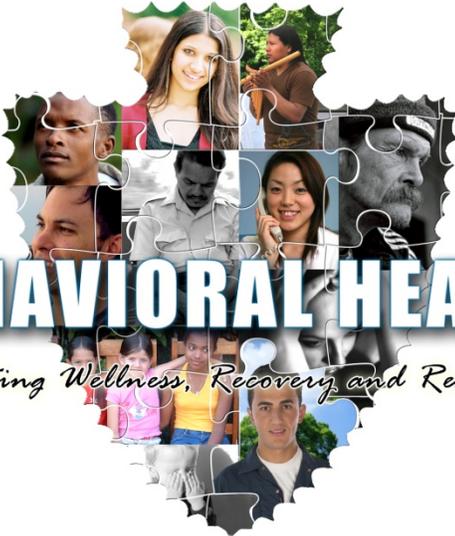


**County of San Bernardino**  
Department of



**BEHAVIORAL HEALTH**

*Promoting Wellness, Recovery and Resilience*

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

**Innovation Plan**

**December 1, 2009 (DRAFT)**

**Innovation Plan Mental Health Services Act  
San Bernardino County**

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**County of San Bernardino  
Department of Behavioral Health  
Mental Health Services Act  
Innovation Component  
Executive Summary**

The voters of the State of California passed the Mental Health Services Act (MHSA) in November 2004. The purpose and intent of the MHSA is **“to reduce the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness...to insure that all funds are expended in the most cost effective manner...to ensure accountability to taxpayers and to the public”**. To accomplish this purpose, funding is provided to adequately address the mental health needs of unserved and underserved populations by expanding and developing services and supports that have proven to produce successful outcomes, are considered to be innovative, cultural and linguistically competent, community based, consumer and family oriented, and consistent with evidence-based practices. MHSA represented the first opportunity in many years for the California Department of Mental Health (DMH) to provide increased funding, personnel and other resources to support county mental health programs and monitor progress toward statewide goals for children, transition age youth, adults, older adults and families.

The MHSA identifies six components for funding that work to transform the mental health services system and that will eventually be integrated into the county’s Three-Year Program and Expenditures Plan. These MHSA Components include:

- Community Program Planning
- Community Services and Supports
- Capital (buildings & housing) and Information Technology
- Workforce Education and Training
- Prevention and Early Intervention
- Innovation

Through the MHSA, government agencies have the responsibility and commitment to ensure that the community has input and is actively involved in the development and implementation of MHSA Component programs at every step of the process. The County of San Bernardino has embraced the opportunities for collaborating with community stakeholders since Community Program Planning for the Community Services and Supports Component began in early 2005. The County’s growing community stakeholder coalition has continuously viewed the various MHSA components as tools for system transformation and each Component another building block toward integration.

The formal guidelines for Innovation are less prescriptive than for the other MHSA components. “Any Innovation will form an environment for development of new and effective practices and/or approaches in the field of mental health.” (Guidelines for the Innovation Component). Innovation projects must contribute to learning and be developed within the community through a process that is inclusive and representative, especially of unserved, underserved and inappropriately served populations.

A culturally diverse population enriches the County of San Bernardino. Latinos constitute 51% of the population; African-Americans account for 10%. There is a growing and diverse population of Asian-Pacific Islanders at 5%, and a small but active population of Native American/Tribal communities (1%). Additionally, through the Community Program Planning process the LGBTQ community and military veterans and their families were also identified as unserved, underserved or inappropriately served. Another challenge to the provision of service is the size of the County. Encompassing 20,105 square miles, San Bernardino County has urbanized areas as well as large and sparsely populated mountain and desert areas. It is in the mountains and deserts where “physical” access to mental health education and services is limited. Within these areas, stakeholders have identified regional “cultures” which also may inform strategies for enhancing access to service. For these reasons, articulated thoughtfully by stakeholders during the Innovation Community Program Planning process and in prior Community Program Planning processes, these populations have been included as ones the County will specifically target for the Innovation component.

The County of San Bernardino conducted an extensive Community Program Planning process throughout the implementation of the MHSA components and Innovation is no exception. In the fall of 2008, the County’s Community Policy Advisory Committee (CPAC) approved the establishment of the Innovation Working Committee (IWC). Beginning with a careful review of the Innovation policy, principles and priorities the Innovation Working Committee dedicated itself to building on prior stakeholder input received during the Community Services and Supports and the Prevention and Early Intervention components as well as to solicit new input specifically for the Innovation component.

Throughout the stakeholder engagement process, each of the “target” communities have been acknowledged as experiencing access challenges that can be addressed in innovative ways, have shared ideas regarding mental health system relevance and are committed to coalition building around existing resources and needs.

Our stakeholders are committed to addressing disparities in access to service for the County’s ethnic and cultural communities, to developing effective mental health education strategies throughout the County’s diverse communities, to tapping into strengths in our diverse communities, to partnering in crisis and self-help modes, to collaboratively addressing “hidden” and vulnerable populations of

children and youth, and to testing and learning from strategies that are adaptable to our county's "specialty" communities.

Emerging from this process, four (4) projects were chosen for implementation under the Innovation component.

- On-Line Diverse Community Experiences
- Coalition Against Sexual Exploitation (CASE)
- Community Resiliency Model
- Holistic Campus

The chart on the following two pages gives a brief overview of each of the projects with budget information:

**County of San Bernardino**  
**Summary of Innovation Component Projects with Budget Information**

<b>Project Title</b>	<b>Project Description</b>	<b>Project Details</b>	<b>Budget Item</b>	<b>Budget Year 1</b>	<b>Budget Year 2</b>	<b>Budget Year 3</b>
<b>On-Line Diverse Community Experience</b>	This project will use popular Internet social networking sites as a model for the distribution of mental health information and resources. Consumers from our diverse cultures and communities will have the ability to access this information and to establish their own “friends” and “groups”, they will have the ability to share with others experiencing the same issues and concerns. One of the many things we hope to learn from this project is how the interaction on the sites will transform the understanding of mental health challenges and promote wellness, recovery and resilience.	Establish sites on Internet sites such as Twitter, Facebook and MySpace.  Provide mental health information, resources, and links to relevant sites on each site.  Provide computer training to consumers to help them access the Internet and how to “post” information on the sites.	Personnel	\$30,000	\$30,000	\$0
			Operating Expenditures	\$9,750	\$9,750	\$0
			Non-Recurring Expenditures	\$7,500	\$7,500	\$0
			<b>Total Expenditures</b>	<b>\$47,250</b>	<b>\$47,250</b>	<b>\$0</b>
<b>Coalition Against Sexual Exploitation (CASE)</b>	CASE will strive to develop and test a collaborative model of interventions and services for diverse children to reduce the numbers drawn into prostitution and exploited. This model will address outreach, education, interventions, outcome measures and ongoing planning. The long-term learning goal is to make use of an innovative collaboration to strengthen clinical practice for those who serve sexually exploited children by developing creative clinical strategies and combining existing best practices in trauma care with local clinical expertise.	Work with existing CASE members to develop collaborative model for Multidisciplinary Team (MDT) to use with sexually exploited minors.  Develop training for those who work with sexually exploited minors.  Establish MDT  Develop and implement collaborative outreach and education strategy	Personnel	\$0	\$483,212	\$483,212
			Operating Expenditures	\$0	\$287,661	\$287,660
			Training Consultant Contracts	\$0	\$125,000	\$125,000
			<b>Total Expenditures</b>	<b>\$0</b>	<b>\$895,873</b>	<b>\$895,872</b>

Project Title	Project Description	Project Details	Budget Item	Budget Year 1	Budget Year 2	Budget Year 3
<b>Community Resiliency Model (CRM)</b>	Through the CRM project, the County will develop a model for use by diverse ethnicities, communities and unserved underserved populations to address personal and community traumatic events through the provision of training to cultural brokers, who in turn will provide training in their communities. The County hopes to strengthen linkages and collaboration with diverse cultures and communities.	Develop the Community Resource Model.	Personnel	\$26,667	\$26,667	\$26,666
		Provide training on CRM to 50 diverse community members (cultural brokers) and receive input from them on content and relevance.	Operating Expenditures	\$284,511	\$8,317	\$8317
		Provide training in the community by cultural brokers.	Training Consultant Contracts	\$169,530	\$136,530	136,530
		Identify the need for and provide additional training to cultural brokers.	Training Materials	\$0	\$3,140	\$3,140
			<b>Total Expenditures</b>	<b>\$480,708</b>	<b>\$174,654</b>	<b>\$174,653</b>
<b>Holistic Campus</b>	The Holistic Campus brings together all of the County's diverse cultures and communities in one location to provide culture specific healing techniques as well as addressing the myriad needs of those individuals who seek information and help at the Holistic Campus. One thing we hope to learn from the Holistic Campus is how people from diverse communities and ethnicities can learn from each other and how they work together.	Establish Advisory Board of Directors from the community.	Personnel	\$0	\$463,634	\$463,634
		The Holistic Campus will be at least 80% peer operated.	Operating Expenditures	\$0	\$409,715	\$408,532
		Identify, contract for and provide culture specific services (acupuncture, pet therapy, sweat lodges, etc.) at the holistic Campus for the community.	Non-Recurring Expenditures	\$0	\$23,665	\$0
			<b>Total Expenditures</b>	<b>\$0</b>	<b>\$897,014</b>	<b>\$872,166</b>

These four (4) Innovation projects represent the County of San Bernardino's response to the Mental Health Services Act Innovation component. Throughout the Community Program Planning Process, our stakeholders attempted to simultaneously address the issues of disparity in access, cultural competence, and specialty population issues that have emerged by considering strategies and resources that could be adapted to a variety of stakeholder communities, settings and concerns. The County of San Bernardino chose these four (4) concepts because they reflect many of the issues, ideas, strategies and design suggestions discussed throughout the process and identified as relevant to our diverse communities.

The Innovation Plan was presented to the Innovation Working Committee on XX-XX-XXXX. The final draft of the plan was presented to the Community Policy Advisory Committee on XX-XX-XXX and to the Mental Health Commission on XX-XX-XXXX. The thirty-day public comment period began on December 1, 2009 with the posting of the plan on the Department of Mental Health website at <http://www.sbcounty.gov/dbh/MentalHealthServicesAct.htm>.

**EXHIBIT A**

**INNOVATION WORK PLAN  
COUNTY CERTIFICATION**

**County Name:** San Bernardino

**County Mental Health Director**

**Project Lead**

Name: Allan Rawland

Name: Michael Knight

Telephone Number: (909) 382-3133

Telephone Number: 909-252-4047

E-mail: arawland@dbh.sbcounty.gov

E-mail: mknight@dbh.sbcounty.gov

Mailing Address:

Mailing Address:

268 West Hospitality Lane, Suite 400  
San Bernardino, CA 92415

1950 S. Sunwest Lane, Suite 200  
San Bernardino, CA 92415

I hereby certify that I am the official responsible for the administration of public community mental health services in and for said County and that the County has complied with all pertinent regulations, laws and statutes for this Innovation Work Plan. Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code Section 5891 and Title 9, California Code of Regulations (CCR), Section 3410, Non-Supplant.

This Work Plan has been developed with the participation of stakeholders, in accordance with Title 9, CCR Sections 3300, 3310(d) and 3315(a). The draft Work Plan was circulated for 30 days to stakeholders for review and comment and a public hearing was held by the local mental health board or commission. All input has been considered with adjustments made, as appropriate. Any Work Plan requiring participation from individuals has been designed for voluntary participation therefore all participation by individuals in the proposed Work Plan is voluntary, pursuant to Title 9, CCR, Section 3400 (b)(2).

All documents in the attached Work Plan are true and correct.

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Signature (Local Mental Health Director/Designee)

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Date

---

Title

## EXHIBIT B

### INNOVATION WORK PLAN

#### Description of Community Program Planning and Local Review Processes

County Name: San Bernardino

Work Plan Name: All

*Instructions: Utilizing the following format please provide a brief description of the Community Program Planning and Local Review Processes that were conducted as part of this Annual Update.*

- 1. Briefly describe the Community Program Planning Process for development of the Innovation Work Plan. It shall include the methods for obtaining stakeholder input. (suggested length – one-half page)*

The County of San Bernardino's Mental Health Services Act (MHSA) Community Program Planning (CPP) process highlighted "robust" program planning since CSS component planning in 2005 and again in 2007 for PEI. Included in the continually evolving infrastructure for the County's stakeholder inclusion process are the Community Policy Advisory Committee (CPAC), the MHSA Executive Planning Committee, four standing Age-Specific MHSA Work Groups, Consumer-Peer-Driven Support Networks, Consumer Clubhouse Networks, the Parent Partner Network, an Older Adults Peer Counselor & Outreach Network, the TAY Peer Support Network, and various Cultural coalitions, including individuals and cultural brokers from our Native American, African American, Latino, and Asian/Pacific Islander communities, the LGBTQ community and military veterans. In the Fall of 2008, the County's MHSA Community Program Planning team, consisting of the MHSA Coordinator, Innovation Coordinator, administrative/analyst staff and, importantly, outreach staff, spearheaded the "plan-to-plan" phase of the Innovation Component, as the CPAC approved the establishment of the Innovation Working Committee (IWC). Through collaborative recruitment, the IWC's membership grew to more than 100, with representation from community based organizations, faith centers, interagency partners, consumer and family networks, cultural communities, department and contractor staff, clients, participants in PEI programs, potential clients and members of the community.

The initial work of the IWC began with careful review of Innovation policy, principles and priorities within the context of the MHSA "big picture", along with a variety of county data, which would inform Innovation program planning. The Committee initiated its work with a strong commitment to building upon prior CPP stakeholder input, representing input and recommendations from 1,792 PEI stakeholders in 2007 and 2,703 CSS stakeholders in 2005. Because prior stakeholder input included concepts and strategies that, when Innovation definitions and guidelines were applied, are relevant to Innovation Work Plan development, the IWC compiled a planning document containing prior stakeholder input (Attachments A, B) for consideration in the planning process. In addition, the continually expanding data base of CPP planning partners (Attachment C) has been utilized by the IWC not only as a source for outreach and coalition-building but

## EXHIBIT B

as a county resource assessment tool as potential innovation approaches have been considered. Since the release of the Innovation Guidelines in early 2009, the work of the IWC has focused on ensuring that further stakeholder input is elicited from the Innovation target communities of the un/underserved and inappropriately served, along with stakeholders from throughout the major geographical regions of our county. With technical assistance from community program planning staff (which included Cultural Competence, Outreach and Workforce Education & Training staff) IWC members and stakeholders convened a series of targeted forums in our communities and with community partners in order to address Innovation priorities and potential learning strategies. In addition, regional Community Public Forums were convened, in collaboration with the Mental Health Commission and the Commission's District Advisory Committees (DAC), in each of the geographical regions of the County. In all, five regional Community Public Forums and 46 targeted forums were held throughout the county. The smaller targeted forum events were organized in collaboration with community and interagency partners and were specifically designed to engage Latino, African American, Asian-Pacific Islander, Native American, LGBTQ, military veteran and TAY participants. In addition, a number of forums were facilitated with planning partners and advocates for survivors of domestic violence, the faith-based community, advocates for vulnerable youth, consumers/families, individuals addressing co-occurring (substance abuse) disorders and our geographically remote communities (Attachments D, E). Throughout our county's MHSA stakeholder engagement process, each of these "target" communities have been acknowledged as experiencing access challenges which can be addressed in innovative ways, have shared ideas regarding mental health system relevance and have expressed commitment to coalition building around existing resources and needs.

Utilizing Innovation and MHSA-informed forum discussion questions, multi-lingual informational materials and translation support, stakeholder input documentation protocols and stakeholder demographic data collection tools, we have been able to self-assess throughout the process to ensure that we have reached out to our county's diverse ethnic groups, isolated communities, "specialty" populations and the agencies and organizations that advocate for them. An analysis of stakeholder data reflects that our Innovation input conversations have engaged at least 563 stakeholder participants.

We have continued to work with our consumer and family networks in order to reach clients with serious mental illness and/or serious emotional disturbance and their families. Client, peer and family advocate and family member representatives serve on the IWC. Community Program Planning stakeholder data reflect that this population has been "at the table" during the Innovation CPP as well as in prior CPP processes. This ongoing partnership has proven to bring unique and complex input to the planning process and has assisted to set a community friendly tone for newcomers to the conversation. The "Demographic Stakeholder Data" analysis (Attachment F) shows the county's continuous effort to engage with our cultural communities since the CSS CPP began in 2005. As indicated above, the IWC membership included a wide variety of representatives of public and community agencies and organizations as well as community advocates, many of whom were new to the table with this CPP. These new

## EXHIBIT B

planning partners enriched the IWC plan-to-plan process, facilitated thoughtful input regarding our underserved communities and provided invaluable expertise to the Work Plan Development process. (Attachment C).

Throughout the planning process, our stakeholder communities have emphasized a broad variety of concerns, specialty population needs and innovative strategies. However, several consistent themes have emerged over more than four years of engagement with our stakeholders. The Innovation CPP process included more than 50 forums, eliciting input from individuals and advocates representing our most geographically remote areas, our cultural/ethnic communities, each targeted "specialty" group, and others. Simultaneously, this provided us with input from many unique perspectives and yet highlighted several powerful common strengths among our communities. The county's stakeholders have expressed commitment to addressing disparities in access to service for our ethnic/cultural communities, to developing effective mental health education strategies throughout the county's diverse communities, to expansion of community- and peer-driven strategies and networks, to tapping into the strengths in our diverse communities, to partnering in crisis and self-help modes, to collaboratively addressing "hidden" and vulnerable populations of children & youth, and to testing and learning from strategies that are adaptable to our county's many "specialty" communities. The Innovation Work Plans that have emerged through dynamic and active stakeholder participation are designed to be responsive to the strengths and commitments articulated by community members. Each project is intended to add to the array of resources and services within the mental health system in a transformative way and in a manner that accommodates significant participation and contribution from community members, partner agencies and organizations, individuals and communities. Most promising about Innovation is the opportunity for partners to learn about promising/best practices, resource-sharing and re-framing outcomes as stakeholders are increasingly included in the dialogue.

### *2. Identify the stakeholder entities involved in the Community Program Planning Process.*

The "Resource/Partnership Grid" (Attachment C) reflects the agencies, consumer groups, cultural and community based organizations, faith centers and other stakeholder entities that have been included in the Community Program Planning process. The Innovation Working Committee (IWC) membership includes consumers/family members, participants in PEI, client advocates & caregivers, interagency partners, community based organizations, faith centers, department and contractor staff, potential clients, veterans advocates and agencies, law enforcement, justice system, primary health care, private mental health providers, social services, schools, NAMI, Parent Partners and cultural liaisons & communities. In addition, our demographic data reflect that 31% of Innovation CPP participants were consumers or family members, 16% Community Based Organizations specifically serving our ethnic and other underserved communities such as LGBT, refugees and others, 11% DBH staff, 9% contract agency staff, 6% specialty "health services", including alcohol/drug treatment, Native American Health Centers, primary health centers, developmental

## EXHIBIT B

disabilities regional centers and others, 5% family resource center settings such as faith centers and senior centers, 5% educational entities and 5% social services. The diversity of stakeholder entities participating throughout the CPP has contributed to ongoing coalition-building and program planning toward system integration.

*3. List the dates of the 30-day stakeholder review and public hearing. Attach substantive comments received during the stakeholder review and public hearing and responses to those comments. Indicate if none received.*

The thirty (30) day public comment period began on XXX-XX-2009 with posting of the plan on the DBH website at <http://www.sbcounty.gov.dbh/MentalHealthServicesAct.htm>.

**EXHIBIT C**  
**(Page 1 of 10)**

**Innovation Work Plan Narrative**

Date: 11/13/09

County: San Bernardino

Work Plan #: INN - 01

Work Plan Name: On-line Diverse Community Experiences

**Purpose of Proposed Innovation Project (check all that apply)**

- INCREASE ACCESS TO UNDERSERVED GROUPS
- INCREASE THE QUALITY OF SERVICES, INCLUDING BETTER OUTCOMES
- PROMOTE INTERAGENCY COLLABORATION
- INCREASE ACCESS TO SERVICES

*Briefly explain the reason for selecting the above purpose(s).*

The County of San Bernardino Department of Behavioral Health (DBH) has engaged in a lengthy inclusive stakeholder process to make informed decisions for all aspects of the Mental Health Services Act and the Innovation component is no exception. Five public community input forums and 46 targeted forums were held over an eleven month period throughout the County to gather input on the Innovation component. Additionally, Innovation Working Committee members reviewed input received as a result of the Community Services and Supports component (2005) and the Prevention and Early Intervention component (2007) for comments relevant to the Innovation component. In San Bernardino County, priority populations for Innovation include African-Americans, Asian/Pacific Islanders, Latinos, and Native Americans/Tribal Communities along with the LGBTQ community, and other underserved communities identified by stakeholder input and other data.

Through this process the need to **increase access to underserved groups** has been clearly articulated. In fact, 392 comments submitted through the input process called for increased mental health education and multiple forum comments specifically mentioned using Internet social networking sites to bring awareness of DBH services to Internet users, for use as a gateway for consumers, and to expand available tools and resources for the development of self-help systems and networks.

San Bernardino County has many geographically remote areas where mental health services and information are not readily available. A County presence on social networking sites will provide an avenue whereby individuals can log-on and obtain information on subjects that are important to them no matter their geographic location.

**EXHIBIT C**  
**(Page 2 of 10)**

Information gathered during the Workforce Education and Training stakeholder process identified the need for computer skills training for consumers to make them more marketable in the workplace. As part of this Innovation basic computer skills training will be provided to diverse consumers to facilitate the implementation and updating of the social networking sites. Some consumers will receive training on accessing the Internet and our sites. Through the provision of these skills we may be able to learn if the provision of basic computer skills and information on how to access the Internet will help San Bernardino County reach our underserved, unserved and inappropriately served communities.

**Innovation Work Plan Narrative**

**Project Description**

*Describe the Innovation, the issue it addresses and the expected outcome, i.e. how the Innovation project may create positive change. Include a statement of how the Innovation project supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320. (suggested length - one page)*

This Innovation introduces a new application to the mental health system of a **promising community driven practice/approach that has been successful in non-mental health contexts or settings**. The prevalence of social networking sites on the Internet and their widespread use by individuals of all cultures, ages, ethnicities, and orientations makes these sites a logical place for providing information on a wide range of mental health topics and resources. In addition, the ability of the internet to provide information in numerous languages is a plus.

The Department of Behavioral Health (DBH) with input from stakeholders will create pages on social networking sites such as Twitter, Facebook and MySpace. Information about upcoming meetings, newsletters, testimonials from consumers, and various mental health topics as well as administrative information and forms will be posted. By providing this service on social networking sites, we hypothesize that the stigma of seeking mental health information will decrease and that access to mental health information will increase to underserved populations by providing information on the Internet where other information is obtained.

Information provided via the Internet is available to individuals who are socially isolated, those who are isolated due to the stigma that is inherent in the current behavioral health system as well as those who are geographically isolated. The Internet social networking sites are places consumers already access to find and meet friends and to give and receive information. Becoming part of a social networking site is socially acceptable to many cultural groups due to the focus on information gathering and networking as well as the inherent confidentiality and anonymity which in turn can help reduce stigma.

One of the triggers of depression is the feeling of isolation. Facebook, and other social networking sites provide a way for individuals to interact with others facing similar challenges from the comfort of one's own home or anywhere a computer and an Internet connection is available. It provides information that may encourage isolated individuals to take the next step, to make a telephone call, or attend a peer support group meeting thereby providing linkage to service or support when it's needed. It will be important to learn if individuals organize and participate in peer support groups as part of this project. This innovation is expected to increase access to underserved groups.

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DBH will initiate a pilot project with Clubhouse and Transitional Age Youth One Stop Center members, which are located in both the urban and rural regions of the County and service the targeted ethnic/cultural populations previously identified, to provide computer training on how to create pages and groups on the various Social Networking sites. Both the TAY Centers and the clubhouses throughout the County are designed to be culturally competent and responsive to the cultural needs of their communities because of their consumer-driven models.

Computers at all of the clubhouses, TAY centers and at the DBH Training Institute will be made available to consumers to research the Internet and find information that is valuable to each individual. Peer and Family Advocate staff will be available to assist consumers in using the computers, providing information as requested, and ensuring that users are receiving the appropriate resources and referrals.

While social networking sites are not a new concept and have been used to disseminate mental health information, as part of the vision for this project, the sites will include information about relevant resources and links to those resources. Stakeholders will be enlisted to help their consumers create virtual support systems/forums for diverse consumers, to monitor utilization to ensure that appropriate referrals and links are facilitated for consumers who need them.

Social networking sites can appeal to diverse communities, youth and additional underserved groups who are likely to use these communication channels especially due to the availability of a wide variety of languages and information in varying literacy levels.

This innovation incorporates the six standards applicable to all MHSA activities:

- **Community Collaboration** – Ideas for this innovation stem from stakeholder forums. Development of materials and pages on social networking sites will include input from stakeholders and be developed with input from contract agency staff; community based organizations that regularly provide input to the Department; and consumers and family members. This project serves as a link for users to find mental health resources, ancillary resources and community organizations.
  
- **Cultural Competence** – the DBH Office of Cultural Competence and Ethnic Services will review all materials. Materials will be translated into the County's threshold languages, where not already available, and underrepresented groups will provide input. Stakeholder input overwhelmingly supports the idea that the County's culturally diverse communities, the geographically isolated communities, and Transitional Age Youth are inclined to respond to this form of social networking.

**EXHIBIT C**  
**(Page 5 of 10)**

- **Client/Family Driven Mental Health System** – Members of the diverse San Bernardino County population will have access to the social networking sites and have the ability to organize their own on-line community/communities around common concerns, find friends, post information and materials and create virtual support groups. Diverse consumers and their family members will have input into the information/materials provided on the social networking sites as well as developing some of those materials. In addition, consumers and families will be key participants in the ongoing evaluation of the project's outcomes and effectiveness. Once the sites are established DBH will ensure that stakeholders are included and have input on programs and services offered by DBH and contract agencies.
  
- **Wellness Recovery and Resilience Focus** – Through the provision of social networking sites, consumers will have the ability to create their own community, which is essentially oriented in a positive, wellness direction. Materials posted on the sites will have a wellness, recovery and resilience focus that addresses a strength based model characteristic of multicultural communities. Provision of a new way to access information via the Internet facilitates consumers' wellness, recovery and resilience.
  
- **Integrated Service Experience** – The addition of social networking sites is an innovative way of providing information on programs and services in a new format to users who might not seek this type of information using established traditional sources. Information on DBH contract agencies and local community based organizations providing mental health services will be included and in some cases, links to those service provider's sites will be available.

The sites will be continuously updated by adding consumer comments about how they found the site useful, adding new resources (and links to those resources) suggested by consumers, and perhaps (if feasible) interactive methods of gaining access to services.

This process is expected to further expand and integrate the overall mental health system.

**Innovation Work Plan Narrative**

**Contribution to Learning**

*Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts. (suggested length - one page)*

**The On-Line Diverse Community Experiences Innovation will contribute to learning in the following ways:**

- The County will learn how individuals and groups use the social networking sites and what materials they will develop and post on the sites.
- The County will learn what groups will be organized as a result of the sites.
- As a result of establishment of the social networking sites, we will learn how the interaction on the sites will transform the understanding of mental health challenges and promote wellness and recovery.
- The County will determine if diverse consumers will utilize social networking sites to access information, resources and support on Department of Behavioral Health programs and services.
- Once information has been accessed, the County will identify if diverse consumers follow up and request additional information, attend peer support group meetings, or seek help to address issues such as stress, depression or anxiety as a result of use of the social networking site.
- The project will identify if social networking sites allow the community a new way to provide input and feedback on programs and services.
- The project will identify if the provision of resources on social networking sites helps reach historically underserved/inappropriately served populations and if people are more likely to seek help via this resource than through traditional outreach strategies.

**EXHIBIT C**  
**(Page 7 of 10)**

- The project will determine if people are more comfortable with mental health services if provided access and a participatory role through social networking sites.
- Work with DBH data and quality management systems to explore, understand, and learn about the impact of social networking on access, referral and linkage processes, where applicable.

**EXHIBIT C**  
(Page 8 of 10)

**Innovation Work Plan Narrative**

**Timeline**

*Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication. (suggested length - one page)*

Implementation/Completion Dates: 6/10-5/12  
MM/YY – MM/YY

<b>Action</b>	<b>Implementation - Completion Dates</b>
Anticipated MHOAC approval	3/10
Anticipated funding of Innovation project	5/10
Work with subject matter experts and stakeholders to identify and/or develop the initial layout and content for sites.	6/10 – 11/10
Purchase and install computers at Clubhouses and TAY centers	6/10 – 11/10
Develop Consumer training for how to securely access and utilize social networking sites	6/10 – 11/10
Provide training to clubhouses and TAY centers on Social networking sites	10/10 - ongoing
Have Office of Cultural Competence and Ethnic Services review materials and write materials into threshold languages	6/10 – 11/10
Obtain diverse stakeholder input on proposed materials for sites.	6/10 – 11/10
Work with Departmental Information Technology unit to establish sites on Facebook, Twitter, MySpace, etc	6/10 – 11/10
Post information on Social Networking sites in multiple languages.	11/10
Use of sites by diverse consumers. Begin collecting surveys and information on site usage.	11/10 - ongoing
Develop evaluation tools to monitor the success of the social networking sites	6/10-11/10
Evaluate efficacy of use of Social Networking sites as a tool for dissemination of information.	11/10 - ongoing
Report findings.	Quarterly - 5/12

**Innovation Work Plan Narrative**

**Project Measurement**

*Describe how the project will be reviewed and assessed and how the county will include the perspectives of stakeholders in the review and assessment.*

The Department of Behavioral Health will obtain feedback from site users using the following:

- Track calls through the ACCESS unit to ascertain if the consumer has viewed the Department's social networking site or sites, including which site or sites were visited.
- Add questions regarding the social networking sites to the existing customer survey cards that are available in the threshold languages.
- Create online customer service cards for each site in the threshold languages.
- Track membership and participation on the sites.
- Work with the social networking site administrators (Twitter, Facebook, and MySpace) to gather additional information.
- Monitor sites and the number of "friends" and "groups" associated with each site.

Once feedback is received, DBH will assess the effectiveness of using social networking sites to increase access to underserved individuals and communities. We will also evaluate the kinds of access individuals use (have "groups" formed around common issues, are consumers posting information and resources?, etc.) DBH will also attempt to answer the overarching question, does the use of social networking sites reduce stigma, reach our underserved/unserved/inappropriately served populations and what kind of difference does that usage make to promote wellness, recovery and resilience.

Once measurement information has been gathered from the above sources, the Department will review the information and evaluate the effectiveness of the project for continuation, expansion within San Bernardino County and beyond, or discontinuance.

**Innovation Work Plan Narrative**

**Leveraging Resources (if applicable)**

*Provide a list of resources expected to be leveraged, if applicable.*

California State University at San Bernardino (CSUSB) has been a stakeholder throughout the MHSA process. University students can serve as mentors/trainers in assisting consumers with computer usage and accessing the Internet. The Department of Behavioral Health may explore the possibility of developing a Memorandum of Understanding with CSUSB for student interns for this project.

## EXHIBIT D

### Innovation Work Plan Description (For Posting on DMH Website)

**County Name**

San Bernardino

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**Work Plan Name**

On-Line Diverse Community Experiences

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**Annual Number of Clients to  
Be Served (If Applicable)**

N/A Total

**Population to Be Served (if applicable):**

The priority populations served by the On-Line Diverse Community Experience Project include African-Americans, Asian/Pacific Islanders, Latinos, Native Americans/Tribal Communities, LGBTQ, and military veterans and their families. This project will serve individuals of all ages throughout the County. Encompassing 20,105 square miles, many of the County's residents live in remote desert or mountain areas where mental health education and services are not readily available. This project makes mental health information and resources available wherever a computer and an Internet connection are accessible.

**Project Description (suggested length - one-half page): Provide a concise overall description of the proposed Innovation.**

The need to provide increased access to the County's underserved populations has been clearly articulated. The County of San Bernardino Department of Behavioral Health's (DBH) On-Line Diverse Community Experiences project will establish a presence on social networking sites such as Facebook, Twitter and MySpace. Information on mental health topics and services will be provided in the threshold languages as well as English. The prevalence of social networking sites on the Internet and their widespread use by individuals of all cultures, ages, ethnicities, orientations and in any location where a computer and an Internet connection are available makes these sites a logical place for providing information. Additionally, the ability to provide information in numerous languages is a plus. The County's diverse cultures and ethnicities will provide input on content for the sites as well as the development of the sites and evaluation of the project. Consumers will have the ability to create groups and communities and have discussions around issues of importance to them.

Another aspect of this project is to work with our Transitional Age Youth in the TAY Centers and with consumers in the clubhouses (which are located in both the urban and rural areas of the County) and at our Training Institute in San Bernardino to provide computer training on how to create pages and groups on the sites. Computers will be available for use by consumers in the Clubhouses, TAY Centers and the DBH Training Institute. Peer and Family Advocate staff will assist consumers in finding the sites and will ensure that users receive appropriate information and referrals.

**EXHIBIT F**

**Innovation Projected Revenues and Expenditures**

County: San Bernardino

Fiscal Year: 2009/10

Work Plan #: INN - 01

Work Plan Name: On-line Diverse Community Experiences

New Work Plan

Expansion

Months of Operation: 01/09 - 06/10  
MM/YY - MM/YY

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
<b>A. Expenditures</b>				
1. Personnel Expenditures	44,000			\$44,000
2. Operating Expenditures	35,500			\$35,500
3. Non-recurring expenditures	15,000			\$15,000
4. Training Consultant Contracts				\$0
5. Work Plan Management				\$0
<b>6. Total Proposed Work Plan Expenditures</b>	<b>\$94,500</b>	<b>\$0</b>	<b>\$0</b>	<b>\$94,500</b>
<b>B. Revenues</b>				
<b>1. Existing Revenues</b>				\$0
<b>2. Additional Revenues</b>				
a. (insert source of revenue)				\$0
b. (insert source of revenue)				\$0
c. (insert source of revenue)				\$0
<b>3. Total New Revenue</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>4. Total Revenues</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>C. Total Funding Requirements</b>	<b>\$94,500</b>	<b>\$0</b>	<b>\$0</b>	<b>\$94,500</b>

Prepared by: \_\_\_\_\_

Date: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

**EXHIBIT F**

**County of San Bernardino  
On-Line Diverse Community Experiences  
Two Year Project**

		Year One	Year Two	Total	Notes
<b>Anticipated Personnel Expenditures:</b>					
.5 FTE	Peer & Family Advocate II	\$22,000	\$22,000	\$44,000	Function may be contracted or hired by County. If contracted, agency will be required to use Peer & Family Advocate equivalent staff.
 <b>Estimated Operating Expenditures:</b>					
	Includes initial development of website, computer maintenance and other related costs.	\$15,500	\$15,500	\$31,000	
	Evaluation (5%)	\$2,250	\$2,250	\$4,500	Evaluation funds are included in DBH Operating Expenses; however, the function may be performed by a contract agency.
		<hr/> \$17,750	<hr/> \$17,750	<hr/> \$35,500	
 <b>Estimated Non-recurring Expenditures:</b>					
	Includes initial purchase of hardware, software and licenses.	\$7,500	\$7,500	\$15,000	
<b>Total proposed Work Plan Expenditures</b>		<hr/> \$47,250	<hr/> \$47,250	<hr/> \$ 94,500	

## EXHIBIT F

**County:** San Bernardino

**Innovation Program:** On-Line Diverse Community Experiences

### Budget Narrative

#### A. Expenditures

##### Personnel Expenditures:

The \$22,000 per year in staffing costs reflects one-half (0.5) of a full time equivalent (FTE) for a Peer and Family Advocate II staff person for a two-year project total of \$44,000. Various Peer and Family Advocates will assist consumers in the Clubhouses, TAY Centers and the Training Institute in using the computers that will be made available for this purpose, accessing the Internet and the Department's sites on social networking sites such as Facebook, MySpace and Twitter. Additionally, they will provide information as requested and ensure that users are receiving the appropriate resources and referrals. Staffing expenditures are estimated based on the County's pay scale. The position may be contracted to an outside agency or hired by the County. If contracted, the agency will be required to use Peer and Family Advocate equivalent staff.

##### Operating Expenditures:

The operating expenditure estimates include:

Computer Maintenance and Other Related Costs	\$31,000
Evaluation (5%)	\$4,500
<b>Total:</b>	<b>\$35,500</b>

A five percent cost for evaluation of the project is included in the Operating Expenditures for the Department of Behavioral Health; however, the function may be performed by a contract agency.

##### Non-recurring Expenditures:

Non-recurring expenditures for this project consist of the initial purchase of hardware, software and licenses for the computers used by consumers.

#### B. Revenues

No revenues are projected for this project.

**EXHIBIT C**  
(Page 1 of 8)

**Innovation Work Plan Narrative**

Date: 11/13/09

County: San Bernardino

Work Plan #: INN - 02

Work Plan Name: Coalition Against Sexual Exploitation (CASE)

**Purpose of Proposed Innovation Project (check all that apply)**

- INCREASE ACCESS TO UNDERSERVED GROUPS
- INCREASE THE QUALITY OF SERVICES, INCLUDING BETTER OUTCOMES
- PROMOTE INTERAGENCY COLLABORATION
- INCREASE ACCESS TO SERVICES

*Briefly explain the reason for selecting the above purpose(s).*

The County of San Bernardino Department of Behavioral Health (DBH) has engaged in a lengthy inclusive stakeholder process to make informed decisions for all aspects of the Mental Health Services Act and the Innovation component is no exception. Five community public forums and 46 targeted forums were held over an eleven month period throughout the County to gather input on the Innovation component. Additionally, Innovation Working Committee members reviewed input received as a result of the Community Services and Supports component (2005) and the Prevention and Early Intervention component (2007) for comments relevant to the Innovation component. In San Bernardino County, priority populations for Innovation include African-Americans, Asian/Pacific Islanders, Latinos, and Native Americans/Tribal Communities along with veterans and their families, the LGBTQ community, and other underserved communities identified by stakeholder input and other data. Through the Community Program Planning process conducted for the Innovation component, stakeholders made over 60 comments and recommendations in multiple forums that sexually exploited minors are a vulnerable population and encouraged comprehensive responses on behalf of these children.

San Bernardino County has an existing group, the Coalition Against Sexual Exploitation (CASE), with members from the District Attorney's Office, Probation, the Department of Children and Family Services, the Public Defender's Office, law enforcement, the Children's Network, the Department of Public Health, DBH, schools, and local church groups, that meets regularly. CASE has identified the need for a collaborative approach to servicing sexually exploited children, but has not had the opportunity or resources to address the needs of this unique and inappropriately served population.

**EXHIBIT C**  
**(Page 2 of 8)**

Exacerbating this problem, law enforcement often treats these children and youth like criminals rather than responding to their status as victims. Stakeholders have identified this population as being highly vulnerable and in great need of appropriate interventions that address their victimization and the concomitant disorders. Additionally, stakeholders have encouraged the development of outreach and mental health education to improve understanding for those who interact with these children, and to broaden our understanding of the scope and impact of sexual crimes against children.

The Coalition Against Sexual Exploitation (CASE) project strives to develop a model of collaborative care that facilitates a safe haven and clinical rehabilitation for children who are sexually exploited and to develop approaches to mental health education that assists in the prevention of future exploitation. This Innovation **increases the quality of services, including better outcomes for sexually abused children in San Bernardino County.**

Expanding CASE, developing a broad based model and formulating effective ways to educate members of the legal and juvenile justice system: law enforcement.; as well as the County's "first responders": parents, foster parents, group home staff, social workers, counselors, public health nurses, teachers, diverse community based organizations, members of the faith community and others who work and connect with these children requires a high degree of innovative and transformed interagency collaboration.

Innovation Work Plan Narrative

Project Description

*Describe the Innovation, the issue it addresses and the expected outcome, i.e. how the Innovation project may create positive change. Include a statement of how the Innovation project supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320. (suggested length - one page)*

The County of San Bernardino is committed to systemically addressing the issue of sexual exploitation of diverse children and youth in a comprehensive manner. The Department of Behavioral Health has limited formal data on the issue and coordinated services or multidisciplinary teams are not specifically in place to provide proactive services to this vulnerable population. In an informal survey conducted of 50 dependent girls placed by the County of San Bernardino's Department of Children and Family Services in group homes, 25% identified themselves as actively engaged in prostitution and another 25% had a sophisticated understanding of the nomenclature used and the means of becoming involved in prostitution. Almost all of the girls knew stories about someone involved in prostitution while living in a group home. Probation has identified a four-fold increase of children arrested for prostitution in San Bernardino County over the last five years. Children of all cultures and ethnicities are affected by this practice and while the western valley region has been identified as a particular problem area, this practice extends throughout the entire County.

Utilizing an interagency approach which includes partners from throughout the community (governmental agencies, community based organizations, parents, foster parents, nurses, teachers and others) a comprehensive model of interventions/services will be designed, implemented and tested. This model will address outreach, education, interventions, outcome measurements and ongoing planning.

A collaborative group that includes members of the diverse San Bernardino community, churches and various partner agencies will work together in a model similar to the County's Interagency Planning Council and other child-serving multidisciplinary teams to develop a comprehensive approach to assist individual children with ongoing legal, health and social/educational needs as well as continuing collaborative planning for ongoing service coordination and provision.

While coordinated interventions, services and multidisciplinary teams are not unique, this model has not been used with exploited youth, especially in an effort to bring more community resources, cultural brokers and child/youth advocates into the effort. Thus, this project **makes a change to an existing mental health practice/approach including adaptation for a new setting or community.**

**EXHIBIT C**  
**(Page 4 of 8)**

This innovation incorporates the six standards applicable to all MHSA activities:

- **Community Collaboration** – Community Collaboration is a key to the development of this project. Each collaborator brings a unique perspective on sexually exploited youth to the conversation. By examining these viewpoints and working together, a truly comprehensive model will be developed and implemented. This project is advanced with the support of numerous community partners as identified through the Community Program Planning process.
- **Cultural Competence** – Stakeholders from all cultures and communities will be represented as the model is created and implemented and the model will benefit from the inclusion of the DBH Office of Cultural Competence and Ethnic Services as a participating member.
- **Client/Family Driven Mental Health System** –Diverse family members and individuals who were formerly sexually exploited minors will be a part of the development of this program, will be represented on the interagency council and participate in the evaluation of the project.
- **Wellness, Recovery and Resilience** – Development of this model will incorporate the idea that wellness and recovery are possible and provide resources that identify and promote resilience. We expect that interventions with sexually exploited children will foster resilience in these children.
- **Integrated Service Experience** –The Coalition Against Sexual Exploitation project has an integrated service experience at its core. Development of multidisciplinary teams (MDT) and provision of collaborative services under the direction of MDTs is an example of utilization of expertise from a range of providers at a single source.

### Innovation Work Plan Narrative

#### Contribution to Learning

*Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts. (suggested length - one page)*

The Coalition Against Sexual Exploitation Innovation will contribute to learning in the following ways:

- Increase our understanding of the impact of sexual exploitation, risk factors, and the means to develop rapport, initiate effective identification and collaborative intervention and treatment.
- Develop an effective means of identifying diverse children who are vulnerable to exploitation. This is vital due to the deliberate targeting of children in foster care and the ever-younger age of children exploited. This will be achieved by applying the Child, Adolescent Needs and Strengths Tool (CANS) to children as they enter foster care. By building a baseline with these profiles, the project will attempt to correlate the information to profiles of children identified in the juvenile detention system as already exploited.
- Develop a means of identifying diverse children brought into the probation system who are exploited. Currently, these children may be arrested on non-prostitution related offenses (shoplifting, giving false information to law enforcement, and drug charges). Apply the CANS and Massachusetts Youth Screening Instrument to these cases.
- Develop a system of comprehensive interventions and treatment models to determine which are the most effective for developing rapport, addressing the “brain washing” phenomenon related to childhood prostitution and improving the child’s survival skills.
- Develop a training and education module, effective for community-based implementation, for those who interact with these children that most effectively works for San Bernardino County’s cultural and ethnic populations.

The long-term learning goal is to make use of an innovative collaboration to strengthen clinical practice for those serving sexually exploited children. The model created by this project will develop creative clinical strategies, combine existing best practices in trauma care with local clinical expertise and utilize ongoing outcome measures.

**EXHIBIT C**  
(Page 6 of 8)

**Innovation Work Plan Narrative**

**Timeline**

*Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication. (suggested length - one page)*

Implementation/Completion Dates:           3/10 – 3/13            
MM/YY – MM/YY

<b>Action</b>	<b>Implementation - Completion Dates</b>
Anticipated MHOAC approval	3/10
Anticipated funding for Innovation Program	6/10
Establish key learning goals with outcome measures	3/10 - 5/10
Establish MDT	6/10
Develop interagency MOU	7/10 - 8/10
Formalize MDT referral and linkage protocols	7/10 - 8/10
Recruitment, hiring & training of staff	9/10 - 12/10
Provide orientation/training to interagency partners and mental health system staff	9/10 - 12/10
Develop and implement collaborative outreach and education strategy	1/11 - Continuous
Conduct Quarterly reviews and monitoring of program to meet learning goals	1/12 - Continuous
Collect, compile , review, assess project outcomes data	1/13
Evaluation of outcomes and options for ongoing funding	1/13 – 3/13

**Innovation Work Plan Narrative**

**Project Measurement**

*Describe how the project will be reviewed and assessed and how the County will include the perspectives of stakeholders in the review and assessment.*

Currently in San Bernardino County, there is no comprehensive model for the care and treatment of sexually exploited minors. No formal statistics have been gathered and analyzed. This project will help us better understand to extent of the problem of sexually exploited minors and establish a baseline for future measurement, system implementation, and integration throughout our community's child-serving system.

The County will administer the Child Adolescent Needs and Strengths Assessment (CANS) and the Massachusetts Youth Screening Instrument to minors in the Probation system to identify children who are being exploited.

Apply an across the system outcome/measurement tool (CANS) on all children going into foster care and staying longer than six months. After two years, the County can evaluate those minors who later were drawn into prostitution and compare their Child Adolescent Needs and Strengths Assessment scores with those who were not. We will do this to determine if there are predictive indicators on the CANS that can be used to identify children who might be especially vulnerable to victimization. This is a basic longitudinal study.

A long-term goal of the project is not only the development and implementation of a collaborative approach to the provision of services to sexually exploited minors, but also to understand what works and what an effective model looks like.

**Innovation Work Plan Narrative**

**Leveraging Resources (if applicable)**

Provide a list of resources expected to be leveraged, if applicable.

It is expected that a variety of partners from throughout the County's child-serving network will serve on the proposed interagency council as in-kind resources.

## EXHIBIT D

### Innovation Work Plan Description (For Posting on DMH Website)

**County Name**

San Bernardino

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**Annual Number of Clients to  
Be Served (If Applicable)**

700 Total

**Work Plan Name**

Coalition Against Sexual Exploitation  
(CASE)

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**Population to Be Served (if applicable):**

The priority populations served by the Coalition Against Sexual Exploitation (CASE) Project include African-Americans, Asian/Pacific Islanders, Latinos, Native Americans/Tribal Communities, and the LGBTQ community. This project will serve individuals from young children (birth – 15) through transitional age youth (16 - 25).

**Project Description (suggested length - one-half page): Provide a concise overall description of the proposed Innovation.**

The County of San Bernardino Department of Behavioral Health (DBH) will institute a project aimed at sexually exploited minors. The mission of this undertaking strives to develop a model of comprehensive and collaborative care that facilitates a safe haven and clinical rehabilitation for children who are sexually exploited and to expand mental health education to assist in the prevention of future exploitation.

A collaborative group that includes members of the diverse San Bernardino County community, churches, and various partner agencies will work together in a model similar to the County's Interagency Planning Council and other child-serving multidisciplinary teams to develop a model to assist individual children with ongoing legal, health and social/educational needs as well as continuing collaborative planning for ongoing service coordination and provision.

As our stakeholders have encouraged, this project will also focus on the development of outreach and education services to improve understanding of the problem for those who interact with sexually exploited minors and to broaden our understanding of the scope and impact of these crimes against children.

## EXHIBIT F

County: San Bernardino

Fiscal Year: 2009/10

Work Plan #: INN - 02

Work Plan Name: CASE

New Work Plan

Expansion

Months of Operation: 01/10 - 06/10  
MM/YY - MM/YY

	County Mental Health Department	Other Governmenta l Agencies	Community Mental Health Contract Providers	Total
<b>A. Expenditures</b>				
1. Personnel Expenditures		966,424		\$966,424
2. Operating Expenditures	85,321	490,000		\$575,321
3. Non-recurring expenditures				\$0
4. Training Consultant Contracts			250,000	\$250,000
5. Work Plan Management				\$0
<b>6. Total Proposed Work Plan Expenditures</b>	<b>\$85,321</b>	<b>\$1,456,424</b>	<b>\$250,000</b>	<b>\$1,791,745</b>
<b>B. Revenues</b>				
<b>1. Existing Revenues</b>				\$0
<b>2. Additional Revenues</b>				
a. (insert source of revenue)				\$0
b. (insert source of revenue)				\$0
c. (insert source of revenue)				\$0
<b>3. Total New Revenue</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>4. Total Revenues</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>C. Total Funding Requirements</b>	<b>\$85,321</b>	<b>\$1,456,424</b>	<b>\$250,000</b>	<b>\$1,791,745</b>

Prepared by: \_\_\_\_\_

Date: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

**EXHIBIT F**

**County of San Bernardino  
Coalition Against Sexual Exploitation (CASE)  
Three Year Project**

	<b>Each</b>	<b>Year One*</b>	<b>Year Two</b>	<b>Year Three</b>	<b>Total</b>	<b>Notes</b>
<b>Anticipated Personnel Expenditures:</b>						
1 Clinical Supervisor (Coordinator)	\$117,038.00		\$117,038	\$117,038	\$234,076	
2 Licensed Clinical Therapists	\$83,268.00		\$166,536	\$166,536	\$333,072	
2 Social Workers II	\$74,448.00		\$148,896	\$148,896	\$ 297,792	
1 Office Assistant III	\$50,742.00		\$50,742	\$50,742	\$101,484	
		\$0.00	\$ 483,212	\$483,212	\$966,424	
<b>Estimated Operating Expenditures:</b>						
Includes, clinical Interventions and Social Services			\$125,000	\$125,000	\$250,000	
Outreach costs			\$120,000	\$120,000	\$240,000	
Evaluation (5%)			\$42,661	\$42,660	\$ 85,321	Evaluation funds are included in DBH Operating Expenses; however, the function may be performed by a contract agency.
		\$0.00	\$287,661	\$287,660	\$ 575,321	
<b>Estimated Training Consultant Contracts:</b>						
Education & Training			\$125,000	\$125,000	\$250,000	
		\$0.00	\$125,000	\$125,000	\$250,000	
<b>Total proposed Work Plan Expenditures</b>		<b>\$0.00</b>	<b>\$895,873</b>	<b>\$895,872</b>	<b>\$1,791,745</b>	

- Activities for year one will be exclusively administrative and will include: development of the interagency MOU, development of multidisciplinary teams, formalization of referral and linkage protocols, and recruitment and hiring of staff.

## EXHIBIT F

**County:** San Bernardino

**Innovation Program:** Coalition Against Sexual Exploitation (CASE)

### Budget Narrative

#### A. Expenditures

##### Personnel Expenditures:

Staffing costs of \$966,424 include clinical staff to provide clinical interventions, social workers to provide social services and one Office Assistant to provide support and assist with coordination functions. This staffing combination is designed to provide services to exploited children/youth as well as to enhance the collaborative nature of this project and support community and interagency coordination and cooperation.

Staffing expenditures are estimated based on the County's pay scale. In the current plan these positions will be provided by another County agency; if contract employees are utilized, the actual amounts expended have a significant potential for variance.

##### Operating Expenditures:

The operating expenditure estimates include:

Clinical interventions and Social Services	\$250,000
Outreach Costs	240,000
Evaluation (5%)	85,321
<b>Total</b>	<b>\$575,321</b>

The clinical interventions and social services estimate of \$250,000 will be used to facilitate our goals of providing clinical rehabilitation for exploited children/youth and expanding the education available to assist in the prevention of future exploitation.

Due to the difficulties involved in contacting and developing a trusting relationship with exploited children, the estimated \$240,000 in outreach costs will fund a variety of creative outreach methods from strategically placed advertising to development of "safety contact" networks. Evaluating the results of the various outreach methods will enhance the Department's knowledge of effective communication in this very difficult area.

A five percent cost for evaluation of the project is included in the Operating Expenditures for the Department of Behavioral Health; however, the function may be performed by a contract agency.

## EXHIBIT F

### **Training Consultant Contracts:**

Education and training costs are estimated at \$250,000 and will encompass training provided at four levels: law and justice system staff; parents and schools; Probation and Children and Family Services (CFS) staff; and Direct Service Providers. This training should result in improved awareness of sexual exploitation in the community, its impact and strategies for intervening.

The educational expertise needed is not available locally; all training will be provided by contractors.

### **B. Revenues:**

No revenue is anticipated from this project.

**EXHIBIT C**  
(Page 1 of 9)

**Innovation Work Plan Narrative**

Date: 11/13/09

County: San Bernardino

Work Plan #: INN - 03

Work Plan Name: Community Resiliency Model

**Purpose of Proposed Innovation Project (check all that apply)**

- INCREASE ACCESS TO UNDERSERVED GROUPS
- INCREASE THE QUALITY OF SERVICES, INCLUDING BETTER OUTCOMES
- PROMOTE INTERAGENCY COLLABORATION
- INCREASE ACCESS TO SERVICES

*Briefly explain the reason for selecting the above purpose(s).*

The County of San Bernardino Department of Behavioral Health (DBH) has engaged in a lengthy inclusive stakeholder process to make informed decisions for all aspects of the Mental Health Services Act and the Innovation component is no exception. Five community public forums and 46 targeted forums were held over an 11-month period throughout the County to gather input on the Innovation component. Additionally, Innovation Working Committee members reviewed input received as a result of the Community Services and Supports component (2005) and the Prevention and Early Intervention component (2007) for comments relevant to the Innovation component. In San Bernardino County, priority populations for Innovation include African-Americans, Asian/Pacific Islanders, Latinos, and Native Americans/Tribal Communities along with military veterans, the LGBTQ community, and other underserved communities identified by stakeholder input and other data.

In the community input process, diverse stakeholders overwhelmingly called for mental health education in the community that should include community coping skills, trauma response skills and resiliency. In addition, diverse stakeholders acknowledged that underserved individuals and communities may be affected by the stigma of having mental health issues, avoiding traditional services and/or settings or they are uncomfortable seeking help. Often, community stakeholders expressed examples of community crisis, trauma or incidents and the potential mental health impact on community members.

Stakeholders and community partners have expressed a willingness to expand their roles in their communities but identify the need for mental health helping skills. In response to this need San Bernardino County Department of Behavioral Health in consultation with the Trauma Resource Institute will develop the Community Resiliency Model (CRM). This model is based on the Trauma Resource Institute's successful Trauma Resiliency Model (TRM).

**EXHIBIT C**  
**(Page 2 of 9)**

The Trauma Resiliency Model (TRM) is a biologically based model developed as a response to catastrophic events and is suitable and culturally appropriate for use by many underserved populations. The TRM model has been well received by the underserved and culturally diverse communities within San Bernardino County and is effectively delivered by non-clinicians/paraprofessionals. The adaptation of TRM to the Community Resiliency Model takes a model that has been used as a response to catastrophic events to a community based model appropriate for use in response to community or individual events/situations. This adaptation to a community model will retain the biological emphasis and the cultural appropriateness.

Ever mindful of the Mental Health Services Oversight and Accountability Commission's (MHSOAC) report on Co-Occurring Disorders, development of the Community Resiliency Model will include the availability of referral to integrated treatment for mental health and substance abuse for individuals identified with co-occurring disorders.

The Community Resiliency project aids in the development and strengthening of current partnerships with organizations that contract with the County as well as community based organizations with ties to our underrepresented communities and is key to this project. This Innovation **promotes interagency collaboration.**

## Innovation Work Plan Narrative

### Project Description

*Describe the Innovation, the issue it addresses and the expected outcome, i.e. how the Innovation project may create positive change. Include a statement of how the Innovation project supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320. (suggested length - one page)*

**The Community Resiliency Model (CRM) introduces a new application to the mental health system of a promising community driven practice/approach that has been successful in non-mental health contexts or settings.**

Developed by Elaine Miller-Karras and used with survivors of catastrophic events TRM teaches consumers to stabilize the nervous system in a short period to reduce and/or prevent emotional and physical symptoms of traumatic stress. TRM is a biologically oriented training program and can be used for the self-care of workers who are exposed to challenging situations (which reduces secondary traumatization and burnout) as well as for people who have directly experienced traumatic events. Based on current neurophysiological research about the impact of fear and threat on the mind-body system, TRM offers concrete skills to reduce symptoms of traumatic stress in the Autonomic Nervous System of children and adults. The goal of treatment is to help the individual understand basic information about the nervous system and then, teach specific skills that help stabilize the body. As the individual becomes aware of how to stabilize their nervous system, by becoming more somatically aware, there is an increase in internal resilience. Mind and body are interdependent and as the body is stabilized, the mind can bring new meaning to the traumatic experience. The emphasis on the biology of trauma makes TRM accessible and relevant to many diverse groups for whom insight-oriented approaches may not be appropriate or for whom the concept of “mental illness” is not the ideal initial introduction to mental health services and resources. As the Community Resiliency Model is developed based on TRM, the cultural appropriateness will be retained.

San Bernardino County initially implemented TRM in March 2007, with the DBH Disaster Response Team. In October 2007, TRM was used in response to local wildfires. TRM training provided the mental health system with another approach/strategy for the community that, if adapted, has been found to be potentially relevant to an “audience” beyond disaster victims, including consumers, family members, community members and cultural brokers.

Since TRM training is suitable for paraprofessionals as well as clinicians, it is ideal for community-based mental health education and skills development, a need identified in the MHSA stakeholder process. As part of this project, San Bernardino County in consultation with the Trauma Resource Institute will adapt and translate TRM to a community-based model called the Community Resiliency Model (CRM) suitable as a response to community or individual events experienced by San Bernardino County’s

**EXHIBIT C**  
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diverse cultures and communities. The model will be used by non-clinicians, paraprofessionals and multi-cultural groups, emphasizing the participation of a variety of native cultural brokers who can effectively serve as credible and accepted “first responders” within established community based organizations.

San Bernardino County DBH will expand the current Train-the-Trainer team by adding eight additional trainers and 10 new facilitators to the TRM 1 Teacher Training and subsequently all 34 trainers and facilitators will receive additional training as trainers for the Community Resiliency Model, TRM 2 and advanced modules.

Fifty diverse community members will be chosen and trained as CRM trainers. Once trained, the community members will provide input on the CRM model to enhance the cultural competence and relevance for their individual communities as well as helping to determine the need for additional modules and the contents of those additional models. These trainers in their roles as cultural brokers will also help evaluate the effectiveness and relevance to our various target, cultural and stakeholder communities.

The community trainers will offer CRM education and skills in 1 hour to half-day presentations to “at risk” and underserved groups in their communities under the supervision of DBH TRM Master Teachers and using DBH trainers and facilitators. The 50 CRM trainers will be paid a stipend for each training conducted. DBH will provide community trainers with mentors and regular instructional follow-up to refresh skills and to introduce advanced modules. The advanced modules include working with veterans, children, and survivors of sexual trauma and domestic violence. The training will be presented in the threshold languages in the communities as appropriate and training materials will be translated into the County’s threshold languages.

Diverse stakeholders have clearly called for mental health education in the community and this project responds to that call. While the original TRM is used as a response to natural disasters or catastrophes, CRM changes the focus to individuals and communities and how to respond to traumatic individual and community events. In addition, as envisioned, the relationships built through the provision of free training and mentoring will help destigmatize mental health help seeking in the community. Importantly, this model relies on the strengthening of the County’s community coalitions, includes an expanded, broad and diverse group of cultural ambassadors who can help to identify and respond to community and individual issues and seeks to enhance the links and mechanisms that facilitate culturally competent and coordinated responses to community mental health needs.

This innovation incorporates the six standards applicable to all MHSA activities:

- **Community Collaboration** – Stemming from diverse stakeholder input requesting mental health education and coping skills the County chose the Community Resiliency Model as an Innovation project. This project promotes and supports collaborative relationships in and with the community by providing training to a broad range of agencies, organizations and individuals. This endeavor will rely on strengthening the Department’s linkages and collaboration opportunities with our diverse communities and cultures.

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- **Cultural Competence** – CRM is physiologically based and is appropriate and relevant/adaptable for many ethnic/cultural groups. It focuses on the physiological which is often far more accepted as a basis for mental health symptoms, than the more culturally stigmatizing psychological basis. As part of this project CRM materials (handbooks, cue cards and teaching materials) will be translated into the County's threshold languages. The training will include trainees from all cultural backgrounds focusing on natural cultural brokers implicit in the diverse communities of San Bernardino County. Once they are trained, these trainers will attract and serve members of their cultural group. It is expected that this collaborative model, which brings together a diverse “cadre” of cultural ambassadors, will result in cross-cultural learning and enhanced cultural competence throughout the County’s mental health system.
  
- **Client/Family Driven Mental Health System** – The County will collaborate with the faith-based community, NAMI, Planned Parenthood, Public Health, the LGBTQ community, Veteran’s groups, the mental health systems’ Peer and Family Advocate network, the Parent Partners network, and the Older Adult Peer Network on CRM. These collaborative partners will bring consumer and family concerns “to the table” and be a part of the ongoing development of the model, identification of additional modules as needed, and the evaluation of the project
  
- **Wellness, Recovery and Resilience** – This project will promote and evolve a shared community perspective about resiliency and trauma response and outreaches to disparate and disenfranchised members of the community enhancing community resilience in its citizens.
  
- **Integrated Service Experience** – The provision of CRM in partner agencies and throughout the community reduces the need for diverse consumers to come to a traditional Department of Behavioral Health facility removing a barrier to service. Interagency and community linkages will be developed and strengthened through the Mentoring portion of the project.

## Innovation Work Plan Narrative

### Contribution to Learning

*Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts. (suggested length - one page)*

The adaptation of the Trauma Resiliency Model to the Community Resiliency Model, training diverse community members as trainers, and the presentation of the new CRM in the community will contribute to learning in the following ways:

The County will learn:

- If the Trauma Resiliency Model can be adapted to a Community Resiliency Model. The original model addresses response to a natural disaster or catastrophe. The new adaptation changes the focus to individuals and how to respond to traumatic individual and community events.
- If training community trainers works and how it works. This might be demonstrated by any of the following:
  - ◆ If underserved individuals will attend this type of training in their own community (church, community center, community based organization, etc.).
  - ◆ If the provision of training for the community in the community leads to the destigmatization of mental health help seeking for underserved individuals.
  - ◆ If expansion of interagency collaboration through cultural brokers and community ambassadors positively influences underserved communities' participation in the mental health system.

Perhaps, most importantly, we will learn if the Community Resiliency Model will strengthen DBH's linkages and collaboration with San Bernardino County's diverse cultures and communities including the LGBTQ community and military veterans and their families.

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**Innovation Work Plan Narrative**

**Timeline**

*Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication. (suggested length - one page)*

Implementation/Completion Dates:           3/10 – 3/13            
MM/YY – MM/YY

<b>Action</b>	<b>Implementation – Completion Dates</b>
Anticipated MHSOAC Approval	3/10
Anticipated Funding of Innovation Project	6/10
Develop Community Resilience Model	3/10 – 7/10
Expand Train the Trainer	8/10 – 9/10
Recruit 50 community members to become trainers	6/10 – 9/10
Train the 50 community members	10/10 – 11/10
50 trainers start training in the community	1/11 – 12/11
Quarterly meetings with all trainers to solicit their input on CRM and to provide additional training to trainers	1/11 – 12/11
Supplemental trainings and continuation of community presentations	1/12 – 12/12
Final evaluation	1/13 – 3/13
Quarterly review and evaluation	1/11 -1/13

**Innovation Work Plan Narrative**

**Project Measurement**

*Describe how the project will be reviewed and assessed and how the County will include the perspectives of stakeholders in the review and assessment.*

The Department of Behavioral health will obtain feedback on the project using the following:

- Diverse community members trained as facilitators will complete training evaluation forms at the end of training.
- Diverse community members that attend training at community locations will be asked to complete training evaluation forms.
- Follow up evaluation forms will be sent to trainees six months following their training session to ascertain whether they have used the techniques learned.
- When the evaluation phase begins, surveys will be sent to all contract agencies and community based organizations that were part of the Community Program Planning and Local Review Process. Questions asked will determine if they have heard of the Community Resiliency Model, if their consumers have attended training, their overall reaction to the program, if in their opinion this program has reduced the stigma of seeking help from the mental health system, and their recommendation for continuance of the project.

By obtaining input from partners, trainers and the community at-large, the department can make the determination if the project warrants further evaluation, continuance of the project, and/or a recommendation to expand the project beyond San Bernardino County.

**Innovation Work Plan Narrative**

**Leveraging Resources (if applicable)**

*Provide a list of resources expected to be leveraged, if applicable.*

Not Applicable

**EXHIBIT D**

**Innovation Work Plan Description  
(For Posting on DMH Website)**

**County Name**

San Bernardino

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**Annual Number of Clients to  
Be Served (If Applicable)**

N/A Total

**Work Plan Name**

Community Resiliency Model

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**Population to Be Served (if applicable):**

The priority populations served by the Community Resiliency Model Project include African-Americans, Asian/Pacific Islanders, Latinos, Native Americans/Tribal Communities, LGBTQ, and military veterans and their families. This project will serve individuals from all age groups and in locations throughout the County, including the remote desert and mountain areas.

**Project Description (suggested length - one-half page): Provide a concise overall description of the proposed Innovation.**

During the community input process, diverse stakeholders overwhelmingly called for mental health education in the community that includes community coping skills, trauma response skills and resiliency. Based on the Trauma Resiliency Model (TRM), the County of San Bernardino Department of Behavioral Health (DBH) in consultation with the developer of TRM, the Trauma Resource Institute, will develop the Community Resiliency Model (CRM). TRM was developed as a response to catastrophic events; CRM will place an emphasis on individual and community responses to trauma. Focusing on the biology of trauma rather than the more culturally stigmatizing psychology of trauma, CRM may be more acceptable to our diverse population as a basis for seeking mental health information and services.

DBH will expand the current TRM train-the-trainer team and provide training in CRM to support trainers in the community. Fifty diverse community members will be chosen and trained as CRM trainers/cultural ambassadors. The CRM trainers/cultural ambassadors will provide input on the CRM model and additional modules as well as help the department evaluate the relevance of the model to the County's diverse population. CRM education and skills will be offered in one-hour to half-day sessions by the cultural ambassadors to "at risk" and underserved groups in their communities. DBH will provide the community ambassadors with mentors and regular instructional follow-up to refresh skills and to introduce advanced models. The advanced models include working with veterans, children, and survivors of sexual trauma and domestic violence. All instructional materials will be translated into the threshold languages and sessions will be presented in those languages as appropriate.

**EXHIBIT F**

**Innovation Projected Revenues and Expenditures**

County: San Bernardino

Fiscal Year: 2009/10

Work Plan #: INN - 03

Work Plan Name: Community Resiliency Model

New Work Plan

Expansion

Months of Operation: 01/10 - 06/10  
MM/YY - MM/YY

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
<b>A. Expenditures</b>				
1. Personnel Expenditures			80,000	\$80,000
2. Operating Expenditures	39,525		261,620	\$301,145
3. Non-recurring expenditures				\$0
4. Training Consultant Contracts			448,870	\$448,870
5. Work Plan Management				\$0
<b>6. Total Proposed Work Plan Expenditures</b>	<b>\$39,525</b>	<b>\$0</b>	<b>\$790,490</b>	<b>\$830,015</b>
<b>B. Revenues</b>				
<b>1. Existing Revenues</b>				\$0
<b>2. Additional Revenues</b>				
a. (insert source of revenue)				\$0
b. (insert source of revenue)				\$0
c. (insert source of revenue)				\$0
<b>3. Total New Revenue</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>4. Total Revenues</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>C. Total Funding Requirements</b>	<b>\$39,525</b>	<b>\$0</b>	<b>\$790,490</b>	<b>\$830,015</b>

Prepared by: \_\_\_\_\_

Date: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

**EXHIBIT F**

**County of San Bernardino  
Community Resiliency Model  
Two Year Project**

	Year One	Year Two	Year Three	Total	Notes
<b>Anticipated Personnel Expenditures:</b>					
1 Trauma Resiliency Institute Project Coordinator	\$26,667	\$26,667	\$26,666	\$80,000	
<b>Estimated Operating Expenditures:</b>					
Training/Consultation with Master Trainers	\$230,900			\$230,900	
Adaptation/translation of training materials	\$ 30,720			\$30,720	
Evaluation (5%)	\$ 22,891	\$8,317	\$8,317	\$ 39,525	Evaluation funds are included in DBH Operating Expenses; however, the function may be performed by a contract agency.
	<hr/>				
	\$ 284,511	\$8,317	\$8,317	\$301,145	
<b>Estimated Training Consultant Contracts:</b>					
Consultation & Planning	\$ 33,000			\$33,000	
Training	\$136,530	\$136,530	\$136,530	\$409,590	Training will include 15 trainers and 19 facilitators from DBH staff. 120 community members will be trained; of those, 50 will receive additional training to become Community Resiliency Trainers.
Training Materials		\$3,140	\$3,140	\$6,280	
	<hr/>				
	\$169,530	\$139,670	\$139,670	\$448,870	
<b>Total proposed Work Plan Expenditures</b>	<b>\$480,708</b>	<b>\$174,654</b>	<b>\$174,653</b>	<b>\$ 830,015</b>	

## EXHIBIT F

**County:** San Bernardino

**Innovation Program:** Community Resiliency Model

### Budget Narrative

#### A. Expenditures

**Personnel Expenditures:**

Staffing for this project includes one (1) Trauma Resiliency Project Coordinator. This position will be provided by a contractor and is estimated at \$80,000 for the three-year project.

**Operating Expenditures:**

The operating expenditure estimate includes:

Training, training materials and consultation with contracted Master Trainers	\$187,400
Outreach – public relations and advertising	25,000
Adaptation and translation of training materials	30,720
Travel expenses	16,000
Stipends for student trainers	2,500
Evaluation (5%)	39,525
<b>Total</b>	<b>\$301,145</b>

The training and training materials included in operating expenditures refer to training conducted by Behavioral Health staff and community agencies. Master trainers will observe, debrief and refine the skills of trainees as they perform their student teaching. Training materials will be adapted for use with diverse populations and translated into the County's threshold languages.

A five percent cost for evaluation of the project is included in the Operating Expenditures for the Department of Behavioral Health; however, the function may be performed by a contract agency.

**Training Consultant Contracts:**

An estimated cost of \$33,000 is included in the Training Consultant Contracts section for consultation with the contractor during the planning phase of each step of this project.

## **EXHIBIT F**

Contracted training costs are estimated at \$409,590 with an additional cost of \$6,280 for training materials to be provided by contractor. This cost includes training for approximately 34 Department of Behavioral Health staff and 120 community members. The services of master trainers are also included. They will provide ongoing consultation to the trainers as well as observing, debriefing and refining the skills of trainees as they perform their student teaching.

### **B. Revenues**

No revenues are projected for this project.

Innovation Work Plan Narrative

Date: 11/13/09

County: San Bernardino

Work Plan #: INN - 04

Work Plan Name: Holistic Campus

**Purpose of Proposed Innovation Project (check all that apply)**

- INCREASE ACCESS TO UNDERSERVED GROUPS
- INCREASE THE QUALITY OF SERVICES, INCLUDING BETTER OUTCOMES
- PROMOTE INTERAGENCY COLLABORATION
- INCREASE ACCESS TO SERVICES

*Briefly explain the reason for selecting the above purpose(s).*

The County of San Bernardino Department of Behavioral Health's ongoing inclusive stakeholder engagement process, including the Innovation Community Program Planning process, continually highlights the challenges faced by the ethnic/cultural communities, the geographically isolated and under-resourced communities and several "specialty" populations that have emerged during the community conversation. The African-American, Latino, Native American, and Asian-Pacific Islander populations are underserved by the mental health system. Importantly, appropriateness, relevance and accessibility of mental health resources and services for these cultural groups are key issues. For the County's LGBTQ stakeholders, access is affected by location, service array, relevance and appropriateness. For the County's military veterans and family members access is greatly affected by issues of stigma and interagency collaboration. While there are unique differences, resources, strengths and skills among each identified population, our diverse stakeholders identified a shared perception that they face challenges in access to service. In addition, stakeholders expressed a common objective of addressing this challenge by establishing consumer, peer, and community-driven strategies in community friendly settings that will inform the County's mental health transformation.

Services and activities provided in mental health settings in the County in the past have not been successful in improving access for the underserved and unserved population and have not addressed the issues of stigma. The clubhouse system that is currently in place is an excellent start. However, the services offered are not sufficient or relevant to meet the needs of our diverse population and have not ameliorated the stigma issues faced by our cultural and ethnic populations, the LGBTQ community and military veterans and their families.

**EXHIBIT C**  
**(Page 2 of 9)**

This project **increases access to underserved groups** by creating a Holistic Campus that will be community driven and culturally informed. Customers from all cultures and ethnicities as well as the “specialty” identified populations will have input into the programs and services to be offered, run the campus, and be part of the ongoing evaluation of the project.

This project creates a setting in which participants and partners can frame cultural differences as learning sources - for each other and the mental health system. Is it possible that out of diversity a common ground can be found?

**Innovation Work Plan Narrative**

**Project Description**

*Describe the Innovation, the issue it addresses and the expected outcome, i.e. how the Innovation project may create positive change. Include a statement of how the Innovation project supports and is consistent with the General Standards identified in the MHSa and Title 9, CCR, section 3320. (suggested length - one page)*

A significant challenge for the County of San Bernardino has been increasing access to services that are culturally appropriate and community based. Stakeholders continue to identify a need for services that are community friendly in destigmatized settings. Not only is there a lack of access to culturally appropriate services, but stakeholders identified a need for those services to be delivered in a non-mental health setting with the support and direction of peers and cultural brokers.

This project establishes a “Holistic Campus” that is at least 80% peer run by community members and cultural brokers, including individuals representing the County’s cultures, ethnic communities, the LGBTQ community and military veterans and their families in one location. This project brings together a diverse group to create their own resource networks/strategies, growing out of their cultural strengths. With the emphasis on peer staff running the center, in a non-mental health setting, and having ties to the community and resources, the “Holistic Campus” is expected to be much more accessible, culturally/ linguistically competent and relevant and community friendly than mental health offices and providers currently in operation.

In addition to having a majority of diverse peer/community member staff, the center will be a hub for local and community based providers and resources. Staff will establish collaborative relationships with physical health providers and community based organizations that deal with housing, employment, education and benefits issues and provide art therapy and culturally specific healing strategies. Examples of the strategies discussed for inclusion are cross-cultural and cross-generational opportunities such as acupressure, acupuncture, sweat lodges, pet therapy, yoga and healing circles. Ultimately, it will be up to the cultural brokers and the Advisory Board of Directors to decide which culturally specific healing strategies are needed, desired, and found to be most effective by the community. By offering services specifically requested by the community and welcoming all to the holistic campus, it is anticipated that diverse consumers will request and receive mental health information and services as needed without stigma.

The focus of the campus will be overall wellness, resilience and resources with *traditional* mental health *entities* taking a more subtle but still readily accessible role to provide mental health services and integrated treatment in a single setting for those consumers with identified co-occurring disorders.

**EXHIBIT C**  
**(Page 5 of 9)**

To ensure that peer and community input drives the direction and the learning process of the campus, an Advisory Board of Directors will be established to oversee the operations of the campus as well as to attract new and culturally specific providers and resources. This Board will be primarily comprised of and run by the peer staff and cultural brokers of the center as well as by vested community groups. During the planning and implementation stages of this project, members of the County's Cultural Coalitions and Cultural Competence Advisory Workgroups will be recruited for the Advisory Board of Directors and requested to provide input into the programs and services offered. One of the first tasks of the Advisory Board of Directors will be to create a name for the center that reflects the diversity of cultures and ethnicities represented and the innovative nature of this project.

The campus will promote collaboration between all providers in addition to becoming a place where those with fewer resources but who provide specific cultural healing techniques and resources can serve their community. The facility will be located in the community in a neutral and non-clinical setting. As currently envisioned, one local community based organization will take the lead responsibility for the campus and with input from the community, cultural brokers, and the Advisory Board of Directors, will invite others, such as traditional healers and culturally specific providers outlined in the project description above to participate in the center and provide culturally and ethnically appropriate services.

This project **introduces a new mental health practice/approach, including prevention and early intervention that has never been done before.** Convening community members from diverse cultures and ethnicities as one decision-making body to develop and run a Holistic Campus serving all is an innovative concept. Individually these cultures and ethnicities expressed a shared sense of challenge in accessing services.

This innovation incorporates the six standards applicable to all MHSA activities:

- **Community Collaboration** – Community Collaboration is a key to the development of this project. Each peer, cultural broker, and service provider brings a unique perspective on the needs of their community to the conversation. The County's existing Cultural Coalitions and Cultural Competence Advisory Workgroups will be invited to provide input into the development, implementation and evaluation of the campus and to ensure that all services provided are appropriate to the community being served.
- **Cultural Competence** – Stakeholders from San Bernardino's diverse cultural communities including LGBTQ individuals and military veterans and their families as well as the County's existing Cultural Coalitions and Cultural Competence Advisory Workgroups will be represented in developing the Holistic Campus, in running the campus, and working together to evaluate the effectiveness of melding many cultures and ethnicities together to address common needs.

**EXHIBIT C**  
**(Page 5 of 9)**

- **Client/Family Driven Mental Health System** – Diverse Consumers as well as their family members will be represented at every step in the development and operation of the Holistic Campus. Consumers and their family members will be recruited as employees of the center. These staff positions will be modeled on the San Bernardino County Peer and Family Advocate classifications. As planned, at least 80% of the staffing at the campus will be peers.
  
- **Wellness, Recovery and Resilience** –The focus of the campus is on wellness, resilience and access to resources for all communities with mental health entities taking a more subtle and yet readily available role. By design, the Holistic Campus seeks to tap into the resiliencies of a broad and diverse community of participants. It is expected that this innovative learning partnership will facilitate an integration of these strengths, skills and resources into the transforming mental health system.
  
- **Integrated Service Experience** – The Holistic Campus brings together many different community members, service providers, culturally specific healers and others under one roof in a true expression of an integrated service experience.

**Innovation Work Plan Narrative**

**Contribution to Learning**

Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts. (suggested length - one page)

Through this project the County will:

- Learn about and evaluate the effectiveness of having a campus run primarily by diverse peers/participants in cooperation with multiple community providers and resources in one centralized location.
- Understand and define what partnership means and what can be accomplished from a program perspective.
- How to respectfully use community resources.
- What type of support and training is needed by peer cultural brokers as well as the small percentage of clinical staff.
- What underrepresented cultures and ethnicities can learn from each other and how they work together.
- Assess the benefits of joining multiple consumer, stakeholder, cultural groups into one community-driven setting to establish relevant peer support networks, resources, linkages around their distinct resources and needs.
- Evaluate if these new approaches, in addition to the Advisory Board of Directors leads to increased access to services from those that would not normally seek mental health services due to stigma and other cultural considerations.
- Determine if this high percentage of culturally diverse peers along with the availability of resources to local providers fosters a more diverse environment in which multiple cultures can be served appropriately and concurrently out of one location with both non-traditional and traditional healing methods.
- Determine if our underserved, unserved and inappropriately served populations are more comfortable seeking mental health services in a Holistic Campus where the community determines the services offered, the majority of employees are peers and cultural brokers, and where the County provides minimal direction.
- Determine if this setting reduces stigma.

**EXHIBIT C**  
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**Innovation Work Plan Narrative**

**Timeline**

Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication. (suggested length - one page)

Implementation/Completion Dates: 3/10 – 3/13  
MM/YY – MM/YY

<b>Action</b>	<b>Implementation – Completion Dates</b>
Anticipated MHSOAC approval	3/10
Anticipated funding of Innovation Project	6/10
Establish Campus Advisory Board of Directors	3/10 – 8/10
Advisory Board will establish key learning goals with outcome measures	3/10 -
Develop a Request for Proposals	6/10 - 8/10
Orientation and technical assistance for potential bidder	8/10
Release RFP, conduct mandatory bidders conference	9/10
Award contract; complete contract procurement process	11/10
Recruit, hire & orientation for core peer/community staff	11/10 – 1/11
Develop MOU among County, contractor and community-based organizations	11/10 – 1/11
Collaborative design of project; review protocols	1/11 – 3/11
Open doors.	3/11
Monthly campus Advisory Board meetings and events	1/11 - continuous
Conduct quarterly reviews and monitoring of programs to meet learning goals.	3/11 - continuous
Collect, compile, review, assess project outcomes data,	3/11 – 3/12 & 3/12 – 3/13
Assess project design; determine recommended changes and adjustments	3/12 - Continuous
Comprehensive project assessment in collaboration with stakeholders	3/12 – Continuous
Evaluation of outcomes and options for replication via alternative funding/resources	1/13 -3/13

**Innovation Work Plan Narrative**

**Project Measurement**

Describe how the project will be reviewed and assessed and how the County will include the perspectives of stakeholders in the review and assessment.

The ultimate measure of success will be “is the community participating?” Are people coming to the campus to meet various needs? Are they then receiving assistance with mental health education and accessing treatment?”

- Collect basic demographic information on users of the Holistic Campus.
- Develop participant surveys to gather information from consumers on their initial visit and any follow up visits. These surveys will be based on those currently used in the department’s clubhouses.
- Track requests for traditional mental health services for those consumers who come to the Holistic Community Center.

Through participant surveys, community hearings, forums, and continual consultation with the Advisory Board of Directors the County will learn if members from diverse cultures and ethnicities including the LGBTQ community and military veterans and their families are willing to come together in one location to access and receive services in a community based location. Does this community based location lead to the destigmatization of seeking mental health services?

Ultimately, the community’s review and assessment as well as utilization of the center and requests for traditional mental health services is the only real method that will determine the success of this project.

**Innovation Work Plan Narrative**

**Leveraging Resources (if applicable)**

Provide a list of resources expected to be leveraged, if applicable.

The following represents a list of possible resources that will be leveraged for this project:

- Mobile medical clinics may schedule stops at the center.
- Community based organizations will be invited to establish a “presence” at the center.
- Local non-traditional healers will be able to use the center to provide their services.

The responsibility for developing the sharing and leveraging of resources will be guided by the community and guided by the Advisory Board of Directors.

**EXHIBIT D**

**Innovation Work Plan Description  
(For Posting on DMH Website)**

**County Name**

San Bernardino

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**Annual Number of Clients to  
Be Served (If Applicable)**

2400 Total

**Work Plan Name**

Holistic Campus

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**Population to Be Served (if applicable):**

The priority populations served by the Holistic Campus Project include African-Americans, Asian/Pacific Islanders, Latinos, Native Americans/Tribal Communities, the LGBTQ community and military veterans the their families. This project will serve individuals from all age groups.

**Project Description (suggested length - one-half page): Provide a concise overall description of the proposed Innovation.**

Input received by the County of San Bernardino Department of Behavioral Health (DBH) continually highlights the challenges faced by our diverse ethnic and cultural communities, the geographically isolated and under-resourced communities. Services and activities provided in mental health settings in the past have not been successful in improving access for our diverse underserved and unserved population and have not addressed the issue of stigma. Yet, throughout the Community Program Planning Process, these populations expressed the same needs and concerns. The Holistic Campus project brings together a diverse group to create their own resources, networks, and strategies. The center will be at least 80% peer run and located in a non-mental health setting. An Advisory Board of Directors will be established to ensure that peer and community input drives the direction and the learning process of the center, to oversee the operations of the center, to attract new and culturally specific healing strategies as well as naming the center.

The center will be a hub for local and community based providers and resources. Staff will establish collaborative relationships with physical health providers and community based organizations that deal with housing, employment, education and benefits issues and provide art therapy and culturally specific healing strategies. Examples of the strategies discussed for inclusion are cross-cultural and cross-generational opportunities such as acupressure, acupuncture, sweat lodges, pet therapy, yoga, and healing circles. Ultimately, it will be up to the cultural brokers and the Advisory Board of Directors with input from the community to decide which services will be provided.

This project creates a setting where participants and partners can frame cultural differences as learning sources for each other and the mental health system.

**EXHIBIT F**

**Innovation Projected Revenues and Expenditures**

County: San Bernardino

Fiscal Year: 2009/10

Work Plan #: INN - 04

Work Plan Name: Holistic Campus

New Work Plan

Expansion

Months of Operation: 01/09 - 06/10  
MM/YY - MM/YY

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
<b>A. Expenditures</b>				
1. Personnel Expenditures			927,268	\$927,268
2. Operating Expenditures	84,247		734,000	\$818,247
3. Non-recurring expenditures			13,665	\$13,665
4. Training Consultant Contracts			10,000	\$10,000
5. Work Plan Management				\$0
<b>6. Total Proposed Work Plan Expenditures</b>	<b>\$84,247</b>	<b>\$0</b>	<b>\$1,684,933</b>	<b>\$1,769,180</b>
<b>B. Revenues</b>				
<b>1. Existing Revenues</b>				\$0
<b>2. Additional Revenues</b>				
a. (insert source of revenue)				\$0
b. (insert source of revenue)				\$0
c. (insert source of revenue)				\$0
<b>3. Total New Revenue</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>4. Total Revenues</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>C. Total Funding Requirements</b>	<b>\$84,247</b>	<b>\$0</b>	<b>\$1,684,933</b>	<b>\$1,769,180</b>

Prepared by: \_\_\_\_\_

Date: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

**EXHIBIT F**

**County of San Bernardino  
Holistic Campus  
Three Year Project**

	Each	Year One	Year Two	Year Three	Total	Notes
<b>Anticipated Personnel Expenditures:</b>						
1 Clinical Therapist II	\$94,051		\$94,051	\$94,051	\$188,102	
1 Licensed Psych Tech	\$61,372		\$61,372	\$61,372	\$122,744	
1 Office Assistant III (peer)	\$50,742		\$50,742	\$50,742	\$101,484	
2 PFA III (peer)	\$48,072		\$96,144	\$96,144	\$192,288	
5 PFA II (peer)	\$32,265		\$161,325	\$161,325	\$322,650	
		\$0.00	\$463,634	\$463,634	\$927,268	
<b>Estimated Operating Expenditures:</b>						
Rent			\$180,000	\$180,000	\$360,000	
Outreach costs			\$20,000	\$20,000	\$40,000	
Programs			\$122,000	\$122,000	\$244,000	
Supplies			\$30,000	\$30,000	\$60,000	
General Office Expenses			\$15,000	\$15,000	\$30,000	
Evaluation (5%)			\$42,715	\$41,532	\$84,247	Evaluation funds are included in DBH Operating Expenses; however, the function may be performed by a contract agency.
		\$0.00	\$409,715	\$408,532	\$818,247	
<b>Estimated Non-recurring Expenditures:</b>						
Staff Training			\$10,000		\$10,000	
Medical Equipment			\$13,665		\$13,665	Initial set up for taking vital signs.
		\$0.00	\$23,665		\$23,665	
<b>Total proposed Work Plan Expenditures</b>			<b>\$897,014</b>	<b>\$872,166</b>	<b>\$1,769,180</b>	

- Activities for year one will be exclusively administrative and will include: establishment of Campus Advisory Board of Directors, establishment of key learning goals, and completion of the competitive procurement process.

## EXHIBIT F

**County:** San Bernardino

**Innovation Program:** Holistic Campus

### Budget Narrative

#### A. Expenditures

##### Personnel Expenditures:

The \$927,268 in staffing costs reflects a unique combination of traditional staff and Peer and Family Advocate equivalent staff. The intent is to populate the Peer and Family Advocate equivalent positions and the Office Assistant III, which represent 80% of the positions, with self-disclosed staff.

Traditional staff will provide behavioral health services as well as basic physical health assessments. In the physical health area, the objective is to build the capacity to link consumers with physical health clinics in the community for more extensive medical services.

The Peer and Family Advocate staff will assist consumers in developing self-directed Wellness and Recovery Action Plans focused on the improvement of quality of life.

Staffing expenditures are estimated based on the County's pay scale. In the current plan these positions are contracted through a community based organization; as a result the actual amounts expended have a significant potential for variance.

##### Operating Expenditures:

The operating expenditure estimates include:

Rent and Related Expenses	\$360,000
Community Outreach	40,000
General Behavioral Health and Wellness Programs	244,000
Supplies	60,000
General Office Expenses	30,000
Evaluation (5%)	84,247
<b>Total</b>	<b>\$818,247</b>

A five percent cost for evaluation of the project is included in the Operating Expenditures for the Department of Behavioral Health; however, the function may be performed by a contract agency.

## EXHIBIT F

### **Non-recurring Expenditures:**

Initial training costs for staff are estimated at \$10,000 and include training on the Recovery Model, Cultural Competence and Diversity and Community Organization. An estimate of \$13,665 is also included for basic medical equipment that will be used for physical health assessments.

### **Revenues:**

The program will be designed with the possibility of billing some services to Medi-Cal, however it is not anticipated that the amount billed in the initial stages of the project will be significant.

**EXHIBIT E**  
**Mental Health Services Act**  
**Innovation Funding Request**

County: San Bernardino

Date: 11/13/09

Innovation Work Plans			FY 09/10 Required MHSA Funding	Estimated Funds by Age Group (if applicable)			
No.	Name			Children, Youth, Families	Transition Age Youth	Adult	Older Adult
1	Inn-01	On-line Diverse Community Experiences	\$ 94,500				
2	Inn-02	CASE	\$ 1,791,745				
3	Inn-03	Community Resiliency Model	\$ 830,015				
4	Inn-04	Holistic Campus	\$ 1,769,180				
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
26	Subtotal: Work Plans		\$ 4,485,440	\$0	\$0	\$0	\$0
27	Plus County Administration		\$ 672,816				
28	Plus Optional 10% Operating Reserve		\$ 448,544				
29	Total MHSA Funds Required for Innovation		\$ 5,606,800				

**County of San Bernardino – Department of Behavioral Health  
Mental Health Services Act (MHSA) – INNOVATIONS**

**A Review of Prior Stakeholder Input from Community Public Forums and Targeted  
Forums for CSS (2005) and PEI (2007) Planning  
Sorted by Innovations Strategies**

***Innovations Working Committee review – December 16, 2008 through January 13, 2009***

All prior MHSA stakeholder input events (Community Public Forums and Targeted Forums) were documented using a standard Forum Minutes format which recorded forum discussions and stakeholder recommendations for resources & strategies. These Minutes are maintained in the DBH MHSA files. This data tool was created by and for the San Bernardino County MHSA Innovations Working Committee (IWC) in an attempt to identify prior stakeholder input which is relevant to the Innovations CPP process. Working Committee members reviewed the compiled documentation of prior stakeholder input, attempting to identify suggestions & strategies that will contribute to learning in one or more of the following ways:

1. introduces new mental health practices/approaches that have never been done before, or
2. makes a change to an existing mental health practice/approach, including adaptation for a new setting or community, or
3. introduces a new application to the mental health system of a promising community-driven practice/approach or a practice/approach that has been successful in non-mental health contexts or settings.

**MHSA CPP Stakeholder Comments since 2005**

Members of the county IWC determined that the following prior stakeholder recommendation(s) fall into the categories as indicated.

**1. Introduces new mental health practices/approaches that have never been done before:**

- Establish self-help network and publicity within community collaboratives that will encourage positive behavior and coping skills
- Enlist families early by joining with natural community resources and leaders, addressing concerns together thru collaborative MH education/promotion
- Hold monthly informational MH forums in the community
- Community participation – include MH awareness and outreach programs that function like “neighborhood watch”, include churches
- Have someone who has “been through it” available to relate to community/public, able to relate to own culture
- Work to educate “regular” people about some of the mental health issues, including landlords, trailer park managers
- Develop public education/informational posters, wallet cards, stickers for display/distribution in doctors’ offices, IEHP/Molina, WIC, Welfare offices, Probation, Police station, even county employee pay stub inserts
- Provide MH education on signs of mental health problems at the earliest stages (such as prenatal/Perinatal education for pregnant women, parenting teens and adults)
- Community /public education effort (including PSA’s & TV) on signs/symptoms, wellness, recovery, resources)
- Publicity & MH promotion campaign to give self-help strategies to people to alleviate isolation, address stigma and promote help-seeking/access
- MH Education of community partners, including faith centers (clergy) in early identification of at risk individuals and linkages with crisis services and follow-up support (in-community)

- MH education & outreach which (1) “normalizes” rather than isolates and (2) relies on peer/family support
- Community wide MHSA outreach initiatives that address and promote recovery, mental health and wellness
- Development of community coalitions that work to eliminate the community factors that contribute to the development of problems associated with substance abuse, mental illness, violence, and homelessness
- Teachers, bus drivers, school safety personnel need to be trained in recognizing early signs of trouble in the child and family
- Use internet/website more interactively (drop box message center, live chat help line)
- Create and manage resource data base like 2-1-1- or using Network of Care
- Create resource data base or clearinghouse (more specialized and comprehensive than 2-1-1)
- Educate children re: mental illness. Possibly speaking at a school assembly regarding mental illness; classroom presentations; outreach/education of kids in schools could be part of “health classes
- Educating school counselors and educators on LGBTQ issue
- Develop resources & support for gays & lesbians, especially in remote/mountain communities
- Support & resources for gay & lesbian community
- Distribute funds/resources geographically (equitably)
- Address regional disparity – increase resources for mountains and upper/high desert areas
- Address access and transportation issues, especially for seniors
- Facilitate access/transportation, especially remote regions & for older adults (address isolation) -- mobile team or multi-disciplinary traveling team recommended
- Provide mental health advocates to individual experiencing “first break” – facilitate help with transportation & navigating system
- Promote easier access to support resources, including transportation to/from resource centers, recreational facilities, clinics
- Consider use of mobile outreach unit and aftercare support unit
- Provide multiple service mobile units in community (MH, health, other resource links)
- Provide daycare
- Create “Advisory Club” where consumers can talk to professional or peer advocate about early symptoms
- Have funding available for activities – e.g. activities for children with “healthy” adults and/or older adults – art, sports, music, reading clubs, parks & recreation activities, TAY activities
- Nontraditional interventions including music, theraplay, massage treatment, sensory integration, meditation, animal therapy, movement therapy, art therapy, recreation therapy, fitness/exercise, health/beauty, motivational speakers
- Infusion of the arts leads to changed behavior (i.e., poetry, music, creative use of technology)
- Create environments like parks, work places, and schools that promote a drug free atmosphere (this can help with mental illness as well)
- Resources: “hardship fund”, clothing closet, vouchers, supplies, shoes, underwear, socks, hygiene products, eyeglasses, basic needs, etc.
- Reimbursement of clients/volunteers for participation, trips, activities, etc.
- Provide orientation to mental health treatment, recovery, wellness
- Conflict resolution, mediation
- Address women’s mental health issues (women alone, domestic violence, poverty, homelessness)
- Lack of child care (eligibility/funding restrictions) is an obstacle to seeking services and other functional issues; address this to facilitate support for stressed families

- Social Security advocate
- DBH staff liaison to Courts for evaluation, service recommendations and referral for support, housing, resources.

**2. Makes a change to an existing mental health practice/approach, including adaptation for a new setting or community**

- Provide assistance to communities (schools, families, health providers) with early assessment & identification of emotional disturbance & mental illness (mental health education)
- Create more community centers where MH education, mental illness and alcohol and drug prevention, treatment, support systems and recovery can be accessed
- Support & resources for gay & lesbian community
- Educating school counselors and educators on LGBTQ issue
- Develop resources & support for gays & lesbians, especially in remote/mountain communities
- Cross-gender/cultural/lifestyle support services (LGBT)
- Children need understanding and there is need for more after-school activities and positive activities with peers.
- MH Education of community partners, including faith centers (clergy) in early identification of at risk individuals and linkages with crisis services and follow-up support (in-community)
- Publicity & MH promotion campaign to give self-help strategies to people to alleviate isolation, address stigma and promote help-seeking/access
- MH education & outreach which (1) “normalizes” rather than isolates and (2) relies on peer/family support
- Hold monthly informational MH forums in the community
- Periodic community public forums/conversations in each region
- Community participation – include MH awareness and outreach programs that function like “neighborhood watch”, include churches
- Have someone who has “been through it” available to relate to community/public, able to relate to own culture
- Educating the community (teachers, schools, law enforcement, public defenders, social services, community center staff, all county employees, church staff, school administrators) about mental illness and how it impacts
- Work to educate “regular” people about some of the mental health issues, including landlords and trailer park managers
- Develop public education/informational posters, wallet cards, stickers for display/distribution in doctors’ offices, IEHP/Molina, WIC, Welfare offices, Probation, Police station, even county employee pay stub inserts
- Provide MH education on signs of mental health problems at the earliest stages (such as prenatal/Perinatal education for pregnant women, parenting teens and adults)
- Community /public education effort (including PSA’s & TV) on signs/symptoms, wellness, recovery, resources)
- Launch a “major” public campaign targeting the stigma of mental health, substance abuse, and behavioral/emotional problems and support resources (audience to include: parents, caregivers, schools, doctors offices, community gathering places)
- Educate community regarding stigma related to mental illness (w/ National Alliance for Mentally Ill)
- Outreach to “hidden” communities including Hispanic, ethnic, single mothers, and victims of domestic abuse
- Provide more MHSA focused community outreach through schools, primary care providers, health promoters, faith community, WIC offices, etc.

- Strengthen existing prevention & early intervention resources/networks by strongly linking & using resources within contractor, agency, community based organization and faith community networks (cross-train for improved collaboration & resource sharing)
- Start at birth, parenting skill development
- For pre-schools and day care centers, provide MH education on wellness, early identification, early intervention and appropriate linkage for follow-up
- Provide ongoing consultation or training for teachers & staff in recognizing red flags. K-8
- Need more community outreach & offer classes/training to educate teachers, therapists, counselors about problems children face from diverse backgrounds while they are young
- Educate teachers about problems children face that are from diverse backgrounds
- Education, training and consultation for foster parents (how to handle physical/emotional outbursts)
- Offer family support groups in schools and places where families go (family friendly), including family crisis intervention
- Address access and transportation issues, especially for seniors
- Address regional disparity – increase resources for mountains and upper/high desert areas
- Facilitate access/transportation, especially remote regions & for older adults (address isolation) -- mobile team or multi-disciplinary traveling team recommended
- Educate/consult and collaborate more about co-occurring disorder for mental health & AOD providers
- Training of and partnership with “health promoters” in community to recognize early signs, intervene and help families support family member
- Outreach & Engagement to Senior Centers, bartenders, hairdressers, funeral homes, pharmacies and interagency partners to educate re: early signs & interventions resources – have a large presence in the community
- Consider use of mobile outreach unit and aftercare support unit
- Expand Peer & Family Advocate (PFA) Support model, customized to address support needs/issues of veterans & their families
- Expansion of proactive outreach networks and community events, promoting services responsive to veteran community and their families
- Outreach to parents of newborns through “Healthy Child” pathway, and mental health education with access to early assessment and family supports
- Establish self-help network and publicity within community collaboratives that will encourage positive behavior and coping skills
- Develop support & self-help groups for parents, foster parents, kinship programs, guardians, other caregivers
- Create “safety zones” to reach kids and link with supports
- Having community places/events available for children to go to when they have no parental support
- Due to substance exposed infants, often in foster care, needing multiple services/supports, recommend improved screening starting with newborns (drug screening) so that services can be better coordinated
- Mental Health and Substance Abuse training for our local school counselors so they can better understand the symptoms
- Alcohol/Drug and Mental Health “first responder” field teams for adults in crisis
- Dual Diagnosis meetings/programs – increase availability
- Work with NAMI in developing family “early support” network for veterans/families and other communities
- Increase outreach to seniors, including their neighbors & friends – use mobile unit to reach seniors in remote areas
- Link MH support services to older adult activity centers
- Establish grief support groups for older adults ( & resources that help elders address anger re: loss of spouse, loved ones, independence)

- Integrate mental health, primary health care and public health services in one location in a collaborative program model for early assessment
- In home family educator approach
- Family approach – family advocates, friendly home visits, respite care
- Offer co-parenting counseling
- Intensive case management for “first break” individuals, diverting them from cycle of hospitalization/institutional care altogether; initiate access to needed services and peer supports and begin recovery process at “first sign”
- Have funding available for activities – e.g. activities for children with “healthy” adults and/or older adults – art, sports, music, reading clubs, parks & recreation activities, TAY activities
- Tutoring and after-school programs (which involve parents, care providers)
- Training/consultation needed (for foster parents, juvenile justice staff, DCS staff, teachers, health promoters, doctors)
- Develop Family Support networks, with mental health education component for facilitators
- Instead of Saturday detention, make it counseling sessions (MH presence)
- Support groups in schools, address issues at play, including grief, trauma, loss, family conflict, crisis and domestic violence
- Make available programs for stressed families that facilitate access to financial assistance/advisors, MH education, law enforcement input/guidance
- Better interagency collaboration (including cities) to identify at risk (stressed) families
- Provide Respite care for parents, caregivers, especially women at risk; respite care (“time out”, not necessarily associated with residential respite care)
- MH education of & consultation for school nurses on recognizing early signs
- Remote/mountain communities – provide services in libraries, where children hang out – and other locally determined gathering places
- Provide multiple service mobile units in community (MH, health, other resource links)
- To assist kids in un/under employed families, mental health presence in schools for early identification
- To assist kids in stressed families, mental health assistance in establishing peer support experiences/groups for kids during play times, in play settings
- MH work with family mediators, domestic violence programs & insert MH expertise early
- Infusion of the arts leads to changed behavior (i.e., poetry, music, creative use of technology)
- Peer support groups can help parents in a variety of topics, such as financial concerns, transportation issues, “stressors”
- Children of probationer or parolees that have had exposure to violent situations or abuse, there should be screening of these children when the parents enter into the system. This is “catch early” post trauma behavior. These kids also at a higher risk of substance use.
- Acknowledge that deaf community exists
- Help, especially MH and Drug courts, devise effective plans that keep families together
- “Building a Generation” – non-profit organization devoted to a proactive approach to child rearing
- Work with community agencies to build resource network
- Acknowledge that the deaf community exists
- Education on relaxation/breathing
- Help with controlling problems/symptoms
- Strengthen Perinatal – identify at risk infants, provide ongoing assessment/monitoring
- Returning veterans/families – recommend peer support groups, family support groups, services in settings where families normally go for support (doctor, church, tap in VA network)
- Hotline services (veterans/families) for those coping with stress and early signs
- Services for people “in the street” who are often dually diagnosed (co-occurring)

- Inland Behavioral & Health Services (IBHS) – program providing volunteer licensed clinical social workers (LCSW's) going into communities to help individual/families and communities deals with violent event (Post Traumatic Stress counseling)
- "Cornerstone Counseling" (Ecclesia Christian Fellowship Church) provides anger management classes (recommended community-based model)
- MH Education re: non-violent conflict resolution
- "Young Visionaries" program assists trauma-exposed individuals in community (recommended link/model/resource)
- "Pastor on the Premises Program" – school-based effort
- Expansion of Peer & Family Advocate network, customized to serve specialty populations
- Integrate mental health into primary health care setting in a collaborative program model for early assessment
- Collaboration w/PCP (family doctors) for better awareness of available referrals, resources
- School presentations (MH education) on school bullying and how to respond
- Intervention classes for domestic violence victims/survivors, including anger management (bilingual)
- Expand support groups, linking with existing programs, for victims of domestic violence
- Create support systems & advocates for "first breaks" - help families navigate the system
- Children of probationer or parolees that have had exposure to violent situations or abuse, there should be screening of these children when the parents enter into the system. This is "catch early" post trauma behavior. These kids also at a higher risk of substance use
- Boys & Girls Club w/ mental health consultation/presence and linkage
- Intergenerational program linking older adults with children and teens
- Address women's mental health issues (women alone, domestic violence, poverty, homelessness)
- LGBTQ support groups.
- "Coming out" support.
- For ethnic/cultural groups, including older adults: increase presence via family support networks and "normalize" help-seeking behavior, the discussion of stress, coping, conflict management, problem-solving, recovery (I am not alone) – work through faith centers, de-stigmatized resources & natural gathering places
- Tutoring programs for parents who cannot afford "Sylvan"
- Sober living with children
- Deaf services

### **3. Introduces a new application to the mental health system of a promising community-driven practice/approach or a practice/approach that has been successful in non-mental health contexts or settings**

- Periodic community public forums/conversations in each region
- Community participation – include MH awareness and outreach programs that function like "neighborhood watch", include churches
- Have someone who has "been through it" available to relate to community/public, able to relate to own culture
- Develop public education/informational posters, wallet cards, stickers for display/distribution in doctors' offices, IEHP/Molina, WIC, Welfare offices, Probation, Police station, even county employee pay stub inserts
- MH education & outreach which (1) "normalizes" rather than isolates and (2) relies on peer/family support
- Facilitate collaborative efforts customized to each region, community, client cultural group and pull network of agencies, faith and community based orgs together

- Collaboration w/PCP (family doctors) for better awareness of available referrals, resources
- Integrate mental health into primary health care setting in a collaborative program model for early assessment
- To assist stressed families, link with family doctors, help them interpret physical symptoms that may also be related to stress
- To address stigma and fear associated with mental health issues, consider teaming mental health psychologist/consultant with family doctors – where parents more willing to go, we are more likely to facilitate early education and assistance
- Training of and partnership with “health promoters” in community to recognize early signs, intervene and help families support family member
- Strengthen existing prevention & early intervention resources/networks by strongly linking & using resources within contractor, agency, community based organization and faith community networks (cross-train for improved collaboration & resource sharing)
- Expansion of proactive outreach networks and community events, promoting services responsive to veteran community and their families
- Provide assistance to communities (schools, families, health providers) with early assessment & identification of emotional disturbance & mental illness (mental health education)
- Reach youth (TAY) through community activities, sports activities, job activities, “inner” activities
- Outreach to parents of newborns through “Healthy Child” pathway, and mental health education with access to early assessment and family supports
- Develop support & self-help groups for parents, foster parents, kinship programs, guardians, other caregivers
- Offer family support groups in schools and places where families go (family friendly), including family crisis intervention
- Support groups in schools, address issues at play, including grief, trauma, loss, family conflict, crisis and domestic violence
- Children need understanding and there is need for more after-school activities and positive activities with peers.
- Start at birth, parenting skill development
- Tap into Kinship/Grandparent Support Group networks
- Kinship centers for grandparents raising grandchildren – provide easy access to services via kinship/senior centers
- Help parents with their relationships to prevent trauma of separation/divorce, domestic violence (settings such as schools, churches, community centers)
- Tutoring and after-school programs (which involve parents, care providers)
- Lack of child care (eligibility/funding restrictions) is an obstacle to seeking services and other functional issues; address this to facilitate support for stressed families
- Educating school counselors and educators on LGBTQ issue
- Form partnerships and a support network in the legal system---have youth serve as links
- Create clubs and forums with teenagers and teach coping, negotiation, and leadership skills. Use Friday Night Live model
- Provide support groups at community college campuses, especially for TAY youth “abandoned” by troubled parents
- “Infiltrate” court system to find fathers who need help managing anger and conflict  
Increase outreach to seniors, including their neighbors & friends – use mobile unit to reach seniors in remote areas
- Mentorship program in late elementary & middle school age kids
- Educate community regarding stigma related to mental illness (w/ National Alliance for Mentally Ill)
- To address variety of trauma affecting kids/families such a bullying, sexual abuse, sexual violence, gang violence, child death, suicide, substance abuse, homelessness, foster

- care placement, poverty, community violence, conflict resolution: provide MH presence/consultation/education in schools which are viewed as “safe” place for learning how to get out of violent situations
- Support groups w/ mental health expertise (for individuals, parents, caregivers) to address trauma, grief, loss, death, divorce, bereavement
  - Provide community resources for social/recreational and artistic activities as recovery options and “outlets”
  - Target children in cases of domestic violence for counseling
  - Following traumatic event, provide assistance to affected family or community (debriefing), assess needs; child support can be coordinated w/ school; family support thru support networks/groups
  - Include co-occurring (substance abuse/PTSD) in all support systems developed for returning veterans
  - Easily accessible education/support for veterans/families on parenting, coping, job re-entry
  - Conflict resolution approach needs to be brought into the community, as opposed to “tickets” and “fines” approach
  - “Young Ingénue” - a character & life skills building program at Temple Community Outreach Center – model/link/resource
  - Inland Behavioral & Health Services (IBHS) – program providing volunteer licensed clinical social workers (LCSW’s) going into communities to help individual/families and communities deals with violent event (Post Traumatic Stress counseling)
  - “Cornerstone Counseling” (Ecclesia Christian Fellowship Church) provides anger management classes (recommended community-based model)
  - Friday Night Live – example of good stigma buster
  - Gang Reduction (GRIT) and other Prevention programs
  - Expand the “Club” concept
  - Consider models such as DRUMLINE, Youth Accountability Boards, Young Visionaries
  - Big Brothers and Sisters Program because kids listen to peers not elders
  - Consider model such as Sunshine Circles, which facilitate children to express emotions
  - MH Education re: non-violent conflict resolution
  - “Young Visionaries” program assists trauma-exposed individuals in community (recommended link/model/resource)
  - “Pastor on the Premises Program” – school-based effort
  - The “Student Advocates” model is a group that attends expulsion hearings and is recommended.
  - Time for Change Foundation
  - The Rose
  - Top Flight
  - “Back to Basics”
  - ART- Aggression Replacement Training – excellent program that works w/ family to instill appropriate behaviors
  - Community Action Partnership
  - Programs that involve field trips, sports, teen camps for youth including therapeutic behavior intervention
  - Drug & alcohol services for chemically dependent youth, and their caretakers, including Spanish Speaking
  - Form partnership between family court mediators, DCS, DBH to address early symptoms of mental illness
  - Universal screening for trauma/stressors in day care centers, pediatricians’ offices, family doctors’ office, pre-schools and schools
  - Improve access for kids to early assessment and early intervention (and diversion)
  - Need sober living resource for males in mountain region
  - Work in conjunction with cities

- Make services available in multiple languages, including sign language (deaf services)
- Provide mentoring/buddy system or Peer-to-Peer support
- Mentoring & support/network for stressed parents, with case management or follow-up
- Create parent education and support groups and workshops
- Facilitate collaborative efforts customized to each region, community, client cultural group and pull network of agencies, faith and community based orgs together
- Head Start programs – perfect place to conduct early screening in collaboration with public health nurse & facilitate needed care at lowest intensity
- Partner with libraries for after school programs
- African-American children/youth do better when they study together in a group (the “collective” experience)
- Identify churches that are already providing “non-traditional” services to this group, as well as federally qualified health centers (FQHC) and other CBO’s
- Parent involvement with strong support system which would include a collaborative among schools, teachers, mental health workers, and community based organizations, to identify at risk children and provide services to child & family
- Church and community involvement to assist the schools
- Add resources to existing programs to assist them with their efforts (such as Student Accountability Board, SART)
- Big Brother- Sister program
- Provide lesbian & gay groups in schools
- Assertively address needs/isolation of LGBTQ kids which represent high suicide risk
- Partner with churches that can mentor kids/youth before and after “coming out” to alleviate stress/isolation/risk (LGBTQ)
- For very young children, consider combination of play therapy and good early childhood practices
- MH be visible in nontraditional gathering places to gain access to men/dads, such a health clubs/gyms – work via trainers/life coaches to provide MH education, teach coping skills, conflict management, problem-solving skills
- MH presence in libraries – educate library staff re: early signs of child/family trouble, at risk homeless kids, runaways, homeless moms, latch-key kids, and kids who don’t want to go home
- Introduce MH education & consultation - prenatal/post-partum women in OB/GYN clinics
- In our county, average age for suicide among boys is 14 & for girls is 16; to impact this, MH education is needed in schools & we must start identifying signs much earlier than these ages
- Often “acting out” kids get (negative) attention while “depressed” kids are ignored and this may lead to self-destructiveness, dropout and even suicide. MH education of school personnel and families needed
- Use gyms to promote over all good health and life coaching. Use questionnaires to identify issues and offer appropriate services
- Mentoring an important concept: family mentoring, peer mentoring, adult support mentoring. Think about linking to potential volunteers as seniors, Rotary Club, professionals/retirees, clergy and church community members. There is also a volunteer data base within 2-1-1
- Infusion of the arts leads to changed behavior (i.e., poetry, music, creative use of technology)
- More educational means for families and children. Use alternative means of communicating the message for immigrants.
- Mentoring program (paid)
- Eliminate the county dress code which creates barrier & “class” division between community, clients, staff
- For remote/ mountain communities, older adults can be accessed via “meals on wheels”, senior centers

- Join with ESL classes to educate parents of at risk kids on mental health issues
- Locate resource/services in one-stop centers, addressing both stigma and transportation issues
- Focus on whole family – younger siblings may be responsibility of at risk student due to family issues
- More 12-step programs, halfway houses, programs like Cedar House

**Community Challenges & Unserved, Underserved, Inappropriately Served Individuals**

**The Innovations Working Committee reviewed prior stakeholder input regarding “trauma” & other challenges experienced by our communities. The following items were highlighted due to the possible relationship to disparity in access.**

- Drugs & Alcohol/Substance Abuse/Addiction
- Domestic Violence/Family Violence (often a child's first exposure to violence)
- Gang activities
- Poverty
- Homelessness
- Community violence
- Lost loved ones
- Crime/Criminal/Parolee Population
- Child Abuse/Neglect
- Sexual Abuse
- Financial reverses, increased bills (especially elders)
- Bouncing around service system; lack of access – lack of services
- Isolation/abandonment among elders, veterans
- Racial Discrimination/Racial Conflict
- Returning Veterans experiencing unemployment, homelessness
- Suicide
- Unemployment
- Urban blight/Negative changes in Neighborhoods
- Bullying
- Older Adults – Lack of Transportation/Isolation
- Date violence
- Discrimination
- Children's Prenatal Exposure to drugs/alcohol
- Traffic Congestion
- Rape
- Prejudice against homosexuality
- Removal from Home – Foster Care
- “Latch Key Kids”
- Multiple losses for elders, including medical problems, death of pets
- Domestic Violence (including elders)
- Hunger
- Teen Pregnancy/Parenting
- Elders living alone
- Isolation/transportation issues

**Common Themes:** Committee members noted common themes from prior stakeholder input.

LGBTQ; Regional disparity in access; Co-occurring; minority ethnic populations; need for community mental health education; potential for expanded support networks/coalitions























Department of Behavioral Health  
 Innovations Stakeholder Comments  
 Prior to November 12, 2008

Comment	Underserved Population								Age				Location						Services																																
	African American	API/Vietnamese	Deaf/HOH	Disabled	Latino	LGBTQ	Military	Native American	Children	TAY	Adults	Older Adults	Upper Desert	Low Desert	Mid Valley	Mountains	West Valley	Isolated	Access	Other Resrc	Childcare	Clinic Issues	Comm Collaboration	Confidentiality	Crisis	Cultural Comp	Cultural Healing	Data Collect	Early ID & Intervention	Employment	Exp Existing	Families	Faith Based	Funding	Homeless	IT Projects	Info Sharing	Interagency	Location	Medical	Mentoring	MH Education & Training	Miscellaneous	Peer Support	Positive Act	Quality	School Pgms	Self Help	Shelter	Support Grps	Transportation
<b>Totals</b>	1				2	13	8	0	39	23	5	13	2	0	0	7	0	8	16	36	3	9	52	0	9	6	0	1	38	1	7	30	18	2	1	3	0	25	35	1	7	111	17	18	18	0	35	6	1	31	7

Resource & Partnership Network for MHS Community Program Planning (CPP)  
San Bernardino County

The stakeholders & partners listed below have been active participants in the county's CPP process, many as early as the CSS or PEI planning phases. Innovation Working Committee members utilized this grid as a tool for outreach to advocates, agencies, communities & organizations as potential participants in planning. In addition, stakeholder representatives listed below provided input during the PEI & CSS CPP processes and the list grew with subsequent stakeholder input & coalition-building throughout the Innovation CPP process. \*The asterisk indicates partners continuing their participation during the Innovation CPP process. *Partners joining during the Innovation CPP are highlighted in italics.*

Sector	Partner Organization/Agency Category	Partner/ Organization/Agency
<b>UNDERSERVED COMMUNITIES</b>	Community Based Organizations (CBOs) representing Native Americans	<ul style="list-style-type: none"> <li>➤ *Fontana Native American Indian Center (Dakota; Kiowa; Chippewa Band of Ojibwa)</li> <li>➤ First Nations Counseling (Apache)</li> <li>➤ Native American Family Services (Apache)</li> <li>➤ Native American Community Council (Yaqui Council; Gabrelino/Tongva Council)</li> <li>➤ San Bernardino Valley College Indigenous Council</li> <li>➤ LaKota Council (California State University, San Bernardino)</li> </ul>
	CBOs - African Americans	<ul style="list-style-type: none"> <li>➤ <i>Time for Change</i></li> <li>➤ <i>The Brightest Star</i></li> <li>➤ <i>Brothers &amp; Sisters in Action</i></li> <li>➤ <i>Positive Changes</i></li> <li>➤ <i>Young Visionaries</i></li> <li>➤ *Knotts Family &amp; Parenting Agency</li> <li>➤ *Inland Empire Concerned African American Churches (IECAAC)</li> <li>➤ *Inland Behavioral &amp; Health Services (IBHS)</li> <li>➤ *African American Health Initiative</li> <li>➤ Quality of Life Group (Child Psychiatry)</li> <li>➤ Temple Community Outreach Center</li> <li>➤ Temple Women's Center</li> <li>➤ Black Voice (African-American newspaper)</li> <li>➤ Pastors on the Premises</li> </ul>
	CBOs - Latinos	<ul style="list-style-type: none"> <li>➤ <i>El Sol Neighborhood Center</i></li> <li>➤ <i>Alas Para Tu Salud</i></li> <li>➤ <i>Bienestar Human Services</i></li> <li>➤ <i>Nuevo Amanecer</i></li> <li>➤ <i>Building a Generation</i></li> <li>➤ *Bilingual Family Counseling</li> <li>➤ *Para Los Niños</li> <li>➤ *Casa de San Bernardino</li> <li>➤ Bilingual Family Solutions</li> <li>➤ Por La Vida Program</li> </ul>

	CBOs - Asian/Pacific Islanders	<ul style="list-style-type: none"> <li>➤ <i>Quan Am Buddhist Meditation</i></li> <li>➤ <i>*Asian American Resource Center</i></li> </ul>
	CBO's - Refugee-Immigrant	<ul style="list-style-type: none"> <li>➤ <i>Bienestar Human Services</i></li> <li>➤ <i>*Asian American Resource Center</i></li> </ul>
	CBOs - LGBTQ	<ul style="list-style-type: none"> <li>➤ <i>Equality Inland Empire</i></li> <li>➤ <i>*Rainbow Pride Youth Center</i></li> <li>➤ <i>Jeffrey Owens Community Center</i></li> <li>➤ <i>LGBT Resource Center</i></li> </ul>
	Military Veterans/Family Support Resources	<ul style="list-style-type: none"> <li>➤ <i>Depression &amp; Bipolar Support Alliance - VA</i></li> <li>➤ <i>*Barstow VA home</i></li> <li>➤ <i>**"Vet to Vet" Program</i></li> <li>➤ <i>*VA Medical Center Loma Linda consumer advocacy</i></li> </ul>
	Domestic Violence Resources	<ul style="list-style-type: none"> <li>➤ <i>Victor Valley Domestic Violence, Inc.</i></li> <li>➤ <i>High Desert Domestic Violence Program</i></li> <li>➤ <i>Desert Sanctuary</i></li> <li>➤ <i>*DOVES - Bear Valley</i></li> <li>➤ <i>*DOVES - Desert</i></li> <li>➤ <i>House of Ruth</i></li> </ul>
	CBO's <b>general</b> un/underserved communities	<ul style="list-style-type: none"> <li>➤ <i>Morongo Basin Unity Home</i></li> <li>➤ <i>South Coast Community Services</i></li> <li>➤ <i>Project Sister Family Services</i></li> <li>➤ <i>A Servant's Heart Outreach</i></li> <li>➤ <i>Building A Generation</i></li> <li>➤ <i>First Chance, Inc.</i></li> <li>➤ <i>Time for Change Foundation</i></li> <li>➤ <i>Reach Out Morongo Basin</i></li> <li>➤ <i>*Reach Out West End</i></li> <li>➤ <i>*West End Family Counseling</i></li> <li>➤ <i>*Knotts Family &amp; Parenting Institute</i></li> <li>➤ <i>*Para Los Niños</i></li> <li>➤ <i>*Lutheran Social Services</i></li> <li>➤ <i>*South Coast Children's Society</i></li> <li>➤ <i>*EMQ Children/Family Services</i></li> <li>➤ <i>CASTLE Positive Parenting</i></li> <li>➤ <i>Family Service Agency</i></li> <li>➤ <i>High Desert New Beginnings</i></li> <li>➤ <i>Family Solutions</i></li> <li>➤ <i>Inland Caregiver Resource Center</i></li> <li>➤ <i>Samaritan Counseling Center</i></li> </ul>

	Community Members, Consumers, Family Members	<ul style="list-style-type: none"> <li>➤ <i>Brothers &amp; Sisters in Action</i></li> <li>➤ <i>Concerned Black Men</i></li> <li>➤ <i>Equality Inland Empire</i></li> <li>➤ <i>Redlands United Church of Christ (RUCC)</i></li> <li>➤ <i>Consumer Advisory Board (CAB)</i></li> <li>➤ <i>Morongo Basin Arch</i></li> <li>➤ <i>Overeaters Anonymous</i></li> <li>➤ <i>New Focus</i></li> <li>➤ <i>Clubhouse - Jewel of the Desert</i></li> <li>➤ <i>CCS Harmony Clubhouse</i></li> <li>➤ <i>Santa Fe Social Clubhouse</i></li> <li>➤ <i>*Make a Difference Association</i></li> <li>➤ <i>*NAMI</i></li> <li>➤ <i>*Consumers</i></li> <li>➤ <i>*Family members</i></li> <li>➤ <i>*Pathways to Recovery</i></li> <li>➤ <i>*Parent Partners Network Program</i></li> <li>➤ <i>*Consumer Clubhouse Network</i></li> <li>➤ <i>Dual Diagnosis Anonymous</i></li> <li>➤ <i>Inland Caregiver Resource Center</i></li> <li>➤ <i>One 2 One Mentors</i></li> <li>➤ <i>The Bridge</i></li> </ul>
<b>EDUCATION</b>	County Schools	<ul style="list-style-type: none"> <li>➤ Superintendent of County Schools (SBCSS)</li> <li>➤ Kids N Care, SBCSS</li> <li>➤ State Preschool, SBCSS</li> </ul>
	School Districts	<ul style="list-style-type: none"> <li>➤ <i>Chaffey Joint Unified HS District</i></li> <li>➤ <i>Etiwanda School District</i></li> <li>➤ <i>*Ontario-Montclair School District - Montclair Community Collaborative</i></li> <li>➤ <i>*Ontario-Montclair School District - Safe Schools/Healthy Students</i></li> <li>➤ <i>*Ontario-Montclair School District - Family Solutions Collaborative</i></li> <li>➤ <i>*Chino Valley Unified School District</i></li> <li>➤ <i>*San Bernardino Unified School District, Superintendent</i></li> <li>➤ <i>Bear Valley Healthy Start Collaborative</i></li> <li>➤ <i>Bear Valley School District</i></li> <li>➤ <i>Redlands Unified School District</i></li> <li>➤ <i>Alta Loma School District (Special Ed., Pupil Services, Psychology, Admin)</i></li> <li>➤ <i>Big Bear School District</i></li> </ul>

		<ul style="list-style-type: none"> <li>➤ Colton School District</li> <li>➤ Fontana Unified School District/Early Education</li> <li>➤ Rialto Unified School District</li> <li>➤ Apple Valley School District</li> </ul>
	Parent-Teacher Associations	<ul style="list-style-type: none"> <li>➤ Via school collaboratives and libraries</li> </ul>
	SELPA's	<ul style="list-style-type: none"> <li>➤ Desert-Mountain SELPA</li> <li>➤ High Desert Collaborative/SELPA</li> </ul>
	School-based Health Centers	<ul style="list-style-type: none"> <li>➤ *Westside (Adelanto) Family Health Center - Public Health CFHS</li> </ul>
	4-Year College/University Institutions	<ul style="list-style-type: none"> <li>➤ *California State Polytechnic University, Pomona</li> <li>➤ *Loma Linda University</li> <li>➤ *California State University, San Bernardino (CSUSB)</li> <li>➤ Foundation for CSUSB</li> <li>➤ UCR Extension</li> </ul>
	Community Colleges	<ul style="list-style-type: none"> <li>➤ *San Bernardino Valley (Community) College</li> <li>➤ Cooper Mountain College</li> </ul>
	Adult Education	<ul style="list-style-type: none"> <li>➤ <i>Escuela de Ingles de Adultos</i></li> <li>➤ UCR Extension - Early Childhood</li> <li>➤ CSUSB</li> </ul>
	First 5 Commission	<ul style="list-style-type: none"> <li>➤ *Knotts Family Agency</li> <li>➤ *Para Los Niños</li> <li>➤ *Vista Guidance Center</li> <li>➤ *Morongo Basin Mental Health</li> <li>➤ *Ontario-Montclair School District</li> <li>➤ *Reach Out West End</li> <li>➤ *Asian American Resource Center</li> <li>➤ *Latino Health Collaborative</li> <li>➤ First 5 San Bernardino</li> <li>➤ START</li> <li>➤ UCR Extension - Early Childhood/Family Services</li> <li>➤ Kids N Care, SB County Superintendent of Schools</li> <li>➤ First 5 East Valley Collaborative</li> <li>➤ Samaritan Counseling Center</li> <li>➤ Montclair Community Collaborative</li> <li>➤ High Desert New Beginnings</li> </ul>
	Pre-schools	<ul style="list-style-type: none"> <li>➤ CSUSB Children's Center</li> <li>➤ Teddy Bear Tymes</li> <li>➤ County Pre-School Services</li> <li>➤ State Preschool Services</li> </ul>

	Technical Assistance/Planning & Advocacy Organizations	<ul style="list-style-type: none"> <li>➤ <i>Renaissance Scholars</i></li> <li>➤ <i>*CiMH</i></li> <li>➤ Childcare Planning Council</li> <li>➤ Countywide Children's START</li> <li>➤ Institute for Public Strategies</li> </ul>
<b><i>INDIVIDUALS W/ SERIOUS MENTAL ILLNESS &amp;/or THEIR FAMILIES</i></b>	Client and family member organizations	<ul style="list-style-type: none"> <li>➤ <i>Santa Fe Social Clubhouse</i></li> <li>➤ <i>TAY Center - Desert</i></li> <li>➤ <i>TAY Center - Rancho Cucamonga/West Valley</i> NAMI Inland Valley</li> <li>➤ <i>*NAMI San Bernardino</i></li> <li>➤ <i>*NAMI Morongo Basin</i></li> <li>➤ <i>*NAMI High Desert</i></li> <li>➤ <i>*NAMI West Valley</i></li> <li>➤ <i>*Parents Partners Network</i></li> <li>➤ <i>*Pathways to Recovery (Client Operated Clubhouse)</i></li> <li>➤ <i>*TEAM House (Client Operated Clubhouse)</i></li> <li>➤ <i>*Amazing Place (Client Operated clubhouse)</i></li> <li>➤ <i>*Lucerne Valley Clubhouse (Client Operated Clubhouse)</i></li> <li>➤ <i>*"Vet to Vet" Program</i></li> <li>➤ <i>NAMI-Patton</i></li> </ul>
<b><i>PROVIDERS OF MENTAL HEALTH SERVICES</i></b>	DBH Clinics and Programs	<ul style="list-style-type: none"> <li>➤ <i>*Adult System of Care</i></li> <li>➤ <i>*Victor Valley Behavioral Health</i></li> <li>➤ <i>*Forensic Services</i></li> <li>➤ <i>*Upland Community Counseling</i></li> <li>➤ <i>*Agewise</i></li> <li>➤ <i>*MHSA Children's Programs</i></li> <li>➤ <i>*Centralized Children's Intensive Case Management Services</i></li> <li>➤ <i>*Children's Crisis Response Team</i></li> <li>➤ <i>*Transition Age Youth (TAY) One Stop Center - San Bernardino</i></li> <li>➤ <i>*Juvenile Justice Programs</i></li> <li>➤ <i>Lucerne Valley Clinic</i></li> <li>➤ <i>Barstow Counseling Center</i></li> <li>➤ <i>Adult Forensics - STAR</i></li> <li>➤ <i>Holt Integrated Health Care</i></li> </ul>
<b><i>PROVIDERS OF MENTAL HEALTH SERVICES</i></b>	DBH Contractor providers	<ul style="list-style-type: none"> <li>➤ <i>TAY Center - Pacific Clinics Desert</i></li> <li>➤ <i>TAY Center - Pacific Clinics Rancho Cucamonga/West Valley</i></li> <li>➤ <i>Victor Community Support Services Pacific Clinics</i></li> <li>➤ <i>*Telecare/High Desert CWIC</i></li> <li>➤ <i>*Lutheran Social Services, Big Bear, desert</i></li> <li>➤ <i>*Valley Star Children &amp; Family Services</i></li> </ul>

		<ul style="list-style-type: none"> <li>➤ *Pacific Clinics</li> <li>➤ *EMQ Children &amp; Family Services</li> <li>➤ *West End Family Counseling</li> <li>➤ *Desert Mountain FICS</li> <li>➤ *Morongo Basin Mental Health</li> <li>➤ *Victor Children's Services</li> <li>➤ Rim Family Services</li> <li>➤ East Valley CHARLEE</li> <li>➤ Bilingual Family Services</li> </ul>
<b>HEALTH</b>	Community Health Clinics/Centers	<ul style="list-style-type: none"> <li>➤ *St. John of God Healthcare</li> <li>➤ Molina Health Care</li> </ul>
	School-based Health Centers	<ul style="list-style-type: none"> <li>➤ *Westside (Adelanto) Family Health Center - Public Health CFHS</li> </ul>
	Primary health care settings/clinics	<ul style="list-style-type: none"> <li>➤ Holt Integrated Health Care</li> </ul>
	Public Health Clinics/Centers	<ul style="list-style-type: none"> <li>➤ *County Public Health-CFHS</li> <li>➤ *Public Health Clinics - countywide</li> </ul>
	Specialist mental health care services	<ul style="list-style-type: none"> <li>➤ *Inland Behavioral &amp; Health Services (IBHS)</li> <li>➤ *Mental Health Systems</li> <li>➤ First Nations Counseling (Native American MH Resource)</li> <li>➤ GM Psychological Services</li> </ul>
	Specialist older adult health services	<ul style="list-style-type: none"> <li>➤ *Department of Aging &amp; Adult Services (specialty care/resources)</li> </ul>
	Native American Health Centers	<ul style="list-style-type: none"> <li>➤ via *Native American Collaborative effort</li> </ul>
	Community Health Centers	<ul style="list-style-type: none"> <li>➤ Kids Come First Clinic</li> </ul>
	Alcohol & Drug Treatment Centers	<ul style="list-style-type: none"> <li>➤ <i>College Community Services</i></li> <li>➤ <i>Matrix Institute</i></li> <li>➤ <i>Panorama Ranch</i></li> <li>➤ <i>Cox Sober Living</i></li> <li>➤ <i>Center for Healing</i></li> <li>➤ *DBH Alcohol &amp; Drug Program Administration</li> <li>➤ *DBH Alcohol &amp; Drug Program Prevention</li> <li>➤ *Drug Court/Treatment Centers Coordination</li> <li>➤ *Morongo Basin MH Clinic</li> <li>➤ *St. John of God Health Care</li> <li>➤ *Mental Health Systems, Redlands CFC</li> <li>➤ *Mental Health Systems, Rancho Cucamonga</li> <li>➤ *Needles Center for Change</li> <li>➤ *San Bernardino Center for Change</li> <li>➤ *Cedar House</li> <li>➤ *Casa de San Bernardino</li> </ul>

		<ul style="list-style-type: none"> <li>➤ *Inland Behavioral &amp; Health Services</li> <li>➤ *Para Los Ninos</li> <li>➤ *Vista Guidance Center</li> <li>➤ *Inland Valley Drug &amp; Alcohol Recovery Services</li> <li>➤ *DBH Chino Multiple Diagnosis Clinic</li> <li>➤ Operation Breakthrough</li> <li>➤ Rim Family Services</li> <li>➤ New House, Inc</li> <li>➤ One 2 One Mentors</li> <li>➤ Institute for Public Strategies</li> <li>➤ Miracles in Recovery</li> <li>➤ City of the Lord FGBC, Inc.</li> <li>➤ Fontana Regional Recovery Center</li> <li>➤ Bilingual Family Counseling</li> </ul>
	Regional Centers (Developmental Disabilities)	<ul style="list-style-type: none"> <li>➤ *Inland Regional Center</li> </ul>
	Emergency Services	<ul style="list-style-type: none"> <li>➤ *Arrowhead Regional Medical Center (ARMC-BH)</li> </ul>
	Maternal Child & Adolescent Health Services	<ul style="list-style-type: none"> <li>➤ *Public Health</li> <li>➤ Planned Parenthood of San Bernardino County</li> </ul>
	Other	<ul style="list-style-type: none"> <li>➤ <i>Quan Am Buddhist Meditation</i></li> <li>➤ <i>Inland Empire Health Plan (IEHP)</i></li> <li>➤ <i>Autism Society Inland Empire</i></li> <li>➤ <i>The Fact Center</i></li> <li>➤ <i>Disability Rights Legal Center</i></li> <li>➤ <i>Rolling Start</i></li> <li>➤ *Inland Behavioral and Health Services (Community Incident Response)</li> <li>➤ *Latino Health Collaborative</li> <li>➤ *African American Health Initiative</li> <li>➤ *Hospital Association</li> <li>➤ Visiting Nurses Association</li> <li>➤ START Pediatric Neuro Center</li> <li>➤ Planned Parenthood of San Bernardino County</li> <li>➤ Canyon Ridge Hospital</li> <li>➤ Redlands Community Hospital</li> <li>➤ San Bernardino Community Hospital</li> <li>➤ Bear Valley Community Hospital District (MOM Project)</li> <li>➤ Private practitioners</li> </ul>
<b><i>SOCIAL SERVICES</i></b>	Child/family Welfare & Child Protective Services (DCS)	<ul style="list-style-type: none"> <li>➤ *Department of Children's Services</li> <li>➤ *Transitional Assistance Department (TAD)</li> <li>➤ California Children Services</li> </ul>

	CalWorks	➤ *Transitional Assistance Department (TAD) - CalWorks
	Child Protective Service	➤ *Department of Children's Services - CPS line/management staff
	Home & Community Care	➤ Visiting Nurses Association
	Disability Services	➤ *Social Security Administration ➤ *Inland Regional Center
	Adult Protective Services	➤ *Department of Adults/Aging (DAAS) ➤ *DAAS - Adult Protective Services ➤ *DAAS - IHSS ➤ *Public Guardian
	Veterans Services	➤ *County Veterans Affairs ➤ *Veterans Administration Hospital ➤ *Barstow Veterans Home
	Interagency Collaboration/Resource Coordination	➤ *Children's Network ➤ Homeless Coalition ➤ Bear Valley Healthy Start Collaborative ➤ 2-1-1 - Inland Empire United Way ➤ County Human Services - Program Development, early childhood ➤ County Human Services - Program Development, aging & adult services ➤ Montclair Community Collaborative ➤ Human Services - City of Montclair ➤ Community Development & Housing ➤ Housing Authority ➤ Healthy Start - Bear Valley ➤ Bear Valley Hummingbird ➤ Discoveries in Recovery (Bear Valley)
	Community Based Organizations - multi-services	➤ <i>Victor Valley Domestic Violence</i> ➤ <i>High Desert Domestic Violence</i> ➤ <i>Urban Community Action Projects</i> ➤ <i>Quan Am Buddhist Meditation</i> ➤ <i>A Servant's Heart Outreach</i> ➤ <i>Leap Through the Fire Faith</i> ➤ *Reach Out West End ➤ *Lutheran Social Services ➤ *Asian American Resource Center ➤ *Westside (Adelanto) Family Health Center - Public Health CFHS ➤ Rim Family Services ➤ DOVES Domestic Violence Education & Services - Bear Valley ➤ DOVES Domestic Violence & Education Services - Crestline/mountains

		<ul style="list-style-type: none"> <li>➤ House of Ruth</li> <li>➤ Project Sister Sexual Assault Crisis/Prevention Services</li> <li>➤ Nonprofit Executive Network</li> <li>➤ First 5 San Bernardino</li> <li>➤ Reach Out (older adults)</li> <li>➤ Samaritan Counseling Center</li> <li>➤ Bilingual Family Services</li> <li>➤ YES Center (foster/group home/ILP youth)</li> <li>➤ Por La Vida</li> </ul>
<b>LAW ENFORCEMENT</b>	County Criminal Justice/Justice System	<ul style="list-style-type: none"> <li>➤ <i>County Counsel</i></li> <li>➤ <i>Superior Court Probate Conservatorship</i></li> <li>➤ *County District Attorney</li> <li>➤ West Valley Juvenile Detention Center</li> <li>➤ Mental Health &amp; Justice Consensus Committee</li> <li>➤ VisionQuest/Lodgemakers</li> </ul>
	Juvenile Courts	<ul style="list-style-type: none"> <li>➤ *Mental Health Court</li> <li>➤ Superior Court Judge</li> <li>➤ Dependency Court Judges</li> </ul>
	Adult Courts	<ul style="list-style-type: none"> <li>➤ Drug Courts (various regions)</li> <li>➤ Superior Court Family Services</li> </ul>
	Adult Probation	<ul style="list-style-type: none"> <li>➤ *County Probation</li> </ul>
	Juvenile Probation	<ul style="list-style-type: none"> <li>➤ *County Probation</li> </ul>
	Public Defenders	<ul style="list-style-type: none"> <li>➤ County Public Defender</li> </ul>
	Sheriff/Police	<ul style="list-style-type: none"> <li>➤ San Bernardino County Sheriff</li> <li>➤ Hesperia Sheriff</li> <li>➤ Morongo Basin Sheriff</li> <li>➤ Colton Police</li> <li>➤ Chief of Police Association</li> </ul>
<b>COMMUNITY &amp; FAMILY RESOURCES &amp; CENTERS</b>	Multipurpose Family Resource Centers	<ul style="list-style-type: none"> <li>➤ <i>Morongo Basin Arch</i></li> <li>➤ <i>Quan Am Buddhist Meditation</i></li> <li>➤ *Asian American Resource Center</li> <li>➤ *Reach Out</li> <li>➤ *Knotts Family &amp; Parenting Agency</li> <li>➤ *Westside (Adelanto) Family Health Center - Public Health CFHS</li> <li>➤ Kids N Care, SB County Superintendent of Schools</li> <li>➤ YES Center</li> <li>➤ Rim Family Services</li> <li>➤ Temple Women's Resource Center</li> </ul>

	Spiritual/Faith Centers	<ul style="list-style-type: none"> <li>➤ <i>Saint Paul African American Episcopal Church</i></li> <li>➤ <i>United Church of Christ, Redlands, CA</i></li> <li>➤ <i>Quan Am Buddhist Meditation</i></li> <li>➤ <i>New Focus Community Development Corps</i></li> <li>➤ <i>A Servant's Heart Outreach</i></li> <li>➤ <i>Leap Through the Fire Faith</i></li> <li>➤ <i>*Inland Empire Concerned African American Churches (54 members)</i></li> <li>➤ <i>Desert Manna Ministries</i></li> <li>➤ <i>Temple Missionary Baptist Church</i></li> <li>➤ <i>Ecclesia Christian Fellowship Church</i></li> <li>➤ <i>Missions for Jesus Christ</i></li> <li>➤ <i>Sunrise Baptist Church (Pastors on the Premises)</i></li> <li>➤ <i>Fresh Start Ministries</i></li> </ul>
	Arts	<ul style="list-style-type: none"> <li>➤ <i>Libraries</i></li> </ul>
	Sports	<ul style="list-style-type: none"> <li>➤ <i>YMCA</i></li> </ul>
	Youth Clubs	<ul style="list-style-type: none"> <li>➤ <i>YMCA</i></li> <li>➤ <i>Redlands Recreation Center</i></li> <li>➤ <i>Boys and Girls Club of San Bernardino</i></li> </ul>
	Parks & Recreation	<ul style="list-style-type: none"> <li>➤ <i>Redlands Recreation Center</i></li> <li>➤ <i>Boys &amp; Girls Club of San Bernardino</i></li> </ul>
	Homeless Shelters	<ul style="list-style-type: none"> <li>➤ <i>County Homeless Program</i></li> <li>➤ <i>New Hope Transitional Living</i></li> <li>➤ <i>Foothill Family Shelter</i></li> </ul>
	Senior Centers	<ul style="list-style-type: none"> <li>➤ <i>Trona Senior Center</i></li> <li>➤ <i>Bonnie Baker Senior Center</i></li> <li>➤ <i>D. Papavero Senior Center</i></li> <li>➤ <i>*Reach Out</i></li> <li>➤ <i>Inland Caregiver Resource Center</i></li> <li>➤ <i>Colton Senior Center</i></li> <li>➤ <i>Rancho Cucamonga Senior Center</i></li> </ul>
	Refugee Assistance Centers	<ul style="list-style-type: none"> <li>➤ <i>Bienestar Human Services</i></li> <li>➤ <i>*Asian American Resource Center</i></li> </ul>
	LGBTQ centers	<ul style="list-style-type: none"> <li>➤ <i>*United Church of Christ, Redlands</i></li> <li>➤ <i>*Equality Inland Empire</i></li> <li>➤ <i>*Rainbow Pride Youth center</i></li> <li>➤ <i>*Transition Age Youth (TAY) One Stop Ctr. LGBTQ Task Force</i></li> <li>➤ <i>LGBT Resource Center</i></li> <li>➤ <i>Jeffrey Owens Community Center</i></li> </ul>

	Charitable Organization/Partners	➤ Inland Empire United Way - 2-1-1
	Resource, Support & Referral Networks	<ul style="list-style-type: none"> <li>➤ *Children's Network</li> <li>➤ Kids N Care</li> <li>➤ UCR Early Childhood &amp; Family Services</li> <li>➤ CSUSB Children's Center</li> <li>➤ Children's Fund</li> </ul>
	Foster Family Support/Resource Groups	<ul style="list-style-type: none"> <li>➤ <i>Clearwater Residential</i></li> <li>➤ <i>ARM Group Homes</i></li> <li>➤ *Making a Difference - adoptive/foster family/caregiver support/resources</li> <li>➤ C.A.S.T.L.E</li> <li>➤ Adoption families group</li> <li>➤ Special Little Angels</li> <li>➤ Special Little Kingdom</li> <li>➤ Inland Caregiver Resource Center</li> <li>➤ Olive Crest</li> <li>➤ Inland Valley Foster Parents (FPA)</li> <li>➤ Foster Parent Support Network/Children's Network</li> </ul>
	Indigenous Gathering Places	<ul style="list-style-type: none"> <li>➤ <i>Quan Am Buddhist Meditation</i></li> <li>➤ *Asian America Resource Center</li> <li>➤ *Westside (Adelanto) Family Health Center - Public Health CFHS</li> <li>➤ Ontario YMCA</li> <li>➤ Pow-Wows countywide</li> <li>➤ Boys &amp; Girls Club of San Bernardino</li> <li>➤ Health Fairs countywide</li> <li>➤ Mexican Consulate</li> </ul>
	Housing/Re-Entry	<ul style="list-style-type: none"> <li>➤ <i>Hope Through Housing</i></li> <li>➤ *Time for Change</li> </ul>
	General Support/Resources	<ul style="list-style-type: none"> <li>➤ Rim Family Services</li> <li>➤ County Library</li> <li>➤ Montclair Branch Library</li> </ul>
<b>EMPLOYMENT</b>	Public/private sector workplaces	➤ *DBH and county employees website
	Employee unions	➤ SBPEA
	Occupational Rehab	➤ *Department of Rehabilitation
	Employment centers	➤ Nabahood Community Development (employment)
	Work Force Investment Boards	➤ Department of Workforce Development
<b>OTHER</b>		<ul style="list-style-type: none"> <li>➤ <i>Inland Counties Stonewall Democrats</i></li> <li>➤ <i>California Senior Legislation Advocacy</i></li> </ul>

		<ul style="list-style-type: none"> <li>➤ <i>Victor Valley Regional Council on Aging</i></li> <li>➤ <i>*Council on Aging</i></li> <li>➤ <i>*Office of State Senator McLeod</i></li> <li>➤ <i>*County Board of Supervisors</i></li> <li>➤ <i>*MH Commission</i></li> <li>➤ <i>Office of Congressman Joe Baca</i></li> <li>➤ <i>City of Montclair - Human Services</i></li> <li>➤ <i>Kiwanis</i></li> <li>➤ <i>Sunset Lions of Big Bear Lake</i></li> <li>➤ <i>City of Chino</i></li> <li>➤ <i>Bautista Mortgage &amp; Realty</i></li> <li>➤ <i>Urban Community Action Projects, Inc</i></li> </ul>
<b>MEDIA</b>	Radio	<ul style="list-style-type: none"> <li>➤ <i>Radio Mexico</i></li> </ul>
	Television	<ul style="list-style-type: none"> <li>➤ <i>n/a</i></li> </ul>
	Internet sites	<ul style="list-style-type: none"> <li>➤ <i>DBH internet</i></li> </ul>
	Print	<ul style="list-style-type: none"> <li>➤ <i>Use of informational flyers by region via provider network, e-mail, US mail and interagency network to publicize PEI-CPP stakeholder input opportunities</i></li> </ul>
	Newspaper	<ul style="list-style-type: none"> <li>➤ <i>*Black Voice News</i></li> <li><i>County Public Information Officer liaison for press releases to:</i></li> <li>➤ <i>Big Bear Grizzly</i></li> <li>➤ <i>Associated Press</i></li> <li>➤ <i>Crestline Chronicles</i></li> <li>➤ <i>Daily Bulletin (West Valley)</i></li> <li>➤ <i>Desert Trail</i></li> <li>➤ <i>Fontana Herald Press</i></li> <li>➤ <i>Press Enterprise</i></li> <li>➤ <i>San Bernardino Sun</i></li> <li>➤ <i>Daily Journal</i></li> <li>➤ <i>Lucerne Leader</i></li> <li>➤ <i>Colton City News</i></li> <li>➤ <i>Needles Desert Star</i></li> <li>➤ <i>Redlands Daily Facts</i></li> <li>➤ <i>Senior Newspaper</i></li> <li>➤ <i>Yucaipa News Mirror</i></li> </ul>
	Ethnic Media	<ul style="list-style-type: none"> <li>➤ <i>*Black Voice</i></li> <li>➤ <i>Radio Mexico</i></li> </ul>

Original Category Criteria -- PEI Guidelines; Source: Enclosure 1, Page 13. Documentation required in Enclosure 3, Form 2, Page 4, 3. a., Page 5, 4. b.  
Updated in 2009 for INN Working Committee (established Nov 13 2009)

9/29/2009

# County of San Bernardino – Department of Behavioral Health Mental Health Services Act (MHSA) – INNOVATION

## Stakeholder Input from Community Public Forums & Targeted Forums Sorted by Key Issues

Innovation Community Program Planning process – November 13, 2008 through September 11, 2009

All Innovation stakeholder input events (Community Public Forums & Targeted Forums) were documented using a standard Forum Minutes format which recorded forum discussions and stakeholder recommendations. These Minutes are maintained in the DBH MHSA Community Program Planning (CPP) files. This data tool was created for the Innovation Working Committee and its Work Plan sub-committees through a review of all Innovation Forum Minutes, attempting to consolidate, within the context of forum discussions, all stakeholder recommendations according to Innovation guidelines, definitions, policies, & principles. Those items below accompanied by a numeral in parentheses (#) are suggestions which were submitted via forums multiple times in multiple forum events. The majority of stakeholder recommendations reflect innovative strategies that might benefit the mental health system throughout the county; those recommendations specifically related to specific regional or target population needs/strategies are so noted.

### Innovation Stakeholder Comments

#### 1. Unserved, Underserved and Inappropriately Served Individuals/Communities and Promising Community Resources

- (12) Facilitate outreach & training in community on wellness, coping in relationships (friendships, family, co-workers) leading to improved functioning in employment & daily life (includes Spanish-speaking communities, and African American community, Asian & Pacific Islander communities, Asian American/Pacific Islander, Native American groups and in all regions)
- (12) County-wide and across all age groups: Strengthen linkages and community education/outreach through schools, primary care providers, health promoters, faith community, social services, WIC offices, etc. (including but not limited to Latino, Spanish speaking community, Indonesian-speaking community, Vietnamese-speaking community and African American community)
- (11) Community /public education effort (including PSA's & TV) on signs/symptoms, wellness, recovery, community and self-help resources (including but not limited to Spanish speaking community, Indonesian-speaking community, Vietnamese-speaking community, African-American community, Native American community and across regions of the county)
- (6) Strengthen resources/networks by strongly linking & using resources within contractor, agency, community based organization and faith community networks (cross-train for improved collaboration & resource sharing) – this is particularly important for Latino, Spanish-speaking community, Indonesian-speaking community, Vietnamese-speaking community along with all age groups and the African American community
- (5) For Spanish-speaking community, more MH clinic/service sites, clinic resources provided in Spanish by individuals from the community or more clinic staff are bilingual
- (5) Provide support resources at local clinics, such as NAMI, support groups. Offer support groups (events) in places where people go, including but not limited to Latino communities, non-English-speaking communities
- (5) Develop support & self-help groups for families, parents, foster parents, kinship programs, guardians, grandparents, other caregivers (including but not limited to Spanish speaking communities)
- (5) Trained Peer Support Groups and networks, custom designed for “specialty” groups such as domestic violence survivors, LGBTQ, returning vets, NAMI members, TAY cultural/ethnic groups, age-specific groups, women, self-identifying “specialty” groups

- (4) Improve access/transportation, include bus passes or van transportation, especially for remote regions, Spanish speaking & older adults, and co-occurring disorders
- (4) African American communities utilize faith-based entities as “first responders” in times of community violence/crisis, for crisis intervention
- (4) Include & integrate community supports such as clergy & faith centers, Salvation Army, local public transportation, Boys & Girls Clubs, social & communities centers, Red Cross, Fire Department, rural health clinics, CalWorks, VocRehab in any MH education and mutual support effort, especially in remote areas (desert communities, mountains)
- (4) Create more or strengthen community centers where MH education, mental illness and alcohol and drug prevention, treatment, support systems and recovery can be accessed
- (3) Expand partnership with “health promoters” (healers) or Promotores de Salud in community to provide mental health education, recognize early signs, intervene and help families support family members – recommended for general community, including Spanish speaking communities
- (3) Periodic community public forums/conversations in each region; monthly informational mental health forums in community
- (3) Need more community outreach & training to educate teachers, therapists, counselors about problems children face from diverse backgrounds while they are young (especially important for Latino/Hispanic children/families)
- (3) Staff should be deployed to where exploited/vulnerable youth ARE rather than expecting this population to come to us (youth & homeless TAY youth outreach)
- (2) For co-occurring (substance abuse) population, peer support programs
- (2) For domestic violence survivors, provide life & coping skills training to decrease dependence
- (2) Peer support groups can help parents in a variety of topics, such as financial concerns, transportation issues, “stressors”, coping (Children’s Society – exceptional example)
- (2) Alcohol/Drug & Mental Health “first responder” community-based field teams
- (2) Dual Diagnosis meetings/programs/networks – increase availability and visibility
- (2) Provide mental health education on wellness, early identification, early intervention and appropriate linkage and working with parents (and foster parents) of young children (day care centers)
- (2) Educate staff at community based organizations (CBO’s) about mental health promotion, outreach and identification of mental health problems and available supports, especially for Spanish speaking communities, all ethnic/cultural groups, all age groups and throughout regions of the county
- (2) Community events & activities that encourage involvement in support resources & decrease or take away stigma from mental health issues; this is especially relevant to Spanish speaking communities, undocumented individuals and other cultural groups
- (2) Work with array of community based organizations who are now trying to help those “falling through the cracks” due to unemployment, housing crisis, community violence, poverty, incarcerated family members and other extraordinary stressors due to economic downturn – especially true in low resource desert communities
- (2) Create age specific services such as Clubhouses, Boys & Girls Clubs and advertise these services to consumers & the public
- (2) Spanish language crisis walk-in clinic, 24/7
- (2) Make mental health educational & training materials available but make them self-help oriented, simpler, user-friendly, welcoming and in multiple languages
- (2) Consultation and education for Senior Centers, bartenders, hairdressers, funeral homes, pharmacies and interagency partners – have a visible presence in the community Provide cultural education workshops and make available in Clubhouses
- (2) For vulnerable youth, at risk of exploitation (prostitution & substance abuse) need to develop ways to identify vulnerable children/youth, which would include youth aging out

- of out of home placement. Example, collaborate with schools and other partners on tracking school absences, target sensitive geographic areas, evaluating behaviors early.
- (2) Remove “bureaucratic barriers/obstacles” to better serve population of vulnerable/exploited youth, assist in accessing services such as TAY centers
  - (2) Consider tapping into internet resources such as My Space and Face Book in order to communicate with and provide info to youth, especially vulnerable and exploited youth
  - (2) Consider trauma issues and how at risk youth can easily be re-traumatized once they enter the system for services
  - (2) Models which might effectively reach and serve hidden population of vulnerable/exploited youth: volunteer/mentor programs using peers and adults, peer counseling, wilderness-like stress challenge model, equine therapy model, expansion of TAY center concept that addresses access and provides specialty services to this resistive population
  - (2) Create alternative, positive outlets in collaboration with partners (in response to youth prostitution/substance abuse); include collaborative/diversion process within Juvenile Court system
  - (2) “Children of the Night” model – or its components such as mentoring, advocacy, peer counseling, “whatever it takes” philosophy – bring together all necessary resources and supports for vulnerable youth in order to counteract environmental forces that reinforce runaway, prostitution, substance abuse behavior
  - (2) Consider customized “street outreach” for the growing population of exploited youth in our county
  - For transitional age youth, especially important to focus on the funding issues that occur at age 18. Youth moving from children’s foster care system into minimal support system or entirely new service system, new “insurance system”, new providers is stressful and destabilizing. Recommend improved outreach, coordination and customized transition process to encourage help-seeking
  - For exploited youth, collaboration between departments/agencies, specifically girls involved with prostitution
  - Recommend local, expert interventions/services for exploited youth
  - Exploited youth (example girls forced into prostitution) are victims; look for alternatives to “lock up”; create links to “survivors”; identify before charges become necessary; improve collaborative assessment process
  - Educate those work with children/youth, increasing awareness of mental health issues
  - For TAY youth, strengthen program by giving youth more responsibilities, larger roles in serving as mentors, leaders
  - For TAY youth, recommend expansion of eligibility criteria to facilitate access to high risk youth, encourage help seeking
  - Assessment of TAY homeless, vulnerable youth population and innovative outreach strategy (to improve access), especially in desert areas
  - Educate primary health care providers to prevent misdiagnosis (failure to identify need)
  - Provide youth friendly, street wise “lifeline” for teens on the streets and homeless youth
  - Create Crisis Centers (walk-in, call-in), especially for youth
  - For exploited, vulnerable youth, need community settings, crisis intervention
  - Morongo/desert area: spirituality & recovery are supposed to be consumer driven but this is not happening
  - Incorporate recovery into mental health system; change/transformation too slow and improving access in Morongo/desert is slow
  - For culturally diverse communities(Vietnamese, Indonesian and Spanish-speaking), activity and outing-oriented approaches are recommended (emphasizing community, not clinic)
  - For Latinos, African Americans, and Asian/Pacific Islanders, co-occurring services are needed

- Co-occurring/dual-diagnosis (substance abuse) population – homelessness a big issue. Launch a campaign showing difference between mental health services and law enforcement services
- Co-occurring (substance abuse) services for youth
- Cross-training of mental health and alcohol/drug staff
- For co-occurring (substance abuse) population - More non-emergency, preventive, pre-crisis services
- Address stigma among military vets, a population affected by co-occurring issues. Address reluctance to reach out for help and stigma issues toward VA and other “institutional” (county) services
- Wraparound service approach can be effective for those with co-occurring (substance abuse) issues
- Education around medications, especially for those with co-occurring (substance abuse)
- Mental health system needs to respond to co-occurring issues by working with alcohol-drug services so that clients receive the full treatment they need; consider co-locating services
- Co-occurring disorders (substance abuse) criteria too intense (restrictive); assess screening, diagnosis, funding issues affecting service to individuals with co-occurring disorder
- Co-occurring disorders (substance abuse) - Provide technical assistance to diminish system barriers
- Co-occurring disorders (substance abuse) - System issues (barriers) need to be addressed and fixed before innovative strategies can be implemented for this population
- Single caregiver resources needed
- Need for LGBTQ resources/supports for adults
- Train law enforcement on mental illness, including appropriate array of culturally sensitive interventions
- For Latino community, provide more advocates; they work with us better and they don't judge us
- For Latino & Spanish-speaking community, provide more trained professionals, more consistent medication follow-ups; it is difficult to entrust so much information when there is so much staff change for our population
- Latino & Spanish-speaking community would benefit from much more community education, awareness of mental illness (myths/truths), where (safe places) to get help, advocacy, funding sources for medications; help individuals who have had bad experiences with providers (in the past) through mental health education
- For Latino community, more family counseling (as opposed to individual), couples counseling
- For Latino community, offer appropriate, professional counseling and education for all genders and orientations
- Help Latino community address mental health stigma through education and community friendly peer-driven services and peer support services
- For African-Americans, individuals and families would benefit from education and training in coping skills
- African-American faith community – mental health challenges affect the whole congregation, not just the person; train pastors in skills to help parishioners who suffer from mental illness
- For African-American community, provide medication education for teachers, churches, parents, foster parents, child protective services, foster care providers and the system
- Pilot non-traditional practices like bio-feedback instead of medications (African-American community)
- Provide age-specific programs in the African American community
- Members of the African-American community need a centralized place to receive mental health services

- Trona area access issues include scant transportation, limited services/case managers for seniors & children, telesite services not necessarily effective, meds but limited pharmacy, and significant within community. Suggestions include mobile multi-service unit, electronic MH education, school-based service, children's case manager, expanded clubhouse across the ages, community center MH-centered, community network anti-stigma campaign
- In Trona area, the following services are found to be helpful: club house, psychiatrist, community college setting services, senior dinners, senior-teen mentoring, faith center and faith based recovery models
- For Trona area, recommend integrating age appropriate activities with MH education activities/campaign
- For Trona area, there is a need for education on updated forms and resources, a children's case manager, readily available assessment, support groups, advocacy and rights groups
- For Trona area, the DBH website could be used to allowing printing of updated forms and other resources
- Create activity centers for learning life skills, job training (Spanish speaking)
- NAMI Family 2 Family model, Spanish speaking
- For military veterans, it is important to provide meaningful, diverse activities, allowing for learning and social connection
- For military veterans, there should be a focus on alcohol abuse and older adults
- For veterans, recommend grief support groups, PTSD support for younger veterans
- For veterans with families, the families need to be included in services, support and resource models
- Peer mentoring, mental health education to address stigma, specifically for military veterans, is recommended
- For military veterans, job-related services, including access to education and vocational counseling
- For military veterans and their families, access to medical services and family supports
- For military veterans and active duty military personnel in our communities, access/visibility of peer support groups with assistance from "moderator" with mental health expertise
- Existing TAY Centers – community friendly & helpful setting
- Use interactive internet/website (online directory, mental health education, chat help line)
- Resource data base like 2-1-1 but specific to mental health consumer community
- Develop resources & support for gays & lesbians, especially in remote/mountain communities
- Need resources & services for LGBT adults and older adults (not only youth)
- Need resources for HIV & LGBTQ community, such as Public Health & Behavioral Health coordination; family counseling; alcohol-drug counselors; outstationed LCSW's, MFT's, case managers, interns at HIV sites
- Improve referral linkage and follow-up system
- LGBTQ self-help educational and referral resources, including multi-cultural (especially Latino), multi-lingual (especially Spanish) and age specific
- Doing drugs/alcohol can lead to unprotected sex and can affect or reflect mental health issues. These issues need to be addressed in schools/colleges (normalize this conversation)
- Collaborate with Gay-Straight Alliances (GSA's) and university Pride Centers
- Collaborate with public health departments on mental health and rape trauma, drugs/alcohol & sex education and LGBTQ issues
- Integrate LGBTQ peer advocates (trained and linked) into the mental health system, including over 30 age group!
- For our cultural communities: addressing stigma through customized marketing

- Create street outreach teams to serve homeless; address the need for housing in order to ensure success of any innovative program (collaboration, linkage, referral, follow-up)
- Emphasize prevention programs
- Educate the community about mental health, especially important for African American community
- For African American communities, we need customized education on “what does mental illness look like?” and how community resources and community members can work to help individuals before crisis happens
- Address basic needs in the mental health system; “unserved and underserved” can mean everyone suffering from mental illness and not receiving service because of not being reached, not enough resources and reluctance of severely ill to seek existing services
- Mental health system must bring services to the community including severely mentally ill (including African American community, Latino community, Asian Pacific Islander community))
- For most communities, including the African American community, the “inappropriately served” also have lack of resources and this must be addressed collaboratively
- For all underserved and inappropriately served communities, there is a need for trauma treatment, support, resources; a need for staff/community training in PTSD and other trauma and impact on community and mental health
- For Native American communities, poverty (32%) is a major issue; recognizing this will assist in establishing partnership
- For Native American communities, it is essential to recognize importance of ethnonational/racial identity and historical grief
- For Native American community, offer mental health instruction, directories and other resource supports in culturally competent ways
- Address transportation issue for Native American communities
- For Native American community, create partnership with club house setting
- For Native American communities, expand and adapt support resources such as NAMI
- For Native American communities, the Indian Health center is recommended as a key center for coordinated service; ensure clarity of roles and opportunities for collaboration and innovation
- For Native American communities, “healing circles” and “sweat lodges” are effective ways of dealing with depression
- Native American communities address issues across age groups and utilize various “healing” processes
- Educate staff and community about veteran/family mental health issues, symptoms, early identification
- Educate public about “safety” of MH system due to confidentiality maintained by providers and peers
- Expand training for community to include meditation for advocates, for care providers of supportive living situations, for PTSD vets, for domestic violence victims (survivors), and for abused children/youth.
- Establish grief support groups for older adults
- Provide resources that help elders address anger re: loss of spouse, loved ones, independence
- Family approach – family advocates, friendly home visits
- Kinship centers for grandparents raising grandchildren – provide easy access to services via kinship/senior centers
- “Early intervention” strategies within communities address access, isolation, stigma and cultural preference issues
- Examples of “early intervention” would be “healing circles”, Boys & Girls Clubs, and other settings that would provide interventions across age groups

- Recommend program development strategies that will help support innovative funding strategies and include faith centers (blended, braided, leveraged funding)
- Create centralized verification unit to help consumers get necessary documents for SSI application; assistance navigating benefits systems
- Address needs of incarcerated individuals by facilitating transportation for family contact
- Have more mental health advocates available
- Expand partners participating in Multidisciplinary Teams (MDTs) and provide funding for support staff to maintain data base, reporting, meeting and other coordination; MDT's offer innovative, collaborative mechanism to develop pathway to care and case plan as well as break down barriers (and funding silos)
- Consider expanding senior center into multi-service resource center
- For seniors and others in geographically isolated communities, involve the community to provide others with and coordinate transportation and ridesharing
- For geographically isolated communities, partner with churches and businesses
- In the Eastern Desert/Morongo Basin, there are homeless older adults with basic needs and who need emergency housing
- Provide mental health education, prescription assistance, hard-of-hearing assistance, PTSD and veteran support groups, information on depression
- Peer support system to fill gaps in our isolated rural areas, especially for seniors
- For people with physical disabilities, access is an extra challenge; partner with community based organizations, public health department and destigmatized settings
- Consider using technology to assist with mental health needs, physical limitations in rural areas
- Collaborate with agencies and schools who serve people with developmental disability
- For dual diagnosis (developmental disability and autism), a better referral system is needed
- For high desert, we need services for parolees, adolescent drug treatment, in-home services, FSP/CWE, services to fill gap for kids age 6 – 15
- 24 hour service availability is most helpful in the remote desert area
- For remote desert communities, transportation issue could be addressed with vehicle to transport clients – or mobile services
- Remote desert communities need PTSD support groups, substance abuse support groups, sexual abuse groups
- For the diverse Asian/Pacific Islander community, there are significant language and various stigma barriers; provide these diverse communities with opportunities to partner with professionals, volunteer or job shadow in order to bring expertise into their communities
- Having Asian language interpreters in counseling sessions is not the same as providing culturally appropriate service; find ways to train our communities in support and intervention skills for better partnership
- Target the Vietnamese communities when recruiting for the mental health system's workforce
- For Asian and Pacific Islander communities, our clinics do not seem family oriented and staff need to be on board with serving our community
- For our diverse Asian and Pacific Islander communities, there is a lack of culturally specific resources and referral sources; existing resources are not linked with mental health resources and may not have mental health expertise
- Multicultural communities need assistance in completing applications for benefits like Medi-Cal and SSI; this approach represents a relapse prevention strategy
- Clinic staff need reasonable size caseloads so they can appropriately serve the community
- Those staff with the skills and commitment to serve Asian and Pacific Islander individuals should be allowed to do so.
- Resource lists need to be updated with correct, current information re: available services

- Having a 1-page matrix of services, showing types of funding accepted, would be helpful, including faith-based
- More resources for long-term drug rehabilitation
- For all age groups, regions and cultures, clients and potential clients need to have ways to support themselves and each other

Victor Valley Clubhouse – District Advisory Committee Regional Community Public Forum

- Transportation and funding assistance
- Services in evening and weekends, expanded hours for Club House during the week
- TAY centers for all age groups as a natural community gathering place
- Educate the community on mental health resources, collaborate on community and faith based events, partner with housing and shelter resources, other local resources.

TEAM House Clubhouse – District Advisory Committee Regional Community Public Forum

- Transportation and funding assistance
- Partner with food banks to encourage participation with local club houses
- Increase support for clubhouses and consumer groups
- TAY centers for all age groups as a natural community gathering place
- Partner with primary care providers and physical health clinics
- Educate the community on mental health resources, collaborate on community and faith based events, partner with Community Care Licensing, fire departments, other local resources.

Santa Fe Social Club – District Advisory Committee Regional Community Public Forum

- Educate the community on mental health resources, collaborate on community and faith based events, partner with housing and shelter resources, employment services, other local resources.
- Work with local business to reduce mental health stigma
- Increase support for clubhouses and consumer groups
- TAY or wellness centers as a one stop resource for all age groups as a natural community gathering place

BHRC Rialto – District Advisory Committee Regional Community Public Forum

- Transportation and funding assistance
- More regulated housing resources along with support services for consumers.
- Educate the community on mental health resources, especially support staff who are often first to see consumers
- Provide assistance for incarcerated or paroled consumers who have mental health issues and challenges, e.g. legal and consumer advocates

**2. Responsiveness to Issues of Age, Gender, Language, Beliefs, Orientation, Ethnic and Cultural Background -**

- (9) Hire from the target population; create more diverse (and nicer!) work force by hiring & training consumers, advocates, family members & building self-help & coping network; help us help ourselves – region-wide, especially from TAY & older adult age group and including Spanish-speaking individuals and our wide variety of Asian and Pacific Islander communities, Native American and the African American communities spread throughout the county
- (9) Work with & build capacity within community agencies to build skilled resource network more relevant to wide variety of cultures, lifestyles, etc; Provide mental health education not only to community based organizations but to communities so they can cope & help each other. (Relevant to African American, Latino, Asian-Pacific Islander, Native/tribal communities and affects all age groups.)
- (9) Assist faith centers, where many underserved communities go for support, to learn how to help those who are emotionally troubled; county-wide, Latino, African-American, Asian & Pacific Islanders, LGBTQ, military veterans, remote areas
- (9) Launch a visible public campaign targeting mental health stigma and opening conversation about relevant support resources (audience to include: parents, caregivers, schools, doctors' offices, community gathering places). This is especially important for Spanish-speaking community, Indonesian-speaking community, Vietnamese-speaking community and our African American community
- (7) Understand co-occurring (substance abuse) disorders – need for community education; find “flexibilities” for serving this population collaboratively
- (4) Collaborate in places that offer job skills training including interviewing skills and job-seeking skills (or referral/access to these supports), especially important to adapt this for non-English-speaking and/or Spanish-speaking individuals
- (4) Outreach & mental health education to schools; put mental health resources in school; inform school staff about mental health issues; fill gap between child & TAY (support resources, consultation in community)
- (3) Recommend expansion of concepts like Promotores de Salud (health promoters) and other approaches that are more holistic (less stigma) for Latino/Hispanic community but should be adapted to other community settings
- (3) Educate school counselors, nurses, educators, clergy, etc. on LGBTQ issue as MH risk factor
- (3) Mentoring very important for all ages, especially for Latino community & children/youth & African American youth & LGBTQ & vulnerable youth
- (3) Use media campaign to reach/educate communities and “rescue” at risk/exploited youth
- (3) Provide multi-language resources and programs (multi-cultural, too), including linkage with ESL settings and populations
- (2) More services should be gender and age neutral in order to include more potential consumers (for example, TAY-specific services in independent living skills would also be helpful to adults!). This means we could adapt successful “specialty” approaches to other special needs groups, also
- (2) Make it easier for LGBTQ to self-identify, including on service provider forms; make help-seeking easier for LGBTQ community (Self-help? Trained Peer support? Natural gathering places?)
- (2) Outreach to undocumented individuals
- Native American youth at high risk of exploitation due to perceived (or actual) access to money; targeted street outreach, education, peer-to-peer support needed
- Recommend using clever advertising to get youth to seek and connect to services (dinner/movie nights)
- Resources are communicated by youth to youth; recommend using peer-to-peer outreach and networking; address the needs of youth where and how they live
- Important in desert areas, outreach program to provide updated info on community resources
- Collaborate with tribal governments

- Provide mental health education and resource information in Spanish, Vietnamese and Indonesian languages; work with communities to disseminate
- Address cultural differences when issuing medication (cultural beliefs and physiology); requires staff training, delivering services in natural settings
- The 12-step community can be viewed as a set of “cultural” beliefs; mental health and medications education should be offered and adapted to this
- Age appropriate waiting rooms, services and environments
- More outreach targeted, adapted to women
- Gender sensitivity training for staff/providers
- Provide drug and alcohol treatment in the community at churches
- Encompass mental health, alcohol and drug treatment, co-occurring in service system
- Targeted alcohol & drug prevention program for LGBT community
- Provide training for bilingual staff in order to provide services in the client’s language
- Culturally specific services are more effective than just having bilingual staff
- Improve referral information system; create a bilingual Spanish comprehensive and up-to-date behavioral health resource network resource directory that is maintained or improve 2-1-1 and keep it up-to-date
- Life readiness, coping skills training for existing users of service and community members
- For women, including from the perspective of current users of service, there is a need for gender specific counseling, support services
- Play therapy is effective for young children and may be more relevant to some cultures
- Consider addressing “spirituality and mental health”
- Provide reader-friendly information in clinics and other community settings, in multiple languages
- Provide interpreter/translation services, especially in desert region
- A peer support system would be helpful in the desert, customized to different cultures
- Improve, enhance referral system
- Public information system is needed, including Spanish/Vietnamese language information & referral
- Recommend a TAY-like center, peer driven, offering self-help, training for other age groups, especially in West Valley of county
- Recommend a TAY-like center, peer-driven with collaborative resource availability and support, particularly for vulnerable/exploited youth
- In order to address needs of children/youth at risk of exploitation (prostitution/substance abuse/homelessness), there is a need to provide psycho education in a de-stigmatized, normalizing way, very early and in collaboration with destigmatized community settings, including schools, faith centers, primary care, agency partners
- Establish information-sharing across child-serving agencies much earlier and much more routinely – regarding risk assessment, “red flags”, and how to address stressors and issues like LGBTQ, sexuality/sex education, stigma (mental illness)
- Include community-based organizations like Bienestar in collaborative processes so that both physical and mental health needs of LGBTQ and HIV communities can be met – especially relevant to Latino LGBTQ community
- Provide mentoring/supports in schools, after school that are destigmatized and facilitate early identification for at risk youth
- Provide DBH staff with clinical training to address identity & specific transgender issues
- Provide training/support to families in caring for their LGBT children, especially in the “coming out” process and to care takers/community that will assist them in caring for & supporting LGBT community/individuals
- Train providers in LGBTQ culture and trends and relationship to mental health services/coordination and follow-up care
- Deaf and hard-of-hearing services

- For African American, Latino, Asian Pacific Islander and Native American communities, there are numerous community based resources which can partner with mental health system – provided that capacity building is provided and partnerships are established
- For Native Americans, set up different club house models adapted for cultural needs
- For Native Americans, consider approaches such as Red Road, Sweat Lodge, White Bison (Native Spirituality)
- For Native Americans, like other culturally diverse groups, respect differences
- Native American communities address issues across age groups and utilize various “healing” processes
- For Native American communities, “healing circles” and “sweat lodges” are effective ways of dealing with depression
- There are behavior differences in students due to culture – provide cultural sensitivity training in schools to teachers and staff
- Hire culturally sensitive staff
- Recruit staff members that reflect the community (from the community) and are sensitive to the cultural needs of the community, especially the African-American community
- African American communities utilize faith-based entities as “first responders” in times of community violence/crisis, for crisis intervention
- Establish a trained cultural “brokers” program for facilitation of community support resources, linkage and consultation
- Use community liaison positions for linkage, consultation and coordination
- “Early intervention” strategies within communities address access, isolation, stigma and cultural preference issues
- Examples of “early intervention” would be “healing circles”, Boys & Girls Clubs, and other settings that would provide interventions across age groups
- Provide supportive experiences to parents of troubled children, provide reassurance: “you’re not alone”; Make it OK to seek help - normalize
- Ensure that staff and support systems have training and understand that sexuality/sexual identity may or may not be relevant to the issue; be open to the issue and the complexities within the LGBT culture (generational differences, ethnic/racial)
- Develop Family Support networks, for all ethnic and cultural groups with mental health education component
- Remote/mountain communities (this is a cultural issue) – provide services in libraries, where children hang out – and other locally determined gathering places
- For youth population, need to be more technologically advanced (access issue)
- Fund activities that appeal to unserved people – e.g. art, sports, art, reading clubs, parks & recreation activities, youth activities
- Create resource data base or clearinghouse that people can navigate on their own
- Help individuals, families and communities find guidance through churches, schools and other everyday settings (destigmatized)
- Local clinics should expand availability during weekends; more medical oversight & consultation (psychiatry)
- Provide training to all providers regarding clients’ culture, country of origin, language, impact on service preferences
- Spread the word on cultural diversity training that is already in place
- Evaluate the language that we use when engaging with potential consumers and community members
- Address issues of stigma/shame (example: kids in foster care don’t want to participate in programs for “mental illness” – language and stigma issue)
- “Re-brand” mental health services and supports to address stigma and perception, keeping in mind that the language that we use matters
- “Normalize” emotional difficulties and help-seeking
- Provide MH consultation/presence at Boys & Girls Clubs- Boys and Girls activities (scouts, Boys and Girls clubs, music groups)

- In home and in school consultation
- All kids headed for Juvenile Justice system should be assessed (screening) for MH issues first
- Develop teens-helping-teens support systems and groups and mentoring
- Ethnic specific services should get priority for Innovation funding that may not have the designation of being an evidence based program but produces positive outcomes
- Presentations for youth at schools with panels/discussion
- Age appropriate identity development support
- Create clubs and forums with teenagers and teach coping, negotiation, and leadership skills. Use Friday Night Live model; art programs as gateway and supportive setting
- Educate community regarding stigma related to mental illness (National Alliance for Mentally Ill)
- Strengthen mental health system's cultural competence approach in relation to faith based communities, potential consumers (e.g., respond to faith as a belief/cultural issue in a culturally competent way in terms of designing, organizing and delivering service)
- For military veterans and active duty military personnel in our communities, access/visibility of peer support groups with assistance from "moderator" with mental health expertise
- To reassure community or potential clients, educate about confidentiality, legal status laws and non discrimination laws
- Don't make asking for (seeking) help a "second trauma"
- Provide varied levels of staff vocational Spanish training (w/ clinical terminology)
- Reach out to Spanish speaking population with mental health information, education through Spanish radio stations and TV channels 52 & 34
- Ensure documents are translated appropriately (including age appropriateness) from English to the second language
- More educational materials in languages other than English, and especially Spanish
- Hire more bilingual staff and/or train staff to provide bilingual/bicultural services (Spanish)
- Don't restrict Innovation funding to those with mental health diagnosis; focus on individual issues and needs instead of funding/billing might result in better recovery, important for older adults
- Deal with individual at onset of issues, difficulty or crisis with short term therapy instead of waiting for diagnosis and the need for more treatment, important for older adults
- Funeral homes may be a link to identify individuals experiencing stress, unusual grief reactions (consultation/linkage) – important for older adults
- Recommend restoring DBH Agewise program's ability to provide earlier interventions with older adult while individuals have cognitive capacity
- Provide counseling, training and coping skills to caregivers of older adults; this can help reduce unnecessary place of older adult in institutional care, reduce abuse of older adult and reduce depression in caregiver
- For culturally competent elder care (and this includes isolated geographical regions!) Innovation can mean establishing formalized collaborative mechanisms that coordinate care across agencies, systems and resources
- In Needles area, community have difficulties with substance abuse, heat and crisis; recommend Narcotics Anonymous, CCRY & a Crisis Area, PTSD support groups, sexual abuse support groups, and cooling area
- In isolated rural areas, we need increased counseling and especially mental health education
- Isolated rural areas: parenting support and children's services
- Isolated rural areas: veteran support services
- In Trona area, there is a need for services for seniors over age 70, for children, and for the indigent. Destigmatized approaches are recommended for these groups. Suggest Agewise approach, parenting support groups and classes; include ethnic workers

- Consider the mental health needs of those with developmental disability – this is an underserved population; facilitate access to case manager, social worker in disability agencies
- There is a need for culturally specific training and staff awareness training on individuals with developmental disabilities
- Disability rights advocates/community recommending improved education on the needs of dual diagnosis, service needs, support needs and coordination needs
- For our diverse Asian and Pacific Islander communities, consider community based support and case management services and collaborate with churches, businesses, temples and community based organizations/agencies
- For military veterans, various cultural issues affect mental health and cultural awareness, education and sensitivity is important in the delivery of service and support
- For transitional age youth, create links with youth with similar issues and disabilities, experiences and needs
- Create referral, support and self-help system for transitional age youth
- Transitional age youth require alternative formats/models, peer leadership, mentoring, focus-driven groups, life management approach, street outreach style

Victor Valley Club House - District Advisory Committee Regional Community Public Forum

- Increased transportation and availability of bus passes
- Satellite locations for behavioral health services
- Offsite assessment centers or warm lines to provide resource planning and recommendations

TEAM House Clubhouse – District Advisory Committee Regional Community Public Forum

- Provide multi-cultural fairs where both staff and consumers learn about other cultures, and providing translation services at events
- Educate the faith based community on how we can partner together.
- Provide mental health education to consumers, family members, and the community
- Provide consumers training on socialization skills, money management, and finance

Santa Fe Social Club – District Advisory Committee Regional Community Public Forum

- Increased access to services to older adults, youth aged 6-15
- Provide mental health education to consumers, family members, and the community on a variety of behavioral health topics

BHRC Rialto District Advisory Committee Community Regional Community Public Forum

- Facilitate groups for LGBTQ adults and older adults
- Hire/train/provide mental health education for volunteers to be advocates in assisting LGBTQ and mentally ill persons released from incarceration.

**3. Interagency Collaboration-**

- (6) Enable community based organizations and faith centers to help emotionally troubled individuals or communities by providing skills-oriented mental health education; this is especially relevant in our Asian and Pacific Islander, African-American and Latino communities, along with at risk/exploited youth, LGBTQ, military veterans
- (5) Address, through interagency collaboration, “survival” needs of TAY youth and struggling families in general (e.g. clothing, toiletries, vouchers, resources); MH system especially needs to, through interagency collaboration, acknowledge serious survival issues related to unemployment, hunger, homelessness, unnecessary incarceration, police harassment, no child care, no transportation
- (5) Establish automated (“living”) resource data base, along with mechanism for multi-agency networking opportunities in service provision, service planning and resource development; this should be accessible to clients, potential clients, families, advocates via kiosks, libraries, public agencies, community friendly gathering places
- (4) Address limited availability of Spanish language services throughout MH system
- (4) Mental health “marketing” or advertising including radio, internet (my space), newspaper (including cultural outlets), magazines, posters/flyers, mailings, TV ads/campaigns, vehicles ads, T-shirts) – includes Latino media, bilingual marketing
- (4) Training volunteers, PFA’s, consumers and peer networks to serve like case/resource managers and peer support networks so that no one is left without services (including some in Spanish); put resources in non-clinic settings
- (4) During economic hard times, county agencies, community agencies, insurance agencies need to collaborate, conserve resources, share funds so communities receive same info and opportunities to recover
- (4) Provide mental health consultation and education to school personnel, especially in cultural context, with bilingual expertise (Spanish)
- (3) Expand support groups/networks,, linking with existing programs, for victims/survivors of domestic violence and other “specialty” groups
- (3) Help us gain access to services of other agencies in the desert; get resources together in one place; get desert agencies to talk to us and each other (TAY-serving)
- (3) Support access to services with more transportation support like bus passes, van transportation, particularly for remote desert areas of county; this is also important for families of incarcerated individuals
- (2) Community-based organizations should collaborate to create job/training setting like restaurant or art gallery, lower desert TAY especially; Vocational programs for teens using linkages and collaborative strategy
- (2) Help us find resources and supports to fill the long gaps between clinic or psychiatrist appointments (self-help) – big issue in our Spanish Speaking communities
- (2) Among agencies, organizations, churches, and communities, collaborate to develop culturally appropriate and effective outreach and support strategies, especially important for our African American, Latino, Asian American/Pacific Islander, LBGTQ, military vets, at risk exploited youth and isolated populations
- (2) Locate support and other services in agencies and organizations in the Latino community, where it is more likely that “reluctant” community members might accept them
- (2) For Latino community, work with agencies to develop support and education groups; partner and collaborate. Use established organizations; don’t invent new ones
- Locate support and other services in agencies and organizations in the Vietnamese community, where it is more likely that “reluctant” community members might accept them
- Locate support and other services in agencies and organizations in the Indonesian-speaking community, where it is more likely that “reluctant” community members might accept them. In this community, churches and nursing home care facilities are resource for partnership
- Alcohol & drug and mental health agencies need to be able to share resources and clinical records

- Train law enforcement in mental health sensitivity
- Anti-stigma mental health campaign; educate partners (e.g. primary care providers)
- Co-locate and/or create consultation linkages: mental health & alcohol drug staff in community centers, schools, primary care providers, emergency rooms, disabilities resources, Access Unit.
- Mental Health organizations and Alcohol/Drug Services “billing” services combined
- Advocacy training for clients (self-help, self-advocacy model)
- System wide case management
- People need to know how to access services department has to offer; train community on how to access services, especially the African-American community
- Medication is not always the right solution to mental health problems; provided mental health education (especially African American community)
- Support NAMI, providers of education and support to consumers and family members, including the Latino community
- Assign DBH staff to manage resource data base, keeping it up-to-date and also useful to consumers, agencies, staff and community in finding, planning & using services
- MH outreach & education in support group format to “normalize” – in community settings
- Set tone, via MH education, for development of early intervention strategies, coping skills, resilience, wellness, recovery instead of acute and residential care
- Mental health education can work if it is done, for vulnerable/exploited youth within a school setting, perhaps as “life skills” training, “coping” exercises. This could be viable for all ages, similar to Red Ribbon Week. Other collaborative partners: Planned Parenthood, Public Health
- Work with senior-serving agencies to infuse mental health awareness and support
- Coordinate with food banks to help homeless, especially TAY youth
- Offer anger management support groups in collaboration with agencies serving at risk individuals; provide MH consultation
- Find arenas where LGBTQ individuals, communities find comfortable and provide mental health education, training on self-help and coping and linkage
- Like the county’s Health Expo & First 5 events, we should have a MH expo, open to public and agency partners for networking.
- Recommend creation of MH collaborative similar to Public Health monthly collaborative meetings – to improve interagency collaborative problem solving and resource sharing
- Development of community coalitions that work to eliminate the community factors that contribute to the development of problems associated with substance abuse, mental illness, violence, and homelessness
- Address joblessness among youth/TAY through better interagency collaboration
- Address shelter and transportation needs in desert and West Valley, especially of TAY youth; create a place where homeless can store their belongings
- Help us find childcare while we try to get help (TAY and other parents)
- Increase community involvement with youth
- Schools-MH youth mentoring programs
- Provide education for parenting teens – skills building such as Independent Living Program (ILP), connected to Public Health programs, Welfare-to-Work, GAIN, etc
- Create effective links for access to early identification and service for alcohol/drug counseling, rehab and support groups, including mental illness (co-occurring)
- Provide mental health education and skills to law enforcement, fire and other public service providers (including working with Latino communities)
- Harassment by law enforcement in West Valley is a problem for TAY youth, especially after hours; need safe havens in evening & night
- Work in conjunction with cities
- Strengthen resources/networks by strongly linking & using resources within contractor, agency, community based organization and faith community networks (cross-train for improved collaboration & resource sharing)

- Identify faith based organizations that are LGBT friendly which can collaborate in providing resources
- Collaborate with University Pride Centers (for LGBT population) in providing resources
- Advertise mental health services at Pride Centers at universities, colleges
- Visibly support LGBT associations and organizations
- Provide training to school counselors on mental health and LGBT culture
- Initiate a Gay-Straight Alliance (GSA)
- “Case managers” need to do more to connect clients and family members to support resources (to be involved in client’s recovery and journey out of the system)
- Better training and visual aides, presentation on real world recovery (next steps)
- Road map to receiving SSI
- Work with Public Health and other agencies to streamline medical records
- Work with cities to expand low cost classes of interest to consumers, using these classes as forms of recovery/therapy
- Partnerships with law enforcement, police, schools, family agencies
- Fund MDT (Public Guardian/older adults) as an Innovation; expand participation and collaboration
- Consider corporate sponsorships, public private partnerships to sustain programs, establish healthy lifestyle programs for youth
- For seniors and others in geographically isolated communities, partner with agencies and community organizations to provide for basic needs for the community’s homeless; allow homeless to use public parks, shower facilities, laundromats
- Mental health system needs to connect with existing community organizations serving developmentally disabled, formalize working and collaborative partnerships, devise better service coordination models
- Dual diagnosis (developmentally disabled, autism) individuals, families, consumers need help in accessing appropriate resources and understanding limitations if those limitations are valid. It would be helpful to have a thorough needs assessment for this dual diagnosis population in our county and to plan and implement services around it
- Ensure that clinics and mental health facilities are ADA compliant (Americans with Disabilities Act)
- Better use of technology to coordinate referrals, follow-through on referrals, provide collaborative services, disseminate public information in simple terminology
- In the high desert, community agency partnership is recommended. Suggested collaborative partners – large employers, parolee services, Boys & Girls Clubs, hospitals, crisis services, military services (PTSD & substance abuse), resource guide
- For our Asian and Pacific Islander communities, the church and temple are considered safe places to talk about mental health issues ( a social setting), along with barber shops and salons
- In our isolated rural areas, there is a need for housing assistance
- In our isolated rural areas, there could be improved collaboration between community organizations and agencies like the VA, churches, primary care doctors, housing/rental organizations and hotels/motels for use of pools
- The Needles area Center for Change could be used for a clubhouse setting
- Collaborate with organizations like Bienestar Human Services, Rainbow Pride Youth Alliance, Gay & Lesbian Alliance against Defamation (GLAAD), & Jeffrey Owens Community Center (JOCC)
- Recommend LGBTQ mental health awareness day
- Work with LGBTQ hotlines in order to arrange and dispatch the appropriate services
- For military veterans, mental health education, outreach, information-sharing, coordination of referrals would improve vets’ ability to seek and obtain the appropriate mental health service and support
- Collaboration is needed to address the continuing issue of homeless military veterans, a seriously underserved population

- From a cultural competence perspective, the assessment process (needs and resource assessment), there should be a comprehensive assessment of social factors before a diagnosis is determined
- Make parents of transitional age youth aware of available resources
- Partner with educational institutions (including higher education) to ensure collaboration
- Infuse community & school settings with play therapy, art, music, dance, animals for kids
- Recommend mental health education among children/youth to normalize, bust stigma and normalize help-seeking
- Recommend collaborative mental health awareness and support events such as mental health retreats
- Network with Native American media, example radio station in Riverside
- Collaborate with Native American resources in Riverside/Riverside County, including UCR and Native American students

Victor Valley Club House – District Advisory Committee Regional Community Public Forum

- Partner with local drug stores for medication education opportunities
- Team up with homeless shelters to provide mental health and medication education
- TAY centers for all age groups as a natural community gathering place
- Partner with PALS (Police Activities League) to coordinate a behavioral health component

TEAM House Clubhouse – District Advisory Committee Regional Community Public Forum

- Partner with dental schools to provide dental screenings and cleanings for consumers
- Partner with food banks to encourage participation with local club houses, develop a program for delivery to consumers
- Educate the community on mental health resources, collaborate on community and faith based events, pow wows.
- Partner with primary care providers and physical health clinics
- Team up with optometry groups to provide low cost or fee eye exams and glasses
- Continue mental health education with law enforcement and provide local alternatives to hospitalization

Santa Fe Social Club – District Advisory Committee Regional Community Public Forum

- Primary needs in Yucca Valley are housing and employment assistance, mental health education, and crisis support.
- Continue mental health education with law enforcement and provide local alternatives to hospitalization
- Educate the community on mental health resources, collaborate on community and faith based events, partner with Goodwill, Red Cross, local business.

BHRC Rialto – District Advisory Committee Regional Community Public Forum

- Partner with and provide mental health education for faith based organizations Salvation Army
- Develop collaborative efforts with Veteran’s Affairs to assist veterans &

families

#### **4. Successful Collaborative Strategies in Your Community? -**

- (6) MH consultants in schools & after school programs; this will help address stigma, access & transportation; Parent involvement with strong support system which would include a collaborative among schools, teachers, mental health workers/liaisons, and community based organizations, to identify at risk children and provide services/supports to child & family
- (6) Strategically coordinate resource awareness, to include community resources agencies, peer and family support resources and other community friendly and self-help resources - this includes indigenous, faith-based and community-based resources and alternatives; this is important to stakeholders from African American, Latino, Native American, Asian American/Pacific Islander, LGBTQ communities
- (6) Non-clinical, walk-in, neighborhood centers are not as stigmatized – link with & provide education & skills to these partners, especially for all ethnic communities and age groups throughout the regions of the county
- (4) Need outreach, mobile, to isolated areas & community centers (especially isolated areas such as Trona and the Morongo Basin)
- (2) Clubs, Study Groups for kids at schools, churches, natural gathering places (after school, after hours)
- (2) Sometimes, consumers need someone to just listen – via phone – recommend expanded use of hot line/warm line, relevant to LBGQTQ, remote areas, cultural groups
- (2) Orange County Bar Assoc. was highlighted as model regarding first time offenders, including education, parent involvement, interagency collaboration and case coordination; our county continues to have obstacles/barriers, especially important for exploited youth
- Utilize multidisciplinary team approach (MDT) in a community based program which provides in home and school based early assessment and intervention services
- For exploited youth, need for collaborative training of community partners, school police, public/private; suggest District Attorney CASE model
- For exploited youth, need identification and intervention quickly, drug/trauma intervention concurrently, prevent “running behavior” (e.g. Iowa cornfield idea)
- For exploited youth, recommend expansion of collaborative approaches (example TAY Centers, Operation Phoenix)
- To offer alternatives to youth, recommend education for all children/youth in safe, natural environments
- Education and street outreach to impact exploitation of youth
- Consider, for at risk youth, non-clinic setting, drop-in or street outreach approach
- For juvenile offenders, approaches such as Girls Circle (group treatment), aggression repression treatment (ART), My Life My Choice, Drug Court, sober living for adults and kids, Centers for Healing/Family-to-Family, prevention programs, TBS and Wraparound
- For homeless population, ensure basic needs are met – this is essential for wellness, mental health
- One-stop service setting, to include mental health and drug-alcohol services
- Bring cultures together that have a common medium, like drumming circles’ Mental health services and referrals at mental health fairs
- Use of alternative medicines
- “Wraparound” services for children are effective
- Expand CCRT availability throughout the remote regions of the county
- Partner with local businesses to share resources and create community friendly settings
- Address stigma by “marketing” mental health education and support options through family activities, family friendly events in normal gathering places
- Recommend responding to suicide crises with crisis intervention staff, support resources instead of sending the cops!

- For LGBTQ community, recommend working with Red Cross, Volunteers of America and other community organizations and social groups to assist in serving mental health needs
- Utilize technology in innovative ways to facilitate access and information to isolated communities such as Trona
- Extend CCRT (responsiveness) for LGBTQ population; LGBTQ-specific services in lower desert area
- Train Promotores de Salud and the community on forming and facilitating support groups for individuals and families; community-driven networks, support systems, education, solutions
- Fund Clubhouse-type setting for Spanish speaking community
- Provide mentoring/buddy system or Peer-to-Peer support
- Teaming mental health consultant with family doctors – where parents more willing to go, we are more likely to facilitate early education and assistance; include consultation for OB/GYN serving pre-natal & post-partum clients; educate pediatricians
- Head Start programs – perfect place to conduct early screening in collaboration with public health nurse & facilitate needed care at lowest intensity
- African-American children/youth do better when they study together in a group (the “collective” experience)
- Churches are already providing “non-traditional” services to their communities, as well as federally qualified health centers (FQHC) and other CBO’s
- Especially for the African-American community, work with existing community programs that know the community
- The “Student Advocates” model is a group that attends expulsion hearings and is recommended.
- Utilize the county website, expand its use to facilitate wider access, especially in addressing geographical isolation (provide LGBTQ info and resources in this way)
- Free, structured activities and safe place to do 24/7, especially for TAY youth
- AA/NA for TAY youth
- Sponsor carpooling to address transportation issues for isolated individuals
- Community garden, good arena for bringing people together
- Drug court, excellent model instead of punishment
- Big Brother- Sister program
- Provide lesbian & gay groups in schools
- Consider model such as Sunshine Circles, which facilitate children to express emotions
- MH presence/partnership in libraries – educate library staff re: early signs of child/family trouble, at risk homeless kids, runaways, homeless moms, latch-key kids, and kids who don’t want to go home
- Partner with churches that can mentor kids/youth before and after “coming out” to alleviate stress/isolation/risk (LGBTQ)
- Support parent participation with ESL classes or linkage to ESL classes
- In home parenting support services, especially for Spanish-speaking families
- Independent living skills program with mentoring/life coaching for parents of at risk youth (Spanish Speaking)
- Hold community meetings at convenient locations & times
- Consider models such as DRUMLINE, Youth Accountability Boards, Young Visionaries
- Work with array of community based organizations who are now trying to help those “falling through the cracks” due to unemployment, housing crisis, community violence, poverty, and other extraordinary stressors due to economic downturn
- Work with the Mexican Consulate to facilitate and provide services early to un/documented population – e.g. establish working contact with advocates for immigrants
- Some of our schools are open to collaboration, open to presentations. Administrators can create barriers. Children benefit when there is interagency collaboration at schools
- MH education for law enforcement (police/sheriff) and Judges/Court could prevent many of our clients from going to jail (applies especially to domestic violence survivors). When

- law enforcement/Courts do not understand how to identify/intervene w/ mental illness, this escalates problems. (This is especially important for upper desert.)
- The Integrated Health Care Project should be considered for Innovation enhancements
  - The CWIC and CCRT models are effective
  - There are multiple “free” support services available in the San Bernardino area which are not available in the upper/high desert; apply these collaborative resource models in the desert
  - For older adults, the Archstone Foundation funded Elder Abuse & Neglect Initiative is recommended as a fairly low cost model of interagency collaboration and community based coordination of assessment, support and protection which can be adapted to a variety of cultural and geographical communities
  - For older adults, develop intranet-based communications system across departments, agencies and community resources. Identify, fund and support a “go to” person in each primary agency who can make decisions, commit resources and ensure follow-through
  - For Latino community, more sports programs are needed
  - Re-direct youth into positive, structured activities – for example, a youth caught doing graffiti can be re-directed into culturally relevant art classes (strength based)
  - Connect with agencies that specifically serve people with disabilities
  - Have services (support resources, information, referral links) available online
  - Phone or online access is a strategy that would address access issues for physically disabled individuals while also addressing stigma
  - Use video relay for deaf clients
  - Recreational activities, TAY-like center and grants for children – underserved population in general is kids age 6 – 15
  - For the Asian and Pacific Islander communities, innovative outreach strategies are recommended, in collaboration with organizations and settings that are part of the community, part of the family’s support system (collectivist culture)
  - Isolated rural communities would benefit from integration of various recreational resources and activities and the creation of a community center to address severe isolation; staff with volunteers
  - In the Needles area, there is a large senior community, a need for transportation, doctors, and difficulties with law enforcement. Partnering with existing community agencies and organizations might help to address these issues – recreational centers, Center for Change, Drug Court, churches, VA, First 5, public health and Angel Food
  - Targeted and ongoing outreach to military veterans, facilitating access to non-stigmatized supports – especially in rural areas
  - Treat the entire family – not just the individual
  - Provide language classes for youth to help them sustain their culture and language
  - For mental health education/awareness, consider the D.A.R.E program approach which would expose children/youth and their families to mental health issues and address stigma
  - Consider “virtual peer mentoring” since youth more responsive to online access and social networking
  - “Special Olympics” model to treatment goal and peer-driven support system
  - Consider combining Alcohol-Drug rec centers with mental health consumer clubhouses
  - Share information and resources across programs and regions (especially important for co-occurring – substance abuse)
  - Combine consumer newsletter (consumer clubhouse and alcohol-drug rec center, and other peer driven networks)
  - Consider incentive system for medications-resistant client populations (co-occurring)
  - For Native American community, apply sweat lodge concept
  - For Native American community, Indian Health services – opportunity for collaboration
  - For Native Americans, have connection, linkage and provide transportation to places like Newberry Springs

- For Native Americans, consider strategies that are inclusive
- For Native American community, provide resources that are both generic and specific
- Give unique programs flexible guidelines in order to demonstrate outcomes (success)
- DBH provide stipends (vouchers) to clients so they can receive the services they need from alternatives
- Collaborate with agencies in our cultural communities who actually serve those who are now unserved by the mental health system

Victor Valley Club House – District Advisory Committee Regional Community Public Forum

- Partner with Public Health to provide services and education to community on mental health issues
- Partner with St. Mary’s hospital to provide services in conjunction with mobile immunization program
- Negotiate with Parks and Recreation and other community centers for mental health consumers to participate at no or reduced fee rate.

TEAM House Clubhouse – District Advisory Committee Regional Community Public Forum

- Educate the faith based community on how we can partner together.
- Continue to partner with substance abuse programs, with DBH being a major collaborative entity
- Partner with food banks to encourage participation with local club houses
- Increase support for clubhouses and consumer groups
- Continue collaboration with NAMI to encourage more mental health education

Santa Fe Social Club – District Advisory Committee Regional Community Public Forum

- There are strong senior assistance groups in Yucca Valley, including UANA (You Are Not Alone) program that helps older adults in the community
- Sponsor and encourage community mixers
- Second Harvest is a food assistance program that helps many local older adults
- Increase local availability and knowledge of rental/housing programs, food pantries, food vouchers, ARCH program (utility/mortgage assistance), CalWorks
- Educate the faith based community on how we can partner together.

**5. Assessing Outcomes and Quality**

- (4) Hard to evaluate quality of services if we don’t know what services we have and what services we could have; education about our local services and the MHSA is needed; Community is still unaware of services and resources available so public awareness campaign is recommended (includes Latino community)
- (4) Do satisfaction surveys, include clients & others in defining satisfaction, satisfactory outcomes
- (4) Hold regular focus groups with users of services and other community members
- (2) Ask us how many clients leave (graduate from) mental health service
- (2) Recidivism rates = indicates outcome
- (2) Good indicator of quality outcome or success = higher school enrollment/graduation, higher employment among clients after mental health service, improved daily living

- Policy makers need to be interested in the “outcomes” that occur when services are removed from communities
- “In home, in school and out of trouble” – track these markers
- Talk to (listen to) peer & family advocates about what is working and what is not with the system per clients’ reports
- Let community know what is being done and available for Native American community
- Monitor department spending; if programs aren’t reaching agreed-upon outcomes, implement new approaches
- Emphasize “street outreach” for unserved, underserved & inappropriately served; have these staff serve as ambassadors (“eyes and ears”) to see what work & what doesn’t – African American, Latino, Asian Pacific Islander, Native American, LGBTQ, at risk exploited youth, military vets, substance abuse co-occurring.
- One way to measure success for children/youth is positive feedback from both child/youth and parents, families
- Following regular focus groups, provide participants with regular updates (feedback loop)
- Oversee contract providers to ensure money is spent as it was intended
- For exploited youth, juvenile offenders, vulnerable youth, have parents/caretakers complete assessments to document change/improvement in youth
- Healthy Homes screening tool – recommend similar for exploited youth
- Update crisis policies and procedures (currently too strict and does not serve all those in crisis)
- Include dual-diagnosis, co-occurring (substance abuse) individuals in the system
- Improve emphasis on and evaluation of case management and interagency collaboration on behalf of consumers
- Less hospitalizations indicate services are working
- Less school suspensions, school detentions suggest treatment is working
- Conduct a study/assessment regarding access, barriers to service, who is served, environmental factors, what services provided in what region
- Providers can do higher quality service with smaller caseloads
- High quality system has more peers and volunteers working in system
- Sensitivity training for front door staff
- Assess the complexity of gaining access for underserved communities “(it depends on who you know”); develop consistent and reliable systems and links for underserved communities to seek and get help
- Use “secret shoppers” to assess quality of service settings
- Include consumers, family members and community members in evaluating county’s transformation according to MHSA goals
- Economic downturn presents opportunity to replace lost services with new innovative services with partner agencies and advocacy groups like NAMI, Parent Partners
- Due to doctor shortage, explore better use of doctor resource and nurses. Nurse Practitioners?
- Customer complaint desk; let us talk to supervisor
- Make sure community knows about new MHSA services, including prevention services
- Make sure community members know that they are partners in MHSA and can help fill service gaps (e.g. grandparents self-help groups) if only MH professionals would provide advice
- Don’t hurry us out of our service/care
- Give us time (support)
- Contact us with follow-up phone calls
- Services should match best practices no matter what insurance pays for
- Evaluate what services consumers are using (prefer) and offer more of those
- Consumer’s positive outcome might be: ability to recognize “trouble” early, connect to support group and regain stability without needing to go into “treatment” or hospital again

- Quality – being able to get quick access to mental health consultation during a rough time or crisis for a “tune up” – without a waiting list
- Quality – getting referred or linked to alternative resource like a peer support group, instead of needing to re-enter weekly treatment or go to hospital before I get help again
- Positive outcome is finding support in a familiar place in my community where people know what help I need and where I can learn to help myself
- Each client, consumer, stakeholder should have access to an “exit” survey with a SASE; perhaps provide incentive for returning the survey. This would prevent agencies from missing constructive criticism from their stakeholders.
- Positive outcome = community feels comfortable engaging with MH system in their community
- The Global Assessment of Functioning (GAF) remains a sound, consistent & universal framework for defining progress toward system and client outcomes
- Outcome, research and evaluation data should be a part of our system not only for “accountability” but for self-assessment and tweaking the MH system
- Consider comprehensive customer satisfaction survey, going cross platform
- Service/treatment programs need to be accountable for participating in engaging on outcomes issues – GAF is a good place to start
- Training recommended for staff on relevance of outcomes, outcome measurement to successful transformation at the client and system level
- The department’s “plan” or “vision” or “mission” needs to integrate outcomes and accountability as relevant to the entire system, its transformation and integration
- The department needs a better “business model”, where outcomes are connected to the mission
- Clients and staff alike have trouble defining outcomes that are relevant to the accountability systems that the department must live within; better education and coordination of message would alleviate this
- Obtain input from community and consumers from phone call line and electronically (technology use)
- Feedback forums in community gathering places
- Reduced incidence of elder abuse, elder self-neglect
- Monitoring individuals not re-entering or recycling through the mental health treatment system
- From Latino community perspective: partnership with my advocate
- Specific tools and skills that are gained through family support groups (Latino community in particular)
- Pre- and post- assessment tools, success stories, post-crisis follow-up
- Inform community about outcomes; make goals clear; involve us in defining goals
- For the Asian and Pacific Islander community, discuss physical and mental health together; work with the public health department; community wellness is an outcome that sounds relevant to our community
- Hold feedback forums at women’s club, Elks Lodge, Senior Center, recreation center, schools (Needles area)
- Work with LGBTQ community on collecting data on LGBTQ community, needs and outcome definitions
- If client is participating in their treatment, this is a sign that mental health services are working
- Evaluate effectiveness of linkage, collaboration; earlier intervention and prevention are less costly than delaying service which causes crisis
- For Native Americans, services are not working but they will once the right approach is brought in

Victor Valley Club House – District Advisory Commission Regional Community Public Forum

- Establish support and mechanism for ongoing community conversations regarding mental health issues
- Assist in coordinating independent forums with consumers and family members
- Conduct survey and telephone polls, providing a feedback loop to the community

TEAM House Clubhouse – District Advisory Committee Regional Community Public Forum

- Conduct survey and telephone polls, providing a feedback loop to the community
- Establish support and mechanism for ongoing community conversations regarding mental health issues

Santa Fe Social Club – District Advisory Committee Regional Community Public Forum

- Establish support and mechanism for ongoing community conversations regarding mental health issues. Quarterly meetings were suggested
- Establish accessible feedback mechanisms from staff and contract providers
- Establish working relationship with the Consumer Advisory Board

**COMMENTS ABOUT THE STAKEHOLDER INPUT FORUM PROCESS FROM STAKEHOLDERS:**

- This forum (held with agency staff) became a useful tool to help our CBO agency better serve our clients.
- During this forum, we were able to identify several shortcomings within our agency. Once the issue was identified, the staff quickly found a solution.
- We (CBO agency stakeholders) identified several areas of outreach that had not been previously identified. Due to this forum, we are scheduling outreach programs with several corporations and churches in the area.
- Our agency would like to thank the Department of Behavioral Health for encouraging us to undergo this process. In coming weeks we will be scheduling more of these forums to solicit input from our clients.
- (Forum) questions need to be revised and tailored to each forum

*For Reference:*

**INNOVATION - Community Program Planning  
Mental Health Services Act (MHSA)  
Community Public Forum and Targeted Forum Questions**

- 1. Unserved, Underserved and Inappropriately Served Individuals/Communities and Promising Community Resources** – Thinking about your own community, what kinds of mental health problems, challenges or issues affecting unserved and underserved individuals could be addressed with more innovative and creative approaches? What kinds of resources are available in your community now that you think are helpful in handling those mental health issues?
- 2. Responsiveness to Issues of Age, Gender, Language, Beliefs, Orientation, and Ethnic and Cultural Background** - Do you have suggestions or ideas about how mental health services could be more relevant and responsive to

clients' age, gender, language, beliefs, orientation, and ethnic and cultural backgrounds?

3. **Interagency Collaboration** - Can you think of ways that mental health programs can work with other organizations, agencies & other resources to better address the mental health needs of your community?
4. **Successful Collaborative Strategies in Your Community** – Are there innovative, collaborative approaches that are effective in your community that might be effective in serving mental health needs for a certain age group? In a certain region of the county?
5. **Assessing Outcomes and Quality** - Can you suggest some ways or ideas that tell us if mental health services are high quality and are working?

Compilation of all forum minutes initiated February 10, 2009  
Completed September 14, 2009

































































**Comments:**

The San Bernardino County Innovation Working Committee (IWC) began its Innovation CPP by reviewing prior stakeholder input generated during the CPP processes for CSS (2005) and PEI (2007). This prior input reflected concerns and recommendations from more than 1,700 PEI participants and 2700 CSS participants. The Innovation CPP specifically targeted those underserved communities not effectively reached during the CSS and PEI CPP processes. This report provides a summary of the Demographic Stakeholder Data Collection Form (blue form) completed by San Bernardino County stakeholders from November/08 to September/09. This form was utilized by the Mental Health Services Act (MHSA) CPP to determine participants' demographic composition as well as how we can best meet the needs of the community using the funds of the MHSA under the Innovation component and to continue our efforts to engage underserved communities effectively in ongoing stakeholder engagement strategies.

A total of **563 forms** were processed covering the following aspects:

Personal Information: gender, ethnic or cultural group most closely identified, and preferred language.

Partner/Stakeholder Information: agency/organization represented (if any), age groups agency specializes in, county area(s) agency serves, and partner contact information. (Our county has been tracking categories of agencies/organizations according to the PEI Guidelines which recommended partnering with "required sectors" to maximize effective MHSA collaboration; organizational headings were determined within these definitions.)

Some notable results are as follows:

By gender, Females (59%) almost doubled the participation of Males (31%) in spite of a significant percent of persons (10%) that did not answer this question.

Caucasians (34%), Latinos (25%), and African Americans (11%) were the ethnic groups with the highest representation.

English (76%) and Spanish (13%) were the most preferred languages.

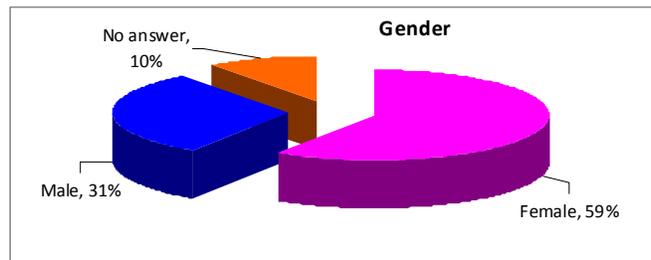
Almost 1/3 of the stakeholders were Individual consumers or family members and 16% representatives of community based organizations. DBH staff/employees (11%), contract agency staff/employees (9%), and Health Services, including various specialty cares (6%) were the partner categories that comprised the top five places on the list.

The responses by "age groups agency/organization specializes in" had no significant differences. Adults (26-59y) with 31% and Transitional Age Youth (TAY) (16-25y) with 27% reached the highest percentages. East Valley/SB (23%), West Valley (20%) and Central Valley (18%) were the "county area agency/organization serves" with the highest percentages. However, Mountains and Desert areas had a significant stakeholder representation not reached in prior "robust" CPP processes.

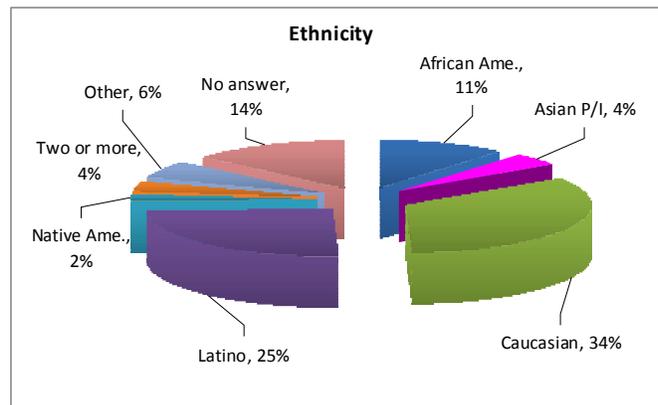
The outcomes of the MHSA Demographic Data Collection Form by question are shown in tables and charts on pages 1 – 4. Finally, a comparison between these most recent CPP results with San Bernardino County's Poverty Population as well as with the MHSA CPP processes for PEI (2007) and CSS (2005) are detailed in pages 5 – 8.

	No.	%	MHSA-INNOVATIONS Demographic Data Collection Form (blue form)
<b>Total questionnaires processed</b>	<b>563</b>	<b>100%</b>	<b>Results by Question</b>

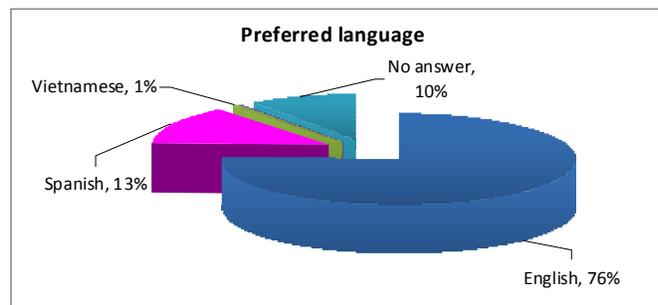
Gender	No.	%
Female	333	59%
Male	172	31%
No answer	58	10%



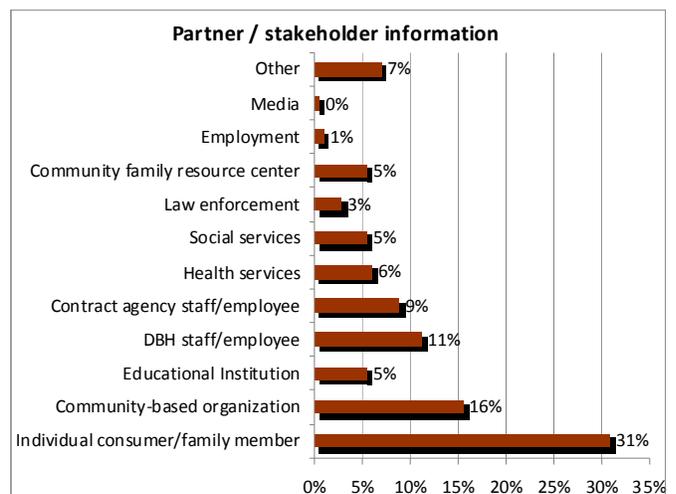
Ethnicity	No.	%
African Ame.	63	11%
Asian P/I	25	4%
Caucasian	190	34%
Latino	140	25%
Native Ame.	14	2%
Two or more	20	4%
Other	34	6%
No answer	77	14%



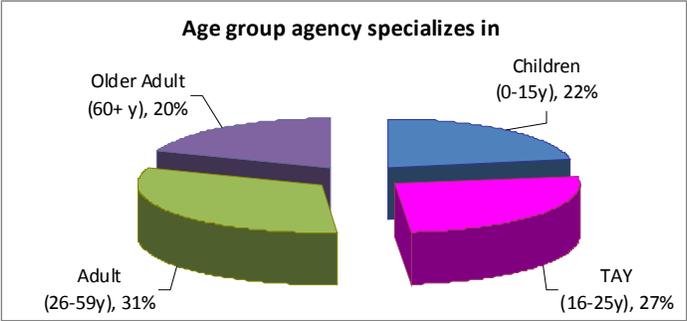
Preferred language	No.	%
English	427	76%
Spanish	76	13%
Vietnamese	3	1%
Other	2	0%
No answer	55	10%



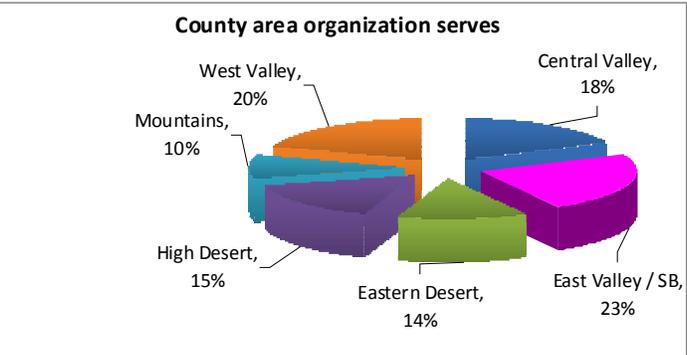
Partner / stakeholder information (total: 734 answers = 100%)		
	No.	%
Individual consumer/family member	227	31%
Community-based organization	114	16%
Educational Institution	40	5%
DBH staff/employee	82	11%
Contract agency staff/employee	65	9%
Health services	44	6%
Social services	40	5%
Law enforcement	21	3%
Community family resource center	40	5%
Employment	7	1%
Media	3	0%
Other	51	7%



Age group agency specializes in (total: 973 answers = 100%)			
		No.	%
Children	(0-15y)	216	22%
TAY	(16-25y)	258	27%
Adult	(26-59y)	306	31%
Older Adult	(60+ y)	193	20%



County area organization serves (total: 1,028 answers = 100%)			
		No.	%
Central Valley		188	18%
East Valley / SB		239	23%
Eastern Desert		141	14%
High Desert		159	15%
Mountains		99	10%
West Valley		202	20%

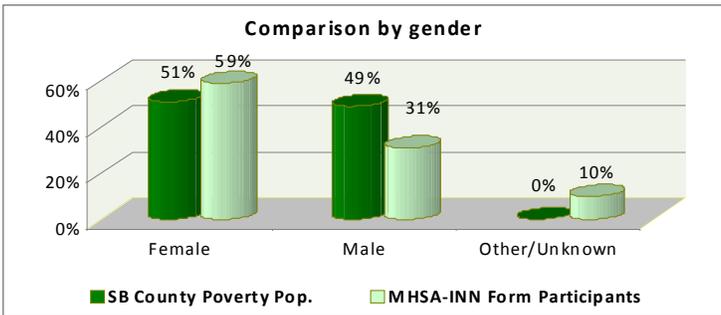


Representation (total: 563 answers = 100%)					
Name	Number	%	Name	Number	%
A Servants Heart Outreach	2	0%	Knotts Family and Parenting	2	0%
ARM Group Homes	1	0%	Leap Through the Fire Faith	1	0%
Arrowhead Regional Medical Center	1	0%	Loma Linda University	2	0%
Asian American Center	1	0%	Lutheran Social Services	4	1%
Autism Society inland Empire	1	0%	Make a Difference Association	5	1%
Bienestar Human Services	5	1%	Matrix Institute	1	0%
Boarding Care	1	0%	MBMH	2	0%
Bonnie Baker Senior Center	1	0%	Mental Health System Inc.	6	1%
Building a Generation	1	0%	MHS TBS San Bernardino	1	0%
CAB Consumer Advocacy Board	1	0%	Morongo Basin Mental Health	7	1%
CAINU Valley USD	1	0%	Morongo Basin Unity Home	2	0%
Cal Polly Pomona	9	2%	NAMI	10	2%
Cal State University	2	0%	New Focus Community Dev.	1	0%
California Senior Legislate	1	0%	No Organization (consumer/family)	14	2%
Casa De San Bernardino Inc	1	0%	Nuevo Amanecer	4	1%
CCS Harmony Clubhouse	1	0%	Ontario Community Counseling	1	0%
CCS Trona	1	0%	Over Eaters Anonymous	1	0%
Cedar House Rehabilitation	1	0%	Pacific Clinics	7	1%
Center for Healing Chino Treatment	2	0%	Panorama Ranch	3	1%
CFS	2	0%	Para los Ninos	1	0%
Chaffey Joint U HS District	1	0%	Pathway to Recovery	14	2%
Childrens Network	1	0%	Project Sister Family Services	1	0%
Chino Valley Unified School District	1	0%	Quan Am Buddhist Meditation	1	0%
CHL	1	0%	Rancho TAY	3	1%
Clearwater Residential	1	0%	Reach Out	2	0%
Clubhouse Jewel of Thedaser	1	0%	Reach Out Morongo Basin	1	0%
College Community Services	4	1%	Reach Out West End	1	0%
Concerned Black Men	1	0%	Renaissance Scholars	1	0%
Consumer Advisory Board	2	0%	Rolling Start Inc	1	0%
County Counsel	1	0%	RPYA	1	0%
Cox Sober Living	1	0%	RUCC	1	0%
DBH	33	6%	SAC	1	0%
DBH- Healthy Homes	1	0%	SAC RCA	1	0%
DBH-AB2726	2	0%	SAC Bonnie Baker Senior Center	1	0%
DBH-ADS Calworks	1	0%	San Bernardino Valley College	1	0%
DBH-Adult Residential Services	1	0%	Santa Fe Social Clubhouse	3	1%
DBH-CCICMS	1	0%	SB County Aging and Adult Services	10	2%
DBH-CCRT	1	0%	SB County Dept Of Childrens Services	3	1%
DBH-Central FAST	1	0%	SB County District Attorney	3	1%
DBH-Housing	2	0%	SB County Dpt. Public Health	1	0%
DBH-Needles	1	0%	SB County Probation	5	1%
DBH-OCCEs	2	0%	SB County Superior Court	1	0%
DBH-OPPD	1	0%	SB County Vets	1	0%
DBH-R&E	5	1%	SB Unified School District	1	0%
DBH-West Valley Juvenile	1	0%	So. Coast Children Society	1	0%
DBH-WET	1	0%	Social Club	1	0%
DBH-WV	1	0%	South Coast Community Services	2	0%
Dino Papavero Senior Centre	1	0%	St. Paul American Church	1	0%
Disability Rights Legal Center	1	0%	TAY Center	2	0%
EI Sol Neighborhood Center	16	3%	TAY Pacific Clinics	1	0%
EMQ Families First	1	0%	TCSCO	1	0%
Equality Inland Empire	4	1%	Team House	9	2%
Escuela de Ingles de Adultos	1	0%	Telecare	1	0%
Etiwanda School District	1	0%	Telecare High Desert CWIC	1	0%
FAST	1	0%	The Fact Center	1	0%
First Chance Inc	1	0%	Time for Change Foundation	1	0%
Fontana Native American Center	1	0%	Trona Senior Center	1	0%
Fostercare and Relative Empire	1	0%	Upland Community Counseling	1	0%
Healthy Homes	1	0%	Valley Star SBHG	1	0%
High Desert Center	1	0%	VCSS	1	0%
High Desert Club House	2	0%	Veterans DBSA Loma Linda	1	0%
High Desert Domestic Violence	5	1%	Veterans Home of CA Barstow	2	0%
IAP Writting Group	1	0%	Veterans Affairs	1	0%
IBHS	2	0%	Victor Community Support Services	1	0%
IECAAC	2	0%	Victor Valley Regional Counseling	1	0%
IEHP	1	0%	Vista Guidance Centers	1	0%
Inland County Stone Wall	1	0%	West Family Counseling	1	0%
Inland Empire Health Plan	1	0%	Young Visionaries	1	0%
Inland Regional Center	1	0%	No Answer	225	40%
Inland Valley Recovery Services	16	3%			

Comparison between SB County Poverty Population and MHSa-Innovation Survey Participants		
	Percentage Estimated of San Bernardino County Population under 200% Federal Poverty Level (FPL) (*)	Percentage Participating of MHSa INNOVATION Demographic Data Collection Form (blue form)
Target Population	SB County Poverty Pop.	MHSa-INN Form Participants
<b>Gender</b>		
Female	51%	59%
Male	49%	31%
Other/Unknown	NA	10%
<b>Age group (agency specializes in)</b>		
Children (0-15y)	29%	22%
TAY (16-25y)	16%	27%
Adult (26-59y)	45%	31%
Older Adult (60+y)	10%	20%
<b>Ethnic group</b>		
African Ame.	10%	11%
Asian P/I	5%	4%
Caucasian	30%	34%
Latino	51%	25%
Native Ame.	1%	2%
Other/Unknown	3%	24%
<b>County area (agency serves)</b>		
Central Valley	23%	18%
East Valley / SB	29%	23%
Eastern Desert	5%	14%
High Desert	18%	15%
Mountain	1%	10%
West Valley	24%	20%

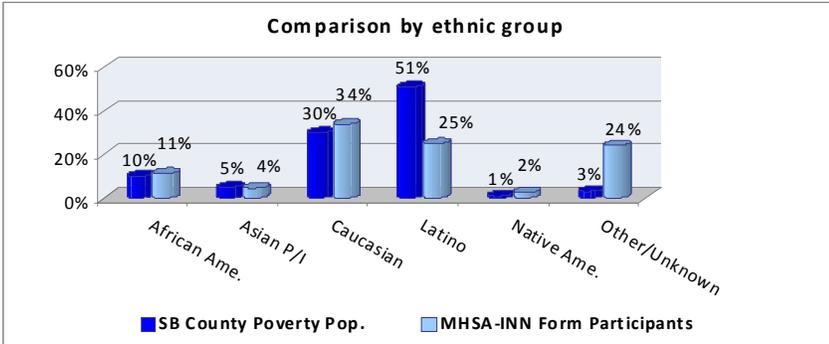
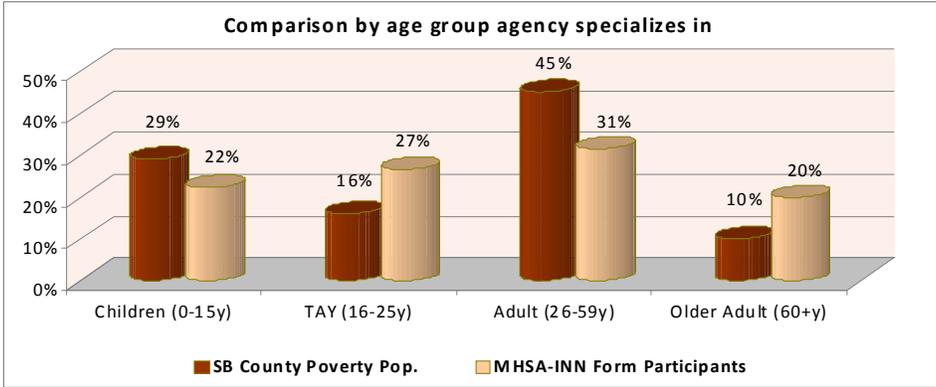
(\*) Estimated based on California Department of Finance, Demographic Research Unit and Census 2000 Population: US Census Bureau Data Finders <http://www.census.gov/>  
Population under 200% FPL: Data Set: Census 2000 Summary File 3 (SF 3)  
Sample Data Table P88 . Ratio of Income in 1999 to Poverty Level [10]  
<http://www.census.gov/Press-Release/www/2002/sumfile3.html>

**Comparison between SB County Population under 200% Federal Poverty Level (FPL) <Poverty Population> and MHS-A-Innovation Demographic Data Collection Form Participants**



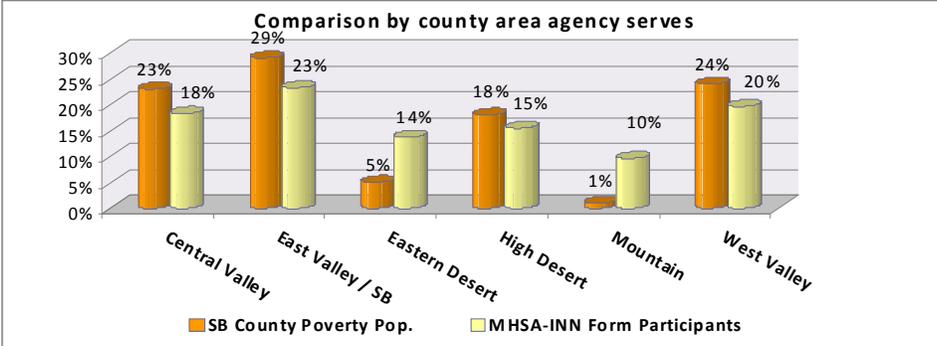
By gender, Male was the participant group underrepresented respect the population under 200% FPL. Female was overrepresented.

Children and Adult were the "age group's agency specializes in" underrepresented. TAY and Older Adults were overrepresented.



Latino and Asian/PI were the ethnic groups underrepresented. Caucasian, African American, and Native American had an overrepresentation respect the county poverty population.

"County areas agency serves" underrepresented: Central Valley, East Valley/SB, High Desert, and West Valley. Overrepresented: Mountain and Eastern Desert areas.



Comparison MHA Stakeholder Participating Process for Innovation (2009), Prevention & Early Intervention (2007), and Community Services & Support Planning Activities (2005).

	Percentage Participating of MHA INNOVATION (INN) Demographic Data Collection Form (blue form) 2009	Percentage Participating of MHA PREVENTION & EARLY INTERVENTION (PEI) Survey (salmon form) 2007	Percentage Participating of MHA COMMUNITY SERVICES & SUPPORT (CSS) Planning Activities 2005
Target Population	MHA-INN 2009	MHA-PEI 2007	MHA-CSS 2005
Total	563	1,792	2,703

Gender			
Female	59%	70%	57%
Male	31%	30%	34%
Other/Unknown	10%	NA	9%
Age group participants			
Children (0-15y)	3%	2%	2%
TAY (16-25y)	10%	8%	11%
Adult (26-59y)	64%	75%	74%
Older Adult (60+y)	15%	15%	8%
Unknown	9%	NA	5%
Ethnic group			
African Ame.	11%	17%	12%
Asian P/I	4%	3%	5%
Caucasian	34%	39%	30%
Latino	25%	30%	27%
Native Ame.	2%	6%	13%
Other/Unknown	24%	5%	12%
Preferred language			
English	76%	83%	NA
Spanish	13%	6%	NA
Vietnamese	1%	1%	NA
Other	0%	1%	NA
No answer	10%	9%	NA
County area served			
Central Valley	18%	10%	12%
East Valley / SB	23%	34%	33%
Eastern Desert	14%	12%	15%
High Desert	15%	16%	18%
Mountains	10%	4%	3%
West Valley	20%	20%	16%
Unknown	NA	4%	3%
Organization			
Individual consumer/family member	31%	25%	25%
Community-based organization	16%	3%	12%
Educational Institution	5%	5%	2%
DBH staff/employee	11%	23%	26%
Contract agency staff/employee	9%	8%	16%
Health services	6%	3%	0%
Social services	5%	NA	1%
Law enforcement	3%	NA	NA
Community family resource center	5%	NA	NA
Employment	1%	NA	NA
Other	7%	29%	18%