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

Outpatient Operational Manual

A Team-based Care approach

2019-2020

Access & Transitions Work group

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INTRODUCTION

What is Team-based Care?

Team-based Care is a multi-disciplinary approach in which all clinic/program members share joint responsibility in providing services, supports and treatments to consumers. Each treatment team carries together an assigned caseload, and each team member – based on his/her role, expertise and scope of practice – contributes towards a consumer's success, recovery and goal achievement. In Team-based Care, members of the treatment team:

- Recognize, respect and value each other's role within the team-based structure;
- Demonstrate proficiency in his/her specific role;
- Work collaboratively to improve client-centered care and outcomes;
- Participate in shared decision-making.
- Focus on client centered care
- Continually assess for continuity and coordination of care needs

Moreover, Team-based Care draws from the philosophy and successes of the Assertive Community Treatment (ACT) model the children's wraparound model, with the initiative to integrate services for client-centered care. Research has shown that team-based care:

- Provides safe, timely, equitable, client-centered care systematically.
- Streamlines and improves the quality of care.
- Improves efficiency.
- Reduces workload on individual staff members.
- Improves consumer and employee satisfaction.
- Encourages the use of wellness and recovery principles within the workforce and with consumer care
- Improves recovery and wellness outcomes.
- Guides teams with the use and implementation of outcome measures and appropriate discharge levels of care for each consumer that is client centered.

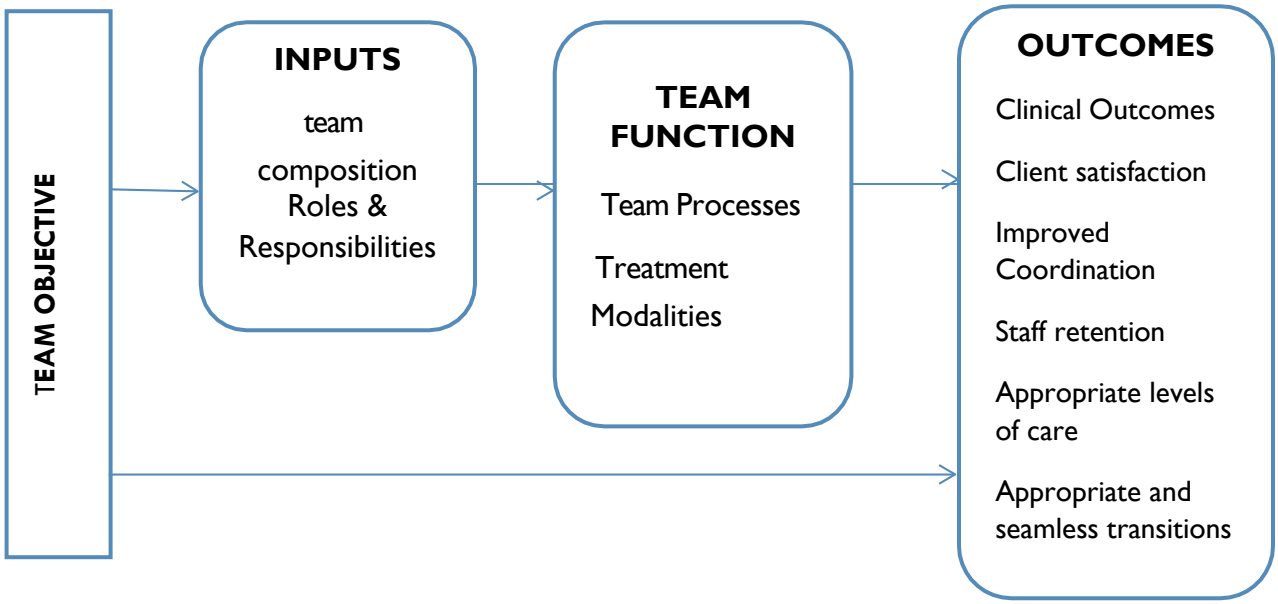
Why Team-Based Care?

In January 2014, all the Santa Barbara County Department of Behavioral Wellness outpatient clinics and programs were transferred to the Mental Health Services Act (MHSA) program model to incorporate the MHSA principles. Based on the Department's three year MHSA plan, Behavioral Wellness outlined a plan to demonstrate adherence to the following program principles:

1) All services and programs provided are consumer centered;
2) Consumers receive treatment and rehabilitation in the most appropriate and least restrictive environment, preferably in their own communities;

3) There is evidence of a coordinated, integrated and effective system of care that operates in conjunction with an interagency network of other services necessary for individual consumers;
4) Services and programs address the special needs of children and youth, adults and older adults with dual disorders.
5) Team staff demonstrates the use of outcome measures in the decision making for appropriate levels of care, and in the planning for the transition to lower or higher level of care.
6) Team staff agree to adhere to principles that demonstrate our commitment to cultural competence across all spectrums of care, including documentation practices and services that are provided.

TEAM-BASED CARE MODEL



TEAM OBJECTIVE

A team objective explains the purpose of the team and is oriented to the desired outcomes. Team objectives are based on the department's vision and mission, which is "to promote the prevention of and recovery from addiction and mental illness among individuals, families and communities, by providing effective leadership and delivering state-of-the-art, culturally competent services."

INPUTS

Team Composition

Teams may consist of the following staff disciplines:

- Psychiatrist/Nurse Practitioner/Physician's Assistant
- Practitioner
- Case Worker
- Recovery Assistant/Peers
- Medical Support Staff
- Alcohol and Drug Specialist
- Vocational Rehabilitation Specialist
- Administrative support staff
- Supervisory staff

The number of staff per team will vary based on the caseload size and acuity of the caseload.

While the team composition is diverse and may cover many specialties, clients may not necessarily receive services from every member of the team. Instead, each consumer's treatment plan is individualized to his/her needs, resulting in a uniquely customized treatment team. Each member of the custom treatment team has a stake in the treatment plan and is responsible for implementing treatment and interventions.

Roles and Responsibilities

Team members must know and understand what the role of each team member is. Specifically, awareness of each team members core function, abilities and limitations, and scope of practice based on licensure or job classification is imperative for a seamless and efficient team dynamic.

Team Supervisor

The Team Supervisor provides administrative and clinical supervision to the treatment team providing assessment, treatment and rehabilitation services to consumers. Within the context of Team-based Care, the Team Supervisor's responsibilities include:

- Uphold Mental Health Services Act (MHSA) Guiding Principles, including client-centered care, family and community inclusion, and creating welcoming environments.
- Directing the day-to-day operations of the treatment team.

- Coordinating the admission and discharge process for new consumers, ensuring that consumers are assessed and assigned within acceptable time limits per Medi-Cal guidelines and assigning consumers to the most suitable treatment team/services depending on the level of care needs.
- Providing supervision in the development of a treatment plan tailored to the needs of the consumer.
- Directing the ongoing treatment and rehabilitation of consumers to ensure the availability of rehabilitation groups to assist consumers in the recovery process.
- Providing direction and supervision to treatment teams in determining when consumers have met their goals and when it is appropriate to step-down to a lower level of care.
- Ensuring that each consumer has integrated care with their health provider or other providers and that the care is coordinated effectively and that the coordination is documented monthly.

Psychiatrist/Nurse Practitioner (NP)/Physician's Assistant (PA)

The Psychiatrist/NP/PA provides psychiatric diagnostics and therapeutic services to consumers. Within the context of Team-based Care, Psychiatrist/NP/PA responsibilities include:

- Establishing a clinical relationship with each consumers assigned to the team that requires Psychiatric services.
- Conducting psychiatric assessments confirming diagnosis or agreement with the primary and secondary diagnosis with practitioner(s) on the team.
- Prescribing psychotropic medication as needed and providing the client with education about the benefits and risks of each medication.
- Assessing and documenting the client's mental health symptoms/impairments and behaviors in response to prescribed medications as well as monitoring and documenting any side effects to medication.
- Collaborating with nursing support staff in assessment of the client's physical health.
- Making appropriate referrals to community physicians for further assessment and treatment.
- Being actively involved with client's treatment during admissions to acute psychiatric facilities, including regular communication and consultation with the attending psychiatrist.
- Working with medical staff to ensuring the consumers have labs completed when prescribed certain medications that require regular labs.

- Ensuring medication consents are completed for all medications prescribed and collaborating with the med support staff when the consents are not completed.

Medical Support Staff – Registered Nurse (RN), Licensed Vocational Nurse (LVN) and Psychiatric Technician (PT)

The Medical Support staff is responsible for coordinating the client's medication support services and ancillary medical needs. Responsibilities and duties vary depending on the scope of license and may include:

- Identifying medical conditions and supporting client in obtaining necessary treatment.
- Identifying health risk factors and providing education, support and rehabilitation activities to reduce risk factors.
- Evaluating clients for medication side effects.
- Packaging & delivering medications depending on level of care needs
- Teaching clients how to identify and keep track of medications.
- Administering standard protocols prior to MD sessions (i.e. vital signs, mental status exam).
- Monitoring laboratories.
- Ensuring all consumers are connected to primary care

Practitioners – Associate Social Workers (ASW), Licensed Clinical Social Workers (LCSW), Associate Marriage and Family Therapist Interns (AMFT), Licensed Marriage and Family Therapists (LMFT), waivered Psychologists, and licensed Psychologists (Ph.D or Psy.D)

Practitioners are responsible for conducting and completing the clinical assessment, providing therapeutic treatment and supportive services to consumers. Responsibilities include:

- A Practitioner may be the designated Care Coordinator, or team lead-
- Providing on-going assessment services including coordinating with the team psychiatrist on the client's diagnosis.
- Facilitating the development of the consumer's treatment plan with the consumer and other team members.

- Providing individual and group therapy to the consumer to assist them in achieving their identified recovery goals.
- Ensuring Evidenced Based Practices (EBP's) are utilized and documented to ensure quality of care.
- Providing clinical leadership in addressing urgent or crisis situations.

Case Worker

Case Workers, and Recovery Assistants, are responsible for providing assistance, support and rehabilitation activities to consumers to help them maintain functioning in the community. Responsibilities may include:

- Assisting consumers in improving or maintaining basic self-care functions.
- Teaching money management skills and monitoring management of consumer funds.
- Supporting clients in obtaining and maintaining their housing by providing support in improving or maintaining their house-keeping abilities.
- Encouraging and facilitating participation in social activities.
- Facilitating activities that improve or maintain the consumer's ability to have healthy interpersonal relationships.
- Assisting consumers in supportive employment and or school functioning.
- Provide skill building, coaching,and behavior management

Recovery Specialist - Peer Recovery Specialist

Peer Recovery Specialists provide peer support services to promote the engagement and treatment services of clients to achieve recovery. Principal responsibilities may include:

- Serving as a role model to consumers and educating them on self-help techniques.
- Provide support and education regarding mental health symptoms, services, programs, and how to navigate the system.
- Teaching symptom management skills and coping strategies based on personal experience.
- Assisting consumers in developing community support systems and networks.
- Engaging and orienting new consumers to outpatient mental health treatment,and ongoing consumers to manage the process when transitioning or needing continuity of care.

- Assisting with transportation barriers
- Assists with outreach efforts to help improve engagement.

Alcohol and Drug Specialist

The Alcohol and Drug Specialist has special training to provide SUD services as an integrated service, and if needed, coordinates referrals to substance use resources that offer additional assessment, treatment planning that is tailored to the consumer's needs. Principal responsibilities may include:

- Providing individual and group services for dual SUD and MH treatment.
- Providing education on substance use and interaction with mental illness.
- Contributing non-confrontational support for harm reduction.
- Providing reflective listening, motivational interviewing and behavioral principles.
- Assisting consumers with a relapse prevention plan.
- Assisting consumers with admission to SUD services or sober living facilities and their transition after completion of treatment.
- Advising the treatment team regarding SUD needs and barriers

Rehabilitation Specialist

The Rehabilitation Specialist works with the Department of Rehabilitation (DOR) to address obstacles to gainful employment as a result of living with mental illness and co-occurring conditions. Principle responsibilities may include:

- Conducting intakes to evaluate daily functioning, work history, academic training, interests and aptitudes in order to assist the consumer with DOR on the eligibility process and service need.
- Coordinating and tracking all vocational and academic services received from DOR and contracted vendors.
- Providing individual skill-building geared toward enhancing community access and identified strengths, resources, and interests in order to prepare for a positive employment or academic outcome.

- Acting as an advisor to the case managers and therapists with regard to vocational planning.
- Being the liaison to DOR and providing expertise to DOR and vendors, working from both the treatment plan and the DOR's Individual Plan for Employment (IPE).
- With the TAY team, providing direct services that involve job coaching, resume writing, improvement of job skills. Assist with addressing all barriers that affect employment.

Administrative Office Support Staff

Administrative Office Support Staff are responsible for organizing and monitoring all nonclinical operations under the direction of the clinic supervisor. Principle responsibilities may include:

- Coordinating communication between team and consumers.
- Triaging in-coming calls.
- Maintaining the MD schedule.
- Doing reminder calls.
- Managing mail.
- Scanning documents to EHR.
- Managing petty cash.
- Maintaining scheduler/calendar.

TREATMENT TEAM PROCESSES

Determining the level of care

Every consumer will be assessed for his/her level of care needs and will be reassessed every 3-6 months depending on the program and consumer's individualized needs. See the Level of Care memo for Adult Services. All services will be appropriate to the needs of each consumer. The designated care coordinator will take the lead to coordinate the services which will include:

- Checking in regularly with consumers to ensure they have the correct information to make contact with the designated care coordinator, and assess any barriers.
- Assessing any barriers to achieving treatment goals, and assessing any current needs.
- Coordinating updates to the treatment plan to ensure that it is an accurate reflection of the consumer's current needs and that the appropriate level of care is reflected in the plan.
- Advocating for the consumer at daily treatment team meetings (or CTS) when the consumer is in need of a higher or lower level of care.

- Ensuring and preparing the consumer to be able to be willing and able to accept informal supports or outside service agency referrals/ involvement.
- Assessing the level of care as indicated through use of the Level of Care tool.

Coordinated Care

Every consumer is assigned a primary care coordinator. The primary care coordinator is responsible for coordinating and monitoring services provided to the client and is the client's primary clinic contact. The role of primary care coordinator can be assumed by various members on the team, such as the case worker, practitioner, alcohol and drug specialist or nursing staff.
Responsibilities include:

- Checking in regularly with consumers to monitor engagement with treatment and oversee the progression the consumer has made towards achieving treatment goals.
- Outreaching to consumers who have missed important treatment appointments.
- Coordinating updates to treatment plan to ensure that it is an accurate reflection of the consumer's current needs and requests at any given time.
- Ensuring that the client is scheduled for annual assessment and treatment plan development.
- Ensuring there is a release of information for the services that are needed to avoid duplication of services and to improve coordination of care across providers.

When the primary care coordinator is unavailable, another member of the treatment team may assume responsibility for the assigned cases to ensure that all clients are not put in a position where their care is compromised or delayed due to the absence of the lead care coordinator. See the Care Coordination memo.

Communication

On-going communication between the treatment team members both formal and informal is a cornerstone to facilitate shared decision-making and improved quality of care for consumers. Informal communication occurs throughout the day through e-mails, mini team-huddles and brief verbal interactions. Formal communication is facilitated in the daily team based care meetings, or scheduled treatment meetings with the consumer/family.

The daily team meetings last no longer than an hour. The meeting is attended by all staff on the treatment team and the meeting has priority over everything except client emergencies.

- The team meeting is chaired by the Lead Team coordinator. This individual is initially assigned by the clinic supervisor, but as the team develop the team members may change,

depending on the need of the consumer. The Team Coordinator will keep notes of all items discussed and review previous agenda items as a follow-up on activities that have been assigned to team members. They will alert the Team Supervisor if barriers are preventing goals and objectives from being met or affecting client care. Documentation into the EHR needs to occur via a team based care progress note to indicate the plan and follow up for each consumer that is presented. All coordination and continuity of care must be documented at minimum monthly.

- The meeting agenda will include at minimum the following topics:
  - Ensure every client has an assigned care coordinator and that it is documented.
  - Review the activities scheduled for the day, such as consumers scheduled for MD appointments, IM, groups, individual therapy. Or whether a consumer should have been scheduled to see the Psychiatrist and what the barriers are.
  - Review whether the consumer is receiving services in the appropriate level of care, whether the consumer's current dx is accurate, has a current active treatment plan that outlines the appropriate services, and whether any changes need to be made to the treatment plan.
  - Review high-risk consumers, including consumers that are currently admitted to an in-patient facility or jail and consumers who require more intense services or higher levels of care.
  - Discuss consumers who missed MD, IM appointments the previous day and assign a staff team member that will be responsible for outreaching to them by a certain time frame.
  - Review consumers that have not engaged with services for more than 45 days in the adult programs and 30 days for the children's programs, and discuss an outreach plan.
  - Review the needs of new consumers and assign the assigned care coordinator that will outreach immediately, and offer/provide services within 5 working days.
  - Review consumers who are ready to step down to a lower level of care and outline the individual continuity of care plan. The assigned care coordinator ensures the consumer is connected prior to closing out.
  - Refer clients to Vocational Rehabilitation or other supportive community programs as appropriate, and follow up on those services for coordination of care.
- The minutes are kept to document the daily team meeting action plans.
- Team members hold one another accountable for attending and participating in team meetings.
- The clinic supervisor rotates amongst team meetings to provide support, communicate expectations, assignments, tasks, and roles to all team members and provides feedback to team members on work well done and opportunities for improvement. The Supervisor is responsible for ensuring the TBC Outpatient Manual is reviewed and followed by all outpatient staff.

Treatment Modalities

The treatment team provides comprehensive, individualized services in an integrated, continuous fashion in collaboration with the consumer aimed at relieving symptoms and reducing time spent in psychiatric hospitals, homelessness, or incarceration. During the development of the treatment plan, the client and treatment team will collaborate on the treatment modalities required to either reduce the client's impairments or prevent deterioration in current functioning.

Psychopharmacological Treatment

The treatment team assumes responsibility for providing on-going medication support to consumers. The team understands that individuals with severe and persistent mental illness do not always take medications as prescribed or are impacted from being able to consistently take their medications without support and education. The team actively works with the consumer to improve medication adherence by identifying the causes and influencing factors and implementing alternative strategies. Examples may include:

- Reducing complexities of medication methods, i.e. pill boxes, injectable vs tablets.
- Reminding consumers regularly to adhere to med appointments.
- Providing education to consumers about coping and self-management skills.
- Incorporating informal supports with education and inclusion in the consumer's treatment.
- Regularly re-assessing the need to reduce medication deliveries to consumers that have been progressing and requiring less support or increasing medication support based on client need.
- Leading and providing 3-4-50 groups as needed.

Rehabilitation Groups

Rehabilitation groups focus on helping consumers attain or restore coping skills and deal with the demands of everyday life as well as help restore relationships that may have become strained or damaged as a result of problems related to their mental illness and/or substance abuse.

Groups are offered based on the needs of the consumers served and within an evidence-based treatment framework. Groups may be facilitated by peers, case workers, nursing staff or clinical practitioners. Attendance of rehabilitation groups is voluntary and consumers may attend multiple groups to address their identified impairments.

Individual Therapy

Individual therapy is focused on developing the client's understanding and identification of impairments, decreasing distress and symptoms, improving role functioning and increasing participation in treatment. Individual therapy modality is in the form of brief solution-focused therapy. These can be accomplished through various therapeutic modalities.

- Goal Directed
- Structured

- Time limited
- Present-oriented/Past-aware
- Collaborative
- Educative

Individual Rehabilitation Services

Vocational rehabilitation staff, case workers, recovery assistants and peer staff will work side-by-side with consumers in community settings to develop greater competencies in employment, volunteer work, activities of daily living and social interactions. The focus is to assist the consumer to participate in activities within the community so that they do not miss out on experiences of developmental and personal growth.

Peer Support Services

Peer staff provides consumers & families with advocacy, support and education to assist them on their road to recovery. They facilitate groups (i.e. WRAP groups) and provide individual support to assist consumers in transitioning into the outpatient, community, or into a lower level of care.

Crisis Intervention Services

The treatment team will provide timely crisis intervention and de-escalation services when needed to prevent psychiatric hospitalizations. The treatment team will collaborate closely with the Crisis Services Team to provide support for consumers after hours and on weekends

Parent Partners

The children's Wraparound teams provide more intensive services for children and families that are at risk of school failure, hospitalization or STRTP placement. The Parent Partners provide consistent support, education, and de-escalation services for the parents to assist in ensuring children can be maintained in their home, community and local school.

OUTCOMES

The Milestones of Recovery Scales (MORS), CANS, and PSC are administered to all consumers upon intake, discharge and every 6 months to track changes in functioning and inform treatment as well as discharge planning. Within our ACT and SPIRIT teams, the outcome measures are completed every 3 months. The recommendation is that the MORS for adults be completed during the morning treatment team meetings. At minimum the results will be discussed at the treatment team meeting. For the CANS/PSC, the recommendation is to compete in partnership with the consumer and family and use to guide the CFT and Treatment planning as applicable. Outcome measures need to be embedded into treatment plans and fully explained to consumers.

Full Service Partnership (FSP) Programs

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

- Psychiatric assessment
- 24-hour crisis intervention and support
- Medication management and monitoring
- Individual and group rehabilitation counseling
- Case management services
- Dual recovery treatment
- Physical health service coordination
- Housing linkage and support
- Assistance with daily living activities
- Pre-vocational rehabilitation with linkage to vocational rehabilitation services in the community
- Educational and employment development and linkage

Santa Barbara County Department of Behavioral Wellness has several FSP programs. A specialized Forensic FSP program (Justice Alliance), New Heights Transitional Age Youth (TAY FSP- Age 16-25), Community Services (aka. Supportive Housing) for adults, Assertive Community Treatment (ACT), and SPIRIT wraparound Teams for children/youth.

The approach for FSPs is "whatever it takes" to help beneficiaries on their path to Wellness and Recovery, using a team-based approach. FSP teams embrace beneficiary driven services with each beneficiary choosing services based on individual needs. Unique to FSP programs are a low staff to beneficiary ratio (ideally 10:1 ratio). The team-based care approach is a partnership between multidiscipline staff and beneficiaries.

Adult FSP programs assist with housing support and linkage, employment preparation and education in addition to providing specialty mental health services and integrated treatment for co-occurring mental health and substance abuse disorder. Services can be provided to beneficiaries in their homes, the community and other locations.

For children/youth FSP programs specialized wraparound services are provided that include parent partners, the TAY FSP New Heights program has dedicated Peers and specialized DOR Voc services.

Assertive Community Treatment (ACT) Program for Adults:

ACT serves consumers 26 years of age or older. Individuals served are suffering from a mental illness as defined by Welfare and Institutions Code (WIC) 5600.3 (b) (2)-(b) (3). ACT is a client-centered, recovery-oriented behavioral health service delivery model that has received substantial empirical support for reducing psychiatric hospitalizations, facilitating community living, and enhancing recovery for persons with serious mental illnesses. ACT is designed specifically for persons who have the most severe and persistent mental illnesses, have severe symptoms and impairments, and who historically have not benefited from traditional outpatient programs. ACT teams provide person-centered services addressing the breadth of a

client's needs, helping him or her achieve their personal goals.

Forensic Service Programs (Justice Alliance):

The Santa Barbara County Department of Behavioral Wellness Forensic Services programs are designed to improve access to behavioral health services among individuals with current involvement in the criminal justice system or the increased potential for criminal justice system involvement due to homelessness status. The Department recognizes that for these individuals, additional steps need to be taken to reduce barriers to accessing services. Justice Alliance is a specialized FSP program that typically operate as outreach and engagement program, assessing clients, providing short term interventions and facilitating their access to longer term care.

Justice Alliance: A Specialized Full-Service Partnership (FSP) for adults who have current or recent criminal justice system involvement, some of who have been adjudicated Incompetent to Stand Trial (IST). Services are provided in each region of the county and staff work in a variety of settings, including outpatient clinics, the inpatient Psychiatric Health Facility (PHF), jail, Superior Court and outpatient residential placement settings. The Justice Alliance team is multidisciplinary and includes Practitioner series therapists, psychologists, caseworkers and recovery assistants; the team is also supported by a psychiatrist and psychiatric technician. Clients are referred into this program through the criminal justice system, for example, after an IST adjudication or after agreeing to participate in mental health treatment court. Depending on their level of care needs, they may receive psychotherapy, case management services, psychiatric medication, rehabilitation services or peer support. Clients are typically transitioned on to longer term care programs, such as clinic-based services, a longer term FSP service for those that meet criteria, or in some situations they are closed to services altogether pending resolution of their legal case. For those clients that meet FSP criteria, the Justice Alliance team provides the case coordination, offers the 24/7 services, and assigns a personal care coordinator.

New Heights Transitional Age Youth (TAY) Full Service Partnership (FSP) Program

New Heights is a Full Service Partnership program which operates with a "whatever it takes" approach which is enacted by methods and means to engage a consumer, determine his or her needs for recovery, and create collaborative services and support to respond to those individualized needs. This concept may include innovative approaches to "no-fail" services in which service provision and continuation are not dependent upon amount or timeliness of progress or the youth's compliance with treatment expectations, but rather on the individual needs and individual progress and/or pace on their path to wellness and resilience.

The New Heights Transitional Age Youth (TAY) Full Service Partnership (FSP) Program serves transitional age youth, ages 16-25, who meet medical necessity criteria for serious and persistent mental illness. This program is designed for TAY youth/young adults with the highest level-of-care needs. The New Heights FSP TAY program offers field based-community services with the TAY team based out of the Children's clinics in the three major regions of the county (Santa Barbara, Santa Maria, and Lompoc).

The program will provide outpatient mental health services for youth and young adults with severe and persistent mental illness that will incorporate family and informal supports as appropriate. The FSP TAY Team will offer intensive treatment to help individuals to recover and live independently within their community. Consumers will be assisted in their efforts to gain the skills needed to make choices that reflect their own values, preferences, and goals. Supports are developed to meet each person's unique needs and to empower each individual to attain their highest level of independence and recovery possible. The New Heights FSP TAY teams (a collaboration between the Department of Behavioral Wellness and the Community Action Commission) will focus closely with consumers to help identify recovery goals and to develop a specific "road map" for each person, with an overall goal of reaching a level of recovery that enables an individual to graduate from the program. If continued services are needed beyond age 24

(through age 24 and to age 25) with Behavioral Wellness, the TAY team will ensure that continuity care is provided as the consumer is linked to Behavioral Wellness Adult System of Care.

Services offered in this model operate within an integrated/holistic model of care that can include individual and/or group treatment interventions, supportive rehabilitation skill building services, medication monitoring and targeted case management in addition to after hours and weekend (24 hours a day, 7 days a week) on-call support provided by the New Heights FSP TAY Team. The team will utilize and integrate natural and professional supports with the consumer being the center of treatment. The provision of services and interventions utilized will reflect the needs identified in the consumer's assessment and individualized treatment plan.

The New Heights FSP TAY Team will function as a multi-disciplinary team that includes a Mental Health Practitioner, Case Workers, Rehabilitation Specialists, Peers, and medication support staff. New Heights FSP TAY Teams meet every morning to review the status of all clients and develop the Daily Organizational Schedule (Team Based Care). The Daily Organization Schedule enables the team to determine which services will be provided that day based upon consumer acuity and regular rehabilitation and medication support needs.

SPIRIT Wraparound Program

SPIRIT is a Full Service Partnership (FSP) Wraparound program. The SPIRIT Team is designed around the following MHSA core principles: consumer and family involvement and empowerment, cultural competency, system integration including collaboration and partnership with community partners to support the wellness and recovery of our youth and families. The SPIRIT Team (capacity 15) is a specialized team that provides integrated, holistic multi-disciplinary care to clients under age 16 and their families. The program offers high frequency services to a disenfranchised, underserved population of consumers and families that have limited resources, have failed to thrive with conventional treatment and whose children are at risk for placement in short term residential facilities or psychiatric hospitalizations.

Three culturally competent Wraparound SPIRIT teams have been established in each region: North, West and South County within Children Services in the Department of Behavioral Wellness. The SPIRIT Team implement services within a Wraparound model of treatment delivery focusing on engagement, plan development, plan implementation and transition. Clients and families are involved at every level of the planning and treatment process is aimed at achieving their family vision, hopes and dreams and wellness goals. Services may include individual rehabilitation for youth, Child and Family Team meetings, and collateral support for caregivers. Case management services are also provided to link families to needed resources such as housing, medical care, food and educational supports. Spirit team advocates for clients and families within the educational system.

The SPIRIT Team consists of the following: Mental Health Practitioner/Family Facilitator, Parent Partner and a Child/Family Specialist. Teams serve clients at a 1:15 ratio and ensure that care is available 24/7. The Spirit team works alongside Core team members which can include any or all of the following: Mental Health practitioners, case workers, psychiatric technician, registered nurse and psychiatrist.

Points of Entry: Consumers can access services through our 24/7 Access line. A consumer can also be referred by Community Based Organizations, Public Health clinics and/or School Districts. The client is scheduled a comprehensive assessment at one of the three children clinic.

Each client receives a comprehensive assessment which determines the level of care required and establishes a unique plan for treatment. Services are customized to address the youth and families' needs. The assessment also demonstrates cultural competency, any barriers/obstacles that need attention and the next steps to support the family.

Referrals to the Children's FSP programs go through the weekly Children's Transitional Services (CTS) meeting. The Spirit Team can refer their clients to a lower level of care when they no longer need Wraparound level of services. This process replicates the process for referring to all FSP Children's Services programs.

MHSA CS&S Programs:

Adult Complex Capable teams (WRR, MIOA, Co-Occurring):

The adult clinics offer Wellness Recovery & Resiliency, Medical Integration/ Older Adult, and Co-Occurring treatment teams (WRR, MIOA, and Co-occurring services). The three services merged into on complex capable team vs three separate teams. The complex capable team helps to reduce the change of staffing for consumers and allows for the assigned care coordinator to assist consumers as they move through the system. Services are client centered and tailored. Each Adult clinic offers the integrated services within one team. The team is comprised of a multidiscipline team.

Children's Wellness Recovery & Resiliency:

The Wellness, Recovery and Resiliency (WRR) program for children is designed to serve consumers who have a higher level of functioning but still meet criteria for specialty mental health services, who may have graduation potential, or need to step down to other lower level of care and need support to connect to outside resources. Services provided to consumers include:

- Focus on Prevention and healthy behaviors
- Skill building & retaining skills
- Empowerment and Self Reliance Skills
- Case Management
- Individual/family therapy
- Initial Assessments for Katie-A children/youth

Services in WRR are provided based on a model of Team-Based Care (TBC). TBC is a multi-disciplinary approach in which all clinic/program members share joint responsibility in providing services, supports and treatment to consumers. Each treatment team carries together an assigned caseload of consumers, and each team member – based on his/her role, expertise and scope of practice – contributes towards a consumer's success, recovery and goal achievement. Consumers therefore are receiving services that are coordinated and integrated while still individualized.

The WRR team treats all referrals from the schools, Probation, Social Services and community in collaboration with other specialty teams to ensure consumers are receiving the appropriate level of care. The WRR team provides evidence based, trauma informed treatment to children ranging from ages five through young adulthood. All treatment is customized and tailored to meet the individualized needs of each consumer as he/she works in collaboration with team members on treatment goals of mental health wellness and recovery. The team focuses on providing an array of services, including the following: individual, family and group therapy, behavioral treatment, rehabilitative services, psychiatric services and medication support. Team members can include any or all of the following: Mental Health Practitioners, Case Workers, a Psychiatric Technician, a Registered Nurse and a Psychiatrist.

A specialized service provided within the WRR program is the "Katie-A" Services that focus on intake and assessment of all children referred by Social Services. Those children that are lower end either remain in the WRR team or the Pathways to Wellbeing Program, and those Katie-A children that require a higher level of

care are connected to higher end services such as Spirit FSP, intensive in home, or Wrap-163. The services are

Provided in collaboration with the Department of Social Services. As indicated in the Integrated Core Practice Model, the Katie-A services strives to work within a team environment, with the Department of Social Services, to build a culturally relevant and trauma informed system of support and services that is responsive to the strengths and underlying needs of families. The Katie-A services include Intensive Care Coordination, Intensive Home Based Services when a client is requiring a higher level of care, and provides Child and Family Team (CFT) meetings in conjunction with all other core clinic support services for all Katie-A clients. For Katie- A and probation children that are shared with Behavioral Wellness, the Interagency Placement Committee (IPC) was implemented in October 2018. This Committee focuses on streamlining and tracking all children in placement or at risk of placement. This IPC committee is in partnership with the Department of Social Services, Probation, schools, and the Regional Center. The goal is to further implement the Continuum of Care Reform (CCR) for children. Treatment Team members can include any or all of the following: Mental Health Practitioners, Case Worker, Psychiatric Technicians, Registered Nurses, and Psychiatrists.

Adult Assisted Outpatient Treatment (AOT)

Assisted Outpatient Treatment (AOT) in Santa Barbara County serves adults with severe and persistent mental illness who need treatment because they have difficulty living safely in the community and have a history of declining care or struggling to engage in mental health treatment when offered. AOT programs are based on Laura's Law which is a discretionary California State law that allows Counties to use the civil court system to supervise mental health care. For eligible individuals, AOT provides expanded intensive mental health services and outreach to link consumers to the ACT Program, with frequent beneficiary contact and a 24-hour team response. Services include mental health treatment, medication, access to primary health care, substance abuse counseling, benefits and resource counseling, housing linkage and support, pre-vocational rehabilitation, and peer and family member education and support. The court process is only used after every other effort has been exhausted to encourage individuals who need treatment to voluntarily participate in services.

Adult Homeless Services:

The Department of Behavioral Wellness's Homeless Services Program provides outreach, engagement, and short term treatment to individuals experiencing or at risk of homelessness and serious mental illness and/or co-occurring disorders, in Santa Barbara County. Homeless Services initially launched as a Santa Barbara-based program, but acquired grant funding (Homeless Mentally Ill Outreach and Treatment funds awarded by CA Department of Health Care Services) in December 2018, to facilitate expansion to Santa Maria and Lompoc.

Outreach and Engagement Services are delivered to the community at-large, special population groups, human service agencies, and to unserved or underserved homeless individuals. These services aim to enhance the mental health of the general population, prevent the onset of mental health problems in individuals and communities, and assist those persons experiencing distress who are not reached by traditional mental health treatment services to obtain a more adaptive level of functioning. Outreach workers build trust through reliability and follow through and services are provided by skilled clinicians with expertise in multifaceted issues that are often barriers to stability.

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

Wellness outpatient treatment teams and community based agencies to ensure linkage to long term care and mainstream resources. Outreach teams have adopted strategies that meet the specific needs of homeless populations in each region of the county (North, West, and South). The program model utilized is culturally and linguistically competent and appropriate. We maintain close collaborative partnerships with United Way North, AmeriCorps, The Santa Barbara Public Health Department, local shelter providers, the Housing Authorities of the City and County of Santa Barbara, transitional housing providers, law enforcement agencies, local hospitals, and other CoC members.

Beginning in January 2018, Behavioral Wellness became Santa Barbara County Continuum of Care (CoC) member. As a participating agency, we serve as a member of the CoC's Coordinated Entry Committee, and have committed to assess and refer eligible clients for services using a low barrier methodology, the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT). The survey is administered to standardize and expedite the process by which people experiencing homelessness, and/ or who are at risk of homelessness (youth, families, and adults), access housing and homeless resources. Trained Behavioral Wellness Homeless Outreach clinicians, serve as mobile points of entry to Santa Barbara County's CES, conducting field VI-SPDAT assessments.

Additionally, clinicians working with the Homeless Services Program conduct comprehensive clinical assessments, provide case management and facilitate short-term treatment. Comprehensive clinical assessments are conducted by a Licensed Professional of the Healing Arts (LPHA) to determine medical necessity for specialty mental health services and severity of functional impairment. In field assessments are conducted in order to remove barriers to accessing treatment and often serve to expedite service connection and delivery. Upon entry the team attempts to gather a financial intake, complete a health history questionnaire, treatment consent, releases of information, and facilitate a service orientation. Case management support stabilizes an individual by addressing the various, often complex day to day needs, long term problems related to homelessness, untreated mental health conditions and/or substance use disorders. Short term treatment services may also include a referral for psychiatry, medication management, rehabilitation, housing retention assistance, employment and education support. When clients present with ongoing service needs necessitating linkage to a long term care provider, the team's clinicians can utilize Behavioral Wellness Community Treatment Solutions (CTS) forum to effectively manage treatment resources. Level of care recommendations are made through CTS and focus on the pursuit of the least restrictive level of treatment in order to maintain community placement and progress in achieving expressed goals.

Behavioral Wellness recently utilized donation and grant funds to purchase two vans for homeless outreach and service delivery. The vans will be retrofitted with tele-psychiatry equipment and have the ability to accommodate medical personnel for the treatment of clients in the field. The van would also be supported by peer support specialists, a case manager, and clinical staff, and will have access to a psychiatric technician and psychiatrist or nurse practitioner via tele-psychiatry. This team would be able to reach homeless and difficult to engage clients in locations around the county. These services will be an extension of those currently provided by Behavioral Wellness Homeless Outreach and Crisis teams.

Crisis Services

The Santa Barbara County Department of Behavioral Wellness Crisis Services program is a county-wide program with offices in Santa Barbara, Lompoc and Santa Maria. Crisis Services staff provide a range of services geared toward addressing an emergent or urgent mental health crisis. Crisis Services staff are available 24/7 to respond in any setting (home, field, jail, clinic, emergency department, etc) to conduct 5150/5585 assessments and determine if an involuntary hold or acute psychiatric hospital admission is needed. Monday through Friday from 9am to 5pm, clinic based Crisis Services staff are available for referrals

from other programs and walk-in's for individuals who are experiencing emergent mental health crisis and need rapid interventions to prevent a full-blown crisis. Services are supportive and strength based in nature and assist the beneficiary to remain in the least restrictive level of care possible. Referrals for short-term (30-45 days max) intensive crisis support are received from other Behavioral Wellness and Behavioral Wellness contracted programs and are aimed at providing intensive treatment services to stabilize individuals, prevent a hospitalization and return the individual to their program of origin quickly.

Children's Triage Program

The Children's Crisis Program receives grant funding from the Mental Health Services Oversight and Accountability Commission (MHSOAC) and falls under the Crisis Services program. It consists of two teams – one in Santa Maria and one in Santa Barbara. Each team has one full-time licensed Mental Health Practitioner and one half-time Parent Partner (Recovery Assistant). Despite a team not being located in Lompoc, either team can be quickly deployed to Lompoc Valley Hospital if there is a youth in crisis in their Emergency Department.

The goal of the program is to prevent inpatient psychiatric hospitalization of youth by providing intensive mental health services to youth placed on involuntary holds in the hospital Emergency Department and awaiting placement in a locked acute psychiatric hospital. The licensed practitioner and Parent Partner will work closely with the hospital staff, the client and the client's caregivers to de-escalate the crisis, develop sound safety plans and rescind the hold, thereby avoiding hospitalization. The Children's Triage Program team members will follow-up to ensure effective community re-integration for children and youth upon discharge including assistance navigating the mental health system and providing linkages to services and supports.

For those youth who cannot be effectively stabilized with a safety plan allowing their immediate return to the community without an acute psychiatric hospitalization, the Children's Triage Program staff will work closely with the psychiatric hospitals upon discharge to provide short-term follow-up assistance when the youth returns home. In addition, as time permits, the Children's Triage Program staff will assist youth and their families who are experiencing sub-acute crisis (when children have been identified as at risk for a mental health crisis, but before they meet the level of acuity necessary for intervention by crisis staff) before hospitalization is required.

Referrals for the sub-acute cases may come from law enforcement, schools, public health, social services, probation, etc. In particular, proactive outreach to difficult-to-engage populations, like children experiencing homelessness and Mixteco-speaking children, will also be conducted. The aim of these proactive services will be to provide brief, intensive interventions to reduce the risk of mental health crises and hospitalizations and to link children and youth to ongoing behavioral health services.

Adult Crisis Stabilization Unit

The Crisis Stabilization Unit (CSU) in Santa Barbara is part of the Crisis Services Program and "Crisis Hub" which includes South County Crisis Services and the Psychiatric Health Facility. The CSU is a voluntary facility that is licensed to provide crisis stabilization services for 8 individuals for up to 23 hours per visit. Clients referred to the CSU are experiencing a mental health crisis and are able to benefit from a short term stay on the unit. Clients referred to the CSU must be medically stable, with no active aggression, be able to follow basic instructions, be awake and alert, and willing to participate in voluntary admission. Clients can be referred from a number of different providers including Behavioral Wellness clinics, Behavioral Wellness contracted provider programs, local Emergency Departments, Law Enforcement and UCSB/SBCC. The CSU provides access to psychiatry services, 24 hour nursing, peer support, mental health counseling and discharge planning.

INNOVATION:

Resiliency Interventions for Sexual Exploitation ("RISE"): RISE is an outreach and engagement program funded through an MHSA Innovations Grant to provide services for transitional aged youth who have been or are at risk for being sexually trafficked. The program was initiated after clinicians observed that a large number of girls in the juvenile justice system had been subjected to commercial sexual trafficking. Many of these youth have extensive trauma histories and do not immediately acknowledge that they have been victimized by their traffickers. RISE outreaches to these youth and uses a variety of tools to help them process their situation and identify alternatives to sexual exploitation. The multidisciplinary team includes Practitioner series therapists, case workers, a rehabilitation counselor and a psychiatric technician; the team utilizes psychiatrists in other departmental clinics for medication support. Referrals to the program most typically come through the collaborative partner agencies, such as the Department of Social Services or Probation Department. Staff outreach to clients and elicit their willingness to engage in clinical services, to include assessment, psychotherapy, rehabilitative treatments and case management. Many clients are then referred to other departmental clinics for longer term care or referred out to other community providers.

PEI SERVICES:

PEI TAY:

Early Detection and Intervention Teams for Transition-Age Youth (TAY) use evidence-based interventions for adolescents and young adults to help them achieve their full potential without the trauma, stigma, and disabling impact of a fully developed mental illness.

Three teams specialize in early detection and prevention of serious mental illness in TAY, ages 16-25. Teams are based in North County (Santa Maria), South County (Santa Barbara) and West County (Lompoc). The Program serves TAY consumers who are at risk for serious mental illness, or were diagnosed within the past 12 months. The target population also includes individuals who are homeless and/or experiencing co-occurring mental health and substance abuse conditions. Youth are typically served for approximately one year.

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

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

The staffing involves Psychiatrist, Psychiatric Technician, practitioners, case workers and extra help TAY peers. The staff are trained with evidenced based model of First Episode Psychosis (FEP) focusing on the use of the TIP model. The staff are trained annually to ensure fidelity of the program.
Youth empowerment services is being explored where TAY Peers take a leadership role to plan, schedule, and offer weekly activities in the community for TAY consumers. Recreational funds will be set aside in the new FY to assist with the planning and creation of social activities for both PEI and New Heights TAY population.

ADULT & CHILDREN'S ACCESS & ASSESSMENT (PEI):

Timely and appropriate access to services is the single most urgent priority identified by County Stakeholders, the State, and Behavioral Wellness. It is equally imperative to identify the need to handle effectively the disposition and referral of consumers who do not meet medical necessity criteria for County behavioral health services. The Department restructured its operations to a centralized access approach in 2017, and an Access call center continues to be expanded and improved. Access screeners handle calls from new consumers requesting services. Callers are screened for appropriate assignment to a level of care within the system. Starting December 1, 2018, all substance use disorder calls are channeled through the Access Line. The access and assessment component handled by the three Access and Assessment teams focuses on performing assessments on new consumers referred by the Access screeners, as well as initial assessments for walk-in consumers, and for hospital discharge appointments.

The specialized Access and Assessment Teams focus on access and assessment services, as well as appropriate disposition and referrals for consumers who do not meet the Department's criteria of Severe and Persistent Mental Illness. This team focuses on simplifying and improving access to care, reducing wait times, reducing barriers to receiving services, and increasing consistency throughout the County.
Assessments and referrals are customized to ensure that appropriate cultural and linguistic needs of each consumer are identified and accommodated. Furthermore, each team includes staff members who are bicultural and bilingual in the primary threshold language (Spanish).

Contracted/MOU Services:

Juvenile Justice Mental Health Services (JJMHS): The Probation Department contracts with Behavioral Wellness to provide services to youth who are involved in the criminal justice system. JJMHS clinicians and Psychiatrist are based in the Santa Maria Juvenile Hall and Los Prietos Boys Camp, where they complete Psychiatric services, mental health assessments, provide crisis intervention, and conduct psychotherapy in both group and individual formats. The staff aim to identify and treat behavioral health problems experienced by these youth and to facilitate the development of skills for managing stress, behaviors, and improving wellbeing. JJMHS also has a "Transitions Team" that works with Probation field officers to facilitate linkage to ongoing services for youth who are not in one of the two institutions. The team consists of seven Practitioner series therapists, a psychiatric technician and a part time psychiatrist. All referrals into JJMHS services come from the Department of Probation. All youth entering the Santa Maria Juvenile Hall undergo an assessment and may be referred into treatment based on level of care need. Youth in need of longer term treatment are referred to services within the broader Behavioral Wellness system of care or among community care providers, often with the assistance of the Transitions Team.

AB 109 Program: This program is funded through the state and administered by the Department of Probation. It is designed to provide services to adult offenders returning to the community from the California

Department of Corrections and Rehabilitation. The program consists of a full time psychiatric technician, part time psychiatrist and part time Practitioner series therapist. Clients undergo an assessment and are provided treatment based on need. Referrals into this program come solely through Probation. Clients in need of more extensive treatment may be referred to other Behavioral Wellness Programs, such as ACT. Clients are served in this program pending completion of their term of probation, but may be eligible to continue services through other departmental providers.

REFERRAL AND ELIBIBILITY CRITERIA FOR FSP PROGRAMS:

Adult ACT Eligibility Criteria:

Significant functional impairments as demonstrated by at least one of the following conditions:

- Significant difficulty consistently performing the range of practical daily living tasks (e.g., personal business affairs; obtaining medical, legal & housing resources; recognizing & avoiding common dangers or hazards to self & possessions; meeting nutritional needs; maintaining personal hygiene; persistent or recurrent difficulty performing daily living tasks except with significant support or assistance from others such as friends or family.

- Significant difficulty maintaining consistent employment at a self-sustaining level or significant difficulty consistently carrying out the homemaker role (e.g., household meal preparation, washing clothes, budgeting, or child-care tasks & responsibilities).

- Significant difficulty maintaining a safe living situation (e.g., repeated evictions or loss of housing)

One or more of the following problems, which are indicators of continuous high-service needs (i.e., greater than eight hours per month):

- High use of psychiatric hospitals (e.g., two or more admissions per year) or psychiatric emergency room services;
  - Intractable (i.e., persistent or very recurrent) severe major symptoms (e.g., psychotic, affective, suicidal);
  - Co-occurring substance abuse disorder of significant duration (e.g., greater than six months);
  - High risk or recent history of criminal justice involvement (e.g., arrest, incarceration);
  - Substandard housing (homelessness or at imminent risk of homelessness).
  - Residing in an inpatient or supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided.
  - Difficulty effectively utilizing traditional office-based outpatient services.

New Heights FSP TAY Eligibility Criteria:

- Client is age 16-25 (through age 24)
- Client has an included Mental Health diagnosis for Serious Persistent Mental Illness (SPMI)
- Client has significant functional impairments in the following areas as demonstrated by at least one of the following conditions:
  - At risk of out of home placement (risk of homelessness, psychiatric hospitalization, residential treatment or multiple foster placements) due to their mental health condition.

- Involvement or at risk of involvement in the criminal justice system due to their mental health condition.

- High risk behaviors (i.e. self-injurious, run away, potential for CSEC involvement)

- Inability or limited ability to perform daily living tasks without prompts or support, which are likely to lead to significant consequences (i.e. client is not able to manage hygiene/self-care to the point where there is serious risk

- Inability or limited ability at maintaining consistent employment or achieving educational goals (i.e. suspension, expulsion, failing classes, not making credits, excessive absences or dropping out, risk of losing job), and/or social/behavioral impairment due to their mental health condition.

- Client displays one or more of the following problems, which are indicators of continuous increased-service needs:
  - 2 or more contacts per year with crisis services and/or emergency room and/or psychiatric hospitalization within the last 6 months, or at current risk of hospitalization.

  - Severe mental health symptoms/impairments, such as symptoms of psychosis, suicidality, disassociation, delusions, paranoia, etc. physical aggression to the point where it affects functioning in an important area of the consumer's life.

SPIRIT FSP Eligibility Criteria:

- Client is age under 16
- Client has an included Mental Health diagnosis for Serious Persistent Mental Illness (SPMI)
- Client has significant functional impairments in the following areas as demonstrated by at least one of the following conditions:

- At risk of out of home placement (risk of psychiatric hospitalization, STRTP, or multiple foster placements) due to their mental health condition.

- Involvement or at risk of involvement in the justice system, school failure due to their mental health condition.

- High risk behaviors (i.e. self-injurious, run away)

- Inability or limited ability to perform daily living tasks as age appropriate without prompts or support, which are likely to lead to significant consequences (i.e. client is not able to manage behavior, hygiene/self-care to the point where there is serious risk

- Inability or limited ability in achieving educational goals (i.e. suspension, expulsion, failing classes, not making credits, excessive absences or dropping out), and/or social/behavioral impairment due to their mental health condition.

- Client displays one or more of the following problems, which are indicators of continuous increased-service needs:
  - 2 or more contacts per year with crisis services and/or emergency room and/or psychiatric hospitalization within the last 6 months, or at current risk of hospitalization.

- Severe mental health symptoms/impairments, such as relational familial disturbance, suicidality, disassociation, etc. physical aggression to the point where it affects functioning in an important area of the consumer's life.

Adolescent CTS Referral Process:

The Children's Transition Services (CTS) is a weekly county wide meeting designed to coordinate referrals for different

levels of care, adding needed adjunctive services, as well as referrals to FSP services. The meeting consists of and is facilitated by Behavioral Wellness Team Supervisors and Regional Managers in collaboration with contracted Community Based Organizations (CBO) and/or other BWELL program team members. CTS participants review and evaluate the presented referrals to determine the appropriate level-of-care needed for each client being referred / transferred. Referrals include new clients, as well as existing clients transitioning to a different level-of-care. The client is then assigned to the program that best addresses their needs. All treatment services are customized and tailored to meet the individualized needs of each client and/or their caregiver(s) to ensure continuity of care**.**

Instructions:

- An initial, updated or comprehensive assessment needs to be completed prior to referring to CTS when possible, unless a child/youth is referred from a hospital or higher level of care.
- The BWELL CTS referral form (Children Transition Services) needs to be completed and submitted via email to the pertaining Team Supervisor and Regional Manager in advance of the next CTS meeting for review unless there is an urgent situation. FSP must be selected if the referral is for FSP services.
- The referring party attends the CTS meeting (in person, via video conferencing or by phone) to present the case for clinical consultation.
- Cases are referred and assigned to the appropriate level-of-care.
- The assigned care coordinator will be assigned and documented.
- when referring a child/youth for FSP services the assigned care coordinator will be tasked with outreaching the client to review and complete the FSP partnership agreement.
- The assigned clinic/program will meet with the client and/or caregiver(s) and open the client to services within three (3) to five(5) business days after the CTS meeting date.
- Established clients will require an updated Assessment and updated treatment plan to reflect the need for a higher or lower level-of-care, in order to be transitioned or referred.
- Once the receiving program has scheduled the intake and opened the client (client attended first appointment and is linked), notify the referring party of the linkage/engagement so that program can close the fac/prog and ensure continuity of care

Adult CTS Referral Process:

Currently the system meets weekly at CTS with as many of the providers within our system of care as possible to effectively manage treatment resources. Santa Maria, Santa Barbara, and Lompoc adult programs lead the CTS process where a case is presented at CTS. Each region initially meets for local case presentations/transition needs, then the three regions teleconference to meet countywide. The discussion prioritizes the client's desires where possible along with the most efficient and least restrictive level of treatment so as to maintain community placement, progress in achieving expressed goals and ensuring continuity of care.

Instructions

- Prior to attending CTS meeting
    - Staff are to have an updated chart (i.e. assessment identifying impairments due to SPMI)- this may not be possible for IMD clients returning to their home county), Level of Care and Recovery Inventory (LOCRI) and Adult Referral form completed when initiating a referral (It is best practice to have all other aspects of the chart in compliance (i.e. care plan, financial intake forms, Health History Questionnaire, MORs/CANs, treatment consents, etc.) when making a referral).
    - The Adult Referral Form is sent one week ahead of the CTS meeting in which the case will be presented. The referring party should scan/email referral to receiving program/clinic's supervisor (cc manager) allowing time to review needed documentation and answer any remaining questions prior to the CTS meeting. This allows for efficiency and processing volume of referrals.
    - This process should be followed even if the client has already relocated and/or the referring program has a preferred receiving program or identified level of care. Geoff-not sure if this is what was meant? I added to what you said…
    - It is expected that the once we receive the referral for the appropriate level of care, the turnaround time for an intake appointment is 3-5 working days.
- During CTS meeting
    - Staff are expected to come prepared to provide a BRIEF synopsis of the referral that was sent one week ahead of time. The referral should illustrate why the client needs a higher level of care or is ready for a lower level of care. Please reference the LOCRI Memo for Level of Care definitions and criteria (i.e. ACT, Supported Services, Clinic, Holman, and Community) and use the one page adult referral form information to guide your case presentation.
    - Provide updates on status of clients referred (ie have been opened to services, barriers to engagement) as needed to be able to close the clinical loop and ensure continuity of care.
- Follow-up from CTS meeting:
    - Staff are expected to review provided minutes, notify facilitator of corrections, updates, errors and follow through on agreed upon warm handoff coordination and outreach plans.
    - Once the receiving program/clinic has opened the client (client attended first appointment and is linked) notify the referring party of linkage/engagement so that the referring program can close the existing fac/progs and discharge from current level of care.

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