

BEHAVIORAL HEALTH ADVISORY BOARD
General Meeting
Monday, January 27, 2020, 1:00 – 3:30 p.m.
Ventura County Behavioral Health (VCBH)
1911 Williams Drive, Training Room • Oxnard, CA 93036

REVISED AGENDA

- I. Call to Order and Pledge of Allegiance
- II. Approval of the Agenda – **ACTION**
- III. Approval of the November 18 2019 Minutes – **ACTION**
- IV. Oath of Office – Michael Rodriguez, New BHAB Member
- V. Welcome and Introductions
- VI. Public Comments (3 min. per speaker)
- VII. Crisis Intervention Team (CIT) Awards and Susan Luckey Mental Health Professional Award Presentations (20 min.)
- VIII. Chair's Report (5 min.)
 - A. Events and Announcements – Ratan Bhavnani (5 min.)
- IX. Board Members Comments and Announcements (3 min. per speaker)
- X. Presentation: Ventura County Medical Center Inpatient Psychiatric Unit and Crisis Stabilization Unit (VCMC IPU/CSU) and VCBH Rapid Integrated Support and Engagement (RISE) – Dan Powell, VCMC Mental Health Operations Supervisor Inpatient Unit, and Felicia Skaggs, VCBH RISE Program Clinic Administrator
- XI. Director's Report – Dr. Sevet Johnson (10 min.)
- XII. Secretary's Report – Gina Petrus (5 min.)
- XIII. BHAB Committees Reports (5 min. each)
 - A. Adult Services Committee – Nancy Borchard and Gane Brooking, Co-Chairs
 - B. Prevention Committee – Janis Gardner, Chair
 - C. Transitional Age Youth (TAY) Committee – Margaret Cortese, Chair
 - D. Youth & Family Committee – Denise Nielsen, Chair
 - E. Lanterman, Petris, Short (LPS) Reform Workgroup – Jerry Harris, Chair
- XIV. New Business
 - A. County of Ventura Mental Health & Safety Task Force Report - Discussion
 - B. BHAB Objectives - Discussion
 - C. Special Meeting on January 15, 2020, 6:00 p.m. – Discussion
 - D. Feasibility of Forming a California Advancing and Innovating Medi-Cal (CalAIM)/Medi-Cal Healthier California for All Workgroup (Time sensitive) Draft Document for BHAB/Stakeholder Input Advocating the State for Changes in Ventura County Concerning Mental Health's Current Stringent Regulations, Changes in Limitation of Mandates, Changes in Limitations of Funding Streams, Institution for Mental Diseases (IMD) Exclusion Waiver - Discussion
 - E. 2019 Data Notebook Review and Approval – **ACTION**
 - F. BHAB Annual Report for Fiscal Year 2018-19 Review and Approval - **ACTION**
 - G. Welfare & Institutions Code (WIC) Changes – Request Update of Bylaws to be Consistent with WIC - Discussion

Members of the public making oral presentations to the Board in connection with one or more agenda or non-agenda items at a single meeting are limited to a cumulative total time not to exceed (5) minutes for all of their oral presentations at such meeting unless otherwise provided. The entire public comment period is limited to no more than (20) minutes total for all speakers. NOTE: The Chair may limit the number or duration of speakers on a matter. In compliance with the Americans With Disabilities Act, if you need special assistance to participate in this meeting, please contact Behavioral Health Administration at (805) 981-6830. Reasonable advance notification of the need for accommodation prior to the meeting (48 hours advance notice is preferable) will enable us to make reasonable arrangements to ensure accessibility to this meeting.

- H. California Association of Local Behavioral Health Boards & Commissions (CALBHB/C) Meeting on January 17, 2020 – Update – Jerry Harris
- I. Site Visit Schedule
- J. Appointment of Member At Large for a Six-Month Term
- K. Institution for Mental Diseases (IMD) – Feasibility of Forming a Workgroup or Hold a Special Meeting - Nancy Borchard, Supervisor Parks
- L. Mental Health Services Act (MHSA) Multi-County Full Service Partnership (FSP) Innovations, Public Hearing – Hilary Carson, MHSA Program Administrator (10 min.)
- M. BHAB Assistant Responsibilities – Dr. Sevet Johnson

XV. Old Business

- A. Future Presentations
- B. Future Recognitions

XVI. Contracts

- A. Board of Supervisors Approved Agreements – November 5, 2019
 - 1. Fiscal Year (FY) 2019-20 Santa Paula Unified School District (SPUSD) Memorandum of Agreement (MOA)
 - 2. FY 2018-21 Department of Health Care Services (DHCS) Performance Standard Agreement (Agreement) # 18-952588 for Mental Health Services Act (MHSA), Lanterman-Petris-Short Act (LPS Act), Projects for Assistance in Transition from Homelessness (PATH), Community Mental Health Services Block Grant (MHBG), Crisis Counseling Assistance and Training Program (CCP), and Bronzan-McCorquodale Act Services
 - 3. FY 2018-21 DHCS Standard Agreement # 18-95150 Amendment Number A01 for Drug Medi-Cal Organized Delivery Services (DMC-ODS)
- B. Board of Supervisors Approved Agreements – December 10, 2019
 - 4. FY 2019-20 Turning Point Foundation (Turning Point) Adult Wellness and Recovery Center (AWRC) and Growing Works Third Amendment and FY 2019-20 Turning Point Quality of Life Improvement (QLI) Fourth Amendment
- C. Board of Supervisors Approved Agreements – December 17, 2019
 - 5. Alcohol and Drug Programs (ADP): January 1, 2020 through June 30, 2021 Evalcorp, Idea Engineering, Reality Improv Connection, Inc., and Ventura Unified School District (VUSD) ADP Prevention Services Agreements
 - 6. FY 2019-23 Catalyst Church Ventura (Catalyst) First Amendment and FY 2019-23 One Step a la Vez First Amendment
 - 7. FY 2019-20 United Parents Six Amendment to the Agreement for Respite Services

XVII. Public Comments (3 min. each)

XVIII. Adjourn

Next Meeting: Monday, February 24, 2020

Members of the public making oral presentations to the Board in connection with one or more agenda or non-agenda items at a single meeting are limited to a cumulative total time not to exceed (5) minutes for all of their oral presentations at such meeting unless otherwise provided. The entire public comment period is limited to no more than (20) minutes total for all speakers. NOTE: The Chair may limit the number or duration of speakers on a matter. In compliance with the Americans With Disabilities Act, if you need special assistance to participate in this meeting, please contact Behavioral Health Administration at (805) 981-6830. Reasonable advance notification of the need for accommodation prior to the meeting (48 hours advance notice is preferable) will enable us to make reasonable arrangements to ensure accessibility to this meeting.

JUNTA ASESORA DE SALUD DEL COMPORTAMIENTO
Junta general
Lunes 27 de enero de 2020 , 1:00 - 3: 3 0 pm
Salud conductual del condado de Ventura (VCBH)
1911 Williams Drive, sala de entrenamiento • Oxnard, CA 93036

PROGRAMA REVISADO

- I. Llamado al orden y promesa de lealtad
- II. Aprobación de la Agenda - **ACCIÓN**
- III. Aprobación del acta del 18 de noviembre de 2019 - **ACCIÓN**
- IV. Juramento del cargo - Michael Rodriguez, nuevo miembro de BHAB
- V. Bienvenida y Presentaciones
- VI. Comentarios públicos (3 min. Por hablante)
- VII. Premios del Equipo de Intervención de Crisis (CIT) y Presentaciones del Premio de Susan Meckey para Profesionales de la Salud Mental (20 min.)
- VIII. Presidente' s Informe (5 min.)
 - A. Eventos y Annou NCE mentos' - Ratan Bhavnani (5 min.)
- IX. Comentarios y anuncios de los miembros de la Junta (3 min. Por orador)
- X. Presentación : Unidad de psiquiatría para pacientes hospitalizados del Centro médico del condado de Ventura y Unidad de estabilización de crisis (VCMC IPU / CSU) y VCBH Rapid Integrated Support and Engagement (RISE) - Dan Powell, VCMC Mental Health Supervisor de Operaciones Unidad de pacientes hospitalizados , y Felicia Skaggs, Administradora de la Clínica del Programa VCBH RISE
- XI. Informe del Director - Dr. Sevet Johnson (10 min.)
- XII. Informe del Secretario - Gina Petrus (5 min.)
- XIII. Informes de los Comités BHAB (5 min. Cada uno)
 - A. Comité de Servicios para Adultos - Nancy Borchard y Gane Brooking , Copresidentes
 - B. Comité de Prevención - Janis Gardner, Presidenta
 - C. Comité de Transitional Age Y outh (TAY) - Margaret Cortese , Presidenta
 - D. Comité de Juventud y Familia - Denise Nielsen, Presidenta
 - E. Grupo de trabajo de reforma de Lanterman, Petris, Short (LPS) - Jerry Harris, presidente
- XIV. Nuevo negocio
 - A. Informe del Grupo de Trabajo de Salud Mental y Seguridad del Condado de Ventura - Discusión
 - B. Objetivos de BHAB - Discusión
 - C. Reunión especial el 15 de enero de 2020 , 6:00 pm - Discusión
 - D. Viabilidad de formar un California Borrador e innovador proyecto de documento de Medi-Cal (CalAIM) / Medi-Cal Healthier California for All Workgroup (sensible al tiempo) para BHAB / Aporte de las partes interesadas Abogando al Estado por cambios en el condado de Ventura en relación con las regulaciones estrictas actuales de Mental Health, cambios en la limitación de mandatos, cambios en las limitaciones de los flujos de financiación, exención de exclusión de la Institución para Enfermedades Mentales (IMD) - Discusión
 - E. Revisión y aprobación del cuaderno de datos 2019 - **ACCIÓN**
 - F. Informe anual de BHAB para la revisión y aprobación del año fiscal 2018-19 - **ACCIÓN**
 - G. Cambios en el Código de Bienestar e Instituciones (WIC) - Solicite la actualización de los estatutos para que sea consistente con WIC - Discusión

- H. Reunión de la Asociación de Juntas y Comisiones Locales de Salud del Comportamiento de California (CALBHB / C) el 17 de enero de 2020 - Actualización - Jerry Harris
- I. Programa de visitas al sitio
- J. Nombramiento de un miembro en general por un período de seis meses
- K. Institution for Mental Diseases (IMD) - Viabilidad de formar un grupo de trabajo o celebrar una reunión especial - Nancy Borchard, Supervisora Parks
- L. Ley de Servicios de Salud Mental (MHSA) Innovaciones de la Asociación de Servicios Completos de Varios Condados (FSP), Audiencia Pública - Hilary Carson, Administradora del Programa MHSA (10 min.)
- M. Responsabilidades del asistente de BHAB - Dr. Sevet Johnson
- XV. Viejo negocio
 - A. Presentaciones Futuras
 - B. Reconocimientos futuros
- XVI. Contratos
 - A. Acuerdos aprobados de la Junta de Supervisores - 5 de noviembre de 2019
 - 1. Memorando de Acuerdo (MOA) del Distrito Escolar Unificado de Santa Paula (SPUSD) del año fiscal (FY) 2019-20
 - 2. FY 2018-21 Acuerdo estándar de desempeño del Departamento de Servicios de Atención Médica (DHCS) (Acuerdo) # 18-952588 para la Ley de Servicios de Salud Mental (MHSA), Ley Lanterman-Petris-Short (Ley LPS) , Proyectos de asistencia para la transición de la falta de vivienda (PATH), la subvención global de servicios de salud mental comunitaria (MHBG), el programa de asistencia y capacitación en consejería de crisis (CCP) y los servicios de la Ley Bronzan-McCorquodale
 - 3. FY 2018-21 Acuerdo estándar de DHCS # 18-95150 Número de enmienda A01 para los Servicios de entrega organizada de medicamentos de Medi-Cal (DMC-ODS)
 - B. Acuerdos aprobados de la Junta de Supervisores - 10 de diciembre de 2019
 - 4. FY 2019-20 Turning Point Foundation (Turning Point) Centro de Bienestar y Recuperación de Adultos (AWRC) y Growing Works Tercera Enmienda y FY 2019-20 Turning Point Quality of Life Improvement (QLI) Cuarta Enmienda
 - C. Acuerdos aprobados de la Junta de Supervisores - 17 de diciembre de 2019
 - 5. Programas de alcohol y drogas (ADP): del 1 de enero de 2020 al 30 de junio de 2021 Evalcorp , Idea Engineering, Reality Improv Connection, Inc. y los acuerdos de servicios de prevención de ADP del Distrito Escolar Unificado de Ventura (VUSD)
 - 6. FY 2019-23 Catalyst Church Ventura (Catalyst) Primera Enmienda y FY 2019-23 One Step a la Vez Primera Enmienda
 - 7. FY 2019-20 United Parents Seis enmiendas al Acuerdo para servicios de relevo
- XVII. Comentarios públicos (3 min. Cada uno)
- XVIII. Aplazar

Próxima reunión: lunes por , 24 de de febrero de , 2020

Los miembros del público que realizan presentaciones orales ante la Junta en relación con uno o más puntos del orden del día o no incluidos en el orden del día en una sola reunión están limitados a un tiempo total acumulado que no exceda (5) minutos para todas sus presentaciones orales en dicha reunión a menos que se indique lo contrario. El período completo de comentarios públicos está limitado a no más de (20) minutos en total para todos los oradores. NOTA: El Presidente puede limitar el número o la duración de los oradores en un asunto. En cumplimiento de la Ley de Estadounidenses con Discapacidades, si necesita asistencia especial para participar en esta reunión, comuníquese con la Administración de Salud Mental al (805) 981-6830 . La notificación anticipada razonable de la necesidad de acomodación antes de la reunión (es preferible un aviso con 48 horas de anticipación) nos permitirá hacer arreglos razonables para garantizar la accesibilidad a esta reunión.

Behavioral Health Advisory Board
Committee Objectives for Fiscal Year 2019-20
Selected at the General Meeting of October 21, 2019

Adult Services Committee

Advocate for the expansion of the Crisis Stabilization Unit (CSU) at the Hillmont Psychiatric Hospital to the maximum approved number of chairs (12) including the capability of conducting medical screening examinations on-site, and for the reactivation of the 12 inpatient beds currently not in use.

Transitional Age Youth (TAY) Committee

Advocate for increased housing options for TAY.

Youth & Family Committee

Follow the continuum of crisis care for children covered by Medi-Cal and children with private insurance. Provide feedback to the Behavioral Health Advisory Board (BHAB), Ventura County Behavioral Health (VCBH) and community providers.

Prevention Committee

Promote vaping and cannabis education and awareness, and advocate for banning flavored vaping products.

The California Behavioral Health Planning Council (Council) is under federal and state mandate to advocate on behalf of adults with severe mental illness and children with severe emotional disturbance and their families. The Council is also statutorily required to advise the Legislature on behavioral health issues, policies and priorities in California. The Council advocates for an accountable system of seamless, responsive services that are strength-based, consumer and family member driven, recovery oriented, culturally and linguistically responsive and cost effective. Council recommendations promote cross-system collaboration to address the issues of access and effective treatment for the recovery, resilience, and wellness of Californians living with severe mental illness.

Acknowledgements: Most of the trauma-informed care information and data presented in the following pages was drawn from several online sources for the purpose of public education. These sources included: www.cdc.gov, www.samhsa.gov, www.kidsdata.org, Center for Youth Wellness, and research studies of Vincent Felitti, M.D., Robert Anda, M.D. and associates (1998).

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Ventura County

Population (2018): 855,489

Total Medi-Cal Eligible Beneficiaries (FY 2016-17): 260,510

Total Specialty Mental Health Service (SMHS) Recipients: (FY 2016-17): 9,645

Children and Youth, SMHS

	FY 16-17		
	Children and Youth with 1 or more SMHS Visits	Certified Eligible Children and Youth	Penetration Rate
All	4,236	121,390	3.5%
Children 0-2	142	17,360	0.8%
Children 3-5	324	17,814	1.8%
Children 6-11	1,374	38,033	3.6%
Children 12-17	1,866	33,432	5.6%
Youth 18-20	530	14,751	3.6%
Alaskan Native or American Indian	11	165	6.7%
Asian or Pacific Islander	56	3,966	1.4%
Black	104	1,466	7.1%
Hispanic	2,772	80,870	3.4%
White	971	20,936	4.6%
Other	116	6,907	1.7%
Unknown	206	7,080	2.9%
Female	1,891	59,673	3.2%
Male	2,345	61,717	3.8%

Adults and Older Adults, SMHS

	FY 16-17		
	Adults and Older Adults with 1 or more SMHS Visits	Certified Eligible Adults and Older Adults	Penetration Rate
All	5,409	139,120	3.9%
Adults 21-44	2,728	74,789	3.6%
Adults 45-64	2,341	44,800	5.2%
Adults 65+	340	19,531	1.7%
Alaskan Native or American Indian	27	464	5.8%
Asian or Pacific Islander	156	9,534	1.6%
Black	199	2,715	7.3%
Hispanic	1,543	59,827	2.6%
White	2,393	41,108	5.8%
Other	357	12,378	2.9%
Unknown	734	13,094	5.6%
Female	2,859	76,492	3.7%
Male	2,550	62,628	4.1%

Introduction: Purpose and Goals: What is the Data Notebook?

The Data Notebook is a structured format to review information and report on each county's behavioral health services. Recent practice has focused on different parts of the public behavioral health system each year, because the overall system is very large and complex. This system includes both mental health and substance use treatment services designed for specific age groups of adults or children and youth.

Local behavioral health boards/commissions are required to review performance outcomes data for services in their county and to report their findings to the California Behavioral Health Planning Council (CBHPC). To provide structure for the report and to make the reporting easier, each year we create a Data Notebook for local behavioral health boards to complete and submit to the CBHPC. Both statewide and county-specific data are provided for review. The discussion questions seek input from the local boards and their departments. These responses are analyzed by Council staff to create a yearly report to inform policy makers, stakeholders and the public.

The Data Notebook structure and questions are designed to meet important goals:

- To help local boards meet their legal mandates¹ to review performance data for their county mental health services and report on performance every year,
- To serve as an educational resource on behavioral health data for local boards,
- To obtain opinion and thoughts of local board members on specific topics,
- To identify unmet needs and make recommendations.

The 2019 Data Notebook focus topic is an examination of behavioral health services and needs from a perspective of "Trauma-informed principles of care across the lifespan." Understanding the role of childhood trauma reveals the urgent need for trauma-informed practices in all parts of the public behavioral health system.

This year the focus topic will comprise only part of the Data Notebook. We also have developed a section with standard data and related questions which will be addressed each year to help us detect any trends. Monitoring these trends will assist in identification of unmet needs or gaps in services, which may occur due to changes in the population, resources available, or public policy (i.e., eligibility criteria).

The Planning Council encourages all members of local behavioral health boards/commissions to participate in developing responses for the Data Notebook. This is an opportunity for the local boards and their county behavioral health departments to work together to identify the most important issues in their community. This work

¹ W.I.C. 5604.2, regarding mandated reporting roles of MH Boards and Commissions in California.

informs county and state leadership about local behavioral health programs, needs, and services. This information is used in the Council's advocacy to the legislature and for input to the state mental health block grant application to SAMHSA².

Note that there are two sets of Discussion Questions. The first group are the standard yearly data questions. The second group, the Focus Topic Questions, are at the end of the Data Notebook, following the presentation on Trauma-informed Care.

Standard Yearly Data and Questions for Counties and Local Advisory Boards

In recent years, major improvements in data availability now permit local boards and other stakeholders to consult extensive Medi-Cal data online that is provided by the Department of Health Care Services (DHCS). These data include populations that receive Specialty Mental Health Services and substance use treatment. Related data are analyzed for yearly evaluations of county programs that are reported at www.CalEQRO.com. Additionally, Mental Health Services Act (MHSA) data can be found in the 'MHSA Transparency Tool' presented on the MHSOAC website.

However, members of the Planning Council would like to examine some county-level data that are not readily available online and for which there is no other accessible public source. The items of interest include data that are collected by the counties because they need to know how much they are spending in these service categories and for how many clients. Collecting this information will fill one gap in what is known about services that might be needed or provided in the course of a fiscal year (FY). And may help identify unmet needs in services.

Standard Annual Questions for the Data Notebook

Please answer these questions using information for fiscal year (FY) 2017-2018 or the most recent fiscal year for which you have data. Not all counties have readily available data for some of the questions. If so, please enter N/A for 'data not available.'

Please note that a second group of Discussion Questions follows the Focus Topic, at the end of this Data Notebook.

Adult Residential Care Facilities

There is little publicly available data on the website of the Community Care Licensing at the CA Department of Social Services. This lack of information makes it difficult to determine how many of the licensed Adult Residential Care Facilities operate with

² SAMHSA: Substance Abuse and Mental Health Services Administration, an agency of the Department of Health and Human Services in the U.S. federal government. For more information and reports, see www.SAMHSA.gov.

services that would meet the needs of adults with chronic and/or serious mental illness (SMI), (and are willing to accept clients with SMI), compared to other adults such as those with physical disabilities, or who are developmentally disabled. There is a bill (AB 1766) before the legislature that would authorize and require the collection of data from licensed operators of adult residential facilities regarding how many residents have SMI, or whether these facilities have the services these clients would need to support their recovery or transition to other housing. The Planning Council supports this bill.

The Planning Council would like to understand what type of data are currently available at the county level regarding ARFs and Institutions for Mental Diseases (IMDs)³ available to serve individuals with SMI, and how many of these individuals (for whom the county has financial responsibility) are served in facilities such as ARFs or IMDs.

There are 82 licensed Adult Residential Care Facilities (ARF) in Ventura County, according to the list provided on the CA Department of Social Services website.⁴

- 1) For how many individuals did your county pay some or all of the costs to reside in a licensed Adult Residential Care Facility (ARF), during the last FY? **557**
- 2) What is the total number of ARF bed-days paid for these individuals, during the last FY? **64,490**
- 3) Unmet needs: how many individuals served by your county need this type of housing but currently are not living in an ARF? **500 best estimate**
- 4) Does your county have any 'Institutions for Mental Disease' (IMD)?
 No. Yes. If yes, how many IMDs? _____
- 5) For how many individual clients did your county pay the costs for an IMD stay (either in or out of your county), during the last FY?
In-county: **N/A** Out-of-county: **21**
- 6) What is the total number of IMD bed-days paid for these individuals by your county during the same time period? **5,426**

³ Institution for Mental Diseases (IMD) List https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-IMD_List.aspx.

⁴ Link at CDSS: <https://secure.dss.ca.gov/CareFacilitySearch/Search/AdultResidentialAndDaycare>

Homelessness: Your County's Programs and Services

The Planning Council has a long history of advocacy for individuals with SMI who are homeless, or who are at risk of becoming homeless, or need assistance to transition to stable housing after a hospitalization or crisis residential stay. Within the last few years, the problem of homelessness has increased significantly, not only for those with SMI, but for large numbers of adults and children lacking resources for stable housing (for many different reasons). This increase has occurred in spite of greater resources allocated by public agencies to the problems of homelessness and affordable housing.

Studies indicate that approximately 1 in 3 individuals who are homeless also have serious mental illness and/or a substance use disorder. The Council does not endorse the idea that homelessness is caused by mental illness nor that the public behavioral health system is responsible to fix homelessness, financially or otherwise, but we know that recovery happens when an individual has a safe, stable place to live so we are interested in what types of things counties are doing. And because this issue is so complex and will not be resolved in the near future, the Council is planning to continue to track and report on the myriad of programs and supports the counties offer to assist individuals who are homeless and have serious mental illness and/or a substance use disorder and who would benefit from such programs.

Current news articles highlighted a recent surge in homelessness numbers in some counties and cities, based on analysis of data from "Point-in-Time" (PIT) counts taken in January of each year, including 2019, 2018, and 2017. From those numbers, local officials found the percent increases from 2017 to 2018, and from 2018 to 2019, to be quite startling, as outlined in New York Times articles in April⁵ and June,⁶ 2019.

The table on the next page shows the January, 2018 'Point in Time Count' for the number of homeless in your county (or federally designated Continuum of Care, 'CoC') from the website at www.hud.gov. (For more information, see URL link in the footnote).⁷

⁵ www.NYTimes.com, April 10, 2019. California Today: How Large is the Bay Area's Homeless Population?

⁶ www.NYTimes.com, June 5, 2019. California Today: Homeless Populations Are Surging. Here's Why.

⁷ Your county data may be grouped with other counties, depending on the assigned group for federal "Continuum of Care" (CoC) designation. Example: data for the **CoC CA-516** includes Redding/Shasta, Siskiyou, Sierra, Lassen, Plumas, Del Norte, and Modoc Counties. The annual HUD "Point-in-Time" counts of homeless persons for all California counties are at:

<https://www.hudexchange.info/programs/coc/coc-homeless-populations-and-subpopulations-reports/?filter Year=2018&filter Scope=CoC&filter State=CA&filter CoC=&program+Coc&group=PopSub>.

Table: Summary of Number of Homeless Persons in each Household Type, 'CoC' Region CA-611 (Includes Ventura County)

SUMMARY of PERSONS in each TYPE of HOUSEHOLD	SHELTERED: in Emergency Shelter	SHELTERED: In Transitional Housing	UNSHELTERED	<u>TOTAL</u>
Persons in Households without any Children	253	47	808	1,108
Persons in Households with at least one adult ≥18 and at least one child <18	36	142	21	199
Persons in Households ^a with <u>only</u> Children <18	0	0	1	1
Total Homeless Persons	289	189	830	1,308

7) During the most recent FY (2017-2018), what new programs were implemented, or existing programs were expanded, in your county to serve persons who are both homeless and have severe mental illness?

- a. Emergency shelter
- b. Temporary housing
- c. Transitional housing
- d. Housing/Motel vouchers
- e. Supportive housing
- f. Safe parking lots
- g. Rapid re-housing
- h. Adult residential care patch/subsidy
- i. Other, please specify: _____

8) **Optional:** If your county (or CoC) has data for 2019, please enter that total number here: Point-in-time Count = 3,688 persons. If you compare that number to the total for 2018, you may determine the percent increase in homeless persons over one year: approximately 10%; see below spreadsheet. This number may provide some indication of how much worse the problem is getting, and how quickly that change is taking place.

^a Data definition: Persons in Households with only Children <18 includes unaccompanied child or youth, parenting youth <18 who have one or more children, or may include sibling groups <18 years of age.

CITY	2007	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Camarillo	10	13	15	29	30	27	38	35	24	27	49	33
Fillmore	5	4	5	10	16	13	6	7	6	0	2	10
Moorpark	13	7	1	7	5	9	15	7	4	7	3	2
Ojai	82	60	52	40	41	43	62	40	29	19	31	47
Oxnard	671	679	520	638	522	645	379	603	584	461	335	548
Port Hueneme	9	1	9	6	12	17	13	22	7	18	19	30
Santa Paula	97	91	54	50	60	34	31	20	56	35	44	106
Simi Valley	163	303	229	226	284	211	194	202	99	105	143	121
Thousand Oaks	81	147	106	87	90	121	130	83	104	102	80	103
Ventura	588	623	601	570	701	519	495	334	300	301	546	555
Unincorporated	242	235	223	209	175	135	86	64	58	77	77	114
TOTALS:	3968	4172	3825	3883	3948	3787	3463	3432	3287	3169	3347	3688

2014 Oxnard count is artificially low due to a reporting discrepancy.

Child Welfare Services: Foster Children in Certain Types of Congregate Care

About 60,000 children, under the age of 18, in California are in foster care. They were removed from their homes because county child welfare departments, in conjunction with juvenile dependency courts, determined that these children could not live safely with their caregiver(s). Most children are placed with a family who receives foster children; however, a small number of the children necessitate a higher level of care and are placed in a Group Home.

California has had a long standing goal of moving away from the use of long term group homes, also known as congregate care, and are increasing youth placement in family settings. Assembly Bill 403, California's Child Welfare Continuum of Care Reform, provided timelines and requirements to reform the foster care system including the reduction in reliance on congregate care as a long-term placement setting, AB 403 narrowly redefines the purpose of group care. Group homes are to be transitioned into a new facility type, Short-Term Residential Treatment Program (STRTP), which will provide short-term, specialized, and intensive treatment and will be used only for children whose needs cannot be safely met initially in a family setting.

A STRTP is a residential facility that provides an integrated program of specialized and intensive care and supervision, services and supports, treatment, and short-term 24-hour care and supervision to children. STRTPs are required to provide trauma-informed and culturally relevant core services, which include: specialty mental health services (SMHS); transition services; education, physical, behavioral, and extracurricular supports; transition to adulthood services; permanency support services; and Indian child services.

All of California's counties are working toward closing long-term group homes and are establishing licensed STRTPs. This transition will take time and it is important for your

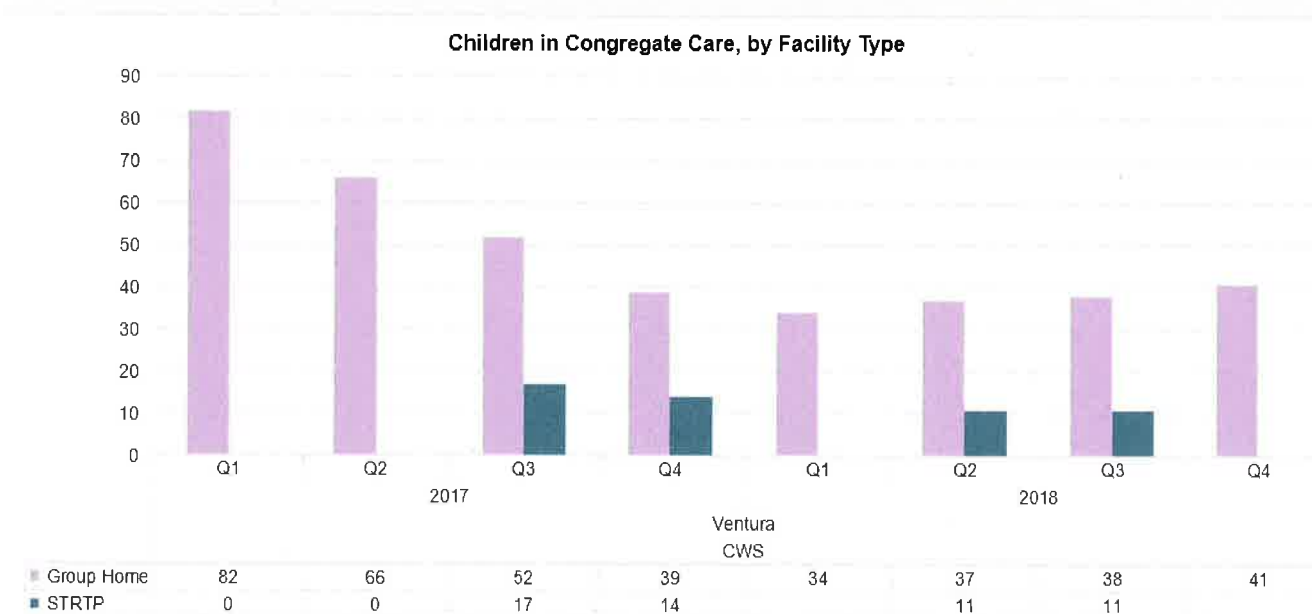
board to talk with your county director about what is happening in your county for any children in foster care who are not yet able to be placed in a family setting or who are in a family setting and experience a crisis which requires short-term intensive treatment.

The following chart displays the count of children age 0-17 years in your county who were in a group home compared to a count of the children age 0-17 years who were in an STRTP at some time during that quarter. Note that it does not display point-in-time counts of children in a group home or STRTP on a particular day in the quarter. This measure looks at all children who were in a group home placement at some time during the quarter and all children who were in an STRTP placement at some time during the quarter as two separate populations. If a child was placed in one type of congregate care home but then was moved to a different type of facility during the quarter, then that child was counted once in each population group. These children are part of an extremely vulnerable population and the Council will be tracking them over the next several years.

Please examine the data below. If there were no children in a given category during that quarter, then a zero was entered. Blanks in the table mean that data were suppressed due to small numbers (<11 cases). Thus, some small population counties may have only, or mostly, blanks, indicating that “some” children were in those groups but not enough to safely depict.

Your county: **Ventura County**

How does the number of children in a Group Home during the quarter compare to the number of children in an STRTP during the quarter?



- 9) Do you think your county is doing enough to serve the children/youth in group care? Yes **X** No _____

If not, what is your recommendation? Please list or describe briefly (in 30 words or less).

VCBH has been engaged in Continuum of Care Reform since 2017 and Pathways to Wellbeing since 2013, all with the premise of decreasing length of stay of children in the dependency system, reducing time and number of children in out of home placement, having children stay in family homes with services attached to the child and network, ensuring trauma informed screening and assessment of all children in dependency.

Many counties do not yet have STRTPs and are having to place children/youth in another county. Recent legislation (AB 1299) directs that the Medi-Cal eligibility of the child be transferred to the receiving county. This means, the county receiving the child now becomes financially responsible for his/her Medi-Cal costs.

- 10) Has your county received any children from another county?

Yes **X** No _____. If yes, how many? 322 in FY 2018-19

- 11) Has your county placed any children into another county?

Yes **X** No _____. If yes, how many? 36 in FY 2018-19

The numbers include only Medi-Cal beneficiaries. For children from another county, the number reflects the cases of children who were linked to a clinic or to the Screening, Triage, Assessment & Referral (STAR) Team; it is unknown whether they received services following the referral.

Background and Context: Trauma-informed Care across the Life Span

One goal of our 2019 Data Notebook is to examine behavioral health services and needs from the perspective of “Trauma-informed principles of care across the lifespan.” Our choice of this focus topic recognizes that childhood adversity and trauma contribute profoundly to an individual’s lifelong mental and physical health outcomes, and in turn, to the well-being of our families and communities.

What is Trauma and How Common is It?⁹

- Experiences that cause ‘intense physical and psychological stress reactions.’

⁹ SAMHSA, Treatment Improvement Protocol (TIP) 57.

- Events that are physically and emotionally harmful or threatening and that cause lasting damage to a person’s physical, social, emotional, or spiritual well-being.’
- Many individuals report a single traumatic event, but ‘others--especially those seeking mental health or substance abuse services--have been exposed to multiple or chronic traumatic events.’

Why focus on trauma? Trauma is more prevalent in our society than many realize. In the U.S. general population, one survey (NSARC, 2012)¹⁰ found that 72% of adults reported witnessing a trauma, 31% experienced trauma due to injury, and one-sixth (17%) had experienced serious psychological trauma. Potential sources of trauma include natural disasters, accidents, interpersonal violence (domestic violence, rape, mass casualty events), and severe childhood maltreatment. (See Appendix I.) Some may experience post-traumatic stress disorder in the course of their work in military service, or as first-responders, providers of emergency healthcare or trauma therapy.

Regardless of cause, screening for psychological trauma is an essential first step to treatment, and can be performed with standard methods targeted specifically for adults, or for children and youth (See Appendix II for methods). Screening is now deemed so important that the state of California has designated specific funding for trauma screenings of all children and adults with full-scope Med-Cal (FY 2019-20).

Multiple, Complex, or Cascading Traumatic Events¹¹

- California is prone to multiple large-scale catastrophes, including fires, floods, landslides, droughts, and earthquakes.
- The primary trauma can lead to secondary losses of home, school, work, and neighborhood relationships, in a cascading sequence of loss and displacement.
- CA residents may experience consecutive and/or simultaneous natural disasters, in a pattern without time for healing from one event before another occurs.
- The mobility of our population can result in a lack of supportive relationships or resources. This lack compounds the vulnerability to trauma and delays recovery.
- Finally, when faced with new disasters, adults who experienced early life ‘adverse childhood experiences’ (ACEs) may find it much more challenging to recover and be resilient in the face of new trauma.

The concept of multiple or complex trauma is particularly important in the discussion of childhood trauma, because children may experience repeated traumatic events, multiple

¹⁰ NSARC: National Epidemiological Survey on Alcohol and Related Conditions, 2012.

¹¹ SAMHSA, TIP 57, page 47.

types of trauma, or chronic circumstances of profound neglect or deep poverty. Substantial research indicates that severe trauma, early in life, has the potential to create a level of stress that is toxic to the developing brains of young children.

The implementation of basic trauma-informed practices can help organizations provide more sensitive, respectful, and effective health care and to avoid triggers of emotional distress. Therefore, this report will include some trauma-informed practices. Briefly, ***trauma-informed care*** involves a model of care intended to promote healing and reduce risk for re-traumatization. Avoiding re-traumatization largely depends on how individuals and organizations interact with the traumatized person from initial point of contact and throughout diagnosis, screening, and the provision of care.

Next, having acknowledged the larger issues of human trauma, this Data Notebook will focus primarily on the effects of childhood trauma because of the greatly increased risks for mental illness, substance use disorders, and other social and health/medical outcomes. Knowledge about the origins and consequences of childhood trauma may yield information about how to reduce its incidence, causes, and consequences.

ACEs: Early Studies Linked Health Effects to Childhood Trauma

Several types of childhood trauma, hardship, and adversity are studied by researchers. Many of these studies build on the foundation laid by Dr. Vincent Felitti of Kaiser Permanente in San Diego and Dr. Robert Anda of the Center for Disease Control and Prevention (1998).¹² They collected data from over 17,000 adult patients of Kaiser Permanente in the San Diego area.

These researchers found that a specific subset of traumatic childhood experiences were highly correlated with later life physical and mental health problems. They defined these traumatic experiences as “adverse childhood experiences (ACEs).” This research was the largest epidemiological study of its kind ever done to examine the health and social effects of ACEs over the lifespan. They further developed a way to categorize and determine scores for ACEs that showed a relationship to later outcomes.

There are three major categories of defined ACEs: abuse, neglect, and household dysfunction. Within these three categories are ten types of ACEs, as follows.

- Abuse: includes physical, emotional and sexual abuse
- Neglect: includes physical and emotional neglect
- Household Dysfunction: includes having a family member with: serious mental illness, substance abuse disorder, or who is incarcerated, or experiencing domestic violence, or divorce.

These adverse events were used for the basis of the “ACEs Score.” The ACE Score for each individual is determined by answering 10 questions regarding events experienced in their life prior to the age of 18 years.

In this original ‘Adverse Childhood Experiences Study’ (1998), the majority of participants were white (74.8%), middle class, had health insurance, and had achieved a college-level education (75.2%) or more. Almost two-thirds (63.9%) had experienced at least one adverse childhood experience. One in eight people (12.5%) had four or more ACEs. Clearly, for the middle class population in this study, the percentages of people who had experienced at least one or more ACE may seem surprisingly high. But these experiences were remarkably common.

The ACE Study also found that ACEs are highly interrelated – where there is one ACE, there are likely others. So, it didn’t make sense to study one category of adversity at a time. It made more sense to study the accumulation of ACEs– so the scientists made a

¹² The definitive early study of Felitti, Anda, et al.,: Vincent J. Felitti, et al., Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) study. American Journal of Preventative Medicine, 245 (1998).

simple score. Each type of ACE adds to the total ACE Score – from experiencing zero ACEs to experiencing all ten ACEs. ACE scores in the study ranged from 0 to 10. So even if a person experienced several different experiences of physical abuse, say spanking or kicking or blows to the head, this is counted as one ACE, that of physical abuse. The separate examples or events physical abuse do not yield any kind of cumulative score, and this was an arbitrary choice made by the researchers to find some kind of way to analyze what could otherwise be a complex data set.

Remarkably, the data showed a strong dose-response relationship between ACEs and poor health and life outcomes. As the number of ACEs increased, the risk of negative health outcomes also increased. Later studies discovered that the life expectancy of a person with six or more ACEs is 20 years shorter than for someone with zero ACEs.

These results led to a new way of thinking about the connection between childhood and adult health. They found that ACE scores directly correlated with the population health. The data showed that, compared to those with zero ACEs, individuals with ACE scores of 4 or more were likely to have exhibited these high-risk behaviors:

- more than twice as likely to be smokers,
- 7 times more likely to be alcoholic,
- 10 times more likely to have injected street drugs, and
- 12 times more likely to have attempted suicide.

In addition, ACEs increased the risk for serious health conditions. The data showed that, compared to those with zero ACEs, individuals with 4 or more ACEs were:

- 2.4 times as likely to have a stroke,
- 2.2 times as likely to have ischemic heart disease,
- 1.9 times as likely to have cancer, and
- 1.6 times as likely to have diabetes.

Those were very serious outcomes documented in that largely white, middle-class San Diego area population studied by Drs. Felitti and Anda. Those findings raised important questions about the effect of early life experiences on lifelong health.

But what are the results when those early studies are compared to more recent data¹³ about the economically diverse populations of the state of California as a whole? Key differences were that significant numbers of our residents lived in poverty, lacked health insurance, had poor access to healthcare, and worse outcomes.

¹³ These statewide data findings (following pages) were derived from four years of statewide data from 27,745 adults that was collected by the annual California Behavioral Risk Factor Surveillance Survey data [BRFSS, 2008-2013]. These data were reported by the Center for Youth Wellness, using analyses by the Public Health Institute.

Recent California Data Confirm Link of early Trauma to Health Outcomes

Recent statewide data (2008-2013) show that the prevalence of ACEs is relatively consistent across race and ethnic groups in the state. However, high numbers of ACEs do correlate with a person's poverty, lack of education and/or unemployment. When compared to someone with no ACEs, data show that a person with **4 or more ACEs** is:

- 21% more likely to be below 250 percent of the Federal Poverty Level (FPL),
- 27% more likely to have less than a college degree,
- 39% more likely to be unemployed,
- 50% more likely to lack health insurance (and more likely to delay seeking care).

Using this recent statewide data, what percentage of California adults recalled one or more ACEs from their childhood, regardless of household type? The data below show that 45% had 1-3 ACEs, and almost 16% (or one-sixth) had 4 or more ACEs.

TABLE: Adult Retrospective Data (2008-2013), from www.kidsdata.org¹⁴

California	Percent		
	Households with Children	Households without Children	All Households
Number of ACEs			
0 ACEs	36.8%	40.8%	39.0%
1-3 ACEs	46.7%	43.9%	45.1%
4 or More ACEs	16.5%	15.3%	15.9%

What is the prevalence of ACEs for adults in your county?

Ventura County	Percent		
	Households with Children	Households without Children	All Households
Number of ACEs			
0 ACEs	LNE	42.2%	39.8%
1-3 ACEs	LNE	41.9%	45.0%
4 or More ACEs	14.4%	16.0%	15.2%

¹⁴Your county data may be found at: <https://www.kidsdata.org/>.

Adult retrospective data are shown above. “Retrospective surveys,” are those in which adults were asked about their life experiences prior to age 18, for example. Take note of the average percent taken from adults in all households (regardless of whether the adult resides in a household with, or without, any children). (LNE means data are suppressed due to a ‘low number event.’)

In some counties, over 75% of residents have at least one ACE. Even in counties with the lowest prevalence of ACEs, 50% had one or more adverse experiences in childhood. If the statewide numbers are very different from your county data, you may wish to explore potential contributing factors. Contributory factors could include poverty, unemployment, lack of education, high rates of child maltreatment or substance abuse, among other possible reasons. However, causes might not be readily identifiable.

Furthermore, the ranking of which ACEs were most common varies among adults in different counties. However, based on statewide data for adults, the most common ACE is emotional abuse. The most common ACEs among California adults are reported as follows (Behavioral Risk Factor Surveillance Survey data, 2008-2013):

- Emotional or verbal abuse: 34.9%
- Parental separation or divorce: 26.7%
- Substance abuse by household member: 26.1%
- Physical abuse: 19.9%
- Witness to domestic violence: 17.5%
- Household member with mental illness: 15.0%
- Sexual abuse: 11.4%
- Physical or emotional neglect: 9.3%
- Incarcerated household member: 6.6%.

ACEs affect every community in California, urban and rural, “regardless of geography, race, income, or education.” A marked percentage of adults has experienced four or more ACEs, a score that confirms a strong correlation with serious health conditions. Some health outcomes include increased lifetime risks for asthma, arthritis, and any cardiovascular disease. Specifically, adults in California¹⁵ with 4 or more ACEs are:

- 2.4 times as likely to have chronic obstructive pulmonary disease (COPD),
- 1.9 times as likely to have asthma
- 1.7 times as likely to have kidney disease, and
- 1.6 times as likely to have a stroke.

¹⁵ These data are from BRFSS and CDC statewide data collection in California during the years 2008-2013. The numbers are similar, but not identical, to the findings from the early studies (1998) of Drs. Felitti and Anda on San Diego area patients of Kaiser Permanente, which were cited earlier in this report.

Most importantly, behavioral health challenges in adulthood have a long association with ACEs. In California, when compared to a person with no ACEs, the data show that a person who has experienced four or more ACEs is:

- 5.1 times as likely to have depression,
- 4.7 times as likely to seek help from a mental health professional,
- 4.2 times as likely to be diagnosed with Alzheimer's disease or dementia,
- 3.2 times as likely to engage in binge drinking,
- 2.5 – 3.0 times as likely to have mental, physical, or emotional conditions that cause difficulty in concentrating, remembering, or making decisions.

Taken together, the findings of these studies strengthen our understanding that ACEs are common, and that ACEs have a strong cumulative impact on the risk of common physical and mental health problems. The results of these adult retrospective studies, where adults were asked about their experiences prior to age 18, help us to recognize the consequences of childhood trauma, and highlight the urgency of providing early screening and treatment for trauma, at every stage of a person's life.

There is a large variety of treatments commonly utilized for adults who have experienced trauma, and there are more therapeutic approaches being developed all the time. Depending on whether a history of trauma occurs with other clinically important issues, different types of therapy may be adapted or combined to meet the individual's current needs.

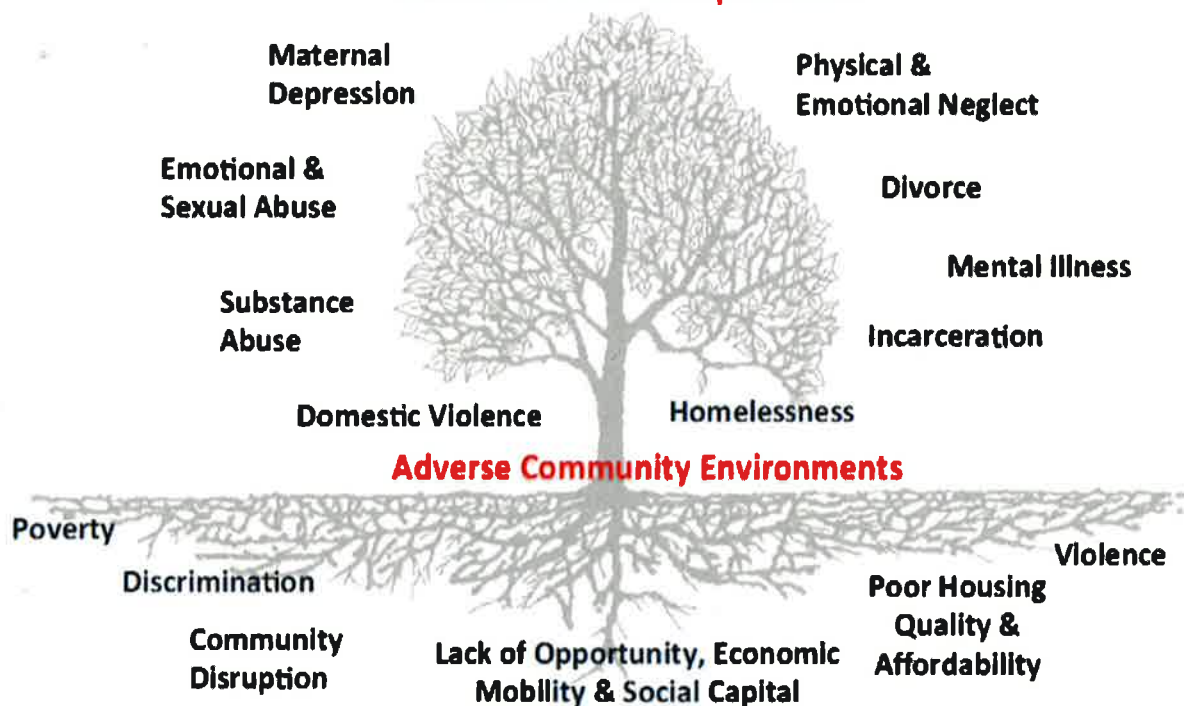
Focus on Trauma in Children and Adolescents

The ACEs Neurodevelopmental Model proposed that ACEs disrupt early brain development, which in turn leads to social, emotional, and cognitive adaptations that can then lead to the risk factors for major causes of disease, disability, social problems, and early death. Since the time of the original ACE Study, breakthrough research in developmental neuroscience showed that the hypothesis of the ACE Study is biologically sound, i.e., that the developing brain is affected by toxic stress. These studies are important because what is predictable is preventable. Preventing ACEs and their intergenerational transmission is the greatest opportunity for improving the health and well-being of our population.

Abundant data demonstrates that trauma in children and youth are linked to a variety of adverse outcomes in behavioral health, physical health and negative life outcomes. Key factors include the larger community environment and the effects of parental hardship, poverty, violence and a general lack of resources. Those resources and needed supports may not be present in a child's family life. Many researchers and clinicians have found that adverse community environments are fertile ground for adverse childhood experiences (ACEs). (See illustration below).

The Pair of ACEs

Adverse Childhood Experiences



Ellis, W., Dietz, W. (2017) A New Framework for Addressing Adverse Childhood and Community Experiences: The Building Community Resilience (BCR) Model. *Academic Pediatrics*. 17 (2017) pp. S86-S93. DOI Information: 10.1016/j.acap.2016.12.011

Prevalence of ACEs in California's Children¹⁶

Compared to the retrospective adult data described earlier, we want to examine what the data show for how common are ACEs in today's children? This type of data¹⁷ is collected from questions asked of a parent about their children's experience of hardships that correspond to 'ACEs'. These 2016 data show that an estimated 16.4% of California children had experienced two or more adverse experiences.

Your county:

Ventura County: 15.2% of children have experienced two or more adverse experiences.

¹⁶ <https://www.kidsdata.org>

¹⁷ National Survey of Children's Health, 2016, Data Source: [Population Reference Bureau](#), analysis of data from the [National Survey of Children's Health](#) and the [American Community Survey](#) (Mar. 2018).

Most county data are similar to those indicating that approximately one-sixth of **California** children (or 16.4%) have experienced two or more hardships (or ACEs). These findings further support the need to implement trauma-informed care in every school or agency or healthcare provider that touches the lives of children.

In particular, foster youth experience many stressors, many emotional losses, and are challenged to constantly make new adaptations to sudden changes in placements, often with corresponding changes in their assigned school. Foster youth are a vulnerable group that receive specific attention in county departments of child welfare and behavioral health. There are now legal requirements for early and prompt screenings and referral to address identified mental health needs. Foster youth are a key demographic in need of trauma-informed care as they interact with multiple agencies.

What is Resilience?¹⁸

“Resilience is an adaptive response to hardship, and can mitigate the effects of adverse childhood experience. It is a process of adapting well in the face of adversity, trauma, threats, or other significant sources of stress.”

“Resilience involves a combination of internal and external factors. Internally, it involves behaviors, thoughts, and actions that anyone can learn and develop. Resilience is strengthened by having safe, stable, nurturing relationships and environments within and outside the family.”

Resilience is most simply described as a quality linked to recovery and the ability to heal and adapt. Research data can be obtained from mothers who were asked about their child’s behaviors when confronting a challenge or stressful experience: “Is your child usually able to stay calm and in control when faced with a challenge?” And the answer is either yes or no.

The estimated percentage of children in **California** (2016) who are ‘resilient’ (using that definition¹⁹) is 52.4%. Examples of county data range from 50.8% to 53.2%. Data ²⁰ for the largest 40 counties can be found at KidsData.org.

¹⁸ Definitions and descriptions from background research material provided at www.KidsData.org.

¹⁹ Definition: Estimated percentage of children ages 6-17 who are calm and in control when facing a challenge (e.g., in 2016, an estimated 52.4% of California children ages 6-17 were resilient). Data Source: [Population Reference Bureau](#), data from the [National Survey of Children's Health](#) and the [American Community Survey](#) (Mar. 2018).

²⁰ You may examine the data tables at the following source. <https://www.kidsdata.org/topic/1928/resilience-nsch/table#fmt=2450&loc=2,127,331,171,345,357,324,369,362,360,337,364,356,217,328,354,320,339,334,365,343,367,344,366,368,265,349,361,4,273,59,370,326,341,338,350,342,359,363,340,335&tf=88>.

Ventura County: data show that 51.9% of children are 'resilient;' that is, they stay calm and in control when faced with a challenge (as reported by parent).

Trauma-Informed Care: The Basics

Trauma-informed care describes a variety of approaches that acknowledge the impact of trauma. Programs and organizations that use a trauma-informed approach may not necessarily treat the consequences of trauma directly, but instead train their staff to interact effectively with participants who have been affected. Approaches include supporting participants' natural coping skills and the use of appropriate behavior management techniques. The desired outcomes are to help young people develop resilience and the ability to deal with difficulties. These methods are increasingly used in systems and settings that involve young people and their families.

Schools are a frontline for meeting children and youth with trauma, in that chronic or acute home stressors may lead to problems in attention, behavior, or actions. There are excellent programs that change a school's focus from discipline to a trauma-informed approach, with one goal being to help children find their own inner calm or strength. The results of implementing such programs have dramatically reduced the number student suspensions in those schools.

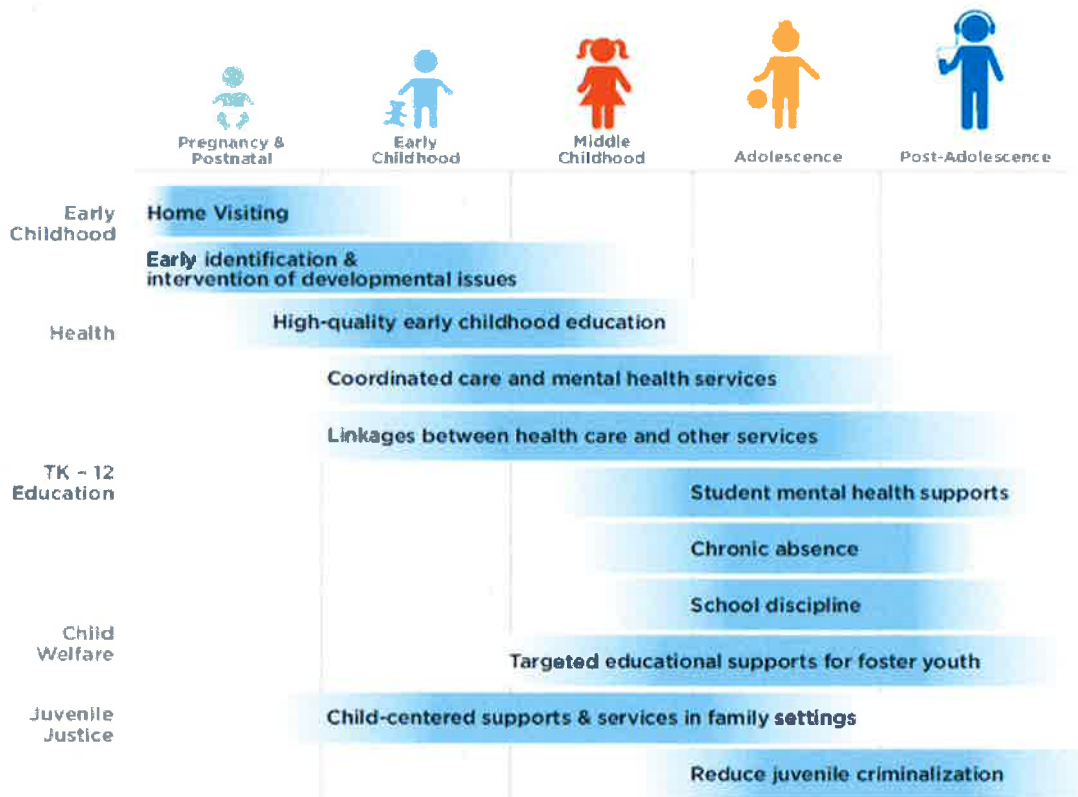
An example of one very important trauma-informed approach that interfaces between the school and first-responders is the FOCUS model, where 'FOCUS' stands for 'Focusing on Children Under Stress.' Most communities refer to the program as 'Handle With Care.' This is a program brought into being to respond when a child is witness or a victim of traumatic events in a child's home or neighborhood. First responders notify the school that the child is under stress and needs a 'focus on the child and handle them with care' approach.²¹

Trauma-informed Programs Developed for Children and Families

One of the most important things to address in discussions of trauma and childhood adversity is to ask: what are some of the positive, prevention-oriented, or problem-solving ways that we can address these issues? Different categories for trauma-related interventions for children have been designed for every stage of growth and development, as shown in the following figure.

²¹ <http://www.focuscalifornia.org>

Trauma Interventions for Every Age



Trauma Interventions for Every Age | ChildrenNow.org

CHILDREN NOW

The next table lists specific programs developed for children and families. These examples are evidence-based practices rooted in the principles of trauma-informed care. These programs are common in California and it is important to publicize those that are found in your community. Often, parents may not be aware of the resources available to help them learn about parenting skills and strategies.

Evidence-Based Practices for Children and Families: Some Examples

40 Developmental Assets: are a set of skills, experiences, relationships and behaviors that enable young people to develop into thriving adults. The Search Institute developed many training materials focused on these '40 Developmental Assets.'

Strengthening Families has a framework that is based on engaging families, programs and communities in building five protective factors:

- Parental resilience.
- Social connections.

- Knowledge of parenting and child development.
- Concrete support in times of need.
- Social and emotional competence of children.

Help Me Grow is a new program that will give parents the opportunity to complete a developmental assessment of their child and provide support and resources for their child if any problems are identified.

Triple P is a multi-level program for children and teenagers that provides parents with training on assertive discipline and child development.

First 5 California and the First 5 county organizations provide leadership and funding for necessary programs specific to children pre-natal to 5 years of age and their families. Since 1998, First 5 CA has worked to improve the lives of children and families with the vision that California's children will receive the best possible start in life and thrive.

In conclusion, trauma-informed care promotes resilience and health for families, communities, and public health. Resilience, in a broader sense, originates from buffers in communities and families to protect individuals from the accumulation of toxic stress due to ACEs and other types of trauma. The long-term goal is to instill trauma-informed principles of care in all systems, i.e., healthcare, social services, schools, child welfare/juvenile justice and criminal justice. Cross-system collaboration is important because many persons with serious mental illness and/or substance use disorders are served by multiple systems. For many, the experience of early trauma plays a causative, contributory, or aggravating role in their present difficulties.

Trauma-informed care: Discussion questions for local boards/commissions.

12) Has your behavioral health board/commission received information or training on trauma-informed practices and/or the need for such?

X Yes **No**

If yes, what type of information/training was it? Please state or list briefly:

Presentation by Dr. Kathleen Van Antwerp, Child Behavioral Specialist, at a Board General Meeting.

Presentations at Board's Youth & Family Committee meeting on Commercial Sexual Exploitation of Children (CSEC) and at Prevention Committee meeting.

All presentations and updates since 2013 to present on Pathways to Wellbeing (Katie A. Reform) and Continuum of Care Reform have highlighted trauma informed practices, cross system collaboration and improvement, joint trainings, evidence informed/based treatment, culturally response treatment and program development.

13) Is your county currently implementing trauma-informed practices for youth? X Yes **No** **For adults: X Yes** **No**

If yes, what evidence-based practices for trauma-informed care are being used in your county? Please state or list briefly:

SAMHSA's GAINS Center provided a training on 9/27/17: "How Being Trauma-Informed Improves Criminal Justice System Responses"; VCBH and CIT staff attended, including Dr. Sevet Johnson and Dr. John Schipper. A SAMHSA's Gains Center/Policy Research Associates training called "How Being Trauma-Informed Improves Judicial Decision-Making" will be presented on 12/3/19, tailored to court professionals and sponsored by VCBH.

VCBH is dedicated in providing quality behavioral health services to the community members who meet medical service necessity for Specialty Mental Health Services. CBT is foundational for complex trauma treatment, is age appropriate, and culturally appropriate for our threshold population.

- 2018 Provided our own Cognitive Behavioral Therapy (CBT) trainings

Evidence-Based Practices (EBPs):

- CBT(Train the Trainer Model) /Advance Peer Mentors 50 trained since 2013. Trained Diplomats of the Academy are now 15 as of 2017. In 2019, CBT Operational Guide established for the Department and VCBH able to certify clinicians at a department standard.
- Seeking Safety
- Parent-Child Interaction Therapy (PCIT)

- Theraplay
- Depression Treatment Quality Improvement (DTQI)
- Dialectical Behavior Therapy (DBT)
- Integrated Dual Disorder Treatment (IDDT)
- Aggression Replacement Therapy (ART)
- HOMEBUILDERS
- Brief Strategic Family Therapy (Trained to Fidelity New Dawn)
- Moral Reconciliation Therapy (MRT)

14) Are you aware of service areas in your county that are not using trauma-informed practices that should be doing so? Yes No

If yes, please identify those service areas briefly below.

Schools

First responders

Child Welfare Services

Juvenile Detention Facilities

Jail (Adults)

Other criminal justice system services, please specify: _____.

Un-served or underserved cultural groups, please specify: _____.

Other, Please specify: _____.

15) If you recommend the expansion of trauma-informed practices in your county for youth and/or adults, what are your top three priorities for services (or programs) for each age group?

Priorities for Children/Youth services, please state or list briefly:

1. Additional family treatment modalities.
2. Modalities with Commercial Sexual Exploitation of Children (CSEC) population and for individuals with Eating Disorders.

3. Community law enforcement and jail custody staff.

Priorities for Adult services, please state or list briefly:

1. No expansion requested.

2. _____

3. _____

Priorities for Older Adult services, please state or list briefly:

1. No expansion requested.

2. _____

3. _____

Appendix I. Types of Trauma. (per SAMHSA).²²

Caused Naturally	Caused by People	
	Accidents, Technological Catastrophes	Intentional Acts
Tornado Lightning strike Wildfire Avalanche Physical ailment or disease Fallen tree Earthquake Dust storm Volcanic eruption Blizzard Hurricane Cyclone Typhoon Meteorite Flood Tsunami Epidemic Famine Landslide or fallen boulder	Train derailment Roofing fall Structural collapse Mountaineering accident Aircraft crash Car accident due to malfunction Mine collapse or fire Radiation leak Crane collapse Gas explosion Electrocution Machinery-related accident Oil spill Maritime accident Accidental gun shooting Sports-related death	Arson Terrorism Sexual assault and abuse Homicides or suicides Mob violence or rioting Physical abuse and neglect Stabbing or shooting Warfare Domestic violence Poisoned water supply Human trafficking School violence Torture Home invasion Bank robbery Genocide Medical or food tampering

²² www.samhsa.gov, Substance Abuse and Mental Health Services Administration, Treatment Improvement Protocol (TIP) 57.

Appendix II.

Examples of Trauma Screening tools²³ designed for specific age/ developmental groups:

Exhibit 1.4-2: Key Areas of Trauma Screening and Assessment

Trauma

Key question: Did the client experience a trauma?

Examples of measures: Life Stressor Checklist-Revised (Wolfe & Kimerling, 1997); Trauma History Questionnaire (Green, 1996); Traumatic Life Events Questionnaire (Kubany et al., 2000).

Note: A good trauma measure identifies events a person experienced (e.g., rape, assault, accident) and also evaluates other trauma-related symptoms (e.g., presence of fear, helplessness, or horror).

Acute Stress Disorder (ASD) and PTSD

Key question: Does the client meet criteria for ASD or PTSD?

Examples of measures: Clinician-Administered PTSD Scale (CAPS; Blake et al., 1990); Modified PTSD Symptom Scale (Falsetti, Resnick, Resnick, & Kilpatrick, 1993); PTSD Checklist (Weathers, Litz, Herman, Huska, & Keane, 1993); Stanford Acute Stress Reaction Questionnaire (Cardena, Koopman, Classen, Waelde, & Spiegel, 2000).

Note: A PTSD diagnosis requires the person to meet criteria for having experienced a trauma; some measures include this, but others do not and require use of a separate trauma measure. The CAPS is an interview; the others listed are self-report questionnaires and take less time.

Other Trauma-Related Symptoms

Key question: Does the client have other symptoms related to trauma? These include depressive symptoms, self-harm, dissociation, sexuality problems, and relationship issues, such as distrust.

Examples of measures: Beck Depression Inventory II (Beck, 1993; Beck et al., 1993); Dissociative Experiences Scale (Bernstein & Putnam, 1986; Carlson & Putnam, 1993); Impact of Event Scale (measures intrusion and avoidance due to exposure to traumatic events; Horowitz, Wilner, & Alvarez, 1979; Weiss & Marmar, 1997); Trauma Symptom Inventory (Briere, 1995); Trauma Symptom Checklist for Children (Briere, 1996b); Modified PTSD Symptom Scale (Falsetti et al., 1993).

Note: These measures can be helpful for clinical purposes and for outcome assessment because they gauge levels of symptoms. Trauma-related symptoms are broader than diagnostic criteria and thus useful to measure, even if the patient doesn't meet criteria for any specific diagnoses.

Other Trauma-Related Diagnoses

Key question: Does the client have other disorders related to trauma? These include mood disorders, anxiety disorders besides traumatic stress disorders, and dissociative disorders.

Examples of measures: Mental Health Screening Form III (Carroll & McGinley, 2001); The Mini-International Neuropsychiatric Interview (M.I.N.I.) Structured Clinical Interview for DSM-IV-TR, Patient Edition (First, Spitzer, Gibbon, & Williams, revised 2011); Structured Clinical Interview for DSM-IV-TR, Non-Patient Edition (First, Spitzer, Gibbon, & Williams, revised 2011a).

Note: For complex symptoms and diagnoses such as dissociation and dissociative disorders, interviews are recommended. Look for measures that incorporate DSM-5 criteria.

Sources: Antony et al., 2001; Najavits, 2004.

²³ www.samhsa.gov, SAMHSA: Treatment Improvement Protocol (TIP) 57.

QUESTIONNAIRE: How Did Your Board Complete the Data Notebook?

Completion of your Data Notebook helps fulfill the board's requirements for reporting to the California Behavioral Health Planning Council. Questions below ask about operations of mental health boards, behavioral health boards or commissions, etc. Signature lines indicate review and approval to submit your Data Notebook.

(a) What process was used to complete this Data Notebook? Please check all that apply.

MH Board reviewed W.I.C. 5604.2 regarding the reporting roles of mental health boards and commissions.

MH Board completed majority of the Data Notebook

County staff and/or Director completed majority of the Data Notebook

Data Notebook placed on Agenda and discussed at Board meeting

MH Board work group or temporary ad hoc committee worked on it

MH Board partnered with county staff or director

MH Board submitted a copy of the Data Notebook to the County Board of Supervisors or other designated body as part of their reporting function.

Other; please describe: _____.

(b) Does your Board have designated staff to support your activities?

Yes No

If yes, please provide their job classification **Management Assistant**

(c) What is the best method for contacting this staff member or board liaison?

Name and County: **Edith Pham – Ventura County**

Email **edith.pham@ventura.org**

Phone #

Signature: _____

Other (optional): _____

(d) What is the best way to contact your Board presiding officer (Chair, etc.)?

Name and County: **Janis Gardner**

Email: **janis@panacea-ent.com**

Phone #

Signature: _____

REMINDER: Please submit this Data Notebook by October 15, 2019.

Thank you for your participation in completing your Data Notebook report.

Please feel free to provide feedback or recommendations you may have to improve this project for next year. As always, we welcome your input.

Please submit your Data Notebook report by email to:

DataNotebook@CMHPC.ca.gov .

For information, you may contact the email address above, or telephone:

(916) 327-6560

Or, you may contact us by postal mail to:

Data Notebook
California Behavioral Health Planning Council
1501 Capitol Avenue, MS 2706
P.O. Box 997413
Sacramento, CA 95899-7413



COUNTY OF VENTURA
BEHAVIORAL HEALTH
ADVISORY BOARD



JULY 1, 2018 – JUNE 30, 2019
ANNUAL REPORT

BEHAVIORAL HEALTH ADVISORY BOARD

1911 Williams Drive, Suite 200, Oxnard, CA 93036 • (805) 981-1115

ANNUAL REPORT 2018-2019

Compiled by Janis Gardner, Chairperson FY 2019-2020

Ventura County Board of Supervisors

District 1 Supervisor Steve Bennett
District 2 Supervisor Linda Parks
District 3 Supervisor Kelly Long
District 4 Supervisor Bob Huber
District 5 Supervisor John Zaragoza

Ventura County Behavioral Health Administration

Director Sevet Johnson, Psy.D.
Medical Director Brian Taylor, M.D.
Children's Medical Director Lisa Acosta, M.D.
ADP/DUI Division Chief Loretta Denering, DrPH, MS
Adult Division Chief John Schipper, Ph.D.
Youth & Family Division Chief Pete Pringle, LCSW
Administrative Division Chief Terri Yanez

Behavioral Health Advisory Board Officers 2018-19

Chair Jerry M. Harris
1st Vice-Chair Ratan Bhavnani
2nd Vice-Chair Gane Brooking
Chair Emeritus/Secretary Janis Gardner
Member At Large Gina Petrus

Behavioral Health Advisory Board Officers 2019-20

Chair Janis Gardner
1st Vice-Chair Ratan Bhavnani
2nd Vice-Chair Gane Brooking
Secretary Gina Petrus
Member At Large Joe S. Ramirez
Chair Emeritus Jerry Harris

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VENTURA COUNTY
BEHAVIORAL HEALTH ADVISORY BOARD

MEMBERSHIP ROSTER 2018-2019

<u>District</u>	<u>BHAB Members</u>	<u>Term</u>
District 1	Claudia Armann Kevin Clerici Mary Haffner Gina Petrus	3/11/18 – 3/10/21 10/7/18 – 10/6/21 4/8/18 – 4/7/21 5/8/18 – 5/7/21
District 2	Jamie Banker Ratan Bhavnani Patricia Mowlavi Ezequiel Sánchez	1/8/19 – 1/7/22 2/24/19 – 2/23/22 3/14/17 – 3/14/20 6/11/19 – 9/13/19
District 3	Nancy Borchard Gane Brooking Janis Gardner Joe S. Ramirez	1/27/18 – 1/26/21 1/11/13/19 – 1/12/22 4/15/18 – 4/14/21 4/9/19 – 12/1/20
District 4	Capt. James Fryhoff Jerry M. Harris Denise Nielsen Sheri Valley	10/14/18 – 10/13/21 9/17/16 – 9/17/19 9/18/18 – 9/17/21 2/6/18 – 2/6/21
District 5	Margaret Cortese Monique Garcia Irene Pinkard Marlen Torres	1/11/18 – 1/10/21 9/24/17 – 9/23/20 1/24/17 – 1/24/20 1/10/17 – 1/10/20
Governing Body	Supervisor Linda Parks	1/1/19 – 12/31/21
Law Enforcement	Vacant	

COUNTY OF VENTURA
BEHAVIORAL HEALTH ADVISORY BOARD

MISSION

The mission of the Behavioral Health Advisory Board (BHAB) is to advocate for members of the community living with mental illness and/or substance use disorders and their families. This is accomplished through support, review and evaluation of treatment services provided and/or coordinated through the Ventura County Behavioral Health Department.

PURPOSE AND AUTHORITY

The BHAB exists under the authority of the California Legislature by its enactment of Section 5604 of the Welfare and Institutions Code as amended by SB43 (McCorquodale, Chapter 564 of 1993). The purpose of the BHAB is provided in Section 5604.1 and 5604.2 which includes, but is not limited to, the following:

- A. All appointed members to the BHAB will have the authority to vote on all issues presented to the board.
- B. Review and evaluate the community's behavioral health needs, including housing, services, facilities, and special problems to ensure that services are provided that promote wellness and recovery, improving and maintaining the health and safety of individuals, families and communities affected by mental health and/or substance abuse issues.
- C. Review mental health service performance contracts entered into pursuant to Section 5650.
- D. Advise the Board of Supervisors and the Ventura County Behavioral Health Department (VCBH) Director (herein after referred to as the Director), as to any aspect of the County's mental health and substance use disorder treatment and prevention services.
- E. Review and approve the procedures used to ensure citizen and professional involvement at all stages of the planning process.
- F. Submit an annual report to the Board of Supervisors on the needs and performance of the County's Behavioral Health system.
- G. Review and make recommendations on applicants for the appointment of the Behavioral Health Director, who also serves as the County Mental Health Director. The board shall be included in the selection process prior to the vote of the Board of Supervisors, who also serves as the County Mental Health Director.
- H. Review the impact of funding streams on the delivery of local Behavioral Health Services in order to make recommendations for any service level expansions or reductions.
- I. Review, evaluate and advise the Board of Supervisors and Director of VCBH regarding the VCBH annual budget and performance goals, as well as the VCBH Quarterly Budget and Performance Status Reports provided by the VCBH Director. Review and comment on the county's performance outcome data and communicate its findings to the California Mental Health Planning Council.

BOARD OBJECTIVES 2018-19

Adult Services Committee

1. Advocate for effective assessment and referral for individuals in crisis at the Hillmont Psychiatric Center in cooperation with local hospitals and law enforcement, with particular emphasis on developing a Crisis Stabilization Unit and increasing inpatient beds, both public and private, within the community.
2. Advocate for increased services to the older adult population.

Transitional Age Youth (TAY) Committee

Identify strategies, including advocacy, to address gaps in services for the Transitional Age Youth (TAY) population related to mental health and substance abuse treatment, housing options, work and volunteer opportunities, and the justice system.

Youth & Family Committee

Advocate for the re-creation of psychiatric hospital beds in the county for the pediatric population.

Prevention Committee

Promote cannabis education and awareness.

INTRODUCTION AND SUMMARY

The BHAB has four committees whose job it is to address issues relating to age-specific populations, collect information and data, and make recommendations to the BHAB. The committees have regular presentations from contractors, providers, stakeholders and the community at large. The committees also assess services provided in the County to these populations and identify gaps in services or programs that may be lacking and need to be addressed. The four committees are as follows:

Adult Services Committee - This committee focuses on the full continuum of care that supports the wellness and recovery of individuals with mental health and substance use disorder issues, including community supports.

Transitional Aged Youth Committee (TAY) – This committee advocates for the mental health, wellness and recovery of youth and young adults ages 16 to 25, including community supports, with the goal of empowering TAY to become healthy and productive adults.

Youth and Family Committee – This committee serves youth through age 18 by advocating for mental health and/or substance use disorders, including community supports and housing.

Prevention Committee – This committee advocates for greater community awareness of Behavioral Health risk factors for individuals with mental illness and substance use disorders, with the primary focus on preventing the onset and exacerbation of behavioral health disorders.

POINTS OF DISCUSSION

The BHAB works diligently to include a broad range of stakeholders as participants and members of each of the committees. It is important to the work of the board that community members, consumers and providers interested in advocating for Ventura County's diverse and underserved populations collaborate in ways to better serve those individuals with unique needs. The BHAB is extremely interested in the community's insight regarding perceived or real gaps in services, particularly in the areas of mental health housing, employment, legal issues, physical health, education, vocational rehabilitation, crisis intervention and evidence-based

practices. Current committee participants include BHAB members, consumers, VCBH contract providers, family members, community-based service representatives, consumers, and VCBH staff. Committees are open to all stakeholders, consumers and the community at large.

An important task of the BHAB is to review and evaluate the community's behavioral health needs and identify gaps in programs or services within the County's behavioral health system of care. BHAB members pay particular attention to this key function and direct a great deal of effort to identify unmet needs, hearing from the public, and advocating for solutions to meet these needs. Some of the most critical areas of advocacy and discussion are as follows:

- Housing for the seriously and persistently mentally ill and those suffering from substance use disorders continue to remain as an important unmet need in Ventura County.

The availability of an adequate number of psychiatric inpatient beds in Ventura County for adults is a priority in order to address the needs of the community, as are the lengthy "holds" in local and regional Emergency Departments. These have been ongoing needs for several years. The adult inpatient bed crisis can be somewhat mitigated if there were more appropriate placement options available within community hospitals and facilities for discharged inpatients. Although these would help make more beds available, it may not fully solve the problem. There remain concerns related to:

- The ongoing availability of a sufficient number and level of supportive care and placement options to address the needs of the community;
- The need for residential care for youth and adults;
- Adequate facilities and housing options for the seriously and persistently mentally ill and those suffering from substance abuse disorders;
- Housing for the Older Adult population with mental health challenges;
- A psychiatric facility to address the needs of older adults;
- Crisis residential services for youth.

BOARD PRESENTATIONS

Presentations during General Meetings are scheduled at the request of BHAB members. Presentations from providers, stakeholders, agencies and County staff are extremely important in dispensing relevant information to the BHAB and the public. Often, presentations are met with critical and/or as-yet unknown areas of concern, as was the presentation about Human Trafficking in Ventura County. Others inform the BHAB and the public about data, outcomes and funding information which may be pertinent to the goals and objectives of the BHAB and the work we do.

July 2018

Ventura County Behavioral Health (VCBH) Fiscal Update – presented by Leisa Donovan, Fiscal Manager.

August 2018

Pharmaceutical Crimes Unit – presented by Sgt. Matthew Young, Ventura County Sheriff's Office.

November 2018

Recovery – presented by Patrick Jeffries, Pacific Clinics Pasadena Peer Partner.

January 2019

Statewide Survey of Parents/Caregivers – presented by Lori Litel, Executive Director, United Parents.

February 2019

Drug Medi-Cal Organized Delivery System (DMC-ODS) – presented by Dr. Loretta Denering, Ventura County Behavioral Health Alcohol & Drug Programs Division Chief.

April 2019

Human Trafficking in Ventura County – presented by Christan Perez, Program Manager, Interface Children & Family Services, Human Trafficking Client Services.

May 2019

Laura's Law/Assist: Mid-year 3 Update – presented by Dr. John Schipper, VCBH Adult Division Chief, and Dr. Patricia Gonzalez, VCBH Project Evaluator.

June 2019

1. Vaping, VCBH's Prevention Efforts to Address New Trends – presented by Daniel Hicks, VCBH Alcohol & Drug Programs, Prevention Services Manager, and David Tovar, Office of Traffic Safety Grant Coordinator/Program Administrator;
2. VCBH Fiscal Update – presented by Leisa Donovan, VCBH Fiscal Manager.

ACHIEVEMENTS

Members of the Behavioral Health Advisory Board take our work seriously about the commitment we have made to the Board of Supervisors who appointed us and to the residents of Ventura County whom we serve. Most BHAB members have families, some with young children. Most members have fulltime employment, and some live a distance away from the VCBH offices located in Oxnard. BHAB members often use personal funds to attend relevant mental health or substance use related events, training, seminars and conferences, some of which are out of town or even out of state.

Although to be certain there is more work to be done, the BHAB is nevertheless proud of the achievements and relationships they have forged and the activities and advocacy with which they have been involved. Following is a sample:

- Collaboration with Crisis Intervention Team staff;
- Strong BHAB Committees and dedicated Committee Chairpersons;
- Presented Recognition Awards for persons who have exhibited excellence in assisting clients and others within vulnerable populations;
- Advocated for and supported the Adult Crisis Stabilization Unit (CSU), which opened in April 2019;
- Formation of the Legislative Workgroup for pertinent Mental Health and Substance Use legislative bills and laws;
- Supported and attended the NAMI Walk;
- Supported the Pinkard Youth Institute and attended the African American Youth Leadership Awards Supper and Memorial Tribute;
- Attended and participated in the VCBH External Quality Review Organization (EQRO) yearly visit, February 26-28th, 2019;
- Participated in various California Association of Local Behavioral Health Boards and Commissions (CALBHB/C) orientations, trainings and meetings.
- Participated in Mental Health Services Oversight and Accountability Commission (MHSOAC) in Sacramento.
- Participated in the Assisted Outpatient Treatment (AOT) Assist Workgroup;

- Drafted BHAB Committee Action Plans for older adults, outpatient services, inpatient services and education, pediatric psychiatric beds and communication between medical providers and children who are hospitalized, education and awareness for youth, housing options for Transitional Age Youth, and vaping and cannabis education and awareness.
- 2018 Data Notebook, focusing on a brief survey of services and system of care, was completed and submitted to the California Association of Local Behavioral Health Boards & Commissions (CALBHB/C);
- Sent a letter to the Board of Supervisors regarding the Institution for Mental Diseases (IMD) Exclusion Waiver;
- Held a Strengths, Weaknesses, Opportunities and Threats (SWOT) Analysis event focusing on the BHAB responsibilities, priorities and objectives;
- Conducted site visits to:
 - Hillmont Psychiatric Center/Inpatient Unit;
 - A New Start for Moms; this program provides substance use treatment and recovery services for mothers with young children;
 - Mental Health Rehabilitation Center (MHRC).
- Amended the BHAB Bylaws to add a new position for Law Enforcement;
- Participated in the Mental Health Services Act (MHSA) Community Needs Assessment Survey;
- Advocated for and participated in the opening of the Growing Works nursery;
- Presented the BHAB Annual Report to the Board of Supervisors;
- Presented monthly committee reports.

VCBH ACCOMPLISHMENTS

(to be added)

RECOGNITION AWARDS

September 2018

Bennie Crayton for his 44 years of service with Ventura County Behavioral Health, his advocacy for youth services, and his community-based prevention efforts.

Cpt. James Fryhoff of the Ventura County Sheriff's Office and Chief of Police for the City of Ojai, for his numerous prevention efforts centering around underage drinking and the opening of cannabis dispensaries.

Karyn Bates for her many years of service on the Mental Health Board and its successor, the Behavioral Health Advisory Board, and for providing inspiration and hope to all.

Cmdr. Ron Nelson for serving on the BHAB, chairing the Transitional Age Youth Committee, and for his passion for improving the lives of those impacted by mental illness or substance use.

October 2018

Camarillo Police Department for responding with concern, compassion and perseverance to numerous calls for services at Hillmont House Mental Health Rehabilitation Center.

November 2018

Anne Sippi facility in Bakersfield for its 40 years of providing quality mental health services and treatment to adults with serious mental illnesses.

Rhonda Fleisher for her years of service at the Ventura County Behavioral Health Older Adult Clinic, where she has transformed the lives of many clients.

Brandy Martin for her service at the Ventura County Behavioral Health Older Adult Clinic, where she engages the most resistant clients and advocates for them.

Michael White, Ventura County Behavioral Health Safety and Facilities manager, for his role during the Thomas Fire, the Borderline Bar & Grill mass shooting, and the Woolsey Fire.

January 2019

The BHAB hosted the **Crisis Intervention Team (CIT) Awards Presentation** ceremony in which four community members were recognized for regularly presenting during the CIT trainings, three Sheriff Deputies and five Officers were recognized for their compassionate interactions with clients, and one Sheriff Deputy and one Officer were announced as CIT Officers of the Year.

April 2019

Dennis Perry for planning, opening and managing the Growing Works Nursery, a therapeutic and vocational training program for clients, where he provides leadership and mentoring with compassion and patience.

May 2019

Frances O'Sullivan, M.D., for her 20 years of service with Ventura County Behavioral Health, and for treating her patients with kindness and compassion, making a positive difference in their lives.

June 2019

Pam Roach for her years of service on the Mental Health Board, including as chair, and for her work as Ventura County Behavioral Health Transformational Liaison which has helped reduce the stigma associated with mental illness.

SITE VISIT REPORTS

October 2018

Ventura County Medical Center's Inpatient Psychiatric Unit (VCMC IPU) – Several BHAB members participated in this site visit and had an overall positive impression of their visit. They recommended that the facility operate at full capacity and that the Crisis Stabilization Unit (CSU) reopen as soon as the licensing issues are resolved.

January 2019

A New Start for Moms (ANSFM) – This program provides substance use treatment and recovery services, which will be expanded under the Drug Medi-Cal Organized Delivery System (DMC-ODS). Several needs have been identified to improve the program: increasing community outreach, difficulty to drive clients living in the East county, the need for a room that can accommodate large groups, and healthy snacks for children.

February 2019

Horizon View Mental Health Rehabilitation Center (MHRC) – This locked facility appears to be well run. Staff and managers are thoughtful in the approach, and clients are involved in their treatment planning. Recommendations for improvement include providing group activities that are more robust and meaningful, and encouraging all client to engage in the activities that are available.

EXECUTIVE COMMITTEE
2018-19 Annual Report
Submitted by Janis Gardner, Chair

Executive Committee Members 2018-19

Jerry M. Harris	BHAB Chair
Ratan Bhavnani	BHAB 1 st Vice-Chair
Gane Brooking	BHAB 2 nd Vice-Chair
Janis Gardner	BHAB Secretary
Gina Petrus	Member At Large

MISSION AND OBJECTIVES

The primary responsibility of the Executive Committee is to address the administrative functions of the BHAB. In this capacity, the Executive Committee plans the agendas of the BHAB General Board Meetings. The Executive Committee may take emergency action on issues that arise between regularly scheduled monthly Board meetings when there is not time for the Board as a whole to act, as well as carry out any responsibilities delegated to it by the BHAB. Any such actions taken by the Executive Committee shall be in compliance with the Brown Act.

OVERVIEW

The Executive Committee is comprised of the Chair, 1st Vice-Chair, 2nd Vice Chair, Secretary, and a Member-at-Large designated by the Chair. The Board officers are responsible for ensuring that all actions of the BHAB are implemented as authorized by a majority of the BHAB members, and that the Bylaws are strictly adhered to. The Committee is supported by the Ventura County Behavioral Health Director, Dr. Sevet Johnson, or one of her representatives, and by a Management Assistant, Edith Pham.

In addition to planning the agendas, the Executive Committee spends a portion of its time discussing membership and attendance issues. The Executive Committee is also involved in planning and scheduling presentations for the BHAB General Board Meetings and discussing potential candidates for recognition awards.

2019-20 OBJECTIVES

The Executive Committee will continue to encourage BHAB members to identify potential candidates for consideration by members of the County Board of Supervisors for appointments to the BHAB. Executive Committee members help to bring information to the BHAB that will enable the full board to make informed decisions and make credible recommendations to the Behavioral Health Department and Board of Supervisors.

ADULT SERVICES COMMITTEE

2018-19 Annual Report

Submitted by Nancy Borchard and Gane Brooking, Co-Chairs

Committee members

Nancy Borchard, BHAB, Committee Co-Chair
Gane Brooking, BHAB, Committee Co-Chair
Jerry Harris, BHAB Chair Emeritus
Ratan Bhavnani, BHAB
Sheri Valley, BHAB
David Deutsch, Client Network
Scott Walker, Crisis Intervention Team
Barbara Keller, Housing Authority City of Ventura

Elizabeth R. Stone, MHSOAC
Bob Wickham, NAMI
Ascencion "Cici" Romero, TAY Tunnel
Cindy Doutt, Telecare
Kalie Matissek, Turning Point Foundation
Dana Secor, Turning Point Foundation
Mark Schumacher, Turning Point Foundation
Gray Wilking, Area Agency on Aging

Participants

Ventura County Behavioral Health

Ventura County Probation Agency

MISSION

The BHAB Adult Services Committee advocates for continuum of care in the development and expansion of mental health and addiction services that support the stabilization and recovery of adult and older adult clients. The Committee's monthly meetings provide a forum for discussion of current department activities regarding Adult Services as well as an opportunity for collaboration with community-based providers and stakeholders. We seek to ensure integrated services for clients seeking mental health and substance abuse services. By educating ourselves and the community, the stigma associated with mental health and substance abuse will be reduced.

2018-19 OBJECTIVES OF THE BHAB ADULT SERVICES COMMITTEE

1. Advocate for effective assessment and referral for individuals in crisis at the Hillmont Psychiatric Center in cooperation with local hospitals and law enforcement, with particular emphasis on developing a Crisis Stabilization Unit and increasing inpatient beds, both public and private, within the community.
2. Advocate for the Crisis Residential Treatment (CRT) to be used as both a crisis prevention to avoid hospitalization and as a step-down from Hillmont Psychiatric Center or other intensive service.
3. Advocate for increased services to the older adult population.
4. Participate in all efforts to establish affordable and supportive housing for individuals who live with mental health and/or substance use disorder challenges.

INTRODUCTION

The BHAB Adult Services Committee meets on the first Thursday of the month from 10:00 a.m. to 12:00 p.m. in the Ventura County Behavioral Health (VCBH) Administration building in Oxnard. Attendance, participation and membership are open to individuals who receive mental health and/or substance use services through Ventura County Behavioral Health (VCBH), to service providers, Behavioral Health Advisory Board (BHAB) members, and

anyone with an interest in the adult and older adult population. The Adult Services Committee reviews the needs, programs and services for this population and reports on these matters to the BHAB.

ACHIEVEMENTS

1. The opening of the Crisis Stabilization Unit (CSU), for which the committee had advocated.
2. Dialogued with local community hospital regarding the opening of a private CSU.
3. Advocated for the development of a Request for Proposal (RFP) for services for the older adult population.
4. Recommendation was made to Mental Health Services Act (MHSA) staff to follow up on a Request for Proposal (RFP) for older adults.
5. Advocated for increased housing for clients.
6. Expanded the representation of stakeholders on this committee.
7. Identified high priority needs and followed up by gathering information.

2018-19 PRESENTATIONS

September 2018: VCBH Office of Health Equity and Cultural Diversity, presented by Maria Hernandez.

October 2018: Coalition for Family Harmony, presented by Sandy Gomez and Cynthia Gonzalez.

February 2019: Crisis Stabilization Unit and Dignity Health, presented by Dr. Robert Streeter, St. John Regional Medical Center.

March 2019: Ventura County Area Agency on Aging, presented by Victoria Jump.

April 2019: Ventura County Crisis Stabilization Unit Update, presented by Dan Powell and Sheri Block.

June 2019: Housing Update, presented by Susan White Wood.

CHALLENGES

1. There is an insufficient number of psychiatric inpatient beds to address Ventura County's needs.
2. Lack of affordable housing options and the high cost of housing in Ventura county.
3. Severe lack of housing options for those with no or little income.
4. The high cost of the Inpatient Unit placements for those who have both mental and developmental challenges.
5. Underutilization of peers in a broader manner within Ventura County's Behavioral Health System of Care added to a limited number of peer programs providing peer support.
6. Gaps in access to certain services that cause clients to be placed out of county. These include: (A) lack of affordable housing; (B) lack of secure supportive housing for individuals who are not currently capable of standing trial; (C) lack of integrated mental and physical health facilities; (D) lack of older adult inpatient psychiatric beds; (E) lack of adult inpatient psychiatric hospital beds.
7. Lack of treatment facilities for those with substance use disorders as well as funding to support this type of treatment.

OPPORTUNITIES

1. Become more involved in advocating for housing, particularly for those with mental health and substance use disorders.
2. Begin the process to address the needs of the projected surge in the older adult population.
3. Monitor MHSA programs in Ventura County to ensure that they address the needs of individuals with Serious and Persistent Mental Illness (SPMI).

4. Determine how peer support is functioning within the Ventura County System of Care; is it increasing; are individuals with lived experience being utilized to their full potential; advocate for the expansion of peer support services in the East County.

RECOMMENDATIONS

1. Continue to closely monitor how MHSAs funds are used and how they address the identified needs of the County's SPMI population.
2. Focus on how crisis situations are being handled within the County.
3. Continue efforts to streamline the process reducing the time from referral/scheduling an appointment to receipt of service.
4. Determine whether the Screening, Triage, Assessment and Referral (STAR) method is the most efficient and best approach to quickly access services.
5. Ensure that Peer Support services are used to run Wellness, Recovery and Action Plan (WRAP) classes and to best help assist clinicians and staff.

2019-20 OBJECTIVES OF THE BHAB ADULT SERVICES COMMITTEE

1. Advocate for the expansion of the Crisis Stabilization Unit (CSU) at the Hillmont Psychiatric Hospital to the maximum approved number of chairs (12) including the capability of conducting medical clearance examinations on-site.
2. Advocate for the reactivation of the 12 inpatient beds at the Hillmont Psychiatric Hospital currently not in use.
3. Advocate for the Crisis Residential Treatment (CRT) facility to be used for both a crisis prevention unit to avoid hospitalizations and as a step-down from Hillmont Psychiatric Hospital or other intensive service.
4. Advocate for the development of a CSU supported by one of the community hospitals in Ventura County.
5. Advocate for access to increased inpatient, community-based and in-home services to the older adult population.
6. Participate in all efforts to establish affordable and supportive housing for individuals who live with mental health and/or substance use disorder challenges that includes additional VCBH staff to provide supportive services associated with No Place Like Home and other potential supportive housing developments.

TRANSITIONAL AGE YOUTH (TAY) COMMITTEE

2018-19 Annual Report

Submitted by Margaret Cortese, Chair

Committee members

Margaret Cortese, Committee Chair

Ratan Bhavnani, BHAB

Jerry Harris, BHAB

Joe S. Ramirez, BHAB

Ezequiel A. Sánchez, BHAB

Anna Guerin, Casa Pacifica

Laura Estrada, Children and Family Services

Diana Hernandez, Client Network

Stuart Fiedler, Client Network

Erin Locklear, Interface

Georgia Perry, NAMI

Anthony Marron, TAY Tunnel

Cathi Nye, Ventura County Office of Education

Lorena Güereca, Vista Real Charter High School

Participants

Ventura County Behavioral Health

Department of Rehabilitation

MISSION

The BHAB TAY Committee promotes effective mental health and substance use disorder services, wellness and recovery for youth ages 16 through 25. The committee focuses on these youth in their efforts to become healthy and productive adults.

2018-19 OBJECTIVES OF THE BHAB TAY COMMITTEE

1. Continue to encourage increased participation of community partners serving TAY in the BHAB TAY meetings.
2. Advocate for increased housing options for TAY. Update the housing opportunity brochure.
3. Advocate for and update availability of TAY services related to work and volunteer opportunities and justice system. Identify strategies, including advocacy, to address gaps in services for the TAY population related to mental health and substance abuse treatment, work and volunteer opportunities, and the child welfare and justice systems.
4. Increase community outreach, especially to underserved community, and improve communication among parents, clients, agencies and the Committee.
5. Keep the Behavioral Health Advisory Board (BHAB) members informed on matters pertaining to the needs of the TAY Community. Make recommendations to the BHAB as appropriate.
6. Provide committee level work for the TAY community at the direction of the Behavioral Health Advisory Board.

INTRODUCTION

The BHAB TAY Committee meets on the fourth Thursday of the month from 10:30 a.m. to noon at the Ventura County Behavioral Health Administration building in Oxnard. Attendance and participation are open to Transitional Age Youth and their families, service providers, Behavioral Health Advisory Board (BHAB) members, and anyone with an interest in the TAY community. The TAY Committee is responsible to look into the needs, programs and services for the TAY population and to report on these matters to the BHAB. The committee also receives direction from the BHAB to research issues that come to the attention of the BHAB on matters related to the TAY population.

ACHIEVEMENTS

1. Increased the number of community partners who regularly participate in the committee meetings.
2. Increased employment opportunities for the TAY population through PathPoint and the Department of Rehabilitation.
3. Increased community outreach. Interface has increased its street outreach through Continuum of Care (CoC) funding. Pacific Clinics TAY Tunnel held open house events and participated in various health and wellness fairs. VCBH Logrando Bienestar outreached to the schools.
4. Provided regular updates on the work of the committee to the Behavioral Health Advisory Board.

2018-19 PRESENTATIONS

September 2018: September is Recovery Month, presented by Patrick Jeffries, Pacific Clinics.

February 2019: Court-Appointed Special Advocate (CASA), presented by Teresa Romney and Michelle Morgan.

April 2019: Screening, Triage, Assessment, Referral (STAR), presented by Julie Glantz and Ana Magbitang, VCBH.

June 2019: TAY Rise Expansion, presented by Felicia Skaggs.

CHALLENGES

1. Housing is the most important challenge.
2. There is a growing need to communicate with Indigenous-language speakers, whether Mixteco or Zapotec, especially in Oxnard.
3. Continue regular attendance from committee members.
4. Make an impact on helping people with legal issues
5. Increase the advocacy to the BHAB.

OPPORTUNITIES

1. Request presentations from Mixteco/Indigena Community Organizing Project (MICOP) and the Oxnard Police Department Clergy Council.

RECOMMENDATIONS

1. Encourage the ongoing participation of agencies/staff working on housing issues.

2019-20 OBJECTIVES OF THE BHAB TAY COMMITTEE

1. Advocate for increased housing options for TAY.
2. Review the needs of the TAY population. Develop and prioritize strategies to address service needs for the TAY population relative to mental health and substance abuse treatment.
3. Encourage increased participation of community partners serving TAY in the BHAB TAY Committee meetings.
4. Develop approaches to increase community outreach, especially to underserved communities. Improve communication among parents, clients, agencies and the TAY Committee.
5. Engage TAY population membership on this committee.

YOUTH & FAMILY COMMITTEE

2018-19 Annual Report

Submitted by Denise Nielsen, Chair

Committee members

Denise Nielsen, Committee Chair

Jamie Banker, BHAB

Irene Pinkard, BHAB

Gina Petrus, BHAB

Marlen Torres, BHAB

Martie Miles, Aspiranet

Marika Collins, Casa Pacifica

Ken McDermott, Children's Family Services

Heather Davidson, First 5 Ventura County

Joelle Vessels, Interface

Crystal Cummings, Kids & Families Together

Scott Abeson, Ventura County Probation

Laurie Jordan, Rainbow Connection

Carole Shelton, Rainbow Connection

Yanka Ricklefts, SELPA

Tyler Baker-Wilkinson, Seneca

Ariann Bulger, Seneca

Dr. Steven Graff, Tri-Counties Regional Center

Lori Litel, United Parents

Danielle Shaw, M.D.

Participants

Ventura County Behavioral Health

Scott Walker, Crisis Intervention Team

MISSION

The BHAB Youth & Family Committee advocates for the continuum of care and development in the delivery of services for youth and their families, believing that addressing the unique needs of minors and their caregivers is essential to the health of the community.

2018-19 OBJECTIVES OF THE BHAB YOUTH & FAMILY COMMITTEE

1. Continuum of Care

- a. Follow and evaluate the implementation of the Continuum of Care Reform (CCR). Identify further needs or gaps in services to children in foster care.
- b. Monitor the Crisis Stabilization Unit. Identify remaining gaps in the continuum of crisis services for both children covered by Medi-Cal and children with private insurance.
- c. Advocate for the availability of psychiatric hospital beds in the county for the pediatric population. Ensure communication and care coordination of medical information between care providers.

2. Community and Parent Outreach

- a. Engage community agencies to schedule presentations regarding the role and activities of this Committee.
- b. Recruit community members to serve on the Committee, and inform families about mental health services available.
- c. Create innovative strategies to learn about parents/caregivers' needs and concerns.
- d. Raise awareness of alcohol and drug use information. Actively disseminate alcohol and drug use prevention information to the community partners, including community-based organizations (CBOs), law enforcement, and school districts.
- e. Maintain the availability of relevant materials on the Ventura County Behavioral Health's [wellnesseveryday/saludsiempre](#) website.
- f. Continue to oversee the development of the family resource app.

- g. Raise awareness of services for children ages 0-5 and access to those services.

INTRODUCTION

The BHAB Youth & Family Committee meets on the second Wednesday of the month from 10:00 to noon at the Ventura County Behavioral Health Administration building in Oxnard. Attendance and participation are open to the families of youth receiving mental health services from Ventura County Behavioral Health, service providers, Behavioral Health Advisory Board (BHAB) members, and anyone with an interest in the children and youth residing in Ventura County. The Youth and Family Committee is responsible to look into the needs, programs and services for children and youth, and to report to the BHAB on these matters.

ACHIEVEMENTS

1. The committee received regular updates on the Continuum of Care Reform (CCR), its successes and challenges.
2. The number of children and youth placed outside the home, either in foster care or Juvenile Justice, has been reduced thanks to early intervention and Trauma-Informed Care.
3. The Children's Crisis Stabilization Unit has prevented the hospitalization of about half the children and youth who were assessed. The CSU is often running at capacity. CSU staff provided information on its services and how to access them.
4. The reopening of Vista del Mar Psychiatric Hospital has been helpful for youth ages 12 to 17.
5. The need for hospitalization of children ages 0 to 5 has been reduced thanks to staff awareness and education.
6. VCBH and providers provided outreach and engagement in psychoeducation to help parents learn to describe what their children are experiencing and to help reduce stigma.
7. Dr. Shaw and Dr. Acosta reached out to primary care physicians (PCPs) to increase their awareness of the mental health services available. Dr. Shaw planned to provide a training on collaborative care to empower PCPs.
8. The Safety Plan was updated/revised.
9. Support was provided to the community following the Borderline shooting and Woolsey Fire.
10. Ongoing collaboration between various agencies and VCBH continues to improve the services available.
11. The committee was instrumental in the development of an eating disorders program within the VCBH Youth & Family clinics.
12. The continuum of crisis care has been strengthened.

2018-19 PRESENTATIONS

September 2018: Youth and Cannabis, presented by Dan Hicks and David Tovar, VCBH Alcohol & Drug Program.

October 2018: Results of the Parent/Caregiver Survey, presented by Lori Litel, United Parents.

April 2019: Commercial Sexual Exploitation of Children (CSEC), presented by Lydia Lopez and Jessica Valenzuela, Health Care Agency READY Program.

May 2019: Mental Health Services Act (MHSA)-funded Youth & Family Programs, presented by Clara Barron.

June 2019: Gold Coast Health Plan and Beacon Health Options, presented by Jennifer Claros and Elizabeth Theis.

CHALLENGES

1. Barriers exist in the process of placing youth coming from outside Ventura County.
2. Additional foster families are needed.

3. Reunification for children and youth in foster care or group homes is problematic.
4. Respite care for parents and caregivers is desperately needed.
5. A Children's CSU is needed in the East County.
6. Law enforcement and clinicians in private practice need to be educated about the Children's CSU, a more appropriate resource than the local emergency department for children and youth in crisis.
7. Increasing the number of parent partners is needed.
8. There is a lack of communication with the local private psychiatric hospital and with out-of-county hospitals.

OPPORTUNITIES

1. Funding will become available during the next couple of years to implement new Mental Health Services Act (MHSA) Innovations projects.
2. A psychiatrist working with VCBH has moved and is now working at Vista del Mar Psychiatric Hospital in Ventura. It is anticipated that this move will help strengthen the communication between psychiatrists and clinicians in various settings.

RECOMMENDATIONS

1. Continue to work toward developing an Innovation project that focuses on children ages 0-5.
2. Design an Innovation project focusing on identifying the early signs of possible mental illness in its early stages.
3. Consider implementing a tool for threat assessment on school campus that is applicable to students and adults alike and standardized across school campuses and law enforcement agencies.

2019-20 OBJECTIVES OF THE BHAB YOUTH & FAMILY COMMITTEE

1. **Continuum of Care**
 - a. Follow the implementation of the Continuum of Care Reform (CCR). Identify further needs or gaps in services to children in foster care.
 - b. Follow the continuum of crisis care for children covered by Medi-Cal and children with private insurance. Provide feedback to the Behavioral Health Advisory Board (BHAB), Ventura County Behavioral Health (VCBH) and community providers.
 - c. Ensure communication and care coordination of health record information between care providers.
2. **Community and Parent Outreach**
 - a. Engage community agencies to schedule presentations regarding the role and activities of this Committee.
 - b. Recruit community members to serve on the Committee, and inform families about mental health services available.
 - c. Create innovative strategies to learn about parents/caregivers' needs and concerns.
 - d. Raise awareness of alcohol and substance use resources. Actively disseminate alcohol and substance use prevention resources to the community partners, including community-based organizations (CBOs), law enforcement, and school districts.
 - e. Maintain the availability of relevant materials on the Ventura County Behavioral Health's wellesseveryday.com website.
 - f. Continue to explore the use of technology to enhance access to services and resources.
 - g. Identify and address system barriers for access to service needs for children ages 0-5. Advocate for improvement in the continuum of services.

PREVENTION COMMITTEE
2018-2019 Annual Report
Submitted by Janis Gardner, Chair

Prevention Committee members

Janis Gardner, Committee Chair
Captain James Fryhoff, BHAB Member
Claudia Armann, BHAB Member
Ezequiel A. Sanchez, BHAB Member
Gane Brooking, BHAB Member
Marlen Torres, BHAB Member
Mary Haffner, BHAB Member
Patricia Mowlavi, BHAB Member
Maya Lazos, Vista del Mar Hospital

Diana Hernandez, The Client Network
Gabe Teran, Ventura County Office of Education
Katherine Kasmir, Straight Up
Lori Litel, United Parents
Natalie Gabrie, Aegis
Rachel McDuffee, Aegis
Stephanie Fournoy, Interface Children & Family Services
Vanessa Alva, Straight Up
Yaakov Cahnman, Saving Lives Camarillo

Participants

Casa Pacifica
Community Coalition United
Conejo Valley Unified School District
MICOP
Pacific Clinics TAY Tunnel

Ventura County Behavioral Health
Ventura County Probation
Ventura County Public Health
Ventura County Sheriff's Office, Crisis Intervention Team (C.I.T.)

MISSION

To promote measures that prevent mental illness and/or substance use issues from becoming destabilizing components in the lives of Ventura County residents. Our aim is to collaborate and help support education, prevention and early intervention efforts with particular emphasis on community health, engagement and the interaction of mental health and substance use challenges.

2018-19 OBJECTIVES OF THE BHAB PREVENTION COMMITTEE

- 1) Support and collaborate with VCBH and the BHAB in helping to prevent the onset of substance use and mental illness amongst multi-generational populations.
- 2) To promote vaping and cannabis education and awareness.

INTRODUCTION

Participating members in the Prevention Committee include individuals who have an interest in helping to mitigate mental illness and substance use challenges for adults, transitional aged youth and children who reside in Ventura County. Its membership and partners include persons from various entities around Ventura County, including, but not limited to, persons from multiple county agencies, stakeholders, contract providers, VCBH staff, health care professionals, law enforcement and consumers.

Chaired by an appointed BHAB member and reporting directly to the BHAB, this committee shall advocate for greater community awareness of behavioral health risks for individuals with mental illness, a dual diagnosis, or substance use disorder and shall: (1) Monitor and advise VCBH regarding its efforts to prevent the onset and exacerbation of behavioral health disorders; (2) Comply with the requirements of the Brown Act.

ACHIEVEMENTS

- 1) This past year, the BHAB Prevention Committee has added numerous new stakeholders, a Sheriff's Captain, community participants and providers from various entities throughout Ventura County. These new members have proved to be valued members of the committee.
- 2) The Ventura County BHAB Prevention Committee has supported, collaborated and advocated for information on topics within the scope of Cannabis Education and Awareness for Youth, MHSA, Mental Health Prevention, Early Intervention, and Alcohol and Drug Substance Abuse concerns.
- 3) The BHAB Prevention Committee, stakeholders and staff attendees have shared information on prevention efforts within Ventura County concerning Mental Illness, Opioid use, E-Cigarette usage, Youth Cannabis usage, Suicide prevention and Vaping .
- 4) BHAB Prevention Committee members' attendance at various events have included Cannabis Prevention Awareness presentations, Opioid and Marijuana conferences, Suicide Prevention Conferences and meetings and MHSA Stakeholders Committees and conferences.
- 5) Prevention committee members have attended local NAMI events (National Alliance for Mental Illness); events related to the LGBTQ population; events with Rainbow Umbrella; ADP Prevention Services contractor meetings, and Straight Up's local "Reality Parties for Parents," (both in English & Spanish), and have participated in CAUSE events and meetings.
- 6) The BHAB Prevention Chairperson attended the National Rx and Heroin Convention in Atlanta, Georgia, the Statewide Substance Abuse conference, the Suicide Prevention Conference and numerous other meetings, conferences and summits throughout the year.
- 7) The BHAB Prevention Committee has advocated for cannabis awareness and education for youth, Transitional Aged Youth, and for cannabis awareness programs within VCBH and in collaboration with other stakeholders.
- 8) The BHAB Prevention Committee has advocated for prevention efforts in the Latino community and for others in disadvantaged populations.
- 9) BHAB Prevention Committee members have pooled resources with members of the Rx Opioid and Heroin Workgroup concerning the workgroup's outreach efforts on the Opioid crisis, Fentanyl and E-Cigarette youth usage.
- 10) The BHAB Prevention Committee has supported efforts for MHSA 's regional Needs Assessment, that gathered information from VC Public Health, VC Behavioral Health, the community, stakeholders and VC School Districts.
- 11) BHAB Prevention Committee members attended the NAMI Walk and several NAMI conferences. The BHAB Prevention Committee advocated for efforts for the LGBTQ+ population and attended events and LGBTQ+ local conferences.
- 12) The VC BHAB Prevention Committee advocated for prevention efforts surrounding the Human Trafficking problem in Ventura County.

13) The BHAB Prevention Committee members, stakeholders and providers advocated for and supported the “No O.D.” program, DUI –Impaired Driving efforts, Drug Disposal efforts, The Ventura County Office of Education Youth Prevention efforts, Latino Outreach efforts, MHSA-PE & I Mental Health efforts and Law Enforcement’s prevention efforts throughout the county.

2018-19 PRESENTATIONS

The BHAB Prevention Committee Presentations are carefully selected. ADP Prevention Services and MHSA/Mental Health Prevention and Early Intervention topics and those of related partners are given the opportunity to give a monthly presentation. These presentations allow the BHAB Prevention Committee to learn about and oftentimes collaborate, concerning current research, educational opportunities and trends within the Ventura County community. The BHAB Prevention Committee meeting attendees share community campaign projects and resources with each other. They, in turn, bring relevant information to their staff, clients and various agencies who can further disseminate this information throughout Ventura County and the Community-At- Large.

August 2018: “Opioid & Cannabis Efforts Update,” presented by Dan Hicks, Manager, Ventura County Behavioral Health ADP Prevention Services.

September 2018: “VCOE: Suicide Prevention Efforts,” presented by Hunter Poulson, Ventura County Office of Education.

October 2018: “Environmental Prevention through Youth Engagement,” presented by Katherine Kasmir, Executive Director, Straight Up.

November 2018: “Pacific Clinics TAY Tunnel 2018” presented by Jennifer Goble, Program Director, and, Anthony Marron, Recovery Specialist, Pacific Clinics TAY Tunnel.

January 2019: “Juvenile Probation Services,” presented by Crystal Davis, Division Manager, Ventura County Probation Services.

February 2019: “The Great Vape Escape,” presented by Dan Hicks, Manager, Ventura County Behavioral Health, Alcohol & Drug Programs, Prevention Services.

March 2019: “Integrated Prevention: Cannabis Dispensaries and City Policies,” presented by Captain James Fryhoff, Ventura County Sheriff’s Office & Chief of Police for the City of Ojai.

April 2019: “Latest Trends from the California Healthy Kids Survey,” presented by Dr. Heidi Christensen, Ventura County Office of Education.

May 2019: “Highlights from the Rx Summit in Atlanta,” presented by Dan Hicks, Manager, and David Tovar, Office of Traffic Safety Grant Coordinator, Ventura County Behavioral Health, Alcohol & Drug Programs Prevention Services.

June 2019: Student Video Presentations presented by Gabe Teran, Operations Specialist for Youth Development, Friday Night Live, and, Katherine Kasmir, Executive Director, Reality Improv Connection, Inc. dba “Straight Up,” which included: “Choose Your Own Path,” by Middle School students from Juan Lagunas Soria School; “Stickman’s Beer,” created by students from Oxnard Middle College High School (OMCHS); “Incarcerated,” by a student from Providence High School; “Teen Depression,” by a student, Caroline M., from

Vista Real High School; "Pretty Brown Eyes," by Pacifica High School students; and, "Just one Puff?" by Hillside Middle School students.

CHALLENGES

The Prevention Committee acknowledges the following Challenges within Ventura County as related to community needs within the scope of Alcohol & Drug related Prevention Services and MHSA's Mental Health Prevention and Early Intervention. Challenges are as follow:

- Concerns about increased access to highly potent opiates such as Fentanyl within Ventura County.
- Piecing together funding from various sources to purchase Naloxone for the VCBH ADP Prevention Services Overdose Prevention Project.
- There needs to be an increase in access to prevention services that serve indicated, higher risk populations.
- The impact of broader availability and normalization of cannabis for youth and young adults.
- Implementation of ordinances and guidelines regarding cannabis sales.
- Ordinances and guidelines regarding youth vaping and vape products.
- Suicide Prevention outreach for older adults, men and youth.
- Address emerging issues related to the cultivation of Hemp in Ventura County
- Odor mitigation regarding Hemp fields which may trigger cannabis cravings or use for Tay and other Ventura County residents due to environmental challenges.

RECOMMENDATIONS

- Advocate and support mental health and substance use prevention and early intervention programs, including those in collaboration with providers and contractors.
- Help educate and inform the Board of Supervisors, VCBH staff, other agencies, and the public, on the negative impacts of alcohol and drug abuse.
- Advocate for policy prevention efforts around vaping products for youth and older adults.
- Advocate and support outreach efforts concerning cannabis and the potential harmful effects on youth's still developing teen brains with consistent cannabis usage.
- Increase the number of Prevention Committee members including persons in the community, stakeholders, providers and contractors.
- Search for gaps and needs in services in both mental health and substance use where no prevention methods or programs currently exist.
- Advocate for prevention efforts concerning suicide prevention and mental health challenges.
- Promote education for raising awareness of the negative impacts of Fentanyl and opioid usage.
- Develop a troupe of spokespersons to engage older adults
- Increase services and businesses at Hillmont, St. Johns, and other private hospitals and entities to adopt public and private Mental Health In-Patient and Crisis Stabilization services at these sites.

2019-20 OBJECTIVES OF THE BHAB PREVENTION COMMITTEE

1. Support and collaborate with VCBH and the BHAB in helping to prevent the onset of substance use and mental illness amongst multi-generational populations.
2. Promote vaping and cannabis education and awareness, and advocate for banning flavored vaping products.

BEHAVIORAL HEALTH ADVISORY BOARD OBJECTIVES FY 2019-20

Adult Services Committee

Advocate for the expansion of the Crisis Stabilization Unit (CSU) at the Hillmont Psychiatric Hospital to the maximum approved number of chairs (12) including the capability of conducting medical screening examinations on-site, and for the reactivation of the 12 inpatient beds currently not in use.

Transitional Age Youth (TAY) Committee

Advocate for increased housing options for TAY.

Youth & Family Committee

Follow the continuum of crisis care for children covered by Medi-Cal and children with private insurance. Provide feedback to the Behavioral Health Advisory Board (BHAB), Ventura County Behavioral Health (VCBH) and community providers.

Prevention Committee

Promote vaping and cannabis education and awareness, and advocate for banning flavored vaping products.

Behavioral Health Advisory Board Site Visit Report

Date: Aug 17, 2018

Facility / Program: Hillmont Psychiatric Center (IPU)

Location: 200 Hillmont Ave., Ventura, CA 93003

Contact Person: Dan Powell

Phone #: (805) 652-6002

E-mail: daniel.powell@ventura.org

BHAB Review Team:

Ratan Bhavnani, Gane Brooking, Kevin Clerici, Gina Petrus

FACILITY / PROGRAM DEMOGRAPHICS

1. Age Group Served: (Check all that apply)

Children (0 - 12) Adolescents (13 - 17) TAY (18 - 25) Adults (18 - 61) Older Adults (60 +)

2. Number of Clients Served:

Maximum possible: IPU 30 Monthly Avg. 110-150 and / or Daily Avg. 28

3. Services Provided: (i.e.: Counseling, Therapy, Medication management, Nursing, etc.)?

Medication Management, Nursing, Individual Psychotherapy, Occupational Therapy, Medication Education, Chemical Dependency and Addiction Counseling, Mind-fullness Meditation Groups, Group Psychotherapy, exercise groups.

4. Miscellaneous Additional Services: (i.e.: transportation, follow-up care, community activities or support, etc.)?

Follow up care appointments made for patients prior to discharge (psychiatrist, psychologist, therapist) Placement, mental health court, conservatorships, referrals.

5. Number of on-site staff having direct client contact:

Approximately 20-25 staff members per shift.

6. What kind of training does your organization provide the staff, and how often?

Required competencies consisting of training on mental health diagnosis, personality disorders, signs of suicide, Medical Screening Exams, Basic and Advanced Life Support.
VCMC required trainings (via Target Solutions, 1:1 instruction and classroom training).

7. Which professionals are involved directly with clients (i.e. Psychiatrist, Psychologist, MFT, ADT, LCSW, Nurse) and how often?

1. Psychiatrist – 1 in OPOS from 7:00 am to 11:00pm each day (7 days a week)
2. Psychiatrists – 2 in the IPU from 8:00am to 6:00 pm each day (7 days a week)
3. Social Worker- 2 licensed and 2 unlicensed
4. Mental Health Worker - 1 Monday-Friday
5. Registered Nurses - approx. 8 RN's, (2 in OPOS and approx. 4 in the IPU) 24/7 working 12 hour shifts.
6. Licensed Psych Techs - 2 LPTs, 24/7 working 12 hour shifts
7. Health Techs - 2 HTs, 24/7 working 12 hour shifts
8. Mental Health Supervisor – IPU, MFT, BCBA Monday-Friday and on call 24/7 each day.
9. Clinical Nurse Manager – Monday-Friday
10. Addiction Counselor - Monday-Friday
11. RISE Team - (Currently hiring for).
12. Occupational Therapist and Recreational Therapist - Each day.

8. Are peer support specialists/individuals in recovery utilized to support your clients? How many and how often? Are family members involved? How?

Peer support specialists are invited upon patient's request.
Family members are involved upon patient's request regarding placement decisions and aftercare plans.

9. Describe Groups - education/support?

Alcohol and chemical dependency groups, Occupational Therapy groups, Group psychotherapy. Groups are structured according to patient's needs and presenting symptoms.

10. Facility/Program Physical Layout (i.e. indoor rooms, outdoor areas, recreational areas)? (Attach floor plan if available)

Licensed 43 bed facility. Currently 30 patient beds available, Occupational therapy room, Two community day rooms, outdoor basketball court and patio area. OPOS is able to accept 4-12 patients at a time, perform mental health triage and immediate psychiatric needs.

BHAB Reviewer Response

What do clients typically do during the day (i.e. work, attend programs)?

This is an acute care facility, and no requirements are placed on clients.
The average length of stay varies from 6 to 8 days.
Groups are available at scheduled hours.
Some clients were seen walking the hallways. We were told that staff manage the patients and space while groups are being offered so that patients don't retreat to watching TV at that time.

Staff identified program needs ?

The Inpatient Psychiatric Unit (IPU) is almost always full, with 30 beds.

The former Admissions & Referral (A&R) unit was shut down in anticipation of a Crisis Stabilization Unit (CSU) in early 2017, but the licensing authority, California Department of Public Health (CDPH) appears to have rejected that application.

In the interim, a 12-bed OutPatient Observation Service (OPOS) was established. This unit accepts patients after medical screening, for up to 23 hours.

Staff are expecting to have the CSU license approved. This will allow clients to enter and be evaluated by a psychiatrist; if appropriate they will be admitted to the IPU. Others may receive short term treatment or care, they must be discharged within the 23 hour maximum period permitted for a CSU.

In addition, staff are hopeful of restoring all available licensed IPU beds, a total of 43 beds.

Overall Impression or Brief Summary (key points, including appearance of clients and facility)?

POSITIVE IMPRESSIONS:

- Impressed with the number of patients who were actively participating in the group that was going on at the time of our visit. Suggests that the program really tries to engage patients and values the importance of their participation in programming.
- Programming is flexible and not a "one size fits all" clinical approach. The type of groups/treatment approach depends on the needs of the client.
- Efforts are being made to make the atmosphere more pleasant. The art murals, painted by college students, are a step in the right direction. Although safety needs are of paramount importance, there may be additional things that can make the units more aesthetically appealing.
- Staff was friendly and had a high level of engagement with patients on the unit.

NEGATIVE IMPRESSIONS:

- The glass barrier between the unit and the nursing station may give patients an impression of "us" and "them", conveying the message to patients that they are not people in need of healing but dangerous people who must be kept at bay. Studies have shown that a more open layout actually decreases the risk of aggressive or violent behavior and creates a more therapeutic environment.

Board Member Recommendations for Program Needs?

The team conducting the site visit concur that we need to express our support for the Crisis Stabilization Unit, and to offer any support to expedite its licensing and opening.

Recommend that the hospital increase staffing as soon as possible to be able to operate at the full licensed capacity of 43 beds.

Behavioral Health Advisory Board Site Visit Report

Date: 11/13/2018

Facility / Program: A New Start for Moms (ANSFM)

Location: 1911 Williams Dr Oxnard

Contact Person: Jonathan Eymann

Phone #: (805) 981-9204

E-mail: jonathan.eymann@ventura.org

BHAB Review Team:

Jamie Banker and Patricia Mowlavi

FACILITY / PROGRAM DEMOGRAPHICS

1. Age Group Served: (Check all that apply)

Children (0 - 12) Adolescents (13 - 17) TAY (18 - 25) Adults (18 - 61) Older Adults (60 +)

2. Number of Clients Served:

Maximum possible: 105 (165 fl stf) Monthly Avg. 85 (110) and / or Daily Avg. _____

3. Services Provided: (i.e.: Counseling, Therapy, Medication management, Nursing, etc.)?

Group counseling and Individual sessions focusing on Substance Use Treatment and recovery; Individual Therapy and Psychiatric services for co-occurring mental health disorders ; TB, HIV and health screening; Parenting education; Trauma Informed care.

4. Miscellaneous Additional Services: (i.e.: transportation, follow-up care, community activities or support, etc.)?

Transportation; Child Care;

5. Number of on-site staff having direct client contact:

14 positions, (including embedded MH staff who are mental health division employees). Currently we have one on LOA and one vacant position.

6. What kind of training does your organization provide the staff, and how often?

Federal, State and County mandated trainings on policy and procedures, key concerns like confidentiality, 42CFR 2. Treatment issues such as suicidality, the opioid epidemic, trauma informed care, motivational interviewing, CBT, cultural competence, etc. Some classes target the entire staff and others are voluntary, or are assigned only to specific job classes as needed. Staff typically averages perhaps 4 hours a month of training outside of the clinic and 4 hours a month of in-clinic or on-line training.

7. Which professionals are involved directly with clients (i.e. Psychiatrist, Psychologist, MFT, ADT, LCSW, Nurse) and how often?

Psychiatrist on site one day per week, Psychologist 3 staff-days per week, MFT 2 full time, ADT 4 full time positions (one currently vacant, one on LOA), Community Service Workers 3 FT staff, Nurse once per month, HIV educator once per month.

8. Are peer support specialists/individuals in recovery utilized to support your clients? How many and how often? Are family members involved? How?

Not in the program itself. All clients are referred to social supports such as AA/NA. Some client's children are involved in the Mindful Parenting program one group session per week.

9. Describe Groups - education/support?

The groups all serve both functions, facilitating peer support while educating client in recovery, relapse prevention, parenting and, as needed, recovery from trauma, parenting, anger management and developing secure attachments.

10. Facility/Program Physical Layout (i.e. indoor rooms, outdoor areas, recreational areas)? (Attach floor plan if available)

Indoor rooms.

BHAB Reviewer Response

What do clients typically do during the day (i.e. work, attend programs)?

Note: Regarding abbreviation in #2. Number of Clients Served. 105 or (165 fully staffed).

Clients attend group sessions at A New Start for Moms (ANSFM) site. Sessions are offered in the morning and/or afternoon on Mondays, Wednesdays and Thursdays. A Mindful Parenting group session is offered on Tuesdays. Treatment is offered by child developmental cohort.

Clients can take their own transportation to A New Start for Moms or they can arrange to be picked up. Three vehicles driven by Community Services Workers, leave to pick up clients throughout Ventura County at 7:30 and arrive at ANSFM before the group sessions start. In order to receive Medi-Cal reimbursement, clients must attend the entire 90 minute group session.

Morning sessions 9:00 - 10:30
Afternoon sessions 2:00 - 3:30

Group size is approximately 6 - 8 clients and can go to 12 maximum (per Medi-Cal group size limit). There is currently no wait list.

While the moms are in group session, the children are being watched by the Community Service Workers. After the group sessions, the drivers return clients to their homes.

Currently clients access services by going to an orientation and a formal assessment (American Society of Addiction Medicine) where the level of care is determined. If the level of care assessment meets state and federal requirements for a perinatal program, clients can access ANSFM. Individuals are referred, as the ASAM assessment indicates, to residential, intensive outpatient treatment or immediate hospitalization. The individual can refuse service or elect a lower level of care. ANSFM helps to coordinate and refer for Mental Health treatment, which is offered through VCBH and co-located at the same facility.

Supplemental services are offered on site and include: perinatal and parenting education, HIV/STD information and testing, nutritional counseling, physical health nurse for health screening and birth control, testing for Child and Family Services to help regain custody.

Clients typically seek services at ANSFM for around 6 months to a year. Clients who have not been seen get reminders at 20 days. If not seen after 30 days, the case is closed and the client would need to re-enter the program. There are no barriers to return to treatment.

Staff identified program needs ?

Funding and staffing are concerns. The Drug Medi-Cal Organized Delivery System Waiver, which goes into effect on 12/1/18 may help cover additional services. Current staff is filling gaps for unfilled positions and those on leave of absence.

Currently program is not at capacity. Clients are referred from child and family services, public health, alcohol and drug clinics, STAR program or clients can walk in.

ANSFM is not able to provide transportation for Simi Valley residents due to traffic congestion and logistics.

Larger meeting room is needed to comfortably accommodate 12 group member sessions.

Looking for non government funding source in order to continue to provide healthy snacks for the children.

Gifts for annual holiday event.

Overall Impression or Brief Summary (key points, including appearance of clients and facility)?

A New Start for Moms' goal is to remove barriers. A client that we spoke with had worked with many of the staff and 'loved the program'. She indicated that she learns something from each of the staff and was so enthusiastic that she recommends A New Start for Moms to others. The staff is friendly and busy. The psychiatrist was on site reviewing files, during our visit.

The facility is clean and welcoming. There is laundry on site to maintain cleanliness.

Regular case conference meetings are held and the treatment plans are reviewed by the treatment team.

Average time from orientation to assessment is around 7 - 10 days. The shift to Drug Medi-Cal Organized Delivery System Waiver, which goes into effect on 12/1/18, is expected to reduce the turnaround time from initial assessment to treatment plan. The waiver will also provide increased funding. Under the current system if group sessions are less than 90 minutes, they are not reimbursed by Medi-Cal (e.g. late arrival of client or fire drill). The waiver will allow for billing by the minute rather than 90 minute block of service. The waiver will also allow payment for individual sessions, counseling, and case management.

The psychiatrist keeps mental health files separate and locked. ANSFM staff cannot access these records.

Success rates and effectiveness are informally demonstrated by clients continuation in treatment, drug testing (clean tests), exit interviews and feedback, client relapse rates.

Board Member Recommendations for Program Needs?

Support in marketing or messaging ANSFM is recommended to increase capacity and attract funding to continue the child snack program and gifts. ANSFM can provide services to general community at reasonable rates or with private insurance.

Providing access to administrative assistant staff or intern would be helpful to support audits and entering data into the system, especially while ANSFM is understaffed.

Support or collaboration to provide transportation to and from ANSFM for Simi Valley residents.

Behavioral Health Advisory Board Site Visit Report

Date: Jan 24, 2019

Facility / Program: Horizon View MHRC

Location: 333 Skyway Dr., Camarillo, CA 93010

Contact Person: Lindsay Cunningham, PsyD Phone #: (805) 383-1155 E-mail: lmcunningham@telecarecorp.com

BHAB Review Team:

Ratan Bhavnani, Jamie Banker, Nancy Borchard, Gane Brooking, Gina Petrus

FACILITY / PROGRAM DEMOGRAPHICS

1. Age Group Served: (Check all that apply)

Children (0 - 12) Adolescents (13 - 17) TAY (18 - 25) Adults (18 - 61) Older Adults (60 +)

2. Number of Clients Served:

Maximum possible: 16 Monthly Avg. 15 and / or Daily Avg.

3. Services Provided: (i.e.: Counseling, Therapy, Medication management, Nursing, etc.)?

(Description offered by provider, Telecare Corp)

Horizon View MHRC is a welcoming, safe, therapeutic environment in which residents begin a learning process that helps them make effective choices, reduces the amount of harm in their lives, and increases their personal strengths. Telecare provides a full range of psychiatric, nursing, rehabilitative and social services designed to improve symptom management, encourage skill development, and promote restoration of normal independent functioning. The focus of treatment is to prepare residents to live and work in the least restrictive environment possible, with the lowest risk of institutionalization. We provide an individualized rehabilitation program based on sound principles of psychiatric assessment, psychosocial rehabilitation techniques, and psychopharmacology. Services include assessment, individual, group and family therapy, medication management, nursing and psychiatric care, a therapeutic milieu, leisure activities, peer support services, substance use services, pet therapy, and discharge planning.

Knowing that a major impetus for the development of Horizon View MHRC was the desire by consumers' family members to play an active role in treatment, we strive to create an environment at Horizon View where families feel welcome and heard, and where familial bonds are supported and strengthened. With the resident's knowledge and consent, we invite families to participate on the treatment team. Staff engage family members and other loved ones to obtain valuable insight on the issues that are important to the resident, determine whether the service plan adequately addresses the resident's goals, and collaborate on how the service delivery system can integrate the needs and interests of families.

4. Miscellaneous Additional Services: (i.e.: transportation, follow-up care, community activities or support, etc.)?

Horizon View provides transportation and escort to appointments outside the facility as detailed in the service plan. We also provide escorted outings as part of community integration, including to local AA/NA meetings. We also provide money management services and follow up services, including support with linkages.

5. Number of on-site staff having direct client contact:

Horizon View has more than 20 Full Time Equivalent positions, with between 3 and 15 staff on site at any given time depending on shift. Staff includes an Administrator, licensed Clinical Director, Clinician, Psychiatrist, Psychologist, Nursing Staff, Recovery Specialists, Peer Support Specialist, Substance Use Specialist, Admission/Discharge Planner, Rehabilitation Therapists, Dietician, Cook and Administrative Support Team.

6. What kind of training does your organization provide the staff, and how often?

Horizon View employees receive 50+ hours of new employee training and annual refreshers in topics that include but are not limited to: the VCBH Code of Conduct, cultural competence, recovery model services (RCCS), Trauma Informed Care, Motivational Interviewing, Medication Education, Whole Person Care, CPI (Crisis Intervention/De-escalation), HIPAA/Confidentiality, and professional boundaries. Telecare also partners with Relias Learning, a worldwide leader in healthcare training that serves over 5,000 healthcare organizations, to provide additional online courses to employees.

7. Which professionals are involved directly with clients (i.e. Psychiatrist, Psychologist, MFT, ADT, LCSW, Nurse) and how often?

Psychiatrist/Medical Director - 16 hours per week
Clinician (Registered Psychologist) - 40 hours per week
Rehab Therapist - 40 hours per week
Admission/Discharge Planner (MA) - 16 hours per week
LVN/LPT - 168 hours per week

8. Are peer support specialists/individuals in recovery utilized to support your clients? How many and how often? Are family members involved? How?

Horizon View currently has one full-time Peer Support Specialist. As an organization we have a goal that all programs will have at least two Peer Support Specialists by 2020. We also strive to ensure that all of our Peer Support Specialists receive training in peer delivered modalities such as Wellness Recovery Action Planning (WRAP), as well as peer support certification training. As described above, we invite families to be involved in treatment planning meetings and we offer family therapy sessions to help improve family communication and coping.

9. Describe Groups - education/support?

Horizon View offers educational groups, process/support groups, leisure groups and activities, life skills groups, medication management groups, and pet therapy.

10. Facility/Program Physical Layout (i.e. indoor rooms, outdoor areas, recreational areas)? (Attach floor plan if available)

Horizon View has 16 client rooms, a day room, a TV room, Inspiration Studio, an Interview Room, an Exam Room, 3 showers and one tub room, a client property storage room, a donation closet, an outdoor patio, and a laundry room. See floor plan attached.

BHAB Reviewer Response

What do clients typically do during the day (i.e. work, attend programs)?

The daily activity schedule included what seemed to be constructive and engaging activities (promoting creativity, personal growth, health).

Based on a review of the Activity Schedule, groups seem to be primarily Leisure and Rehab Groups. It is unclear from the schedule, which are Mental Health groups that focus on managing symptoms, building coping skills, trauma, etc. Also, it is unclear whether any of the groups are Evidenced-Based and/or led by the Registered Psychologist or Licensed MFT.

Clients are offered 20 hours per week of individual and group therapy; they are encouraged to attend groups, and most do so. During the site visit there were 3 clients who were not participating in group. There was limited staff interaction with these clients.

There is an emphasis on community outings for clients who are at the appropriate level. This allows them to practice generalization of skills in community and to connect with community resources that they can continue to access upon graduation from the program (e.g., NA, AA, provider appointments).

The program follows a philosophy which appears to empower clients to participate to whatever degree they choose. The team felt that this is an expensive program and encouraging residents a little more may increase utilization of available resources.

Staff identified program needs ?

Management expressed a desire to publicize the Horizon View program and facility more widely in the community. They have a storage room containing clothing and shoes, which are offered to clients when they enter; they welcome additional donations.

Overall Impression or Brief Summary (key points, including appearance of clients and facility)?

Horizon View fills a critical need in the community. The facility was specifically designed to create a sense of community and foster interactions between clients and staff, while also affording privacy and personal space. Management expressed a commitment to accepting most clients in need of this level of care, with few exclusion criteria. Management also expressed a commitment to helping clients remain in the program and successfully transition to a less restrictive level of care. Due to the small size of the program (capacity 16), the program is individually tailored to the client. The flexible approach is relationship-based, utilizing Motivational Interviewing techniques to engage clients, honor freedom of choice, with the ultimate goal of having the client access all available services.

The facility is open, clean and filled with natural light. Clients have space and privacy. The design allows for more acute clients to be closer to the nursing station and staff. The BHAB team appreciated the fact that there was no barrier between nursing and clients -- fostering a sense of community -- and that positive language was used to label different areas of the facility. Some of the staff offices are in the same open space. There are limited fitness options. There is no designated place for fitness activities. Two stationary bicycles are located in the movie room and there is a small courtyard. There is a nearby basketball court but this requires staff to accompany the client. A private chef/kitchen offers healthy and nutritious meals for clients.

Staff were professional, knowledgeable, and compassionate. Staff brings a lot of relevant clinical experience. Staff articulated the mission statement clearly. Staff appeared to understand the complex needs of the clients and are committed to addressing all needs, not just those related to mental illness/substance use.

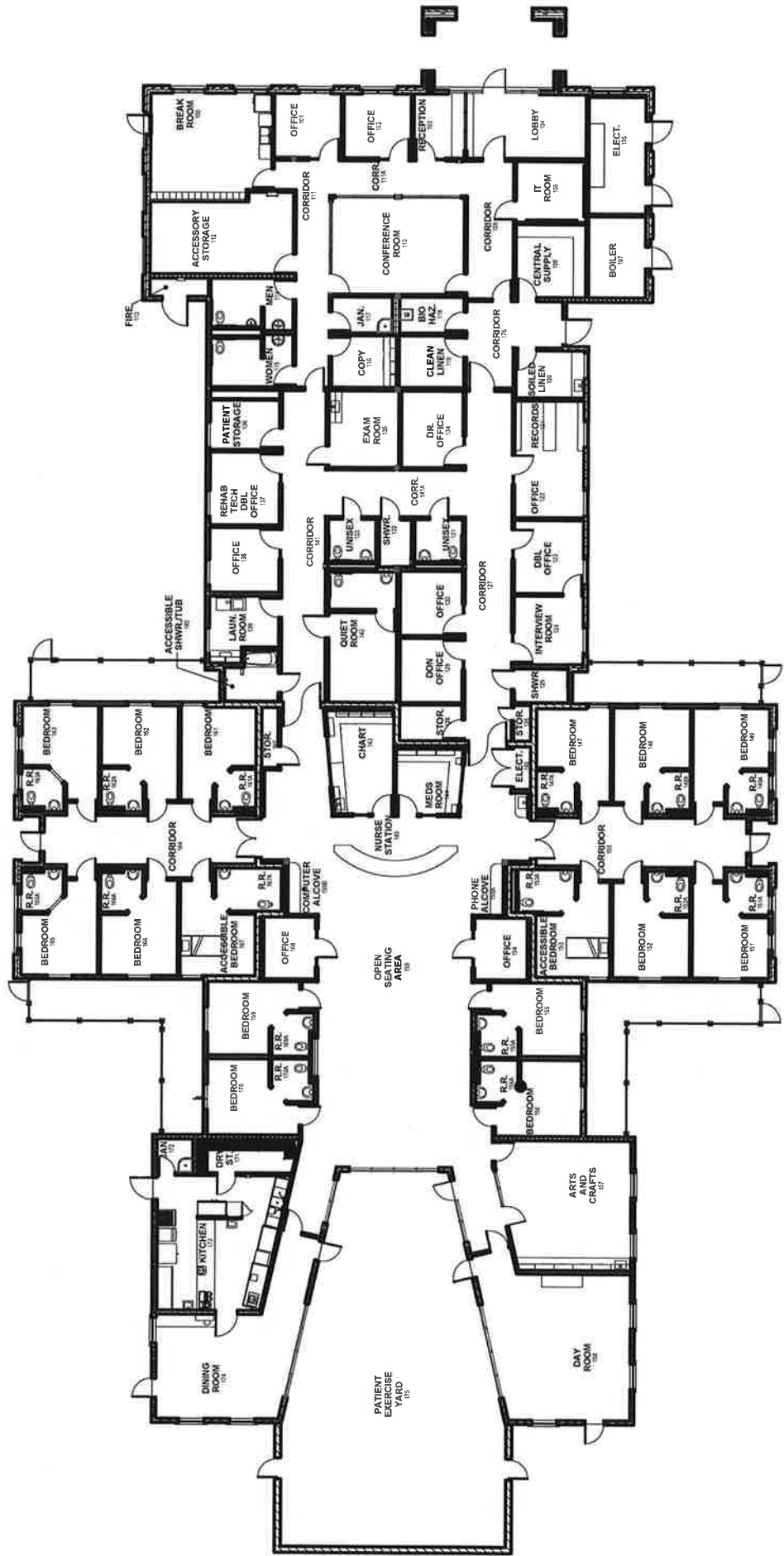
The program has a Certified Addiction and Drug Abuse Consultant who can provide specialized substance abuse interventions.

The only family intervention currently offered is family therapy (if requested by the client) and the opportunity to participate in treatment planning. Management has expressed a desire to expand treatment interventions for families. There did not seem to be a lot of emphasis on the family.

The program currently offers a limited peer support component but has plans to offer a suite of peer support services. A peer is the first point of contact when the client initially enters the program.

Board Member Recommendations for Program Needs?

Suggested to Telecare staff that they offer presentations on this program (and other Telecare programs in Ventura County) to BHAB committees, NAMI groups and at other mental health events.



Horizon View MHRC

DRAFT INNOVATION WORK PLAN

Participating Counties: Fresno¹; Sacramento; San Mateo²; San Bernardino; Siskiyou; Ventura (Lead County)

Project Title: Multi-County Full Service Partnership (FSP) Innovation Project

Duration of Project: January 1, 2020 through June 30, 2024 (4.5 years)

Section 1: Innovation Regulations Requirements Categories

General Requirement: An Innovative Project must be defined by one of the following general criteria. The proposed project:

- Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention
- Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
- Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system
- Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite

Primary Purpose: An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement. The proposed project:

- Increases access to mental health services to underserved groups
- Increases the quality of mental health services, including measured outcomes
- Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes
- Increases access to mental health services, including but not limited to, services provided through permanent supportive housing

¹ Fresno County has already submitted an Innovation Project plan to the MHSOAC detailing its plans to participate in this project; this plan was approved by the MHSOAC in June 2019.

² San Mateo County does not have MHSA INN funds available to commit to this project, but instead intends to use a combination of PEI and CSS funds to participate in the goals and activities of this project, alongside other counties. Some of this funding is currently available, while the remainder will require additional stakeholder input and approval in the spring (March to April 2020). These are one-time funds that have been designated and approved to meet a similar purpose and set of objectives as the INN project. San Mateo County is not submitting a proposal to use INN funds but intends to participate in the broader effort and, thus, is included here and in the Innovation Project plan.

Section 2: Project Overview

Primary Challenge

Since the creation of the Mental Health Services Act (MHSA) in 2004, California has made significant strides in improving the lives of those most in need across the state. In particular, Full Service Partnerships (FSP) support people with the most severe and often co-occurring mental health needs. These MHSA-funded FSP programs are designed to apply a “whatever it takes” approach to serving and partnering with individuals living with severe mental illness. In many counties, FSP programs are effectively improving life outcomes and staff can point to success stories, highlighting dedicated staff and programs tailored to specific cultural groups and ages.

Despite the positive impact of FSP, the program has yet to reach its full potential. Many Californians with serious mental illness still struggle to achieve fuller, more independent lives and avoid the negative outcomes that MHSA prioritizes (i.e., reduced criminal justice involvement, incarceration, unnecessary hospitalizations, in-patient stays, and homelessness).

Counties and FSP providers have identified two barriers to improving and delivering on the “whatever it takes” promise of FSP. The first is a *lack of information* about which components of FSP programs deliver the greatest impact. Counties desire metrics that paint a more complete picture of how FSP clients are faring on an ongoing basis, are closely aligned with clients’ needs and goals, and allow comparison across programs, providers, and geographies. These metrics might move beyond the current state-required elements and allow the actionable use of data for more effective learning and continuous improvement. The second barrier is inconsistent FSP implementation. FSP’s “whatever it takes” spirit has allowed necessary flexibility to adapt the FSP model for a wide variety of populations and unique local contexts. At the same time, this flexibility inhibits meaningful comparison and a unified standard of care across the state. While some variation to account for local context is to be expected, standardizing these processes using data, evidence, and best practices from across California offers the promise of significant performance improvements and better client outcomes.

Proposed Project

This project responds to the aforementioned challenges by reframing FSP programs around meaningful outcomes and the partner (client) experience. This multi-county Innovation Project represents an innovative opportunity for a diverse group of participating counties (Fresno, Sacramento, San Bernardino, San Mateo, Siskiyou, and Ventura) to develop and implement new data-driven strategies to better coordinate FSP service delivery, operations, data collection, and evaluation. The Mental Health Services Oversight and Accountability Commission (MHSOAC) has identified Ventura as a lead county in this project.

The MHSOAC has supported Third Sector in leading counties through the process of developing and implementing this Innovation Project, as well as in facilitating a broader statewide exchange of collective learning and shared opportunities for improving FSPs. A San Francisco-based nonprofit, Third Sector has helped behavioral and mental health programs nationwide create an improved focus on outcomes, guiding government agencies through the process of implementing and sustaining outcomes-oriented,

data-driven services focused on improved meaningful life outcomes. Section 4 below further describes Third Sector's experience and approach to transitioning social services programs to an outcomes orientation. Third Sector will act as the overall project lead and project manager, developing recommendations and customized strategies, leading working group calls and collaborating with each participating county to meaningfully elevate stakeholder voice, while ensuring the project remains on schedule and adjusting responsively to any challenges.

Through participation in this multi-county Innovation Project, participating counties will implement new data-informed strategies to program design and continuous improvement for their FSP programs, supported by county-specific implementation and evaluation technical assistance. Staff will examine what matters in improving individual wellness and recovery and take a data-informed approach to program design, evaluation, and continuous improvement, leading to more effective and responsive programs. The overall purpose and goals of the Innovation Project are to:

1. **Improve how counties define and track priority outcomes** and related performance measures, as well as counties' ability to apply these measures consistently across FSP programs
2. **Develop new and/or strengthen existing processes for continuous improvement** with the goals of improving outcomes, fostering shared learning and accountability, supporting meaningful program comparison, and better using qualitative and quantitative data to inform potential FSP program modifications
3. **Develop a clear strategy for how outcomes and performance measures can best be tracked and streamlined** through various state-level and county-specific reporting tools
4. **Develop a shared understanding and more consistent interpretation of the core FSP components** across counties, creating a common FSP framework that both reflects service design best practices and is adaptive to local context
5. **Increase the clarity and consistency of enrollment criteria, referral, and graduation processes** through the development and dissemination of clear tools and guidelines intended for county, providers, and referral partners

Collaboration with a Statewide FSP Learning Community: In addition to the county-specific implementation technical assistance (TA) proposed in this Innovation Project, counties participating in this Innovation Project have co-developed and will participate in a concurrent, statewide FSP Outcomes-Driven Learning Community that Third Sector is leading with funding from the MHSOAC. County MHSAs and FSP staff, FSP providers, FSP clients, and other community stakeholders will engage in an interactive learning process that includes hearing and sharing lived experiences, developing tools to elevate FSP participant voice, and attending sessions at local FSP sites. Third Sector will synthesize and disseminate learnings between counties participating in this Innovation Plan and the Learning Community, helping each group build upon the work of the other, and develop a set of recommendations for any state-level changes to FSP requirements and/or data collection practices that are supported by a broad coalition of participating California counties.

Rationale for Using the Proposed Approach

Over the past several months, a broad group of counties (beyond just those participating in this Innovation Project) and Third Sector have convened to further unpack these challenges in a collective

setting. Specifically, counties and Third Sector have collaborated in several virtual and in-person convenings to develop (i) an initial baseline understanding of counties' current FSP programs, including unique assets and challenges as it relates to defining and measuring important FSP client outcomes; data collection, data sharing, and data use; FSP services and population guidelines; and ongoing FSP performance management / continuous improvement processes, and (ii) an initial, shared plan for implementing outcomes-focused FSP improvements. The activities and goals proposed by this project are directly informed by these efforts, designed to respond to common challenges, capacity needs, and shared opportunities for FSP program improvements cited by counties. This approach is also inspired by the Los Angeles (LA) County Department of Mental Health's journey to similarly focus their FSP programs on meaningful outcomes. This Innovation Project will build off LA County's early successes, implementing adjusted strategies and approaches that are appropriate for a statewide context.

Number & Description of Population(s) Served

This project focuses on transforming the data and processes counties use to manage their FSP programs to improve performance at scale; it does not entail direct services for FSP clients. Accordingly, we have not estimated the number of individuals that will be served or identified specific subpopulations of focus. This project will build outcomes-focused approaches across a variety of age-specific and population-specific FSP programs statewide, exploring and identifying key commonalities and relevant differences by population of focus, and building a flexible, scalable set of strategies that can be further implemented statewide

Research on the Innovative Component

This Innovation Project presents a new opportunity and innovative practice for participating counties in several ways:

1. Systems-Level Changes to Accelerate Performance

Instead of piloting a new FSP service or intervention, this project will reduce barriers that prevent counties from leveraging data and evidence to deliver better outcomes in FSP programs. While piloting and testing new service interventions remains a key tool for driving mental health services innovation, far too often promising innovations are expected to take root in systems that lack the infrastructure or capacity to support them—leading to suboptimal replication, challenges disseminating learnings, or failure to scale. This Innovation Project seeks to address those structural barriers by accelerating counties' ongoing efforts to use data and shared outcome goals to continuously improve their FSP programs, and do so in a manner that centers on increasing statewide learning.

2. County-Driven Origins with Statewide Impacts

This project also represents an opportunity for counties to drive state progress on reporting requirements, data collection, and data use. Many counties have individually struggled to track client outcomes and make meaningful use of the existing data, but have to-date approached this problem alone. Recognizing these gaps and the power of a collective effort, counties themselves took the initiative to form this project as a response to their individual FSP program challenges and after hearing reflections on LA County's Department of Mental Health FSP transformation.

The county-driven origins of this project, paired with support from the MHSOAC, present a unique opportunity for participating counties to both (i) pursue county-specific implementation efforts that will drive lasting improvements within their *individual* FSP programs, and (ii) exchange learnings from these implementation efforts with other counties via a structured Learning Community designed to help increase *statewide* consensus on FSP's core components and develop shared recommendations for state-level changes to FSP data requirements and guidelines.

3. Introducing New Practices for Encouraging Continuous Improvement & Learning

This project proposes to introduce new data-driven practices for managing FSP programs that center on improving clients' experiences, client life outcomes, and aim to increase consistency in how FSP's are administered within and across different counties. This project will build on tools and learnings emerging from Third Sector's existing work with the Los Angeles County Department of Mental Health's FSP transformation, which centered on understanding and improving core child, adult, and older adult FSP outcomes, inclusive of improving stable housing, reducing emergency services utilization, and reducing criminal justice involvement.

Importantly, the project will also contribute to these learnings and tools, creating new approaches and strategies intended to achieve similar and further results. It aims to develop and pilot continuous improvement processes and actionable data use strategies that are tailored to each participating county's specific context, and to generate new learning and shared consensus around FSP program and performance management best practices, alongside other participating counties. For example, a county may implement a new data dashboard that helps better illustrate client utilization of emergency services over time. This dashboard could be used to understand the relationship between an incoming client's needs, FSP services delivered, and changes in emergency services utilization over time. With this newly clarified data, county staff and/or providers would be able to understand and collaboratively discuss how different clients' needs should determine the services they receive, based on the historical success of other, similar clients.

4. Proposing Changes to State-level FSP Data Requirements

Building from the above, this project also intends to surface specific data collection and data use elements that counties can use to track their FSP outcome goals in a more streamlined, consistent fashion that can be feasibly applied across the state. Through this project, counties will develop a more cohesive vision around which data elements and metrics are most relevant and recommend changes to state-wide FSP data requirements that better prioritize and streamline their use. Ultimately, these recommendations and any changes aim to better support counties in understanding who FSP services, what services they receive, and the outcomes that clients ultimately achieve.

Stakeholder Input

Through individual discussions and group convenings, Third Sector and participating counties have discussed several strategies to ensure that the Innovation Project aligns with each county's goals, including priorities expressed in stakeholder forums. The Appendix includes more detail about each county's specific stakeholder needs, how this project addresses these needs, and how community planning processes in each county have impacted the overall project vision.

To date, Third Sector has supported counties in sharing the project with local stakeholders by providing summary materials (i.e. project descriptions and talking points) and answers to frequently asked questions. These materials were requested by counties and designed to be accessible to a broad audience. Counties such as Sacramento and San Bernardino have already used and adapted these for community planning meetings, soliciting feedback that has helped to inform into this plan. Currently, all participating counties have either shared or scheduled near-term dates for sharing this project as a part of their three-year plan, annual update, or standalone proposal for public comment and county Board of Supervisors' review.

Once the MHSOAC has reviewed this draft Innovation Plan is approved and all counties have posted it for public comment, Third Sector will work with counties to incorporate feedback. Based on this feedback, counties may make adjustments to specific focus areas and priorities addressed within the Innovation Plan before sharing it with their local mental health board and Board of Supervisors for review and final approval.

Furthermore, this project intends to engage county stakeholders—including program participants, frontline staff, and other key community partners—throughout its duration. In the implementation stage, engagement activities may include consulting and soliciting feedback from stakeholders when defining the outcome goals, metrics, service components, and referral and graduation criteria. Counties may choose to do this through focus groups, interviews, and working group discussions. Counties may also invite participants or community representatives to participate in statewide Learning Community events. Since the community planning process is ongoing, stakeholders will continue to receive updates and provide input in future county meetings that are open to the public. Additional description of these activities can be found in the *Work Plan & Timeline* section below.

Learning Goals & Project Aims

This project expects to contribute new learnings and capacities for participating counties throughout the county-specific technical assistance and evaluation activities involved. Guiding research questions that this project aims to further explore include, but are not limited to, the following:

1. What was the process that each participating county and Third Sector took to identify and refine FSP program practices?
2. What changes were made and piloted?
3. What impacts did they generate following implementation, both for FSP clients and FSP program providers?
 - a. Compared to current FSP program practices, do practices developed by this project streamline, simplify, and/or improve the overall usefulness of data collection and reporting for FSP programs?
 - b. To what extent has this project helped to streamline data collection/reporting within participating counties (e.g. improved satisfaction with reporting forms; reduced paperwork)? Has this project improved how data is shared and used to inform discussions on FSP program performance and strategies for continuous improvement?
 - c. What impacts has this project and related changes create for clients' outcomes and clients' experiences in FSP?

4. What broader learning did the project produce?
 - a. How have staff learnings through participation in this FSP-focused project lead to shared learning across other programs and services within each participating county?
 - b. How has the statewide FSP Learning Community helped to drive collective learning and fostered a unified county voice for potential state-level change? Specifically, which types of forums and topics have yielded the greatest value for county participants?

Evaluation & Learning Plan

The Innovation Project includes a significant learning and evaluation component. Third Sector and the counties will pursue a number of evaluation and data analysis activities throughout the duration of the project (as described in the *Work Plan & Timeline* section below) to better understand and measure current FSP outcomes and identify appropriate strategies for improving these outcomes. Third Sector will also support counties in identifying, procuring, and establishing an ongoing governance structure for partnering with a third-party evaluator that can provide an independent assessment of the project's impacts and meaningfully assess the above learning goals via a post-implementation evaluation.

This post-implementation evaluation will aim to assess two types of impacts: (A) the overall impact and influence of the project activities and intended changes to FSP practices and program administration ("systems-level impacts"), and (B) the overall improvements for FSP client outcomes ("client-level impacts"). These two types of measures will help determine whether the practices developed by this project effectively simplify and improve the usefulness of data collection and management, *and* whether these practices supported the project's ultimate goal of improving FSP client outcomes.

A description and example measures for each of the client-level and system-level impacts follows below. Counties, Third Sector, and the evaluator will develop and finalize these measures after procuring the third-party evaluator (i.e. 2021) via a written evaluation plan. The evaluation plan will include a timeline for defined deliverables and will crystallize these research questions, outcome measures, data-sharing requirements and resulting evaluation activities.

A. System-Level Impacts: In order to better understand the systems-level impacts, this project proposes to capture both quantitative and qualitative data to assess the positive value and changes experienced by participating counties and community stakeholders. These measures will be tracked during and following the initial 23-month implementation TA period, and directly answer Learning Goals 1, 2, and 4 above. Example quantitative process measures include:

- Number of county policy changes that a county, the Department of Health Care Services (DHCS), or the MHSOAC implemented as a result of the Project
- Number of counties implementing a new FSP service approach as a result of the project
- Total FSP dollars tied to measurable achievement of outcome goals, including racial equity goals, that are embedded in contracts and/or program performance plans
- Number of new data sharing mechanisms and/or agreements created to support ongoing evaluation, feedback, and analysis of disparities
- Number of counties adopting improvements or changes to FSP continuous improvement practices
- Number of new FSP metrics or data elements measured in each county

- Number of FSP metrics or data elements removed by each county due to lack of relevance/usefulness

Additionally, the project will gather qualitative feedback (based on stakeholder interviews, surveys, and focus groups). These qualitative measures may include:

- Overall satisfaction with quality/impact of outcome measures selected, changes to data collection practices and service guidelines
- Increased confidence that measures tracked are meaningful for participants and/or are regularly reviewed and used to inform programs
- Increased understanding across providers and/or county staff of how priority outcome are defined and corresponding data collection/reporting requirements
- Increased stakeholder engagement and representation in decision-making and FSP program discussions that increase trust, collaboration, and transparency
- Sustainable continuous improvement processes that focus on regular review and discussion of performance data & community feedback
- Better coordinated continuum of care facilitates transitions across programs and services

B. Client-Level Impacts: This project proposes to measure overall improvements in FSP client outcomes that may occur during the project timeframe. Note that the time period for observing and evaluating changes in outcomes and metrics may end sooner (e.g., end of 2023), so as to provide sufficient time for the third-party evaluator to measure and synthesize evaluation findings and to share this information with counties. Third Sector, the evaluator, and the counties will determine the exact measures and an appropriate evaluation methodology for assessing client-level impacts during the project. These measures will address Learning Goal 3 above and may include:

- Changes in cross-system outcomes, such as:
 - Increased percentage of housing-insecure FSP clients connected with housing supports
 - Decreased recidivism for justice-involved FSP clients
 - Decreased use of emergency psychiatric facilities
 - Increased percentage of clients engaging in recreational activities, employment, and/or other forms of meaningful use of time, including employment
 - Increased percentage of clients graduating FSP successfully
- Reduced FSP outcome disparities (i.e. disparities by race/ethnicity; language)
- Increased percentage FSP clients reporting trust and satisfaction with their FSP provider
- Timely access to programs and services aligned with individuals' long-term goals
- Increased sense of agency for people served
- Increased program graduation rates for clients due to increased capacity (i.e., exits because clients are stable and re-integrated into the community)
- Decreased utilization of crisis services (e.g., emergency rooms, mental health, justice) due to increased emphasis on prevention and wellbeing

Third Sector, participating counties, and the evaluator will jointly develop an evaluation plan during the first year of the project. The evaluation plan will include a timeline for defined deliverables and will crystallize these research questions, outcome measures, data-sharing requirements and resulting evaluation activities. Third Sector, participating counties, and the evaluation partner(s) will also carefully consider and discuss strategies for mitigating possible unintended consequences when designing the evaluation and selecting measures to be tracked (e.g., any perverse incentives to graduate clients from FSP before they are ready).

See the *Budget Narrative* section below for additional detail on the post-implementation evaluation activities.

Section 3: Additional Information for Regulatory Requirements

Contracting

Participating counties intend to contract with a technical assistance provider to support counties with project implementation activities. As described above in the *Proposed Project* section, the MHSOAC has supported Third Sector (a San Francisco-based nonprofit) in leading counties through the process of developing and implementing this Innovation Project, as well as in facilitating a broader statewide exchange of collective learning and shared opportunities for improving FSPs. Third Sector will act as the overall project lead and project manager, developing recommendations and customized strategies, leading working group calls and collaborating with each county to meaningfully elevate stakeholder voice, while ensuring the project remains on schedule and adjusting responsively to any challenges.

Participating counties will also identify and contract with an evaluation partner during the first year of the project. The evaluation partner will support counties in designing and implementing a shared strategy for assessing the project impact.

Counties intend to directly contract with Third Sector and/or the evaluation consultant for this project, while other counties may choose to contract through the existing Joint Powers Agreement (JPA) via the California Mental Health Services Authority (CalMHSA). The JPA sets forward specific governance standards to guide county relationships with one another and Third Sector/the evaluator and ensure appropriate regulatory compliance. CalMHSA will also develop participation agreements with each participating county that will further memorialize these standards and CalMHSA's specific role and responsibilities in providing fiscal and contract management support to the counties. As further detailed in Section 4, counties intend to use a portion of the Innovation Project budget to pay CalMHSA for this support

Community Program Planning

The Appendix to the Innovation Plan includes more detail about each participating county's specific stakeholder needs, how this project addresses these needs, and what the overall community planning process has involved in each county. Since the community planning process is ongoing, stakeholders will continue to receive updates and provide input throughout the duration of this project, including via specific focus group and stakeholder interview activities outlined in the project work plan.

Alignment with Mental Health Services Act General Standards

This project meets MHSOAC General Standards in the following ways:

- It is a **multi-county collaboration** between Fresno, Ventura, Sacramento, Siskiyou, San Bernardino, and San Mateo to address FSP program challenges and opportunities
- It is **client-driven**, as it seeks to reframe FSP programs around meaningful outcomes for the individual, centering on holistic client **wellness and recovery**
- It seeks to create a coordinated approach to program design and service delivery, leading to an **integrated service experience for clients and family**
- It will establish a shared understanding of FSP's core components and create a common framework that reflects best practices while adapting for local context and **cultural competency**

- **Diverse stakeholders** will be meaningfully engaged throughout the development and implementation of the project

Cultural Competence and Stakeholder Involvement in Evaluation

This project intends to engage each county's stakeholders (i.e. program participants, frontline staff, other key community partners) throughout its duration, including in evaluation activities. Example engagement activities may include, but are not limited to:

- Asking for input from FSP provider staff, clients / client representatives, partner agencies, and other stakeholders (via focus groups, interviews, surveys, and/or working group discussions) as counties identify and define outcome goals, develop meaningful metrics for tracking these goals over time, identify key FSP service components, and surface opportunities to clarify and streamline referral/graduation criteria
- Sharing and reviewing data gathered and analyzed throughout this project--including in the post-implementation evaluation phase--with community members to gather additional input and insight in interpreting trends
- Inviting clients and/or client representatives to participate in statewide FSP Learning Community events
- Soliciting qualitative feedback from stakeholders on how this project has helped (or hindered) improved FSP service delivery in each county and opportunities for further improvement
- Sharing learnings and regular updates from this project with stakeholders at MHSA community planning meetings and county-specific stakeholder committees

Innovation Project Sustainability and Continuity of Care

Given this Innovation Project does not propose to provide direct services to FSP clients, protecting continuity of client care is not applicable.

Participating counties are strongly interested in sustaining any learnings, practices, and/or new statewide collaborative structures developed through this Innovation Project that demonstrate effectiveness in meeting the project goals. The Innovation Project work plan includes dedicated time and resources for sustainability planning among counties and Third Sector. Specifically, Third Sector will support counties during the final two months of the implementation technical assistance period to develop a clear transition plan and ensure participating staff have the capacity to continue these new strategies through the end of the Innovation Project period (these plans are further described below in the *Work Plan & Timeline* section). Counties will then use findings from the post-implementation evaluation to identify which specific practices or changes were most effective for achieving the different client and systems-level impacts that the project will measure, prioritizing these for continuation in future years.

Similarly, while Third Sector will organize and facilitate the Statewide FSP Learning Community in 2020, the counties and Third Sector intend for the Learning Community to be largely county-driven and county-led. The counties and Third Sector will gather feedback on the efficacy of the Learning Community at various points throughout the first year of the project (2020) and will develop a plan for

continuing prioritized activities in an ongoing fashion, whether through county-led facilitation, ongoing Third Sector support, and/or another strategy. The counties and Third Sector welcome and hope to solicit the MHSOAC's input in these conversations.

Communication and Dissemination Plan

Throughout the ideation and development of this Innovation Project, Third Sector has maintained ongoing conversation with the MHSOAC to share updates on county convenings, submit contract deliverables, solicit feedback about project decisions, discuss areas of further collaboration, and generally ensure alignment of interests, goals, and expectations. As the project progresses and moves into a phase of county-specific landscaping and implementation TA, Third Sector will continue to share regular updates, questions, and deliverables with Commission staff. These updates may include summaries of common challenges that participating counties experience on their FSP programs, from state-level data collection and reporting to performance management and continuous improvement practices. Based on these common challenges, participating counties intend to develop a set of shared recommendations for changes to state-level data requirements. Through the statewide FSP Learning Community, these recommendations will be co-created and informed by counties across the state. Third Sector will share regular updates on Learning Community workshops and may even invite Commission staff to attend select events. Additionally, Third Sector and the counties will collaborate with the MHSOAC to determine if and when presentations to the Commission may be valuable for further disseminating project learnings.

As the implementation phase of work comes to a close, Third Sector will work with participating counties to develop a plan for sustaining new outcomes-focused, data-driven strategies. This will include developing a communication plan for sharing project activities, accomplishments, and takeaways with the MHSOAC and DHCS. Third Sector will share counties' recommended revisions to state data requirements, and it will initiate discussions about opportunities for the MHSOAC and DHCS to streamline and clarify guidelines and requirements, supporting more effective and responsive FSP programs. Third Sector will also share insights about the process itself, from Innovation Plan development to implementation TA, and reflect on the successes and challenges of these efforts, promoting a discussion about the sustainability and scalability of future Innovation projects.

Work Plan & Timeline

Project Activities and Deliverables and Timeline

The Innovation Project will begin in January 2020 and end in June 2024 for a total project duration of 4.5 years. The project will be divided into two periods: an implementation technical assistance (TA) period and an evaluation period.

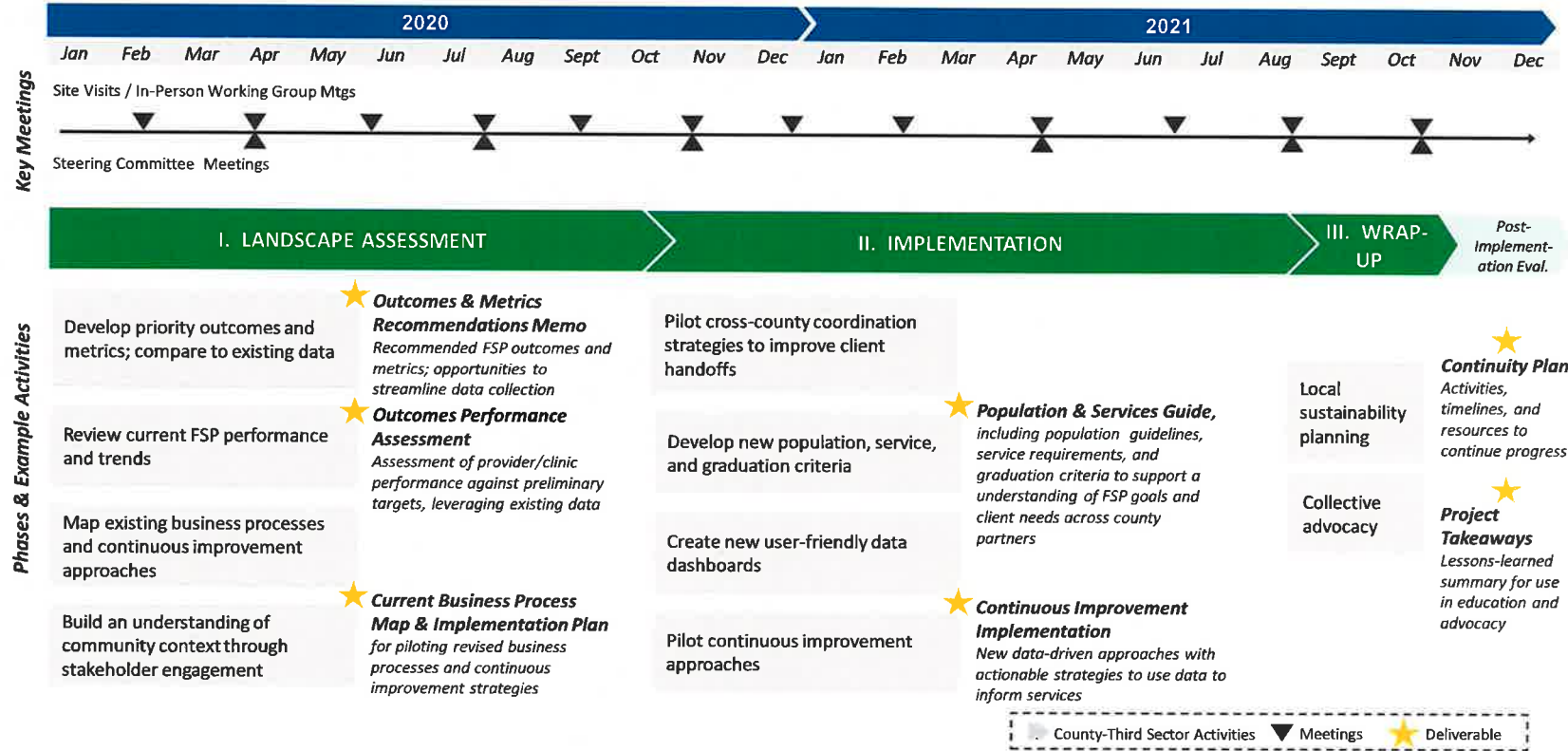
In the first 23-month implementation technical assistance (TA) period, Third Sector will work directly with each participating county to understand each county's local FSP context and provide targeted, county-specific technical assistance in implementing outcomes-focused improvements. Third Sector will leverage a combination of regular (weekly to biweekly) virtual meetings/calls with counties' core project staff, regular site visits and in-person working groups, and in-person stakeholder meetings, in order to advance the project objectives. These efforts will build on learnings and tools developed in Third

Sector's work with the Los Angeles County Department of Mental Health, as well as Third Sector's previous partnerships with other California and national behavioral health, human services, justice, and housing agencies. Each county will receive dedicated technical support with a combination of activities and deliverables tailored for their unique county context, while also having access to shared resources and tools applicable across all FSP programs and counties.

This TA period will be divided into three discrete phases (Landscape Assessment; Implementation; Sustainability Planning). The activities and deliverables outlined below are illustrative, as exact phase dates, content, and sequencing of deliverables will depend on each county's needs and goals. County staff and Third Sector will collaborate over the next several months to identify each county's most priority activities and goals and to create a unique scope of work to meet these needs. See **Figure 1** below for an illustrative Implementation TA work plan and timeline by phase.

In the second period of the project, participating counties will pursue a post-implementation evaluation, conducted by a third-party evaluator, with the goal of assessing the impacts and learning that this project produces. This post-implementation evaluation and the overall Innovation Project will conclude at the end of June 2024.

Figure 1: Illustrative Implementation TA Work Plan



Phase 1: Landscape Assessment

The Landscape Assessment phase will act as a ramp-up period and an opportunity for Third Sector to learn about each county's context in further detail, including local community assets, resources, and opportunities, existing FSP program practices, and performance on existing outcomes measures. Building off of templates from national mental/behavioral health projects, Third Sector will customize deliverables and activities for each county's local FSP context. During this phase, Third Sector will work with county staff to lead working groups and interviews, analyze county data, and facilitate meetings with local stakeholders to identify opportunities for improvement. County staff will share data and documents with Third Sector and provide guidance on local priorities and past experiences. Other example activities may include conducting logic models and root cause analyses to create consensus around FSP's desired outcomes, reviewing current outcomes and performance data to understand trends, and gathering qualitative data about the client journey and staff challenges. By the end of this phase, each participating county will have an understanding of the current state of its FSP programs, customized recommendations to create a more data-driven, outcomes-oriented FSP program, and a realistic work plan for piloting new improvements during the Implementation phase.

Third Sector will produce a selection of the following illustrative deliverables, as appropriate for each county's unique context and needs:

- *Outcomes & Metrics Plan*: Recommended improved FSP outcomes and metrics to understand model fidelity and client success, including recommended areas of commonality, alignment, and consistency across counties.
- *Population to Program Map*: A map of current FSP sub-populations, FSP programs, and community need, to illuminate any potential gaps or opportunities.
- *Population Criteria Outline*: Recommended changes to population eligibility criteria, service requirements, and graduation criteria.
- *Current State to Opportunity Map*: A map of metrics and existing data sources, including identification of any gaps and opportunities for improved linkages and continuity (e.g., auto-population of fields, removal of duplicate metrics, linking services/billing data to understand trends, opportunities to use additional administrative data sources to validate self-reported data).
- *Outcomes Performance Assessment*: An assessment of provider and clinic performance against preliminary performance targets, leveraging existing data and metrics.
- *Process Map*: A process map identifying current continuous improvement and data-sharing processes and opportunities for improvement.
- *Implementation Plan*: An implementation plan for new continuous improvement processes, both internal (i.e., creating improved feedback loops and coordination between county data, funding, and clinical/program teams) and external (i.e., creating improved feedback loops between county teams and contracted providers).

Included in this phase, Third Sector and the counties will develop a set of qualifications and work plan for procuring a third-party evaluator. Example evaluator-led activities and deliverables include:

- Recommended evaluation methodology (e.g., randomized control trial, quasi-experimental method, etc.)
- Work plan for executing any required data-sharing agreements and/or research board approvals that may be necessary to implement the post-implementation evaluation
- Post-implementation evaluation plan that identifies specific outcomes, metrics, data sources and timeline for measuring client and systems level impacts
- Final impact report

Phase 2: Implementation

Third Sector will provide individualized guidance and support to each county through the Phase 2 Implementation process, piloting new strategies that were developed during Phase 1. Understanding limitations on staff capacity, Third Sector will support county staff by preparing materials, analyzing and benchmarking performance data, helping execute on data-sharing agreements, and leading working group or project governance meetings. County staff will assist with local and internal coordination in order to meet project milestones. Additional activities in Phase 2 may include the following: improving coordination across county agencies to create a human-centered approach to client handoffs and transfers, completing data feedback loops, and developing new referral approaches for equitable access across client FSP populations. As a result of this phase, county staff will have piloted and begun implementing new outcomes-oriented, data-driven strategies.

With Third Sector's implementation support, participating counties may achieve a selection of the following deliverables in Phase 2:

- *Referral Strategies*: Piloted strategies to improve coordination with referral partners and the flow of clients through the system.
- *Population and Services Guide*: New and/or revised population guidelines, service requirements, and graduation criteria.
- *Updated Data Collection & Reporting Guidelines*: Streamlined data reporting and submission requirements.
- *Data Dashboards*: User-friendly data dashboards displaying performance against priority FSP metrics.
- *Continuous Improvement Process Implementation*: Piloted continuous improvement and business processes to create clear data feedback loops to improve services and outcomes.
- *Staff Training*: Staff trained on continuous improvement best practices.
- *FSP Framework*: Synthesized learnings and recommendations for the FSP Framework that counties and Third Sector can share with the broader statewide Learning Community for further refinement.

- *FSP Outcomes & Metrics Advocacy Packet*: Recommendations on improved FSP outcomes, metrics, and data collection and sharing practices for use in conversations and advocacy in stakeholder forums and with policy makers.

Further, in this phase, a third-party evaluator will be selected based upon the qualifications and work plan developed in Phase 1. Third Sector, counties, and the evaluator will develop a scope of work detailing the exact deliverables and activities that the evaluator will lead as part of the post-implementation evaluation.

Phase 3: Sustainability Planning

In Phase 3, Third Sector will work with participating counties to understand the success of the changes to-date and develop strategies to sustain and build on these new data-driven approaches. Third Sector will work closely with county staff to ensure that there is a transition plan in place and that county staff have the capacity to continue these new strategies. Participating counties may also partner with other counties to elevate project implementation successes in order to champion broad understanding, support, and continued resources for outcomes-focused, data-driven mental health and social services. Specific activities may include articulating lessons learned, applying lessons learned to other mental health and social service efforts, creating ongoing county work plans, and developing an FSP impact story. As a result of Phase 3, each participating county will have a clear path forward to continue building on the accomplishments of the project.

Third Sector will produce a selection of the following deliverables for each county=:

- *Project Case Study*: A project case study highlighting the specific implementation approach, concrete changes, and lessons learned.
- *Continuity Plan*: A continuity plan that identifies specific activities, timelines and resources required to continue to implement additional outcomes-oriented, data-driven approaches.
- *Project Toolkit*: A project toolkit articulating the specific approaches and strategies that were successful in the local FSP transformation for use in similarly shifting other mental health and related services to an outcomes orientation.
- *Communications Plan*: A communications plan/strategy articulating communications activities, timelines, and messaging.
- *Project Takeaways*: Summary documents articulating major takeaways for use educating statewide stakeholders on the value of the new approach.
- *Evaluation Work Plan & Governance*: An evaluation work plan to assist the counties and the evaluation partner in project managing the post-Implementation evaluation phase.

Expected Outcomes

At the end of this project, each participating county will have clearly defined FSP outcome goals that relate to program and beneficiary priorities, well-defined performance measures to track progress towards these outcome goals, and a clarified strategy for tracking and sharing outcomes data to support meaningful comparison, learning, and evaluation. The specific implementation activities may vary based on the results of each county's landscape assessment, but may include the following: piloting new

referral processes, updating service guidelines and graduation criteria, using qualitative and quantitative data to identify program gaps, sharing data across providers, agencies, and counties, streamlining data practices, improving data-reporting formats, implementing data-driven continuous improvement processes, and recommending changes to state-level data requirements.

Section 4: INN Project Budget & Source of Expenditures³

Overview of Project Budget & Sources of Expenditures: All Counties

The total proposed budget supporting six counties in pursuing this Innovation Project is approximately \$5.08M over 4.5-years.³ This includes project expenditures for four different primary purposes: Third Sector Implementation TA (\$3.18M); Fiscal and Contract Management through CalMHSA (\$.314M); Third-Party Evaluation (\$.25M); as well as additional expenditures for county-specific needs (“County-Specific Costs”) (\$1.34M).

All costs will be funded using county MHSAs Innovation funds, with the exception of San Mateo County which will contribute available one-time CSS & PEI funding. Counties will contribute varying levels of funding towards a collective pool of resources that will support the project expenditures (excluding County-Specific Costs which counties will manage and administer directly). This pooled funding approach will streamline counties’ funding contributions and drawdowns, reduce individual project overhead, and increase coordination across counties in the use of these funds. See *Figure 2* below for the estimated total sources and uses of the project budget over the 4.5-year project duration across all six participating counties. The Appendix includes additional detail on each county’s specific contributions and planned expenditures.

Budget Narrative for Shared Project Costs

Consultant Costs/Contracts: Each county is contributing funding to a shared pool of resources that will support the different contractor and consultant costs associated with the project. These costs include support from Third Sector (implementation TA), CalMHSA (fiscal and contract management), and the third-party evaluator (post-implementation evaluation). These consultants and contractors will operate across the group of participating counties, in addition to supporting each individual county with its own unique support needs.

CalMHSA will act as the fiscal and contract manager for this shared pool of resources through the existing Joint Powers Agreement (JPA). The pooled funding approach intends to streamline counties’ funding contributions and drawdowns through sharing resources, reduce individual project overhead, and increase coordination across counties in the use of these funds.

³ As mentioned above, Marin County informed Third Sector on November 27, 2019 that they will no longer participate in the Innovation Project. Marin will remain an active participant in the state-wide FSP learning community (more details on learning community goals and activities below). Given this information, budget details in the Innovation Plan are subject to change as Third Sector and the six participating counties determine appropriate budget adjustments moving forward. Given these adjustments have not yet been determined, This Section 4 does not reflect updates that account for Marin County’s withdrawal from the project.

The total amount of consultant and contractor costs is approximately \$3.74M across all six counties over the 4.5 year timeline. A description of each of these three cost categories follows below:

Third Sector Costs

As described in the Project Activities & Deliverables section above, Third Sector will lead counties through individualized implementation TA over a 23-month timeframe (January 2020 through November 2021). The total budget for Third Sector's TA across all six counties is \$3.18M over the full 23-month TA period. These costs will fund Third Sector teams who will provide a wide range of dedicated technical assistance services and subject matter experience to each individual county, as they pursue the goals of this Innovation Plan. Third Sector staff will leverage regular site visits to each county, in addition to leading weekly to biweekly virtual meetings with different working groups, developing recommendations for the project Steering Committee, and supporting county staff throughout each of the three implementation TA phases.

Based in San Francisco and Boston, Third Sector is one of the leading implementers of outcomes-oriented strategies in America. Third Sector has supported over 20 communities to redirect over \$800M in public funds to data-informed, outcomes-oriented services and programs. Third Sector's experience includes working with the LA County Department of Mental Health to align over \$350M in annual MHSA FSP and PEI funding and services with the achievement of meaningful life outcomes for well over 25,000 Angelenos; transforming \$81M in recurring mental health services in King County, WA to include new performance reporting and continuous improvement processes that enable the county and providers to better track each providers' monthly performance relative to others and against specific, county-wide performance goals, and advising the County of Santa Clara in the development of a six-year, \$32M outcomes-oriented contract intended to support individuals with serious mental illness and complex needs through the provision of community-based behavioral health services.

CalMHSA Costs

Six counties (San Mateo, Sacramento, San Bernardino, Ventura, Siskyou, and Fresno) have selected to contract using the existing Joint Powers Agreement (JPA) via CalMHSA. The JPA sets forward specific governance standards to guide county relationships with one another and Third Sector/the evaluator. CalMHSA will develop participation agreements with each participating county that will further memorialize these standards and CalMHSA's specific role and responsibilities in providing fiscal and contract management support to the counties.

CalMHSA charges an estimated 9% for its services. Rates are based on the specific activities and responsibilities CalMHSA assumes. Note that rates have not yet been finalized with CalMHSA at the time of this draft Innovation Plan proposal submission. Counties will update this plan based on any changes to these costs, prior to submitting this plan to their local Mental Health Board, the MHSOAC, and their Board of Supervisors for approval.

Evaluation Costs

Third Sector and the counties will determine the appropriate procurement approach and qualifications for a third-party evaluator during the first nine months of the project. Once selected, the third-party

evaluator will contract with counties either individually or collectively via the JPA administered through CalMHSA. Third Sector will support counties in determining the appropriate statement of work, budget, and funding plan for the third-party evaluator.

The current budget projects a total evaluation cost of \$250,000 (combined across all counties, excluding Marin). The evaluator will be responsible for developing a formal evaluation plan, conducting evaluation activities, and producing an evaluation report. Estimated costs assume that the counties, Third Sector, and the to be determined third-party evaluator will collaborate to develop a uniform evaluation approach set of performance metrics, and corresponding metric definitions that can be applied consistently across all counties. Costs are estimates and subject to change. Additional charges, such as academic overhead rates and/or the costs for completing any required data sharing agreements, may apply. If, during the evaluator selection phase, it becomes apparent that costs will need to exceed initially budgeted amounts, the counties and Third Sector will work in partnership with the OAC to identify appropriate additional funding.

Budget Narrative for County-Specific Costs

The remaining project costs are intended to support additional, county-specific expenditures. Counties will fund these costs directly, rather than thru a pooled funding approach. A summary of the total \$1.34M in County-Specific Costs across all seven counties follows below. The Appendix includes additional detail of each county's specific expenditures within these categories:

Personnel Costs

Total personnel costs (county staff salaries; benefits) for all counties are approximately \$844,000 over 4.5 years and across seven counties. Each county's appendix, attached, details the specific personnel that this will support.

Operating Costs

Total operating costs for counties are approximately \$308,000 over 4.5 years and across seven counties. Operating costs support anticipated travel costs for each county (\$91,000) and requisite County-specific administrative costs (\$217,000). Each county's appendix, attached, details their specific operating costs.

Non-Recurring Costs

This project will not require any technology, equipment, or other forms of non-recurring costs.

Additional Contractor Costs

Siskiyou County intends to commit \$190,000 for additional evaluation and data analysis support for Siskiyou County, specifically. Additional detail on these costs can be found in Siskiyou's appendix.

FIGURE 2: BUDGET BY FUNDING SOURCE AND FISCAL YEAR							
EXPENDITURES							
Personnel Costs (salaries, wages, benefits)		FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	Total
1	Salaries	\$116,271	\$181,117	\$187,502	\$137,735	\$128,071	\$750,696
2	Direct Costs	\$15,454	\$26,614	\$27,945	\$10,323	\$4,700	\$85,036
3	Indirect Costs	\$1,409	\$2,856	\$2,999	\$624	\$624	\$8,512
4	Total Personnel Costs	\$133,134	\$210,587	\$218,446	\$148,682	\$133,395	\$844,244
Operating Costs (travel, hotel)		FY 19/20	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24
5	Direct Costs	\$24,390	\$39,390	\$30,390	\$24,390	\$12,390	\$130,950
6	Indirect Costs	\$16,368	\$61,507	\$40,602	\$29,293	\$29,294	\$177,064
7	Total Operating Costs	\$40,758	\$100,897	\$70,992	\$53,683	\$41,684	\$308,014
Non-Recurring Costs (technology, equipment)		FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	Total
8	Direct Costs	\$0	\$0	\$0	\$0	\$0	\$0
9	Indirect Costs	\$0	\$0	\$0	\$0	\$0	\$0
10	Total Non-Recurring Costs	\$0	\$0	\$0	\$0	\$0	\$0
Consultant Costs/Contracts (training, facilitation, evaluation)		FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	Total
11a.	Direct Costs (Third Sector)	\$527,309	\$1,715,715	\$750,669	\$186,000	\$0	\$3,179,693
11b.	Direct Costs (CalMHSA)	\$34,502	\$197,029	\$72,085	\$6,564	\$4,687	\$314,866
11c.	Direct Costs (3rd Party Evaluator)	\$0	\$62,502	\$62,502	\$72,919	\$52,085	\$250,008
12	Direct Costs (Additional County Evaluation)	\$0	\$0	\$0	\$95,000	\$95,000	\$190,000
13	Indirect Costs	\$0	\$0	\$0	\$0	\$0	\$0
14	Total Consultant Costs	\$561,811	\$1,975,246	\$885,256	\$360,483	\$151,772	\$3,934,567
Other Expenditures (explain in budget narrative)		FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	Total
14	Program/Project Cost	\$0	\$0	\$0	\$0	\$0	\$0
15		\$0	\$0	\$0	\$0	\$0	\$0
16	Total Other Expenditures	\$0	\$0	\$0	\$0	\$0	\$0
BUDGET TOTALS							
Personnel		\$133,134	\$210,587	\$218,446	\$148,682	\$133,395	\$844,244

DRAFT Multi-County FSP Innovation Plan

Direct Costs	\$586,201	\$2,014,636	\$915,646	\$384,873	\$164,162	\$4,065,517
Indirect Costs	\$16,368	\$61,507	\$40,602	\$29,293	\$29,294	\$177,064
Total Innovation Project Budget	\$735,703	\$2,286,730	\$1,174,693	\$562,848	\$326,851	\$5,086,825

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)							
ADMINISTRATION:							
A.	Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources:	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	Total
1.	Innovative MSHA Funds	\$672,503	\$1,919,321	\$1,039,555	\$549,014	\$313,019	\$4,493,413
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*	\$100,000	\$200,000	\$200,000	\$93,412	\$0	\$593,412
6.	Total Proposed Administration	\$772,503	\$2,119,321	\$1,239,555	\$642,426	\$313,019	\$5,086,825
EVALUATION:							
B.	Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	Total
1.	Innovative MSHA Funds						
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	Total Proposed Evaluation						
TOTAL:							
C.	Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	Total
1.	Innovative MSHA Funds	\$672,503	\$1,919,321	\$1,039,555	\$549,014	\$313,019	\$4,493,413
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*	\$100,000	\$200,000	\$200,000	\$93,412	\$0	\$593,412
6.	Total Proposed Expenditures	\$772,503	\$2,119,321	\$1,239,555	\$642,426	\$313,019	\$5,086,825
*If "Other funding" is included, please explain.							

*San Mateo County does not have MHSA INN funds available to commit to this project, but instead intends to use a combination of PEI and CSS funds to participate in the goals and activities of this project, alongside other counties. Some of this funding is currently available, while the remainder will require additional stakeholder input and approval in the Spring (March to April 2020). These are one-time funds that have been designated and approved to meet a similar purpose and set of objectives as the INN project. San Mateo County is not submitting a proposal to use INN funds but is committed to participating in the broader effort and, thus, are included here and in the Innovation Project plan.

Innovation Plan Appendix

Appendix Overview

The following appendix contains specific details on the local context, local community planning process (including upcoming local review dates), and budget details for Ventura County

Participating Counties and their proposed contributing funds:

Participating Counties	Proposed Funding Contribution
Sacramento	\$500,000
San Bernardino	\$979,634
Ventura	\$979,634
Siskiyou	\$700,000
Fresno	\$950,000
San Matteo	\$593,412

Appendix: Ventura County

County Contact and Specific Dates

The primary contacts for Ventura County are:

Kiran Sahota
 Email: kiran.sahota@ventura.org
 Tel: (805) 981-2262

Hilary Carson
 Email: hilary.carson@ventura.org
 Tel: (805) 981-8496

Ventura County’s upcoming local review dates are listed in the table below. More detail on Ventura’s stakeholder engagement process can be found in the “Local Community Planning Process” section.

Local Review Process	Date
Innovation Plan posted for 30-day Public Review	December 17, 2019
Local Mental Health Board Hearing	January 27, 2019
Board of Supervisors (BOS) approval, or calendared date to appear before BOS	February 5, 2019

Dates are proposed and subject to change, especially BOS calendar date of Feb 5, which is the earliest that the project could be calendared.

Description of Local Need

Ventura County has 7 FSP programs serving 619 individuals in the 2018/19 fiscal year. Each of these programs has a specific focus, yet they overlap in the age groupings as compared to age groupings as prescribed by MHSA regulations. One (1) of these serves juveniles currently on probation, 1 of these programs serves transition age youth, 4 serve adults age 18 years and older, and another serves older adults. The majority of these programs focus on individuals who are currently experiencing or at risk of experiencing incarceration, substance abuse, or homelessness. Eligibility is determined by the following factors: experience or at risk of incarceration, substance abuse, homelessness, hospitalization, or removal from the home, as well as the individual’s age, and case manager/clinician recommendation.

The specificity and number of these FSP programs is both an asset and a challenge. While they enable our county to better serve specific age, cultural, and geographical groups, our county often struggles to establish consistent FSP service guidelines, evaluate outcomes, or disseminate best practices.

A common, recurring theme at community engagement gatherings has resonated toward offering more concentrated care for the seriously and persistently mentally ill homeless population. Along this line, Ventura County conducted a Mental Health Needs Assessment recently that indicated a need to address issues of homelessness and dual diagnosis as priority populations. Ventura County FSP services are fewer for those under 18 years of age and with respect to ethnicity. There has been consistent communication in Santa Paula and Oxnard community meetings to stress the need to increase services in breadth and depth to the Latinx community.

Conversations with Ventura County FSP staff and clinicians have revealed that outcome goals and metrics are not regularly reassessed or informed by community input, nor are they well-connected to actual services received and provided by FSP programs. There is not a shared, clear understanding of FSP service guidelines among providers and county department staff—interpretation and implementation of these guidelines varies widely. Further, there is not a standard documented model of care designed for each FSP age grouping (Youth, TAY, Adult, Older Adult). FSP has a different meaning and objectives within each group. As age categories are further documented, identifying the idiosyncratic challenges particular to each target group due to the needs being very different.

Staff and clinicians have also indicated that data is collected for state mandated compliance and does not inform decision-making or service quality improvements. In addition, data is collected within one system, but outcomes are designed to be measured with cross-agency data collection systems (such as health care, criminal justice, etc.) meaning many counties are reliant on self-reported progress toward outcomes rather than verified sources. Providers and peer agencies do not have a forum to meet regularly and share learnings and best practices or discuss opportunities. Standards for referral, enrollment, and graduation are inconsistent or outdated. Finally, there is a need for more clarity in the understanding of FSP funding allowances. The “whatever it takes” category is especially open to interpretation and there’s no standard across counties to compare approved expenditures or to know what resources are available through FSP funds

Response to Local Need

Through this Innovation proposal, Ventura County seeks to participate in the statewide initiative to increase counties’ collective capacity to gather and use data to better design, implement, and manage FSP services. The key priorities outlined in the Innovation Plan will allow Ventura County Behavioral Health to address current challenges and center FSP programs and services around meaningful outcomes for participants. More specifically, participating in this project and aligning with the identified priorities will enable the department to:

1. Develop a clear strategy for how outcome goals and performance metrics can best be tracked using existing state and/or county-required tools to support meaningful comparison, learning, and evaluation.
2. Explore how appropriate goals and metrics may vary based on population.
3. Update and disseminate clear FSP service guidelines using a common FSP framework that reflects clinical best practices.
4. Create or strengthen mechanisms for sharing best practices and fostering cross-provider learning.
5. Improve existing FSP performance management practices (i.e., when and how often program data and progress towards goals is discussed, what data is included and in what format, how next steps and program modifications are identified).

In addition, this project will provide Ventura County Behavioral Health the opportunity to share and exchange knowledge with other counties through the statewide learning community.

Local Community Planning Process

The community planning process helps Ventura County determine where to focus resources and effectively utilize MHSA funds in order to meet the needs of county residents. The community planning process includes participation from the Board of Supervisors, Behavioral Health Advisory Board, providers, and community members. Since the community planning process is ongoing, stakeholders will continue to receive updates and provide input in future meetings.

The project was shared in the following Behavioral Health Advisory Board subcommittee meetings:

- Adult Committee on Thursday, November 7, 2019
- Executive Meeting on Tuesday, November 12, 2019
- Prevention Committee on Tuesday, November 12, 2019
- Youth & Family Committee on Wednesday, November 13, 2019
- TAY Committee on Thursday, November 21, 2019
- General Meeting on Monday, November 18, 2019
- Community Input Session January 15, 2020
- Community Input Session January 21, 2020
- Community Input Session January 23, 2020

This project was shared as a part of the 3 year-plan update in the section of proposed use of Innovation funds. A more detailed draft plan proposal will be publically posted for a 30-day comment period beginning on December 17 2019. The Behavioral Health Advisory Board will hold a public hearing on the proposed plan January 27 2019. The plan will be revised based on feedback received, after which it is scheduled to go before the Ventura County Board of Supervisors for review and final approval in early February.

County Budget Narrative

Ventura County will contribute \$979,634 amount over the 4.5-year project period to support this statewide project. As detailed below, Ventura County will pool most of this funding with other counties to support consultant and contracting costs, with a small portion of Ventura County's funding also set aside for county staff travel and administrative costs:

- *County Travel and Administrative Costs:* Ventura County anticipates travel costs up to \$13,000 over the 4 years, or \$3,000 per year, which may vary based on the number of staff traveling and the number of in-person convening's. Based on current rates for administrative costs, Ventura County will allocate \$ 296,801 for 4 years of personnel costs. The following positions have been allocated at a few hours annually over the next few years in order to achieve the project goals of system change.
 - Senior Project Manager
 - Program Administrator
 - Quality Assurance Administrator
 - Electronic Health Record System Coordinator
 - Behavioral Health Clinician
- *Shared Project Costs:* The remaining amount, \$593,412 will support project management and technical assistance (e.g. Third Sector's technical assistance in project implementation), fiscal intermediary costs, and evaluation.

County Budget Request by Fiscal Year

The table below depicts Ventura County's year-over-year contribution to the Innovation Project.

County Budget Request & Expenditures by Fiscal Year and Budget Category

BUDGET BY FUNDING SOURCE AND FISCAL YEAR							
EXPENDITURES							
Personnel Costs (salaries, wages, benefits)		FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	Total
1	Salaries	\$21,531	\$65,797	\$67,771	\$44,909	\$46,256	\$246,264
2	Direct Costs						
3	Indirect Costs						
4	Total Personnel Costs	\$21,531	\$65,797	\$67,771	\$44,909	\$46,256	\$246,264
Operating Costs (travel, hotel)		FY 19/20	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24
5	Direct Costs	\$1,000	\$3,000	\$3,000	\$3,000	\$3,000	\$13,000
6	Indirect Costs	\$9,785	\$29,293	\$29,293	\$29,293	\$29,294	\$126,958
7	Total Operating Costs	\$10,785	\$32,293	\$32,293	\$32,293	\$32,294	\$139,958
Non-Recurring Costs (technology, equipment)		FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	Total
8	Direct Costs	\$0	\$0	\$0	\$0	\$0	\$0
9	Indirect Costs	\$0	\$0	\$0	\$0	\$0	\$0
10	Total Non-Recurring Costs	\$0	\$0	\$0	\$0	\$0	\$0
Consultant Costs/Contracts (training, facilitation, evaluation)		FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	Total
11a.	Direct Costs (Third Sector)	\$58,353	\$326,706	\$113,435	\$0	\$0	\$498,494
11b.	Direct Costs (CalMHSA)	\$5,850	\$33,338	\$12,188	\$938	\$938	\$53,250
11c.	Direct Costs (Evaluator)	\$0	\$10,417	\$10,417	\$10,417	\$10,417	\$41,668
12	Indirect Costs	\$0	\$0	\$0	\$0	\$0	\$0
13	Total Consultant Costs	\$64,203	\$370,461	\$136,040	\$11,355	\$11,355	\$593,412
Other Expenditures (explain in budget narrative)		FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	Total
14	Program/Project Cost	\$0	\$0	\$0	\$0	\$0	\$0
15		\$0	\$0	\$0	\$0	\$0	\$0
16	Total Other Expenditures	\$0	\$0	\$0	\$0	\$0	\$0

DRAFT Multi-County FSP Innovation Plan

EXPENDITURE TOTALS						
Personnel	\$21,531	\$65,797	\$67,771	\$44,909	\$46,256	\$246,264
Direct Costs	\$65,203	\$373,461	\$139,040	\$14,355	\$14,355	\$606,412
Indirect Costs	\$9,785	\$29,293	\$29,293	\$29,293	\$29,294	\$126,958
Total Individual County Innovation Budget*	\$96,519	\$468,551	\$236,104	\$88,557	\$89,905	\$979,634
CONTRIBUTION TOTALS						
Individual County Contribution	\$64,203	\$370,461	\$136,040	\$11,355	\$11,355	\$593,412
Additional Funding for County-Specific Project Costs	\$32,316	\$98,090	\$100,064	\$77,202	\$78,550	\$386,222
Total County Funding Contribution	\$96,519	\$468,551	\$236,104	\$88,557	\$89,905	\$979,634

Ventura County Behavioral Health

Board Letter Summary of Contracts for November and December 2019

Board Date	Contractor	Amount	Term	Description
11/5/2019	Santa Paula Unified School District	\$0	7/1/2019 to 6/30/2020	Ventura County Behavioral Health (VCBH) is working with Santa Paula Unified School District (SPUSD) to maintain educational support services at selected school sites in a collaborative relationship using a shared model "Pyramid of Intentions," which incorporates the resources of each agency. Under this Memorandum of Agreement (MOA), SPUSD agrees to provide a primary contact at each school site. SPUSD plans to work with VCBH staff to deliver a parent educational series on mental health issues twice per academic year to reduce barriers in identifying and treating mental illness.
11/5/2019	California Department of Health Care Services	\$0	7/1/2018 to 6/30/2021	The Performance Standard Agreement #18-952588 (Agreement) with Department of Health Care Services (DHCS) specifies the terms and conditions VCBH must follow with respect to the Mental Health Services Act (MHSA), Lanterman-Petris-Short (LPS) Act, Projects for Assistance in Transition from Homelessness (PATH), Community Mental Health Services Block Grant (MHBG), Crisis Counseling Assistance and Training Program (CCP), and Bronzan-McCorquodale Act services.
11/5/2019	California Department of Health Care Services	\$69,558,350	12/1/2018 to 6/30/2021	The DHCS multi-year Drug Medi-Cal-Organized Delivery System (DMC-ODS) Standard Agreement #18-95150 is the established mechanism for the County to receive federal and state allocated funds for the array of Substance Use Disorder (SUD) services that are provided under the DMC-ODS waiver. This Agreement Amendment Number A01 (Amendment) revises contract language, with no change in the maximum contract amount.
12/10/2019	Turning Point Foundation: Adult Wellness and Recovery Center (AWRC) and Growing Works	\$805,849	7/1/2019 to 6/30/2020	Turning Point operates two Adult Wellness and Recovery Center (AWRC) programs and the Growing Works program, with goals of reducing symptoms, and preventing decompensation and psychiatric hospitalization. The Third Amendment to the FY 2019-20 Agreement includes the logic model as part of the scope of work and revises various budgetary line items to better align with program needs. These adjustments exceed the 20% threshold currently allowed under the Agreement and require board approval, with no change in the existing maximum contract amount.

12/10/2019	Turning Point: Quality of Life Improvement (QLI): Rapid Integrated Support and Engagement (RISE)	\$239,936	7/1/2019 to 6/30/2020	Turning Point QLI RISE Expansion utilizes peer recovery coaches to perform outreach and maintain connection with clients through continued outreach after discharge in order to assist with transportation, service coordination and any other barriers in connecting clients with their home VCBH clinic. The Fourth Amendment funds one additional peer recovery coach position.
12/17/2019	Evalcorp	\$498,050	1/1/2020 to 6/30/2021	Evalcorp develops process and outcome measures, tailored data collection protocols, and corresponding data and performance outcome reports for VCBH and its funded Alcohol and Drug Program (ADP) services contractors. This ADP Prevention Services Agreement funds the project for the second six months of FY 2019-20 and for FY 2020-21, providing research and evaluation services to address vaping and drug trends, marijuana and prescription drug initiatives, alcohol, tobacco and other drug prevention efforts, and technical assistance in application of the State-required Strategic Prevention Framework.
12/17/2019	Idea Engineering, Inc.	\$396,000	1/1/2020 to 6/30/2021	Idea Engineering, Inc. provides communication materials and graphic design services, a custom localized library to support various program publications, using social host and related community education efforts, and internet-based digital messaging services to youth and young adults. The project for the second six months of FY 2019-20 and FY 2020-21 provides the above-listed services in support of all prevention services initiatives, consistent with the Substance Abuse and Mental Health Services Administration's (SAMHSA) Strategic Prevention Framework through media at the local level.
12/17/2019	Reality Improv Connection, Inc.	\$287,100	1/1/2020 to 6/30/2021	Reality Improv Connection, Inc. provides youth, young adult and parent engagement services and education strategies to address binge drinking, impaired driving, prescription drug abuse, and health disparities using school and community-based workshops, performances, and new media (podcasts, blogs, e-news, and text messaging). The project for the second six months of FY 2019-20 and for FY 2020-21 provides significantly enhanced media and health advocacy efforts, as well as community presentations about vaping, underage and binge drinking, and impaired driving harms.

12/17/2019	Ventura Unified School District (VUSD)	\$269,996	1/1/2020 to 6/30/2021	VUSD began training staff on the systemic use of the Brief Risk Reduction Interview and Intervention Model (BRRIM) in early 2019. In August 2019, VUSD began providing individualized, evidence-based ADP support services to identified students and their families. This ADP Prevention Services Agreement supports the project for the second six months of FY 2019-20 and for FY 2020-21, providing full development of district level programs using BRRIM. Multi-year training and support efforts are necessary to complete the transition of Student Assistance Program efforts to serve all secondary schools.
12/17/2019	Catalyst Church Ventura (Catalyst)	\$447,164	7/1/2019 to 6/30/2023	Catalyst provides Conocimiento: Addressing Adverse Childhood Experiences Scale (ACES) through Core Competencies services through its Ignite after-school program, serving at-risk youth ages 13-19 in Santa Paula. Catalyst is working in association with local schools and utilizing community collaboration to reduce adverse outcomes, increase core competencies and build resilience. The First Amendment provides previously allocated transportation funds to Catalyst, and removes transportation barriers for participants to access the program.
12/17/2019	One Step a La Vez	\$433,510	7/1/2019 to 6/30/2023	One Step a La Vez provides Conocimiento: Addressing ACES through Core Competencies services through its after-school program, serving teens ages 13-19 in Fillmore. This program is like the Santa Paula program described above. In addition to providing prevention services, it will ensure at-risk youth caregivers receive support and assistance in building community. The First Amendment provides previously allocated transportation funds, and removes transportation barriers for participants to access this program.
12/17/2019	United Parents	\$169,299	7/1/2019 to 6/30/2020	United Parents provides respite services for parents and caregivers of children with serious emotional, behavioral and mental health issues. Program services are designed to minimize stressors on caregivers and families which could lead to destabilization, crisis and the potential for children to be placed out of the home. The Sixth Amendment will extend the term of the agreement for three additional months.

MEMORANDUM

DATE: January 27, 2020
TO: Behavioral Health Advisory Board
FROM: Contracts Administration
SUBJECT: Board of Supervisors Approved November & December Agreements/Board Items

Board of Supervisors Approved Agreements – November 5, 2019

1. **FY 2019-20 Santa Paula Unified School District (SPUSD) Memorandum of Agreement (MOA).**

This item recommended the Board of Supervisors (Board) approve and authorize the Ventura County Behavioral Health (VCBH) Director or designee to sign the MOA for educational support services with SPUSD, effective July 1, 2019 to June 30, 2020. There is no fiscal impact associated with this recommendation.

SPUSD is working collaboratively with VCBH to provide educational support services at selected school sites to children and families jointly through a shared model, "Pyramid of Intentions," which incorporates the resources of each agency. SPUSD is planning to work with VCBH staff to deliver a parent education series on mental health issues twice per academic year, collaborate with VCBH staff to reduce barriers to identify and treat mental illness, and provide access to mental health services. The MOA is necessary to establish the terms by which VCBH and OSD will maintain a collaborative relationship to facilitate inter-agency services to staff, students and families at selected school sites.

VCBH recommended approval for the VCBH Director or designee to sign the FY 2019-20 SPUSD MOA for educational support services.

2. **FY 2018-21 Performance Standard Agreement (Agreement) #18-952588.**

This item recommended approval for the VCBH Director or designee to sign the California Department of Health Care Services (DHCS) Agreement #18-952588 for Mental Health Services Act (MHSA), Lanterman-Petris-Short Act (LPS Act), Projects for Assistance in Transition from Homelessness (PATH), Community Mental Health Services Block Grant

(MHBG), Crisis Counseling Assistance and Training Program (CCP), and Bronzan-McCorquodale Act services, in zero amount, effective July 1, 2018 through June 30, 2021.

DHCS administers the MHPA, LPS Act, PATH, MHBG, CCP, and Bronzan-McCorquodale Act programs and oversees VCBH's provision of the Bronzan-McCorquodale Act community mental health services, which are provided with realignment funds. VCBH is required to meet certain conditions and requirements to receive funding for these programs and community health services, and this DHCS annual Agreement specifies those conditions and requirements.

The main changes from the prior Agreement include: (1) revisions to MHPA distribution and use contract language, (2) revision to the MHPA funding reversion requirements, (3) addition of county obligations related to Bronzan-McCorquodale Act community mental health services for the indigent population, (4) addition of LPS Act and Laura's Law client and program data reporting requirements, and (5) addition of federal Uniform Guidance regulation requirements for the MHBG, PATH and CCP programs.

VCBH recommended approval for the VCBH Director or designee to sign the FY 2018-21 DHCS Agreement #18-952588.

3. FY 2018-21 DHCS Standard Agreement #18-95150 Amendment Number A01 for Drug Medi-Cal Organized Delivery Services (DMC-ODS).

This item recommended approval for the VCBH Director or designee to sign the DHCS Agreement #18-95150 Amendment Number A01 for DMC-ODS services, in the existing amount of \$69,558,350, effective December 1, 2018 through June 30, 2021.

DHCS' multi-year DMC-ODS Agreement #18-95150 is the established mechanism for the County of Ventura (County) to receive federal and state allocated funds for the array of SUD services provided under the DMC-ODS waiver. Through the proposed DMC-ODS Standard Agreement #18-95150 Amendment Number A01, DHCS is amending VCBH's existing DMC-ODS Standard Agreement to incorporate revisions to the following Agreement requirements: (1) beneficiary enrollment non-discrimination, (2) oral interpretation and written translation services, (3) discrimination grievances, (4) disabled individuals services, (5) network adequacy standards, (6) provider-beneficiary communications, (7) treatment service requirements, (8) interim rate reimbursement and fiscal audit provisions, and (9) special terms and conditions (termination and compliance with statutes and regulations). There is no change to the maximum contract amount of \$69,558,350.

VCBH recommended approval for the VCBH Director or designee to sign the FY 2018-21 DHCS Agreement #18-95150 Amendment Number A01.

Board of Supervisors Approved Agreements – December 10, 2019

4. FY 2019-20 Turning Point Foundation (Turning Point) Adult Wellness and Recovery Center (AWRC) and Growing Works Third Amendment and FY 2019-20 Turning Point Quality of Life Improvement (QLI) Fourth Amendment.

This item recommended approval for the VCBH Director or designee to sign the: (1) Third Amendment to the agreement with Turning Point for AWRC and Growing Works services within the existing contract maximum amount of \$805,849, effective July 1, 2019 through June 30, 2020; and (2) Fourth Amendment to the agreement with Turning Point for QLI services, in the amount of \$239,936 (an increase of \$35,509), for an overall contract maximum of \$573,280, effective July 1, 2019 through June 30, 2020. These agreements are funded with MHSA and Triage Grant Funds.

Turning Point operates two AWRC programs, as well as the Growing Works program. AWRC focuses on outreach to and engagement with individuals with serious and persistent mental illness who have been unserved or underserved by the traditional mental health system. Using 1-on-1 interaction and serving as a portal to other mental health, medical, dental, housing, and employment services, AWRC's goal is to reduce symptoms and prevent decompensation and psychiatric hospitalization. In FY 2018-19, they served 985 unduplicated individuals.

The Growing Works program is a nursery/horticultural peer job readiness program using established recovery principles to provide job readiness training to VCBH clients. The program goal is to identify 50 VCBH clients per year for potential participation, enrolling 25 clients into the program. Growing Works is based on a logic model which delineates specific activities, outputs and outcomes.

The Third Amendment to the Agreement incorporates the logic model into the scope of work, and revises budgetary line items within the existing contract maximum to better align with program needs. These adjustments exceed the 20% threshold currently allowed under the Agreement and requires board approval.

Turning Point Foundation QLI RISE Expansion uses peer recovery coaches as essential client advocates, with three peer recovery coaches funded. These coaches perform outreach to clients in jail/juvenile facilities, the Crisis Stabilization Unit, and the Psychiatric Inpatient Unit, building trust and connecting clients with clinical teams. Peer recovery coaches maintain connection with clients through continued outreach after discharge to assist in decreasing barriers to connecting clients with their home VCBH clinic. Peer recovery coaches provide an array of services to ensure mitigation of barriers to mental health and supportive services, including transportation, making appointments and facilitating timely services. The program served 260 unduplicated individuals in FY 2018-19, currently serving clients in six board and care sites (Sunrise Manor, Elms, Cottonwood, Villa Callegus, Castillo del Sol, and River Haven).

The Fourth Amendment to the Agreement increases the contract maximum amount, specifically the RISE Expansion portion of the budget to a total of \$239,936 (an increase of

\$33,509), to fund one additional peer recovery coach position.

VCBH recommended approval for the VCBH Director or designee to sign the FY 2019-20 Turning Point Third and Fourth Amendments.

Board of Supervisors Approved Agreements – December 17, 2019

5. Alcohol and Drug Programs (ADP): January 1, 2020 through June 30, 2021 Evalcorp, Ideal Engineering, Reality Improv Connection, Inc., and Ventura Unified School District (VUSD) ADP Prevention Services Agreements.

This item recommended approval for the VCBH Director or designee to sign the ADP Prevention Services Agreements, effective January 1, 2020 through June 30, 2021 with: (1) Evalcorp, in the amount of \$498,050, (2) Idea Engineering, in the amount of \$396,000, (3) Reality Improv Connection, in the amount of \$287,100, and (4) VUSD, in the amount of \$269,996. These agreements are funded with Office of Justice Programs (OJP) Comprehensive Opioid Abuse Site-Based Program (COAP) Grant, and Substance Abuse Prevention and Treatment Block Grant (SABG).

Evalcorp develops process and outcome measures, tailored data collection protocols, and corresponding data and performance outcome reports for VCBH and its funded prevention services contractors. Evalcorp provides prevention research and evaluation services to VCBH, including: (1) data management and analysis for the Place of Last Drink (POLD) survey among driving under the influence (DUI) arrestees, (2) evaluation, data collection and analysis of overdose prevention data sets, (3) development of evaluation tools to document Straight Up Reality Party and prevention activity outcomes, (4) prevention planning, consultation and community survey design and administration services, and (5) support of opioid abuse prevention and suppression efforts. The project for the second six months of FY 2019-20 and FY 2020-21 provides research and evaluation services, statistical analysis and data collection to address vaping and drug trends, marijuana and prescription drug initiatives, alcohol, tobacco and other drug prevention efforts, and technical assistance in the application of the State-required Strategic Prevention Framework, with emphasis on local research and evaluation activities.

Idea Engineering, Inc. provides VCBH with communication materials and graphic design services, a custom and localized image library to support various program publications, including prescription drug abuse and heroin prevention initiative, impaired driving prevention, opioid overdose prevention and rescue efforts, using social host and related community education efforts and internet-based digital messaging services to youth and young adults. The project for the second six months of FY 2019-20 and for FY 2020-21 provides marketing, media and prevention messaging services in support of all prevention services initiatives, consistent with the Substance Abuse and Mental Health Services Administration's (SAMHSA) Strategic Prevention Framework, through media at the local level.

Reality Improv Connection, Inc. provides youth, young adult and parent engagement services, as well as education strategies to address binge drinking, impaired driving,

prescription drug abuse, and health disparities using school and community based workshops, performances and new media (podcasts, blogs, e-news, and text messaging). These strategies alter the expectations and community norms that support and condone alcohol abuse, prescription drug misuse, and marijuana use among young people. The project for the second six months of FY 2019-20 and FY 2020-21 provides significantly enhanced media and health advocacy efforts to suppress opioid overdose, prescription drug and marijuana abuse dangers, and includes video and audio public announcements and displays, community presentations about vaping, underage and binge drinking, impaired driving harms, and the implementation of an innovative examination of substance use risk among historically underserved populations.

VUSD began training staff on the systemic use of the Brief Risk Reduction Interview and Intervention Model (BRRIM) in early 2019, using their Student Assistance Program (SAP) staffing and resources, and County-sponsored technical assistance. In August 2019, VUSD began providing this individualized evidence-based alcohol and drug prevention support services to identified students and their families. The project for the second six months of FY 2019-20 and for FY 2020-21 supports full development of district-level programs using BRRIM, designed to address substance use and related challenges for students district-wide, utilizing strength-based and family involved approaches. Multi-year training and support efforts are necessary to fully develop district capacity and to complete the transition of current SAP efforts to serve all secondary schools, increasing average daily attendance and further reducing rates of suspensions and other disciplinary actions.

VCBH recommended approval for the VCBH Director or designee to sign the ADP prevention services agreements with: (1) Evalcorp, in the amount of \$498,050, of which \$163,415 will be for the service period January 1, 2020 through June 30, 2020, and \$334,635 will be for the service period of July 1, 2020 through June 30, 2021, (2) Idea Engineering, Inc., in the amount of \$396,000, of which \$132,000 will be for the service period January 1, 2020 through June 30, 2020, and \$264,000 will be for the service period of July 1, 2020 through June 30, 2021, (3) Reality Improv Connection, Inc., in the total amount of \$287,100, of which \$95,700 will be for the service period of January 1, 2020 through June 30, 2020, and \$191,400 will be for the service period of July 1, 2020 through June 30, 2021, and (4) VUSD, in the total amount of \$269,996, of which \$90,000 will be for the service period of January 1, 2020 through June 30, 2020 and \$179,996 will be for the service period of July 1, 2020 through June 30, 2021.

6. FY 2019-23 Catalyst Church Ventura (Catalyst) First Amendment and FY 2019-23 One Step a La Vez First Amendment.

This item recommended approval for the VCBH Director or designee to sign the FY 2019-23 First Amendments to the Agreements for Conocimiento: Addressing Adverse Childhood Experiences Scale (ACES) through core competencies services with: (1) Catalyst, in the amount of \$477,164, an increase of \$44,259, and (2) One Step a La Vez, in the amount of \$433,510, an increase of \$44,262. These programs are funded with MHSA funds.

Catalyst provides Conocimiento: Addressing ACES through Core Competencies services through its Ignite after-school program serving teens ages 13-19 in Santa Paula, working in

association with local schools to serve at-risk youth and provide prevention services designed to utilize community collaboration to reduce adverse outcomes in adolescents living in poverty or with ACES by increasing core competencies and building resilience.

The First Amendment will: (1) provide previously allocated transportation funds to Catalyst, (2) remove transportation barriers for participants to access the program, and (3) increase the maximum contract amount from \$432,905 to \$477,164, an increase of \$44,259.

One Step a La Vez provides Conocimiento: Addressing ACES through Core Competencies services through its after-school program, which serves teens ages 13-19 in Fillmore. This program is like the Santa Paula program described above. In addition to prevention services being provided, it will ensure that at-risk youth caregivers receive support and assist in building community.

The First Amendment will: (1) provide previously allocated transportation funds to One Step a La Vez, (2) remove transportation barriers for participants to access this program, and (3) increase the maximum contract amount from \$389,248 to \$433,510, an increase of \$44,262.

VCBH recommended approval for the VCBH Director or designee to so sign the FY 2019-23 Conocimiento services agreement First Amendments with: (1) Catalyst, in the total amount of \$447,164, an increase of \$44,259; and (2) One Step a La Vez, in the total amount of \$433,510, an increase of \$44,262.

7. FY 2019-2020 United Parents Sixth Amendment to the Agreement for Respite Services.

This item recommended approval for the VCBH Director or designee to sign the Sixth Amendment to the Agreement for respite services with United Parents, extending the term for three additional months, and increasing the agreement maximum from \$112,867 to \$169,299, an increase of \$56,432, for the period of January 1, 2020 to March 31, 2020. This agreement is funded with SAMHSA Grant funds.

United Parents provides respite services (short-term, temporary relief/care) for parents and caregivers of children with serious emotional, behavioral and mental health issues, with trained respite providers caring for children in or out of the home. Program services are designed to minimize stressors on primary caregivers and families which could lead to destabilization, crisis and the potential for children to be placed out of the home. In 2018-19, the United Parents respite program enrolled 30 families and served a total of 101 unduplicated families. This sixth amendment to the respite services agreement with United Parents will extend the term for three additional months, January 1, 2020 to March 31, 2020, replace Exhibit 1 and increase the agreement maximum to reflect the additional three months of service, not to exceed the annual pro-rata amount.

VCBH recommended approval for the VCBH Director or designee to sign the FY 2019-20 Sixth Amendment to the Agreement with United Parents, in the total amount of \$169,299, an increase of \$56,432.