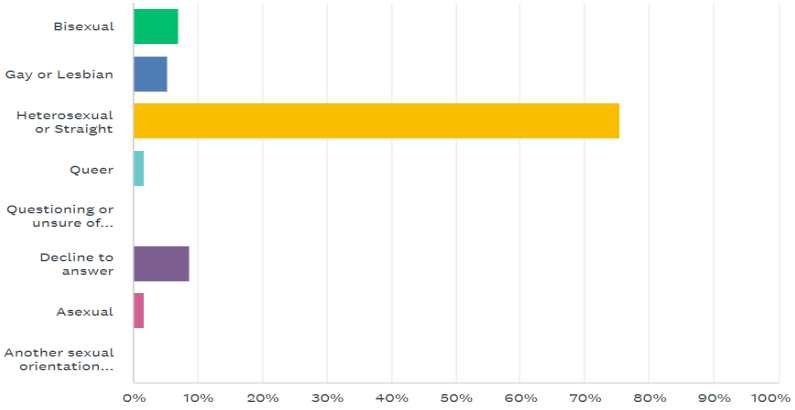
Question 17: What is your sexual orientation?

Q17

Customize Save as

What is your sexual orientation?

Answered: 57 Skipped: 2



ANSWER CHOICES	RESPONSES	
Bisexual	7.02%	4
Gay or Lesbian	5.26%	3
Heterosexual or Straight	75.44%	43
Queer	1.75%	1
Questioning or unsure of sexual orientation	0.00%	0
Decline to answer	8.77%	5
Asexual	1.75%	1

Attachment 9: County 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 Barbara County Department of Behavioral Wellness 300 N. San Antonio Road Santa Barbara, CA 93110	

I hereby certify that I am the official responsible for the administration of county mental health services in and for said county and that the County has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting an annual update, including stakeholder participation and non supplantation 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: 5/13/2022

Attachment 10: Fiscal Accountability Certification

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County: Santa Barbara

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

Local Mental Health Director	County Auditor-Controller/City Financial Officer
Name: 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 2095C5A1BFE1474...	5/2/2022
Local Mental Health Director (PRINT)	Signature	Date

I hereby certify that for the fiscal year ended June 30, 2021, 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 8/28/20 for the fiscal year ended June 30, 2020. I further certify that for the fiscal year ended June 30, 2021, 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 825AE342FF7B425...	5/4/2022
County Auditor/Controller/City Financial Officer (PRINT)	Signature	Date

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