



County of San Bernardino Department of Behavioral Health:
Evidence Based Practice in Behavioral Health Services
Presented by Veronica Kelley, LCSW



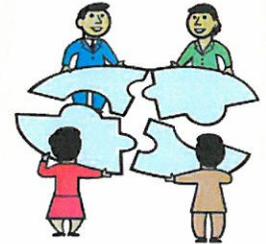
May 1, 2014

12:50 pm - 1:50 pm

(The presentation is part of the Behavioral Health Commission Meeting)

County of San Bernardino Health Services
Auditorium

850 E. Foothill Blvd
Rialto, CA 92376



Objectives: After completing this training attendees will ...

- ⇒ Know the definition of evidence based practices (EBPs).
- ⇒ Know the basic role of EBPs in contemporary healthcare, behavioral health and substance use disorder services.
- ⇒ Have a demonstrated understanding of treatment areas, populations, settings and requirements for Cognitive Enhancement Therapy, Moral Reconciliation Therapy, Seeking Safety and Matrix.
- ⇒ Have a demonstrated understanding of efficacy of EBPs.

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This course meets 1
hour of the Cultural
Competence
Requirement

Please note that all participants
attending this training must be
in accordance with the DBH
Dress Code Policy.

Psychologist CE Credits:

County of San Bernardino Department of Behavioral Health is approved by the American Psychological Association to sponsor continuing education for psychologists. The County of San Bernardino Department of Behavioral Health maintains responsibility for this program and its content. This course is approved for 1 continuing education credits.

BBS:

County of San Bernardino Department of Behavioral Health, Provider #3766. This course meets the qualifications for 1 hours of continuing education credit for MFTs, LPCC's, LEPs and/or LCSWs as required by the California Board of Behavioral Sciences.

CBRN CEU Credits:

County of San Bernardino Department of Behavioral Health, approved by the California Board of Registered Nursing, Provider # CEP-15400, for 1 contact hours.

CAADE:

County of San Bernardino: Department of Behavioral Health, provider approved by CAADE, Provider Number CP10 872 C 0715 for 1 CEUs.

Note: Participation for the entire class period is required to qualify for continuing education credit, no partial credit will be awarded.

For alternative communication methods, call 800-722-9866 or 7-1-1 for T-T-Y



Evidence Based Practice in Behavioral Health Services

Veronica Kelley, LCSW
Assistant Director, DBH
May 1, 2014

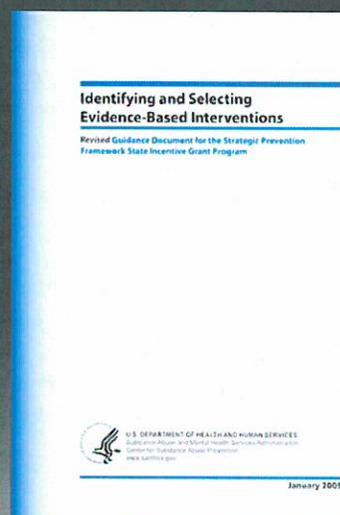
What is EBP?

- Evidence Based Practice (EBP) refers to practice activities that evaluation research has shown to be effective (SAMHSA, 2014)
- SAMHSA: Included in federal registry of EBP's, Reported in peer reviewed journals, documented effectiveness based on SAMHSA guidelines which include:

What is an EBP?

1. The intervention/treatment is based on a theory of change that is documented in clear conceptual mode, **AND**
2. Intervention is similar in content and structure to those in peer reviewed literature, in registries, **AND**
3. Intervention is supported by documentation for effectiveness, multiple times, addressing scientific standards of evidence with credible, consistent results, **AND**
4. Intervention is reviewed and deemed appropriate by panel of treatment experts including key community and partner leaders.

What is an EBP?



History of EBP

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- The concept of EBPs first came into use in medicine.
- An often-cited definition of EBP is the "conscientious, explicit and judicious use of current best evidence in making decisions about the care of individuals".
- This is a reasonable definition, but it raises the question of what constitutes "current best evidence"—
- Today, research evidence in the medical field has become quite rigorous and plentiful, so "current best evidence" is of a very high quality.
- In medicine, it is currently generally accepted that a well-implemented randomized controlled trial is the ideal means by which to establish that an intervention is effective and to minimize the biases that might render a study's conclusions invalid.
- Since its emergence from the field of medicine, the EBP concept has been adopted in other fields.

(Clairidge, J. a. & Fabian, T. C. (2005). History and development of evidence-based medicine. World Journal of Surgery, 29(5), 547-553.

EBPs for Child/Family Services

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- Programs shown to be effective through rigorous research are known as evidence-based practices (EBPs). EBPs have garnered a new prominence in the field of child and family services in the past decade.
- What is the best available research evidence? And how can decision makers without research training make sense of that evidence?
- Federal funding streams have increasingly been tied to research evidence, particularly around programming related to children and youth.
- Concurrent with these trends, the field of child and family studies has become savvier in designing and publishing research studies, with the goal of establishing research evidence in support of programs and practices that improve outcomes for children and their families.
- However, the research evidence supporting these programs can be of varied quality. This can be problematic, because there is no single set of standards against which EBPs are evaluated in the field of child and family services.

EBPs for Child/Family Services 7

- Promising Practices Network- children and families thru Rand.
- Programs are generally assigned either a Proven or a Promising rating, but in some cases a program may receive a Proven rating for one indicator and a Promising rating for a different indicator.
- In this case the evidence level assigned will be Proven/Promising, and the program summary will specify how the evidence levels.

National Registry for Evidence based Programs and Practices(NREPP) 8

- The National Registry of Evidence-based Programs and Practices (NREPP) is a searchable online database of mental health and substance abuse interventions. All interventions in the registry have met NREPP's minimum requirements for review and have been independently assessed and rated for Quality of Research and Readiness for Dissemination.
- The purpose of NREPP is;
 1. To help the public learn more about available evidence-based programs and practices and determine which of these may best meet their needs.
 2. NREPP is one way that SAMHSA is working to improve access to information on evaluated interventions and reduce the lag time between the creation of scientific knowledge and its practical application in the field.

NREPP

- NREPP is a voluntary, self-nominating system in which intervention developers elect to participate
- NREPP publishes a report called an intervention summary on this Web site for every intervention it reviews.
- Each intervention summary includes:
 - General information about the intervention,
 - A description of the research outcomes reviewed,
 - Quality of Research and Readiness for Dissemination ratings,
 - A list of studies and materials reviewed, and
 - Contact information to obtain more information about implementation or research.

NREPP

- NREPP originated in 1997 in SAMHSA's Center for Substance Abuse Prevention (CSAP).
- Substance Use Disorder (SUD) was the original focus of SAMHSA's EBP monitoring.
- When these designations were discontinued in 2004 and were replaced by the current NREPP rating system, SAMHSA decided to include all 150 Model, Effective, and Promising programs on the NREPP Web site. Programs that were previously designated as Model and have undergone a re-review are included in the current NREPP system. Many of those previously labeled Effective or Promising are included on this page as Legacy Programs.

Cognitive Enhancement Therapy (CET)

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- Cognitive Enhancement Therapy (CET) is a cognitive rehabilitation training program for adults with chronic or early-course schizophrenia or schizoaffective disorder (per DSM-III-R or DSM-IV criteria), who are stabilized and maintained on antipsychotic medication and not abusing substances.
- CET is designed to provide cognitive training to participants to help them improve impairments related to:
 - neurocognition cognitive style,
 - social cognition, and
 - social adjustment.
- Through CET, participants learn to shift their thinking from rigid serial processing to a more generalized processing of the core essence or gist of a social situation and a spontaneous abstraction of social themes.

CET

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- CET is manualized and delivered over a period of 18 months:
 - Starts with approximately 3 months of weekly 1-hour sessions of computer-assisted neurocognitive attention training conducted with pairs of participants.
 - As the treatment proceeds over 18 months, participants engage in 60 hours of targeted, performance-based neurocognitive training exercises to improve their attention, memory, and problem-solving abilities.
 - After approximately 3 months of neurocognitive training, participants start to attend social-cognitive group sessions, which last for 1.5 hours each and are held weekly.
 - There are a total of 45 social-cognitive group sessions in the program.
 - In these sessions, clinicians help groups of six to eight participants improve social-cognitive abilities (e.g., taking perspectives, abstracting the main point in social interactions, appraising social contexts, managing emotions) and achieve individualized recovery plans.

CET

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- Participants also use experiential learning and real-life cognitive exercises to facilitate the development of social wisdom and success in interpersonal interactions.
- Clinicians provide active, supportive coaching to keep each participant on task and to encourage greater understanding of social cognition and greater elaboration, organization, and flexibility in thinking and communication. After social-cognitive group sessions begin, neurocognitive training and social-cognitive training proceed concurrently throughout the remainder of the program.
- Both neurocognitive training and social-cognitive group sessions are facilitated by master's-level clinicians who have at least 2 years' experience in the treatment of schizophrenia. Social-cognitive group sessions require a minimum of two master's-level clinicians, who follow a comprehensive structured curriculum. CET is designed to be implemented in agency- and center-based treatment settings.

CET

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- Areas of Use: Mental Health.
- Outcomes Review Date: January 2012.
- Outcome Categories: Mental Health & Social Functioning.
- Ages: 18-25 (Young adult) & 26-55 (Adult).
- Genders: Male & Female.
- Ethnicities: Asian, African American, Caucasian.
- Settings: Outpatient.
- Geographic Locations: Urban, Suburban.
- Implementation History: CET was initially developed and piloted in the early 1990s. NIH Funding/CER Studies.
- Partially/fully funded by National Institutes of Health: Yes.
- Evaluated in comparative effectiveness research studies: Yes.
- Adaptations: No population- or culture-specific adaptations of the intervention were identified by the developer.
- Adverse Effects: No adverse effects, concerns, or unintended consequences were identified by the developer.
- IOM Prevention Categories: IOM prevention categories are not applicable.

Moral Reconciliation Therapy (MRT)¹⁵

- Moral Reconciliation Therapy (MRT) is a systematic treatment strategy that seeks to decrease recidivism among juvenile and adult criminal offenders by increasing moral reasoning.
- Its cognitive behavioral approach combines elements from a variety of psychological traditions to progressively address ego, social, moral, and positive behavioral growth.
- MRT takes the form of group and individual counseling using structured group exercises and prescribed homework assignments.
- The MRT workbook is structured around 16 objectively defined steps (units) focusing on seven basic treatment issues.
- Participants meet in groups once or twice weekly and can complete all steps of the MRT program in a minimum of 3 to 6 months.

MRT

- Areas of Interest: Mental health treatment, Substance abuse treatment, Co-occurring disorders.
- Outcomes: Review Date: May 2008.
 1. Recidivism
 2. Personality functioning
- Outcome Categories: Crime/delinquency, Social functioning.
- Ages: 13-17 (Adolescent), 18-25 (Young adult), 26-55 (Adult).
- Genders: Male & Female.
- Ethnicities: African American, Caucasian.
- Non-U.S. population
- Settings: Correctional

MRT

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- Geographic Locations: No geographic locations were identified by the developer.
- Implementation History: MRT has been implemented in a variety of treatment settings in more than 45 States and in Australia, Bermuda, and Canada. Several States have system wide implementations of MRT. It is estimated that more than 1 million individuals have participated in the intervention.
- NIH Funding/CER Studies: Partially/fully funded by National Institutes of Health: No.
- Evaluated in comparative effectiveness research studies: No.
- Adaptations: While MRT was first designed as a criminal justice-based drug treatment method, a host of other treatment adaptations have been made, including more individualized programs that deal with parenting, spiritual growth, anger management, juvenile offenders, sexual and domestic violence, and treatment and job readiness. Different workbooks based on the fundamental MRT concepts exist for each of these areas.
- Adverse Effects: No adverse effects, concerns, or unintended consequences were identified by the developer.
- IOM Prevention Categories: IOM prevention categories are not applicable.

Seeking Safety

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- Seeking Safety is a present-focused treatment for clients with a history of trauma and substance abuse.
- The treatment was designed for flexible use: group or individual format, male and female clients, and a variety of settings (e.g., outpatient, inpatient, residential).
- Seeking Safety focuses on coping skills and psychoeducation and has five key principles:
 1. Safety as the overarching goal (helping clients attain safety in their relationships, thinking, behavior, and emotions);
 2. Integrated treatment (working on both posttraumatic stress disorder (PTSD) and substance abuse at the same time);
 3. A focus on ideals to counteract the loss of ideals in both PTSD and substance abuse;
 4. Four content areas: cognitive, behavioral, interpersonal, and case management; and
 5. Attention to clinician processes (helping clinicians work on countertransference, self-care, and other issues).

Seeking Safety

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- Areas of Interest: Mental health treatment, Substance abuse treatment, Co-occurring disorders .
- Outcomes Review Date: October 2006
 - 1.Substance use
 - 2.Trauma-related symptoms
 - 3.Psychopathology
 - 4.Treatment retention
- Outcome Categories: Alcohol, Drugs, Mental health, Trauma/injuries, Treatment/recovery
- Ages: 13-17 (Adolescent),18-25 (Young adult), 26-55 (Adult).
- Genders: Male &Female .
- Races/Ethnicities American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino, Caucasian.
- Settings: Inpatient, Residential, Outpatient.

Seeking Safety

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- Geographic Locations: No geographic locations were identified by the developer.
- Implementation History: Since 1992, Seeking Safety has been implemented in more than 3,000 clinical settings and as part of statewide initiatives in Connecticut, Hawaii, Oregon, Texas, and Wyoming. It has been implemented in programs for substance abuse, mental health, domestic violence, homelessness, women and children, and veterans and in correctional, medical, and school settings in the United States and internationally, including in Argentina, Australia, Canada, France, Germany, Italy, Japan, the Netherlands, New Zealand, Scotland, and Sweden.
- NIH Funding/CER Studies: Partially/fully funded by National Institutes of Health: Yes.
- Evaluated in comparative effectiveness research studies: Yes.
- Adaptations: Seeking Safety has been tested with dually diagnosed women, men, and adolescent girls. Samples have included clients in outpatient and residential settings, low-income urban women, incarcerated women, and veterans (both men and women). The treatment manual is available in both English and Spanish.
- Adverse Effects No adverse effects, concerns, or unintended consequences were identified by the developer.
- IOM Prevention Categories IOM prevention categories are not applicable.

Matrix Model

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- The Matrix Model is an intensive outpatient treatment approach for stimulant abuse and dependence that was developed through 20 years of experience in real-world treatment settings.
- The intervention consists of relapse-prevention groups, education groups, social-support groups, individual counseling, and urine and breath testing delivered over a 16-week period.
- Patients learn about issues critical to addiction and relapse, receive direction and support from a trained therapist, become familiar with self-help programs, and are monitored for drug use by urine testing.
- The program includes education for family members affected by the addiction. The therapist functions simultaneously as teacher and coach, fostering a positive, encouraging relationship with the patient and using that relationship to reinforce positive behavior change. The interaction between the therapist and the patient is realistic and direct, but not confrontational or parental.
- Therapists are trained to conduct treatment sessions in a way that promotes the patient's self-esteem, dignity, and self-worth.

Matrix Model

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- Areas of Interest: Substance abuse treatment.
- Outcomes Review Date: December 2006.
 1. Treatment retention
 2. Treatment completion
 3. Drug use during treatment
- Outcome Categories: Drugs, Treatment/recovery.
- Ages: 18-25 (Young adult), 26-55 (Adult).
- Genders: Male, Female.
- Races/Ethnicities: Asian, Black or African American, Hispanic or Latino, White.
- Race/ethnicity: Unspecified.
- Settings: Outpatient.

Matrix Model

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- Geographic Locations: Urban, Suburban .
- Implementation History: Dozens of States and numerous community agencies in the United States have received training and have begun implementing the Matrix Model. At the Southern California Matrix Institute clinics, approximately 20,000 individuals have been treated using this approach. Internationally, the Matrix Model has been implemented in Beirut and Lebanon and throughout Thailand in substance abuse treatment facilities.
- NIH Funding/CER Studies: Partially/fully funded by National Institutes of Health: Yes.
- Evaluated in comparative effectiveness research studies: Yes.
- Adaptations: The Matrix Model has been adapted for use with gay and bisexual men who use methamphetamine. It has also been adapted for use with Spanish-speaking, Thai, Native American, and Slovakian populations.
- Adverse Effects: No adverse effects, concerns, or unintended consequences were identified by the developer.
- IOM Prevention Categories: IOM prevention categories are not applicable.

Functional Family Therapy

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- Functional Family Therapy is a family-based intervention program for youth ages 11-18 who have demonstrated dysfunctional and maladaptive behaviors such as delinquency, violence, substance use, Conduct Disorder, Oppositional Defiant Disorder, or Disruptive Behavior Disorder, and depression.
- It provides 8-30 sessions of direct service time for the referred youth and their families.
- The program can be delivered in a variety of settings including home, school, clinical and juvenile justice facilities.

Functional Family Therapy 25

- Indicators:
 - Youths not using alcohol, tobacco, or illegal drugs,
 - Children and youth not engaging in violent behavior or displaying serious conduct problems,
 - Children not experiencing anxiety or mood disorders, such as depression.
- Age of Child: Adolescence (13-18).
- Type of Setting: High School, Home Visiting.
- Type of Service: Family Support, Parent Education, Youth Development.
- Type of Outcome: Addressed Behavior Problems, Juvenile Justice, Mental Health, Physical Health, Substance Use and Dependence, Violent Behavior.

EBPs and DBH 26

DHCS provides some guidance about the areas EBPs should cover such as:

- Programs/services delivered in a culturally-competent manner that incorporate practices with generally accepted scientific fidelity, and that measure the impact of the practice on clients, participants and/or communities.
- (These evidence-based practices were described by the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2007 and were available at <http://www.nri-inc.org/CMHQA.cfm>.)

EBPs and DBH

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- **Assertive Community Treatment:** A team-based approach to the provision of treatment, rehabilitation, and support services.
- **Supportive Employment:** Services that promote rehabilitation and a return to productive employment for persons with serious mental illness.
- **Supportive Housing:** Services to assist individuals in finding and maintaining appropriate housing arrangements and independent living situations.
- **Family Psychoeducation:** Offered as part of an overall clinical treatment plan for individuals with mental illness to achieve the best possible outcome through active involvement of family members in treatment and management.
- **Integrated Dual Diagnosis Treatment:** Treatments that combine or integrate mental health and substance abuse interventions at the level of the clinical encounter.
- **Illness Management and Recovery:** A practice that includes a broad range of health, lifestyle, self-assessment and management behaviors by the client, with the assistance and support of others.

EBPDs and DBH

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- **Medication Management:** A systematic approach to medication management for severe mental illnesses that includes the involvement of consumers, families, supporters, and practitioners in the decision-making process. Includes monitoring and recording of information about medication results.
- **New Generation Medications:** A practice that tracks adults with a primary diagnosis of schizophrenia who received atypical second generation medications
 - (including Clozapine) during the reporting year.
- **Therapeutic Foster Care:** Services for children within private homes of trained families. The approach combines the normalizing influence of family-based care with specialized treatment interventions, thereby creating a therapeutic environment in the context of a nurturant family home.
- **Multisystemic Therapy:** A practice that views the individual as nestled within a complex network of interconnected systems (family, school, peers). The goal is to facilitate and promote individual change in this natural environment. The caregiver(s) is viewed as the key to long-term outcomes.

EBPDs and DBH

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- **Functional Family Therapy:** A program designed to enhance protective factors and reduce risk by working with both the youth and their family. Phases of the program are engagement, motivation, assessment, behavior change, and generalization.
- **Peer and/or Family Delivered Services:** Services and supports provided by clients and family members who have been hired as treatment program staff, or who provide adjunct supportive or administrative services, such as training, information dissemination and referral, support groups and self-help support and empowerment. Please note that if the service/support is to be reimbursed by Medi-Cal, client and family member staff duties and credentials must meet Medi-Cal provider certification requirements.
- **Psychoeducation Services:** Services that provide education about: Mental health diagnosis and assessment, Medications, Services and support planning, Treatment modalities, Other information related to mental health services and needs.
- **Family Support Services:** Services provided to a client's family member(s) in order to help support the client.
- **Supportive Education Services:** Services that support the client toward achieving educational goals with the ultimate aim of productive work and self-support.

EBPs and DBH

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- **Delivered in Partnership with Law Enforcement:** Services that are integrated, interdisciplinary and/or coordinated with law enforcement, probation or courts (e.g., mental health courts, jail diversion programs, etc.) for the purpose of providing alternatives to incarceration/detention for those with mental illness/emotional disturbance and criminal justice system involvement.
- **Delivered in Partnership with Health Care:** Integrated, interdisciplinary and/or coordinated physical and mental health services, including co-location and/or collaboration between mental health and primary care providers, and/or other health care sites.
- **Delivered in Partnership with Social Services:** Integrated, interdisciplinary and/or coordinated social services and mental health services, including co-location and/or collaboration between mental health and social services providers.
- **Delivered in Partnership with Substance Abuse Services:** Integrated, interdisciplinary and/or coordinated substance use services and mental health services, including co-location and/or collaboration between mental health providers and agencies/providers of substance use services. This strategy is distinguished from the Federal evidence-based practice, "Integrated Dual Diagnosis Treatment", in that for this strategy the integration does not need to occur at the level of the clinical encounter.

EBPs and DBH

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- **Integrated Services for Mental Health and Aging:** Integrated, interdisciplinary and/or coordinated services for mental health and issues related to aging, including co-location and/or collaboration between mental health providers and agencies/providers of services specific to aging (e.g., health, social, community service providers, etc).
- **Integrated Services for Mental Health and Developmental Disability:** Integrated, interdisciplinary and/or coordinated mental health services and services for developmental disabilities, including co-location and/or collaboration between mental health providers and agencies/providers of services specific to developmental disabilities.
- **Ethnic-Specific Service Strategy:** Culturally appropriate services that reach and are tailored to persons of diverse cultures in order to eliminate disparities. Includes ethnic-specific strategies and community cultural practices such as traditional practitioners, natural healing practices, and ceremonies recognized by communities in place of, or in addition to, mainstream services.
- **Age-Specific Service Strategy:** Age-appropriate services that reach and are tailored to specific age groups in order to eliminate disparities. Age-specific strategies should promote a wellness philosophy including the concepts of both recovery and resiliency.

List of DBH EBPs and Practices

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- 3-5-7- youth- IYRT (EMQ)-grief and loss;
- Transition to Independence Process (TIP) - IYRT , STAY (Valley Star)-independence facilitation;
- Caring for Children Who Have Trauma - IYRT (Valley Star) - trauma;
- CBT-DBH-bx and emotions via cognitive change process - PEI School Based;
- Intensive Case Management and Screening for Foster Youth - Children's;
- Parent Child Interactive Therapy (PCIT) - SART providers – parenting;
- Aggression replacement Therapy (ART) - DBH Children's, TAY(VCSS), STAY (Valley Star), PEI school based /community based;
- Incredible Years – Childrens, PEI School based;
- Theraplay ;
- Motivational Interviewing- DBH;
- Family Based Services Model-DBH Children's- Eating Disorders;
- Integrative Treatment for Complex Trauma for Adolescents – Childrens/contractors-trauma youth;
- TF-CBT – DBH - trauma and youth;
- Nurturing Parents-TAY-(Pacific Clinics) – Parenting;
- Assertive Community Treatment (ACT) –TAY (Pacific Clinics) -community based psych treatment and rehab;
- Seeking Safety - DBH Forensics, AOD, TAY (VCSS), STAY;
- MATRIX - DBH AOD/contractors;
- Dialectical Behavioral Therapy-DBH- emotional regulation, mindfulness;
- Trauma Resiliency Model-DBH -Trauma;
- Moral Reconciliation Therapy(MRT) - DBH TAY, AOD, Contract Providers-moral reasoning

DBH & EBPS

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- Wellness Recovery Action Plan (WRAP)-DBH, SART providers, STAY (Valley Star);
- MIMS –STAY (Valley Star) -LGBTQ support;
- Mental Health First Aid – DBH Clubhouses;
- Solutions for Wellness - DBH Clubhouses - wellness and nutrition;
- Interactive Journaling - DBH Clubhouses - life skills;
- 48 Developmental Assets - PEI School Based;
- 7 Habits of Highly Effective Teens - PEI, CBO;
- Adolescent Community Reinforcement Approach (ACRA)- PEI school based;
- Aggressors, Victims and Bystanders -PEI School Based;
- AI's Pal's - PEI School Based;
- All Star Building Bright Futures - PEI School Based;
- Ascent Curriculum - Smoking Cessation Program -PEI School Based;
- Assertive Continuing Care-PEI School Based;
- Beyond Blame- PEI Community Based;
- Brain Scan- PEI School Based;
- Bullying Free Living in Middle School Students - PEI School Based;
- Bullying in the Girl World - PEI School Based;
- Caring School Community - PEI School Based;
- Children in the Middle - PEI School Based;
- Choose Direction for Change - PEI School Based;
- Choose Not to Choose - PEI School Based;
- Club Drugs - PEI School Based;
- Effective Black Parenting - PEI School Based, RPIAAC;

DBH EBPS

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- Equine Assisted Therapy - PEI Community Based;
- Go LEAPS - PEI School based;
- Grab Bag Guidance - PEI School Based;
- Grieving, Sharing and Healing - PEI School Based;
- Grief and Loss - PEI School Based;
- Growing Great Girls - PEI School Based;
- Guilding Good Choices - PEI School Based;
- Hazelton Life Skills - PEI Community Based;
- How Does Your Engine Run? -PEI School Based.

Questions?

Please contact:

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