



County of San Bernardino
DEPARTMENT OF BEHAVIORAL HEALTH
Mental Health Services Act

**Community Services and Supports (CSS)
Plan
2007 Progress Report**

July 9, 2008

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2007 Progress Report
San Bernardino County**

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Community Services and Support Implementation 2007 Progress Report

Introduction and Overview

This report covers the calendar year from January 1, 2007 to December 31, 2007. San Bernardino County Department of Behavioral Health (DBH) has implemented Four (4) Full Service Partnerships (FSP) and six (6) General System Development (GSD) programs. All the programs that were implemented have Outreach and Engagement (O&E) services built in which focus on providing countywide mental health education and resources.

The FSP programs implemented during the 2007 calendar year include:

- Success First Wraparound Program
- Transitional Age Youth (TAY) One-Stop Center
- Older Adult Mobile Outreach and Intensive Case Management

Two other FSP programs, the Forensic Assertive Community Treatment (FACT) and the Assertive Community Treatment (ACT) Team for High Utilizers of Hospital and Jail Services, were implemented in March of 2008. Three additional regional TAY One-Stop Centers became fully operational in June 2008. These programs experienced start-up delays due to the additional time needed for the Request for Proposal (RFP) and contracting process.

The GSD programs implemented during the 2007 calendar year include the:

- Comprehensive Child/Family Support System (CCFSS) which includes,
 - Children's Crisis Response Team Expansion
 - Success First Wraparound Program
- Transitional Age Youth (TAY) One Stop Centers
- Consumer-Operated Peer Support Services and Clubhouse Expansion
- Crisis Walk-In Centers (CWIC)
- Psychiatric Triage Diversion Team
- Case Management Expansion and Senior Peer Counseling Outreach Program

Implementation of the Three Year Community Services and Supports (CSS) plan has progressed as planned. The San Bernardino County Department of Behavioral Health (DBH) continues to use the essential elements of the Mental Health Services Act (MHSA), which include community collaboration, cultural competence, integrated client and family driven services as well as wellness, recovery and resilience-focused programs to aid in a successful transformation of the mental health system's service delivery.

A. Program Services Implementation

1) a) The County is to briefly report by Work Plan how the implementation of the approved programs/services is proceeding. The suggested length for the response for this section is no more than half a page per Work Plan. Small counties may combine Work Plans and provide a comprehensive update in two to three pages.

d) Report on whether the implementation activities are generally proceeding as described in the County's Approved Plan and subsequently adopted in the MHSA Performance Contract/MHSA Agreement. If not, please identify key differences. Describe the major implementation challenges that the County has encountered.

****San Bernardino County has submitted all required quarterly Progress Goals and Reports. Thus, for all programs, the answer to questions 1b and 1c are omitted.**

Work Plan C-1: Comprehensive Child/Family Support System

a) Implementation activities for the **Comprehensive Child/Family Support System (CCFSS)** are proceeding as described in San Bernardino County's approved Community Services and Supports (CSS) Plan. There are two programs under this CCFSS Program.

- The Children's Crisis Response Team
- The Success First Wraparound Program

The **Children's Crisis Response Team (CCRT) Expansion Program** operates 24 hours a day, seven (7) days a week and provides mobile crisis intervention services, respite care for children and families, and crisis and transitional residential treatment alternatives throughout San Bernardino County with the goal of reducing hospitalizations and out of home placements. During calendar year 2007 CCRT provided services to 1,659 individuals throughout San Bernardino County, diverting 979 from needing psychiatric hospitalizations or out of home placements.

In calendar year 2007 the San Bernardino County, Department of Behavioral Health received a National Association of Counties (NACO) award for the Children's Crisis Response Team and was designated "Best of Category", which highlights the most outstanding county model programs submitted to the awards competition. This was one of only 14 such awards conferred on counties across the nation.

The **Wraparound Service Model**, called "**Success First**" began providing services in October of 2007. There are currently six (6) providers covering services to all four (4) regions of San Bernardino County. The CCFSS Program provides in home services to children who do not meet full SB 163 criteria. Since its implementation CCFSS staff has been successful in providing quick responses to crisis calls and as a result has reduced the number of psychiatric hospitalizations and out-of-home placements. Despite its late start-up the Success First program provided wraparound services to 59 children and their families.

d) The blending of the Mental Health Services Act (MHSA) and Medi-Cal funding in this program has challenged the Department of Behavioral Health (DBH) to move beyond traditional business processes for funding mental health services. A particular challenge for CCFSS has been maintaining adequate staffing levels in remote regions of San Bernardino County.

Work Plan TAY-1: Transitional Age Youth (TAY) One Stop Centers

a) Implementation activities for the **Transitional Age Youth (TAY) One Stop Centers**, as described in the Community Services and Supports (CSS) Plan, have proceeded as planned. However, the extensive Request for Proposal (RFP) and contract negotiation process has delayed the implementation of all four (4) regional centers. One center has been fully operational since April 2007 and provided Full Service Partnership services to 88 TAY and System Development services to an additional 246 TAY. The center provides integral services that are both culturally and linguistically appropriate to TAY with significant functional impairment that are high users of acute facilities, homeless, have co-occurring disorders, been incarcerated, institutionalized, and/or recidivists of emergency mental health services. The TAY Center is open seven days a week and provides access to peer counselors through an after hours "warm line" 24 hours a day seven (7) days a week. In addition to a wide range of on site services, individuals have access to e-mail and the Internet for resource information. Partnerships have been established with numerous public and private agencies including community housing providers who assist the One Stop TAY Center program in developing a comprehensive and seamless system of care for this population.

d) One of the unanticipated challenges of implementation of the TAY program is the lack of daycare for infants and toddlers of TAY. The lack of daycare resources limits the ability of parenting TAY to participate in the full range of services. Another unanticipated issue is the lack of access to showers for many homeless TAY.

It should also be noted that the Department of Behavioral Health TAY program also won a NACO award in June 2008 "in recognition of an effective and innovative program which contributes to and enhances county government in the United States."

Work Plan A-1: Consumer-Operated Peer Support Services and Clubhouse Expansion

a) Implementation activities for the **Consumer-Operated Peer Support Services and Clubhouse Expansion Program** are proceeding as described in San Bernardino County's approved Community Services and Supports (CSS) Plan. Consumer-Operated Peer Support Services and Clubhouse Expansion Programs continue to exceed the original target numbers and during calendar year 2007 provided System Development services to 500 consumers.

Clubhouses have used the Mental Health Services Act (MHSA) funding to locate and access numerous community resources, and have invited agencies to make presentations or assisted clubhouse consumers in accessing various resources. These presentations include speakers or representatives in the areas of employment, education such as General Education Degrees (GED) or community colleges, assistance with entitlement benefits, and other services providing recreational and social support activities.

Clubhouses have also assisted consumers with transportation support with the distribution of bus passes and with program vans to take consumers to appointments and/or community events.

The Consumer-Operated Peer Support Services and Clubhouse Expansion Programs have hired 18 consumers to work in various programs. Consumers facilitate support groups and assist with case management. Currently over 75 consumers have attended certified Peer Advocate training programs.

d) The main difficulty in implementation of this program has been the challenge of expeditiously recruiting and hiring staff from various disciplines as well securing adequate building space and supplies for the clubhouse expansions throughout San Bernardino County.

Work Plan A-2: Forensic Integrated Mental Health Services

a) Implementation activities for the **Forensic Integrated Mental Health Services Program** are proceeding as described in the approved Community Services and Supports (CSS) Plan. With the Mental Health Services Act (MHSA) expansion, the Mental Health Court System in San Bernardino County now has four (4) Mental Health Courts. During calendar year 2007 an additional 44 clients received services through the Mental Health Court expansion. This program has created a productive collaboration between the San Bernardino County Superior Court, San Bernardino County Department of Behavioral Health (DBH), the District Attorney's Office, the Public Defender's Office, the Probation Department and a Residential Treatment provider.

The **Crisis Intervention Training (CIT) Program** is being implemented successfully with various law enforcement agencies countywide. DBH and the San Bernardino County Sheriff's Department formed a CIT Committee to develop and standardize policies and procedures in support of the CIT Program after a successful initial CIT training to local law enforcement.

The RFP and contract negotiation process for the **Forensic Assertive Community Treatment (FACT) Program** took place in the latter half of calendar year 2007 and the program opened for services in March 2008. The FACT Program provides intensive case management for individuals with mental illness who have been incarcerated and assists them to live independently in the community. It is also designed to reduce homelessness, further incarceration, emergency room and involuntary mental health care.

d) The implementation challenges include delays in developing contracts for the FACT Program. Longer than expected lead times for contract development and negotiation have slowed progress. However, these challenges were resolved and the program opened for services in March 2008. Access to housing for FACT clients continues to be a challenge due to limited capacity for these clients within communities. The housing shortage is even more severe in the more rural areas of San Bernardino County. There are also capacity issues for co-occurring residential substance abuse treatment facilities, because these services are non-existent in the rural areas San Bernardino County.

Work Plan A-3: Assertive Community Treatment Team (ACT) for High Utilizers of Hospital and Jail Services

a) Although not implemented during calendar year 2007, activities for the **Assertive Community Treatment (ACT) Team for High Utilizers of Hospital and Jail Services Program** are proceeding according to the approved Community Services and Supports (CSS) Plan. The ACT Team Program is designed to provide community-based assertive case management and support, 24 hours a day, seven (7) days per week to 60 seriously and persistently mentally ill (SPMI) clients, who are frequent users of acute psychiatric hospitalization and/or who are caught in the cycle of arrest and release for minor crimes. Many of these clients are homeless and have co-occurring disorders. The RFP began in February of 2007 and the contract was awarded by Fall 2007. Negotiations with the selected contractor were more extensive than expected which delayed the opening of the ACT Team Program in 2007. However, a contract has been signed and the program began accepting referrals in April 2008.

d) Due to longer than expected contract negotiations, the implementation of the ACT Team Program was delayed. In addition, the provider agreed to relocate to a site that is more amenable to clients' needs, which also extended the process further.

Work Plan A-4: Crisis Walk-In Centers (CWIC)

a) Program implementation activities for the **Crisis Walk-In Centers (CWIC)** are proceeding according to the approved Community Services and Supports (CSS) Plan. The plan consisted of establishing a Crisis Walk-In Clinic (CWIC) with a Crisis Stabilization Unit. As a result of this planning process it was determined that there was a need for a 16-bed adult Psychiatric Health Facility (PHF) in the High Desert/Victor Valley area, serving San Bernardino County residents who have psychiatric emergencies, are a danger to themselves/others, and/or are gravely disabled as a result of mental disorders. The PHF is not part of the MHSA CSS plan, but it is an integral component of the plan for the High Desert area.

The CWIC Program is the first phase of this endeavor and provides urgent mental health and resource services 24 hours a day, 7 days a week. The High Desert/Victor Valley CWIC opened on September 13, 2007. It immediately began providing needed services to residents in the High Desert/Victor Valley area. The CWIC in Low Desert/Morongo Basin opened on November 13, 2007. Despite not opening until the latter half of the year both CWICs saw a total of approximately 610 clients, 362 of whom were diverted from being hospitalized as a result of the services provided.

d) A delay in obtaining Medi-Cal certification has been one of the main difficulties in implementing the CWIC Program. Another issue is the lack of transportation for inpatient care. Transportation from CWIC to inpatient hospitals was not originally considered to be an issue for the High Desert/Victor Valley CWIC because of a plan to implement a PHF within the same building. To resolve the transportation issue, the contractor for the CWIC will call upon San Bernardino County Department of Behavioral Health (DBH) staff when transportation is required to an inpatient unit. The contractor and DBH have collaborated to provide a more seamless level of care for consumers requiring assistance with transportation issues.

In the Central Valley region of San Bernardino County, the Crisis Stabilization Unit (CSU) is located at the county hospital, Arrowhead Regional Medical Center (ARMC). The CSU has been providing services since February 2007. A total of 1457 consumers were seen in 2007 at the CSU and it has made an impact in terms of providing an alternative to inpatient hospitalization. San Bernardino County residents who required some stabilization were previously hospitalized. Now there is now an alternative to hospitalization. As with other counties, San Bernardino County has been challenged with reconciling the current regulations with respect to having an outpatient service on an inpatient unit. DBH is working with the Department of Mental Health (DMH) and the Department of Public Health (DPH) to find an appropriate solution that is consistent with MHSA principles.

Work Plan A-5: Psychiatric Triage Diversion Team at County Hospital

a) Implementation activities for the **Psychiatric Triage Diversion Team Program** are proceeding according to the approved Community Services and Supports (CSS) Plan. The goal of the plan was to provide culturally competent screening and diversion of clients who present at ARMC's emergency room due to homelessness, co-occurring disorders, recent release from incarceration, and/or medical conditions, but who may not be in actual need of hospitalization. The targeted goal of the program was to serve 300 adults annually. However, the Psychiatric Triage Diversion Team, located at ARMC has far exceeded its original annual goal as described in the approved CSS Plan. For the 2007 calendar year, the Psychiatric Triage Diversion Team saw a total of 2,401 clients. Of the total number of clients, 1,455, received a culturally competent screening, were diverted and linked to more appropriate lower levels of care, thus avoiding unnecessary hospitalization. Efforts are being made to continually expand the Psychiatric Triage Diversion Program's resource options (clinics, outreach, drug rehabilitation centers, and housing), including culturally specific services for the clients being seen. Service days have been expanded to 365 days a year. Additionally, services are available from 6:00 a.m. until 10:00 p.m. several days a week. It is anticipated that additional hours will be available as more staff are added to address the needs of the volume of clients accessing the Psychiatric Triage Diversion Team Program. It should be noted that an Amendment to utilize growth funds to expand this program recently received approval by the State Department of Mental Health (DMH).

d) There was a need to add more staff than was anticipated in the approved CSS Plan due to the higher than expected number of clients being served. Staff members have been borrowed from other programs, in order to meet the demands of the Psychiatric Triage Diversion Program. This challenge was addressed by requesting an expansion to this program which was included in the Performance Contract Amendment Proposal submitted to the State on November 26, 2007 and approved on March 19, 2008.

Work Plan OA-1: Circle of Care: Case Management Expansion and Senior Peer Counseling Outreach

a) Implementation of the **Case Management Expansion and Senior Peer Counseling Outreach Program** is proceeding as described in the approved Community Services and Supports (CSS) Plan. Case management staff is in place to service the East Valley, West Valley, High Desert and Low Desert Regions. Additionally, the Mental Health Education Consultant has established rapport throughout San Bernardino County through outreach, education and other activities. Treatment staff has been serving clients in the extended regions since November 2006. The Case Management Expansion and Senior Peer Counseling Outreach Program exceeded its target goals for 2007 and provided System Development services for 285 consumers. It is anticipated that targeted goals will be exceeded for 2008. All components of the program have been implemented.

d) One of the main implementation challenges has been the recruitment and hiring of experienced staff that specialize in providing effective mental health treatment to the older adult population. However, San Bernardino County Department of Behavioral Health (DBH) is working closely with the San Bernardino County Human Resource Department in seeking and identifying qualified potential candidates.

Work Plan OA-2: Circle of Care: Mobile Outreach and Intensive Case Management

a) Implementation of the **Mobile Outreach and Intensive Case Management Program** proceeded as described in the Community Services and Supports (CSS) Plan. However, the program start date was delayed due to the recruitment and hiring of staff with specialized training to work with older adults. In spite of these challenges DBH succeeded in hiring a small treatment team, including a clinic supervisor, two clinical therapists, a mental health nurse, a mental health education consultant and an office assistant. As a result the Mobile Outreach and Intensive Case Management Program began providing services in June 2007. One of the primary goals of early implementation was to educate the surrounding community regarding program services which was provided through extensive Outreach and Engagement (OE) activities.

Intensive staff training was also provided prior to implementing System Development services. In calendar year 2007 54 individuals received System Development (SD) services. The implementation of SD services amplified the need for Full Service Partnership (FSP) services, therefore, the FSP program followed shortly and in calendar year 2007. Eight (8) consumers received FSP services in calendar year 2007. The **Mobile Outreach and Intensive Case Management Program** now has one mobile unit and one FSP team. Recruitment and hiring of additional staff to work in this non-traditional service delivery model continues to be a challenge.

d) One implementation challenge was the lack of qualified applicants, from a variety of mental health disciplines, to work with this specialized population which delayed start up of services. Another challenge was finding a centralized location which provided adequate space for the treatment team.

2) For each of the six general standards in the California Code of Regulations, Title 9, Section 3320, very briefly describe one example of a successful activity, strategy or program implemented through CSS funding and why you think it is an example of success e.g. what was the result of your activity. Please be specific. The suggested length for the response to this section is three pages total (or one page for small counties).

a) Community collaboration between the mental health system and other community agencies, services, ethnic communities, etc.

Work Plan A-2: Forensic Integrated Mental Health Services

The successful implementation of additional Mental Health Courts throughout San Bernardino County was made possible through the collaboration of the San Bernardino County Superior Courts, San Bernardino County District Attorney's Office, San Bernardino County Public Defender's Office, San Bernardino County Sheriff's Department, San Bernardino County Department of Behavioral Health (DBH) and San Bernardino County Probation Department. The **Forensic Integrated Mental Health Services Program** has made it possible to successfully screen a larger number of inmates at the West Valley Detention Center for possible entrance into Mental Health Court. Additionally, with the consultation of the District Attorney, Pubic Defender, and the Superior Court, DBH is identifying inmates with mental illness who could benefit from participating in Mental Health Court and are interested in getting additional voluntary treatment and avoiding penalties in the criminal justice system.

Upon enrollment in Mental Health Court, clients benefit from the collaboration between the residential substance abuse treatment providers, San Bernardino County Department of Behavioral Health's Treatment Team, and San Bernardino County Probation Department. A Parole Officer from the Probation Department serves on the treatment team. The Mental Health Court Judge provides regular review with the client in the Mental Health Court, and assists the treatment team in empowering the client in their recovery.

b) Cultural Competency

Work Plan OA-2: Circle of Care: Mobile Outreach and Intensive Case Management

The Older Adult **Mobile Outreach and Intensive Case Management Program** has a cultural competent staff which serves a diverse clientele from varied ethnic and cultural communities throughout the San Bernardino County. Recently an elderly Latino woman who was living in a homeless shelter following the death of her husband and son made a crisis call. She spoke only Spanish. She had been evicted from her home because she could not afford the mortgage on her Social Security alone. A bilingual case manager was able to communicate with her and identify her needs. The case manager assisted her in completing an application for Section 8 Housing, supported her move towards permanent housing, while addressing her loss issues and helping her access the necessary community resources she needed to live independently in the community. These steps alleviated a lot of her stress and anxiety. This scenario is an example of how the Mobile Outreach and Intensive Case Management Program is partnering with other agencies to meet the needs of older adults in a cultural and linguistic manner. Provision of intensive case management services and linkage with other

agencies to initiate a plan for permanent housing, in a supportive environment which considered her cultural needs, made a positive impact on her recovery.

Many older adult consumers live in remote communities and are isolated, with little support, so it is imperative that they have quick access to resources that will address their immediate needs. Having Mobile Outreach and Intensive Case Management Program staff that can address their cultural and linguistic needs and provide them with the individualized services they need is crucial to the success of the Older Adult **Mobile Outreach and Intensive Case Management**.

c) Client/Family Driven Mental Health System

Work Plan A-1: Consumer-Operated Peer Support Services and Clubhouse Expansion

The **Consumer-Operated Peer Support Services and Clubhouse Expansion Program** has two full-time Peer and Family Advocates (PFA) who assisted in establishing the Department of Behavioral Health (DBH) Office of Consumer and Family Affairs (OCFA). One PFA represents a consumer and the other a family member. Both play a major role in overall operations of DBH by attending all major committees, task forces and planning groups to provide consumer/family input and advocacy. The OCFA staff has been instrumental in assisting consumers and family members overcome bureaucratic obstacles and receive services in a more effective and efficient manner. They also contribute to implementing customer friendly policies and procedures by providing input and feedback at DBH planning and executive meetings.

Another function of the OCFA staff is to attend monthly meetings with the DBH PFA staff where issues relating to successful integration into the workforce are discussed. They also participate in PFA trainings and are instrumental in developing workshops for DBH and contract staff relating to wellness, recovery and resiliency. The PFAs continue to attend weekly meetings with the Director of DBH to discuss issues relating to the implementation of the Recovery Model.

d) Wellness/recovery/resiliency focus

Work Plan A-1: Consumer-Operated Peer Support Services and Clubhouse Expansion

The **Consumer-Operated Peer Support Services and Clubhouse Expansion Program** is truly an example of services that represent the philosophy of wellness, recovery and resiliency. The Consumer-Operated Peer Support Services and Clubhouse Expansion Program has established daily rosters of peer support, education, socialization, and daily living skills groups which focus on topics aimed at providing consumers with the skills and knowledge to access the resources they need to live independent and satisfying lives within their own communities. Other groups that are made available via the Clubhouse Program include:

- Money Management,
- Stress Reduction,
- Communication Skills, and
- Building Support Systems.

All the groups provide resiliency focused activities and are held daily at various Clubhouses. The Peer Support staff have begun the process of assisting all the Clubhouse members in developing personal plans and in identifying goals and adjunctive resources needed to increase his/her integration in the community.

e) Integrated services experience for clients and families: changes in services that result in services being seamless or coordinated so that all necessary services are easily accessible to clients and families.

Work Plan C-1 Comprehensive Child/Family Support System

The **Comprehensive Child/Family Support System (CCFSS) Program**, which includes the **Children’s Crisis Response Team (CCRT)** and the **Success First Wraparound Program**, utilizes blended funding to support integrated services which create a seamless and coordinated system of care. These blended services eliminate the need for children and families to negotiate multiple agencies and/or programs to access necessary services. The concept of blending programs and funding sources enables the programs included in the CCFSS work plan to truly embrace the “whatever it takes” philosophy of the Mental Health Services Act.

The **Success First Wraparound Program** brings intensive wraparound services to children and families who are not eligible for full SB 163 wraparound services. Many service systems offer intensive services only after a “child fails first”. As a result, the child’s functioning worsens and the family system experiences high levels of strain as they attempt to get services that are only accessible after multiple events bring the child to the attention of a legal or protective service system. The early wraparound program has adopted the name “**Success First**” to reflect the new approach San Bernardino County is taking in the provision of services to the unserved, underserved, and inappropriately served children and families in San Bernardino County.

Partnering agencies, such as hospitals, Child Protective Services, probation, and other community partners make referrals without having to demonstrate the failure of services to help the child and family. In other words, utilizing blended funding to support Full Service Partnerships allows the CCFSS Program to embrace a success first approach rather than a failure first approach in the provision of a full spectrum of services. As a result, this program has been successful in transforming access to the mental health system.

Six (6) providers cover services all four (4) regions of San Bernardino County, from our urban centers to remote desert and mountain locations. Due to

tremendous community response to the “**Success First**” Program, and despite a delayed start-up, it is anticipated the target enrollment of 203 children will be met in FY 2007-2008.

3) For the Full Service Partnership Category Only

a) If the County has not implemented the SB 163 Wraparound (Welfare and Institutions Code, Section 19250) and has agreed to work with their county department of social services and the California Department of Social Services toward the implementation of the SB 163 Wraparound, please describe the progress that has been made, identify any barriers encountered, and outline the next steps anticipated.

San Bernardino County has implemented a Wraparound program.

b) Please provide the total amount of MHSA finding approved as Full Service Partnership funds that was used for short-term acute inpatient services.

No Mental Health Services Act (MHSA) funding was approved for FSP funds to be used for short-term acute inpatient services.

4) For the General System Development category only, briefly describe how the implementation of the General System Development programs have strengthened or changed the County’s overall public mental health system. If applicable, provide an update on any progress made toward addressing any conditions that may have been specified in your DMH approval letter.

Implementation of the **Consumer-Operated Peer Support Services and Clubhouse Expansion Program** under the System Development category has significantly changed the direction of the Behavioral Health Service Delivery System toward a Wellness, Recovery and Resilience Model. Eighteen (18) consumers/family members were hired under this program and have assisted hundreds of peers to connect with Clubhouses and/or attend various outreach activities which has increased consumer integration in the community. Also implemented under this program is the new Office of Consumer and Family Affairs (OCFA). The OCFA has hired a consumer and a family member as Peer and Family Advocates (PFA). The PFAs sit on all major Department of Behavioral Health (DBH) committees and/or task forces and report to the Director of DBH on Recovery Model implementation progress. The results of the **Consumer-Operated Peer Support Services and Clubhouse Expansion Program** have provided a tremendous increase in the collaboration of consumers/family members and DBH administrative and treatment staff in providing services that support recovery and provide many more opportunities for employment, education, housing and community involvement.

The primary goal and objective of the **Crisis Walk-In Centers (CWIC)** is to reduce hospitalizations and to adhere to the recovery principle of “whatever it takes,” in order to stabilize clients and keep them in the communities where they have family and social support. It is recognized that there is a high co-occurrence of substance abuse with mental illness, and in response, the CWIC Program provides integrated substance abuse treatment services for co-occurring clients. The CWIC Program offers urgent mental health services to acute and sub-acute mentally ill individuals. Services include crisis intervention, crisis risk assessments, medications, substance abuse counseling, case management, referrals to DBH and/or contract clinics, family support and education, transportation, and 24 hour crisis stabilization. The CWIC staff provides direct linkage to the **Assertive Community Treatment (ACT) Team for High Utilizers of Hospital and Jail Services Program**, residential drug/alcohol programs, DBH programs, community based agencies, housing and employment programs. All services are provided in a culturally, linguistically, and developmentally competent manner. The goals for the CWIC program are soundly based in recovery principles using less restrictive settings, client driven treatment delivery, and client support systems. With regard to children and adolescents, CWIC provides evaluation and support services to this population and coordinates with DBH’s **Children’s Crisis Response Team (CCRT)** which provides mobile crises services.

Implementation of the **Psychiatric Triage Diversion Team Program** at Arrowhead Regional Medical Center has also changed the mental health services system by allowing DBH to provide the most appropriate alternative levels of care and link clients to alternative resources; thus, avoiding unnecessary hospitalization while continuing to provide clients with quality care.

The CCRT provides crisis intervention services wherever the child is located, 24 hours a day, seven (7) days a week. Families are able to reach a mental health worker by phone 24 hours a day. The CCRT Unit provides mobile crisis services, resource referrals and linkages to help children and families access the most appropriate levels of care. CCRT has improved the overall mental health service system for families by making services more accessible, personable and convenient. Case managers provide follow up services that include facilitating appointments, transportation for children and caretaker to service providers, and introducing the children and caretaker to the providers.

The **Transitional Age Youth (TAY) One Stop Centers** have increased access to mental health services for the TAY population who otherwise would not have been eligible or able to access available services. The 24 hours a day, seven (7) days a week access has successfully diverted TAY from hospitalization and incarceration. Collaboration with other San Bernardino County departments, include the Workforce Development Department, which provides employment and training resources, Department of Children’s Services, Probation Office, Department of Public Health, Superintendent of Schools, Children’s Network, and

Children's Fund as well as other community based agencies such as Job Corps, Planned Parenthood, Rainbow Pride and Youth Alliance, Victory Outreach, Salvation Army, Goodwill and the National Alliance on Mental Illness (NAMI) just to name a few have made this a very successful example of community collaboration. All these agencies have contributed to provide TAY with a comprehensive array of services and resources which are tailored to their individual needs.

San Bernardino County's mental health system has been strengthened by the Older Adult **Circle of Care: Case Management Expansion and Senior Peer Counseling Outreach Program** which consistently maintains its focus on addressing the mental health needs of the older adult population throughout San Bernardino County. The program has developed a successful referral program which facilitates access to a variety of services and provides older adults with the ability to contact DBH and receive courteous and professional services which are culturally competent and specific to their needs. Presentations are made to the public regarding available services for older adults. Requests continue to be received for presentations from various organizations. Additionally, individuals and family members have the ability to contact program staff for services and referrals directly.

The Older Adult **Mobile Outreach and Intensive Case Management Program** has proven to be effective in reaching unserved older adults who are homeless and/or in crisis. The Mobile Outreach Team staff members visit senior centers, parks, hospital emergency rooms, homeless encampments and other sites to locate older adults in need of mental health or other services. The outreach services provided to older adults have enabled them to become stabilized on their medication, obtain necessary health care and remain in (or obtain) stable housing thus preventing numerous hospitalizations and institutional placements.

B) Efforts to Address Disparity – The suggested response length for this section is three pages (or one page for small counties).

1) Briefly describe one or two successful current efforts/strategies to address disparities in access and quality of services to unserved or underserved populations targeted in the CSS component of your Plan. If possible, include results of your efforts/strategy.

The Department of Behavioral Health (DBH) has established three (3) Multicultural Coalitions with ethnic minority community groups: African-American, Latino, and Native-American, which include the involvement of consumers, families, and/or community stakeholders. There are current efforts in place to establish similar coalitions with members of the Asian-American and Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) communities, as well. These Multicultural Coalitions represent priority target populations and are a result of outreach efforts to engage the unserved and underserved ethnic-

minority/multicultural communities within San Bernardino County. Members of these coalitions have provided assistance in identifying mental health needs within their communities, as well as, providing information regarding culturally appropriate strategies to address identified disparities. These coalitions are strengthening relationships between DBH and unserved and underserved communities, as well as, opening up communication avenues that have not previously existed.

DBH has offered comprehensive multicultural trainings (quarterly) to staff and contractors in an effort to increase multicultural knowledge, sensitivity, and awareness. The training provided was the California Brief Multicultural Competency (Scale-Based) Training (CBMCS). The CBMCS Multicultural Training is an evidenced-based, nationally renowned curriculum published by Sage Publications. The training has resulted in the assessment of staff's level of cultural competence in the following areas: Multicultural Knowledge, Sensitivity to Consumers, Awareness of Cultural Barriers and Sociocultural Diversity. 7% of our DBH direct service providers have completed this training, in addition to 25 contract agency staff members who have completed between one (1) to four (4) modules of the training. The development of a Cultural Competency Training Team has been implemented, as well. We have established a team of six (6) certified CBMCS trainers (1 Master Trainer and 5 Resident Trainers), with an additional eight (8) individuals in progress for certification. Efforts to provide the CBMCS Multicultural Training to both DBH and contract agency staff are ongoing.

DBH bilingual staff members have attended the National Latino Behavioral Health Association's (NLBHA) Mental Health Interpreter's Training Program. The Mental Health Interpreter's Training Program is the only one of its kind in the industry of mental health interpretation and translation. We have provided this training annually, and 28% of our DBH bilingual staff members have completed this training to date. This training program is increasing the knowledge, proficiency and skill of bilingual staff providing interpretation services on behalf of consumers. Additionally, we have established quarterly meetings with trained interpreters in an effort to broaden their knowledge and skill, and evaluate the processes for delivering interpretation services to the consumers, with the goal of improving access to quality mental health care for those of limited English proficiency (LEP).

Finally, DBH has participated in targeted outreach with the Spanish-speaking community through the provision of three (3) educational presentations broadcasted through "Radio Mexico", as well as providing educational materials and resource information to community members participating in various health fairs throughout the vast San Bernardino County region.

2) Briefly describe one challenge you faced in implementing efforts/strategies to overcome disparities, including where appropriate what you have done to overcome the challenge.

One of the primary challenges in establishing the Multicultural Coalitions is the historic distrust of governmental agencies based on the history of oppression, neglect and discrimination that various cultural/ethnic groups have experienced. Efforts to overcome these factors include persistent engagement and dialogue with key community stakeholders and cultural coalitions.

3) Indicate the number of Native-American organizations or tribal communities that have been funded to provide services under MHSAs and what results you are seeing to date, if any.

A coalition of various tribal councils including, but not limited to, Dakota, Apache, Kiowa, Yaqui, LaKota and Gabrieleño/Tongva was funded to conduct an integrated health and mental health survey to identify the needs of the various tribes that reside in the Inland Empire area of Southern California. The results of the survey are being utilized to develop a proposal for an American Indian Resource Center. Extensive outreach and engagement (e.g. frequent communication and relationship building, coordination meetings between the Department of Behavioral Health and the tribal coalition, attendance at tribal meetings, and assistance with technical support) has continued with key cultural brokers in the American Indian community. Outreach efforts continue to strengthen the communication between this population of unserved individuals and County of San Bernardino Department of Behavioral Health.

4) List any policy or system improvements specific to reducing disparities, such as the inclusion of linguistic/cultural competence criteria to procurement documents and/or contracts.

As a result of continuous monitoring of available San Bernardino County and regional data, consumer input, and consumer family requests and preferences, San Bernardino County Department of Behavioral Health is continuing in efforts to develop and refine policies and procedures related to cultural competence. An example of this is the refinement and development of policies and procedures, which include Evaluation of Culturally Competent Service Delivery Policy, Bilingual Capacity Testing Policy (pending), inclusion of Cultural Competency requirements in the Education and Training Policy, Satisfying Consumer Language Needs Policy, Translation of Written Materials Policy and Procedures, and the development of Guidelines and Strategies To Integrate Cultural Competency Into Training Curriculum.

Additionally, adherence to “Cultural and Linguistic Competency” standards continues to be included in Contract Requirements for Requests for Proposals for behavioral healthcare services.

C) Stakeholder Involvement:

As counties have moved from planning to implementation many have found a need to alter in some ways their Community Program Planning and local review processes. Provide a summary description of any changes you have made during the time period covered by this report in your Community Program Planning Process. This would include things like addition/deletion/alteration of steering committees or workgroups, changes in roles and responsibilities of stakeholder groups, new or altered mechanisms for keeping stakeholders informed about implementation, new or altered stakeholder training efforts. Please indicate the reason you made these changes. The suggested response length for this section is two pages (or one page for small counties).

Community Planning Process

From the inception of the Mental Health Services Act (MHSA), San Bernardino County Department of Behavioral Health (DBH) has made it a priority to engage consumers, family members, and the community at large in the Community Services and Supports (CSS) planning and implementation process. From January 2007 to December 2007 the membership of steering committees and work groups have remained consistent and steady. Efforts continue to be made to strengthen our stakeholder groups by engaging those ethnic and cultural populations from unserved, underserved and inappropriately served populations throughout San Bernardino County. As a result of those efforts DBH has made significant inroads towards involving the African-American and Native-American communities in the decision-making and planning process of developing additional community based programs.

The MHSA Workgroups, comprised of mental health program staff as well as community members, service providers, consumers and family members, in collaboration with the MHSA Coordination Team, continued to work towards completing the implementation process for the nine (9) programs in San Bernardino County Community Services and Supports (CSS) Plan. Open and continued dialogue with the community stakeholders was maintained, which included frequent feedback and participation in the decision making at each stage of the ongoing planning and implementation process. The following are the six (6) major stakeholder groups which oversee San Bernardino County’s MHSA Implementation:

1. **MHSA Executive Planning Group**

This group, of approximately 25 members, which began meeting in 2005, consists of CSS work group chairs, DBH staff as well as consumer and family members. The MHSA Executive Planning Group, which is chaired by the Director

of DBH and meets weekly, is a decision making body which deals with the “nuts and bolts” of MHSA implementation. It oversees the planning of MHSA and provides guidance and support to the CSS implementation process. Some stakeholders and family members who attend State stakeholder meetings also provide updates that are helpful in addressing various implementation issues.

2. Community Policy Advisory Committee

The Community Policy Advisory Committee (CPAC) established early in the CSS planning phase, is comprised of 79 representatives from 36 key agencies/organizations from public and private systems, including mental health, law enforcement, education, social services, health care system, courts, consumers and family members, community based organizations, contractors, members of various ethnic and cultural groups as well as other providers and community stakeholders. It is co-chaired by the Director of DBH and a consumer, who also is a member of the San Bernardino County Mental Health Commission, and meets monthly for MHSA program implementation updates from various work group chairs. It also reviews MHSA legislation and other State updates, as well as provides final review, feedback and approval of new MHSA plans and programs.

3. MHSA Workgroup Chairs

The MHSA Workgroup Chairs Meeting meets as needed and is comprised of MHSA age-specific workgroup chairs and contract agency staffs that are responsible for implementing MHSA CSS funded programs. The primary focus is on discussing and developing effective strategies to resolve implementation challenges.

4. Association of Community Based Agencies Meeting

The Association of Community Based Agencies (ACBO) meets monthly. It is co-chaired by the Director of DBH and the ACBO Chairperson. The ACBO Committee includes ACBO members and the Department of Behavioral Health’s administrative staff. It is a collaborative forum to discuss and plan for the successful delivery of recovery based mental health services. MHSA State updates and the progress of local MHSA planning and implementation is a standard agenda item at this meeting.

5. Housing Policy Advisory Committee

The Housing Policy Advisory Committee (HPAC), which was established to develop the MHSA Housing Plan, meets monthly. It is comprised of various agencies and service providers who provide housing resources as well as community stakeholders, consumers and family members. The group is co-chaired by DBH’s Housing Manager and a Project Manager from the Corporation for Supportive Housing who is contracting with DBH to assist with the development of the MHSA Housing Plan.

6. Mental Health Commission

The Mental Health Commission (MHC) meets monthly. It is comprised of 15 members who are appointed by the County of San Bernardino Board of Supervisors and represent the five (5) supervisorial districts. The MHC has been actively involved in the planning and implementation of the CSS Plan as well as the other components of MHSAs. During each meeting they receive updates on the County's MHSAs implementation as well as ongoing status reports on the various CSS programs.

In addition to the above-mentioned ongoing meetings the Community Outreach and Education (CORE) Unit, a program within the Office of Program Planning and Development (OPPD), has focused their efforts outreaching to community members and organizations through their involvement in various ethnic specific coalitions that include Native-Americans, Latinos, African-Americans and Asian-Americans. The CORE Team has also assisted in creating some alliances which has resulted in increased trust, open communication and active participation amongst key community leaders and DBH. During these partnership meetings, CORE has had the opportunity to be placed on the agenda to specifically talk about the nine (9) approved programs of the CSS plan. Program specific information and access to resources were shared. Through these efforts CORE has had the opportunity to establish relationships with the following unserved/underserved populations in San Bernardino County that include Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ), Faith-Based Organizations, Community-Based Organizations, Veterans Association, school districts, children, transitional aged youth (TAY), adults and older adults. CORE has utilized participation in these various collaboratives as an opportunity to obtain feedback from community members and leaders to assist in identifying community mental health needs. The age-specific CSS programs have also hired outreach staff who attend children, TAY, adult and older adult meetings and coalitions. These staff also work in collaboration with other agencies, such as social services, public health, mental health, primary health care agencies, school districts, community based organizations, law enforcement, the justice system as well as consumer and caregiver advocacy groups. In addition, the forensic outreach staff meets with San Bernardino County Sheriff's, Police and Probation Departments where the implementation of the **Crisis Intervention Team (CIT) Program** (one of our CSS programs) is discussed. These staff members provide ongoing updates to stakeholders regarding the programs being developed to serve specific populations, as well as the status of other related CSS programs which serve as resources.

Consumers and family members continue to play an important role in assisting the outreach staff to reach the broad stakeholder base. DBH plans to develop an "Expert Pool" comprised of consumers and family members to function in an advisory capacity as well as assist program and outreach staff to develop and implement more effective outreach tools to engage the diversified stakeholders in San Bernardino County.

D) Public Review and Hearing:

Provide a brief description of how the County circulated this Implementation Progress Report for 30-day public comment and review period including the public hearing. The statute requires that the update be circulated to stakeholders and anyone who has requested a copy. The suggested response length for this section is two pages (or one page for small counties). This section should include the following information.

1) Dates of the 30-day stakeholder review and comment period, including the date of the public hearing conducted by the local mental health board of commission. (The public hearing may be held at a regularly scheduled meeting of the local mental health board or commission.)

2) The methods that the county used to circulate this progress report and the notification of the public comment period and public hearing to the stakeholder representatives and any other interested parties.

3) Summary and analysis of any substantive recommendations or revisions.