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Strategic Plan 2024–2029

County of San Luis Obispo
Behavioral Health Department

Released February 20, 2024
Revised April 1, 2024

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MESSAGE FROM THE COUNTY OF SLO'S BEHAVIORAL HEALTH DIRECTOR

Greetings!
We are excited to share the 2024-2029 Strategic Plan for the San Luis Obispo County Health Agency's Behavioral Health Department (SLO BHD).

We are also ready to get to work.

This strategic plan comes at a pivotal time for the agency and the community. To emerge from a difficult era marked by the pandemic, an explosion in opioid overdose and suicides, and a growing need for crisis services for all ages, the County has turned its sights forward. The strategic plan serves to strengthen our commitment to having a mission and workforce that is equitable, flexible, and creative in its response to the emergent and unfolding behavioral health environment.

This strategic plan was developed in partnership with the community to assess and adjust our direction as we face challenges and opportunities. Like most California counties, San Luis Obispo has a population with behavioral health issues affected by the economy, lack of equitable access, workforce shortages, stigma, and gaps in services. The Department also faces changes in policy which will impact its ability to serve. The California Advancing and Innovating Medi-Cal initiative (CalAIM), will significantly improve opportunities to engage the population. However, as the healthcare workforce gap grows, so do the expectations for behavioral health departments to rapidly build new services and identify sustainable funding sources.

This plan will guide SLO BHD in navigating these changes and serve as a compass on our journey to more inclusive, integrated, coordinated, and responsive services. It provides us with new strategic priorities, focuses resources, aligns system-wide goals, and identifies desired key outcomes.

I want to thank our consumers and family members, County partners, contracted providers, and other valuable community advisors for their input to this strategic plan. We chose to engage in this process during a difficult time of significant change, and I want to give special thanks to our staff for their dedication and perseverance. On behalf of our leadership team, I look forward to our engagement and collaboration with the local behavioral health system, our Board of Supervisors, our County Administration, and the community at large as we begin to implement this strategic plan on behalf of the people of San Luis Obispo County.

Starlene Graber, PhD, LMFT
County of San Luis Obispo
Behavioral Health Director

“Nothing can dim the light that shines from within.” – Maya Angelou

PURPOSE FOR A STRATEGIC PLAN

Mental health and substance use disorders, collectively known as behavioral health conditions, are among the most common and disabling healthcare conditions facing California and the nation. Despite ongoing progress in understanding how to best treat these conditions, many of the nation's annual indicators for behavioral health have been trending in a negative direction, leading many state and national leaders to describe the situation as a crisis. [1, 2, 3, 4, 5]

Behavioral health challenges are common across the nation, and California is no different. Mental illnesses include many different conditions that vary in degree of severity, ranging from mild to moderate to severe. Up to one in five (22.8%, 57.8 million as of 2021) US adults has a mental illness, and approximately one in 20 (5.5%, 14.1 million) experiences severe mental illness.[6] Moreover, about one in six (16.5%) people in the US (12 years of age and older) have a substance use disorder (roughly half with an alcohol use disorder, and the other half with a drug use disorder).[7] In California, an estimated one in seven adults (14%) report having some mental health issues, and one in 25 (4.4%) have a severe mental illness.[8] One in 14 (7%) California minors has a significant mental health concern, known as a "serious emotional disturbance,"[9] and approximately nine percent (9%) of Californians 12 years and older have a substance use disorder.[10]

Improving access to behavioral health care is the central purpose of this strategic plan. Nationally, the average delay between onset of mental illness symptoms and treatment is 11 years. Untreated behavioral health issues are linked to increased risks of cardiovascular and metabolic diseases, unemployment, academic failure, hospitalizations, and lost earnings.[11] The impact of untreated mental illness and addiction can be devastating. The national suicide rate hit a historic high in 2022 (49,000, a nearly 6% spike from 2020), driven by a surge in the number of such deaths by older adults.[12] Preventable drug overdose deaths have increased in the U.S. by estimates as high as 781% since 1999.[13]

San Luis Obispo County, despite being considered one of "the happiest, healthiest places in the United States,"[14] still has behavioral health challenges which must be addressed by improvements in access to prevention, early intervention, treatment, and aftercare.

- The County's Behavioral Health Department has made improvements in the past few years to exceed the average rates of access for treatment services in California. In 2022 the County's Medi-Cal population accessed mental health services 24% more than the statewide average. The same principle applies for substance use services, with Medi-Cal beneficiaries accessing services 69% more than the state average.[15]

- However, there are significant gaps in local services which delay or complicate accessing care. There are no crisis residential services for youth or adults in the county. There are not enough acute inpatient beds and care facilities to meet the need for services for those with severe mental illness or substance use disorders. A workforce shortage has resulted in wait lists and delays in receiving services.[16]

- Of the 58 counties in California, San Luis Obispo ranks 12th for suicide. Though California has a lower age-adjusted rate than the national average (10.3 per 100,000 and 14.3 per 100,000, respectively), SLO County far exceeds both with an age-adjusted rate of 16.2.[17]

- As recently as 2021, just more than 10 people died of an overdose, on average, every month in SLO County. Opioid overdoses account for three-quarters of the county's overdose deaths, with nearly 80 percent of opioid overdose deaths involving fentanyl. In 2021, 123 overdose deaths were reported; six were classified as suicides.

- On January 24, 2023 the County of San Luis Obispo's Board of Supervisors elected to name "Homelessness, Housing, and Behavioral Health" as key priorities for the 2023-2024 fiscal year. While the Department had already launched a gaps analysis project with community partners, the Board recommended the Department conduct a strategic planning process to outline the goals and objectives needed to meet the demands of the shifting behavioral health atmosphere.

The purpose of this Strategic Plan is to provide the Department with a roadmap to address the needs of a unique community, a rise in health challenges, and a post-pandemic environment which has changed the workforce and the expectations of the public. The Strategic Plan is designed to be a primer for planning Department projects and partnerships for the next five years. Changing conditions, including funding opportunities and challenges, as well as unknown emergent crises, may impact the Plan; but the goals and objectives detailed in this document are meant to be guideposts for ensuring sustainable and successful access to behavioral health care in San Luis Obispo County.

San Luis Obispo County's Public Behavioral Health System

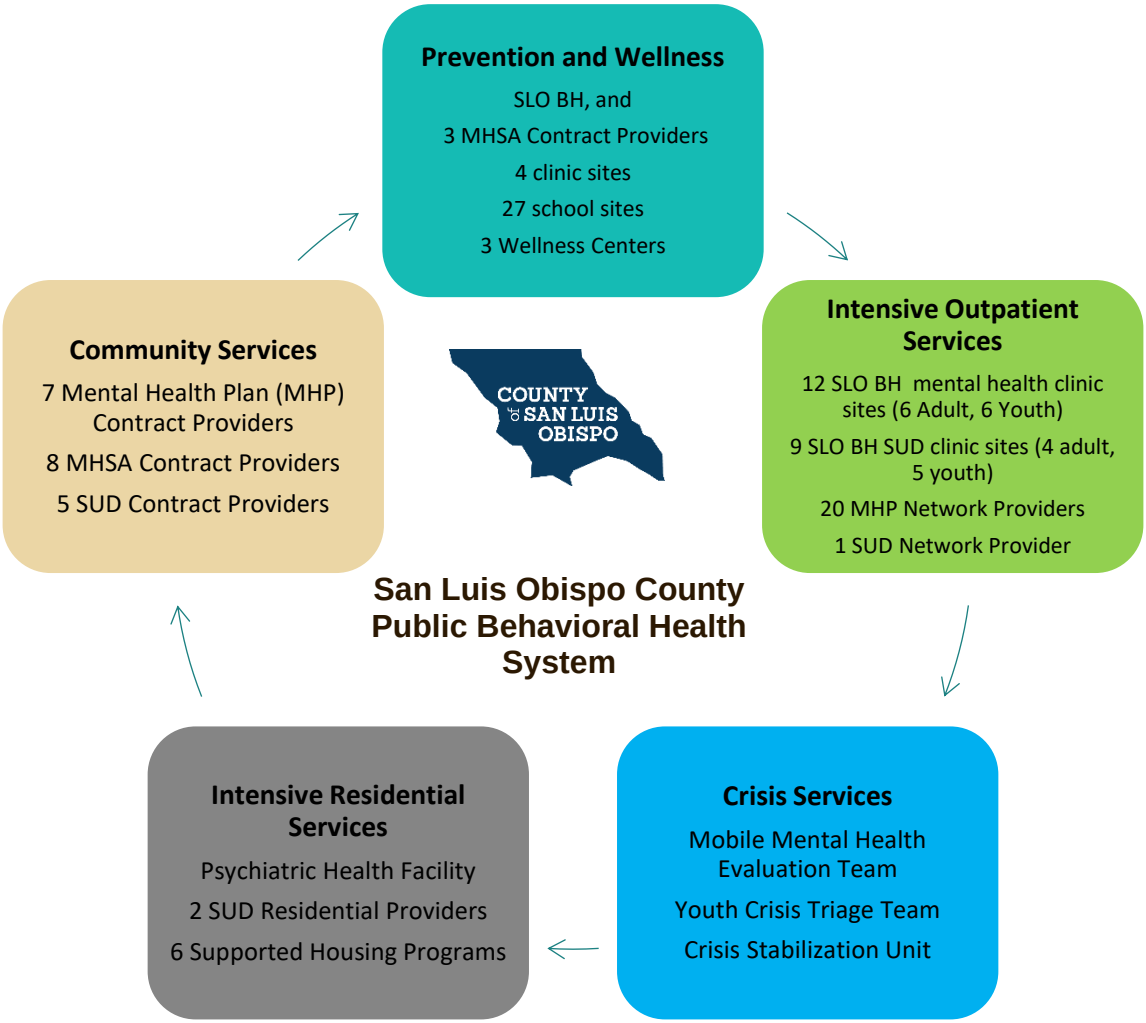
The local public behavioral health system is a continuum of services organized and provided through the County's Behavioral Health Department, other public agencies, and many community-based organizations. Figure 1 outlines the continuum which serves and moves consumers through programs representing Prevention and Wellness, Intensive Outpatient Services, Crisis Services, Intensive Residential Services, and Community Services.

The Behavioral Health Department is part of the County's Health Agency, which includes the Public Health Department, Animal Services Division, and the Office of the Public Guardian. It is the largest department in San Luis Obispo County Government, with more than 800 employees and an annual operating budget of $150 million. The Health Agency's mission is to "provide an array of services essential to the health and well-being of people living in and visiting San Luis Obispo County." Figure 2 outlines the structure of the Health Agency and the Behavioral Health Department.

County behavioral health departments administer California's specialty mental health and substance use disorder (SUD) services in agreement with the Department of Health Care Services (DHCS). Counties are required to provide a range of behavioral health services, including:

- Prevention and early intervention activities.
- Child and family mental health and SUD services.
- Individual and group counseling.
- Psychological testing.
- Psychiatric recovery and rehabilitation services.
- Case management.
- Psychiatric consultation and medication management.
- Residential care.
- Acute psychiatric inpatient.
- Crisis services.

Figure 1. San Luis Obispo County Public Behavioral Health Continuum



San Luis Obispo County Behavioral Health Department Services

Adult Mental Health Services

Regional outpatient clinics have multidisciplinary treatment teams that collaborate with clients on their treatment goals to improve their wellness, recovery, and resiliency in the community. Services include Screening, Assessment and Treatment Planning; Individual and Group Psychotherapy; Medication Services; Psychiatry; Case Management; Rehabilitation Services; and Residential Options.

Programs include:

- Adult, Older Adult, and Homeless Outreach Full Service Partnerships - intensive services in partnership with Transitions Mental Health Association and Wilshire Community Services, and
- Crisis Stabilization Unit (CSU) and inpatient Psychiatric Health Facility (PHF) in partnership with Sierra Mental Wellness Group and Crestwood Behavioral Health Inc.

Drug and Alcohol Services

Offer a variety of services and programs to help people with substance use problems, including public walk-in clinics, outpatient treatment, and court-mandated programs. Services include: Screening, Assessment and Treatment Planning; Individual and Group Counseling and Therapy; Medication Assisted Treatment (MAT) Services; Case Management; Recovery Services; and Residential Options.

Programs include:

- Co-Occurring Disorders program.
- Court Mandated programs.
- Medication-Assisted Treatment.
- Narcotics Treatment Program.
- Perinatal Outpatient Extended Group (POEG).
- Withdrawal Management.

Justice Services

Primary focus on providing co-occurring treatment for people at risk of incarceration or who have already entered the criminal justice system. The division is part of the County's "Stepping Up" plan, a national initiative to reduce the number of people in jail who have mental illness and addiction. Services are designed to provide improved coordination between criminal justice, mental health, substance use treatment and other community agencies.

Programs include:

- Adult Drug Court.
- Assisted Outpatient Treatment.
- Behavioral Health Treatment Court.
- Co-Occurring Treatment Court.
- Community Actions Teams (in partnership with law enforcement).
- Court Screening.
- Mental Health Diversion Court.

Prevention and Outreach Services

Provides a continuum of wellness promotion, prevention, early intervention services, and co-occurring treatment for youth and special populations, including administration of the Mental Health Services Act.

Programs include:

- Adolescent and Youth Substance Use Treatment.
- College Prevention and Wellness.
- First Episode Psychosis early intervention.
- Friday Night Live/Club Live.
- Mental Health First Aid.
- Middle School Comprehensive Student Assistance Program.
- Student Support Counseling.
- Veterans Outreach, Treatment, and Court services.

Quality Support Services

Manages compliance with required standards and best practices, along with ensuring access to effective, high quality behavioral health treatment services for Medi-Cal beneficiaries in San Luis Obispo County.

Programs include:

- Access to Mental Health and Substance Use Disorder Services,
- Behavioral Health Managed Care, and
- Quality Support Team.

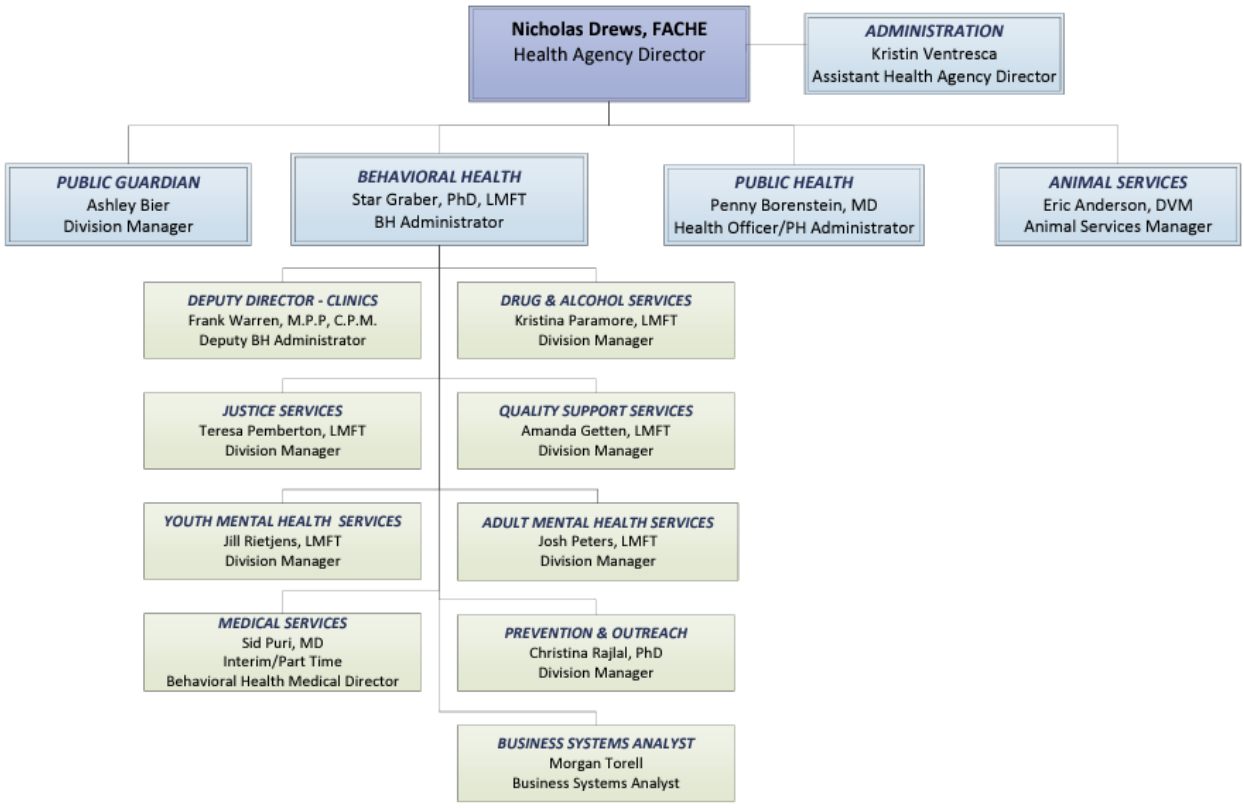
Youth Mental Health Services

Provides a range of services for children and youth affected by mental illness, trauma, and environmental stress, including individual and family therapy, rehabilitation, case management, and psychiatric care. Services include Screening, Assessment and Treatment Planning; Individual and Group Psychotherapy; Medication Services; Psychiatry; Case Management; Rehabilitation Services; and Residential Options.

Programs include:

- Abused Children's Treatment Services (ACTS).
- Child and Transitional Aged Youth Full Service Partnerships - intensive services in partnership with Family Care Network.
- Intensive Care Coordination and Home Based Services.
- Katie A Intensive services.
- Juvenile Hall Services.
- Latino Outreach Program.
- Martha's Place Child Assessment Center.
- Mobile Crisis Services.
- Services Affirming Family Empowerment (SAFE).
- Therapeutic Learning Classrooms.
- Wraparound Services.
- Youth Group Home/Residential services in partnership with Transitions Mental Health Association.

Figure 2. Health Agency/Behavioral Health Department Organization Chart



Key Services

The San Luis Obispo Behavioral Health Department (SLO BHD) provides medicine support, specialty mental health services (SMHS), and Drug Medi-Cal Organized Delivery System (DMC-ODS) services. Specialty mental health services include an array of rehabilitative and psychiatric services for individuals meeting medical necessity criteria. The DMC-ODS provides a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria for substance use disorder (SUD) treatment services.

Figure 3 depicts the number of San Luis Obispo County adults (by region) who received specialty mental health services in fiscal years (FY) 2022–2023 versus FY 2021−2022. In FY 2022-2023 there were 4,899 adults served; a 7% increase over the 4,579 adults served in FY 2021-2022.

Figure 3. Adult Ages 21 and Older Receiving SMHS, FY 2021−2022 and FY 2022−2023

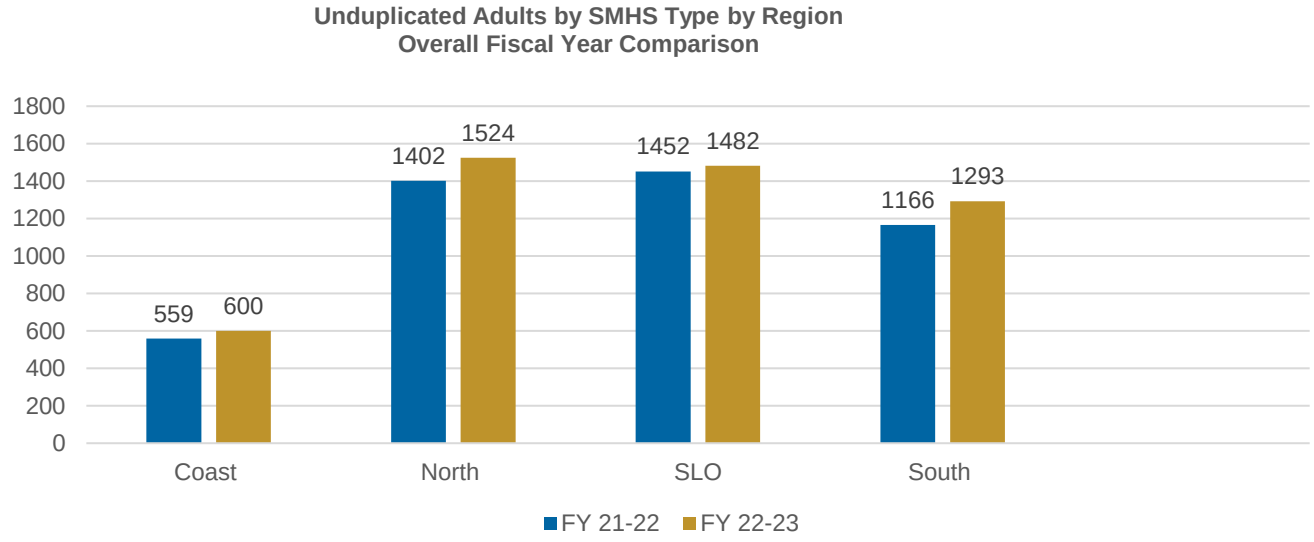


Figure 4 depicts the number of children, by local region, who received behavioral health services in fiscal years (FY) 2022–2023 versus FY 2021−2022. In FY 2022-2023 there were 2,265 youth served; a 14% increase over the 1,981 youth served in FY 2021-2022.

Figure 4. Youth (Ages 20 and Younger) Receiving SMHS, FY 2021−2022 versus 2022−2023

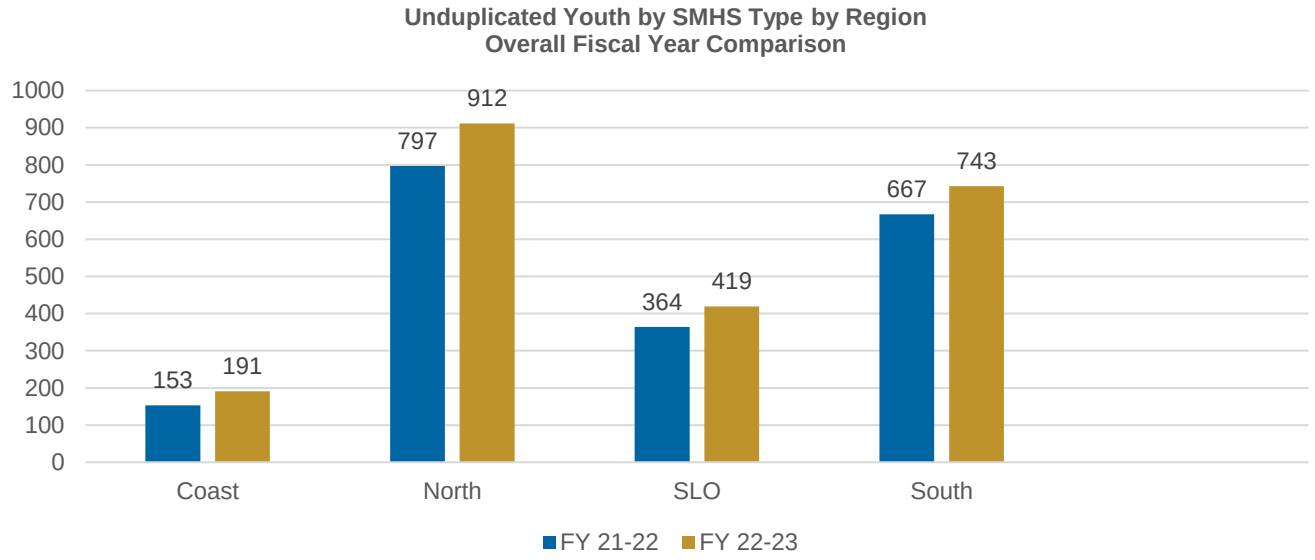


Figure 5 depicts the number of adults in San Luis Obispo County, by region, who received DMC-ODS substance use disorder treatment services in fiscal years (FY) 2022–2023 versus FY 2021−2022. In FY 2022-2023 there were 1,903 adults served; a, 11% increase over the 1,714 adults served in FY 2021-2022.

Figure 5. Adult DMC-ODS Services, FY 2021−2022 and FY 2022−2023

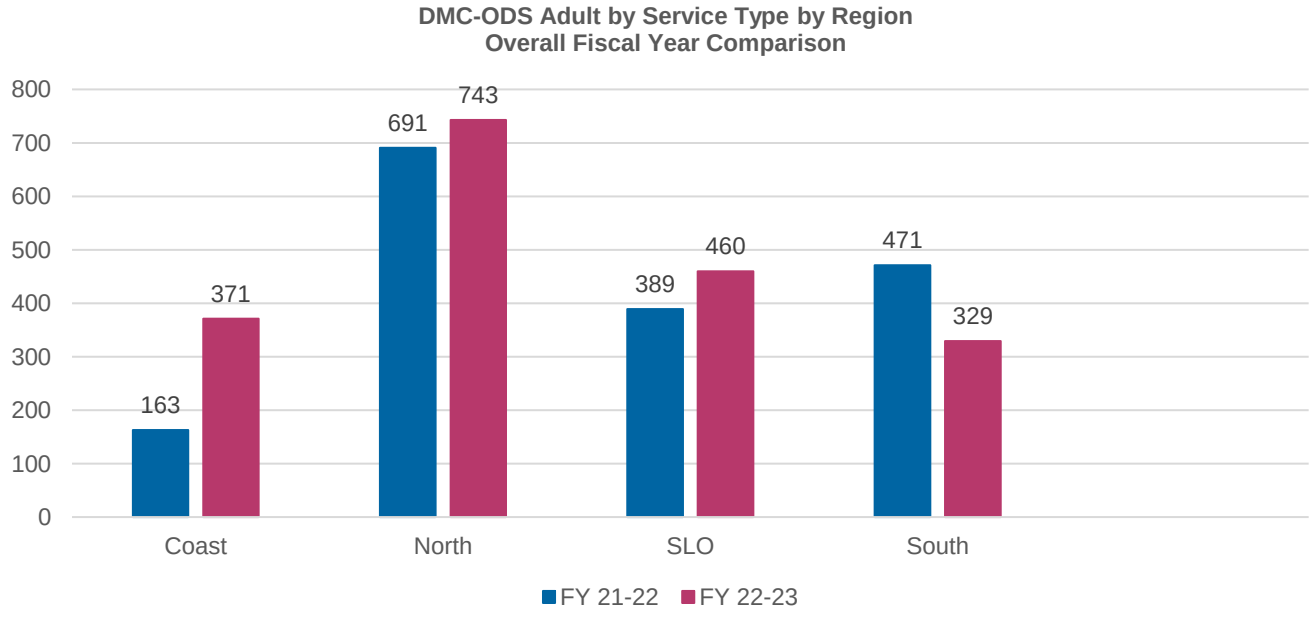
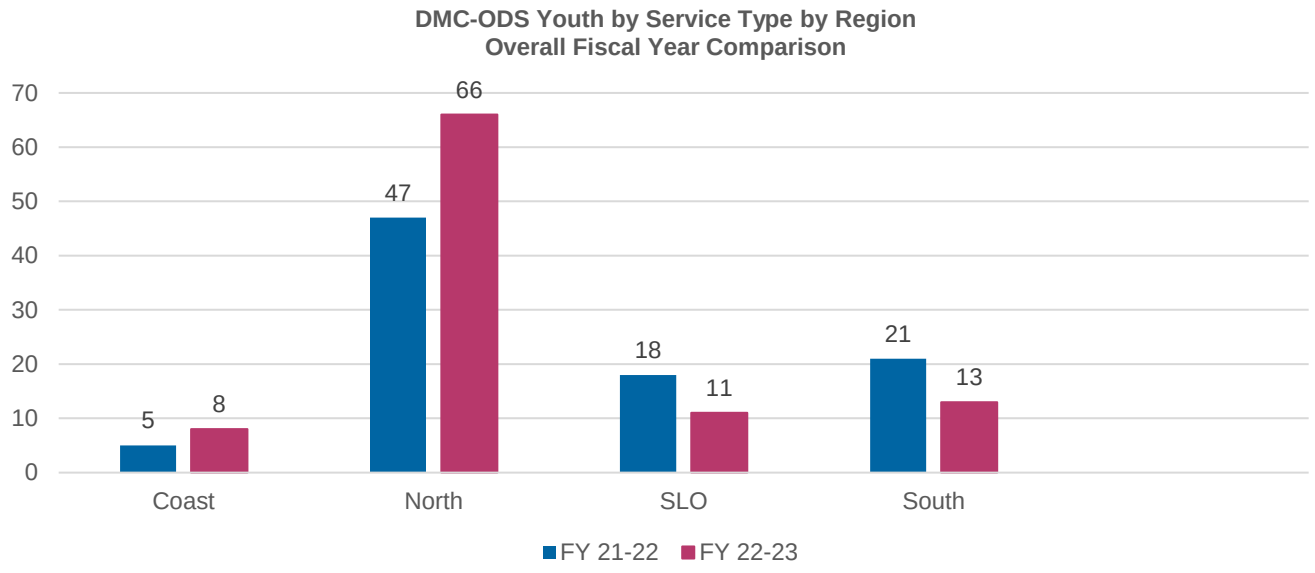


Figure 6 depicts the number of youth, by local region, who received DMC-ODS substance use disorder treatment services in fiscal years (FY) 2022–2023 versus FY 2021−2022. In FY 2022-2023 there were 98 youth served; an 8% increase over the 91 youth served in FY 2021-2022

Figure 6. Youth SUD Services, FY 2021−2022 and FY 2022−2023



Fiscal Growth

Over the past few years, the San Luis Obispo County's Behavioral Health Department has experienced growth in revenue, accompanied by a rise in operational and contracted service costs. The augmentation of salaries and benefits, coupled with strategic adjustments in services and supplies, has played a pivotal role in shaping the budgetary landscape. However, locally and statewide, there are projected budget gaps in FY 2024-25 and in future fiscal years that are anticipated to affect health and human services programs.

Table 1. Operational and Contracted Services Behavioral Health Costs in SLO County

Object Level	FY 2022-23 Adopted	FY 2023-24 Adopted	Increase/(Decrease) Difference	Difference by Percentage
Realignment	$20,820,158	$25,281,532	$4,461,374	21.4%
MHSA	$18,923,703	$22,918,713	$3,995,010	21.1%
Medi-Cal	$29,915,859	$31,432,597	$1,516,738	5.1%
Other Revenues	$9,452,435	$8,748,208	($704,227)	-7.5%
Total Revenue	**$79,112,155**	**$88,381,050**	**$9,268,895**	**11.7%**
Salaries & Benefits	$42,355,218	$47,197,239	$4,842,021	11.4%
Other	$54,377,085	$59,625,019	$5,247,934	9.7%
Total Expense	**$96,732,303**	**$106,822,258**	**$10,089,955**	**10.4%**
General Fund Support	**$17,620,148**	**$18,441,208**	**$821,060**	**4.7%**

Overall, the Behavioral Health Department's FY 2023-2024 revenue increased by $9,268,895 (11.7%) and expenses increased $10,089,955 (10.4%) above the FY 2022−2023 adopted budget. A notable contributing factor to increased expense is the substantial increase in the costs of contracted services, most significantly for out-of-county placements in behavioral health facilities. Referrals for adult and youth inpatient hospital placements rose 9.5%. Other factors that led to the budget increase include:

- A surge in institutions for mental disease (IMD) costs are attributable to the ability for facilities, beginning in FY 2022-2023, to charge counties for higher levels of enhanced and modified services. This, coupled with a consumer price index (CPI) increase of 4% for all facilities, and increased use of board-and-care and out-of-county placement have driven cost increases. One factor is there are no facilities in San Luis Obispo County for youth. The future youth crisis center (to be built in Atascadero) should help reduce some of these costs.

- Over the last year the Department has experienced a large increase in patients needing transportation from local hospital emergency departments to out-of-county hospitals and board and care facilities. Only one local provider can currently bill the local managed care plan (CenCal) at this time. The Department is working to expand its network of transportation providers who can bill CenCal to reduce this cost.

- Other increases, including significant service level and anticipated contract increases for psychiatrists; increases related to anticipated demands for mental health services for foster youth; and rising costs related to housing programs.

- Income increases to help offset rising expenditure included a collective 21.4% increase in the Department's Realignment revenues. The MHSA revenue for 2022-2023 was also increased as the Department drew down trust balances to fund additional services (including a Forensic Full Service Partnership) and support increases in community based organization cost of living increases.

To address cost containment and revenue enhancement in several key areas:

- The Department began addressing inefficiencies by reassigning work and reducing staff (i.e. holding positions vacant) to better manage capacity and productivity.

- For FY 2024-2025 the Department plans to reduce its budget by 6%, reflecting other cost-cutting in order to improve efficiency (i.e. reducing transportation costs due to expanded billing by providers).

- A strong effort is underway to maximize revenue collection by improving Medi-Cal billing. The Department launched its new electronic health record in July of 2023 which should streamline billing for services across the continuum, including an expansion of billable school-based early intervention, and case management.

- The Department has long been prolific in seeking grant funding and continues to enhance and expand services while reducing the impact on the General Fund.

STRATEGIC PLANNING CONDITIONS

The County of San Luis Obispo's Board of Supervisors recommended its Behavioral Health Department (SLO BHD) undertake a strategic planning process to address the shifting sands in the funding, regulations, and expectations which currently guide mental health and substance use disorder services. Changes impacting the field include reforms in Medi-Cal payment structures, increased public demand for access, state initiatives for supported housing and opioid overdose prevention, and a significant decrease in funding for community-based programming. While the SLO BHD has begun to meet all of these challenges, the Strategic Planning Process was undertaken with the intent to set the County on a solid course to address future demands.

Factors Reshaping SLO BHD's Operating Environment

Behavioral health integration (BHI) prompted transformations in service provision. Adjustments in the California Advancing and Innovating Medi-Cal (CalAIM), Drug Medi-Cal Organized Delivery System (DMC-ODS), Mental Health Services Act (MHSA) Modernization (added as Proposition 1 on California's March 2024 ballot), and behavioral health payment reform underlie a wave of change that continues to transform the institutional and financial environments in which public agencies like SLO BHD and its network must operate in the coming years. In addition, the need for BH services has heightened, especially among children and youth and other vulnerable populations, while workforce shortages have impacted service delivery across the continuum of care. The following descriptions represent some of the factors that were present in the strategic planning discussions.

Behavioral Health Integration

Behavioral Health Integration (BHI) is an approach to delivering mental healthcare that makes it easier for primary care providers to include mental and behavioral health screening, treatment, and specialty care into their practices. BHI has been defined as the care that results from a practice team of primary care and behavioral health clinicians collaborating with patients and families through a systematic and cost-effective approach to provide patient-centered care for a defined population. In California, CalAIM is intended to move the state in this direction.

CalAIM

CalAIM is a multi-year innovative overhaul of the Medi-Cal program and healthcare delivery system.[18] Two key components of CalAIM are Enhanced Care Management (ECM) and Community Supports (CS).

ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and nonclinical needs of members with the most complex medical and social needs. ECM provides systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, and person-centered.[19]

The most relevant community supports are housing transition/navigation services, housing deposits, housing tenancy and sustaining services, short-term post-hospitalization housing, and recuperative care (medical respite). Community Supports includes services or settings that county mental health plans (MHP) may offer in place of services or settings covered under the California Medicaid State Plan and that are medically appropriate, cost-effective alternatives to state plan covered services.[20] Managed care plans may offer community supports as an option for Medi-Cal beneficiaries to utilize.

Substance Use Disorder Expansion

The State's efforts to expand opportunities to engage and treat individuals with substance use disorder (SUD) has resulted in key policy changes impacting the Department. The proposed "modernization" of the behavioral health system includes allowance for use of Mental Health Services Act (renamed *Behavioral Health* Services Act) funds to be used to serve individuals with primary and co-occurring SUD diagnoses. In October 2023 the Governor signed Senate Bill 43, which reforms the state's conservatorship system, expanding the definition of "gravely disabled" to include people who are unable to provide themselves basic needs such as food, clothing and shelter, medical care and self-protection due to an untreated mental illness and/or severe drug and alcohol use. The law allows counties to conserve people with a severe substance use disorder only, such as chronic alcoholism, and no longer requires a co-occurring mental health disorder. Counties will need to implement this policy by 2026. The County of San Luis Obispo began implementation in January 2024.

The SLO BHD has long been a leader in advancing SUD prevention and treatment. In 2017 the County opted in to the Drug Medi-Cal Organized Delivery System (DMC-ODS) through the Department of Healthcare Services was approved to expand, improve, and reorganize its program for treating people with SUD. DMC-ODS provides a continuum of SUD services modeled after the American Society of Addiction Medicine's (ASAM's) criteria.[ii] In-scope services include but are not limited to narcotic treatment program services, outpatient drug-free services, outpatient drug-free group counseling, intensive outpatient treatment, residential services, case management, and Medication Assisted Treatment services.

Mental Health Services Act (MHSA) Modernization

The passage of Proposition 63 (now known as the Mental Health Services Act or MHSA) in November 2004, which placed an additional one-percent (1%) tax on California millionaires, provides the California Department of Health Care Services (DHCS) increased funding, personnel and other resources to support county mental health programs and monitor progress toward statewide goals for mental health. MHSA was established to address a continuum of prevention, early intervention, and service needs. It also provided funding for the infrastructure, technology, and training necessary to sustain the community mental health system.[21] MHSA funds 30% of the state's (and local) mental health system.
Five components of funding are provided in MHSA:

- Community Services and Support (79%): Direct services to adults and older adults with SMI and children and youth with SED.
- Prevention and Early Intervention (13%): Programs to prevent mental illnesses from becoming severe and disabling, with an emphasis on improving timely access to services for underserved populations.
- Innovation (4%): Projects designed to test time-limited new or changing MH practices.
- Capital Facilities and Technological Needs (2%): Projects designed to enhance the infrastructure needed to support the BH system, including improving or replacing existing tech systems and/or developing capital facilities to meet the needs of local mental health systems.
- Workforce Education and Training (2%): Programs to enhance public mental health workforce.

California's Behavioral Health Services Act, S.B. 326 (Proposition 1, March 2024 ballot), proposes to change the funding allocation as follows:

- Thirty-percent (30%) for housing interventions for children and families, youth, adults, and older adults living with serious mental illness/serious emotional disturbance (SMI/SED) and/or SUD who are experiencing homelessness or are at risk of homelessness.
- Thirty-five-percent (35%) for full-service partnership (FSP) programs, which would be optimized to leverage Medi-Cal as much as is allowable.
- Thirty-five-percent (35%) for behavioral health services and supports, including early intervention, outreach and engagement, workforce education and training, capital facilities, technological needs, and innovative pilots and projects, to strengthen the range of services individuals, families, and communities need.

If the initiative passes, the County would be required to shift approximately $6 million from direct prevention, early intervention, and treatment services into housing interventions. Potential impacts will have significant effects on the current public mental health system, and were considered when building this strategic plan.

Emerging Trend: Youth Mental Health Crisis

In 2021, US Surgeon General Vivek Murthy issued an advisory[22] to highlight the urgent need to address the nation's youth mental health crisis, which stated, "Mental health challenges in children, adolescents, and young adults are real and widespread. Even before the pandemic, an alarming number of young people struggled with feelings of helplessness, depression, and thoughts of suicide — and rates have increased over the past decade."

The report outlines the COVID's unprecedented impact on the mental health of America's youth and families, as well as the challenges that existed before the pandemic, including:

- Mental health challenges were the leading cause of disability and poor life outcomes in young people, with nearly 20 percent of youth ages 3 to 17 in the United States experiencing psychological/psychiatric, emotional, developmental, or behavioral disorders.
- The number of high school students who reported persistent feelings of sadness or hopelessness increased from 2009−2019 by 40 percent to more than one in three students.
- High school students who considered suicide from 2009−2019 increased by 36 percent, and the number of high school students who made a suicide plan in the prior year during that time increased by 40 percent.

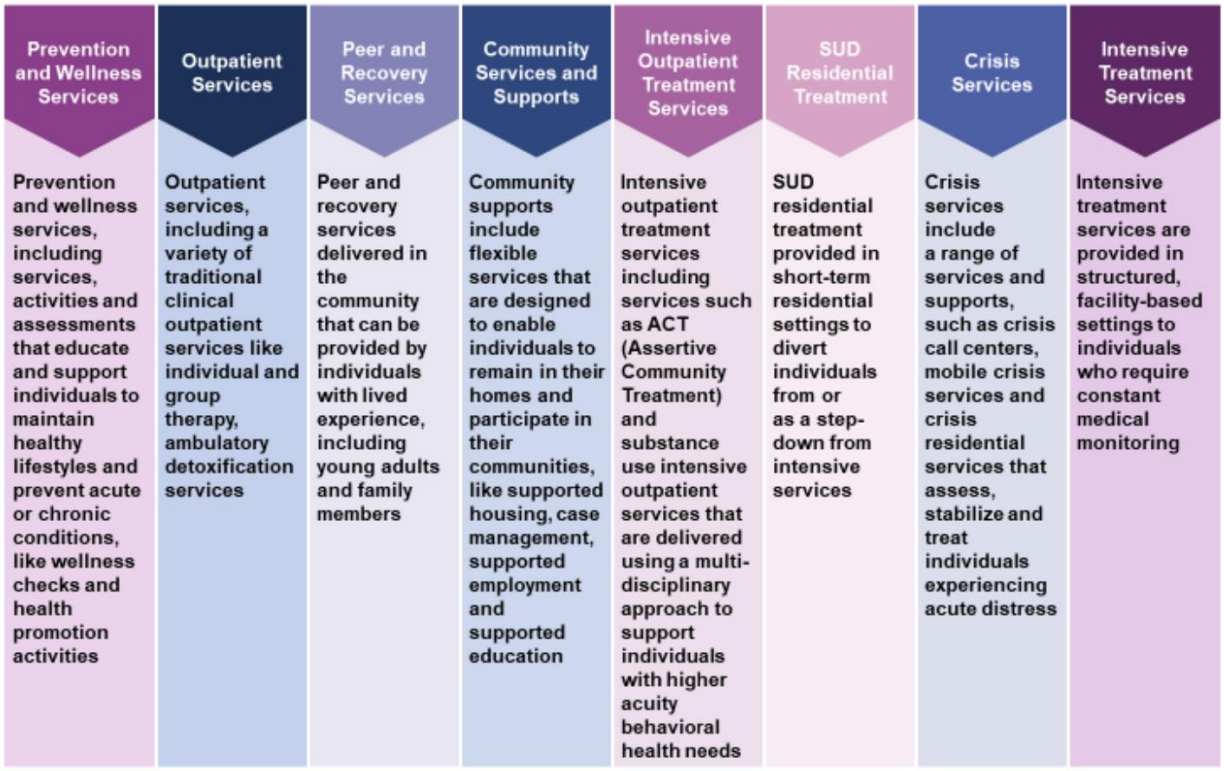
Public schools in California and nationally are reporting increased BH needs among school-age youth with the most commonly reported mental health issues as: 1) Anxiety – serious stress and worry; 2) Attention Deficit/Hyperactivity – severe inability to focus or manage emotions; 3) Mood Disorders, including Depression; and 4) Eating Disorders – anorexia, bulimia, binge eating.

In sum, mental health was a serious health issue affecting young people even before the COVID-19 pandemic and has had a disproportionate impact on some populations such as LGBTQ+ youth, youth in immigrant and low-income householders, youth in the child welfare and/or juvenile justice systems, etc., and is also impacting schooling.

Statewide System Assessment

In January 2022, DHCS released a comprehensive report "Assessing the Continuum of Care for Behavioral Health Services in California" prepared by Manatt Health. The "Manatt Report" examined the state of BH throughout California in relation to a continuum of care. This report identified eight key issues and opportunities that provided a frame of reference for SLO County's strategic plan process. These issues highlight specific components of the BH continuum of care (e.g. prevention, services, and crisis), refer specifically to the need for greater equity and focus on specific populations of need (children/youth and justice-involved individuals), and encourage other practice and service delivery improvements. Figure 7 below outlines the eight categories in the public behavioral health care continuum.

Figure 7. Continuum of Care for Behavioral Health Services in California (Manatt)



The Manatt Report also outlined key findings which have informed the County of SLO's strategic planning process, including:

- **Prevention**: Prevention and early intervention are critical for children and youth, especially young people who are at high risk.
- **Crisis**: It is critical to have a comprehensive approach to crisis services that emphasizes community-based treatment and prevention and connects people to ongoing services.
- **Equity**: Behavioral health services should be designed and delivered in a way that advances equity and addresses disparities in access to care based on race, ethnicity, and other factors.
- **Evidence-based Practices**: More can be done to encourage the consistent and faithful use of evidence-based and community-defined practices are used consistently and with fidelity throughout California's behavioral health system.
- **Youth Mental Health**: More treatment options are vital for children and youth living with significant mental health and substance use disorders.

- **Justice-Involved Populations:** Effective means of addressing the behavioral health issues and related housing, economic, and physical healthcare issues of people who are justice-involved are critical.

- **Housing**: Community-based living options are essential for people who are living with SMI and/or SUD.

Workforce

The county's public behavioral health system, composed of Behavioral Health Department services and contractual partnerships, provides a culturally competent and client-centered continuum of behavioral health (mental health and substance use disorder) care. The public behavioral health system includes organizations and individuals that provide crisis, prevention, early intervention, outpatient, residential, and inpatient services for all eligible residents.

For its part, the Behavioral Health Department has faced challenges in recruiting and maintaining a clinical workforce to meet the public's needs. At present, SLO BHD has budgeted for 327.75 full-time equivalent positions (FTE) but operates with 281 filled positions. As a result, people often experience delays in care. It was a goal of the County to align future workforce planning with the projected needs of the department.

The SLO BHD faced a notable challenge in 2022, with a record 110 separations and only 84 hires, which resulted in a fill rate of 76 percent, indicating a significant gap in staffing levels. Though staffing improved in 2023, with the current fill rate standing at 86 percent, it is essential to acknowledge that the department operated more efficiently in the pre-pandemic year of 2019. In that year, the department experienced 75 separations and a commendable 100 percent fill rate, signaling a state of equilibrium and operational excellence.

According to the Network Adequacy Certification Tool (2022) provided by the Department of Health Care Services, the county's public behavioral health system has 289 qualified providers, 52 percent of which specialize in serving people younger than 20 years old, with 31 percent serving people ages 21 and older, and 17 percent serving all ages. Licensed clinical social workers and marriage and family therapists comprise 25 percent of that workforce.

However, language capacity remains an area for improvement. Only 14 percent of people in the treatment provider network speak Spanish fluently, compared with the 18 percent of Medi-Cal members who prefer services in Spanish (CenCal Member Demographics, 2021). Furthermore, 16 percent of the county's population report that a language other than English is spoken primarily at home (American Community Survey, 2021). No other languages are represented by local providers at a full percentage (one provider is certified in American Sign Language, one fluent in Armenian, and two fluent in Tagalog). Of course, the broader provider network, which includes prevention, early intervention, wellness, and recovery programming, expands language capacity with 10 percent of the workforce fluent in Spanish.

Another limitation is the lack of racial, ethnic, and cultural representation in direct service provision. Furthermore, the County's public behavioral health system, like many across the country, is struggling to recruit and retain clinicians to provide in-person services. This situation is partly a result of the emergence of telehealth, which has opened a new market for mental services, as well as growing cost-of-living barriers for professionals who want to live and work on the Central Coast.

SLO BHD has faced severe staffing shortages in the past few years, with vacancy rates as high as 25 percent for clinical staff. This is partially because of the rising costs of living on the Central Coast and difficulties with relocation. According to recent estimates, the San Luis Obispo cost of living is 64 percent higher than the national average. In comparison, the cost of living in California is 50 percent higher than the national average. Hence, recruiting providers from other communities is becoming increasingly difficult. Though this challenge has been true for some time with respect to hiring and retaining psychiatrists, the shifting job markets and cost of living have negatively affected the behavioral health workforce.

STRATEGIC PLAN 2024–2029

County of SLO Behavioral Health Department Mission

To provide compassionate behavioral health services that empower individuals to embrace their unique journeys toward wellness and promote a community that fosters healing and recovery.

SLO BHD Vision

On the road to wellness, every path leads toward unwavering compassion and an opportunity to thrive.

Values

Integrity. *We are dedicated to high ethical and moral standards and uncompromising honesty in our dealings with the public and each other. We behave in a consistent manner with open, truthful communication, respecting commitments, and being true to our word.*

Collaboration. *We celebrate teamwork by relying on the participation and initiative of every employee. We work cooperatively within and between departments and the public to address issues and achieve results.*

Professionalism. *We are each personally accountable for the performance of our jobs in a manner which bestows credibility upon ourselves and our community. We consistently treat customers, each other, the County, and the resources entrusted to us with respect and honesty.*

Accountability. *We assume personal responsibility for our conduct and actions and follow through on our commitments. We are responsible managers of available fiscal and natural resources.*

Responsiveness. *We provide timely, accurate and complete information to each other and those we serve. We solicit feedback from customers on improving programs and services as part of a continuous improvement process.*

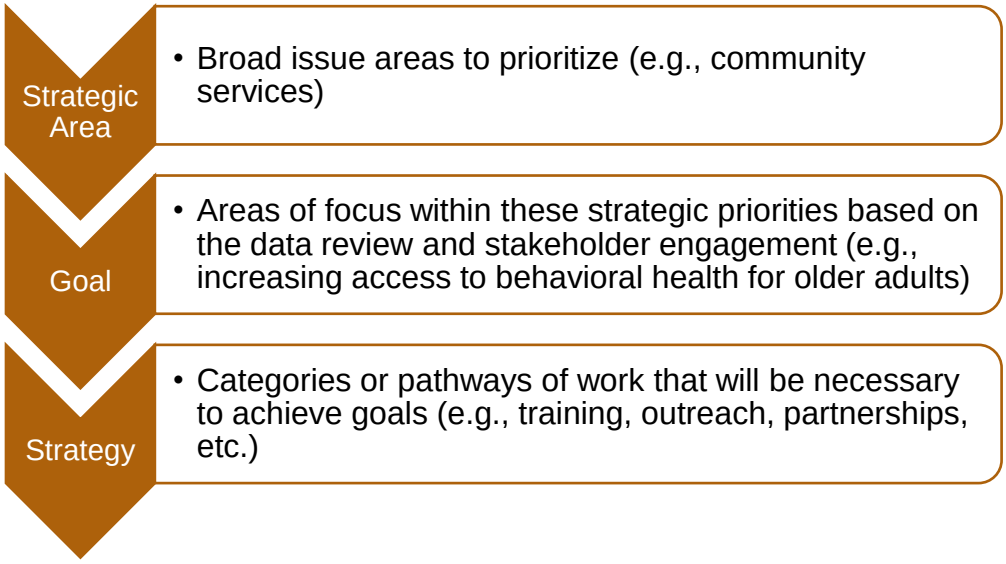
Compassion: *a core value of the Health Agency. We allow ourselves to be moved by suffering and experiencing the motivation to help alleviate and prevent it. An act of compassion is defined by its helpfulness. Qualities of compassion are patience and wisdom; kindness and perseverance; warmth and resolve*.

Framework for Strategic Planning

This Strategic Plan provides a road map of priorities for SLO BHD to organize and navigate the next five years. As such, it provides high-level guidance on what and where to focus attention and resources, considering current assets and needs, as well as the policy and economic environment. Strategy recognizes we cannot do everything, everywhere, all at once. Instead, strategic planning offers data-derived areas of focus where we can or must make an impact to best meet the needs of SLO County.

HMA's conception of strategy uses a three-point typology illustrated in Figure 8 below. First, broad Strategic Priorities are identified. Under each of these are nested Goals and accompanying Strategies to accomplish these goals. Taken together, this type of Strategic Plan is explicit in describing why the SLO BHD is focused on a given priority area, and what the agency will do (alone or in partnership with others) to address this priority. This strategic plan does not identify detailed activities, personnel, tasks, or tactics that comprise the SLO BHD's day-to-day workplans.

Figure 8. Typology for Strategic Planning

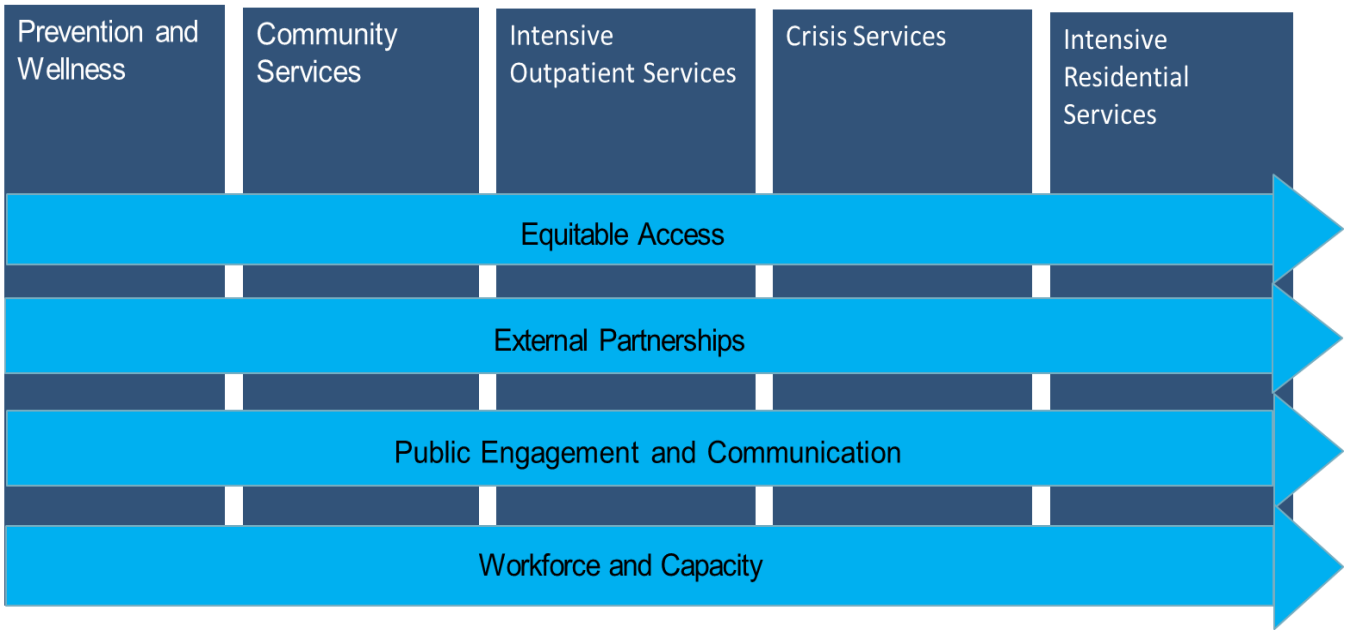


To identify the Strategic Areas, HMA used the Manatt Report's eight categories or domains of services within the BH continuum of care:

Prevention and Wellness Services	Outpatient Services	Peer and Recovery Services	Community Services and Supports	Intensive Outpatient Treatment Services	SUD Residential Treatment Services	Crisis Services	Intensive Treatment Services

To aid in the prioritization of strategy, the BH Continuum of Care was abridged to form five categories that capture the entire continuum of care and integrate both dimensions of mental health and SUD. Outpatient services were combined with Intensive Treatment Services to reflect the model of clinic-based services provided by the Department. Peer and Recovery Services were joined to Community Services and Supports to reflect the movement to increase peer-based strategies in community-based programs. A category of Intensive Residential Services was formed to capture the unique needs of the County to expand its capacity for in-patient services. These five categories (see Figure 9 below) function as **Strategic Areas** for how SLO BHD organizes its work and delivers services and programs to county residents.

Figure 9. Categories of the Behavioral Health Continuum of Care



Based on the engagement of Community Advisors and analysis of data, HMA also identified four **cross-cutting issues** that shape and exert influence on BH services delivery in SLO County, and need to be addressed to maintain continuous improvement:

1. Equitable access: The necessity to advance and accelerate equity to ensure that all county residents have access to BH services.

2. External partnerships: The necessity to collaborate and partner with other agencies, organizations, and sectors to provide quality BH services and support.

3. Public engagement and communication: The necessity to conduct outreach that informs and educates diverse audiences and provides opportunities for feedback and input.

4. Workforce and capacity: The necessity to recruit, train, and retain the larger BH workforce in both the near and longer term.

As shown in the section that follows, the Strategic Plan encompasses both dimensions, providing a description of each Strategic Area, followed by goals and strategies to address the relevant and prioritized aspects of the cross-cutting issues within each strategic area.

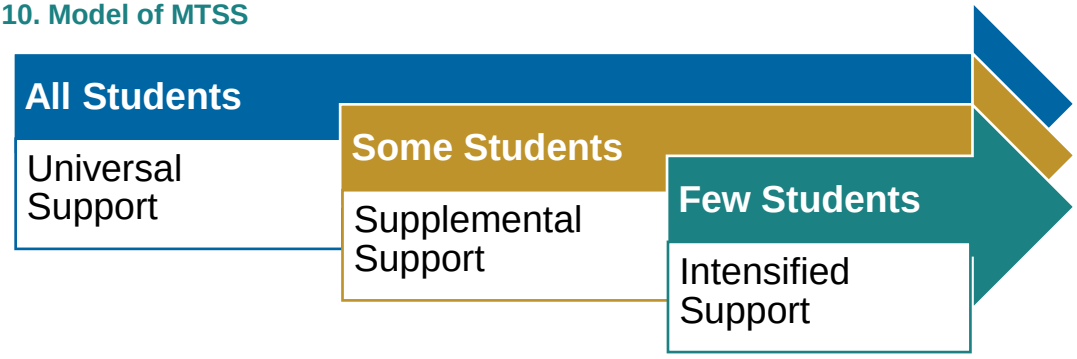
STRATEGIC AREAS

1. Prevention and Wellness

Prevention and wellness services focus on activities and assessments that educate and promote healthy lifestyles and prevent acute or chronic conditions. A major component of these efforts centers on prevention and early intervention (PEI) programs funded through the Mental Health Services Act (MHSA), typically delivered in partnership with community-based organizations (CBOs), public schools, and other cross-sectoral partners. PEI efforts tend to focus on addressing preventive and protective factors that reduce the risk of mental illness, as well as community outreach designed to destigmatize and increase awareness of BH services.

SLO BHD has long been involved in providing youth development and prevention programming and is working to expand access to school-based and school-linked BH services. SLO BHD also is actively involved in BH destigmatization campaigns and training, as well as the provision of early identification (screening) services, family education, and other community-based outreach. In public schools, these kinds of universal BH services and supports fall under Tier 1 of the Multi-Tiered System of Support (MTSS) as shown in Figure 10.

Figure 10. Model of MTSS



The key challenges in this area center on the need for greater focus, consistency, and scale for service delivery. An ongoing challenge is ensuring sustainable funding amid competing priorities within the continuum of care. For instance, the proposed reform of the Mental Health Services Act would essentially eliminate requirements and funding for a wide array of local prevention and wellness programming. However, there remains a need to focus on equitable access to information and services across the diverse constituencies and communities of SLO County to both reduce the onset and impact of addiction and severe mental illness, and to make the public aware of available services. Put simply, prevention and early intervention are critical for children, youth, and families. The goals and strategies below are intended to impart intentionality and focus to prevention and wellness in the County.

Prevention and Wellness Goals

- Enhance community outreach to diversify the participation and voice of County residents who access prevention and wellness services.
- Expand access to school-based services by building and maintaining relationships with all local school districts and the County Office of Education.
- Leverage public interest in BH to expand informational campaigns regarding preventive messaging and wellness information.
- Improve workforce retention and increase staff time spent providing direct services and programs in diverse communities.

Key Goals and Metrics of Success

Service Delivery and Utilization	Client Satisfaction	Other Key Milestones
• Engage 20% of the population annually through outreach, education, training, and prevention services. • Increase participation of priority populations by 10% annually.	Improved outcomes including: • Knowledge of service array (wellness promotion, prevention, and early intervention), and • Capacity to provide culturally and linguistically competent services to priority populations.	• Establish and maintain formal partnerships and/or MOUs with all school districts and the COE. • Build relationships with priority population-serving organizations. • At least one local education agency (LEA) involved in the Children and Youth Behavioral Health Initiative of (CYBHI) Multi-Payer Fee Schedule. • Increased resources and funding.

Strategies and Action Plan

1.1. Equitable access: Enhance community outreach to diversify the participation and voice of County residents who access prevention and wellness services.

Strategies	Year 1	Years 2-3	Years 4-5
a. Expand prevention-oriented communication and destigmatization outreach in languages other than English (e.g., Spanish and Mixteco)	X	X	
b. Organize differentiated outreach on accessing prevention and wellness services tailored to needs of LGBTQ+ and older (age 60+) adults.		X	X
c. Expand opportunities for a diverse set of youth ambassadors to elevate youth voice in shaping prevention and wellness within school communities throughout the County.	X		

1.2. External Partnerships: Expand access to school-based services by building and maintaining relationships with all local school districts and the County Office of Education.

Strategies	Year 1	Years 2–3	Years 4–5
A. Support the continued expansion of school-based wellness centers in the County that provide BH services to school-age children and youth.	X		
B. Expand and strengthen the Services Affirming Family Empowerment (SAFE) program[1] to ensure access and an active program presence in all key geographic regions of the County and for children of any age.	X	X	
C. Reinforce the implementation of Tier 1 (universal) MTSS services such as diagnostic screening and early identification, as well as proactive education and training for families and school staff on BH signs and symptoms.		X	X
D. Work cooperatively with County Public Health and County Office of Employment to strengthen connections to CBOs and faith-based organizations involved in addressing the social drivers or determinants of health (i.e., upstream factors associated with where people live, work, and play).		X	X

1.3. Public Awareness and Communication: Leverage public interest in BH to expand informational campaigns regarding preventive messaging and wellness information.

Strategies	Year 1	Years 2–3	Years 4–5
a. Build partnerships to expand efforts to destigmatize BH, focusing these efforts on key underserved constituencies such as non-English speaking adults, LGBTQ+ individuals, and adults age 60+.	X	X	
b. Expand access to community-based training and information on preventive BH strategies and resources for families and community members.		X	X
c. Design a communication and outreach plan that highlights the importance and availability of harm reduction services and resources among unhoused populations throughout the County.		X	

[1] Services Enhancing Family Empowerment (SAFE) is a team-based collaboration involving the BH Department, Department of Social Services, Probation, and County Office of Education, CAPSLO, and others. SAFE is focused on reducing the number of children who require out-of-home care (foster, group homes, or hospitalization), reducing recidivism among probation-involved youth, and improving school attendance.

d.	Work closely with partners in public health and education to impart a consistent set of messages and informational campaigns on understanding and addressing-critical issues such as youth mental health access, suicide, and opioid overdose	X	X

1.4. Workforce and Staffing: Improve workforce retention and increase staff time spent providing direct services and programs in diverse communities.

Strategies		Year 1	Years 2–3	Years 4–5
a.	Explore opportunities for greater efficiency in data and reporting functions, as well as possibilities for outsourcing grant writing.		X	
b.	Expand opportunities for cross-training, certification, and education supports to better position non-clinical staff to enhance the operations of the Department.		X	X

Key Policy and Budgetary Considerations

- Scale an existing effort by expanding SAFE programming.
- Fund public information campaigns, training, and other outreach.
- Allocate staff time for strengthening and nurturing relationships with Public Education leadership.

2. Community Services

Community services encompass several related components of supports, including:

- Outpatient therapeutic services such as early intervention and individual and group therapy.
- Peer and recovery services delivered in the community, often by people with lived experience and/or family members.
- Community supports designed to enable individuals to remain in their homes and participate meaningfully in their communities.

All these services tend to focus on individuals with mild to moderate BH issues through the use of evidence-based and community-defined practices. Indeed, California recognizes and encourages bottom-up BH approaches that serve a specific community or population, often grounded in cultural relevance and responsiveness.

Another common feature is the connection and integration of community-based services. The focus should be on whole-person, community-based care that helps individuals develop the emotional, social, and coping skills required to live in a community as independently as possible. These supports often include a mix of housing, employment, psychosocial, and case management services that help people facilitate and sustain their recovery. As such, community supports help people avoid institutional stays, or contribute to shorter stays that make it easier for individuals to return to the community and participate in a meaningful way.

SLO BHD is actively involved in coordinating community-based services across multiple public agencies and local organizations. For example, the Justice Services team participates in weekly re-entry meetings with Community Actions Teams (CATs), Law Enforcement, Probation, and local nonprofits to reduce recidivism. Similarly, SLO BHD has helped galvanize partnerships focused on increasing BH access for the LGBTQ+ population across a network of agencies and community allies.

Community Services also include resources and training for families and caregivers of individuals engaged in BH recovery. Peer and recovery services delivered in the community provide a necessary augmentation of the BH workforce, encouraging individuals with lived experience (both young adults and family members) to be participants in coaching life skills (social, daily, and cognitive) and advancing BH recovery. Peers are often uniquely positioned to provide hope, encouragement, and a network of transitional support.

SLO BHD has also improved community access to SUD services with streamlined screening and intake procedures, as well as more timely linkage to outpatient programs. Staff have improved coordination of wraparound support services and have developed healthy partnerships with the other public agencies (e.g., Department of Social Services, Probation, etc.) to be responsive to patient needs.

Coordination across partners and sectors continues to be the key ongoing challenge for Community Services. Because it is based on a whole-person care model, these services and supports require a high degree of partnership and collaboration across multiple communities and geographies. Another key issue is getting actionable information and resources into the hands of underserved communities and populations (many of whom distrust public institutions), as well as disseminating information about funding opportunities (both programmatic grants and more sustainable sources) within the provider community to expand and scale community based BH services.

Community Services Goals

- Close gaps in access to BH community services among key underserved populations and communities.
- Identify opportunities for joint projects, collaboration, and information sharing with other public agencies actively involved in community outreach and community engagement efforts in SLO County and the region.
- Ensure that there is a county-wide understanding and lexicon for accessing community based BH resources, services, and supports.
- Augment the BH workforce with incentives and non-clinical personnel well positioned to provide culturally responsive and sustainable services in local communities.

Key Goals and Metrics of Success

Service Delivery and Utilization	Client Satisfaction	Other Key Milestones
• Increase by 20% peer and people with lived experience service delivery as a Medi-Cal reimbursable intervention, particularly among bilingual Spanish-speaking peers. • Increase by 10% Behavioral Health Bridge and Permanent Supportive Housing units dedicated to homeless individuals located in SLO County. • Increase by 20% the number of community- and faith-based organizations partnering with SLO BHD that offer MAT.	Improved outcomes including: • Ease of access to BH services, • Multiple points of access to BH services, • Quality of care among contracted partners providing BH services, and • Connection to supportive and wraparound services as needed.	• CATs in all four regions of County (north, coastal, central, and south). • Completed gaps analysis report on BH needs of older adults in County. • Expand number of partners and joint partnerships providing services that support the tenancy of vulnerable unhoused individuals with BH disorders.

Strategies and Action Plan

2.1. Equitable Access: Close gaps in access to BH community services among key underserved populations and communities.

Strategies	Year 1	Years 2–3	Years 4–5

Strategies		Year 1	Years 2–3	Years 4–5
a.	Increase the number of Community Action Teams (CATs) to ensure that this model[2] is available in all key regions and communities in SLO County.	X	X	
b.	Accelerate existing efforts aimed at expanding BH access for LGBTQ+ youth and adults in SLO County in tandem with a network of CBOs, other public agencies, and community allies.		X	X
c.	Continue to expand and incentivize access to community housing for justice involved BH clients upon release from jail.		X	X
d.	Establish a task force focused on assessing the BH needs specific to aging and older adults (60+ years old); conduct a gaps analysis to discern adaptation of community services and supports for this growing county population.		X	X

2.2. External Partnerships: Identify opportunities for joint projects, collaboration, and information sharing with other public agencies actively involved in community outreach and community engagement efforts in SLO County.

Strategies		Year 1	Years 2–3	Years 4–5
a.	Enhance communication and coordination of services with County community health centers (CHCs) to reinforce BHD's focus on integrated care and expansion of MAT.	X		
b.	Partner with school districts and the COE to encourage participation in the Multi-Payer Fee Schedule, a new opportunity (under the Children and Youth Behavioral Health Initiative of CYBHI) that offers a sustainable funding source for school-based and school-linked BH services at all MTSS tiers.	X	X	X
c.	Improve collaboration with Law Enforcement to advance alternatives to incarceration and further de-stigmatize BH.		X	X

[2] CAT is a partnership with local law enforcement agencies, including the Sheriff's Office. It is a co-responder model that provides proactive outreach, engagement, screening, and assessment for early identification of people with mental illness or substance use issues to encourage them to receive treatment and other services prior to or in lieu of arrest.

2.3. Public Awareness and Communication: Ensure that there is a county-wide understanding and lexicon for accessing community based BH resources, services, and supports.

	Strategies	Year 1	Years 2−3	Years 4−5
a.	Continue to focus on community based BH education and training (e.g., MH First Aid) that engages families, prioritizing the use of bilingual staff and *promotores*[3] in communities where languages other than English are dominant.	X	X	
b.	Organize a publicity and awareness campaign centered on the message of "No Wrong Door" to showcase the multiple community access points and integrated nature of community-based BH services in the County, especially those that encourage greater participation in prevention and mild to moderate BH services.		X	
c.	Develop a communication plan with the COE to streamline BH outreach and information dissemination to families of school-age children and youth in response to the youth mental health crisis.		X	X
d.	Assemble data and develop accompanying social marketing materials that communicate the story of increased accessibility of BH services in SLO County, emphasizing key foci, rationale, and measures of impact.		X	X
e.	Increase public understanding of eligibility criteria and the multiple points of access to SUD services and programs available to county residents.	X	X	
f.	Advance education and training with community-based and faith-based organizations to destigmatize SUD and MAT.		X	

2.4. Workforce and Staffing: Augment the BH workforce with incentives and non-clinical personnel well positioned to provide culturally responsive and sustainable services in local communities.

	Strategies	Year 1	Years 2−3	Years 4−5
a.	Explore an increase in the stipend paid to bilingual staff to increase BH access in communities where languages other than English are more prevalent (i.e., geographic concentrations of Spanish and/or Mixteco speakers).		X	

[3] In this Strategic Plan, "promotores" refers to trusted individuals who empower their peers through education and connections to health and social resources in Spanish-speaking communities. The term is being used generically and not related to any specific program, organizations, or funding source.

b.	Recruit and train additional cohorts of *promotores* to enhance their capacity to conduct effective BH outreach in targeted communities; supplement and/or share personnel costs for *promotores* employed by other public agencies.		X	X
c.	Partner with school districts and community nonprofits to apply for CYBHI funding aimed at catalyzing wellness coaches, a new, unlicensed BH job classification capable of providing reimbursable, school-based and school-linked services.		X	
d.	Explore and expand the involvement of peers and people with lived experience in community wellness centers, drop-in programs, and outpatient treatment teams.	X	X	

Key Policy and Budgetary Considerations

- Scaling an existing effort by increasing the number and distribution of CATs
- Adopting a policy on Wellness Coaches employed by contracted partners
- Keeping PEI funding stable and creating added community information campaigns and school-based prevention programs

3. Intensive Outpatient Services

The intensive nature of some outpatient services distinguishes them from the community-based services mentioned earlier. Intensive outpatient services commonly involve therapeutic approaches, such as individual, group, and family therapy, as well as school-based and/or school-linked BH services, typically for a smaller group of children and youth with more severe BH symptoms (Tier 3 of MTSS). Intensive outpatient substance use disorder (SUD) services may include Medication Assisted Treatment (MAT), ambulatory withdrawal management, and programs with extended monitoring.

One of the largest and most prominent challenges both statewide and in SLO County is the shortage of licensed clinical staff (e.g., therapists, social workers, psychiatrists, etc.). Caseloads are high and workforce turnover and burnout affect the County's capacity to deliver timely, intensive outpatient services to both youth and adults. These circumstances add to the growing interest in augmenting the BH workforce with multidisciplinary team approaches, including peer and recovery support services. Other efforts worth exploring and implementing include those which establish local career development pipelines to recruit and train young people, often from underserved populations, interested in BH careers.

In alignment with state direction, SLO BHD has also made strides to prioritize equitable access to MAT, regardless of where individuals receive treatment for their SUD. In SLO County, the BHD has supported the expansion of MAT (including its use in county criminal justice settings) while also improving the management of detoxification services delivered by nurse practitioners. In addition, the SUD team in SLO County has supplemented MAT with psychiatric treatment for mild to moderate MH within its programming.

The County has a strong interest in improving the coordination of transitions from residential to intensive outpatient care, as well as so-called stepdown models that move clients from intensive to ongoing case management that employs and involves peer support and the accompanying need for a host of supportive services, often referred to as wraparound supports. Full-service partnership (FSP) programs provide intensive, community-based services for clients with complex needs, ranging from coordination of hospital appointments and other follow-up and monitoring of health to helping individuals access food, education, employment, and housing.[4] Indeed, FSP programs in the County have been successful, and will continue to be strengthened through monitoring and with potential for increased capacity with statewide proposed reforms (e.g. Proposition 1). SLO BHD may be able to scale lessons and best practices from its Justice Services Division, which has a track record of helping individuals transition from jails to the community through effective re-entry programs.

In addition, SLO BHD has an opportunity to reimagine its relationship with public education. Multiple new initiatives (e.g. CalAIM) and funding streams affect school-based and school-linked BH services. The goals and strategies below provide a set of priorities to strengthen and enhance SLO BHD's capacity to address the multiple challenges described above and to deliver timely, quality intensive outpatient services to youth and adults.

[4] In this regard, the scarcity of affordable housing options (permanent supportive housing, adult residential facilities, and sober living) in SLO County is especially concerning, given the high risk of homelessness among individuals with SMI and co-occurring disorders.

Intensive Outpatient Services Goals

- Expand access to facilities that have been restructured to integrate BH services and enhance coordination of whole-person care.
- Leverage CalAIM as an opportunity to develop and/or strengthen collaborations focused on coordination of outpatient supportive services, especially stepdown models that ease client transitions to less intensive and/or community-based care.
- Increase public education on the prevalence of co-occurring disorders and the availability of services and resources that address both MH and SUD needs.
- Develop more peer support and team-based approaches to augment clinical staff (shorter-term) while also developing career pipeline programs with higher education partners (longer-term).

Key Goals and Metrics of Success

Service Delivery and Utilization	Client Satisfaction	Other Key Milestones
• Increase the number of clinicians who achieve productivity targets by 15% through new hires, better staff retention, and shifts toward team-based care with certified peer specialists and paraprofessionals. • Increase by 20% school-age youth referrals to intensive outpatient BH services from school districts. • Increase by 25% service utilization among older adults (60+). • Increase by 10% service utilization among infants and children up to five years old.	Improved outcomes including: • Timely access to outpatient treatment services, • Quality of outpatient treatment services, • Cultural competence of service providers and sites, and • Connection to wraparound and support services.	• Complete restructuring of at least two existing BHD offices to integrate MH and SUD services (co-located). • Establishment of CTE pathway in health and human services in at least one County school district. • 20% increase in student trainees at educational sites.

Strategies and Action Plan

3.1. Equitable Access: Expand access to facilities that have been restructured to integrate BH services and enhance coordination of whole-person care.

Strategies	Year 1	Years 2–3	Years 4–5
a. Restructure targeted BHD facilities so that MH and SUD services are co-located and/or in proximity to one another.	X	X	
b. Establish an outpatient clinic in north SLO County focused on the BH needs of the youngest children (0-5) modeled on the success of a similar program (Martha's Place) in south County.			X

c.	Investigate option for increasing access to mobile BH services and field-based treatment to overcome transportation barriers.	X	X	
d.	Continue to expand access to affordable community housing for BH clients transitioning from residential treatment, especially individuals living with SMI.	X	X	

3.2. External Partnerships: Leverage CalAIM as an opportunity to develop and/or strengthen collaborations focused on coordination of outpatient supportive services, especially stepdown models that ease client transitions to less intensive and/or community-based care.

Strategies		Year 1	Years 2–3	Years 4–5
a.	Enhance communication and coordination with the County Office of Education and two to three school districts to increase the availability of the intensive outpatient BH services (Tier 3 of MTSS) tailored to the needs of school-age youth.		X	
b.	Collaborate across partners (Department of Social Services, Probation, Public Health, etc.) to develop a stepdown approach that eases transitions from residential treatment to outpatient care and wraparound supports. A person-centered system of care allows people to move up and down the continuum and across systems. Assess and strengthen transitions of care and support for people as they transition to different levels of care.		X	
c.	Continue to collaborate with law enforcement, probation, and Wellpath to ease the transition of incarcerated individuals to step down models of transitional care with wraparound supports, including housing.	X	X	
d.	Provide a forum for case managers from BHD to meet regularly with peers employed by key contracted partners to engage in case conferencing, including enhanced data sharing and use of data for continuous improvement.		X	X

3.3. Public Awareness and Communication: Increase public education on the prevalence of co-occurring disorders and the availability of services and resources that address both MH and SUD needs.

Strategies		Year 1	Years 2–3	Years 4–5
a.	Organize a social marketing campaign that explains and highlights the nature of co-occurring disorders and availability of outpatient services for these individuals		X	

b.	Collect and publicize data from intensive outpatient clients (e.g., surveys and focus groups) on their experiences to drive responsive, continuous improvements at key points in the delivery system.		X	X
c.	Work with the COE to disseminate information and best practices to triage BH needs and coordinate student referrals to outpatient BH services from public schools.	X	X	
d.	Expand education and awareness for providers and hospitals tied to MAT, including medication for alcohol use disorder (AUD) and opioid use disorder (OUD).		X	

3.4. Workforce and Staffing: Develop more peer support and team-based approaches to augment clinical staff (shorter-term) while also developing career pipeline programs with higher education partners (longer-term).

Strategies		Year 1	Years 2–3	Years 4–5
a.	Establish an internal task force to identify key opportunities and recommendations for improving work flexibility, supervision, and other factors driving employee job satisfaction and retention.	X		
b.	Develop a cadre of certified outpatient peer specialists to assist with BH service navigation and accompanying wraparound supports.		X	
c.	Partner with the COE to encourage the development and/or scaling of career technical education (CTE) pathways in health and human services for high school students to get exposure to and prepare for careers in BH or related health professions.		X	X
d.	Work with institutions of higher education (e.g., Cuesta College and Cal Poly) to expand opportunities for career development, certificate and credential programs, and other employment preparation and training for key entry and mid-level career positions in the BH ecosystem.		X	
e.	Develop protocols for oversight, supervision, and accountability to enable more strategic contracting with CBOs to augment services BHD clinical staff provide.			X
f.	Increase professional learning and interaction between MH and SUD staff focused on supporting individuals with co-occurring disorders, including cross-referrals, sharing of information and data, and joint use of evidence-based tools		X	X

Key Policy and Budgetary Considerations

- Invest in facility restructuring to advance BH integration and proximity of MH and SUD services and personnel, as well as accompanying investments in technology and information infrastructure.
- Modify policies to allow and encourage peer involvement in team-based approaches to care (see also Workforce Recommendations on page 47).
- Develop policies related to new “stepdown” approach as intermediary between intensive and more community-based outpatient BH services.
- Revise and modify MOUs with all key external partners to update strategic vision.
- Develop new programming for older adults.

4. Crisis Services

Crisis services are intended to assess, stabilize, and treat individuals who are experiencing acute distress. A behavioral health crisis is any situation in which a person's behavior puts them at risk of hurting themselves or others. According to the California Department of Health Care Services, "It is critical to have a comprehensive approach to crisis services that emphasizes community-based treatment and prevention and connects people to ongoing services."[5] Hence, BH efforts are shifting toward development of a continuum of prevention and crisis services that are provided in the least restrictive setting, minimize the strain on emergency departments and hospitals, and change the role of law enforcement in responding to crises.

Significant challenges to making this transition include those related to increasing staff capacity and facilities, service utilization, and partnership coordination. In addition, there are challenges tied to equitable access and coverage for crisis services across the diverse constituencies and communities that comprise SLO County. The goals and strategies below are intended to guide SLO BHD in moving toward a more efficient and effective continuum of crisis services.

Crisis Services Goals

- Build community understanding of crisis management to ensure equitable access to culturally appropriate and responsive services throughout the system of care.
- Enhance interagency collaboration focused on ensuring efficient, equitable access to crisis and intensive residential services.
- Clarify and standardize expectations of how best to navigate the crisis and acute services system.
- Bolster crisis staffing and capacity with peer and partnership staffing models.

Key Goals and Metrics of Success

Service Delivery and Utilization	Client Satisfaction	Other Key Milestones
• Increase the practice of de-escalation in the community. • Increase the percentage of crisis contacts diverted without a 5150 hold. • Increase percentage of crisis contacts provided; follow-up within 24-72 hours. • Increase connections to the next level of BH care or treatment within 30 days of crisis incident. • Decreased readmissions to the CSU and PHF. • Expedite follow-up and outpatient services for people seen at EDs for BH crises.	Improved outcomes including: • Access to crisis stabilization services, • Quality of crisis care received, and • Connection to follow-up services post-crisis.	Increase implementation of peer support specialists for both mental health and SUD-related crisis response.

[5] California DHCS (2022), Assessing the Continuum of Care for Behavioral Health Services in California: Data, Stakeholder Perspectives, and Implications. Prepared by Manatt Health with support from Dr. Anton Nigussa Bland.

Strategies and Action Plan

4.1. Equitable Access: Build community understanding of crisis management to ensure equitable access to culturally appropriate and responsive services throughout the system of care.

Strategies		Year 1	Years 2–3	Years 4–5
a.	Work with community partners to define the crisis continuum and establish a process to define, develop, review, monitor, and improve equitable crisis access.	X		
b.	Conduct the feasibility study for a BH Urgent Care Center for emergency BH services, walk-ins and alternative drop-off, medical clearance, and prescription and medication services.		X	
c.	Investigate the development of a CSU or equivalent facility to serve children and youth.	X	X	
d.	Work with managed care partners to allow individuals with health insurance to use CSU and/or other County crisis services.		X	X
e.	Expand the number and distribution of sobering centers and/or PHF for individuals in need of SUD-related crisis services.	X		

4.2. External Partnerships: Enhance interagency collaboration focused on ensuring efficient, equitable access to crisis and intensive residential services.

Strategies		Year 1	Years 2–3	Years 4–5
a.	Solidify the relationship between hospitals/FQHCs, law enforcement, and mobile crisis teams to make timely response more efficient and streamlined.	X		
b.	Expand Mobile Crisis and Community Action Teams, drawing on the assets and expertise of collaborative partnerships.	X		
c.	Convene a multi-advisory workgroup to review practices and resources to improve mobile crisis team configuration, dispatch and response protocols, and cross-agency coordination and data sharing.		X	X

4.3. Public Awareness and Communication: Clarify and standardize expectations of how best to navigate the crisis and acute services system.

Strategies		Year 1	Years 2–3	Years 4–5
a.	Launch an awareness campaign to help community leaders and partner agencies and organizations (e.g., hospitals, LE, schools, etc.), understand how the crisis system is intended to work.	X		
b.	Engage people who have accessed the crisis system to better understand the challenges associated with crisis services; distill implications for revisions to services delivery.		X	
c.	Increase crisis intervention education and training to share best practices and clarify protocols and processes among staff, key partners, and local government leaders.		X	
d.	Develop and implement communication strategies to improve service access that are culturally and linguistically appropriate.	X	X	X

4.4. Workforce and Staffing: Bolster crisis staffing and capacity with peer and partnership staffing models.

Strategies		Year 1	Years 2–3	Years 4–5
a.	Establish a crisis services agency to oversee programs and contractors.	X		
b.	Develop new staffing models in partnership with hospitals to embed BH crisis staff in medical settings.		X	
c.	Explore the expanded use of peers and other allowable paraprofessionals on crisis teams.		X	
d.	Investigate the feasibility of crisis respite services staffed by trained counselors and peer support specialists.		X	X

Key Policy and Budgetary Considerations

- Determine feasibility and cost of new BH urgent care facility.
- Enhance crisis/sobering center array of services.
- Expand both mobile BH service delivery and CATs.
- Extend engagement and length of crisis services to provide a bridge if longer-term residential services are needed.

5. Intensive Residential Services

Intensive residential services support individuals experiencing BH, SUD, or co-occurring disorders in a facility designed for longer-term treatment and recovery. Intensive treatment services are structured within facility settings for individuals who require close monitoring.

SLO County has a 16-bed licensed psychiatric health facility (PHF) for observation and treatment of individuals experiencing a psychiatric crisis and/or an acute mental illness. A four-bed crisis stabilization unit provides care to individuals who could benefit from urgent psychiatric services, including medications and supportive services, in order to reduce 5150 holds.

Significant challenges include the lack of capacity and facilities for both in-patient MH care and sober living housing. SLO County has few options for in-patient residential SMI and SUD care,[6] and few facilities dedicated to meeting the needs of youth and women. Instead, SLO County contracts with outside facilities, often located hours away. Moreover, few harm reduction options are available as most county residential facilities require clients to abstain from substance use, limiting treatment options such as MAT (i.e., provider resistance to MAT). The goals and strategies below are intended to guide SLO BHD in becoming a more efficient, integrated BH delivery system.

Intensive Residential Services Goals

- Expand access to residential facilities offering in-patient treatment including designated facilities for both women and children.
- Identify and collaborate with partners to increase adult and youth access to longer-term BH facilities, including sober living and board-and-care homes.
- Develop a communication plan with hospitals, FQHCs, and community partners on best practices for meeting the needs of patients with co-occurring disorders.
- Increase opportunities for joint professional learning between MH and SUD staff focused on supporting individuals with co-occurring disorders, including shared use of evidence-based tools and exchange of data.

[6]According to *Assessing the Continuum of Care for Behavioral Health Services in California: Data, Stakeholder Perspectives, and Implications* (CHCS by Mannat Health with support from Dr. Anton Niguesse Bland, January 2022), 70 percent of counties in California report urgently needing residential SUD treatment services, and 22 counties have no residential SUD treatment facilities. In addition, 75 percent of counties lack SUD residential beds for youth patients.

Key Goals and Metrics of Success

Service Delivery and Utilization	Client Satisfaction	Other Key Milestones
• Increase by 10% the options for in-patient residential SMI and SUD care, particularly for women and youth. • Increase by 20% the number of beds available for sober living in the County. • Increase by 30% the number of recovery residence facilities compatible with MAT	Improved outcomes including: • Better process for accessing residential services, • Access to MAT within residential facilities, • Quality of residential care received, and • Connection to step down to outpatient treatment.	• Staff/personnel gaps analysis report for residential programs and services • Establish at least two partnerships to provide Harm Reduction services in county residential facilities. • Addition of at least one residential BH in-patient facility within SLO County

Strategies and Action Plan

5.1. Equitable Access: Expand access to residential facilities offering in-patient treatment including designated facilities for both women and children.

Strategies	Year 1	Years 2–3	Years 4–5
a. Establish a sobering center within the behavioral health crisis continuum with low-barrier entry criteria, and connection to outpatient SUD treatment.	X		
b. Investigate the development of BH and SUD residential treatment facilities and/or cooperative agreements to ensure access for youth (ages 13-18) and women within SLO County.[7]		X	X
c. Develop partnerships with local and nearby partners to increase step-down opportunities.		X	X

[7] SLO County lacks a recovery residence that accepts women with children if she is receiving MAT services.

5.2. External Partnerships: Identify and collaborate with partners to increase adult and youth access to longer-term BH facilities, including sober living and board-and-care homes.

Strategies		Year 1	Years 2–3	Years 4–5
a.	Identify and collaborate with partners to increase adult access to longer-term sober living programs and board and care housing compatible with MAT throughout SLO County.	X	X	
b.	Explore the feasibility of a multi-county, regional approach to expanding access to intensive residential treatment services for the Central Coast.		X	X

5.3. Public Awareness and Communication: Develop a communication plan with hospitals, FQHCs, and community partners on best practices for meeting the needs of patients with co-occurring disorders.

Strategies		Year 1	Years 2–3	Years 4–5
a.	Increase public understanding of eligibility criteria (i.e., Medi-Cal) and the points of access to residential BH services and programs available to county residents.	X	X	

5.4. Workforce and Staffing: Increase opportunities for joint professional learning between MH and SUD staff focused on supporting individuals with co-occurring disorders, including shared use of evidence-based tools and exchange of data.

Strategies		Year 1	Years 2–3	Years 4–5
a.	Identify and map key personnel gaps in staffing SUD residential programs and services.		X	X

Key Policy and Budgetary Considerations

- Develop a regional approach that envisions leveraging resources across counties (e.g., Kern, Kings, Monterey, Santa Barbara, Santa Cruz, and Ventura) to operate residential facilities in a cost-effective manner for key populations where gaps exist (e.g., youth). This inter-county approach would likely unfold over a longer time and require changes to a host of policies regarding sharing of data and resources.

WORKFORCE POLICY AND BUDGET CONSIDERATIONS

Given the chronic behavioral health (BH) workforce shortages,[8] Health Management Associates has included additional details on policy and budgetary considerations pertaining to Workforce and Capacity issues. We know that employee recruitment and retention are longstanding challenges. These two recommendations cut across the five BH strategic areas, touching on most aspects of SLO BHD's work.

Recommendation 1: Build a Workforce-Centric Growth Model

Build the workforce based on what people will need to best serve individuals with BH needs. Competition for talent is fierce and employees have more choices among BH employers due to the high demand.

Figure 11. Worker-Centric Growth Visualization

As such, Figure 11 above places workers at the center of multiple policies and HR considerations including:

- Creating new financial incentives, such as childcare assistance, on-site childcare, enhanced loan repayment support
- Increasing wages for language and cultural competency skills
- Emphasizing workforce well-being and flexibility with wellness support, job sharing, staff driven scheduling
- Developing pipeline and pathway partnerships through staff recruitment with a systems orientation that includes other public agencies and institutions.

[8] California has the largest deficit nationally of health professions. See Health Professional Shortage Areas (hrsa.gov)

Recommendation 2. Take Advantage of Enhanced State Flexibility to Implement Team-Based Approaches to Care

California has allocated $1.7 billion over three years in the “care economy workforce” intended to increase the overall workforce with a mix of incentives and expansion of key job classifications including:

- Recruitment and training of new community health workers
- Stipends and scholarships to increase the number of social workers
- Expansion of the overall number of SUD professionals and nurses
- Scholarships and loan repayment for multilingual applicants
- Multiple new career paths into CBOs and other BH provider and other entities

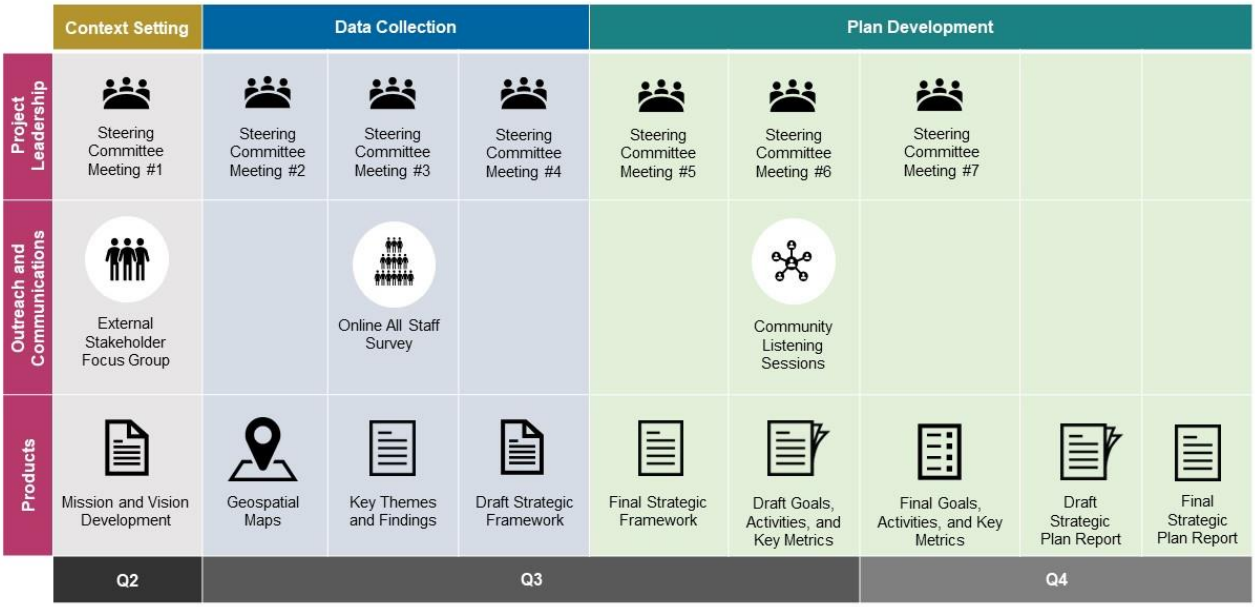
In addition, California has added flexibility to include CHWs, certified peers, EMTs, and BH technicians on crisis teams and in BH systems. As such, the environment is ripe for team-based approaches that use an array of employee and peer classifications. The future BH clinical workforce may be drawn largely from these positions over time.

PLANNING PROCESS

SLO BHD initiated the strategic planning process in the spring of 2023. The process included input from SLO BHD leadership and staff, as well as external partners, affiliated organizations, and community members with coordination and facilitation from HMA. The Strategic Plan leverages extensive research and analysis pulled from reports, neighboring county's behavioral health department strategic plans, as well as efforts other agencies in SLO County have led. SLO BHD staff and community partners have a wealth of lived experience and subject matter expertise that informed the Strategic Plan. Regular meetings with the SLO BHD Steering Committee, targeted focus groups, and interviews with key Community Advisors allowed HMA to distill critical insights and key themes from an array of perspectives. The combination of applying research with ongoing input and feedback resulted in a strategic plan that is both uniquely structured for San Luis Obispo County - and flexible to face future circumstances.

The strategic planning process included three phases: context setting, data collection, and plan development. Numerous stakeholder activities were held as depicted by Figure 12 below.

Figure 12. Phases of the Strategic Planning Process



Document Review

HMA reviewed relevant documents to inform the development and direction of the strategic plan, including the Manatt Report ("Assessing the Continuum of Care for Behavioral Health Services in California"), "The San Luis Obispo Countywide Plan to Address Homelessness 2022−2027," and the County's "Three-Year Stepping Up Strategic Plan." HMA also reviewed data and findings from two reports (one adult-focused and the other youth-centered) that Capstone Solutions prepared on behalf of SLO BHD, which identified key challenges and potential solutions tied to service access, departmental capacity, and integration of BH services.

Focus Groups

HMA conducted focus groups to identify and explore key BH themes and issues relevant to the formulation of strategy and prioritization. HMA conducted seven focus group sessions, six in-person and one virtual, with internal and external stakeholders including Transitions Mental Health, Sierra Mental Wellness Group, Family Care Network, County Adult and Youth SMHS, Justice Services, and Drug & Alcohol Services in August 2023. Information gleaned from the sessions provided HMA with a general concept of the strategic areas of focus for the framework, as well as four cross-cutting goals and subsequent activities that encompass SLO BHD's overarching mission and vision.

Geospatial Mapping

Geospatial mapping was conducted to illustrate the correlation between county demographic factors that BH serves (both location of services and service utilization). In this way, the maps provided visualization of system gaps and needs.

The maps were developed with US Census Bureau data and visualized on Tableau software. Demographic information captured total population by ZIP code in San Luis Obispo County included race, languages spoken other than English, transportation used when no personal vehicle is available, poverty rate (FY 16−21), median household income, total uninsured population, and the unemployment rate. A composite hardship index was captured to demonstrate the synthesis of poverty, unemployment, uninsured, and household income data (FY 16-21).

SLO BHD provided additional data, which were visualized on Tableau to illustrate where behavioral health services were delivered and received. HMA shared these maps with key members of the SLO BHD Core Team in September 2023.

Staff Survey

SLO BHD distributed an electronic survey to all staff in late October 2023. In total, 139 of the active 291 (48%) department employees completed the survey, which focused on staff priorities for the agency, as well as suggestions for improvement in the four cross-cutting issues (equity, partnerships, outreach/communication, and workforce capacity). Table 2 summarizes the priorities of staff survey respondents.

Table 2. Staff Survey Respondent Priorities

Desired Agency Priorities	Key Partners to Prioritize	Equity Populations for Focus	Outreach and Communication Priorities	Workforce Priorities
BH Integration	Schools	Non-English speakers	Agency website	Increased compensation
Crisis System and Response	Hospitals/clinics	Unhoused/homeless	Online presence and social media	Additional staff; reduced caseloads
Focus on Equity and /Underserved Populations	CBOs	Undocumented and immigrants	Marketing and Advertisements	Flexible schedules and hybrid working
External Partnerships	Law Enforcement	LGBTQ+	Staff presence at Community events	Bilingual staff
Enhanced SUD Services	DSS/Child Welfare	Individuals with co-occurring disorders	Destigmatization campaigns	Peers and staff with lived experience

Listening Sessions

HMA convened two community listening sessions to provide opportunities for input on draft findings and strategic direction. The listening sessions were promoted through SLO BHD communication channels and facilitated by HMA. A total of 26 individuals, not including HMA or SLO BHD staff, attended the two sessions in November 2023.

ACKNOWLEDGEMENTS

SLO BHD Steering Committee

Nicholas Drews, Health Agency Director

Star Graber, PhD., LMFT, Behavioral Health Director

Frank Warren, Behavioral Health Deputy Director

Amanda Getten, LMFT, Quality Services Team Division Manager

Sarah Hayter, County Administration

Rachael Koenig, Behavioral Health Administrative Services Manager

Kristina Paramore, LMFT, Drug and Alcohol Services Division Manager

Teresa Pemberton, LMFT, Justice Services Division Manager

Matthew Pennon, Diversity, Equity, and Inclusion Program Manager

Josh Peters, LMFT, Adult Mental Health Services Division Manager

Jill Rietjens, LMFT, Youth Mental Health Services Division

Nisa Solis, Administrative Services Officer

Morgan Torell, Business Systems Analyst

Community Advisor Interviews

Ian Parkinson, Sheriff's Office, County of San Luis Obispo

Kenneth Dalebout, Arroyo Grande Community Hospital

Jon Nibbio, Family Care Network, Inc.

Jill Bolster-White, Transitions-Mental Health Association

Barbara Levenson, Behavioral Health Board, County of San Luis Obispo

Linda Belch, Adult and Children's Services, County of San Luis Obispo

Amber Gallagher, Special Education Local Plan Area

Ben Jacobson, Sierra Mental Wellness Group

Robert Reyes, Probation Department, County of San Luis Obispo

Bruce Gibson, County Board of Supervisors

Nestor Veloz-Passalacqua, Administration Department, City of San Luis Obispo

James Watson, Recovery Support Network

Melinda Sokolowski, Child, Youth and Family Services Division

Janna Nichols, 5Cities Homeless Coalition

Christy Mulkerin, County of San Luis Obispo

Nicholas Drews, Healthy Agency, San Luis Obispo County

Focus Groups

We would like to thank the participation of staff from the following community-based organizations: Transitions Mental Health, Sierra Mental Wellness Group, Family Care Network. We would also like to thank SLO BHD staff from Adult Services, Justice Services, Youth Services, and Drug and Alcohol Services.

Health Management Associates

SLO BHD would like to thank Health Management Associates for their guidance in developing the Strategic Plan. Team members included Charles Robbins, Michael Butler, Devon Schechinger, Paul Fleissner, Kamala Greene Génecé, and Cieara Simmons.

APPENDICES

A. Demographics

B. Service Heat Maps

C. Staff Survey

D. Key Informants

E. Resources and Endnotes

A. Demographics

Data Sourced from the US Census Bureau

Demographics of San Luis Obispo County Residents

San Luis Obispo (SLO) County is the jewel of California's Central Coast and a community that prides itself on a healthy, friendly atmosphere. From the rolling hills surrounding the lush agricultural regions, to the unparalleled beaches and dramatic shorelines, SLO County attracts tourists, students, retirees, businesses, and families seeking an active environment and terrific neighbors. DCHS considers SLO County a medium-sized jurisdiction and has a mix of suburban and rural communities, with an estimated population of 282,013, and a density of 85.6 people per square mile (US Census, 2022).

As Figures A1 and A2 indicate, the county is whiter and older than other locations in California. SLO County residents are mostly White, with Hispanics/Latinos comprising the second-largest racial/ethnic group. SLO County has approximately 5 percent fewer residents younger than 18 years old, and about six percent (6%) more residents ages 65 years and older.

Figure A1. US Census 2022 Comparison of Racial Demographics, California and SLO County

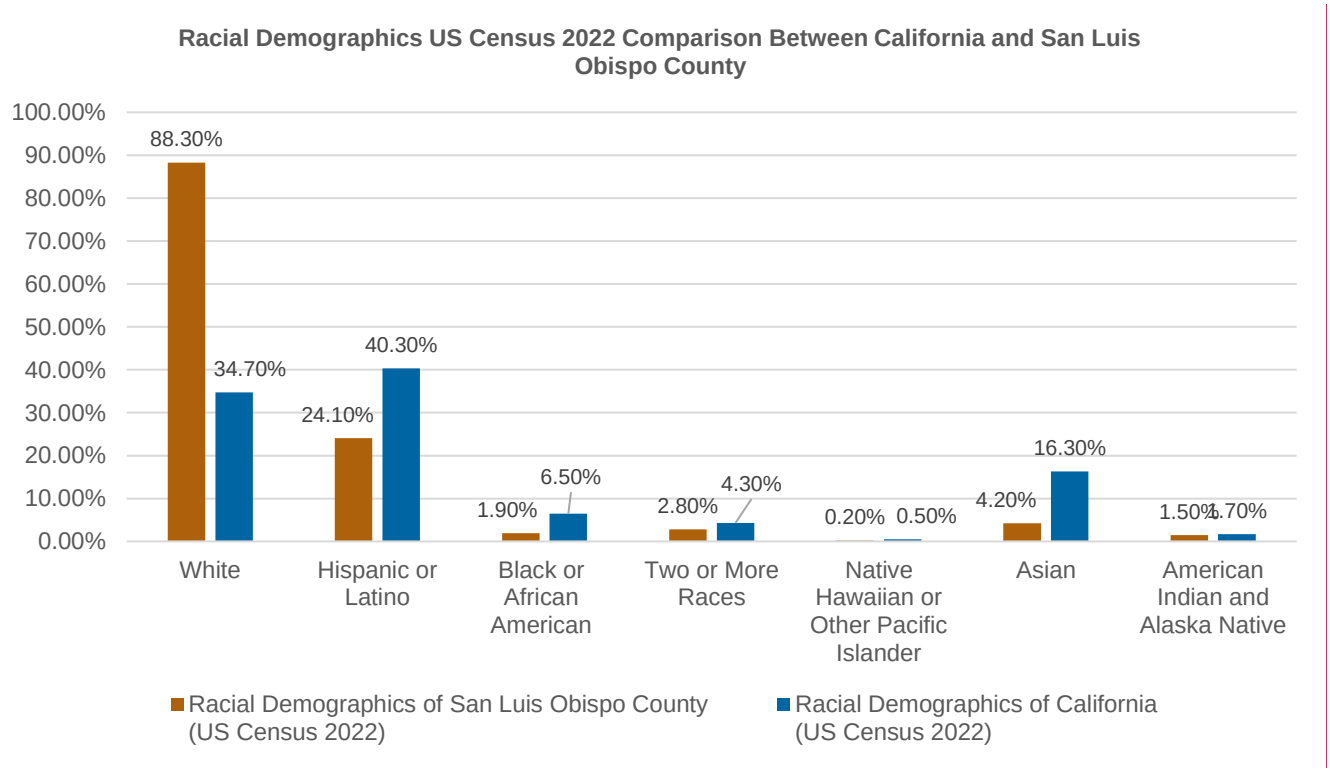


Figure A2. Age Demographics: US Census 2022 Comparison Between California and SLO County

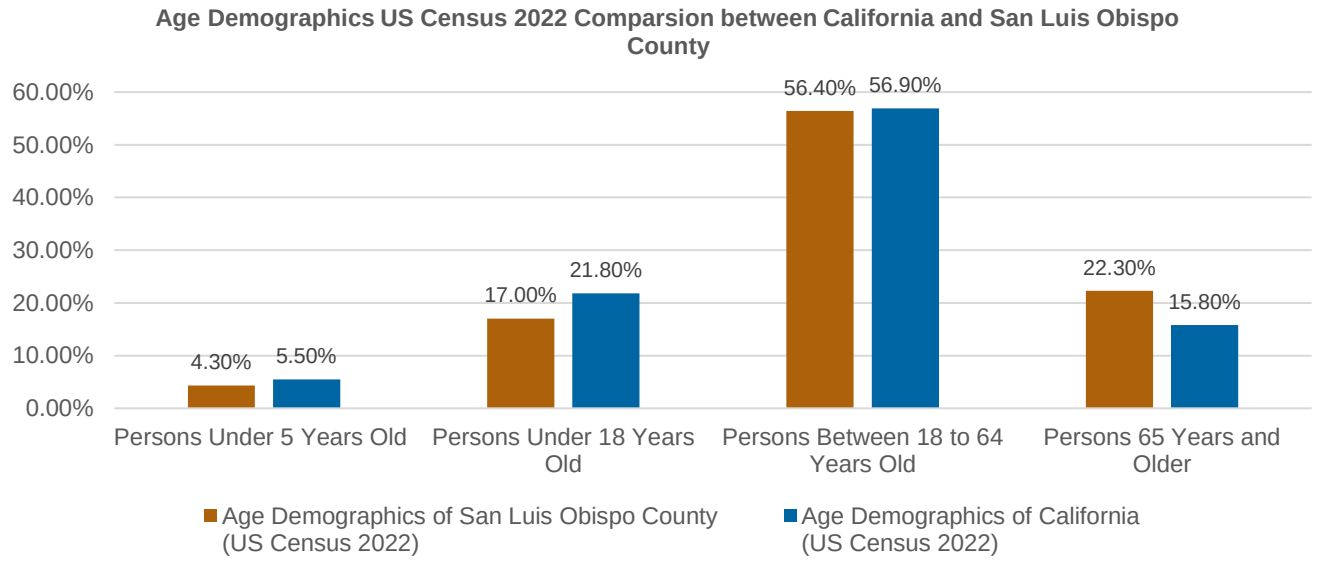


Figure A3. Total San Luis Obispo County Population by Zip Code

Source: US Census Bureau

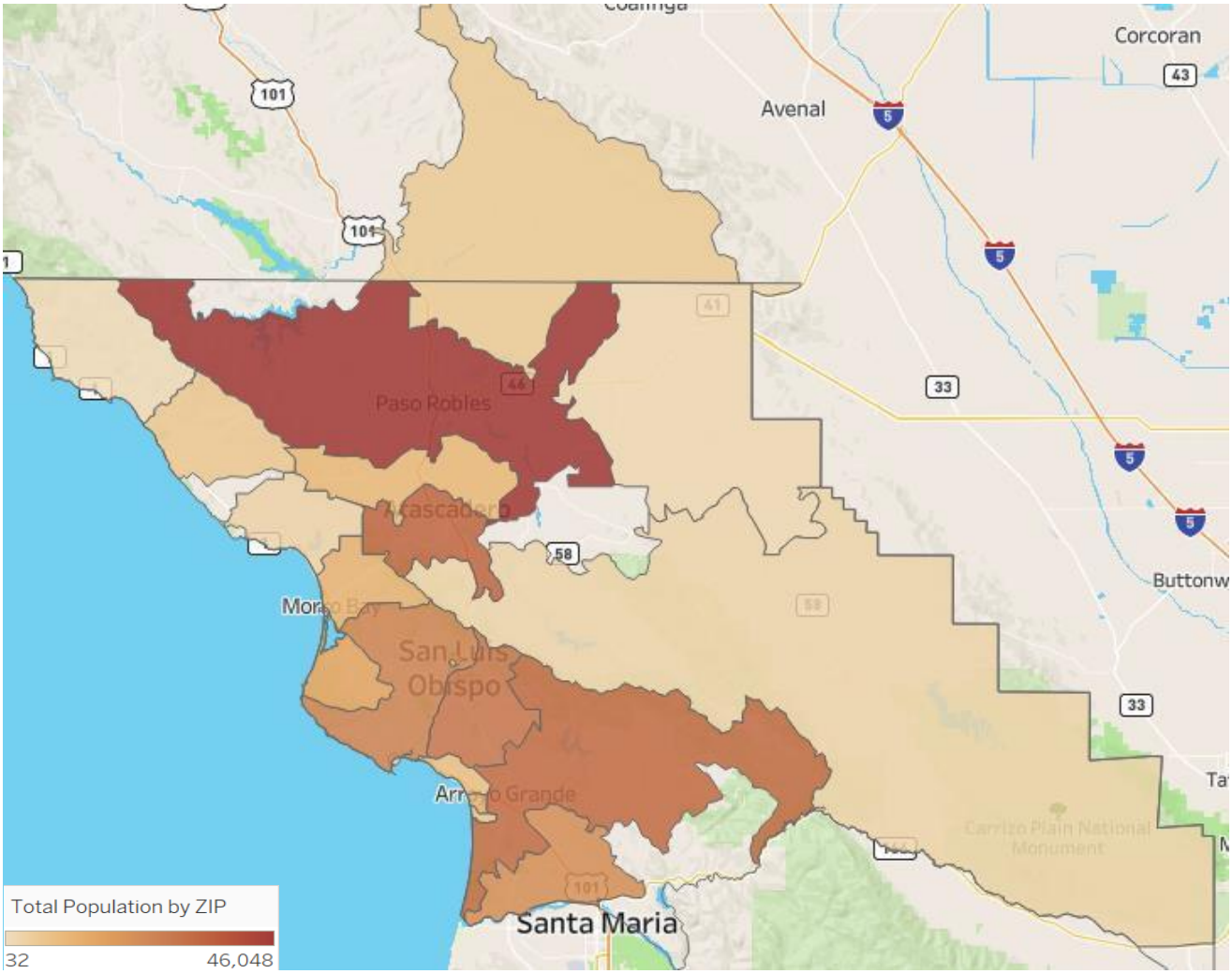


Figure A4. Languages (other than English) Spoken Around San Luis Obispo County

Source: US Census Bureau

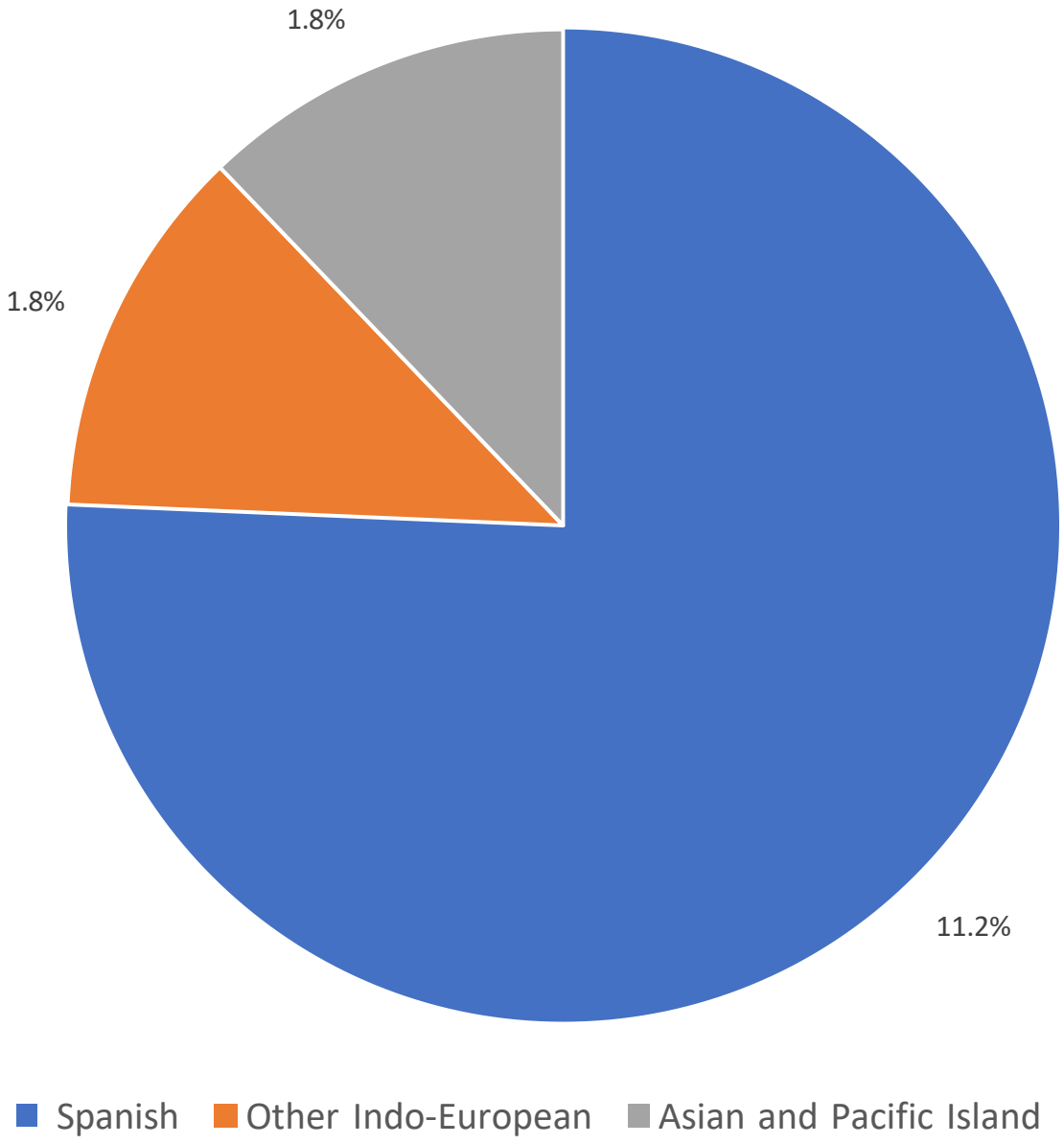


Figure A5. Transportation Utilized (when no personal vehicle available) by Region

Source: US Census Bureau

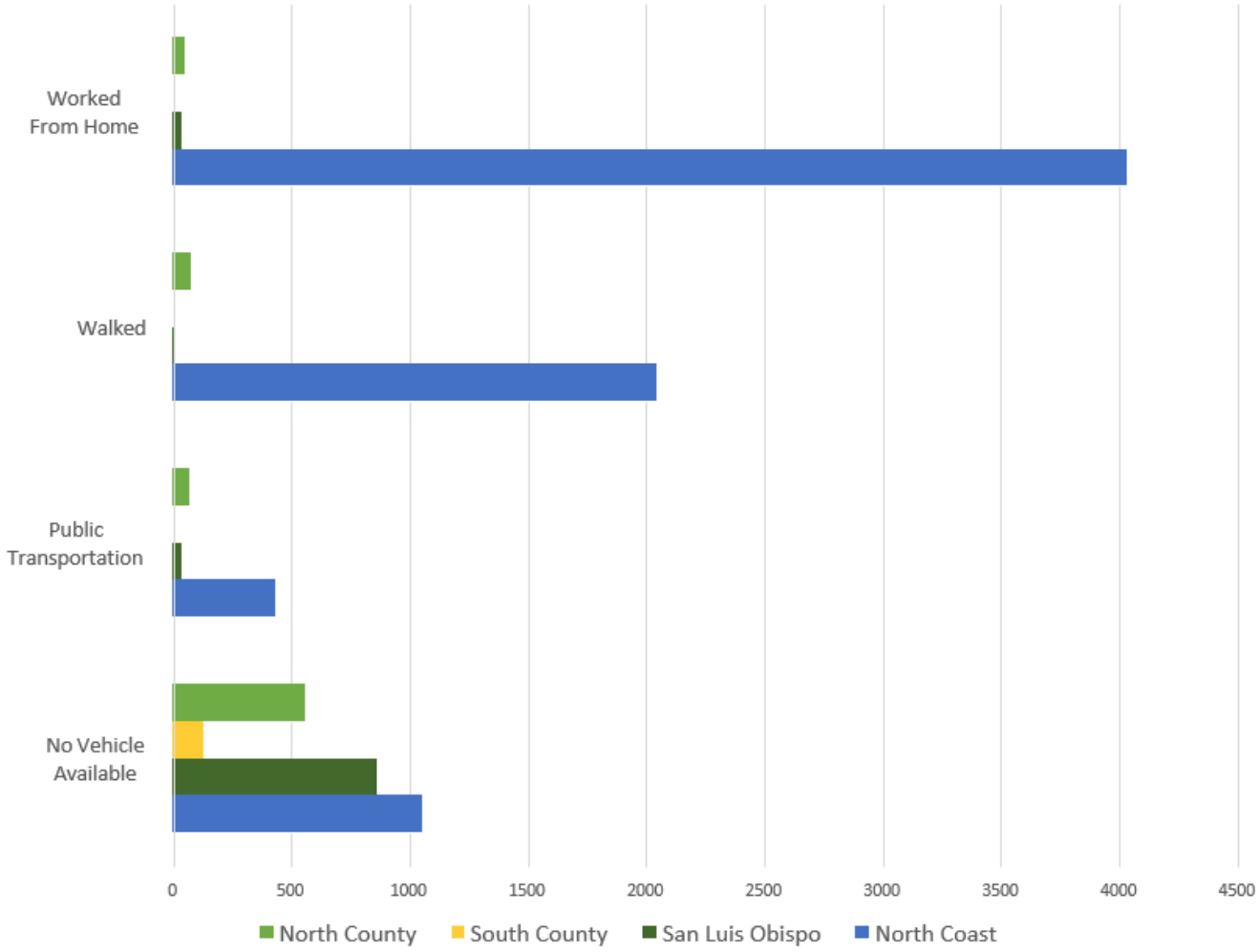


Figure A6. Poverty Rate, 2016-2021

By Zip Code Region

Source: US Census Bureau

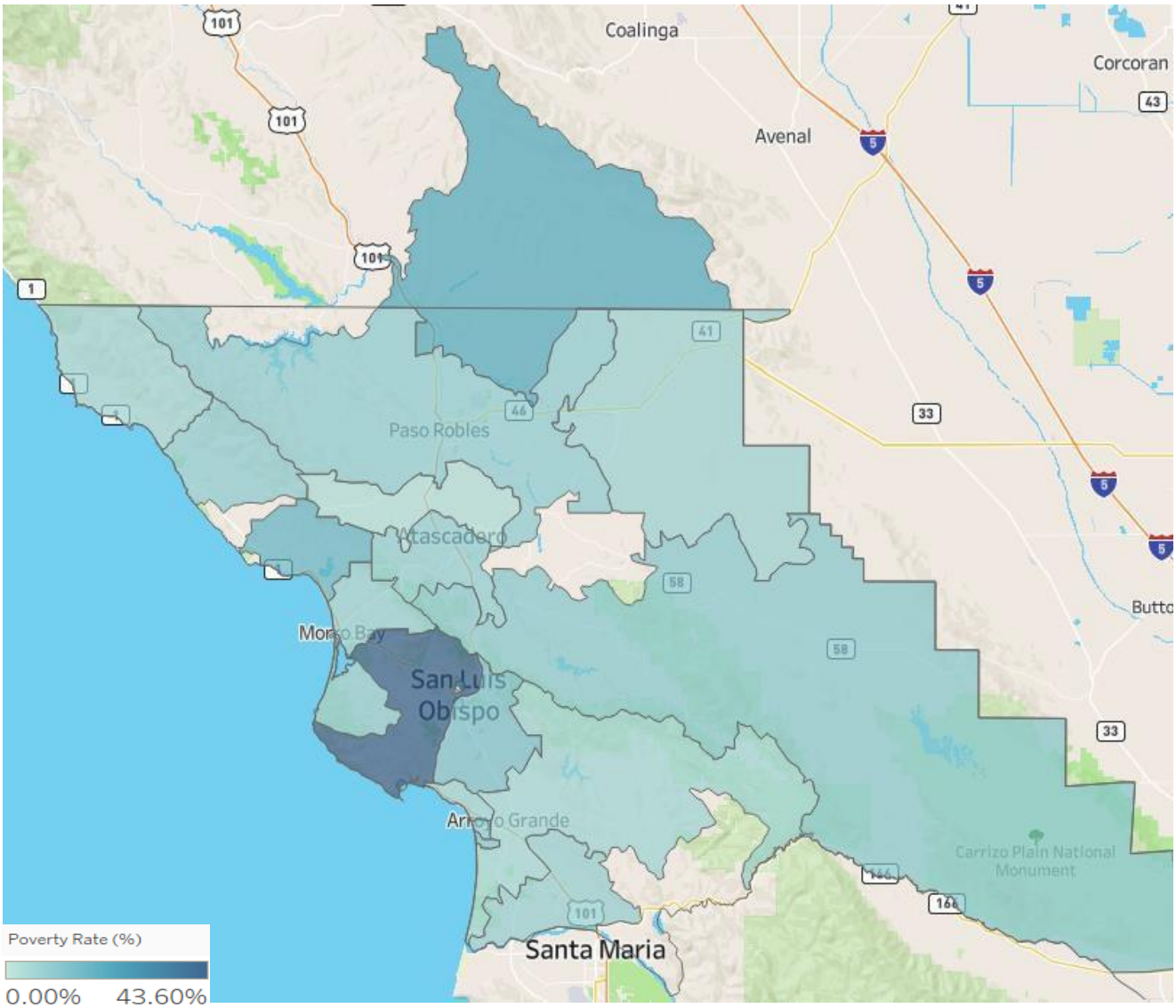


Figure A7. Median Household Income, 2016-2021

By Zip Code Region

Source: US Census Bureau

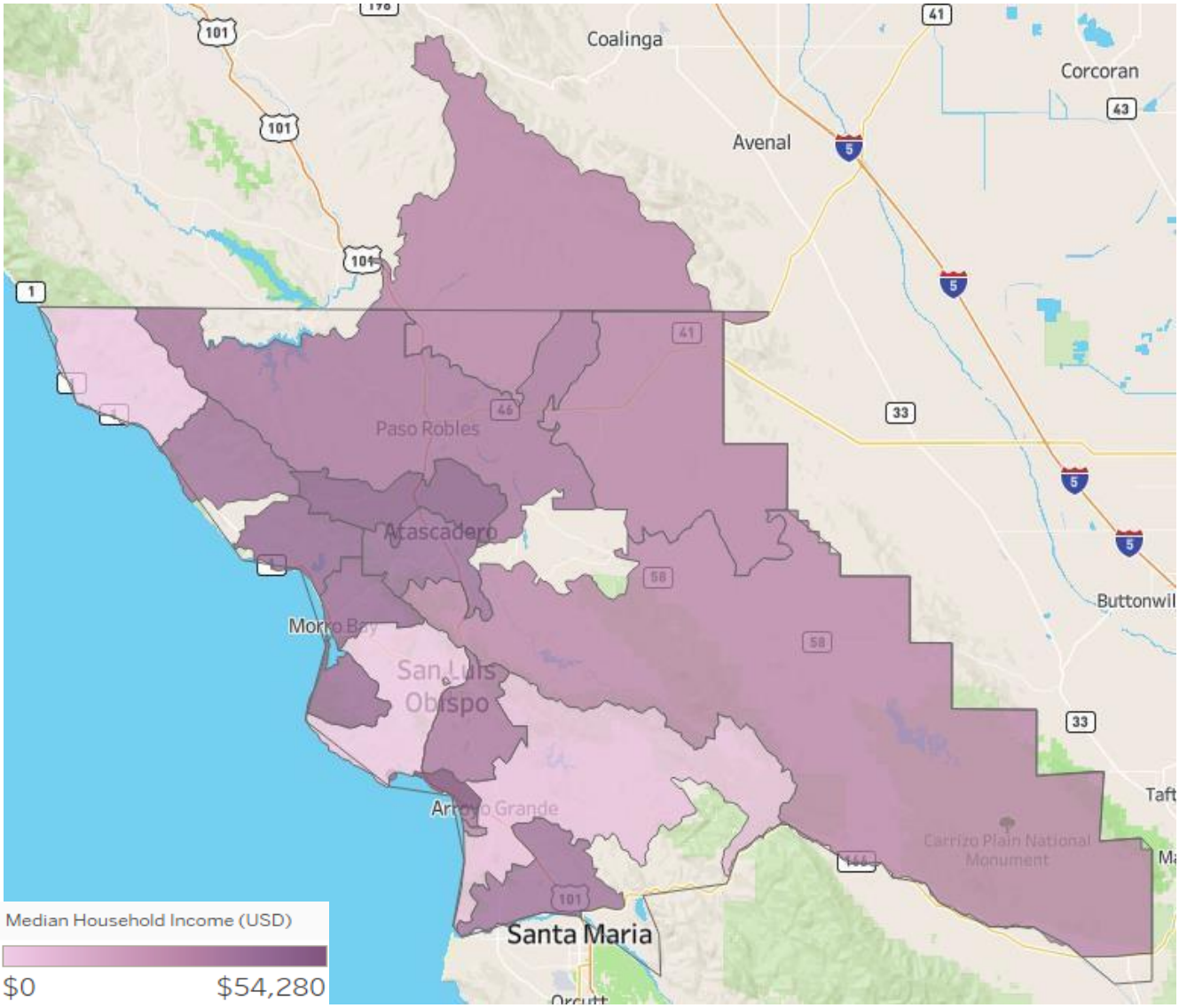


Figure A8. Uninsured Population, 2016-2021

By Zip Code Region

Source: US Census Bureau

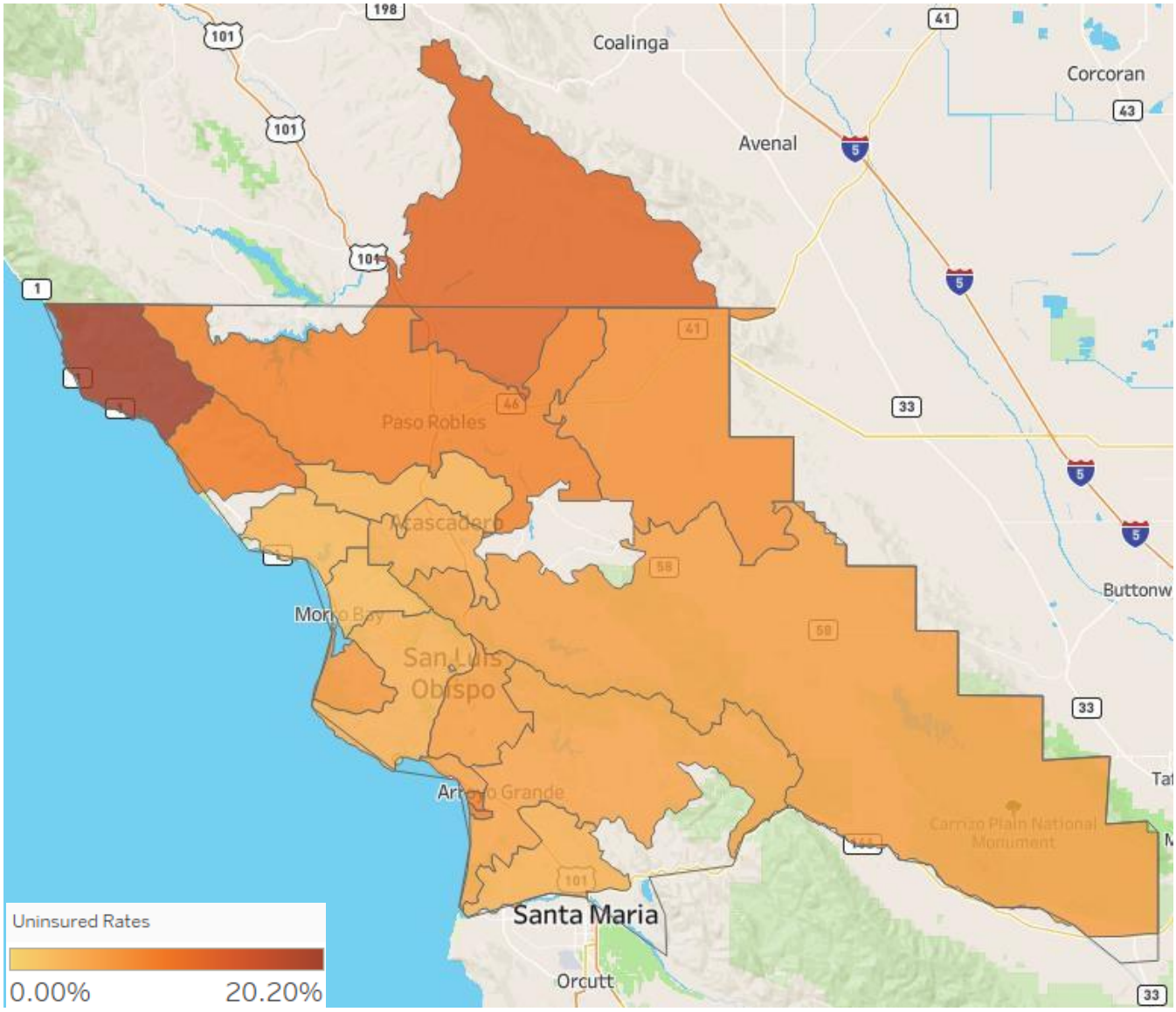


Figure A9. Unemployment Rate, 2016-2021

By Zip Code Region

Source: US Census Bureau

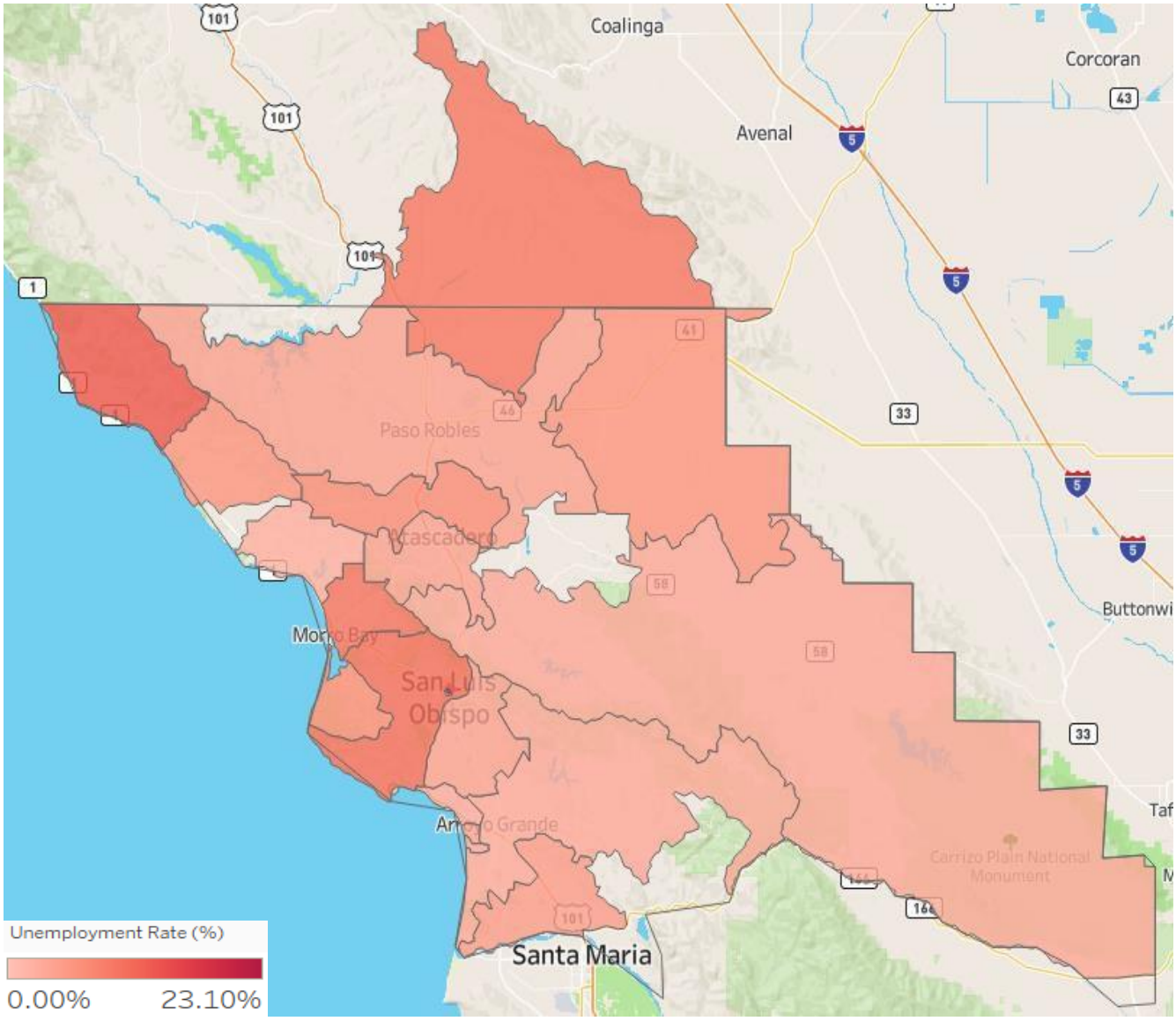


Figure A10. Trends, 2016-2021

- The circled areas tend to have lower median household income, higher unemployment rates, higher poverty rates, and more individuals without health insurance.
- Each of these factors contributes to a hardship index, which captures difficult economic conditions between communities.
- Source: US Census Bureau

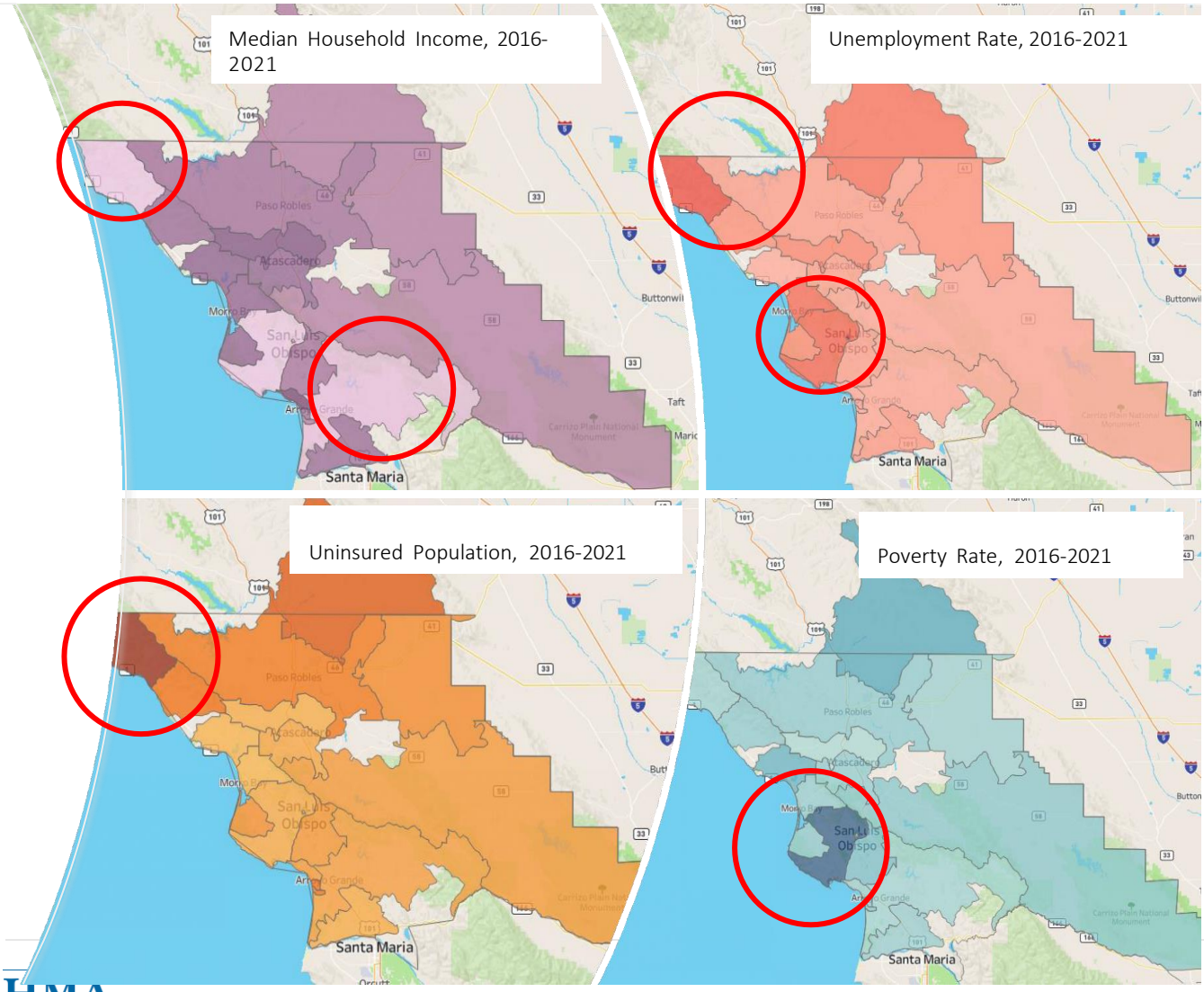
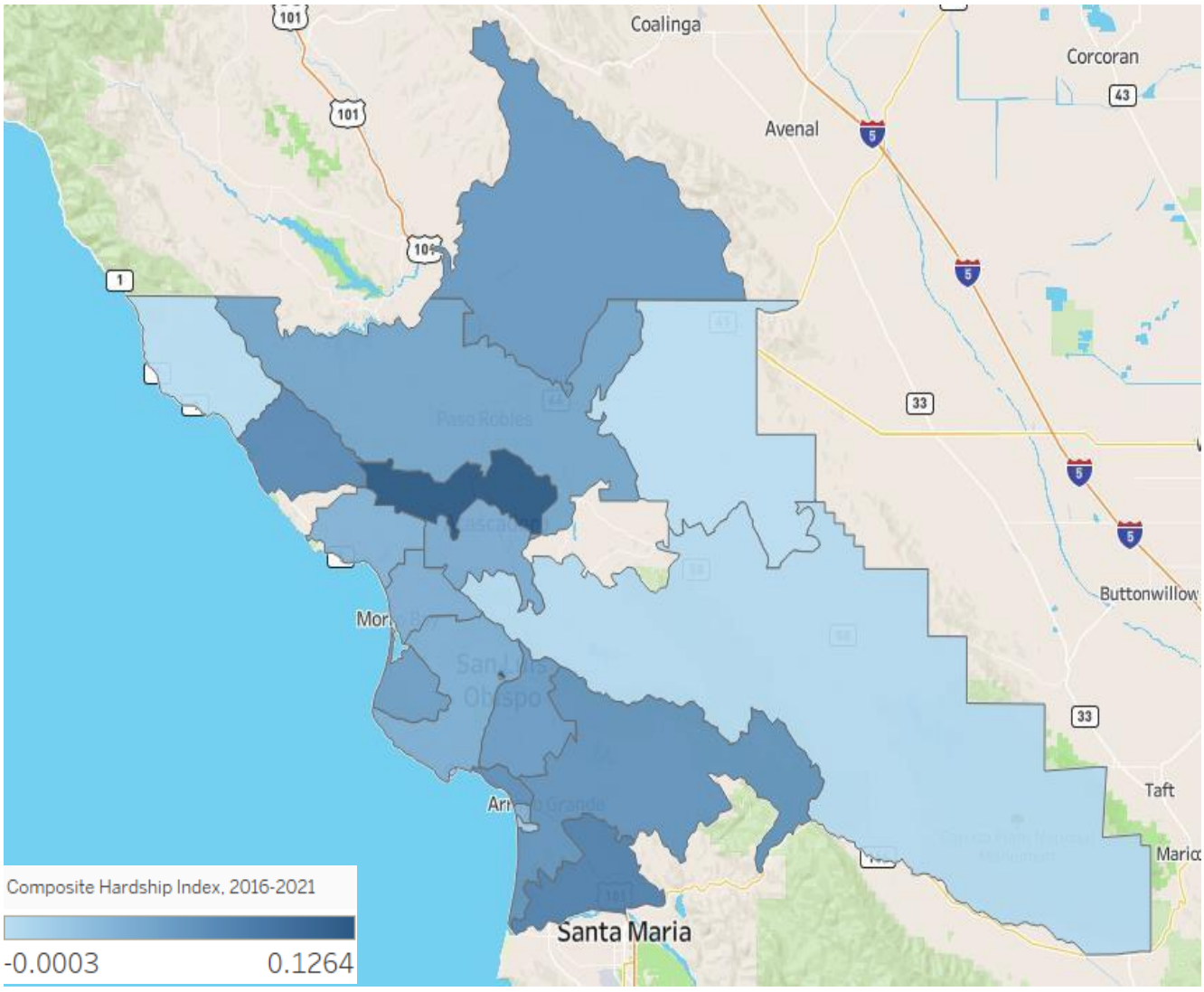


Figure A10. Trends, 2016-2021

- Synthesizes poverty, unemployment, uninsured, and household income data.
- This visual combines the trends noted across the four individual maps and creates a composite visual of areas that experience more economic hardship than others in SLO County.
- Source: US Census Bureau



B. Service Heat Maps

Data Provided by the San Luis Obispo Behavioral Health Department

Figure B1. Total Number of Adults Receiving Services (SMHS + Med Support) by Region: Pre- COVID-19, 2018-2020

- Source: SLO Behavioral Health Department

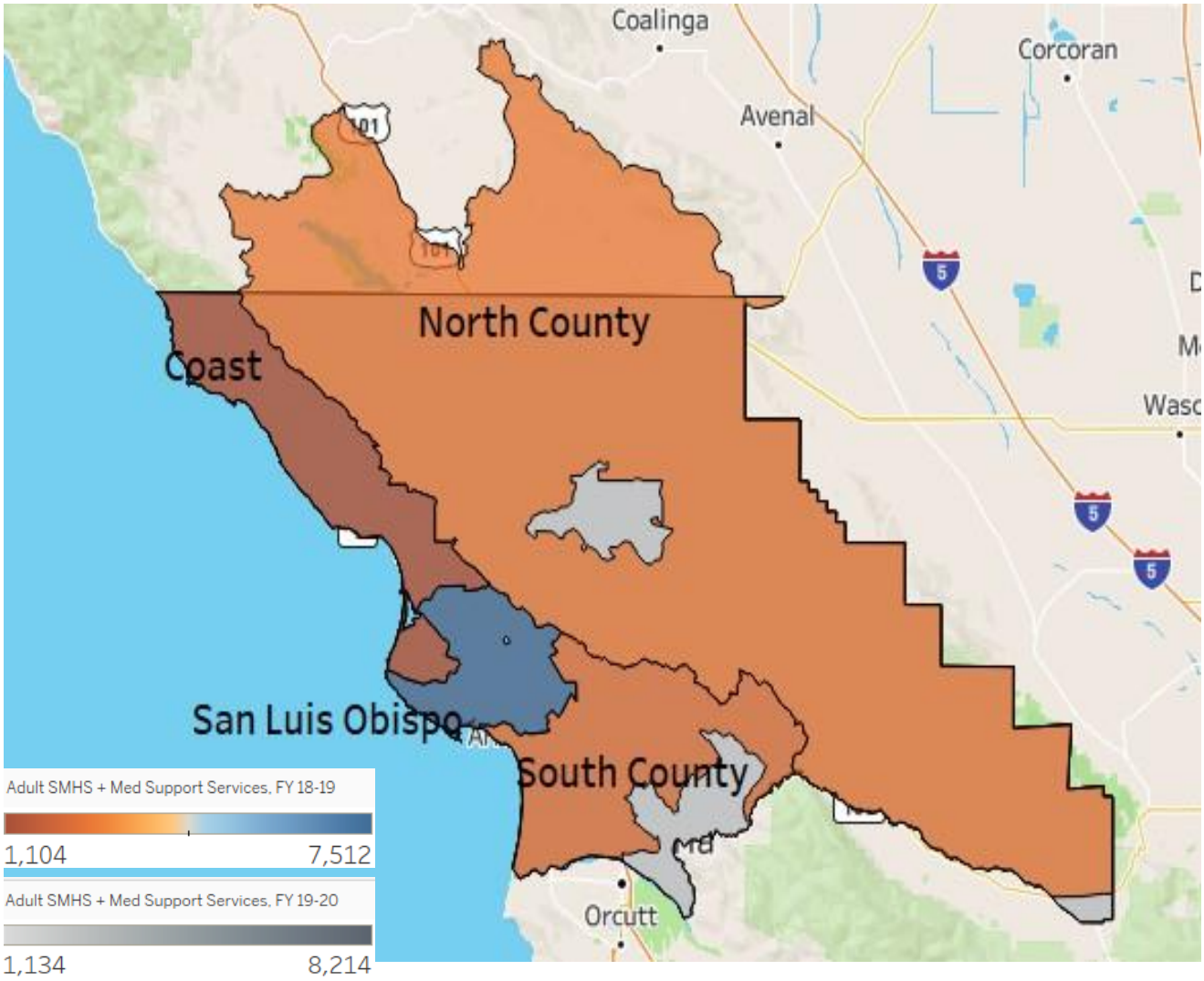


Figure B2. Total Number of Adults Receiving Services (SMHS + Med Support) by Region: During COVID-19, 2020-2022

- Source: SLO Behavioral Health Department

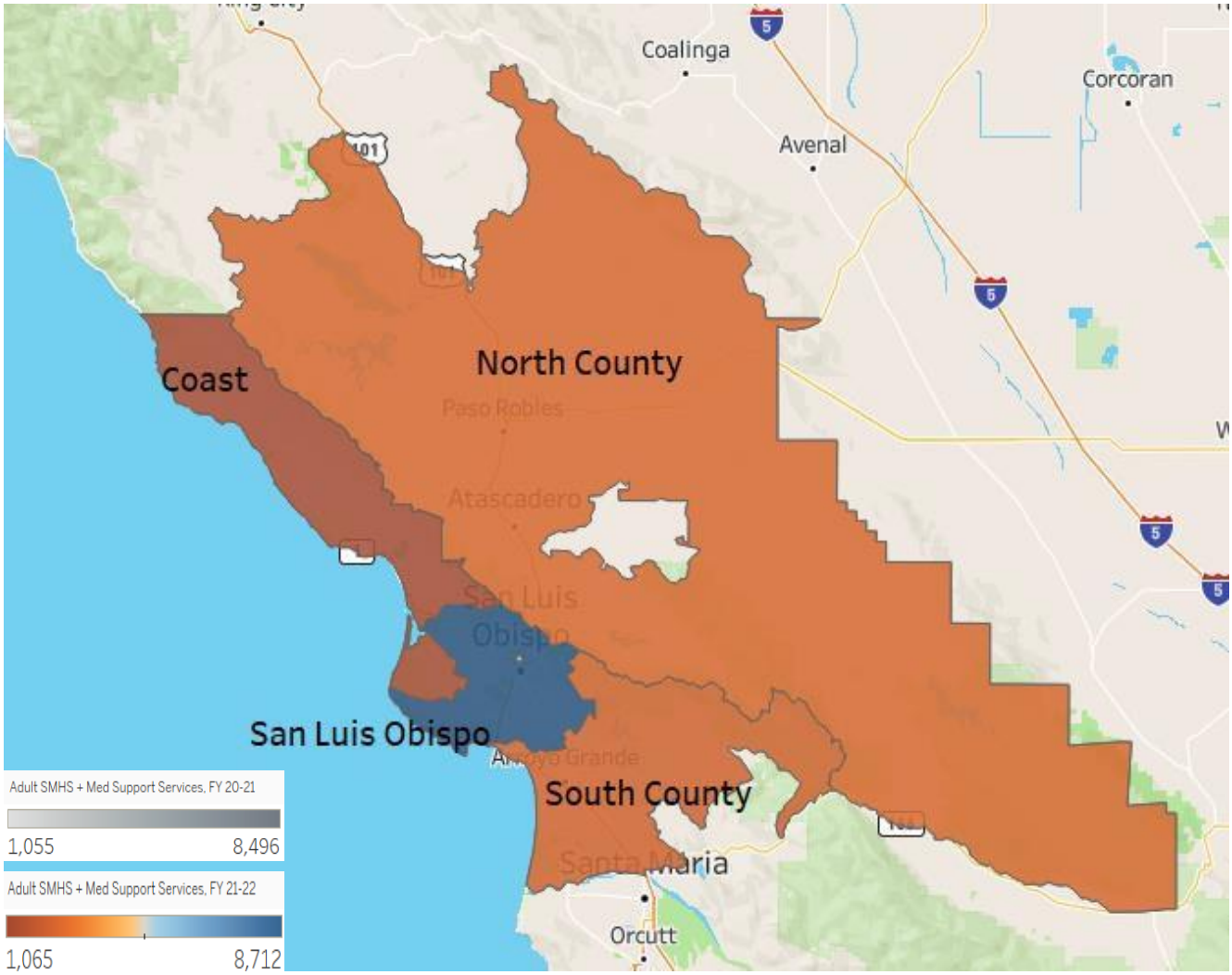
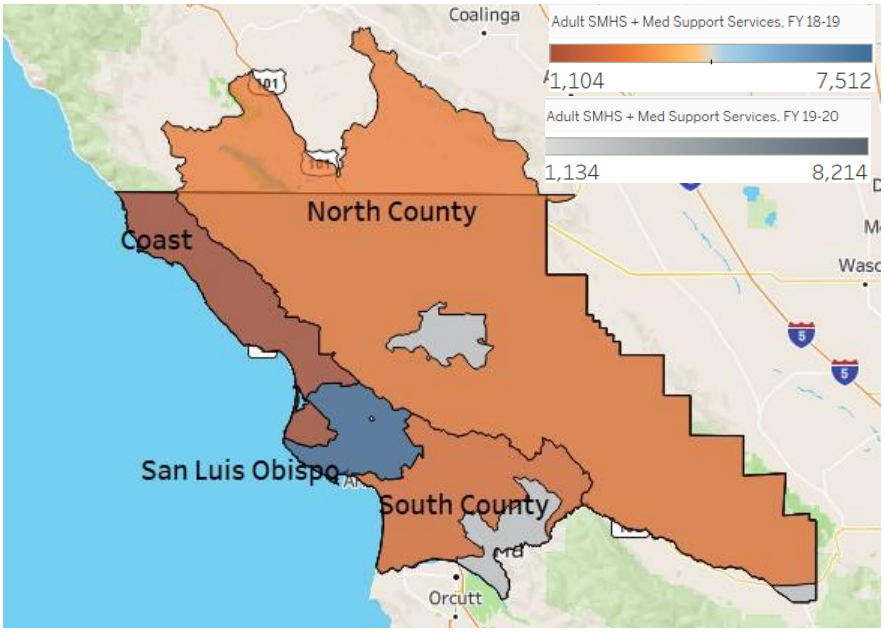


Figure B3. Total Number of Adults Receiving Services (SMHS + Med Support) by Region: During COVID-19, 2020-2022

- TREND: Service utilization distributions did not appear to change significantly following the onset of the COVID-19 pandemic (color distributions appear the same). However, the number of adults receiving SMHS and Med Support increased after FY 20.
- Source: SLO Behavioral Health Department

Pre- COVID-19 (FY 18-20)

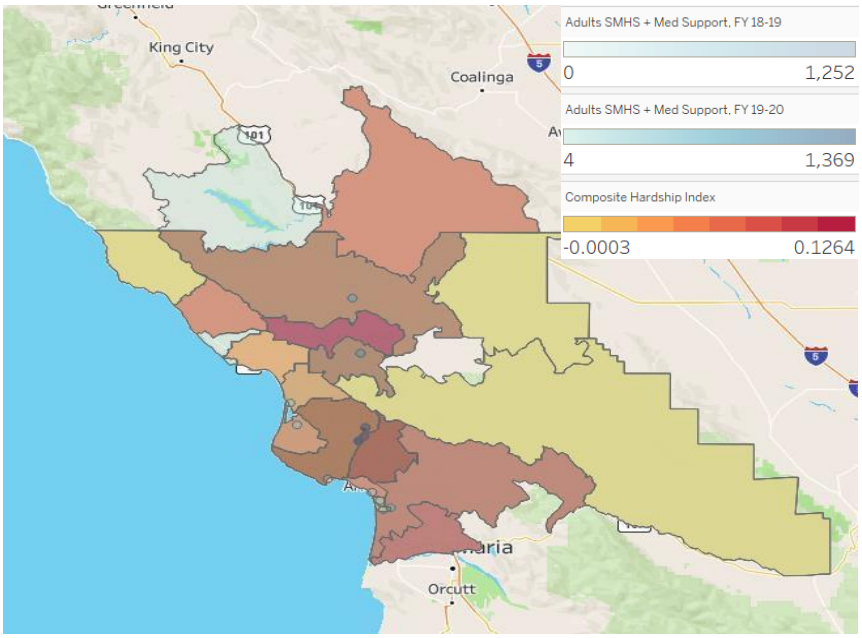


During COVID-19 (FY 20-22)

Figure B4. Adult Utilization of SMHS and Med Support Services + Hardship Index

- Areas that appear in deeper brown or red colors are ones that experience more economic hardships and had higher utilization of SMHS and Med Support services among adults. Although the number of adults receiving services increased during COVID-19, the geographic distribution of service utilization remained relatively consistent compared to pre- COVID-19 data.
- Source: SLO Behavioral Health Department

Pre- COVID-19 (FY 18-20)



During COVID-19 (FY 20-22)

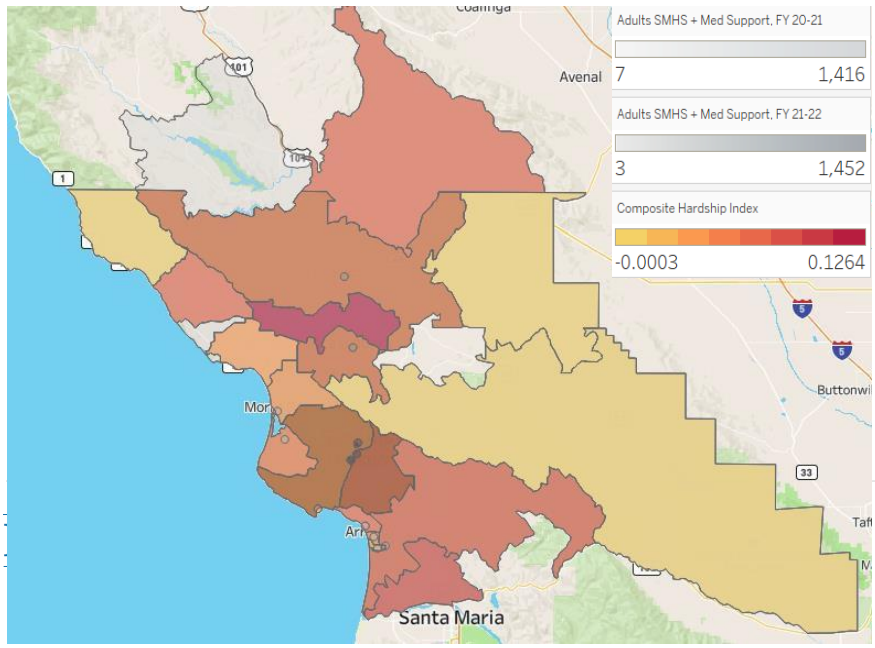


Figure B5. Total Number of Youth Receiving Services (SMHS + Med Support) by Region: Pre- COVID-19, 2018-2020

- Source: SLO Behavioral Health Department

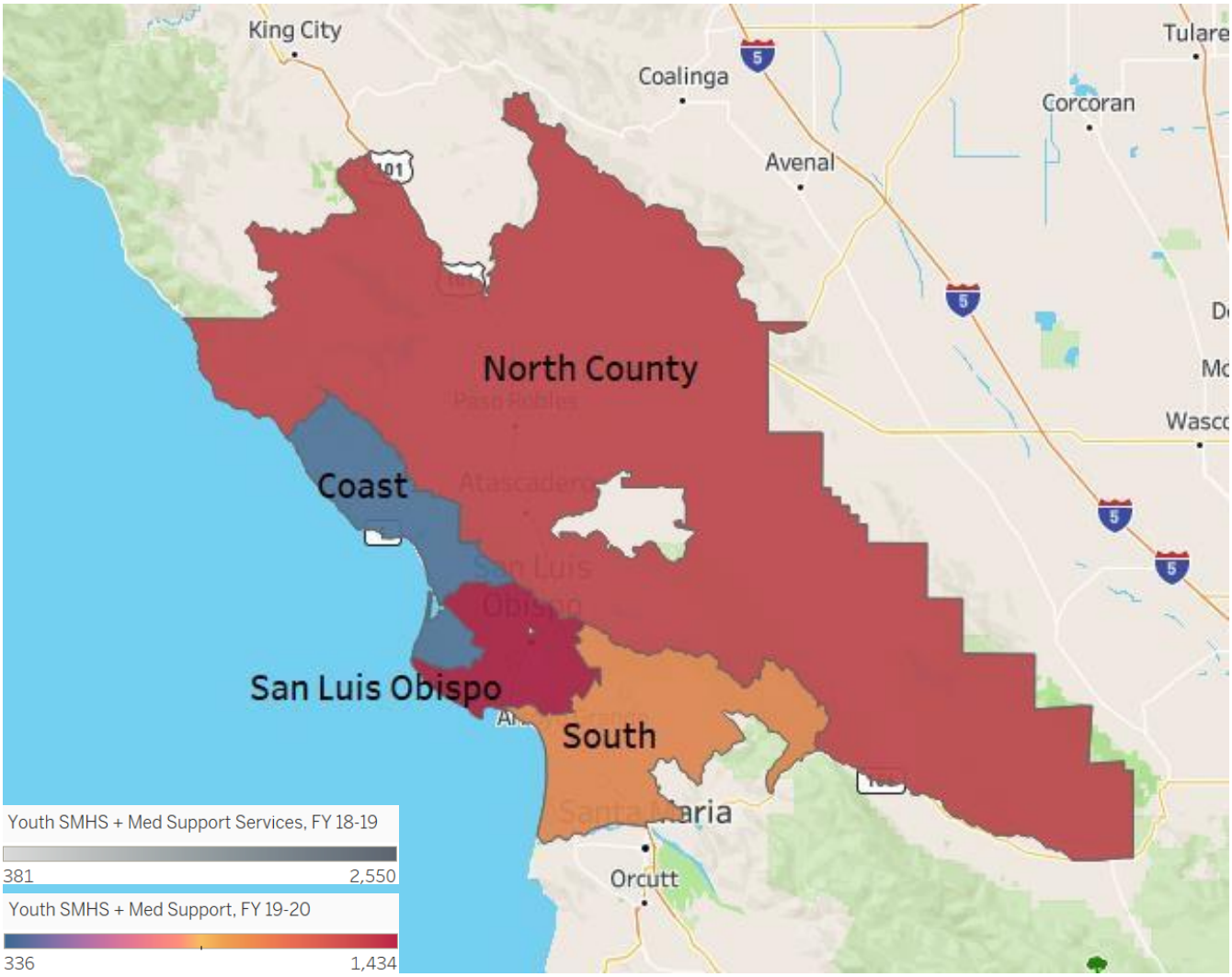


Figure B6. Total Number of Youth Receiving Services (SMHS + Med Support) by Region: During COVID-19, 2020-2022

- Source: SLO Behavioral Health Department

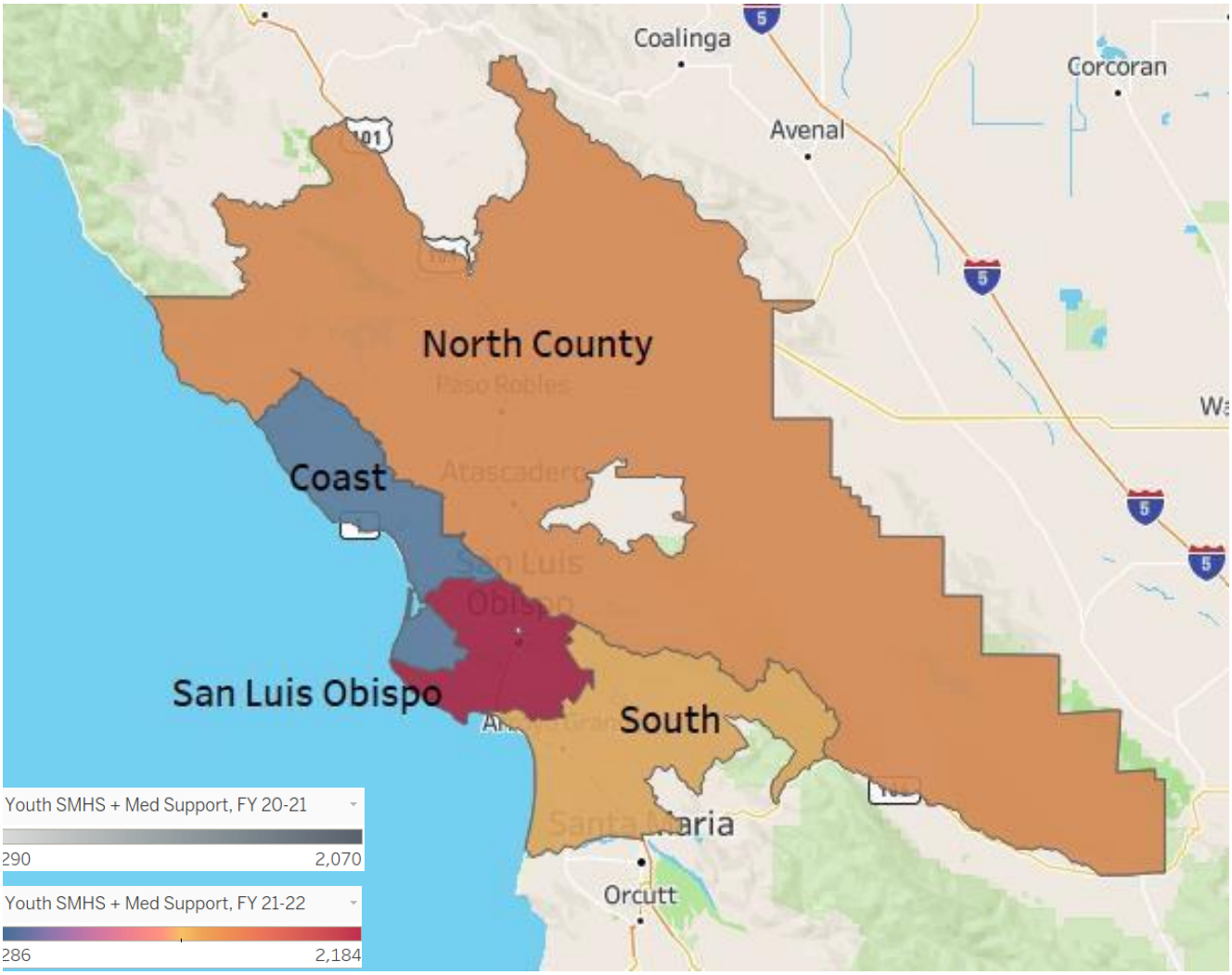
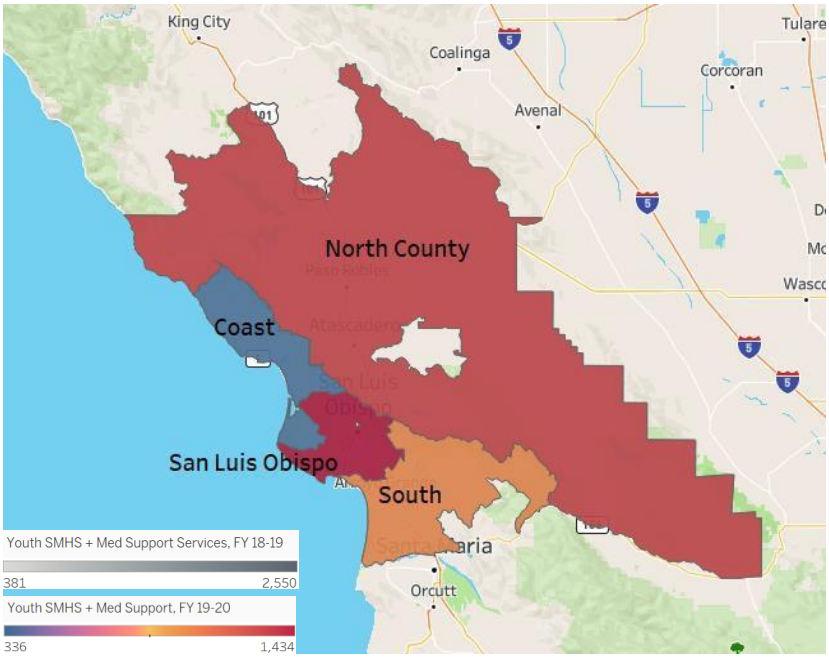


Figure B7. Youth Utilization of SMHS and Med Support Services by region

- TREND: As with adults, youth utilization of SMHS and Med Support services by region did not change significantly following the onset of the COVID-19 pandemic. Utilization of SMHS decreased overall while Med Support increased. The North County and South regions experienced a decrease in service utilization overall.
- Source: SLO Behavioral Health Department

Pre- COVID-19 (FY 18-20)



During COVID-19 (FY 20-22)

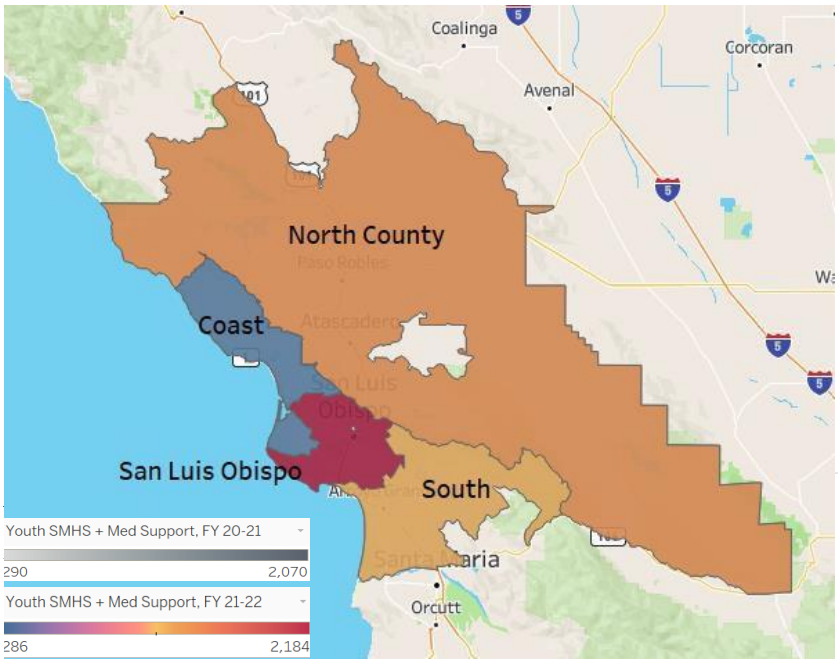
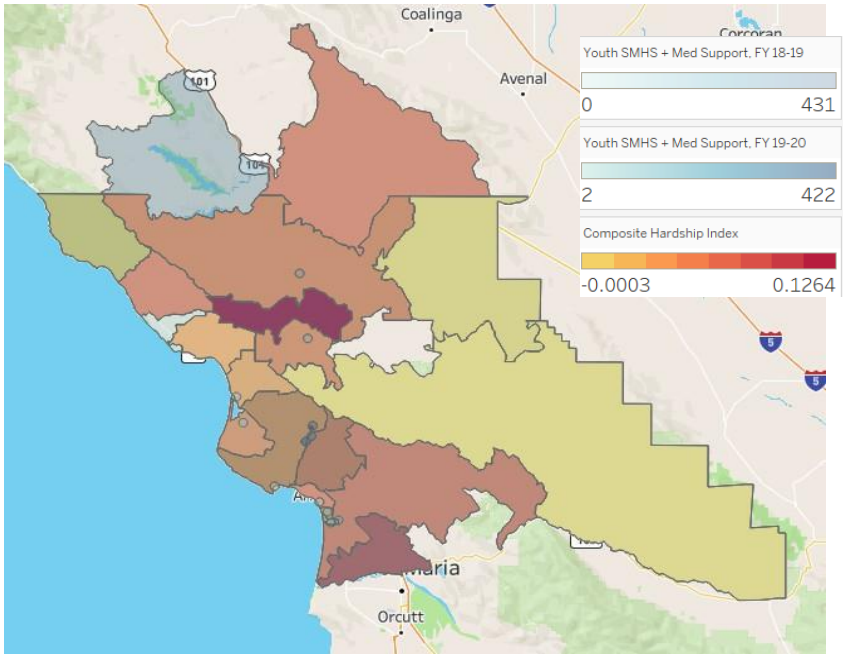


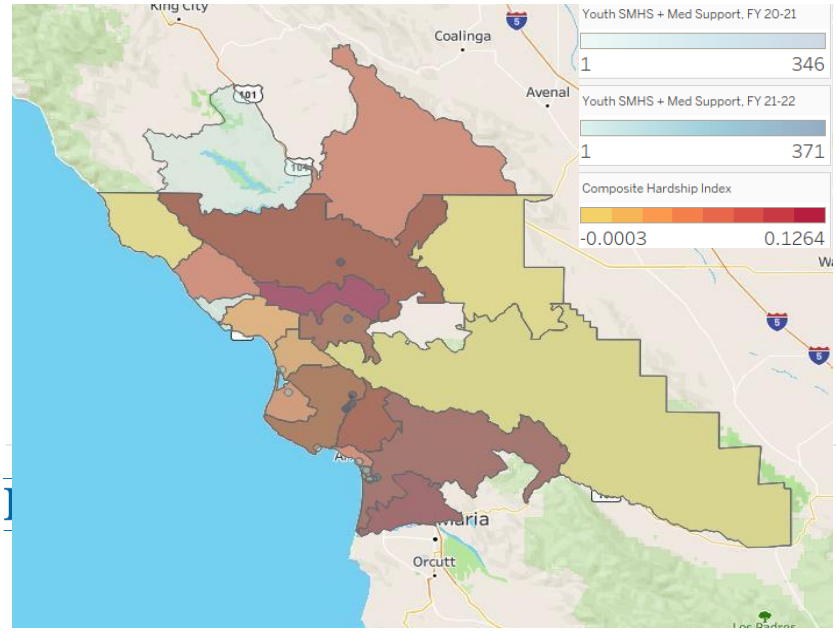
Figure B7. Youth Utilization of SMHS and Med Support Services by region

- TREND: Areas that appear in deeper brown or red colors are ones that experience more economic hardships and had higher utilization of SMHS and Med Support services among youth. Although the number of youth receiving services decreased during COVID-19, the geographic distribution of service utilization remained relatively consistent compared to pre- COVID-19 data, with some areas in the North County, San Luis Obispo, and South regions displaying greater density of youth enrolled in services.
- Source: SLO Behavioral Health Department

Pre- COVID-19 (FY 18-20)



During COVID-19 (FY 20-22)



C. Staff Survey

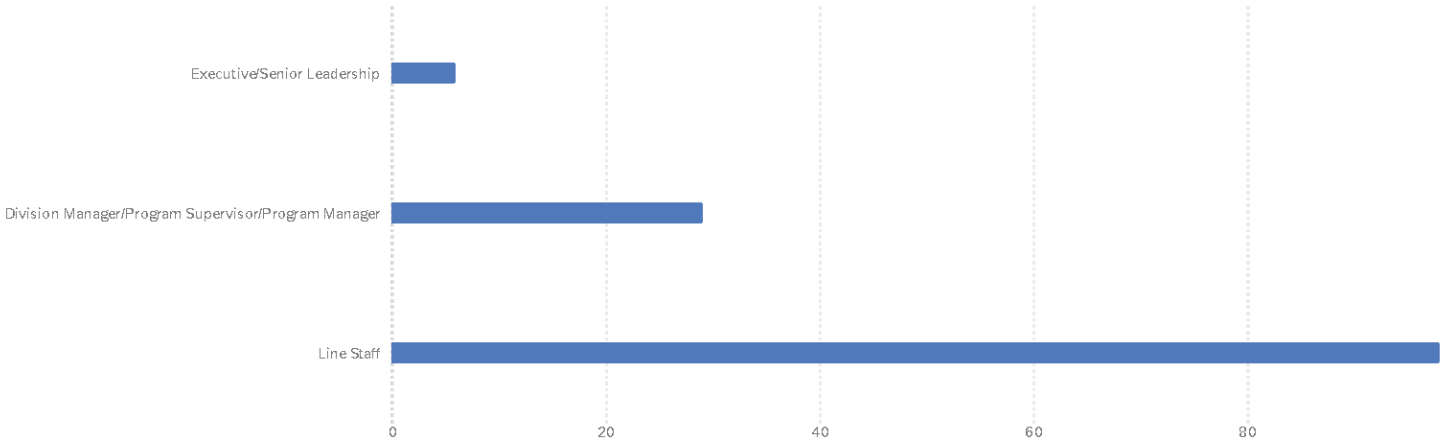
Staff Survey Questions and Qualtrics Default Report

Appendix C: Staff Survey Questions and Qualtrics Default Report

San Luis Obispo BH Dept._Staff Survey / Page 1

Responses: 139

Which of the following best describes your job classification at SLO BHD? 133



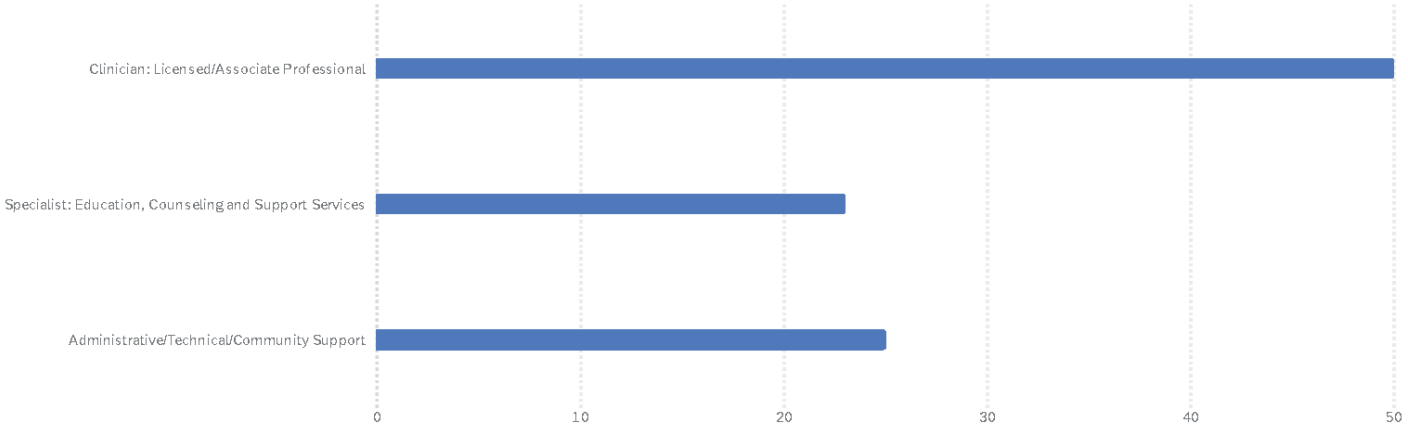
Which of the following best describes your job classification at SLO BHD? 133

1. - Which of the following best describes your job classification at SLO BHD?	Percentage	Count
Executive/Senior Leadership	5%	6
Division Manager/Program Supervisor/Program Manager	22%	29
Line Staff	74%	98
Sum	100%	133

Which of the following best describes your job classification at SLO BHD? 133

Which of the following best describes your job classification at SLO BHD?	Average	Minimum	Maximum	Count
Executive/Senior Leadership	1.00	1.00	1.00	6
Division Manager/Program Supervisor/Program Manager	2.00	2.00	2.00	29
Line Staff	3.00	3.00	3.00	98

2. 98



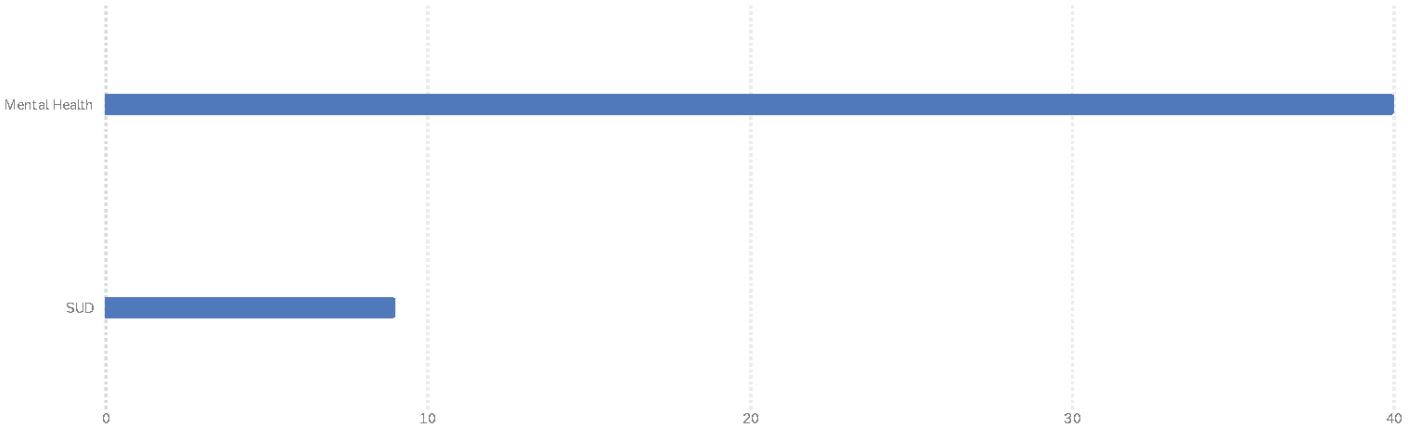
2. 98

2.	Percentage	Count
Clinician: Licensed/Associate Professional	51%	50
Specialist: Education, Counseling and Support Services	23%	23
Administrative/Technical/Community Support	26%	25
Sum	100%	98

2. 98

2.	Average	Minimum	Maximum	Count
Clinician: Licensed/Associate Professional	1.00	1.00	1.00	50
Specialist: Education, Counseling and Support Services	2.00	2.00	2.00	23
Administrative/Technical/Community Support	3.00	3.00	3.00	25

3 49



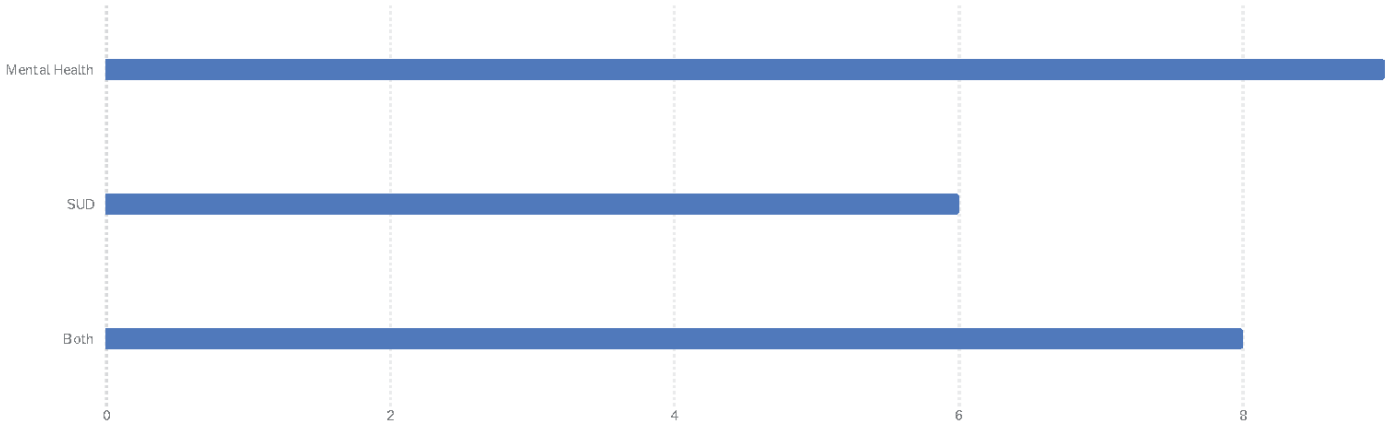
3 49

3	Percentage	Count
Mental Health	82%	40
SUD	18%	9
Sum	100%	49

3 49

3	Average	Minimum	Maximum	Count
Mental Health	1.00	1.00	1.00	40
SUD	2.00	2.00	2.00	9

4 23



4 23

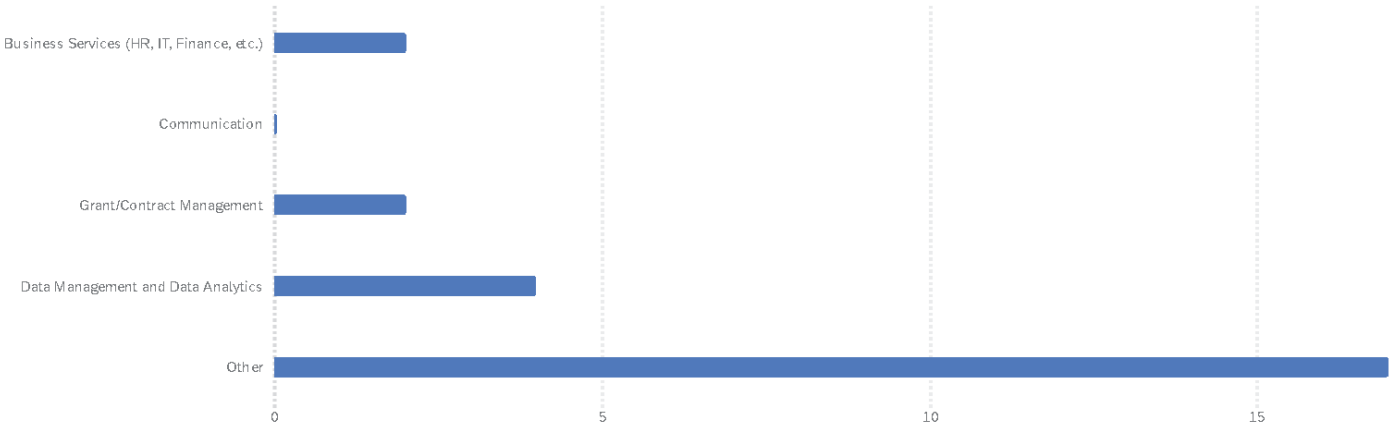
4	Percentage	Count
Mental Health	39%	9
SUD	26%	6
Both	35%	8
Sum	100%	23

4 23

4	Average	Minimum	Maximum	Count
Mental Health	1.00	1.00	1.00	9
SUD	2.00	2.00	2.00	6

4	Average	Minimum	Maximum	Count
Both	3.00	3.00	3.00	8

5 25



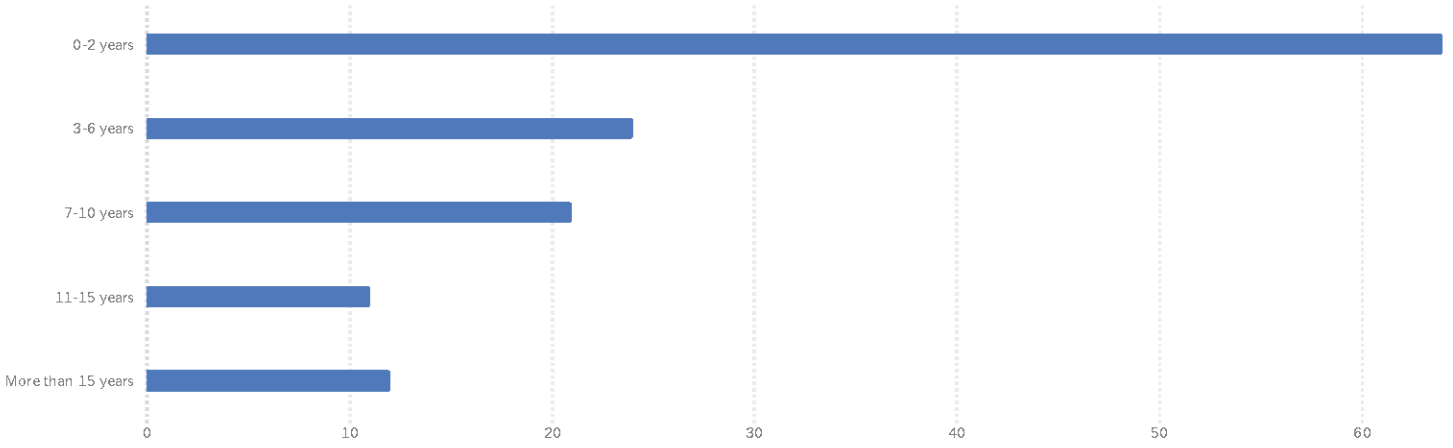
5 25

5	Percentage	Count
Business Services (HR, IT, Finance, etc.)	8%	2
Communication	0%	0
Grant/Contract Management	8%	2
Data Management and Data Analytics	16%	4
Other	68%	17
Sum	100%	25

5 25

5	Average	Minimum	Maximum	Count
Business Services (HR, IT, Finance, etc.)	1.00	1.00	1.00	2
Communication	-	-	-	0
Grant/Contract Management	3.00	3.00	3.00	2
Data Management and Data Analytics	4.00	4.00	4.00	4
Other	5.00	5.00	5.00	17

How long have you worked at SLO - BH? 132



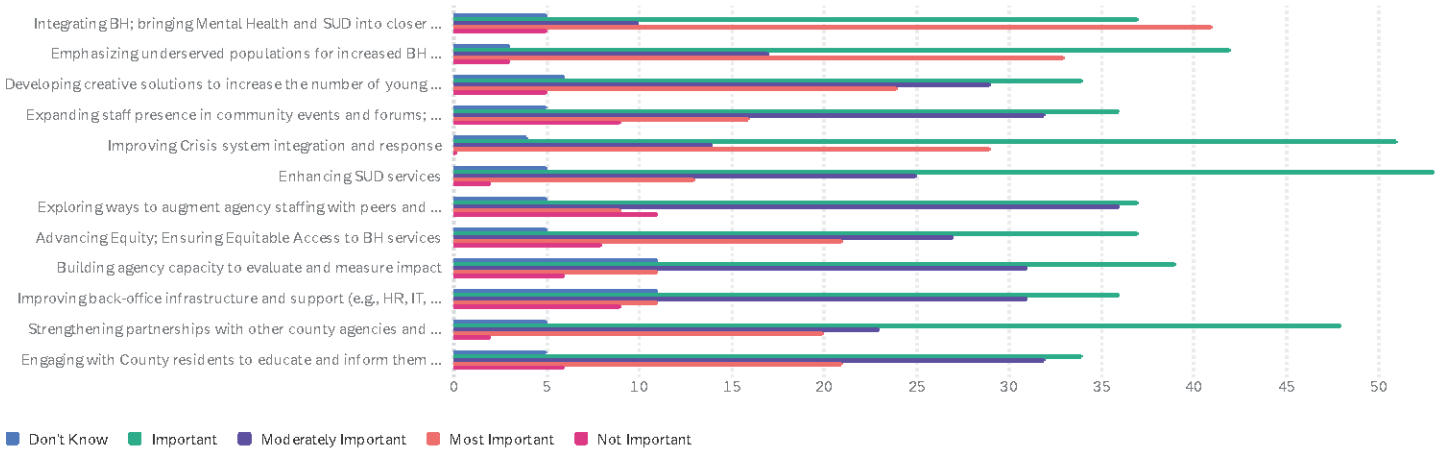
How long have you worked at SLO - BH? 132

2 - How long have you worked at SLO - BH?	Percentage	Count
0-2 years	48%	64
3-6 years	18%	24
7-10 years	16%	21
11-15 years	8%	11
More than 15 years	9%	12
Sum	100%	132

How long have you worked at SLO - BH? 132

How long have you worked at SLO - BH?	Average	Minimum	Maximum	Count
0-2 years	1.00	1.00	1.00	64
3-6 years	2.00	2.00	2.00	24
7-10 years	3.00	3.00	3.00	21
11-15 years	4.00	4.00	4.00	11
More than 15 years	5.00	5.00	5.00	12

Core Services 98



Core Services 98

Core Services	Don't Know	Important	Moderately Important	Most Important	Not Important
Integrating BH; bringing Mental Health and SUD into closer alignment	5	37	10	41	5

Core Services	Don't Know	Important	Moderately Important	Most Important	Not Important
Emphasizing underserved populations for increased BH messaging, outreach, and service delivery.	3	42	17	33	3
Developing creative solutions to increase the number of young people interested in working in BH.	6	34	29	24	5
Expanding staff presence in community events and forums; increasing non-clinical interactions with County residents.	5	36	32	16	9
Improving Crisis system integration and response	4	51	14	29	0
Enhancing SUD services	5	53	25	13	2
Exploring ways to augment agency staffing with peers and paraprofessionals	5	37	36	9	11
Advancing Equity; Ensuring Equitable Access to BH services	5	37	27	21	8
Building agency capacity to evaluate and measure impact	11	39	31	11	6
Improving back-office infrastructure and support (e.g., HR, IT, budgets, etc.)	11	36	31	11	9
Strengthening partnerships with other county agencies and organizations	5	48	23	20	2
Engaging with County residents to educate and inform them about BH topics and issues.	5	34	32	21	6
Sum	70	484	307	249	66

Core Services 98

Core Services	Average	Minimum	Maximum	Count
Integrating BH; bringing Mental Health and SUD into closer alignment	4.06	1.00	5.00	98
Emphasizing underserved populations for increased BH messaging, outreach, and service delivery.	4.01	1.00	5.00	98
Developing creative solutions to increase the number of young people interested in working in BH.	3.66	1.00	5.00	98
Expanding staff presence in community events and forums; increasing non-clinical interactions with County residents.	3.50	1.00	5.00	98
Improving Crisis system integration and response	4.03	1.00	5.00	98
Enhancing SUD services	3.68	1.00	5.00	98
Exploring ways to augment agency staffing with peers and paraprofessionals	3.35	1.00	5.00	98
Advancing Equity; Ensuring Equitable Access to BH services	3.62	1.00	5.00	98

Core Services	Average	Minimum	Maximum	Count
Building agency capacity to evaluate and measure impact	3.34	1.00	5.00	98
Improving back-office infrastructure and support (e.g., HR, IT, budgets, etc.)	3.28	1.00	5.00	98
Strengthening partnerships with other county agencies and organizations	3.78	1.00	5.00	98
Engaging with County residents to educate and inform them about BH topics and issues.	3.61	1.00	5.00	98

I think we need additional resources to refer clients out to clinicians outside of the county (even if they meet county criteria of mod/severe). Clients continue to get assessed and assigned to clinicians despite high caseloads which causes burnout to staff and clients to fall through the cracks or be transferred from clinician to clinician.

Even more access to Levels of Care above 3.5 and/or adding in more MH specialties in our 3.5 RT Level of Care

More Bilingual Staff.

Would like to find alternative ways to reach clients that are not capable of telehealth and do not show up for appointments.

More staff for MHET team, we have had multiple clients report that they are turned away from the Mental Health Evaluation Team resources because the team is "short staffed" or "not available right now". This should be a 24 hour service available for crisis situations.

continue streamlining as much as possible

HIRE MORE PEOPLE TO HELP SERVE BH CLIENTS

To allow all that needs our services to attend individual counseling, groups and meetings and not just Medi Cal eligible folks.

Accessibility to services

integrated health care

Integrate MH and SU services into single clinics.

The integration of technology with spreading information about how to access resources, patient portals, ease of filling out/updating paperwork, ability to have telehealth appointments

More co-occurring options.

A better way of serving clients who don't have phones or addresses to receive communication. These client's often miss calls or appointment's due to their inability to access these resources on their own.

Providing more staff that is Bilingual especially clinicians.

The process for clients to receive tx at the appropriate level of care. Many times, our clients are not integrated into tx services adequately and get lost in the lengthy process of being required to attend engagement/stabilization groups.

Instead of MC calling people back to schedule they should forward call to staff to schedule. The argument has been made that they may be on the other line. We should add a phone system like IT has in which callers are on hold and let caller know their number on line. " you are caller 2, someone will be with you" etc....

improve housing support/coordination

Clients that graduate programs and are SMI waiting over 5-6 months for a therapist which are desperately needed

Our clinics would be clean, spacious, welcoming, and comfortable, and there would be enough space for staff members from DAS and MH to be co-located. Until that happens, true integration will be a struggle.

More staff, easier access to services

A safe place to house our severely mentally ill which are currently self-medicating with drugs and alcohol.

We would have physical healthcare available at the clinics.

The name of our program so it was more representative of what we do.

More knowledge across programs to help clients who need multiple services

Stopped using resources on projects with minimal impact, returns or that cause additional waste and red tape for justice involved processes.

Lower case loads, especially for associates, but for all, allowing time for proper preparation, consultation, growing skills and services to better serve our clients. Investment of funds in facilities, creating physical spaces that are warm, inviting and to the standard our clients desire (not forcing line staff to purchase all their furniture, supplies, books and needed items for work with client).

Truly working together mental health, drug and alcohol united as one...no separation

Increase responsibility of Adult MH and Prevention - It is not reasonable or realistic for Adult SUD services to be mandated to accept everyone - including individuals with Severe MH while MH services routinely turn away individuals citing SUD as the reason. it is also not reasonable/realistic for Prevention to be allowed to decline clients with no true reason besides they don't want to take them

Simplify the paperwork process, county information is not streamlined, each program should have one designated name (North County Youth Services and Atascadero Youth Services are the same thing for us, but clients would not know.)

It would be nice to have quality staff and the ability to retain quality staff. It would be nice if the county invested in ongoing trainings for staff.

Ensuring staff coverage is available and that we are not short staffed. Making positions desirable to ensure there is not turn over and we have a larger pool of interested candidates to choose from.

more spanish speaking clincians and case workers

More consistent data collection. Consistent data is more important than better data.

Create walk in access to services in all clinics and enhance BH integration of services

Have a better flowing system, combining med-ical, screening and treatment.

Consistency among clinics

Drug and alcohol only offer walk in I would like a schedule appointment for some of the clients

More In-Patient PFH beds. Mobility Crisis unit, add more CAT Team services to help our BH Clients.

Currently long wait times to access therapy after assessment due to lack of available therapists

walk-in hours for MH screening, to give better access to our unhoused or those without regular phone service.

It would be great to simply the intake process for all clients, using electronic and online options.

Awareness for the community regarding services that are available. Access for families or individuals with barriers to obtain services and consistency in staffing so that rapport can be built.

More access and promotion in Spanish. Make the information culturally adaptable.

I think we strive to do the above things, the measuring outcomes and billing services has created challenges to creativity and other pieces around care that have frustrated line staff. It's hard to observe stressed staff and create healthy office cultures when work becomes unsatisfying, especially with our most vulnerable community members.

Better, more comprehensive training with qualified, excellent trainers.

Employ more people of color. In order to meet the needs of the entire community, the entire community must be represented within staff.

We have so many different services and so many entry points that it can be really confusing for community members to know what services are available, if they are eligible for services, and how to start services. Additionally, the health care crisis in SLO County is leaving even more people who should be able to access non-County services in need of care, which adds even more confusion and longer wait time. There should be more clarity and transparency around how to access services and what the process is like for clients.

More robust system of supports at different acuity levels

I think we should make it more known to schools, shelters and jobs across the county as a newcomer coming into the BH Department I didn't know these programs existed. Overall, I think there should be more public outreach.

First: I would eliminate MH vs DAS. Second: 1. Have all the Prog Sups get ready to answer the same survey. 2. From the survey get 10 topics of “what would you do if this way your family?” to address immediately. 3. 5 topics to address in 3 years’ time. 4. Have the Prog Sups who have similar goals get together in groups of 5 to 6 to address each topic in three brainstorming sessions with the goal that at the end of these sessions a detailed plan to make the 10 topics come to reality within one years time and who will do what. And where the money for said plans will come from. 5. Meanwhile, the Division Manager’s role will be to look at the Prog Sups who are rising to the leadership roles and find the strengths of each individual. 6. The Div Managers’ will then decide to staff the next 5 long term projects with the people who want that second chance to address the next set of topics/projects. Topics to consider: 1. Outreach to tell our local community what we offer. 2. Hold classes for the staff wanting to learn how to write grants for the things we want to do to change this county for the better. 3. Look at the infrastructure of this county to increase business and corresponding housing issues and how to solve that problem. 4. Look at biodiversity for the crops grown in this county, more than vineyards. 5. “SLO Medical Services” the umbrella that covers Public Health+Mental Health+ DAS all working in unison.

I would focus on supporting our Hispanic population especially or Mixteco speaking clients. I have clients that will call the clinic and have a hard time speaking with AA due to language barrier. Currently, I have two clients that are waiting to be assigned to a clinician. Those clients have been waiting for about 2 months. Collaborating with outside agencies and schools should be encouraged. We should be meeting clients in the field when it's a challenge for them to come to the clinic. The Latino Outreach program should be doing more outreach and participating in community resource events.

Make Administrative Assistants responsible for completing non-clinical duties such as confirmation calls, scheduling appointments and completing non-clinical paperwork like Release of Information and UMDAPs. Clinicians should be free to complete clinical duties and not be overwhelmed with administrative work.

Supervisors

More psychotherapists with better benefits so the therapists are able to continue working with the agency instead of moving to better paying positions elsewhere.

Increase Therapy availability, decrease waiting time for services.

Coordinate efforts in MH & SUD treatment to better serve our client community through more efficient use of staff time and clients' time interacting with staff.

Streamline the process for getting clients screened and into programs

More timely access to care

Streamline and speed for efficiency.

Staff burnout

Be able to truly understand level of care and understanding clear definitions of work responsibilities per our licenses "not a catch all."

Technology, our website is not user friendly, we need a patient portal

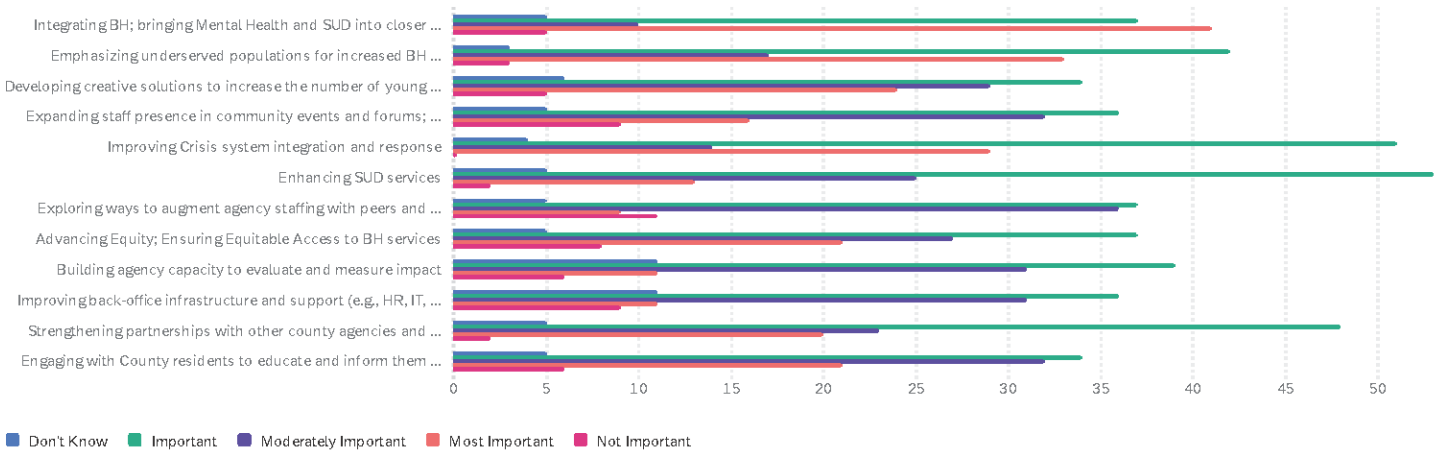
Offering same day services, such as entering a residential or detox facility.

Creating easy to understand flow charts of services for clients. Most clients report that they are very confused about what services we provide and complain about being stuck in a "referral loop".

Easier access to services, more collaboration between Crestwood and outpatients services, more services to bridge needs between FSP level and outpatient as well as CenCal level and outpatient, more therapy services for long term patients too severe to maintain at community level, more in home behavioral services for adults (sorry it says one thing but there are so many things to change....)

na

External Partnerships 98



External Partnerships 98

External Partnerships	Don't Know	Important	Moderately Important	Most Important	Not Important
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Building agency capacity to evaluate and measure impact	11	39	31	11	6
Improving back-office infrastructure and support (e.g., HR, IT, budgets, etc.)	11	36	31	11	9
Strengthening partnerships with other county agencies and organizations	5	48	23	20	2
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Sum	70	484	307	249	66

External Partnerships 98

External Partnerships	Average	Minimum	Maximum	Count
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Improving Crisis system integration and response	4.03	1.00	5.00	98

External Partnerships	Average	Minimum	Maximum	Count
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Building agency capacity to evaluate and measure impact	3.34	1.00	5.00	98
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Strengthening partnerships with other county agencies and organizations	3.78	1.00	5.00	98
Engaging with County residents to educate and inform them about BH topics and issues.	3.61	1.00	5.00	98

Relationships with hospitals/mental health facilities. There needs to be more streamlined communication, documentation, and support in supporting clients being discharged from holds/stays.

Law Enforcement

Schools and law enforcement.

Department of social services needs to be strengthened

Hospitals.

Social Services

I think education/decreasing stigma in the hospitals is still needed for mental health.

YES

Social Services, because the children of this community are our future.

they're all important, so it's hard to pick.

Our partnership with DSS could be strengthened by co-locating staff as was done in early CalWRKS and SAFE programs.

Schools

Improvement on CBOs.

Court and law enforcement

Whatever partners provide housing guidance or assistance, it is the number on priority and the majority of our client's minds.

Our partnerships are becoming more streamlined which is adding to the interactions between entities as there have been struggles in the past with system issues and time-management with the other entities.

Continue to develop safe housing facilities for our clients and strengthen partnerships with ancillary organizations in our community.

ERSESS was helpful.

CBOs

Non profits

Mental Health and DAS need to be more connected

Hospitals and EDs.

Schools and CBOs

SSA and HASLO. More private financial participation in community MH/DAS issues. Strategic partnerships should have a greater stake and responsibility in addressing issues. Lack of funding from state government, but continued expectations are unrealistic and not based in reality of issues at hand. Private funding apparently is necessary if state government refuses to address the most important needs of local communities and counties and continues to spend valuable resources on wasteful and unproductive, immeasurable outcomes. Housing would be better addressed by private donations of resources that can and will help local housing shortages and safe places for homeless and co-occurring challenges.

Schools, CWS, probation (youth and adult) and hospitals.

continue to build on schools, create more contracts, education and trainings.

Lawenforcement/probation

Social services

I think they are all important relationships. I think probation might be the most important since treatment is often part of someone's terms of probation.

I think we need to strengthen our partnership with local schools. At this time it is challenging to get the children we serve the support they need in public school settings.

probation and the courts

Peer groups

hospitals and clinics schools

The local er's. 5150 are a nightmare for them

CAT Team

Law enforcement and probation

Our community-based organizations.

Youth Services

Law enforcement

Internally that county have so many programs available and yet the ground staff are at times too overwhelmed to be made aware of all the programs that would benefit their existing clientele.

Community based organizations

I would like to see stronger connection with Public Health.

Dept of Social Services, specifically Child Welfare

School Districts - Prevention Focused!

Public Health. There is such a huge overlap between BH & PH, even more so since the pandemic, and we need to increase collaboration efforts.

Hospitals and other network providers of mental health services

I believe that partnering with the schools is most important, but we should also be more involved with the hospitals and other health clinics..

Definitely the local CBOs and hospitals. We see people like physicians as the leaders in our community and yet we dont tap that resource to address the outreach of services we offer and can offer to make the lives of our community better.

Law enforcement, and hospitals.

I would have to say that working to strengthen the relationship between Community Based Organizations would be the most important. Our clients need resources, and it is up to us to know the resources and where they will best be served. Having a strong relationship with Community Based Organizations will help us to know when and where to refer clients based on the client need.

Schools and community based.

hospitals and health clinics

All are important however the recent change in/reduction of communication from the Psychiatric Health Facility has been problematic in the provision of continuity of care

I think we are doing a good job with our partnerships. As with anything, I think we should continue to grow and strengthen them.

DSS (strengthen)

I don't have an answer for this question.

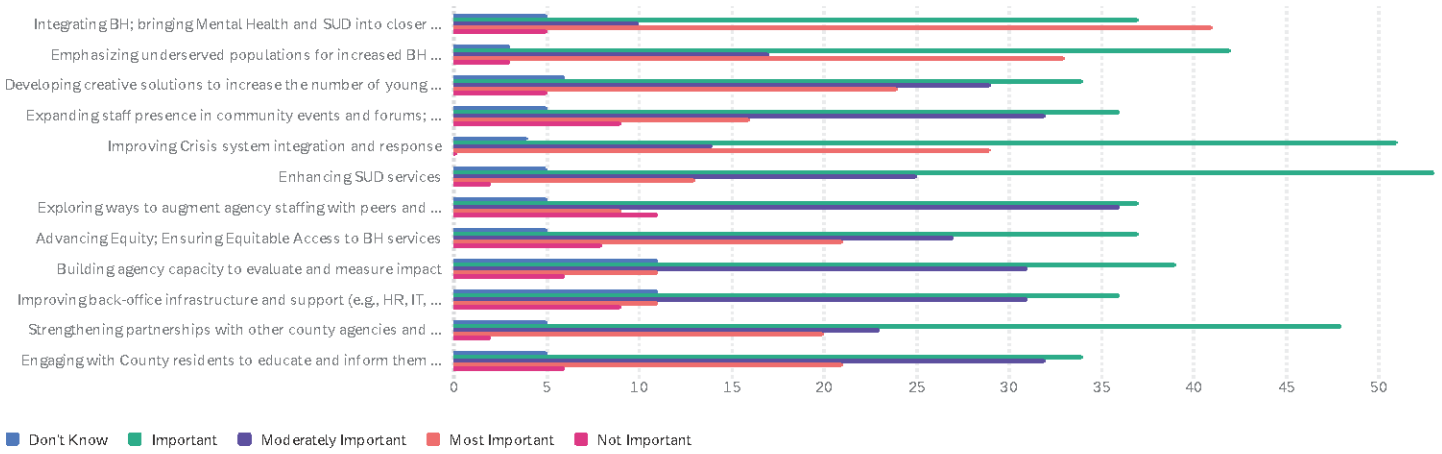
first responders

Meeting quarterly to work out contracts/level of care and understand how we can all collaborate.

increase collaboration with CHC, hospitals and Cencal resources.

na

System Issues 98



System Issues 98

System Issues	Don't Know	Important	Moderately Important	Most Important	Not Important
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Emphasizing underserved populations for increased BH messaging, outreach, and service delivery.	3	42	17	33	3
Developing creative solutions to increase the number of young people interested in working in BH.	6	34	29	24	5
Expanding staff presence in community events and forums; increasing non-clinical interactions with County residents.	5	36	32	16	9
Improving Crisis system integration and response	4	51	14	29	0
Enhancing SUD services	5	53	25	13	2
Exploring ways to augment agency staffing with peers and paraprofessionals	5	37	36	9	11
Advancing Equity; Ensuring Equitable Access to BH services	5	37	27	21	8
Building agency capacity to evaluate and measure impact	11	39	31	11	6

System Issues	Don't Know	Important	Moderately Important	Most Important	Not Important
Improving back-office infrastructure and support (e.g., HR, IT, budgets, etc.)	11	36	31	11	9
Strengthening partnerships with other county agencies and organizations	5	48	23	20	2
Engaging with County residents to educate and inform them about BH topics and issues.	5	34	32	21	6
Sum	70	484	307	249	66

System Issues 98

System Issues	Average	Minimum	Maximum	Count
Integrating BH; bringing Mental Health and SUD into closer alignment	4.06	1.00	5.00	98
Emphasizing underserved populations for increased BH messaging, outreach, and service delivery.	4.01	1.00	5.00	98
Developing creative solutions to increase the number of young people interested in working in BH.	3.66	1.00	5.00	98
Expanding staff presence in community events and forums; increasing non-clinical interactions with County residents.	3.50	1.00	5.00	98
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Engaging with County residents to educate and inform them about BH topics and issues.	3.61	1.00	5.00	98

Which inequity or disparity do you believe is MOST CRITICAL for SLO BHD to focus on in the next five years?

having more bilingual staff available.

More interpreters for clients who need one.

HEALTH DISPARITY

Integrated care and coordination with outside agencies to provide clients with the resources they needs.

Trust.

continuing to increase representation of individuals with diverse backgrounds in leadership positions.

More awareness of minority groups.

Religion

Housing overall is a continued problem and could be a main focus over the next 5 years. Clients transitioning from County jail to sober living environments and then even trying to secure stable housing at the end of treatment/aftercare onto low-income housing is very limiting.

Getting clients into "actual" tx services in a timely manner and hopefully bring in other inpatient/residential tx options in the near future for our clients.

Making SLO County BH the Employees Choice of Employment. Focusing on Staff needs, example, Hybrid Schedules (flexibility), better pay that matches cost of living in SLO County. Cost of living is always compared to same size counties but is not compared to counties with same cost of living.

Spanish speakers

Disparity

Resources for the homeless and how to access those resources easily. This way we do not have to spend millions of dollars on TRACKING the homeless which is lame when we can spend those millions on impound fees or DMV fees or other barriers that take transportation away from people which in turn leads to job loss and then homelessness. We need to focus on positive and actual attainable ways to help homeless people that show actual real time results and not just graphs and statistics. I want to be able to go to my supervisor and ask her for funds to get my clients car out of the impound so she doesn't lose her job as a door dasher. I want to be able to go in our closet at our outpatient facilities and give this gentleman new fresh clothes and socks and a bus pass or gas card without all the barriers it takes to get these items.

housing and care for the severely mentally ill

Homeless

Those with specific lived experiences relating to SUD and Mental Health disorders.

Increase recruitment of peers and foster more educational opportunities and mentorship into county treatment positions.

Lived experience is important to help increase awareness

LGBTQ

It would be nice to have more Spanish speaking staff especially in DAS.

More representation for our underserved populations (people of color, people with disabilities...)

lack of resources to serve monolingual Spanish speaking clients

Creating peer certified staff positions

Peer support groups.

Youth

We do not have clinicians appropriately trained to work with autistic youth

Having folks with lived experience involved in our policy, programming, and service delivery.

immigrant population, especially Spanish speaking

I don't know

Train on similarities and stop focusing on differences.

language barriers

Give me choices, not sure I can name an inequity or disparity in BH

Employing people of color. Leadership roles, not just direct services. Almost all of the clinical supervisors are white and all of the leadership I've interacted with are white as well.

Homelessness

I feel that there continues to be a language barrier

Asian

BH Specialists should have the option to take Spanish classes/training through the County. We need to be able to communicate our message to all county residents.

Just hiring people that speak more languages.

The prejudice of the unseen people in our community--the homeless, some drug addicted, some working but underpaid. The worst kind of violence in this world is poverty. We have to create a more seamless way to fill our food banks, supply chains to get the food to the homeless, poor, under served.

More peers into our teams.

I'm not sure.

LGBTQX

Adding more peer support specialists

Low-income housing.

Peer staff/volunteers.

access to services, transporation for services

LGBTQIA+

lack of housing resources, lack of residential placement for people with severe MI and severe drug use, lack of supportive housing

da

undocumented people

Monolingual families who do not have English as their first/primary language.

Latino community is underserved in SLO county

Spanish Speaking population (undocumented/non-insured)

Unhoused population

SMI, Homeless should always be top priority

HOMELESS MH

Low income and underserved communities. Families services supported by mediCal, not just related to substance abuse.

Non-Medical individuals that need help and support.

Latin/a; children in foster care; children involved in the juvenile justice system.

Native American and African American

North County - Shandon, Creston, etc.

Latinx population.

Religion

Still feel it is our homeless population.

Homeless as mentioned above, the housing market is so high for clients to be able to gain stable affordable housing.

Spanish speaking community

The homeless population and people with co-occurring conditions.

Youth.

Homeless

Any monolingual persons and people of color

homeless population and the working Amercian population. Not the low-income population who is already getting food stamps and has a section 8 voucher they do not need and extra allotment of food stamps but the working single mother American who works for the county. who's fridge is empty would really benefit from an allotment of food stamps for the montth.

housing and care for the severely mentally ill

Oceano

foster youth

Vets and other Co-occurring individuals that are increasing in numbers due to inequity created at state political level pushing legal solutions to problems that can ONLY be solved through community actions and local accountability. Counties are fighting against state policies and laws that are creating further crime, homelessness, use and mental illness.

Homeless population

Individuals of Color

Hispanic population

unhoused clients

Gaining more diversity by employing more people of color in all roles of county - Currently we have very few people of color in a leadership position across our behavioral health system.

Mixteco and Latino

the homeless

LGBTQIA+

The hispanic groups- especially the Spanish speaking.

Youth

Autistic youth, trans youth

Spanish speaking folks.

immigrant population, especially Spanish speaking

I don't know

Balance...no more extreme goals that go no where.

Hispanic and Asian populations

Youth Substance Use Treatment

Black and Brown people

Unhoused community members.

Elderly and/or aging adults

Asian

Latinx Communities

Probably the part of the community that speak mainly Asian Americans.

The people who fit into the category of Homeless, mentally ill, addicted to drugs and alcohol. Therefore the ones who have no way to safety without us helping them.

Hispanic-especially Mixteco speaking, ASL

I would have to say the LGBTQ+ community as there is a large community in San Luis Obispo.

Youth LGBTQX

Homeless community

I am not sure that this population is MOST critical, but I would like to see services/education available to our undocumented neighbors. They are often too scared to reach out.

Mixteco speaking individuals LGBTQ+ individuals

Unemployed persons.

SUD/MH Co-occurring.

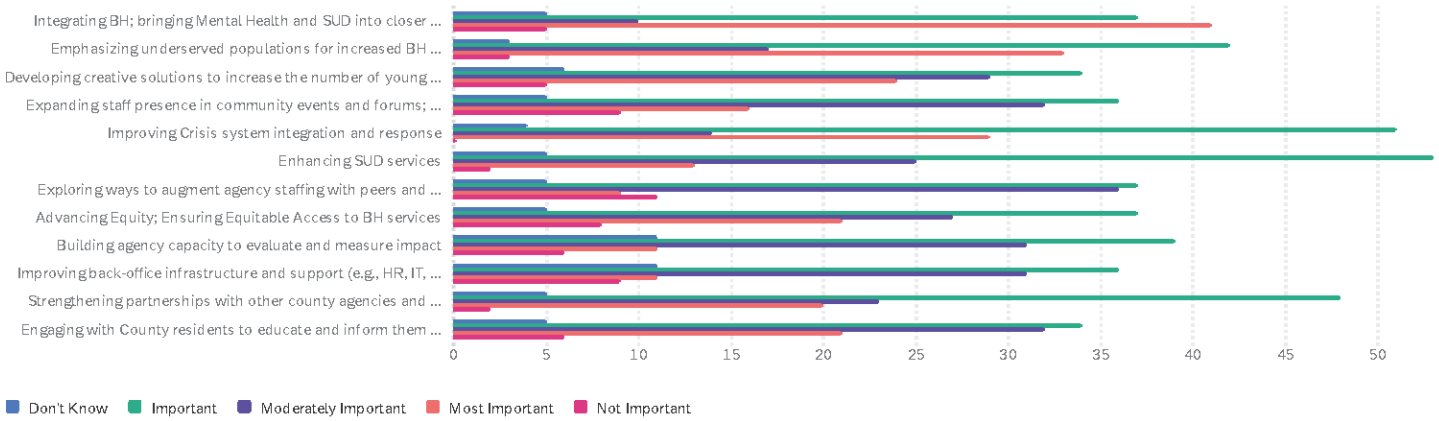
Spanish speaking services.

Homeless population

adults with co occurring disorders.

da

PART IV – Strategic Priorities Please rank the five key areas of the BH Continuum of Care using a 1-5 scale where 1 = Top Priority; Needs much more focus and investment and 5 = Low Priority; Doing well and should be maintained and supported. 98



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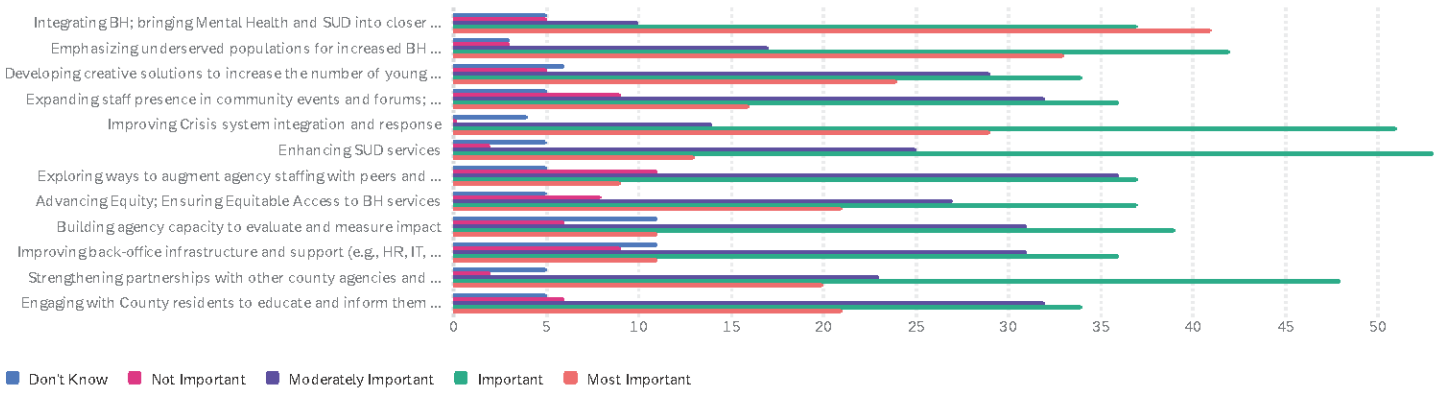
PART V – Strategic Issue Areas Over the past three months, we have met and identified several issues relevant to agency strategy. Please provide your feedback on the relative level of importance making strategic improvements in the following areas of focus. 5-Point Likert Scale: Most Important; Important; Moderately Important; Not Important; Don't Know. 98



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Improving Crisis system integration and response	4	0	14	51	29
Enhancing SUD services	5	2	25	53	13
Exploring ways to augment agency staffing with peers and paraprofessionals	5	11	36	37	9
Advancing Equity; Ensuring Equitable Access to BH services	5	8	27	37	21
Building agency capacity to evaluate and measure impact	11	6	31	39	11
Improving back-office infrastructure and support (e.g., HR, IT, budgets, et...	11	9	31	36	11
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I think we are doing a good job. More participation in activities where undocumented people might be.

outreach in rural communities

Inform community members what to do when they see a stranger in a mental health crisis or substance use crisis.

I think education on how SUD and MH are fairly comorbid, is needed.I think educating people on SMI thought processing to validate their experiences during crisis helps community dialogue.

COMMUNICATE AT SOCIAL EVENTS

Word of mouth is the best form of PR. Service that is friendly, easy to navigate, fair, speedy, and nonjudgmental will increase engagement and discussion.

Start with community clinicians like MFTs LCSWs and Psychologists and connect how together we can better serve the clients they also are dealing with.

Give presentations at workplaces.

Stop tabling at events where you have only a handful of community members present. It is a waste of time and money.

Keep the programs going like "Stop the stigma" and help the public understand more about MH and what it is and isn't.

More detail about BH Programs on County website and then engagement on Social Media to inform the general public of the services offered.

Reaching people at school age, informing of services and educating on services.

Outreach or materials that are easy to understand especially for non-English speakers.

Form a committee to designate various members of the BH agency to conduct monthly meetings and outreach the community about the BH services within our agency.

Creating BH App where County residents can request assessments, complete intake paperwork and schedule appointments. They can be linked to community resources as well.

Increased media presence

Commercials!

Less partnership with law enforcement and the criminal justice system. Police officers should not be the first contact for those who call 911 in a BH crisis. The presence of law enforcement scares people off, especially people of color, and other groups who are often the target of discrimination and police brutality.

Making sure our website and online presence is relevant, informative and easy for the public to navigate will help improve how the public views and accesses our services.

improvement of our facilities and training of our staff, will bring public awareness of the quality of the services and treatment with county.

Community Meetings

Online presence. Expand social media but also advertise in other community groups or newsletters. As a cal poly alum I always read their news releases and alum letters for example. Even just talking about the partnership with Cal Poly in a newsletter could lead me to want to learn more about BH in general.

Better advitisement

Have more outreach to advertise what we do - participate in career days at local schools and engage kids in learning and developing interest in behavioral health.

more participation in community activities/cal poly, increased social media presence

Never underestimate the value of physical flyers put up in public places or on store corkboards.

Better signage and improve our website

Outreach at Farmer's Market- Social services.

Provide information about the important work we are doing and focusing on the value of this work and how it helps the community as a whole.

SLO times

This survey needs to be sent to our Clients and Families so you can really see where the BH health issues are; The 1st 10-12 questions you should be asking them.

I'm not sure I'm clear on this question.

participation in community events, Farmer's Market, Health Expo

We need to be enhancing our CBO partnerships to develop PSA that inform our community about the service offered at BH. A main goal of this is the help develop trust.

Provide community education at lifelong learning activities for seniors

Public engagement must grow and adjust to meet the community where it is at

Flexibility and availability to the underserved population

Bring Behavioral Healths voice at well attended Forums that tend to be more popular with the public, so that our reach expands beyond our own staff and CBOs.

Brief interviews on local news, about a Behavioral Health topic

Fireside chats and community discussions. listening to people's stories before attempting to educate them.

Increasing outreach to community spaces- especially where underserved clients are.

Provide clarity around who can access what services.

We must be given opportunities to learn Spanish

farmer's market or maker's markets, people are always out at fairs and love free stuff - get them involved by sharing our mission for BH at these events

Have more County sponsored events where the primary goal is for the county to teach what we can offer the people who show up. "Bread and Circuses" of sorts.

Outreach events and collaborating with schools.

Have a table at community events around San Luis Obispo with information on County Behavioral Health services and people there to answer questions about our services.

Using TikTok videos to reach out to younger audiences.

Outreach and increased collaboration with community partners

Social media, school fairs, festivals

I love that BH has tables/booths at so many local events. I would like to see that continue and expand.

Online dashboards

An Open House forum?

Free community forums or educational seminars by licensed staff.

being out in the community, events and collaboration with schools and hospitals etc

News channels, social media, college campus outreach

Social media presence.

da

I think providing higher pay and better, more affordable benefits to employees would be a good start. The unexpected 15.5% increase in healthcare insurance premiums is making a lot of employees reconsider working for the county. Knowing that I will be taking home even less of my pay starting in 2024 leaves me feeling very discouraged and underappreciated. The former financial stability provided by step increases is barely enough to keep up with inflation of an already expensive area to live and work in. And the cafeteria contributions will be less than enough to cover the lowest tier PPO coverage in 2024. This has left myself and many of my coworkers confused and unsure about the future as a county employee.

More benefits such as money , health care, etc.

Particular to BH, the classifications of Specialist vs. Clinician has too much overlap. We are constantly losing staff to each other. It is difficult to keep Specialists. Also, the Clinician I position is a waste and never used. DAS uses their BH Clinicians classifications differently than the MH side. There needs to be more consistency between DAS and MH, and there needs to be a more significant difference between classifications to promote more opportunities for growth.

having flexibility with staff (working from home options).

More flexible schedules that may align with client schedules.

Raises

Overtime, inc. wage, adjustment scale to pension fund, limit staff 1 per 10-15 clients

NEED MORE HELP. HIRE MORE EMPLOYEES

Increased pay and better health plans (currently unaffordable for most families). We need to stop including lower cost of living areas in our compensation comparison- we are most like Santa Barbara, Monterey, etc. Santa Barbara (Santa Maria county jobs pay about 20% more than SLO on average. Both SB and Cal Poly have better/more affordable benefit options as well.

Trust, leadership and support. Managers & supervisors need to appreciate the employees and stop the bulling and badgering we have experienced the last 3 years. It's been awful. 35 or more long term employees have quit, retired or moved on. It's a shame. I blame the top leaders.

Provide more support/training opportunities and focus on retention.

Improving the onboarding process and front-loading training to prepare staff for their role.

Higher income to meet the cost of living in this community and allow us to be competitive with clinician's ability to find income in private practice.

More transparency.

Stop promoting people that have not shown they can handle their jobs as a line staffer. Stop making position for upper management and pay the line staffers better salaries.

This is a tough one, because I understand having to balance the public who funds us with the needs of employees living in this expensive area. Better wages would be nice, but having a way to make people feel seen and appreciated instead of just a replaceable spoke on a never-ending wheel.

Streaming training on software programs with all staff as transitioning to Smart Care has been problematic for staff to maintain expectations of tasks and documentation of service to be billable. Trained transportation staff to help with treatment obligations and during times of crisis.

Pay comparably to private sector

Offering competitive wages.

Make each person feel important and like their voice is being heard. Make an honest effort to include everyone concerning birthday celebrations. Sometimes people don't receive birthday cards like others.

1. Better pay that matches cost of living in SLO. Instead of comparing pay rates other Counties with same size that do not relate to our cost of living,

Increased pay

Better pay, let us decide on how much we want for retirement

increase wages so BHD employees can afford to live on the Central Coast

Allow Clinicians to telecommute 1-2 days a week.

Better health insurance policies, higher pay, and more time off to prevent burn out. Benefits used to be to be a huge selling point for working for the county, but with the new increases, it makes younger staff reconsider why they would even work in government as opposed to looking for private industry work that might pay more and offer more flexibility with better benefits. Truthfully, the new health insurance policies for 2024 have made me strongly reconsider my employment with the county, despite my passion for BH and serving the community.

Ensuring there is equity among staff - often in public employment there are some who work hard, and others who skate by. I think staff moral goes down when those who skate by aren't given any consequences. People will stay if they see value in their work and if their hard work is recognized by their supervisors and teams. Also giving staff opportunities for advancement is important in their longevity as an employee.

Lower caseloads, increase employee benefits, increase consultation groups, increase training opportunties (and benefits to attend), You can offer trainings but if everyone is worried about billable hours, then we can not stop for trainings.

COLA increases regularly and opportunities for promotion..

Benefits. Medical, dental ect. but also the other perks. Wellness stipend, remote work, flexibility in schedule and work. Work life balance is how you get people to apply but also stay.

Raise our take home pay to be more competitive and in line with other local agencies which are paying $5-$30 more per hour

Support from supervisors, including workable caseload.

Pay us more. I have to have a roommate and a second job to be able to afford to live here. It's so hard with health insurance going up every year. The COLA's are appreciated but it's not a lot after taxes and other deductions.

Have a plan and limit regarding what a reasonable caseload is and how many clients a clinician can ethically and safely manage. Ensure pay equity when there is a discrepancy between like employees. Find ways to reward and acknowledge hard work.

better wages, bring back cafeteria cash out for employees that opt out of county plan due to having other health insurance and be paid retroactively for every month it was taken away.

More competitive compensation, particularly 457(b) matching contributions.

Improve compensation and benefits package to be more competitive with our neighboring counties.

Less caseloads and more supportive staff.

Provide the tools and support needed to do the difficult work.

Life time health insurance like the state

SLO BHD Trainings on ways to better support our Clients that are in crisis and are failing.

Increase tier three pension/retirement to tier one or two after specified number of service years (increase to 2 after 10 years, 1 at 20 years)

We need to be looking at ways to promote current staff into management and leadership positions. This should be done with education, coaching, and support for all levels.

Supervisors and managers who are more engaged with their staff. Willing to listen and engage in conversation.

Address lack of affordability in housing

Create a healthy and supportive work environment where growth and mentorships are possible withing departments..

Promote and offer free BH services and wellness services ie. paying gym membership, traveling Chair massages to all parts of county not just at the San Luis Office. Discounted daycare services or contracts with external child care services. Incentives for taking care of ourselves as employees. Incentives for completing a wellness exam each year, for attending therapy, or other healthy stress management or reliefs. Creating atmosphere of self-care. If we aren't taking care of ourselves how can we help those in most in need?

Flexibility, money, growth.

Communicating with staff about the impact they can make, how important their jobs are.

Make the pension optional. ALWAYS ensure that new hires understand that at this moment, it is not and option and allow them to decide if they can afford to have huge cuts to their monthly salary.

Reduce health care cost or increase salary.

Consider pay similar to other county behavioral health systems that sustains employment. Most clinicians can work for much more money and more flexibility through other private employers in our county.

The culture of our office is boring and lacks togetherness

relevant and advanced training opportunities (i.e. paid/encouraged opportunities for EBP or CEUs)

Pay them a true wage for the jobs they are doing. Give them challanges that enhance their family life and offer alternative work schedules to have lives. They are already dedicated to you.

Giving employees flexibility, I have a child under one and it's important for me to have the support of my employer when my child becomes ill and I have to work from home. There are many working moms that are employed by SLO County.

Support line staff employees especially within the first 6 months of hire. Make sure they have all the answers of what to do, how to do it and when to do it. Walk them through step by step and train them so that they know exactly how things are done. Don't just have them read the policy. Everyone learns different and Supervisors need to be able to teach in different ways. Answer questions like How do I complete a discharge? And follow up by sitting with the clinician and walking them through the process step by step so that they know where to find documents and how to appropriately complete them.

Pay increase.

More feedback on performance. I.E. employee having access to statistical tracking that is done on their personal performance as well as periodic updates on program outcomes. ALTERNATIVE WORK SCHEDULES!

flexible time schedules, different work options (home/office, hybrid)

Increase in wages. Many of us are not making enough money to afford basic necessities without being creative. For example, in my role, I make less than some people that I supervise and in order for me to afford rent, there are 3 adults work 3 full time jobs and 2 part time jobs to even try to make ends meet every month. It isn't sustainable to expect people to work 60 hours per week in order to afford housing.

Flexible schedules; allow hybrid schedules and modifications to hours when possible

Lower health insurance costs.

More flexible schedules/ hours per week required to work

Pay or flexible schedule.

work life balance and technology access and training to have clinical staff do clinical work and not work with broken eforms. Access to updated P&P that are searchable and user friendly.

Offering more flexibility, balancing home and work life, better medical benefits, more retirement solutions, and allow staff to work closer to their home. Also, more stability, not be re-assigned often.

Livable wages.

increase wages, increase possibility for carrier advancement, offering a flexible schedule around childcare issues,

da

Hire competent Spanish -speaking therapists. Work on housing options..

An exceptional MHET team that can evaluate clients in the field and transport them to the services they need in the same day.

Affordable/Supportive Housing for all in need.

HIRE MORE PEOPLE

Easy, regular, and seamless communication between departments and programs. Shared goals with technology and protocols to support collaboration and communication.

Something weird happened in 2020 and the domino effect started to roll the employees straight out the door. I feel Dr Graber knows what I'm talking about, we met on many occasions to discuss manager harassment. Thankfully, many who harassed me have now moved on and that is a HUGE number of staff. The point wasn't by accident, it was caused in my opinion by administration to clean the slate. I stuck it out but wanted to quit many times. Its good now, but I had to fight for peace at work. Thank you.

Implement fully staffed community assessment services and immediate entry into integrated services with multiple levels of care (including day treatment 2.5) available and full family and friends included into the treatment experience from the beginning.

A vending machine.

Equal work ethic across all employees. Good employees shouldn't have to do other people's jobs.

Unlimited funding so we could have all the supports for all the different populations, like parents who can no longer care for their children who are severely mentally ill, not really needing hospitalization but needing more care than parents can provide. Housing programs for all different levels of income, as homelessness seems to greatly affect MH. Expanding services for our youth.

Approved overtime for staff when work volume increases instead of flexing hours as that can be unattainable when working with MH and SUD clientele.

Having enough staff for BH clinics and DAS services.

A residential tx facility would open within the next year that would have at least 30 beds available.

Make every one Tier I. This will make SLO BH the Employees Choice of Employment.

Housing

same day appointments and treatment

Supportive living environment for severely mentally ill

If more outcomes and data are wanted, we need more QST/research staff. Santa Barbara County has a BH research department.

I would create more roles and opportunities for advancement within the department with flexibility on education requirements. This would allow for retention of current employees as they would have more opportunities to advance, earn more money to keep up with the rising cost of living in SLO County, and plan their future in the organization. It would also allow us to hire more diverse populations if the requirements were not so rigid for non-clinical roles. The lack of upward mobility, salary increases, and opportunity for advancement is a detriment to retention as it forces employees to wait for someone else to move on for a position to open up. This in turn can cause many people, especially younger staff members, to look for work elsewhere that has more financial opportunities.

Create community housing and employment that caters to co-occurring SMI populations in a way that would promote a full integration into community and promote a positive experience, instead of the current "tent city" or "build it and they will come" solutions being promoted at the state level.

No billable hours, beautiful office spaces with unlimited supplies and outdoor spaces at all of our facilities. Lower caseloads for more preparation time and an improved EHR.

I would make sure everyone was paid fair, compensation for their hard work and recognition.

More funding for clinics. Opportunity for more groups as well as other activities going in in the clinics. Make it more of a community for the clients. Along with that comes much more staff to serve the clients.

Better structure

I would create mental health housing, another board and care facility and a residential substance use treatment program that served men and women.

I would contract with our local partner agencies to hire our clients to provide the services we need to upkeep our clinics - cleaning staff, maintenance and yardwork could be done by our clients. We could have client's complete beautification projects to make our work environments more pleasant (our youth clients if provided with the paint and supplies could create a mural on our building to beautify our space) & with client's engaging in the creation and maintenance of the environment they would take more pride and care in treating our clinics with respect.

integrate DAS with Mental Health

An absurd amount of new housing; lower housing costs would help retain employees, would make us a more attractive place to work, and it would also improve the quality of life for patients who would have more financial resources and less stress related to housing. If I was homeless, even if I found a job and did everything right, I couldn't afford to find housing.

Create walk in access to services and invest in more software engineers to provide better reporting capabilities

More structure when it comes to policies and procedures. More training.

Have sud treatment is the same visit

More staff working with the public and CAT team to support our most challenging Clients.

Grant funding to support specific treatment modalities and at least part of positions to reduce the stress related to billing.

I would take all of our intake paperwork and client documents and make them accessible via our website and tablets within the clinics.

There is no magic wand.

More community involvement of trained volunteers

Peace and Joy for all staff so that it could be shared with clients organically

Accessible Free or low cost Therapy for everyone in the community.

Peer support specialist that goes with Law Enforcement and MHET calls, who provides a care package for anyone experiencing a mental health crisis with the option to provide follow up call through Hotline.

Higher wages, lower workload

Focus on prevention over cure. PEI should not be offered such a low salary to do the incredible work they do! Prevention is so valuable. If there was a focus on prevention, there would be less need for moderate to severe levels of care.

Residential Youth Mental Health Crisis Facility.

Urgent care clinics to serve people with full scope services for MH, SUD, and physical health needs in a one stop shop wellness center.

Spanish trainings/classes that we can partake in at work

I would incorporate all of MH, PHD, DAS into one large building and have them orient together from the beginning.

All clinics, and departments are fully staffed.

I would make the process run smoothly from the time that a client calls for an appointment to the day that they graduate from services.

Loan forgiveness for SLO BHD employees after working for 5 years.

The integrate the divisions of Mental Health Services and Drug and Alcohol services into one multifaceted Behavioral Health Entity.

Fully staffed with living wages available.

Incentives for employees- signing bonuses (similar to the City of SLO), flexible schedules (e.g. hybrid, flexible start/stop times where possible, 9/80), cover higher amount for employees+dependents

Adding a small cafe for clients and staff.

improve staff burnout - we can't do anything if we can't hire and continue to have staff leave

flexible schedule.

Computer Programmers! So we do not have admin staff creating excel documents to track info that is not automated nor user friendly and only sometimes work.

Same day services, residential, detox, medications, better resources with housing placement.

Higher emphasis on training and supporting new employees for 6 months with written procedures and processes so new employees don't feel like they have to figure everything out on their own. I have only been here about 6 months, and every coworker I have spoken to feels overwhelming burn out from the lack of support, training, lack of livable wages, and expectations to meet quotas. Most of my counterparts are not interested in staying with the county due to the burn out.

better buildings in order to integrate MH and SUD services close to DSS to ease access to services for people.

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D. Key Informants

Interviews and Focus Groups

D1: Notice Sent to Key Informants by HMA

San Luis Obispo Behavioral Health Department (hereafter SLO BHD) is currently developing its strategic plan for the next five years and would like your feedback on how you envision SLO BHD reaching its mission and vision.

Through this brief, confidential survey, we'd like to obtain your feedback on the direction of the emerging strategic plan. This survey will be used to refine our strategic priorities and goals over the next five years.

Your responses, and those of your colleagues, will be collected and analyzed by Health Management Associates (HMA), an independent management consulting firm as part of the strategic planning process. **Only the consultants will see your individual survey responses and no information will be used to identify individual staff members, so please respond as honestly as possible**.

Please complete this survey by no later than noon on November 3, 2023.

If you should have any questions, please contact Charles Robbins at crobbins@healthmanagement.com.

Thank you for providing your time and prompt attention to this survey!

D2: Key Informant Survey Questions

PART I – Staff Role

1. Which of the following best describes your job classification at SLO BHD?

- Executive/Senior Leadership
- Division Manager/Program Supervisor/Program Manager
- Line Staff
    - Clinician: Licensed/Associate Professional
        - Mental Health
        - SUD
    - Specialist: Education, Counseling and Support Services
        - Mental Health
        - SUD
        - Both
    - Administrative/Technical/Community Support
        - Business Services (HR, IT, Finance, etc.)
        - Communication
        - Grant/Contract Management
        - Data Management and Data Analytics
        - Other

2. How long have you worked at SLO - BH?

- 0-2 years
- 3-6 years
- 7-10 years
- 11-15 years
- More than 15 years

PART II – Employee Feedback

Please rate the following statements about SLO BHD using a *5-Point Likert Scale: Strongly Disagree/ Disagree/ Neither Agree nor Disagree/ Agree/ Strongly Agree/ Don't Know*

Core Services

- Our adult clients can navigate our BH services without difficulty.
- Our youth clients and their families can navigate our BH services without difficulty.
- We do a good job of informing County residents about the availability of BH services and resources.
- We are communicating the importance of BH prevention and wellness throughout SLO County.
- We maximize opportunities for the integration of Mental Health and SUD.
- We are a trusted provider of community based BH services.
- We provide culturally responsive BH services to meet the needs of the diverse communities that make up SLO County.
- We provide timely BH services to those in crisis.
- We provide timely BH services to those with severe challenges.
- We are committed to ensuring equitable access to BH services.
- We are focused on measuring outcomes and impact.

Short Answer: If you could change one thing about your BH delivery system, what would it be?

External Partnerships

- Our partnership with Department of Social Services (child welfare) is working well for the people we serve.
- Our partnership with law enforcement (police and sheriff) is working well for the people we serve.

- Our partnership with the justice system (courts and probation) is working well for the people we serve.
- Our partnership with public education (school districts and county office of education) is working well for the people we serve.
- Our partnership with hospitals and health clinics is working well for the people we serve.
- Our partnership with Public Health is working well for the people we serve.
- Our partnership with Community-based Organizations (CBOs) is working well for the people we serve.

Short Answer: Which EXTERNAL PARTNERSHIP do you believe is most important for SLO BHD to develop and/or strengthen?

System Issues

- We exemplify the core values of diversity, equity, and inclusion at SLO BHD.
- We have an inclusive process to engage the community and solicit ideas to improve the BH service system.
- We have a strong partnership assessing our services with people who have lived experience.
- We need to be creative and determine how we can incorporate more peers into our BH system as part of our teams.
- Increasing the number of peers with lived experience would enhance our BH services and add to our cultural competency.

Short Answer: Which inequity or disparity do you believe is MOST CRITICAL for SLO BHD to focus on in the next five years? AND

Which underserved population or community do you believe is MOST CRITICAL for SLO BHD to focus on in the next five years?

PART IV – Strategic Priorities

Please rank the five key areas of the BH Continuum of Care using a 1-5 scale where 1 = T*op Priority; Needs much more focus and investment and 5=Low Priority; Doing well and should be maintained and supported.*

- Prevention and Wellness – Conducting proactive BH outreach and training in the community
- Community Services – Providing community-based access to mild to moderate BH outpatient services
- Intensive Outpatient – Ensuring access to intensive outpatient services for adults and youth
- Substance Use Disorder (SUD) – Enhancing SUD services for adults and youth
- Crisis Response and Intensive Residential – Improving Crisis system integration and access to longer-term residential treatment

PART V – Strategic Issue Areas

Over the past three months, we have met and identified several issues relevant to agency strategy. Please provide your feedback on the relative level of importance making strategic improvements in the following areas of focus:

5-Point Likert Scale: 1=Most Important; Important; Moderately Important; *Not Important; Don't Know*.

- Integrating BH; bringing Mental Health and SUD into closer alignment
- Improving Crisis system integration and response
- Enhancing SUD services
- Exploring ways to augment agency staffing with peers and paraprofessionals
- Advancing Equity; Ensuring Equitable Access to BH services
- Building agency capacity to evaluate and measure impact
- Improving back-office infrastructure and support (e.g., HR, IT, budgets, etc.)
- Strengthening partnerships with other county agencies and organizations
- Engaging with County residents to educate and inform them about BH topics and issues.
- Emphasizing underserved populations for increased BH messaging, outreach, and service delivery.

- Developing creative solutions to increase the number of young people interested in working in BH.
- Expanding staff presence in community events and forums; increasing non- clinical interactions with County residents.

Suggestions for Improvement

1. What is ONE suggestion you have for improving PUBLIC ENGAGEMENT or COMMUNICATION that seeks to educate and inform County residents about BH?
2. WHAT is ONE suggestion you have for how to support and retain SLO BHD employees?
3. If you had a magic wand, what is ONE innovative SOLUTION you would make happen for SLO BHD?

D3: Key Informant Interview Questions

SLO BH Strategic Planning
Informant Interview Guide

WELCOME

My name is _____, and my colleague here is _____. We have been hired to develop a strategic plan for San Luis Obispo Behavioral Health Department that identifies agency priorities and a roadmap for the next 5 years. We are conducting interviews with multiple individuals from organizations that work with or alongside SLOBHD.

We want to learn about your impressions of SLOBHD's strengths and challenges in delivering high quality BH services to county residents. We are also interested in your input on what to prioritize and suggestions on how to improve the quality and responsiveness of SLOBHD.

There are no wrong answers to the questions we ask. Please be candid. We really want to know what you think, so we hope you feel free to talk openly. What you share is up to you.

We will be taking notes and these notes are only to make sure we remember what you have said. Your name or any identifying information will not be reported with findings from this discussion. In other words, we will consider what you say as confidential.

Do you have any questions so far?

Strengthening Core BH Services

1. How well is SLOBHD doing in terms of prevention and wellness/health promotion services? Is the level of effort/focus commensurate with the needs of the county?

2. How well is the managed care plan (Cencal) doing in terms of meeting the mild to moderate MH needs of adults? Children and Youth? What would you like to see done differently or better?

3. How well is SLOBHD doing in terms of meeting more severe and specialized MH needs of adults? Children and Youth? What would you like to see done differently or better?

4. To what extent is SLOBHD appropriately focused on SUD and co-occurring disorders? What would you like to see done differently or better?

Accelerating Equity

1. What are the most critical/important BH disparities or gaps that need to be prioritized in SLOBHD's strategy in the next 3-5 years?

2. Which specialized populations are most likely to be "falling through the cracks"? Where is access to BH most problematic or inconsistent? *Probe BIPOC as well as homeless, disabled, TAY, LGBTQ+, etc.*

3. What would you like SLOBHD to do to build a deeper level county understanding of the need for greater BH equity and access?

4. [For internal stakeholders} What would you like SLOBHD to emphasize to model its commitment to equity in the workplace? What should be prioritized to show employees that the agency is becoming more aligned to DEI principles?

5. [For internal stakeholders] What is the most important thing SLO BH can do to support providers in addressing health disparities?

Adapting to Changing Policies and External Trends

CalAIM is now State policy. CalAIM focuses on managing risk and need through whole person care approaches and by addressing SDOH often called Enhanced Care Management or ECM. In practice, this means more robust outpatient and community-based services that can address crises, link individuals to more integrated care between BH/physical health and BH/SUD, and prevent psychiatric hospitalizations, as well as promote diversions from the criminal justice system.

1. How well positioned is SLOBHD to implement CalAIM? How is SLOBHD reorganizing to move in response to CalAIM? *Probe: connections to SDOH partners, shifting contracting arrangements with local providers of BH services, etc.*

2. Which aspects of CalAIM are likely to be more challenging? What advice of guidance do you have on how to overcome or address these challenges?

As you likely know, California is proposing to embark on a series of policy and legislative reforms that are intended to change the Mental Health Services Act (MHSA) and link BH more closely to issues of SUD and homelessness. These proposals also include details on building the BH workforce, and reforms tied to outcomes, accountability, and equity.

1. To what extent is SLOBHD ready for these changes? How might SLOBHD prepare for a greater cross-sector collaboration and integration of BH with housing, SUD, as well as new conceptions of accountability?

California is building out the mobile crisis services system. HMA has worked with counties through the CBHDA to assist with building out the required 24/365 mobile crisis response teams. There is funding, but there are workforce

challenges counties faced based on the requirements for the teams.

1. [For external stakeholders] How responsive are the mobile crisis services in SLO now? Are there gaps you are experiencing or aware of in the crisis services system? What improvements would you like to see from SLOBHD in crisis services?

2. [For internal stakeholders] Is SLOBHD able to get the staff it needs to build the teams necessary to have 24/365 coverage across the entire county? How is the planning and building going in comparison to the state requirements and timeline?

Another big policy change is the California Youth Behavioral Health Initiative (CYBHI) which is intended to expand child and youth access to BH services. At the risk of oversimplification, CYBHI is a "corrective" to the historical emphasis placed on adult BH services. As such, it likely requires more of a preventative mindset, outreach to families, and greater interaction with sectors such as child welfare, public education, and youth-oriented CBOs.

1. To what extent is SLOBHD organized to address BH to include more emphasis on child and youth populations? How is SLOBHD changing its partnerships, outreach, etc. to ensure that CYBHI is implemented in SLO county?

Communication/Outreach

1. How well do you think SLOBHD is doing in terms of "telling the story" about BH needs in the county? Communicating its progress and accomplishments?

2. What suggestions do you have on how SLOBHD can improve externally facing communication?

    a. How might SLOBHD increase awareness of programs and resources that are available to county residents?

3. If you could change one aspect or facet of SLOBHD's reputation, what would it be? Why?

Partnerships/Collaboration

1. [For external partners] In which areas have you (or your organization) partnered and collaborated with SLOBHD? What have been your best and worst experiences?

2. Which existing partnerships need to be nurtured and strengthened? Who are SLOBHD's most strategic partners? *Probe both other public agencies and CBOs.*

a. Where in the larger BH ecosystem does SLOBHD need to enhance relationships – Primary Health Care, Public Education, Public Health, Law Enforcement, Child Welfare, Justice System, Managed Care, etc.?

3. Are there any partners missing who need to be invited to collaborate with SLOBHD? Who else in the county needs to become connected to SLOBHD's work?

Internal Infrastructure/Capacity

1. What are the key challenges in terms of recruiting and retaining a high-quality workforce? Which staffing needs require more focus and attention?

Wrap Up

1. What advice do you have for SLO BH as we embark on this strategic planning process?

2. Is there anything we didn't ask that you thought we would?

Questions for Steering Committee and other Internal Stakeholders

Continuous Quality Improvement

1. How would you characterize the "data culture" at SLOBHD? To what extent is SLOBHD committed to consistent data collection, data analysis, and (most importantly) data use for program improvement?

2. Can you provide an example of where SLOBHD has revised a policy or practice based on review and reflection on data?

    a. How do you know that leaders are making data-informed decisions?

3. How does SLOBHD define "accountability" and/or "success"? OR What would convince you that SLOBHD is "successful"?

    a. Which outcomes and metrics are most important and reinforced? What needs to be added or subtracted?

Internal Infrastructure/Capacity

1. Which internal systems (e.g., HR, Technology, Data, Grants Management, etc.) do you feel need more attention? Where should we focus to build the capacity of the agency to do its work?

    a. Do you have any suggestions to help with organizational restructuring or better integration/coordination across different parts of SLOBHD?

2. What kinds of professional development and/or learning would you prioritize to help staff do their work more efficiently and effectively?

    a. Which kinds of training and professional support are most relevant and necessary?

D4: Focus Group Questions

San Luis Obispo, Dept of Behavioral Health, Strategic Planning, 2023
Focus Group Questions

Prevention and Wellness

1. You noted that school-based (prevention) programs have decades of strong performance and relationships. What is working well with school-based programs? How might SLO BHD work collaboratively with the County Office of Education and/or school districts to advance MTSS (Multi-Tiered Systems of Support)?

    a. Where are the best opportunities for collaboration tied to Tier 1 Universal Supports (prevention, destigmatization, family awareness, etc.)

    b. There was also some interest expressed in developing Wellness Centers on high school campuses. How far along are these efforts? Which barriers are most challenging?

2. What has SLO BHD done to reduce the stigma tied to accessing BH resources? Which messages or outreach campaigns have been most successful?

    a. Has SLO BHD advanced any localized de-stigmatization work that targets a specific community or population? If yes, please describe.

3. What would you like to see Prevention and Wellness doing 3 years from now that it is not doing currently? How would you define success in this area?

    a. For example, what would deeper integration with community-based programs look like in practice?

Community Services

1. Several of our informant interviews mentioned the need for more integration of BH with primary care. Can you please tell us more about the status of these efforts and the level of collaboration between BH and healthcare/hospitals/FQHCs?

    a. What is needed to enhance intake, referrals, and/or information sharing?

2. If you had more access to Community Health Workers, *promotores*, or MH navigators, where would you deploy them? Which gaps in service or communities

would you prioritize and why?

3. Which wraparound supports have been most critical and important to providing effective case management for the outpatient populations you serve?

4. What suggestions do you have to improve the level of collaboration and partnership with the following organizations and sectors:
    - Public Education/County Office of Education
    - Public Health
    - Law Enforcement
    - Probation
    - Another agency or sector

Intensive Outpatient

1. The overarching challenge identified in the Capstone report for this area can be summarized as "How might we meet the full range of needs of highly vulnerable mental health clients through clinical programs, including FSPs?" To better understand the opportunities in this area, can you please tell us your hopes and fears regarding the two most common statewide approaches:
    a. Advancing whole person care
    b. Providing more team-based approaches to care that involve multiple licensed and unlicensed professionals and peer supports

2. The Capstone report recommends consideration of a FSP stepdown level of care for individuals transitioning from FSP to the outpatient clinics. The term used is "FSP-lite." Is this suggestion realistic and feasible?
    a. What would it take to implement this?
    b. Which aspects of "stepdown" need further discussion and planning?

3. Let's talk a little about outcomes and definitions of success in the area of specialty MH. Three years from now, which outcomes would you like to see? What would increase/decrease?

4. Which external partnerships are most important and critical to focus on in this area?
    - Hospitals/FQHCs

- Managed Care
- CBO partners
- Public Health
- Law Enforcement
- Justice System

5. What is needed to improve the relationship with these prioritized partners? What would improve interagency coordination and collaboration?

Substance Use Disorders (SUD)

1. How well is SLO County doing in terms of early intervention and recovery services for SUD?
    a. How is SLO doing in term of Naloxone training and community-wide distribution of overdose prevention kits?
    b. Is there easy access to a guide of local SUD treatment resources?
    c. Has there been sufficient counselor training on early intervention techniques? (i.e., what to do with clients showing signs of relapse to help them remain in treatment).
2. A key challenge is the ability of the BH system to provide SUD services for a population that requires timely access upon demand. People in addiction, both youth and adults, are not well equipped to wait weeks for services. What are your suggestions for expanding SUD capacity and ensuring timely access to SUD services?
    a. How easy is it to navigate access to SUD services in SLO County?
    b. What role are FQHCs playing currently? What would you like to see done differently?
    c. Is there a role for data/measurement systems in deepening accountability for timely access to care? [Capstone recommendation]
    d. What would it take to expedite referrals to SUD treatment?

3. We've clearly heard about the lack of capacity to stabilize clients who end up in the hospital and require a higher level of care post hospitalization. The Capstone report recommends investment in a crisis residential treatment program.

    a. How would you advance development of crisis residential treatment services?

    b. How realistic is this?

    c. What is your sense of the potential partnership this might involve with:

        - Sober living homes?
        - Existing hospitalization programs?
        - Existing outpatient programs?
        - Who else is needed?

Crisis/Intensive Services

During our informant interviews, the consensus view was that Crisis/Intensive services need improvement and should be prioritized in the context of strategic planning. Multiple data sources indicate that key aspects of the Crisis system are not working as well as they could. Data show, for example, that the CSU is under-utilized. We've heard also that MHET teams are mostly responsive to hospitals and that this limits the overall crisis response.

1. Given all this, which aspect of Crisis/Intensive services do you feel deserve the most attention in our planning and discussion? What do you want to see prioritized for support, resources, revised direction, etc.? Possible areas of focus include:

    - Use and focus of MH Evaluation Team or MHET? (i.e., service priorities)
    - Assessment during primary care and ED visits?
    - Transitioning individuals from hospitalization to intensive care?
    - Increasing access to CSU and PHF?
    - Relationships between 988 and 911?

2. Another conclusion from our interviews is that more work is needed to solidify the triad relationship between hospitals, law enforcement, and MHET. A key strategic question is whether to establish and improve the process centrally within SLO BHD or to empower health providers to deal with these issues once they arrive at the hospital.

a. What are your thoughts on the appropriate degree of centralization/decentralization?

3. The Capstone report recommends several new structures to improve crisis and intensive service access in SLO County. We would love to hear your thoughts about the following solutions:

    a. Adding a crisis residential treatment program to the continuum of care to increase flow from the CSU and PHF.

    b. Redesigning the Crisis Stabilization Unit as an Urgent Care Center.

    c. Adding another PHF that accepts private insurance and Medi-Cal

4. The Capstone report also offers several recommendations to improve staffing of crisis and intensive services. What are your reactions to the following proposed solutions:

    a. Dedicating staff positions in hospitals for transition and discharge planning.

    b. Using MHET teams to de-escalate clients and prevent need for a higher level of care

    c. Expanding mobile crisis teams through CalAIM.

5. Which external partnerships are most important and critical to focus on in this area?

    - Hospitals/FQHCs
    - Managed Care
    - CBO (contracted) partners
    - Law Enforcement
    - Justice System

6. What is needed to improve the relationship with these prioritized partners? What would improve interagency coordination and collaboration?

Equity

1. In our interviews, several groups or populations were consistently mentioned as priorities for accelerated equity. We'd love to hear your recommendations for improving equitable access for the following populations:

    - Monolingual Spanish speakers

- The Mixteco population, typically concentrated in the agricultural workforce
- LGBTQ+ youth and adults
- Older adults and seniors (a growing proportion of the county)
- Homeless adults and youth

2. SLO has a large geography and a concentration of BH services in the metro SLO city area of the county. How big is the equity barrier posed by transportation?

    a. To what extent can you envision more emphasis on mobile services that bring BH to communities and households rather than expecting clients to come to where the services are provided?

    b. What about door-to-door options?

3. Another issue that has surfaced repeatedly is the need for SLO County to address its own internal culture in terms of DEI issues and principles. What would you like SLO BHD to do to build a deeper understanding of the need for greater BH equity and access?

    a. What should SLO BHD do to demonstrate (or model) its commitment to equity in the workplace? What should be prioritized to show employees that the agency is becoming more aligned to DEI principles?

    b. What is the most important thing SLO BHD can do to support providers in addressing health disparities? Reallocating resources to address these disparities?

Workforce and Professional Development

1. It is abundantly clear that staffing and workforce development are top challenges for BH generally. This is exacerbated in SLO County by other factors tied to cost of living and proximity to other counties willing to pay higher salaries. Without minimizing these realities, we would like to hear your ideas and input on non-traditional ways to increase BH staffing including:

    a. Peer models that involve youth and adult peers in BH navigation and support

        a. Promotors

        b. Peer support specialists

    b. Team-based models that involve both licensed and unlicensed staff providing BH care and support

a. Community Health workers

b. Wellness coaches

c. Partnerships with higher education (Cuesta College and Cal Poly SLO, for example) to build career pathways into the BH workforce

d. Arrangements with CBOs and Public Education to think collectively about workforce trajectories and movement of BH staff between different sectors and systems

2. In addition to the challenges of staff recruitment, there is the issue of staff retention. Do you have any recommendations on how best to keep staff?

    a. Compensation and benefits

    b. Working conditions

    c. Opportunities for voice and inclusion in decision making

    d. Flexibility and other accommodations

    e. Ongoing learning and opportunities for advancement

3. Another potentially productive line of inquiry is how we might better support BH professionals with ongoing learning and career development. What kinds of professional development and/or learning would you prioritize to help BH staff do their work more efficiently and effectively?

    a. Which kinds of training and professional support are most relevant and necessary?

Data and Infrastructure

Continuous Quality Improvement

1. How would you characterize the "data culture" at SLO BHD? To what extent is SLO BHD committed to consistent data collection, data analysis, and (most importantly) data use for program improvement?

2. Can you provide an example of where SLO BHD has revised a policy or practice based on review and reflection on data?

    a. How do you know that leaders are making data-informed decisions?

    b. Which outcomes and metrics are most important and reinforced? What needs to be added or subtracted?

3. What data do you wish you had to better understand and/or deliver BH services?

a. Which data would be most beneficial for you to see on a regular basis? Why?

Internal Infrastructure/Capacity

4. Which internal systems (e.g., HR, Technology, Data, Grants Management, etc.) do you feel need more attention? Where should we focus to build the capacity of the agency to do its work?

    a. What investments in technology or data platforms are needed to improve connectivity and integration of services? Improve access to data outcomes and measures of efficiency (i.e., time to care)?

5. Another capacity issue centered on measurement of quality. Some would like to see more investment in program evaluation to ensure data is driving decisions. Others reported that SLOBHD could do a better job in terms of oversight and quality assurance with contracted agencies.

    a. What do you think is needed to increase the use of evaluation and data to inform decisions?

E. Resources and Endnotes

Integration Tools Provided by HMA

E1: Integration Tools

Harvard's Leadership for a Networked World – Health and Human Services Initiative https://lnwprogram.org/content/health-human-services

Leadership Framework – The Human Services Value Curve
https://lnwprogram.org/frameworks/human-services-value-curve

American Public Human Services Association – Toolkit: Moving through the Value Curve Stages
https://www.aphsa.org/APHSA/Policy_and_Resources/Guidance_and_Toolkits/HSVC_Toolkit.aspx

Includes Organizational Effectiveness Tools:

- Adaptive Leadership Assessment Guide
- Adaptive Leadership Article
- Executive Functioning, Resilience and Leadership Article
- Sponsor Group Overview
- Chartering Teams Template

E2: Endnotes

[1] AAP-AACAP-CHA Declaration of a National Emergency in Child and Adolescent Mental Health
[2] America is facing a mental health crisis | Bernie Sanders | The Guardian
[3] As Mental Health Crisis Grows, More Doors Open to Care - The New York Times (nytimes.com)
[4] Kids' mental health is in crisis. Here's what psychologists are doing to help (apa.org)
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