Artwork by Marisa Franklin

Mental Health Services Act Annual Update 2016-17

DRAFT

Behavioral Health

Message from the Director

Welcome to the San Bernardino County, Department of Behavioral Health's (DBH) Mental Health Services Act (MHSA, Prop. 63) Fiscal Year (FY) 2016/17 Annual Update. Since the passage of the Mental Health Services Act in 2005, the Department has diligently worked to integrate and weave the transformational principles and philosophies of the MHSA throughout the public behavioral health system. This approach has assisted the Department to consider and integrate the needs of diverse individuals, families, and communities into all aspects of program development, implementation, and evaluation.

The MHSA Annual update is the opportunity for the Department to highlight the accomplishments of the previous fiscal year and communicate stakeholder informed updates to the final year of the approved MHSA Three-Year Integrated Plan that spans from FY 2014/15 through FY 2016/17.

The last fiscal year has been full of activity as the Department has focused on expanding the Crisis System of Care, increased community education opportunities, and has continued to focus on expanding a cohesive system of behavioral health services and care. The result of this action has resulted in the development of two new programs, the Crisis Residential Treatment Program and the Regional Adult Full Service Partnership program. Additional highlights include the implementation of two evidence-based mental health education programs, and the inclusion of the MHSA Summit to enhance our robust Community Program Planning process. All of this information, and more, can be found in this comprehensive document.

It is my hope that you find the Annual Update informative and a reflection of both the progress of the Department in meeting the intent of the MHSA and the Wellness Component contained within the Countywide Vision. Together we move to support a healthy county that values prevention programs, superior healthcare services, and reducing chronic disease and socio-economic disparities through health education, promotion of healthy lifestyles, and development of outcome-based health services. We look forward to continuously increasing the collaboration between and among providers and community-based organizations.

Thank you for taking the time to review and provide feedback on this plan. The DBH Office of Program Planning and Development looks forward to receiving your input at MHSA@dbh.sbcounty.gov.

Sincerely,

CaSonya Thomas, MPA, CHC
Director, Department of Behavioral Health
County of San Bernardino

Our job is to create a county in which those who reside and invest can prosper and achieve well-being.

Mensaje de parte de la Directora

Bienvenido al Informe Anual de Actualización de la Ley de Servicios de Salud Mental (MHSA por sus siglas en Ingles, Proposición no. 63) del Departamento de Salud Mental (DBH por sus siglas en Ingles) del condado de San Bernardino. Desde la aprobación de la Ley de Servicios de Salud Mental en el 2005, el Departamento ha trabajado diligentemente para integrar y tejer los principios y las filosofías transformativas de MHSA en el sistema público de salud mental. Este enfoque ha ayudado que el Departamento considere e integre las necesidades diversas de individuos, familias y comunidades en todos los aspectos del desarrollo, la implementación y la evaluación de programas.

La Actualización Anual de MHSA da la oportunidad al Departamento para destacar los logros del año fiscal anterior y comunicar los cambios cuyos fueron informados por la comunidad. Este es el año final del Plan Integrado de MHSA de tres años y que extiende desde el año fiscal 2014/15 hasta el año fiscal 2016/17.

El último año fiscal ha sido muy activo porque el Departamento se ha enfocado en expandir el Sistema de Cuidado de Crisis, en aumentar las oportunidades educativas para la comunidad, y ha continuado a centrarse en la expansión de un sistema de servicios y cuidados de salud mental coherentes . El resultado de este enfoque se ha traducido en el desarrollo de dos programas nuevos, el programa de Tratamiento Residencial de Crisis y el programa de Asociación Regional de Servicios Completos para Adultos. Otros puntos destacados incluyen la implementación de dos programas de educación de salud mental basados en evidencia científica, y la inclusión de la Cumbre de MHSA como vehículo para mejorar nuestro proceso comunitario de planificación de programas. Toda esta información, y más, se puede encontrar en este documento integral.

Es mi esperanza que encuentren la Actualización Anual informativa y que sea tanto un reflejo de los avances del Departamento en cumplir la intención de MHSA y como del componente de bienestar contenido dentro de la Visión del Condado. Juntos nos movemos para apoyar un condado sano que valora los programas de prevención, servicios superiores de salud, y la reducción de las enfermedades crónicas y en reducir las disparidades socioeconómicas mediante la educación de salud, la promoción de estilos de vida saludables, y el desarrollo de servicios de salud basados en los resultados. Esperamos aumentar continuamente nuestra colaboración entre y con los proveedores y las organizaciones comunitarias.

Gracias por tomarse el tiempo en revisar y ofrecer retroalimentación en este plan. La Oficina del Programa de Planificación y Desarrollo de DBH espera recibir sus opiniones en MHSA@dbh.sbcounty.gov.

Atentamente:

CaSonya Thomas, MPA, CHC
Directora, Departamento de Salud Mental
Condado de San Bernardino

Nuestra labor es crear un condado en el cual los que viven e invierten puedan prosperar y lograr el bienestar.

Table of Contents

Title	Page
Message from the Director	**02**
Message from the Director (Spanish)	**03**
Table of Contents	**04**
County Compliance Certification	**07**
County Fiscal Accountability Certification	**08**
Executive Summary	**09**
Community Program Planning	**37**
Summary of Program Changes	**59**
New Programs	**65**
Prevention and Early Intervention (PEI)	**80**
Introduction	**81**
Statewide PEI Projects	**83**
Local Impact	**84**
Responding to Policy Change	**85**
School Based Initiative	
PEI SI-1: Student Assistance Program	**89**
PEI SI-2: Preschool PEI Program	**92**
PEI SI-3 Resilience Promotion in African American Children	**95**
Community Based Initiative	
PEI CI-1 Promotores de Salud/Community Health Workers	**99**
PEI CI-2 Family Resource Centers	**102**
PEI CI-3 Native American Resource Center	**105**
PEI CI-4 National Curriculum and Training Institutes Crossroads Education Program©	**109**
System Enhancement Initiative	
PEI SE-1 Older Adult Community Services	**113**
PEI SE-2 Child and Youth Connection	**117**
PEI SE-3 Community Wholeness and Enrichment	**121**
PEI SE-4 Military Service and Family Support	**124**
PEI SE-5 Lift Program	**128**
PEI SE-6 Coalition Against Sexual Exploitation	**131**
Community Services and Supports (CSS)	**136**
Introduction	**137**
Children	
C-1 Comprehensive Children and Family Support Services	**139**
C-2 Integrated New Family Opportunities	**147**

Table of Contents

Title	Page
Transitional Age Youth	**151**
TAY-1 One Stop Transitional Age Youth Centers	
Adults	
A-1 Clubhouse Expansion	**163**
A-2 Forensic Integrated Mental Health Services	**168**
A-3 Members Assertive Positive Solutions/ Assertive Community Treatment	**177**
A-4 Crisis Walk-in Centers	**183**
A-5 Psychiatric Triage Diversion Program	**186**
A-6 Community Crisis Response Teams	**190**
A-7 Homeless Intensive Case Management	**195**
A-8 Big Bear Full Service Partnership	**207**
A-9 Access, Coordination, and Enhancement	**210**
Older Adults	
OA-1 AgeWise Circle of Care	**214**
OA-2 Mobile Outreach and Intensive Case Management	**218**
Innovation (INN)	**223**
Introduction	**224**
INN-06 Transitional Age Youth Behavioral Health Hostel	**226**
INN-07 Recovery Based Engagement Support Team	**235**
INN-04 Holistic Campus Final Report	**245**
INN-05 IYRT Final Report	**277**
Workforce Education and Training (WET)	**300**
Introduction	**301**
Positive Results	**303**
Capital Facilities and Technology (CFTN)	**318**
Introduction	**319**
Updates and Results	**320**
Fiscal	**328**
Cost Per Client FY 2015/2016 (PEI, CSS, INN)	**329**
MHSA Funding Summary	**332**
PEI	**333**
CSS	**334**
INN	**335**
WET	**336**
CFTN	**337**

Table of Contents

Title			Page
Attachments:			**338**
Attachment A	—	Press Releases (English & Spanish): Community Planning Meetings	**339**
Attachment B	—	Stakeholder Meeting Schedules (English and Spanish)	**345**
Attachment C	—	Community Planning Meeting Comment Forms (English and Spanish)	**355**
Attachment D	—	Press Releases (English and Spanish): 30-Day Public Posting	**357**
Attachment E	—	Media Outlet List for Public Releases	**359**
Attachment F	—	Measurement and Assessment Tools	**360**
Attachment G	—	Innovation Final Report Attachments	**364**

MHSA COUNTY COMPLIANCE CERTIFICATION

County/City: _San Bernardino_____

☐ Three-Year Program and Expenditure Plan
☒ Annual Update

Local Mental Health Director	Program Lead
Name: CaSonya Thomas, MPA, CHC	Name: Michelle Dusick
Telephone Number:	Telephone Number:
E-mail:	E-mail:
Local Mental Health Mailing Address: Department of Behavioral Health 303 East Vanderbilt Way San Bernardino, CA 92415	
DRAFT - INTENTIONALLY BLANK	

I hereby certify that I am the official responsible for the administration of county/city mental health services in and for said county/city and that the County/City has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this Three-Year Program and Expenditure Plan or Annual Update, including stakeholder participation and nonsupplantation requirements.

This Three-Year Program and Expenditure Plan or Annual Update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft Three-Year Program and Expenditure Plan or Annual Update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on _____.

Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code section 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant.

All documents in the attached annual update are true and correct.

_____ _____

Local Mental Health Director (PRINT) Signature Date

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: San Bernardino

☐ Three-Year Program and Expenditure Plan
☒ Annual Update
☐ Annual Revenue and Expenditure Report

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: CaSonya Thomas, MPA, CHC Telephone Number: E-mail:	Name: Michelle Dusick Telephone Number: E-mail:
Local Mental Health Mailing Address: Department of Behavioral Health 303 E. Vanderbilt Way San Bernardino, CA 92415 **DRAFT - INTENTIONALLY BLANK**	

I hereby certify that the Three-Year Program and Expenditure Plan, Annual Update or Annual Revenue and Expenditure Report is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations sections 3400 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the Mental Health Services Act. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for counties in future years.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached update/revenue and expenditure report is true and correct to the best of my knowledge.

_____ _____
Local Mental Health Director (PRINT) Signature Date

I hereby certify that for the fiscal year ended June 30, _____, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated _____ for the fiscal year ended June 30,_____. I further certify that for the fiscal year ended June 30,_____, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

I declare under penalty of perjury under the laws of this state that the foregoing, and if there is a revenue and expenditure report attached, is true and correct to the best of my knowledge.

_____ _____
County Auditor Controller / City Financial Officer (PRINT) Signature Date

[1] Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)

Artwork by David Pacheco

Executive Summary

Executive Summary

Introduction

The Mental Health Services Act (MHSA) is integral in assisting the transformation of the public mental health system. Through the MHSA, county agencies ensure that key community stakeholders have the opportunity to provide input into program development, implementation, evaluation and policy of MHSA funded programs. This approach assists the Department of Behavioral Health (DBH) in integrating the needs of diverse individuals, families, and communities in it's programming.

The San Bernardino County Mental Health Services Act (MHSA) Fiscal Year (FY) 2016/17 Annual Update provides a comprehensive overview of the MHSA programs and services that contribute to sustaining the mental health and wellness of County residents. It includes an overview of the ongoing stakeholder-engaged community planning process conducted by DBH, highlights Behavioral Health program goals and related outcomes, provides updates to the approved FY 2014/15 through 2016/17 MHSA Integrated Plan, as well as demonstrates the ongoing planning that DBH and our stakeholder have been engaging in over the last decade. The programs contained in the Update are designed to develop a continuum of services in which consumers, family members, providers, county agencies, staff, and faith and community-based organizations can work together to systematically improve the public mental health system.

Also, the Annual Update is an example of the Department of Behavioral Health's (DBH) efforts to continue to integrate healthcare services across access points to create pathways that are easy to travel and in a way that allows individuals to navigate resources. Program successes are described for each program and areas of opportunity are included, such as continued efforts to improve evaluation of programs across multiple domains, enhancing the use of technology in clinical care, efforts to recruit and retain qualified staff, and responding to policy changes. The overall purpose of the Annual Update is to inform community member stakeholders, leadership and policy makers in the administration and management of public Behavioral Health Programs of changes in the provision of services, as well as meet the regulatory requirements of the MHSA.

Background

In November 2004, California voters passed Proposition 63, which imposed a 1% tax on adjusted annual income over $1,000,000, to adopt the Mental Health Services Act (MHSA) (effective January 1, 2005). According to the MHSA, the intent of the funding is "to reduce the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness…" In addition, local mental health delivery systems have been charged to "create a state-of-the-art, culturally competent system that promotes recovery/wellness for adults and older adults with serious mental illness and resilience for children and youth with serious emotional disorders and their families." The MHSA identifies five (**5**) primary program components for funding that are locally developed via a Community Program Planning (CPP) process that is now integrated into a Three-Year Program and Expenditures Plan (Plan). An update to the Plan, such as this document, is required on an annual basis. The components include:

- Prevention and Early Intervention.
- Community Services and Support.
- Innovation.
- Workforce Education and Training.
- Capital Facilities (buildings and housing) and Technological Needs.

In alignment with the Mental Health Services Act (MHSA) Transformational Framework, San Bernardino County Department of Behavioral Health (DBH) has embraced the concepts of community-driven, culturally competent recovery services.

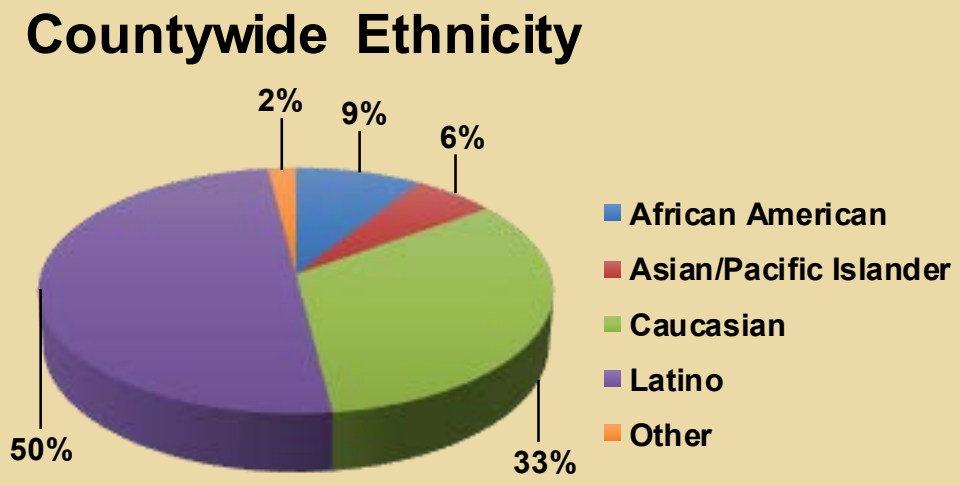
Executive Summary

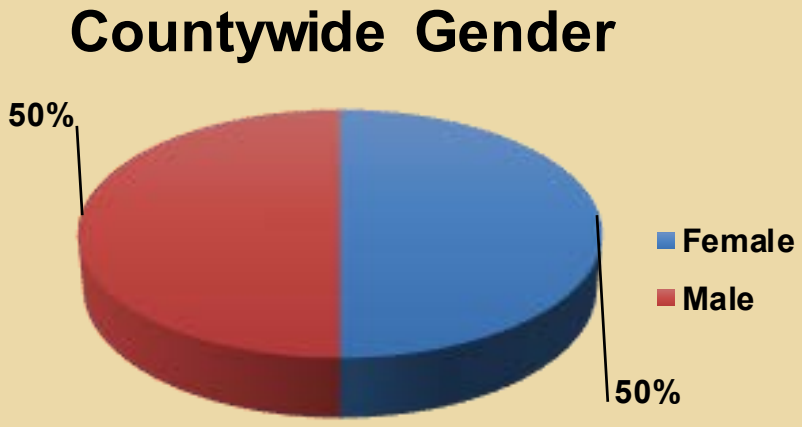
Overview of San Bernardino County

San Bernardino County is located in Southeastern California, approximately **60** miles inland from the Pacific Ocean. The County is the largest, in terms of land mass, in the continental United States, covering over **20,000** square miles. There are **24** cities in the County and multiple unincorporated and census designated places. Over **80%** of the land is owned by federal agencies (Federal Bureau of Land Management and the Department of Defense). According to the California Department of Finance, the estimated population for 2014 is **2,085,669**. Approximately **75%** of the County population resides in the Valley region of the County, which accounts for only **2.5%** of the land.

The County has four (**4**) military bases, utilizing **14%** of the land, which include: Fort Irwin, Marine Corps Air Ground Combat Center Twentynine Palms, Marine Corps Logistics Base Barstow, and Twentynine Palms Strategic Expeditionary Landing Field.

San Bernardino County is the fifth largest county in the State of California in terms of population and ethnic diversity. The largest population in the county is Latino, with **50%**, followed by Caucasian, then African American, Asian/Pacific Islander, then Native American. The gender breakdown is nearly even, with **50.3%** male and **49.7%** female.

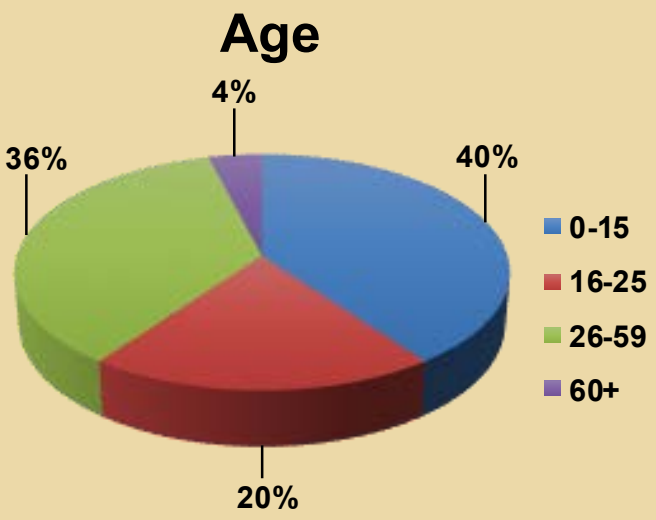


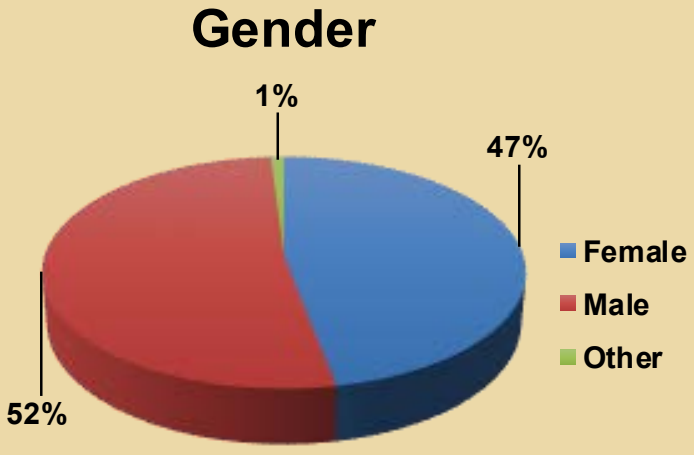


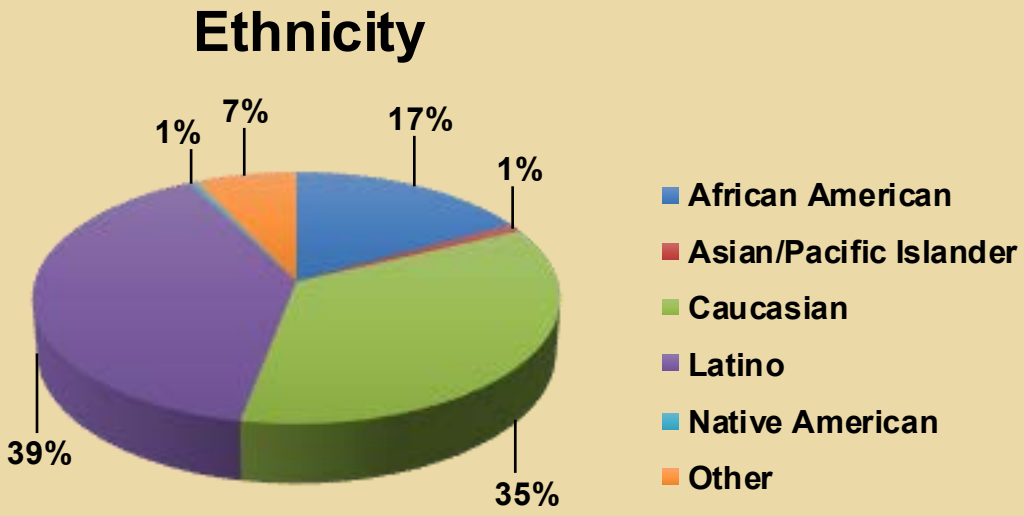
Demographic Overview of Community Members Served in MHSA Programs

MHSA services are far reaching and span the continuum of care by providing prevention, early intervention, outpatient, full service partnership, and recovery services. Clients served in Community Services and Supports (CSS), Prevention and Early Intervention (PEI), and Innovation (INN) components in Fiscal Year 2014/15 totaled **236,713**. This includes individuals that participated in outreach and education activities.

The demographic breakdown related to age category, gender, and ethnicity are as follows:

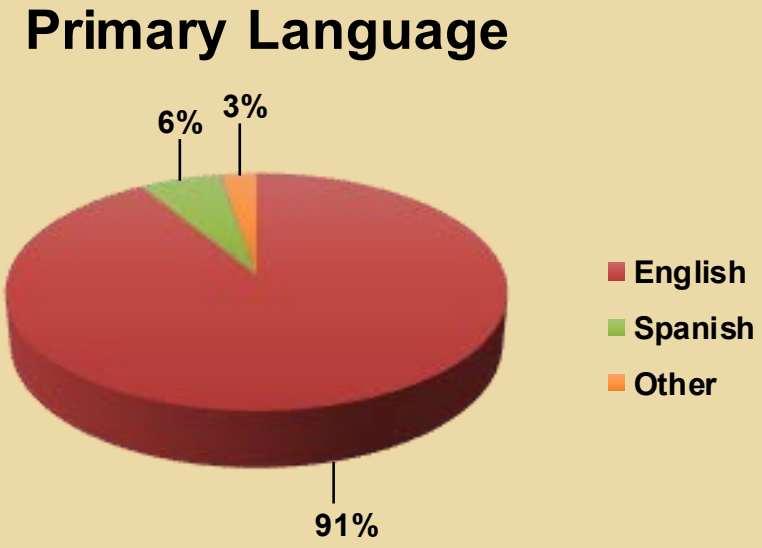




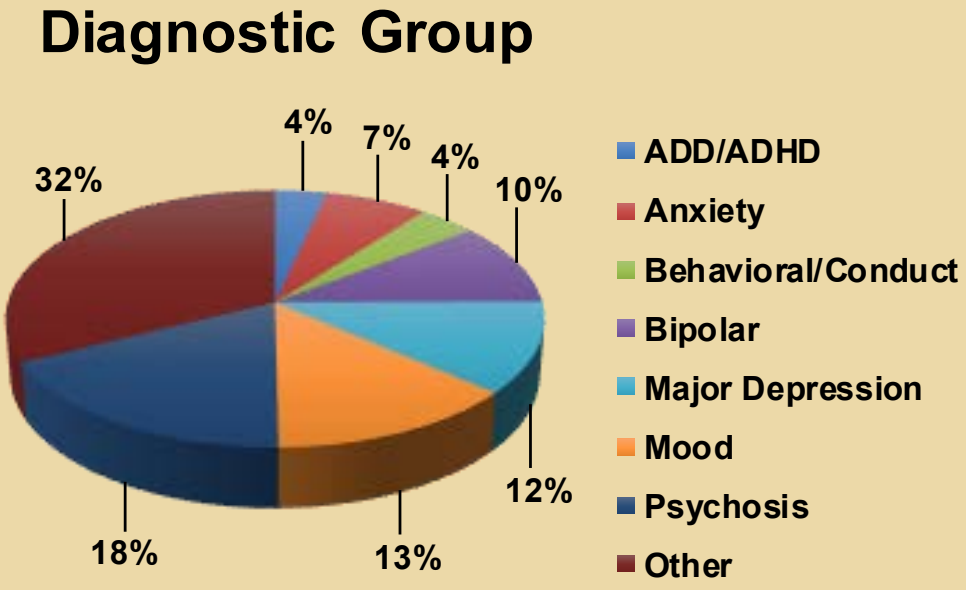


Executive Summary

The demographic breakdown of individuals served across Community Services and Supports (CSS), Prevention and Early Intervention (PEI) and Innovation (INN) related to primary language categories are as follows:



The Diagnostic group category describes the primary diagnosis of individuals participating in therapeutic services in Community Services and Supports (CSS), Prevention and Early Intervention (PEI) and Innovation.



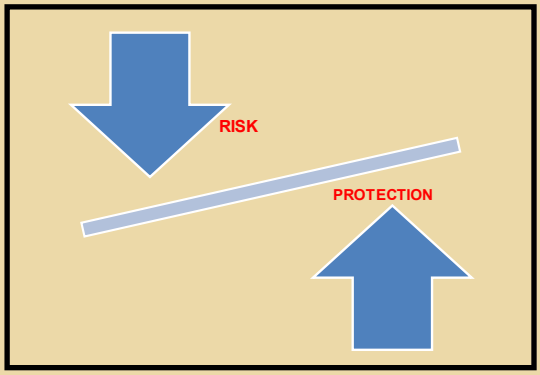
Brief Overview of the Components of MHSA

Prevention and Early Intervention

Prevention and Early Intervention (PEI) program services are intended to implement strategies to **prevent** mental illness from becoming severe and disabling, emphasizing improvement to timely access to services for underserved populations. Strategies and activities are implemented early on to deter the onset of mental health conditions or relapse among individuals and to change community conditions that contribute to risk factors for developing behavioral or mental health issues.

The overall Mental Health Service Act (MHSA) goals, as defined by law, of PEI include:

- Suicide reduction.
- Reduction of juvenile justice involvement.
- Reduction of school failure/dropout rates.
- Reduction of unemployment among mental health consumers.
- Reduction of prolonged suffering.
- Reduction of homelessness among consumers.
- Reduction of stigma and discrimination associated with mental illness.
- Reduction in the number of minor consumers removed from their home.



PEI incorporates the values of cultural competence, consumer and community empowerment, collaboration and inclusion in providing services that emphasize recovery, wellness and resiliency. PEI programs work to transform the public mental health system by meeting both the priority needs identified by local community stakeholders and the key community and priority population needs outlined in the MHSA. Services are designed to meet the needs of three distinct populations:

- Those that are not identified on the basis of individual risk;
- Individuals or groups with known risk factor(s) that can contribute to behavioral health problems;
- Individuals exhibiting early signs of a mental illness or early onset of mental illness or emotional disturbance with psychotic features.

While prevention and early intervention can occur across the entire mental health intervention spectrum, the purpose of the PEI component is to provide programs at the beginning of the continuum of care. Prevention programs and services **can occur prior to diagnosis and address research identified risk factors.** The Early Intervention component provides early access to mental health services for those individuals experiencing their first symptoms of mental illness. PEI also provides relapse prevention and supports. MHSA funding directed toward Prevention and Early Intervention (PEI) services is mandated at **20%** of the overall MHSA funding received.

Since 2008 and with stakeholder input, thirteen **(13)** PEI programs have been developed and implemented. Prevention and Early Intervention programs are designed to allow participants to access services in natural settings where individuals might go for other non-mental health services or activities. Based on these access points, programs have been categorized to fit within three initiatives:

1) **School-based Initiatives** - Designed to strengthen student health and wellness by working to reduce behavioral risk factors, barriers and/or stressors, build protective factors and supports, and provide appropriate interventions at schools and after school programs.
2) **Community-based Initiatives** - Designed to build and strengthen the capacity of communities to provide prevention and early intervention opportunities in natural settings.
3) **System Enhancement Initiatives** - Designed to build and strengthen collaboration across public service organizations and work to implement efforts to promote wellness across all systems.

School-based Initiative programs include:

- ***Student Assistance Program (SAP)*** - This program is a science-based model that minimizes barriers to learning as a result of behavioral health issues and supports students in developing academic and personal success. Identified students receive appropriate interventions at school or through referrals. Services can include; group and individual counseling, anger management classes, or curriculum based psychosocial education. A portion of the program is dedicated toward building the capacity of schools to appropriately identify and respond to student behavioral health needs. The estimated funding for this program for FY 2016-17 is **$3,147,677** to serve approximately **27,500** individuals.

- ***Preschool PEI Program*** - The Preschool PEI program provides support for preschool children (ages 3-5) and education for their parents and teachers. The intent of this program is to prevent and reduce the occurrence of aggressive and oppositional behavior in preschool children in an effort to reduce problem behaviors later in life. There is a bereavement and loss component that works with children to address loss related to death, separation and/or divorce. This program serves children enrolled in the County's Head Start program. The estimated funding for this project is **$425,000** to serve approximately **900** individuals.

- ***Resilience Promotion in African-American Children (RPiAAC)*** - This program provides prevention and early intervention services to African American children/youth (ages 5-18) and their families by incorporating African American values, beliefs and traditions in mental health educational programs. This program promotes resilience in African American children in order to mediate the development of mental health and/or substance abuse disorders. The program includes curriculum-based education, cultural awareness activities, conflict resolution training, educational workshops, on-going weekly interventions, career-related presentations, parent support/education and linkage to additional resources. The estimated funding for this project is **$672,477** to serve approximately **7,519** individuals.

Community-based Initiative Programs include:

- ***Promotores de Salud/Community Health Workers (PdS/CHW)*** - The PdS/CHW program is designed to increase awareness and access to community-based prevention and mental health services without stigma or fear of discrimination. This program promotes health awareness, education and available resources for the members of various culturally-specific populations throughout the county in a culturally and linguistically appropriate manner. Services are specifically targeted at unserved and underserved groups, including Latino and Spanish-speaking communities, African-American communities, Asian/Pacific Islander communities, and Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) communities. The estimated funding for this program is **$1,148,630** to serve approximately **30,000** individuals.

- ***Family Resource Centers (FRC)*** - FRCs offer various culturally and linguistically competent services tailored to meet the identified needs of the communities they serve. This program serves all ages and includes the following: personal development activities, parent/caregiver support and education; behavioral health education workshops, after school programs for children/youth/transitional age youth, health education workshops, adult skill-based education (e.g. education and employment assistance), community counseling and individual counseling. The estimated funding for this project is **$3,350,000** to serve approximately **22,000** individuals.

- ***Native American Resource Center*** - The Native American Resource Center functions as a one-stop center offering several prevention and early intervention resources for American Indian and Alaskan Native participants of all ages. The center provides services utilizing strength-based traditional Native-American practices. Services include outreach and education, family support, parenting education, youth empowerment, healthy choice prevention activities, talking circles, drumming circles, employment development and education assistance. The estimated funding for this program is **$500,000** to serve approximately **1,751** individuals.

- ***National Curriculum and Training Institutes (NCTI)® Crossroads Education Program*** - NCTI® is a curriculum-based education strategy that fosters positive, pro-social behavior in children (ages 10-15) and transitional age youth (ages 16-25) with emphasis on prior offenders. This program employs a cognitive behavioral change model to teach pro-social behaviors through an interactive learning process. The curriculum focuses on the relationship between values, attitudes and behaviors as they relate to the decision making process. Class topics include: anger management; life skills; parent education; substance abuse prevention; gang involvement; truancy intervention; graffiti prevention. Parenting classes are offered to the families of those participating in the program. The estimated funding for this program is **$530,000** to serve approximately **4,500** individuals.

System Enhancement Initiative Programs include:

- ***Older Adult Community Services (OACS)*** - OACS is designed to promote a healthy aging process for older adults (ages 60+) by providing prevention and early intervention services to assist in maintaining positive mental health. Services include mental health and substance abuse screenings, wellness activities, home safety education, suicide prevention services, case management and therapeutic interventions. These services are delivered via a mobile unit, in senior centers, community centers and in the home. The estimated funding for this program is **$963,818** to serve approximately **6,300** individuals.

- ***Child and Youth Connection (CYC)*** - CYC provides prevention services to children and transitional age youth involved in the foster care and juvenile justice systems. This program is a collaborative between the Department of Behavioral Health (DBH), the Juvenile Public Defender's Office, Children's Network, Children and Family Services (CFS) and local contract providers. Services include mental health screenings, drug assessments, therapeutic interventions, and consultations regarding the mental health needs of minors for appointment of appropriate experts to facilitate changes in plan hearings or change of placements. Additionally, a Mentoring Resource Network is maintained where various agencies and stakeholders meet to conduct needs assessments and create mentoring opportunities for system involved youth. The estimated funding for this program is **$16,112,051** to serve approximately **21,125** individuals.

- ***Community Wholeness and Enrichment (CWE)*** - This program serves transitional age youth (ages 16-25) and adults (ages 26-59) who are experiencing the initial onset of a mental or emotional illness and/or substance use disorder. Services include risk/depression/substance use screenings, community mental health support and education; support groups (including suicide bereavement groups) and short term mental health services. The estimated funding for this program is $**1,643,755** to serve approximately **4,003** individuals.

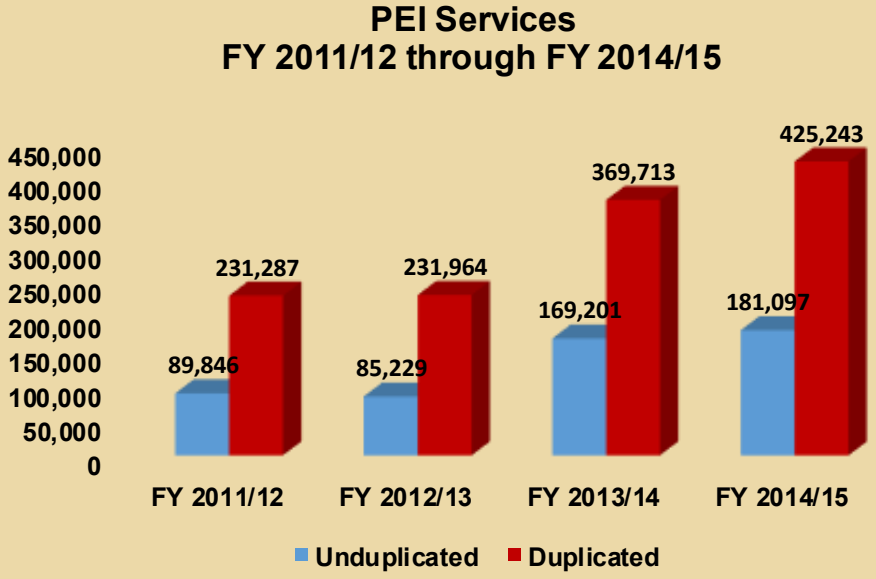
- ***Military Services and Family Support (MSFS)*** - The MSFS program addresses the effects of traumatic events and other unique challenges of military life by providing prevention and early intervention services to military personnel and veterans and their families in-home or in other community locations, and includes mental health and substance abuse screenings, case management, and individual and/or family counseling. The estimated funding for this program is **$725,000** to serve approximately **4,187** individuals.

- ***LIFT Home Visitation Program*** -The LIFT program seeks to improve the health, well-being and self-sufficiency of low-income mothers and their children. Services are delivered in the home by nurses who provide educational information that promotes the physical and emotional care of children by their mothers, family members and caretakers. Program nurses link family members with needed physical and mental health services. Services also include prenatal screenings, postpartum depression screenings, maternal attachment support, substance use/abuse screenings, support, parenting education/support, life and employment skills development, case management, and assistance with developmental milestones for the child. These services last for the duration of the mother's pregnancy up until the child is two years old. The estimated funding for this program is **$396,000** to serve approximately **120** individuals.

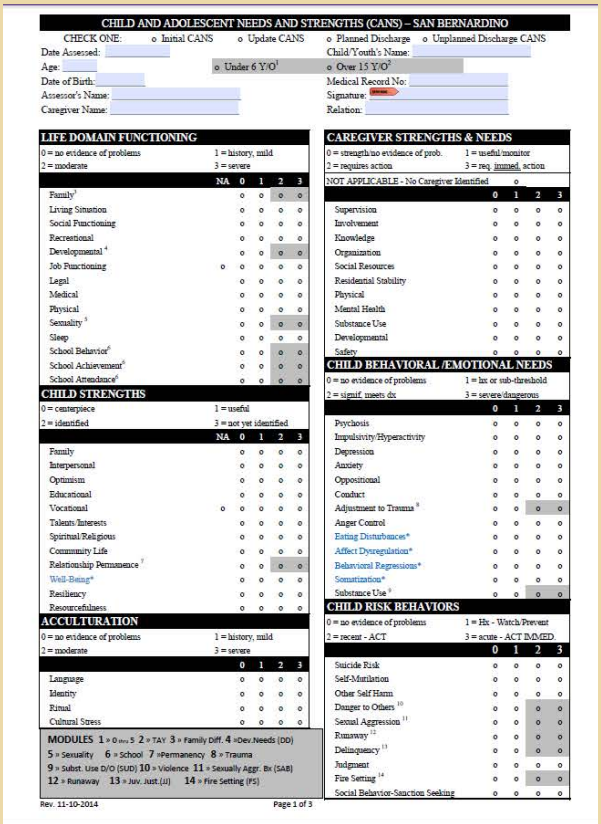
- ***Coalition Against Sexual Exploitation (CASE)*** - CASE is a collaborative approach between ten public agencies that serve sexually exploited children (ages 12-15) and youth (ages 16-25), or those at risk for sexual exploitation, through a centralized referral mechanism. This former Innovation funded project had community support to continue successful practices as a PEI program. The program coordinates community outreach and education, as well as direct services. Services include mental health assessments, crisis intervention, case management, school enrollment assistance, therapeutic interventions, transportation, placement and linkage/referral to community resources. Collaborating agencies include County Department of Behavioral Health, Department of Public Health, Children and Family Services, Children's Network, District Attorney's Office, Probation Department, Public Defender, San Bernardino County Superintendent of Schools, and Superior Court of California-Juvenile Court Division. The estimated funding for this program is **$311,498** to serve approximately **4,050** individuals.

Highlights of Key PEI Outcomes

The implementation of MHSA services has yielded many positive results. The chart below shows the level of PEI services provided over a four year period. Overall, there has been an average increase in unduplicated services of **33%** and average increase in duplicated services of **25%** over the four year period. This demonstrates an increase in participation in Prevention and Early Intervention services over time.



Executive Summary



CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS) – SAN BERNARDINO

CHECK ONE: o Initial CANS o Update CANS o Planned Discharge o Unplanned Discharge CANS

Date Assessed: Child/Youth's Name:

Age: o Under 6 Y/O[1] o Over 15 Y/O[2]

Date of Birth: Medical Record No:

Assessor's Name: Signature:

Caregiver Name: Relation:

LIFE DOMAIN FUNCTIONING

0 = no evidence of problems 1 = history, mild
2 = moderate 3 = severe

	NA	0	1	2	3
Family[3]		o	o	o	o
Living Situation		o	o	o	o
Social Functioning		o	o	o	o
Recreational		o	o	o	o
Developmental[4]		o	o	o	o
Job Functioning	o	o	o	o	o
Legal		o	o	o	o
Medical		o	o	o	o
Physical		o	o	o	o
Sexuality[5]		o	o	o	o
Sleep		o	o	o	o
School Behavior[6]		o	o	o	o
School Achievement[6]		o	o	o	o
School Attendance[6]		o	o	o	o

CHILD STRENGTHS

0 = centerpiece 1 = useful
2 = identified 3 = not yet identified

	NA	0	1	2	3
Family		o	o	o	o
Interpersonal		o	o	o	o
Optimism		o	o	o	o
Educational		o	o	o	o
Vocational	o	o	o	o	o
Talents/Interests		o	o	o	o
Spiritual/Religious		o	o	o	o
Community Life		o	o	o	o
Relationship Permanence[7]		o	o	o	o
Well-Being*		o	o	o	o
Resiliency		o	o	o	o
Resourcefulness		o	o	o	o

ACCULTURATION

0 = no evidence of problems 1 = history, mild
2 = moderate 3 = severe

	0	1	2	3
Language	o	o	o	o
Identity	o	o	o	o
Ritual	o	o	o	o
Cultural Stress	o	o	o	o

MODULES 1 » 0 Dev 5 2 » TAY 3 » Family Diff. 4 »Dev.Needs (DD)
5 » Sexuality 6 » School 7 »Permanency 8 » Trauma
9 » Subst. Use D/O (SUD) 10 » Violence 11 » Sexually Aggr. Bx (SAB)
12 » Runaway 13 » Juv. Just.(JJ) 14 » Fire Setting (FS)

CAREGIVER STRENGTHS & NEEDS

0 = strength/no evidence of prob. 1 = useful/monitor
2 = requires action 3 = req. immed. action

NOT APPLICABLE - No Caregiver Identified o

	0	1	2	3
Supervision	o	o	o	o
Involvement	o	o	o	o
Knowledge	o	o	o	o
Organization	o	o	o	o
Social Resources	o	o	o	o
Residential Stability	o	o	o	o
Physical	o	o	o	o
Mental Health	o	o	o	o
Substance Use	o	o	o	o
Developmental	o	o	o	o
Safety	o	o	o	o

CHILD BEHAVIORAL /EMOTIONAL NEEDS

0 = no evidence of problems 1 = hx or sub-threshold
2 = signif. meets dx 3 = severe/dangerous

	0	1	2	3
Psychosis	o	o	o	o
Impulsivity/Hyperactivity	o	o	o	o
Depression	o	o	o	o
Anxiety	o	o	o	o
Oppositional	o	o	o	o
Conduct	o	o	o	o
Adjustment to Trauma[9]	o	o	o	o
Anger Control	o	o	o	o
Eating Disturbances*	o	o	o	o
Affect Dysregulation*	o	o	o	o
Behavioral Regressions*	o	o	o	o
Somatization*	o	o	o	o
Substance Use[9]	o	o	o	o

CHILD RISK BEHAVIORS

0 = no evidence of problems 1 = Hx - Watch/Prevent
2 = recent - ACT 3 = acute - ACT IMMED.

	0	1	2	3
Suicide Risk	o	o	o	o
Self-Mutilation	o	o	o	o
Other Self Harm	o	o	o	o
Danger to Others[10]	o	o	o	o
Sexual Aggression[11]	o	o	o	o
Runaway[12]	o	o	o	o
Delinquency[13]	o	o	o	o
Judgment	o	o	o	o
Fire Setting[14]	o	o	o	o
Social Behavior-Sanction Seeking	o	o	o	o

Rev. 11-10-2014 Page 1 of 3

Sample of CANS-SB Score Sheet

One of the tools used tor program monitoring and outcome measurement is the Child and Adolescent Needs and Strengths Assessment– San Bernardino (CANS-SB). The CANS-SB provides information regarding the impact services have on children participating in PEI services as categorized in various domains such as life functioning, behavioral and emotional problems, risk behaviors or issues specific to the 0-5 population. CANS-SB data allows analysis of individual scores for each domain to determine if there has been significant progress in working with the child. If a child's need is resolved in a domain it is an indication that the child may no longer require assistance with addressing that need. Data from the CANS-SB indicates positive results in a areas.

As previously indicated, an important goal under the Prevention and Early Intervention component is to reduce the number of children being removed from their homes due to behavioral health concerns. The key outcome indicator that supports this goal is to increase relationship permanence for children at risk of removal. CANS data for the Child and Youth Connection - SART program provided data on Maternal Availability. This domain addresses the physical and emotional availability of a child's caretaker which affects the emotional and physical well being of a child. The CANS data indicates that **32%** of participants needed assistance at intake with Maternal Availability. At discharge, **31.67%** of participants needed assistance with this problem. This data indicates a **6%** improvement in Maternal Availability.

Maternal Availability Indicators
FY 2014/15

CANS-SB Domain Item	Percent Resolved
Communication	39%
Regulatory Problems	53%
Affect Dysregulation	58%
Adaptability	59%

Executive Summary

Reduction of juvenile justice involvement is an additional goal in the PEI component. NCTI® Crossroads Education© is a curriculum-based education strategy designed to foster positive, pro-social behavior in children (ages 10-15) and transitional age youth (ages 16-25) with emphasis on prior offenders or those at risk of justice involvement. This program employs a cognitive behavioral change model to teach pro-social behaviors through an interactive learning process.

The following chart reflects the average percentage of improvement in children/youth's level of understanding/learned objectives in various curriculum areas from the NCTI® Crossroads© program for FY 2014/15 (n= **5,473**). The chart shows progress in improving learning and building of protective factors that directly impact and reduce the aforementioned risk factors. This includes:
Individual – building positive social orientation, changing perceptions about consequences for breaking the law; Family – building supportive relationships and engaging parental involvement; School – improving commitment in school, recognition of involvement in positive/acceptable activities. Overall, "improvement" across curriculum areas averaged **66%**.

Children/Youth Skills and Knowledge
FY 2014/15

Crossroads Skills Progression		
Class Title	**Class Learning Objectives**	**Students' Increased Understanding of Course Content**
Youth Cognitive Life Skills 1	Learn how to overcome negative behaviors, become more productive and set goals.	57%
Youth Anger Management Level 1	Understanding the influence that strong emotions have on behavior and gaining better control.	56%
Youth Drugs & Alcohol Level 1	Identity skills and resources that help develop a healthy, positive lifestyle.	58%
Shoplifting	Identify and take positive steps to change present behavior.	93%

Executive Summary

Early Intervention services are targeted toward individuals first exhibiting signs and symptoms of a serious mental illness. These services are intended to reduce the subjective prolonged suffering of individuals by addressing mental health concerns early in their manifestation. One example of the reduction of such suffering is demonstrated in the PEI Military Service and Family Support program. Individuals and families participating in early intervention services demonstrated improvements in key areas such as reducing symptoms of depression and anxiety and increasing life functioning.

Beck Depression Inventory	
Pre Score	**Post Score**
28.8	**9.1**

68% Average Improvement

Beck Anxiety Inventory	
Pre Score	**Post Score**
21.4	**14.8**

31% Average Improvement

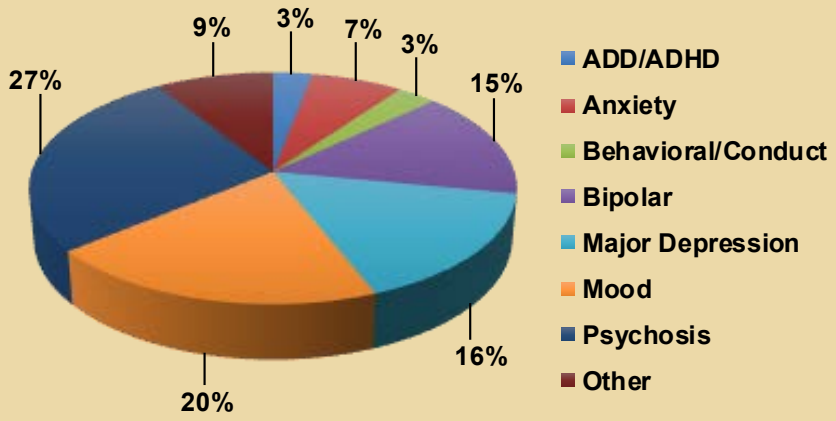
GAF	
Pre Score	**Post Score**
48.7	**60.5**

24% Average Improvement

Community Services and Supports

The majority of MHSA funding (**80%**) is mandated to be directed toward the Community Services and Supports (CSS) component. CSS provides access to mental health services and targets Seriously Emotionally Disturbed (SED) children, youth, and populations with Serious Mental Illness. SED, as defined by regulation, refers to children and youth with difficulty functioning in multiple life domains, such as school, home, and/or community. Serious Mental Illness (SMI) is a term defined by Federal regulations that generally applies to mental disorders that significantly interfere with some area of functioning. The chart below provides an overview of the primary diagnosis of consumers participating in CSS services.

Primary Diagnosis of CSS Clients



Executive Summary

CSS has four primary service purposes:
1) **To provide Full Service Partnership (FSP) programs** designed for individuals who have been diagnosed with a severe mental illness or serious emotional disturbance and would benefit from an intensive service program. FSP programs continue to develop and improve by identifying and implementing key practices that consistently promote good outcomes for mental health clients and their families.
2) **To develop General System Development (GSD) strategies** intended to improve programs, services and supports for the identified initial full service populations and for other clients consistent with the MHSA target populations. GSD funds help counties improve programs, services and supports for all clients and families to change their service delivery systems and build transformational programs and services.
3) **To conduct outreach and engagement activities** that are specifically aimed at reaching unserved populations. The activities help to engage those reluctant to enter the system and provides funds for screening of children and youth.
4) **To develop a Mental Health Services Act (MHSA) Housing Program** that offers financing and capitalized operating subsidies for the development of permanent supportive housing, including both rental and shared housing, to serve persons with serious mental illness and their families who are homeless or at risk of homelessness.

The overall Mental Health Service Act (MHSA) goals as defined by law for CSS include:
- Reduce the subjective suffering from serious mental illness for adults and serious emotional disorders for children and youth.
- Reduce homelessness and increase safe and permanent housing.
- Increase in self-help and consumer/family involvement.
- Increase access to treatment and services for co-occurring problems; substance abuse and health.
- Reduce disparities in racial and ethnic populations.
- Reduce the number of multiple out-of-home placements for foster care youth.
- Reduce criminal and juvenile justice involvement.
- Reduce the frequency of emergency room visits and unnecessary hospitalizations.
- Increase a network of community support services.

Program strategies under MHSA must address the legislated goals listed above.

This component has greatly contributed to the ongoing transformation of the public mental health system by augmenting existing services, establishing a system of care for crisis services, developing programming to address the needs of Transitional Age Youth (TAY), developing supportive housing and maximizing MHSA funds for housing opportunities and enhancing and expanding wraparound services to children and youth.

There are currently fourteen **(14)** CSS programs designed to serve all age groups.

- ***Comprehensive Children and Family Support Services (CCFSS)*** - The Comprehensive Children and Family Support Services (CCFSS) program is comprised of a continuum of services targeting three populations for inclusion in Full Service Partnerships (FSP) to provide "Wraparound" services to diverse children and youth with emotional disturbances and co-occurring disorders. The estimated funding for this program is **$23,420,516** to serve approximately **2,081** individuals.

- ***Integrated New Family Opportunities (INFO)*** - The Integrated New Family Opportunity (INFO) program provides mental health services for diverse in-custody and post-custody juvenile children/youth (ages 13-18) and their families that have been unserved or underserved and who are on probation. The estimated funding for this program is **$1,357,290** to serve approximately **55** individuals.

- ***Transitional Age Youth (TAY) One Stop Centers***—TAY One Stop Centers provide integrated mental health services to individuals age 16 to 25 with mental and/or emotional problems who may be emancipating from: foster care, group homes, the juvenile justice system, or county jail. The estimated funding for this program is **$5,781,754** to serve approximately **1,565** individuals.

- ***Clubhouse Expansion Program***—Clubhouses are recovery oriented centers for members, 18 years or older that operate with minimal support from department staff. Clubhouses provide Wellness, Recovery and Resilience Model programs in stigma free environments for the Seriously Mentally Ill (SMI) population. The estimated funding for this program is **$2,925,739** to serve approximately **5,871** individuals.

- ***Forensic Integrated Mental Health Services (FACT, STAR and CIT)*** - This program consists of three distinct components:
    - **Forensic Assertive Community Treatment (FACT):** FACT provides a variety of mental health treatment options to meet the needs of probationers with mental illness, using the Assertive Community Treatment (ACT) Model. FACT is a full service partnership.
    - **Supervised Treatment After Release (STAR):** The Supervised Treatment After Release (STAR) program is the treatment provider for the courts in several regions of the County. The STAR program is a full service partnership. Services are delivered as part of a voluntary Mental Health Court.
    - **Crisis Intervention Training (CIT):** Crisis Intervention Training (CIT) is a partnership between law enforcement and behavioral health. Law enforcement staff attends a 32 hour CIT Academy regarding behavioral health issues, alternatives to 5150s in the field and within the officers assigned patrol, and culturally competent interventions.

  The estimated funding for this program is **$9,127,589** to serve approximately **263** individuals.

- ***Members Assertive Positive Solutions/Assertive Community Treatment (MAPS/ACT)*** -The ACT program provides intensive case management services 24/7 to maintain high risk clients in the community and provide a system of care to those ready to transition from a locked facility into a lower level of care. The estimated funding for this program is **$5,871,090** to serve approximately **185** individuals.

- ***Crisis Walk-in Centers (CWIC)*** - The Crisis System of Care provides urgent mental health services to residents of the County of San Bernardino. Crisis Walk-In Clinics (CWIC) provide crisis intervention, crisis risk assessments, medications, referrals to county, contract and community resources, education and, when necessary, evaluations for hospitalization. The estimated funding for this program is **$8,495,216** to serve approximately **2,825** individuals.

- ***Psychiatric Triage Diversion Program***—The Triage Diversion Unit is located at Arrowhead Regional Medical Center (ARMC) and provides interventions for those at-risk of hospitalization. Services include screening and assessment, crisis intervention, linkage and referral, placement, transportation, mental health education, discharge planning, and consultation. The estimated funding for this program is **$3,101,928** to serve approximately **3,000** individuals.

- ***Community Crisis Response Team (CCRT)*** -The Community Crisis Response Team (CCRT) utilizes specially trained mobile crisis response teams to provide crisis interventions,

assessments, case management, relapse prevention, medication referrals, and linkage to resources through collaboration with law enforcement, hospitals, Children and Family Services, Adult Protective Services, schools, and other community organizations. The estimated funding for this program is **$8,327,774** to serve approximately **5,582** individuals.

- ***Homeless Intensive Case Management and Outreach Services*** -The Homeless Intensive Case Management and Outreach program is comprised of three focus areas: **Intensive Outreach and Case Management**, **Integrated Housing and Employment** and **Homeless Outreach Support Team (HOST)** to provide engagement, case management services, emergency shelter beds and permanent supportive services. The estimated funding for this program is **$9,439,460** to serve approximately **1,348** individuals.

- ***Big Bear Full Service Partnership*** -The Big Bear Full Service Partnership is an alliance of mental health service providers in the geographically isolated Big Bear Lake area that provides mental health services to children and adults. The estimated funding for this program is **$370,000** to serve approximately **145** individuals.

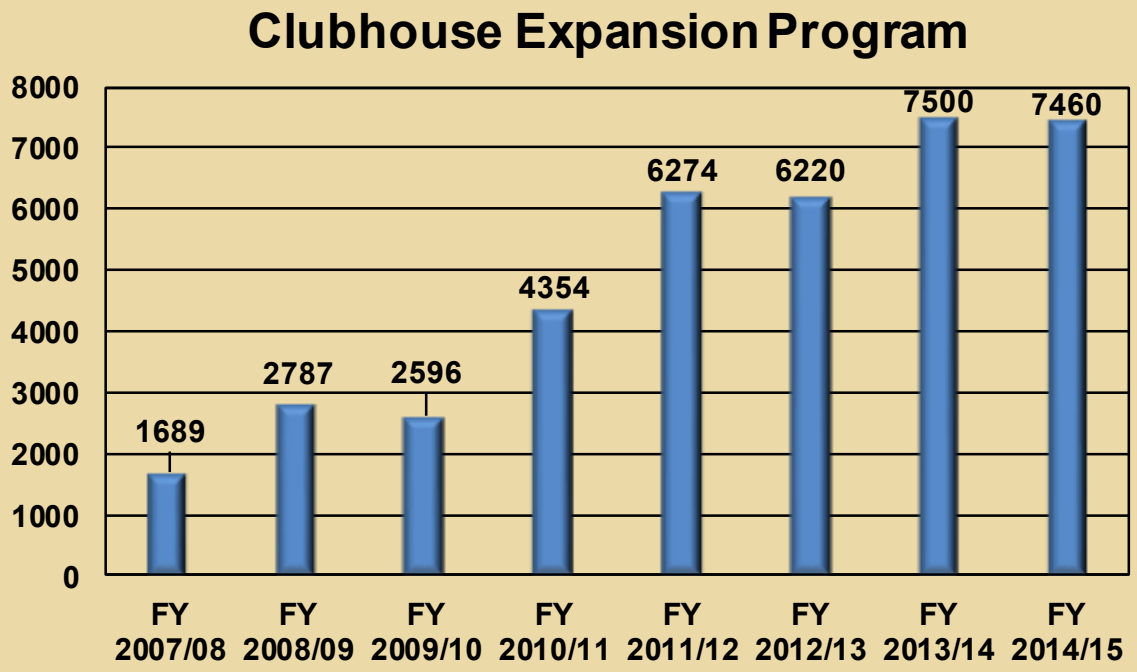
- ***Access, Coordination and Enhancement (ACE) of Quality Behavioral Health Services*** -ACE enhances screening and assessment services at each of DBH's major clinics to expedite access to mental health services, specifically for individuals recently discharged from an inpatient psychiatric hospital. The estimated funding for this program is **$2,515,962** to serve approximately **1,908** individuals.

- ***AgeWise-Circle of Care*** - The Age Wise Program is a non-traditional mental health program for the high-risk and underserved older adult population. Services include mobile case management services, counseling services, groups provided in the community, and the Senior Peer Counseling program. The estimated funding for this program is **$1,722,206** to serve approximately **190** individuals.

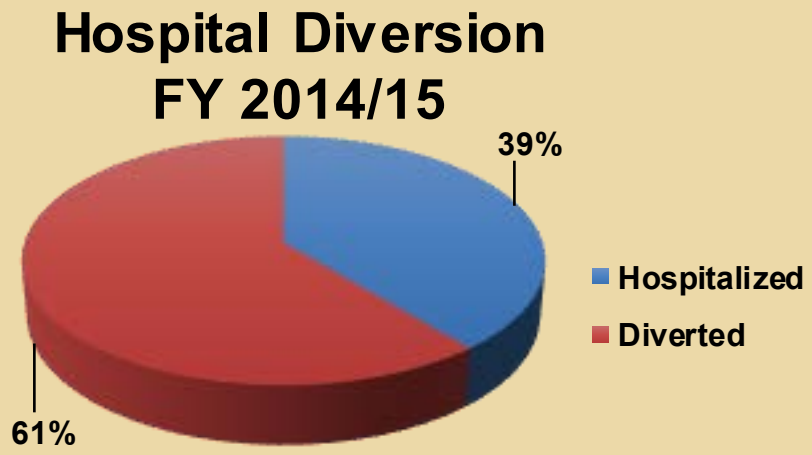
- ***AgeWise-Mobile Response*** - The program is located in the high desert and provides crisis intervention and mobile response services to prevent hospitalizations and homelessness for older adults in that area. Both the mobile response unit and the Full Service Partnership (FSP) intensive case management services work to identify mentally ill older adults and help them be stable in their own homes and the community. Older adult programs work collaboratively with the Department of Aging and Adult Services. The estimated funding for this program is **$573,203** to serve approximately **150** individuals.

Highlights of Key CSS Outcomes

One of the goals of the MHSA CSS component is to increase self-help and consumer involvement. The design of the Clubhouses is intended to accomplish this objective. The data demonstrates the increasing number of adults participating in adult, consumer run, peer support programs. In FY 2014/15, **90%** of groups offered at Clubhouses were facilitated by Clubhouse members.



Reducing the rate of unnecessary psychiatric hospitalizations was identified as a key outcome during early stages of MHSA community planning for CSS programs and continues to be a priority across the system. Review of San Bernardino County data from the Psychiatric Triage Diversion program indicates that of the **4,192** individuals who received services through this program in FY 2014/15, **61%** were successfully diverted from an unnecessary hospitalization and referred to appropriate outpatient levels of care.



An additional example of efforts to reduce hospitalization include Crisis Walk-in Clinics (CWIC). CWICs function as an alternative to the Emergency Department for intervening in a mental health crisis. In FY 2015/15, the CWIC provided **6,433** clients with crisis intervention services. Of those served, **6,010**, or **93.4%**, were successfully diverted from unnecessary psychiatric hospitalization and **92%** of clients served through CWIC were not hospitalized within at least **30** days after their visit, which is in alignment with community feedback regarding decreasing inappropriate hospitalizations and overcrowding of Emergency Rooms.

Innovation

The purpose of the Innovation component of the Mental Health Services Act (MHSA) is to test methods that adequately address the mental health needs of unserved and underserved populations by expanding or developing services and supports that produce successful outcomes, are considered to be innovative, novel, creative, and/or ingenious mental health practices that contribute to learning rather than a primary focus on providing services. Innovation projects form an environment for the development of new and effective practices and/or approaches in the field of mental health. Innovation projects are time-limited, must contribute to learning, and be developed through a process that is inclusive and representative, especially of unserved, underserved, and inappropriately served populations.

Innovation projects are designed to support and learn about new approaches to mental health care by doing one of the following:

- Introducing new mental health practices or approaches, including, but not limited to, prevention and early intervention.
- Making a change to an existing mental health practice or approach, including, but not limited to, adaption for a new setting or community.
- Introducing a new application to the mental health system of a promising community-driven practice or an approach that has been successful in non-mental health context or settings.

This component is unique, as it focuses on research and learning that can be utilized to improve the overall public behavioral health system. All Innovation projects must be reviewed and approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC).

Every Innovation project must identify one of the following primary purposes:

- **Increase** access to underserved groups.
- **Increase** the quality of services, including better outcomes.
- **Increase** access to services.
- **Promote** interagency collaboration.

New Innovation component regulations were approved in October 2015 and included a refined description of the elements in any Innovation project; a clear distinction that Innovation Projects are considered time-limited pilot projects and should have an end date that is not more than five (**5**) years from the start date of the project; successful parts of the project may continue under a different funding source or be incorporated into existing services; projects may be terminated prior to planned end date; and reporting requirements are defined.

Currently, five (**5**) Innovation projects have ended and three **(3)** final reports have been published. Of the five projects, two (**2**) projects had final reports published in the MHSA Three-Year Integrated Plan, and one **(1)** project had the final report included in the Fiscal Year 2014-15 Annual Update. Of

the two (**2**) remaining projects that have ended, both final reports are contained in this Annual Update, and are included in the Fiscal Year 2015-16 Annual Update, detailing project outcomes, successes and what practices will be continued based on learning during the project.

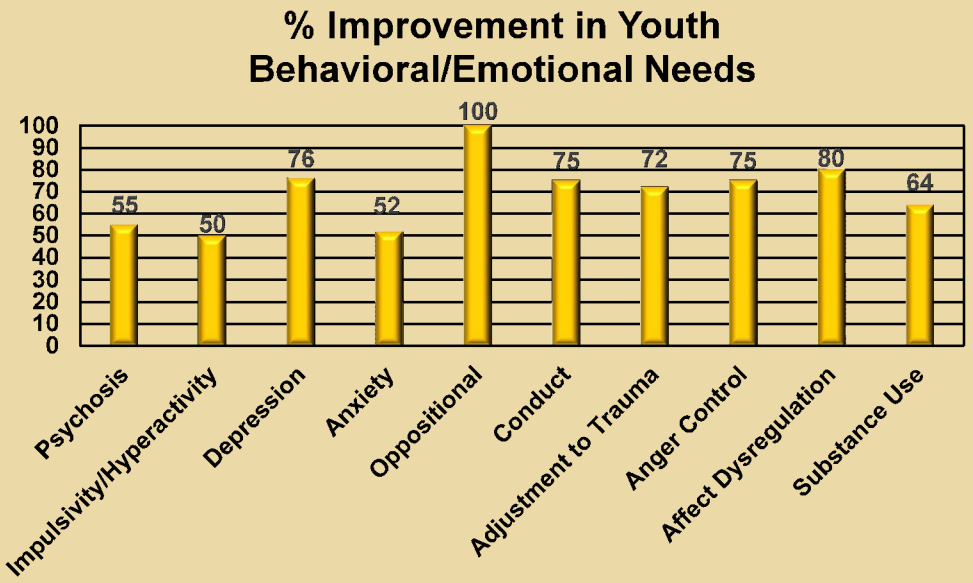
In fiscal year (FY) 2016/17, there will be two remaining active INN projects:

- ***TAY Behavioral Health Hostel (The STAY)*** - This hostel project is a short-term, 14-bed, crisis residential program for the Transition Age Youth (TAY) population, who are experiencing an acute psychiatric episode or crisis, and are in need of a higher level of care than board and care residential, but a lower level of care than psychiatric hospitalization. Services are culturally and linguistically appropriate crisis stabilization services, with particular emphasis on diverse youth (African American, Latino, LGBTQ youth, etc.). The hostel is designated to be **80%** peer run, by individuals representing the County's diverse ethnic communities and cultures. The estimated annual funding for this project is **$1,875,000** to serve approximately **72** individuals. Innovation funding for services related to this time-limited project is set to end March 2017 with the final report anticipated for inclusion in the Fiscal Year 2018/19 Annual Update.

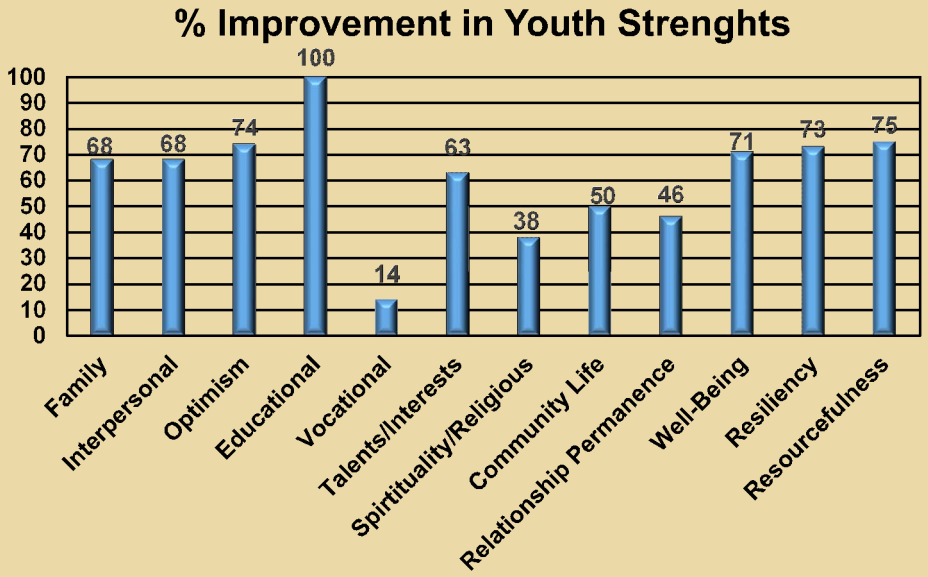
- ***Recovery Based Engagement Support Team (RBEST)*** - The RBEST project provides community (field-based) services throughout San Bernardino County for those mentally ill individuals who are noncompliant and/or resistant to necessary psychiatric care in an effort to "activate" the individual into the mental health system to receive appropriate services. The estimated annual funding for this project is **$1,509,502** to serve approximately **300** individuals. Innovation funding for services is set to end November 2017 with the final report anticipated in subsequent Annual Update.

Highlights of INN Outcomes

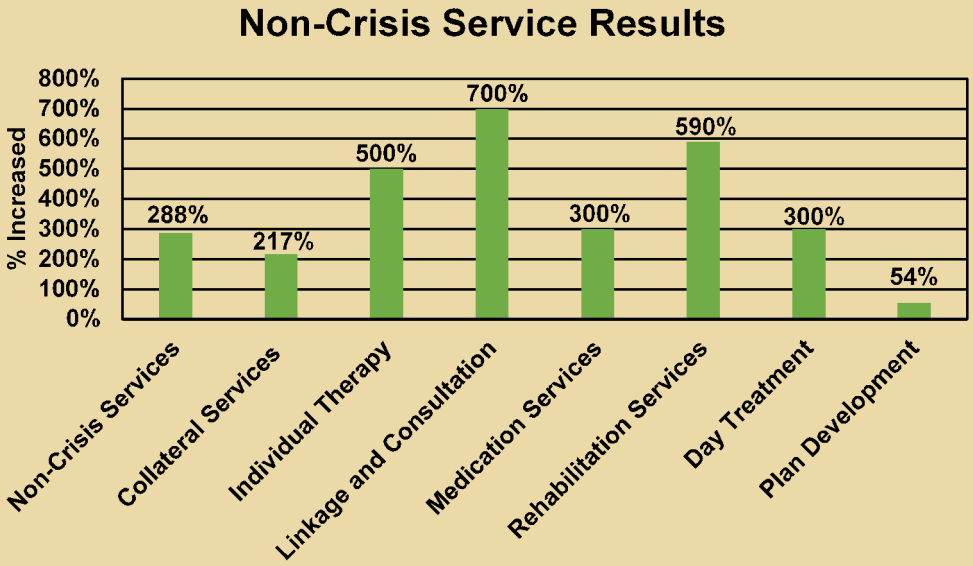
The TAY Behavioral Health Hostel contributes to learning by making a change to an existing mental health practice that in theory is being practiced in behavioral health systems but is not specific to the TAY population and is not peer run. This approach is being tested to determine if the quality of services will be increased, including better outcomes. All of the residents at The STAY receive an assessment at time of enrollment and discharge from The STAY. The assessment identifies the residents' needs and strengths across a variety of domains. The following data represents outcomes for residents of the STAY who had planned discharge assessments during Fiscal Year 2014/15.



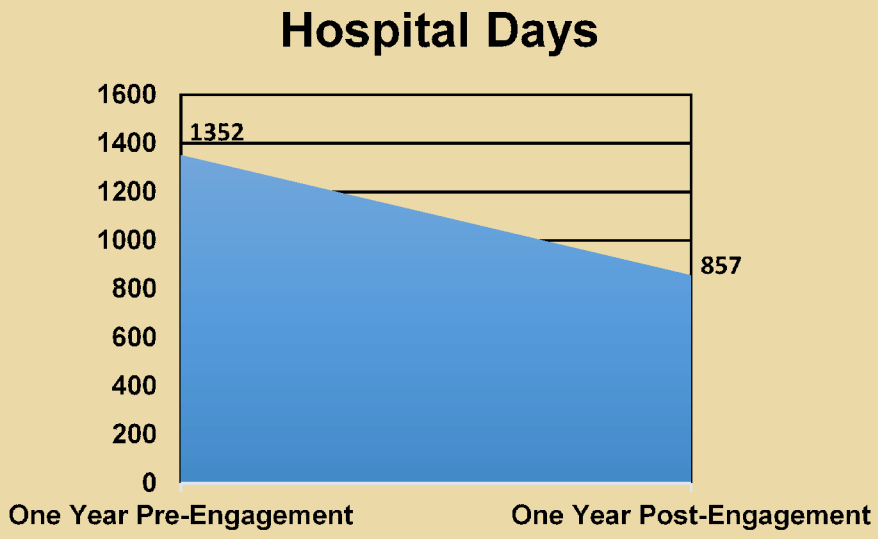
The graph below represents the percentage of stay residents whose strengths improved while at the STAY. These are the tools in a resident's life that can be used on the path to recovery.



As a short-term learning project, the two primary learning goals of the RBEST project are to 1) increase the quality of services, including better outcomes, and 2) reduce the frequency of mental health related emergency room visits and unnecessary psychiatric hospitalizations. RBEST strives to serve clients in the least intrusive, restrictive, and disruptive way in order to promote consumer resiliency and recovery, while linking them to appropriate behavioral health services. To date, RBEST has engaged **364** individuals. Of all consumers engaged, **24** started engagement over one year ago, giving us a chance to look at the long-term impact of RBEST. All data presented is based on the outcomes of those individuals. The graph below represents the percentage of non-crisis services that were increased through RBEST engagement, an indication of improvement in quality of service and improved outcomes.



A primary goal for RBEST is to reduce unnecessary psychiatric hospitalizations. Review of hospital admissions prior to engagement in comparison to post engagement indicate a **43% reduction** in hospital admissions. The graph below represents the number of days in the hospital for these individuals. The two numbers represent the individuals prior to engagement and after engagement. The graph demonstrates a **58% reduction** in total hospital days.



Workforce Education and Training

California's public mental health system has suffered from a shortage of public mental health workers, misdistribution of certain public mental health occupational classifications, a recognized lack of diversity in the workforce, and under-representation of professionals with consumer and family member experience. To address the public mental health workforce issues, the MHSA included a component for Workforce Education and Training (WET) programs.

WET carries forth the vision of the MHSA to create a transformed, culturally-competent system that promotes wellness, recovery and resilience across the lifespan of age groups.
The goals for the WET component include:

- Address workforce shortages and deficits Identified in the Workforce Needs Assessment.
- Designate a WET Coordinator.
- Educate the workforce on incorporating the general standards.
- Increase the number of clients and family members employed in the public mental health system.
- Conduct focused outreach and recruitment to provide equal employment opportunities in the public mental health system for individuals who share the racial/ethnic, cultural and/or linguistic characteristics of clients, family members of clients and others in the community who have serious mental illness and/or serious emotional disturbance.
- Recruit, employ and support the employment of individuals in the public mental health system who are culturally and linguistically competent or, at a minimum, are educated and trained in cultural competence.
- Provide financial incentives to recruit or retain employees within the public mental health system.
- Incorporate the input of clients and family members of clients, and when possible, utilize them as trainers and consultants in public mental health WET programs and/or activities.
- Incorporate the input of diverse racial/ethnic populations that reflect California's general population into WET programs and/or activities.
- Establish regional partnerships.
- Coordinate WET programs and/or activities.

Highlights of WET Outcomes

To meet the MHSA Legislative Goal to address workforce shortages and deficits identified in the workforce needs assessment several strategies have been implemented. One such strategy is the expansion of the Internship Program. WET coordinates all aspects of the internships and practicums placed within DBH. Currently, the Internship Program trains students who are enrolled in bachelor and graduate programs in:

- Social Work.
- Marriage and Family Therapy.
- Psychology.

Depending on their discipline, interns can be placed in the Internship Program for **12** to **18** months. During that time, interns learn to provide clinical services in a community mental health setting. DBH is committed to hiring applicants that were previously interns. As seen in the following table, the number of new pre-licensed CT I's hired increased between FY 2013/14 and FY 2014/15.

Pre-licensed Clinicians Hired	FY 2011/12	FY 2012/13	FY 2013/14	FY 2014/15
Total Number of Interns Hired	13	18	13	18
Total Number of Non-Interns Hired	11	9	16	22
% of Interns Hired	54%	67%	45%	45%

Capital Facilities and Technological Needs

Each County's Capital Facilities and Technological Needs Component and the Capital Facilities and/or Technological Needs Project must support the goals of the MHSA and the provision of MHSA services. The planned use of the Capital Facilities and Technological Needs funds should produce long-term impacts with lasting benefits that move the mental health system towards the goals of wellness, recovery, resiliency, cultural competence, prevention/early intervention, and expansion of opportunities for accessible community-based services for clients and their families which promote reduction in disparities to underserved groups.

These efforts include development of a variety of technology uses and strategies and/or of community-based facilities which support integrated service experiences that are culturally and linguistically appropriate. Funds may also be used to support an increase in peer-support and consumer-run facilities, development of community-based, less restrictive settings that will reduce the need for incarceration or institutionalization, and the development of a technological infrastructure for the mental health system to facilitate the highest quality, cost-effective services and supports for clients and their families.

Community Program Planning

The County of San Bernardino Department of Behavioral Health (DBH) is dedicated to including diverse consumers and stakeholders from throughout the county in the planning and implementation of Mental Health Services Act (MHSA) programs and services. These efforts include informing

stakeholders of fiscal trends, evaluation, monitoring, and program improvement activities as well as obtaining feedback. DBH has consistently demonstrated commitment to incorporating best practices in our planning processes that allow our stakeholder partners to participate in meaningful discussions around critical behavioral health issues. DBH considers Community Program Planning (CPP) a constant practice and as a result, this component has become a robust, year-round practice incorporated into standard operations. Like the other MHSA components, the CPP process undergoes review and analysis which allows DBH to enhance and improve engagement strategies.

CPP Meeting

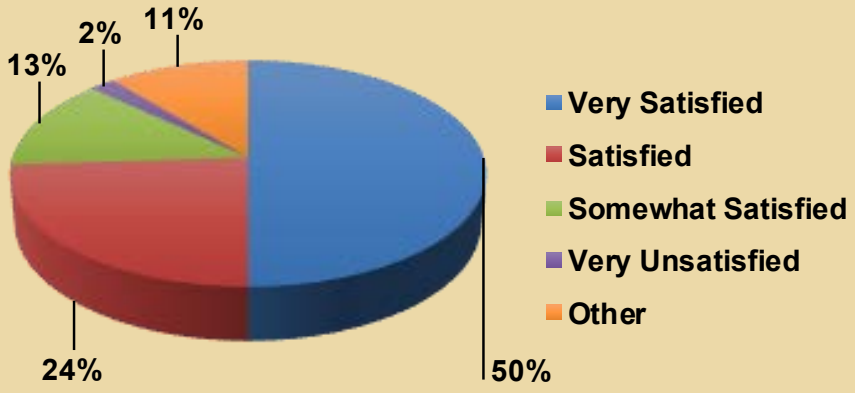
DBH is fully committed to a year round stakeholder engagement process. Preparation and development of this Annual Update included meetings hosted in multiple venues in each region of the County, an interactive countywide webinar and a monolingual Spanish session hosted in collaboration with the Consulate of Mexico, held March 10, 2016, in San Bernardino and a MHSA Summit, held on March 01, 2016 at the University of Redlands.

To meet the requirements of the MHSA, extensive outreach was conducted to promote the Annual Update Planning Process. A variety of methods were used at multiple levels to give stakeholders the opportunity to have their feedback included and their voice heard. This included press releases to all local media outlets and distribution of emails and flyers to community partners, community and contracted organizations, other county agencies, cultural subcommittees and coalitions and regularly scheduled stakeholder meetings such as the San Bernardino County Behavioral Health Commission. These materials were distributed in both English and Spanish to reach representatives of our diverse population. Social media sites such as Facebook, Twitter, Pinterest, YouTube, and Instagram were also used to extended the reach of the department in connecting interested community members with the stakeholder process.

During the stakeholder meetings for the Annual Update, several community members voiced their support and approval of the Update, as well as the Community Program Planning process that has occurred over the last year.

Executive Summary

The following represents the level of satisfaction reported from attendees from the MHSA Annual Update stakeholder meetings. **270** of the **300** individuals that participated in a Community Planning Meeting for the MHSA Annual Update completed a survey. Of the participants that completed a survey, **87**% indicated they were somewhat to very satisfied with the Annual Update.



Summary of Program Changes

DBH has made a practice of planning for sustainable growth in the development and implementation of MHSA and system of care services. This Annual Update reflects stakeholder informed changes, expansion, and includes new programs that were identified as opportunities for growth in last years Annual Update that will be sustained under the Community Services and Supports (CSS) component.

With input from stakeholders, DBH has identified several program areas that require expansion of services beginning in Fiscal Year 2016/17. In addition, two (**2**) “new” programs will be introduced as part of this Annual Update.

New programs and expansion efforts are contingent on MHSA funding estimates which are based on tax receipts and monthly cash projections. If cash projections change such that expansion is not feasible, program efforts detailed within this report will not be implemented as services provided under MHSA are contingent upon available funding.

The following provides a brief summary of proposed program changes. Detailed information can be found in the Summary of Program Changes and New Program section of this document.

The updates below are being proposed to a few of the CSS programs based on stakeholder feedback:

- The Comprehensive Children’s and Family Support Program will expand to include additional targeted and intensive case management and mental health services directed toward foster children. The expansion will allow the Department, along with our Children and Family Services department stakeholders, to serve an additional **275** system involved children.

- The Forensic Integrated Mental Health program will expand services to serve additional individuals in the high desert region and to enhance services and include Peer Mentoring for the re-entry population. The primary intent of the enhancement is to provide consumers with a Peer Support Specialist who has lived forensic experience through incarceration or probation and is also in active recovery. The purpose of pairing program participants with a Peer Support Specialist is to have the Peer Support Specialist act as a functional role model providing technical guidance and sharing their experience with successful reentry. In addition, the Crisis Intervention Training component will be expanded to include additional training for targeted groups.

- The Crisis Walk-In Centers (CWIC) provide urgent mental health services to San Bernardino County residents located in the Morongo Basin, Victorville, and the Rialto. Recently, DBH has been successful in applying for grants under the California Health Facilities Financing Authority. This opportunity will allow the Department to expand the Crisis Walk-in Centers program by including an additional Crisis Stabilization Unit (CSU). This additional short-term crisis assessment and treatment program will assist consumers during a mental health crisis who require a 23-hour supervised crisis intervention services. The expanded program will work to stabilize the emotional, mental, and behavioral crisis of those seeking treatment and link them to mental health resources.

- The Regional Adult Full Service Partnership program component will begin to be expanded during fiscal year 2016/17. This vital component will be reorganized form within the A-7: HICMOS work plan to create a “new,” stand-alone Regional Adult Full Service Partnership program (A-11). This administrative change will allow easier planning, tracking, and evaluation of this very important service provided under CSS. In addition, use of CSS funding to expand the Housing and Employment component for mental health consumers has been identified for expansion, as allowable.

No new programs are included in the Prevention and Early Intervention component. However, on October 6, 2015, updated Prevention and Early Intervention (PEI) Component Regulations, designed by the Mental Health Services Oversight and Accountability Commission (MHSOAC), became effective. The updated regulations:

- Changed the framework and structure of the PEI component as compared to the guidance received via Department of Mental Health in 2007 via Information Notice 07-19.

- Includes many of the concepts that guided the original design of PEI Component Programs.

- Define individual Programs that are described as “a stand-alone organized and planned work, action or approach.

The new regulations will result in changes to the Scope of Work and the reporting structure for future PEI component updates.

Additional planned program changes for the Workforce Education and Training (WET) component include the continued expansion of the Psychiatry Residency Program.

The Capital Facilities and Technological Needs component will receive transferred CSS funding to leverage costs associated with building one (1) Crisis Stabilization Unit and three (3) new Crisis Residential Treatment Centers (details about the new Crisis Residential Treatment program can be read in full in the New Programs section of this Annual Update). Additionally, DBH continues to work on the development of an Electronic Health Record.

Summary of New Programs

The behavioral healthcare system in San Bernardino County is in need of alternatives to inpatient hospitalization, institutionalization and/or incarceration to address the needs of adult individuals experiencing a mental health crisis. In an effort to address this need, San Bernardino County Department of Behavioral Health (DBH) has developed a new Crisis Residential Treatment (CRT) program to strengthen the continuum of care. The CRTS will support the community by increasing access and capacity to efficiently and effectively serve the individualized needs of those in crisis who do not meet the criteria for inpatient hospitalization.

Accordingly, DBH is in the process of creating three (**3**) CRTs that provide recovery based services and interventions as well as step down services from hospitalization or incarceration for adult individuals in crisis. The three CRT facilities are unlocked, voluntary, short-term 16 bed crisis residential treatment centers for San Bernardino County residents. The CRT facilities will consist of a homelike environment that supports and promotes the individual's recovery, wellness and resiliency (RWR) in the community. Each facility will be designed to accommodate a living/common space area, family room, group rooms, separate interview rooms, bedrooms designed with separate living and visiting spaces, laundry, cooking facilities and outdoor patio and gardening areas. The CRT program is designed to empower and support diverse individuals in the process of stabilization and transition to outpatient services. The CRT program will serve diverse county residents ages 18 and older, experiencing acute psychiatric crisis who will benefit from short-term crisis residential treatment services as an alternative to hospitalization or incarceration and provide the following structured recovery-based, enriched treatment services and activities:

- Housing.
- Psychiatric/medication support.
- Comprehensive clinical assessments and therapies.
- Life skills coaching.
- Peer and family support networks.
- Coping techniques.
- Recovery education.
- Community resource linkages.

DBH estimates **1,251** new, individual admissions of crisis residential treatment annually. Services will be culturally and linguistically appropriate, allow for freedom of choice and will embrace recovery principles.

- All consumers will have a medical assessment within **24** hours of entering the program.
- Staff shall observe, monitor and document the consumer's status and develop an individualized service plan within **24** hours of admission into the program.
- The client service plan will be generated with the consumer's participation and identify specific goals and objectives.
- Consumers shall be actively involved in ongoing planning, review of progress towards goals, and evaluation of their treatment.

Executive Summary

The "new" Regional Adult Full Service Partnership (RAFSP) represents an expansion of an existing program as well as a change in the administrative reporting structure. Through this expansion, Full Service Partnership (FSP) programs will be expanded in every region of San Bernardino County and will be reported as a new stand-alone program, in lieu of being combined with the HICMOS program. The RAFSP programs include intensive services that both assist individuals to step down to a lower level of care and services to assist at-risk individuals to receive services in the least restrictive setting possible.

The Full Service Partnership (FSP) is a vital component of DBH and provides a broad array of integrated services and a supportive system of care for adults who are living with severe mental illness. The Program serves those individuals living with serious mental illness who are at imminent risk of homelessness, incarceration, hospitalization or re-hospitalization and may be unserved, underserved or inappropriately served and do not receive the appropriate services to meet their specialized needs. The strategies are recovery oriented and incorporate cultural competence and evidence-based practices.

Individuals requiring this level of care are often unable to maintain independence in the community without the assistance of intensive case management support. The ratio of staff to consumers is one (**1**) to ten (**10**) to allow for intense support of the consumers **24** hours a day/**7** days a week. The FSP offers a true one-stop shop of all available resources such as housing, interim assistance, medication support services, therapy, and intensive case management. FSP service providers help individuals cope with the behavioral health challenges by linking them to community programs and agencies through direct, one-to-one support. Individual RAFSP treatment services include clinical assessments, risk assessments, housing placement, coordination of care with mental health and substance abuse outpatient clinics and physical healthcare physicians.

Artwork by Gary Bustin

FSP service providers help individuals cope with the behavioral health challenges by linking them to community programs and agencies through direct, one-to-one support. Under this framework, Regional Adult FSPs can provide for the needs of individuals in need of intensive medication support, complex care coordination, such as eating disorders, or other voluntary medical interventions.

The RAFSPs target population will serve diverse county residents ages 18 and older, experiencing living with serious mental illness who will benefit from wraparound treatment services.
This includes:

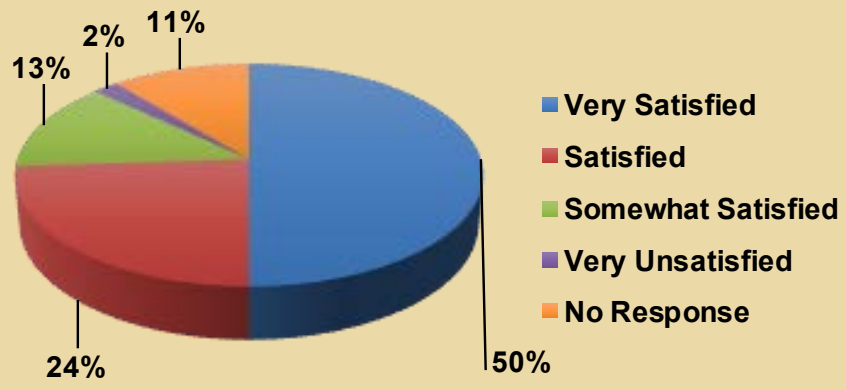
- The unengaged homeless.
- Individuals living with co-occurring disorders.
- High users of crisis and hospital services.
- Those who are at imminent risk of homelessness, incarceration, hospitalization or re-hospitalization.
- Underserved individuals who do not receive the appropriate services to meet their specialized needs.

Executive Summary

***WIC § 5848** states that an Annual Update shall be prepared and circulated for review and comment for at least 30 days to representative of stakeholder interests and any interested party who has requested a copy. Additionally the mental health board shall conduct a public hearing on the draft Annual Update at the close of the 30 day comment period.*

Public Posting and Hearing

The Annual Update is scheduled for posting for public review and comment from **April 1, 2016 through May 1, 2016** on the DBH website at www.sbcounty.gov/dbh with a request to review the draft document and take the opportunity to comment. During the thirty (**30**) day public posting of the MHSA Annual Update, DBH will continue to promote the thirty (**30**) day posting and provide overviews and information related to the MHSA Annual Update. The graph below illustrates the reported general feelings about the MHSA Annual Update from stakeholders that have participated in Community Program Planning and provided feedback to date. In total, **270** individuals completed a stakeholder comment form. Of the respondents, **87%** indicated they were satisfied to very satisfied with the MHSA Annual Update, **0%** indicated they were dissatisfied, and **2%** indicated they were very dissatisfied.



A Public Hearing hosted by the San Bernardino County Behavioral Health Commission is scheduled to be conducted on **May 5, 2016**, as part of the regular Commission meeting. The Behavioral Health Commission will be requested to affirm that the Department has adhered to the MHSA Community Program Planning process and support the submission of the MHSA Annual Update to the San Bernardino County Board of Supervisors for approval.

A full description of the 30 Day Public Posting and Comment period and Public Hearing will be included in the Final version of this document.

Conclusion

The development and preparation of San Bernardino County's Mental Health Services Act Fiscal Year (FY) 2016/17 Annual Update resulted from concentrated efforts from the community, consumers, family members, service providers, county agencies, and representatives of interested organizations throughout the county.

DBH, through the MHSA, is supporting the Countywide Vision by providing behavioral health services and ensuring residents have the resources they need to promote wellness, recovery and resilience in the community.

Should you have any questions, would like to provide additional input, receive additional information about San Bernardino County MHSA services or activities, or be included on our distribution lists please contact:

Department of Behavioral Health
Office of Program Planning and Development
1950 S. Sunwest Lane, Ste. 200
San Bernardino, CA 92415
(909) 252-4017
MHSA@dbh.sbcounty.gov

Please follow us on social media sites!

March 2016: MHSA Summit

Community Program Planning (CPP)

Overview of Stakeholder Process

WIC § 5848 *states that counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on:*

- *Mental health policy.*
- *Program planning.*
- *Implementation.*
- *Monitoring.*
- *Quality Improvement.*
- *Evaluation.*
- *Budget Allocations.*

CCR Title 9 Section 3300 *states that involvement of clients and their family members be in all aspects of the community planning process and that training shall be offered, as needed, to stakeholders, clients, and client's family who are participating in the process.*

Please click the image below to see a message from the MHSACoordinator.

The San Bernardino County Department of Behavioral Health (DBH) is dedicated to including diverse consumers and stakeholders from throughout the county in the planning and implementation of Mental Health Services Act (MHSA) programs and services. These efforts include informing stakeholders of fiscal trends, evaluation, monitoring, and program improvement activities as well as obtaining feedback. DBH has consistently demonstrated commitment to incorporating best practices in our planning processes that allow our stakeholder partners to participate in meaningful discussions around critical behavioral health issues. DBH considers community program planning a constant practice and as a result, this component has become a robust, year-round practice incorporated into standard operations. Like the other MHSA components, the community program planning process undergoes review and analysis which allows us to enhance and improve engagement strategies.

DBH's Community Program Planning (CPP) protocol over the years has included a participatory framework of regular, ongoing meetings with diverse stakeholders to discuss topics related to behavioral health policy, pending legislation, program planning, implementation and evaluation, and financial resources affiliated with behavioral health programs. This practice has allowed DBH to be responsive to changes in the public behavioral health environment, be proactive in identifying areas of improvement, and continue to educate diverse stakeholder and consumers about the MHSA, behavioral health resources and topics, and the public behavioral health system as a whole. A published schedule for regular meetings is available to stakeholders and is distributed widely to the public along with anticipated meeting topics. To ensure participation from diverse stakeholders, meetings include interpreter services, as well as meetings that are held in languages other than English. Monthly meetings are documented through agendas, sign-in sheets and detailed minutes and include the following regularly scheduled meetings:

Latino Awareness Sub-Committee Meeting

- Behavioral Health Commission (BHC).
- District Advisory Committee meetings: five (**5**) monthly meetings, one (**1**) held in each of the five (**5**) supervisorial districts within the county and led by the Behavioral Health Commissioners in each district.
- Community Policy Advisory Committee (CPAC).
- Cultural Competency Advisory Committee (CCAC), along with twelve (**12**) separate cultural subcommittees/coalitions.
- Transitional Age Youth (TAY) Center Advisory Boards.
- Consumer Clubhouse Advisory Boards.
- Quality Management Action Committee (QMAC).
- MHSA Executive Committee.
- Association of Community Based Organizations (ACBO).
- Room and Board Advisory Coalition.
- Screening, Assessment, Referral and Treatment (SART) Collaborative.
- System-wide Program Outcomes Committee (SPOC).

Additional regular stakeholder engagement and education meetings include:

- Bi-monthly Workforce Development Committee.
- Quarterly PEI Provider Network Meeting.
- Ad hoc Juvenile Justice Program meetings.
- Clubhouse Consumer Peer Support Groups.
- Parent Partners Network.
- DBH Peer and Family Advocate employee meetings.
- Older Adult Peer Counselor Support and Outreach System.
- Transitional Age Youth (TAY) Network.

Stakeholder attendance is recorded through meeting sign-in sheets and consumer feedback forms. These sign-in sheets document the attendance of underserved, unserved, and inappropriately served populations as outlined in Welfare and Institutions Code (WIC) 5848.

Cultural Competency

DBH has a commitment to cultural competency and ensures that this value is incorporated into all aspects of DBH policy, programming and services including planning, implementing and evaluating programs. To ensure cultural competency in each of these areas, DBH has established twelve (**12**) monthly cultural subcommittees and coalitions, a Cultural Competency Advisory Committee, and the Office of Cultural Competence and Ethnic Services (OCCES) which reports to the DBH Director. These elements are an essential part of the stakeholder process including the use of the regularly scheduled committee and subcommittee meetings to obtain feedback and input on services and programs. The Cultural Competency Officer (CCO) and the OCCES work in conjunction with each MHSA program lead to provide feedback and input into all programs. This

targeted coordination ensures the delivery of culturally and linguistically competent and appropriate services. The CCO or OCCES staff regularly sit on boards or committees to provide input or effect change regarding program planning or implementation. OCCES also provides support by translating documents for the department as well as coordinating interpretation services for stakeholder outreach, meeting and training events. Language regarding cultural competence is included in all department contracts with community based organizations and individual providers to ensure contract services are provided in a cultural competent manner. Additionally, cultural competence is assessed in each DBH employee's annual Work Performance Evaluation.

Mental Health First Aid Training with Mt. Zion Baptist Church

DBH is highly committed to including consumers and stakeholders within all levels of our organizational structure. From the highest level of commission oversight, the Behavioral Health Commission**,** to the administrative structure within DBH, it has been our mission to include consumers and family members as an active system of stakeholders. Within DBH's organizational structure, the Office of Consumer and Family Affairs is elevated, reporting to the Cultural Competency Officer, with access to the Department Director. Outreach to consumers and family members is performed through the Office of Consumer and Family Affairs as well as the department Public Information Office, Community Outreach and Education division, DBH's four (**4**) TAY centers and DBH's **9** consumer clubhouses, and by contracted provider agencies to encourage regular participation in MHSA activities.

Consumer engagement occurs through community events, department activities and committee meetings. Consumer membership in department committees include meetings in which meaningful issues are discussed and decisions are made. Consumer input, along with staff and community input, is always considered when making MHSA related system decisions in the Department of Behavioral Health. This includes decision makers such as the Director, Assistant Director, Medical Director, Deputy Director, Program Manager, Clinic Supervisor, Clinicians, and clerical staff.

Improvement in Progress

Stakeholder feedback received during prior Community Program Planning (CPP) indicated that stakeholders would like more education in recognizing the signs and symptoms associated with mental illness, as well as information related to suicide prevention, and would like to have the opportunity to participate in targeted education on these topics.

Using this information as an opportunity for improvement, the department placed deliberate focus on building the capacity to respond to these requests through investing in the delivery of two evidence-based trainings to support these community education efforts:

- Applied Suicide Intervention Skills Training (ASIST).
- Mental Health First Aid (MHFA).

Focused Community Education

Throughout the 2015/16 fiscal year, the department hosted **18** Community Education Sessions focusing on two areas, identifying signs and symptoms of behavioral health conditions and preventing suicide. The education sessions were presented in various locations across the County and included representatives from crisis services, the justice system, law enforcement, education, hospitals, other county agencies, homeless services, faith-based organizations, alcohol and drug services, community based organizations, and veteran organizations. Several communication channels were enlisted to advertise the education sessions, including web blasts, a list serve, electronic mail invitations to contract providers, as well as the use of the Department social media accounts. The overarching goals of the educational sessions were to provide information on how to understand mental health concerns and link individuals and organizations to resources based on the individuals needs.

Mental Health First Aid © (MHFA)

Mental Health First Aid © is a training course managed by the © 2013 National Council for Behavioral Health. MHFA is described as an 8-hour course that teaches community members how to identify, understand, and respond to signs of mental illness and substance use disorders. The training gives participants the key skills needed to be able to reach out and provide initial help and support to someone who is developing a mental health problems or experiencing a mental health crisis. In addition to the training, it is standard practice to provide additional community resource and DBH services information. The learning objectives of this training included:

"Fantastic Course! Very informative ways of getting the right help for the right people."

- MHFA Participant

- The potential risk factors and warning signs for a range of mental health problems, including: depression, anxiety/trauma, psychosis, eating disorders, substance use disorders, and self-injury.
- An understanding of the prevalence of various mental health disorders in the U.S. and the need for reduced stigma in their communities.
- A 5-step action plan encompassing the skills, resources and knowledge to assess the situation, to select and implement appropriate interventions, and to help the individual in crisis connect with appropriate professional care.
- The evidence-based professional, peer, social, and self-help resources available to help someone with a mental health problem.

MHFA Training

Fourteen (**14**) Mental Health First Aid trainings were provided for **236** diverse stakeholders over the course of 2015 and a portion of 2016. Trained partners include cultural brokers from the Asian Pacific Islander and African-America populations, faith-based organizations, Foster Family Agencies and foster parents, youth groups, community-based organizations, Transitional Assistance Department staff, a disabilities advocacy organization, a local university, and veteran serving groups. In addition, the Workforce Education and Training (WET) unit provided MHFA trainings to DBH employees.

Overview of Stakeholder Process

Applied Suicide Intervention Skills Training (ASIST)

Applied Suicide Intervention Skills Training (ASIST) is an evidence-based training course managed by Living Works Education. ASIST is a two-day interactive workshop in suicide first-aid. ASIST teaches diverse participants to recognize when someone may be at risk of suicide and work with them to create a plan that will support their immediate safety. ASIST can be learned and used by anyone. In the course of the two-day workshop, ASIST participants learned to:

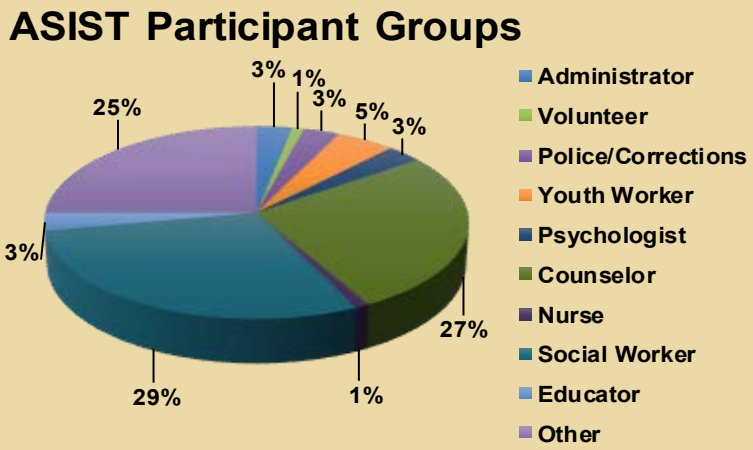
- Understand the way personal and societal attitudes affect views on suicide and intervention.
- Provide guidance and suicide first-aid to a person at risk in ways that meet their individual safety needs.
- Identify the key elements of an effective suicide safety plan and the actions required to implement the plan.
- Appreciate the value of improving and integrating suicide prevention resources in the community at large.
- Recognize other important aspects of suicide prevention including life-promotion and self-care.

ASIST Trainer Sonia Rubio

Four (**4**) ASIST workshops were provided for **120** diverse stakeholders during Fiscal Year 2015/16. Each ASIST workshop is facilitated and guided by two Living Works registered trainers and include group discussion, audiovisual learning aids, skills practice and development, and address a balance of challenge and safety. Of the **120** ASIST participants, **78** completed post education surveys and comment forms. The following information was reported by the **78** individuals that completed the post survey.

"I feel so much more prepared for helping a suicidal person. This training was really great!"

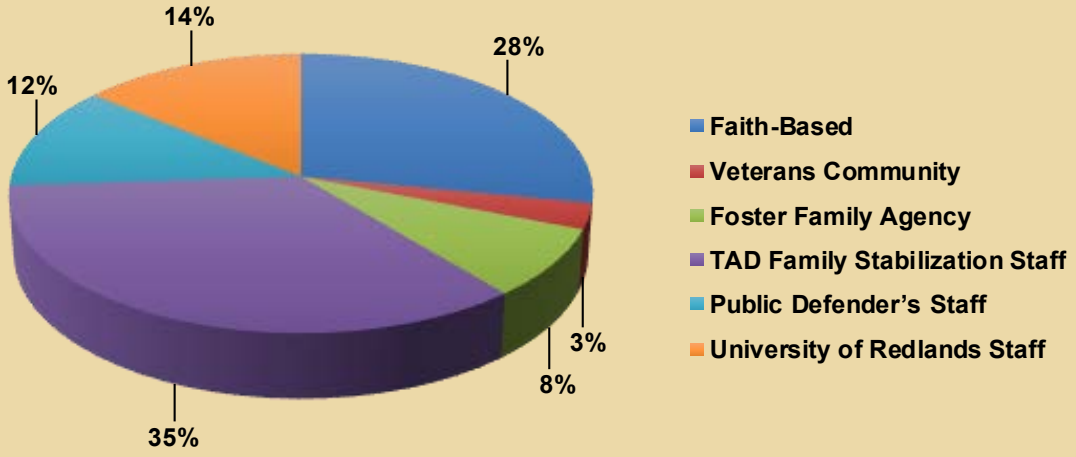
-ASIST Participant



Overview of Stakeholder Process

Approximately **297** diverse MHFA participants completed post training surveys and comment forms at each of the MHSA Community Education Trainings. The following information was reported by **211** participants who participated in community Mental Health First Aid training.

Mental Health First Aid Community Groups



WIC § 5848 *states that each Annual Update shall be developed with local stakeholders, including:*

- *Adults and seniors with severe mental illness.*
- *Families of children, adults, and seniors with severe mental illness.*
- *Providers of services.*
- *Law enforcement agencies.*
- *Education.*
- *Social services agencies.*
- *Veterans.*
- *Representatives from veteran organizations.*
- *Providers of alcohol and drug services.*
- *Health care organizations.*
- *Other important interests.*

CCR Title 9 Section 3300 *further includes:*

- *Representatives of unserved and/or underserved populations and family members of unserved/ underserved populations.*
- *Stakeholders that represent the diversity of the demographics of the county, including but not limited to geographic location, age, gender, and race/ethnicity.*
- *Clients with serious mental illness and/or serious emotional disturbance, and their family members.*

Overview of Stakeholder Process

Annual Update Community Program Planning (CPP) Process

DBH is fully committed to a year-round stakeholder engagement process. Preparation and development of this Annual Update to the Integrated Plan included meetings hosted in multiple venues in each region of the County, an interactive countywide webinar, a monolingual Spanish session hosted in collaboration with the Consulate of Mexico in San Bernardino, and an MHSA Summit. A schedule of these meetings with dates, time and locations is provided in this document.

To meet the requirements of the MHSA, extensive outreach was conducted to promote the Annual Update Planning Process. A variety of methods were used at multiple levels to give stakeholders the opportunity to have their feedback included and their voice heard. This included press releases to all local media outlets, including cultural specific media, and distribution of emails and flyers to community partners, community and contracted organizations, other county agencies, cultural subcommittees and coalitions and regularly scheduled stakeholder meetings such as the San Bernardino County Behavioral Health Commission. These materials were distributed in both English and Spanish to reach representatives of our diverse population. Social media sites such as Facebook, Twitter, Pinterest, and Instragram were also used to extended the reach of the department in connecting interested community members with the stakeholder process. DBH's Facebook is accessible at www.facebook.com/sbdbh.

Office of Program Planning and Development Staff who can assist in connecting with an MHSA stakeholder conversation in your area. Call 800-722-9866 to find out about meetings near you.

Overview of Stakeholder Process

The following pages provide examples of the flyers distributed to the community to promote the Annual Update Planning Process.

SAN BERNARDINO COUNTY
Behavioral Health

Please join the Department of Behavioral Health for a Mental Health Services Act Stakeholder Engagement!

District Advisory Committee Meetings

MENTAL HEALTH SERVICES ACT 63 CALIFORNIA

These community stakeholder engagements will focus on the Mental Health Services Act (MHSA) Annual Update. Special focus will be placed on sharing how MHSA has been integrated into existing services and a discussion regarding the future of mental health policy and program planning.

First District

February 17, 2016
11:00 A.M.-12:00 P.M.
Victor Community Support Services
15400 Cholame Rd.,
Victorville, CA 92392

Second District

February 25, 2016
2:00-3:30 P.M.
Mariposa Community Counseling
2940 Inland Empire Blvd.,
Rm 168
Ontario, CA 91764

Third District

February 16, 2016 11:00 A.M.–12:00 P.M. Phoenix Community Counseling
820 E. Gilbert St.
Rm 153
San Bernardino, CA 92415

Fourth District

February 25, 2016
2:00-3:30 P.M.
Mariposa Community Counseling
2940 Inland Empire Blvd.,
Rm 168
Ontario, CA 91764

Fifth District

February 22, 2016
5:30-7:30 P.M.
New Hope Family
Life Center Auditorium
1505 W. Highland Ave.
San Bernardino, CA 92411

For questions, concerns, interpretation services or requests for disability-related accommodations, please contact:
Cheryl McAdam (909) 252-4021 or 7-1-1 for TTY users or Cheryl.McAdam@dbh.sbcounty.gov. Please request accommodations at least 7 business days prior to the event.

MHSA (Proposition 63) was passed by California voters in November 2004 to expand mental health services for children and adults.
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Revised 1/23/15

SAN BERNARDINO COUNTY
Behavioral Health

¡Únase al Departamento de Salud Mental (DBH por sus siglas en inglés) para reuniones comunitarias para partes interesadas sobre la Ley de Servicios de Salud Mental!

Reunión de Comité Consultiva de Distrito

MENTAL HEALTH SERVICES ACT 63 CALIFORNIA

Estas reuniones comunitarias para las partes interesadas se centrarán en la actualización anual de la Ley de Servicios de Salud Mental (MHSA por sus siglas en inglés). Enfoque especial se colocará en compartir cómo MHSA se ha integrado en los servicios existentes y habrá discusión sobre el futuro de la política de salud mental y planificación de programas.

Primer Distrito

Miércoles, 17 de febrero del 2016
11:00 a.m. - 12:00 p.m.
Victor Community Support Services
15400 Cholame Road
Victorville, CA 92392
Contacto: Chris Croteau (760) 955-8313

Segundo Distrito

Jueves, 25 de febrero del 2016
2:00 - 3:30 p.m.
Mariposa Community Counseling
2940 Inland Empire Blvd., Room 168
Ontario, CA 91764
Contacto: Karina Esparza (909) 458-1381

Tercer Distrito

Martes, 16 de febrero del 2016
11:00 a.m. - 12:00 p.m.
Phoenix Community Counseling Center
820 E. Gilbert Street, Room 153
San Bernardino, CA 92415
Contacto: Margaret Hernandez (909) 387-7607

Cuarto Distrito

Jueves, 25 de febrero del 2016
2:00 - 3:30 p.m.
Mariposa Community Counseling
2940 Inland Empire Blvd., Room 168
Ontario, CA 91764
Contacto: Karina Esparza (909) 458-1381

Quinto Distrito

Lunes, 22 de febrero del 2016
5:30 - 7:30 p.m.
New Hope Family Life Center - Auditorium
1505 W. Highland Avenue
San Bernardino, CA 92411
Contacto: Crista Wentworth (909) 421-4606

Para preguntas, dudas, servicios de interpretación o solicitudes de acomodos especiales por razones de incapacidad, por favor comuníquese con Aidery Hernandez al (909) 386-8223; marque el 7-1-1 si usted es usuario TTY; también puede ir a: Aidery.hernandez@dbh.sbcounty.gov. Por favor solicite estos acomodos por lo menos 7 días laborales previos al evento.

La Ley de Servicios de Salud Mental (Proposición 63) fue pasado por votantes de California en noviembre de 2004 para aumentar servicios de salud mental para niños y adultos. El Acta es financiada por un pago de impuesto de 1% en ingreso personal que sobrepasa un millón de dólares por año.

Revised 2/2016

Overview of Stakeholder Process

SAN BERNARDINO COUNTY Behavioral Health

Please join the Department of Behavioral Health for a Mental Health Services Act Stakeholder Engagement!

Cultural Competency Advisory Committee Subcommittee Meetings

These community stakeholder engagements will focus on the Mental Health Services Act (MHSA) Annual Update. Special focus will be placed on sharing how MHSA has been integrated into existing services and a discussion regarding the future of mental health policy and program planning.

Spirituality Awareness Subcommittee **February 9, 2016** Department of Behavioral Health Administration, Rm 106 303 E. Vanderbilt Way, San Bernardino, CA 92415 1:00 - 2:30 p.m.	**Asian Pacific Islander Awareness Subcommittee** **February 12, 2016** Asian American Resource Center 1115 S. E Street, San Bernardino, CA 92408 10:00 - 11:30 a.m.	**Native American Awareness Subcommittee** **February 16, 2016** Native American Resource Center 11980 Mt. Vernon Ave., Grand Terrace, CA 92313 2:00 - 3:30 p.m.
Transitional Age Youth Awareness Subcommittee **February 17, 2016** One Stop TAY Center 780 E. Gilbert St., San Bernardino, CA 92404 11:00 a.m. - 12:30 p.m.	**Disabilities Awareness Subcommittee** **February 17, 2016** Department of Behavioral Health Administration, Rm 106 303 E. Vanderbilt Way, San Bernardino, CA 92415 3:00 - 4:30 p.m.	**Co-Occurring and Substance Abuse Subcommittee** **February 18, 2016** EMQ Families First 572 North Arrowhead Ave., San Bernardino, CA 92401 3:00 - 4:00 p.m.
Consumer & Family Member Awareness Subcommittee **February 22, 2016** Pathways to Recovery Clubhouse 850 E. Foothill Blvd., Rialto, CA 92376 2:00 - 3:30 p.m.	**LGBTQ Awareness Subcommittee** **February 23, 2016** Department of Behavioral Health Administration, Rm 109 A 303 E. Vanderbilt Way, San Bernardino, CA 92415 12:00 - 1:30 p.m.	**Women's Awareness Subcommittee** **February 24, 2016** Department of Behavioral Health Administration, Rm 109 A 303 E. Vanderbilt Way, San Bernardino, CA 92415 1:00 - 2:30 p.m.
Veteran's Awareness Subcommittee **March 7, 2016** Department of Behavioral Health Administration, Rm 109 A 303 E. Vanderbilt Way, San Bernardino, CA 92415 3:00 - 4:00 p.m.	**Latino Health Awareness Subcommittee** **March 10, 2016** Consulate of Mexico in San Bernardino — Lobby 293 North D Street, San Bernardino, CA 92401 10:00 a.m. - 12:00 p.m.	**African American Awareness Subcommittee** **March 14, 2016** Young Visionaries 1580 N. Waterman Ave., San Bernardino, CA 92404, 2:00 - 3:30 p.m.

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SAN BERNARDINO COUNTY Behavioral Health

¡Únase al Departamento de Salud Mental (DBH por sus siglas en inglés) para reuniones comunitarias para partes interesadas sobre la Ley de Servicios de Salud Mental!

Coaliciones y Subcomités del Comité Consultivo de Competencia Cultural

Estas reuniones comunitarias para las partes interesadas se centrarán en la actualización anual de la Ley de Servicios de Salud Mental (MHSA por sus siglas en inglés). Enfoque especial se colocará en compartir cómo MHSA se ha integrado en los servicios existentes y habrá discusión sobre el futuro de la política de salud mental y planificación de programas.

Subcomité de Concientización de Espiritualidad **9 de febrero del 2016** Administración de DBH— Cuarto 106 303 E. Vanderbilt Way, San Bernardino, CA 92415 1:00 - 2:30 p.m.	**Subcomité de Concientización de Asiáticos/Isleños del Pacífico** **12 de febrero del 2016** Asian American Resource Center 1115 S. E Street, San Bernardino, CA 92408 10:00 - 11:30 a.m.	**Subcomité de Concientizacion de Nativos Americanos** **16 de febrero del 2016** Native American Resource Center 11980 Mt. Vernon Ave., Grand Terrace, CA 92313 2:00 - 3:30 p.m.
Subcomité de Concientización de Jóvenes en Edad de Transición **17 de febrero del 2016** One Stop TAY Center 780 E. Gilbert St., San Bernardino, CA 92404 11:00 a.m. - 12:30 p.m.	**Subcomité de Concientización de Discapacidades** **17 de febrero del 2016** Administración de DBH - Cuarto 106 303 E. Vanderbilt Way, San Bernardino, CA 92415 3:00 - 4:30 p.m.	**Subcomité de Concientización de Diagnostico Dual y Drogadicción** **18 de febrero del 2016** EMQ Families First 572 North Arrowhead Ave., San Bernardino, CA 92401 3:00 - 4:30 p.m.
Subcomité de Concientización de Consumidores y Miembros de Familias **22 de febrero del 2016** Pathways to Recovery Clubhouse 850 E. Foothill Blvd., Rialto, CA 92376 2:00 - 3:30 p.m.	**Subcomité de Concientización de LGBTQ** **23 de febrero del 2016** Administración de DBH - Cuarto 109 A 303 E. Vanderbilt Way, San Bernardino, CA 92415 12:00 - 1:30 p.m.	**Subcomité de Concientización de Mujeres** **24 de febrero del 2016** Administración de DBH - Cuarto 109 A 303 E. Vanderbilt Way, San Bernardino, CA 92415 1:00 - 2:30 p.m.
Subcomité de Concientización de Veteranos **7 de marzo del 2016** Administración de DBH - Cuarto 109 A 303 E. Vanderbilt Way, San Bernardino, CA 92415 3:00 - 4:00 p.m.	**Subcomité de Concientización Latino** **10 de marzo del 2016** Consulado de México en San Bernardino - Sala de Espera 293 North D Street, San Bernardino, CA 92401 10:00 a.m. - 12:00 p.m.	**Subcomité de Concientización de Afroamericanos** **14 de marzo del 2016** Young Visionaries 1580 N. Waterman Ave., San Bernardino, CA 92408 2:00 - 3:30 p.m.

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La Ley es financiada por un pago de impuesto de 1% en ingresos personal que sobrepasa un millón de dólares por año.

Overview of Stakeholder Process

SAN BERNARDINO COUNTY
Behavioral Health

Join the community forum in Spanish regarding the Mental Health Services Act

Consulate of Mexico in San Bernardino

Topic: Mental Health Services Act (MHSA)

Invited by: San Bernardino County, Department of Behavioral Health

Location: Consulate of Mexico in San Bernardino

293 North D Street, San Bernardino, CA 92401

Date: Thursday, March 10, 2016

Time: 10:00 a.m. - 12:00 p.m.

SRE
Consulados de Carrera de México en San Bernardino

Ventanilla de Salud

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Revised 2/2016

SAN BERNARDINO COUNTY
Behavioral Health

Participe en el foro comunitario en español sobre La Ley de Servicios de Salud Mental

Consulado de México en San Bernardino

Temas: Ley de Servicios de Salud Mental (MHSA)

Invita: Condado de San Bernardino Departamento de Salud Mental

Lugar: Consulado de México en San Bernardino

293 North D Street, San Bernardino, CA 92401

Fecha: 10 de marzo del 2016

Horario: 10:00 a.m - 12:00 p.m.

SRE
Consulados de Carrera de México en San Bernardino

Ventanilla de Salud

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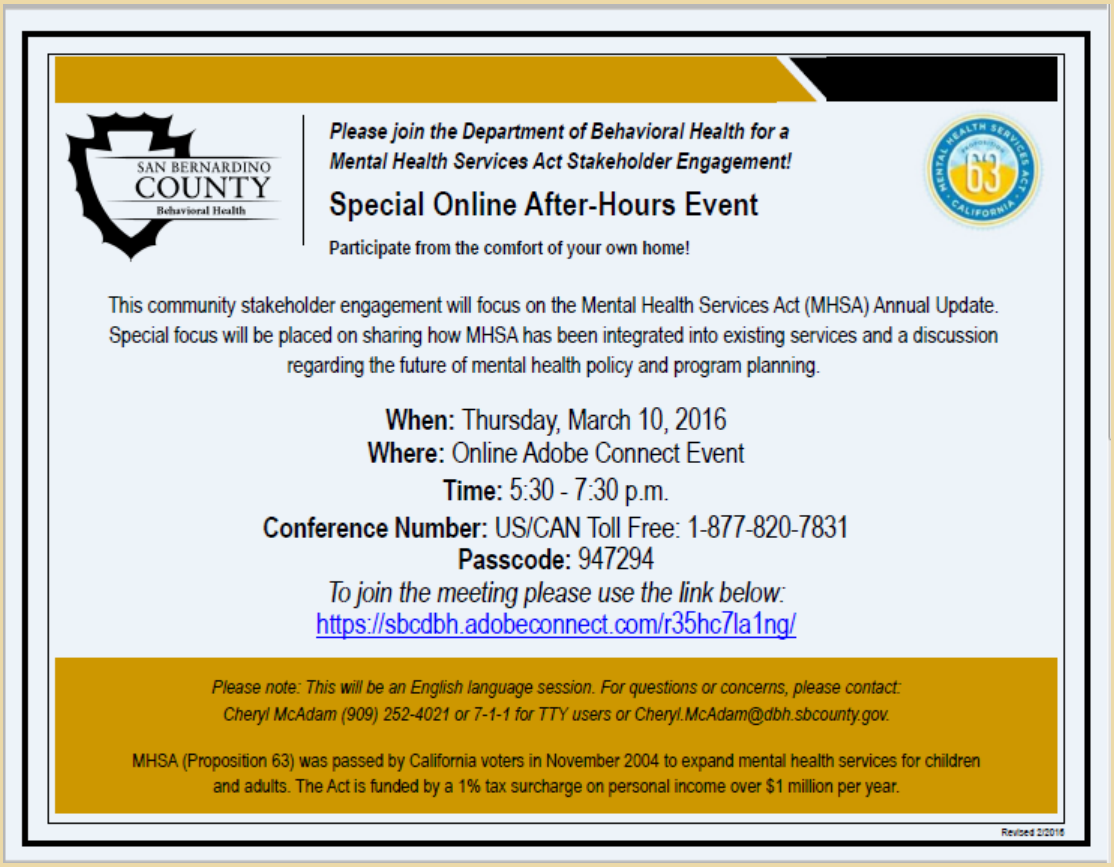
Overview of Stakeholder Process



SAN BERNARDINO COUNTY
Behavioral Health

Please join the Department of Behavioral Health for a Mental Health Services Act Stakeholder Engagement!

Special Online After-Hours Event

Participate from the comfort of your own home!

This community stakeholder engagement will focus on the Mental Health Services Act (MHSA) Annual Update. Special focus will be placed on sharing how MHSA has been integrated into existing services and a discussion regarding the future of mental health policy and program planning.

When: Thursday, March 10, 2016
Where: Online Adobe Connect Event
Time: 5:30 - 7:30 p.m.
Conference Number: US/CAN Toll Free: 1-877-820-7831
Passcode: 947294
To join the meeting please use the link below:
https://sbcdbh.adobeconnect.com/r35hc7la1ng/

Please note: This will be an English language session. For questions or concerns, please contact: Cheryl McAdam (909) 252-4021 or 7-1-1 for TTY users or Cheryl.McAdam@dbh.sbcounty.gov.

MHSA (Proposition 63) was passed by California voters in November 2004 to expand mental health services for children and adults. The Act is funded by a 1% tax surcharge on personal income over $1 million per year.

Revised 2/2016

SAN BERNARDINO COUNTY
Behavioral Health

¡Únase al Departamento de Salud Mental (DBH por sus siglas en inglés) para reuniones comunitarias para partes interesadas sobre la Ley de Servicios de Salud Mental!

Sesión en Línea por la Tarde

Estas reuniones comunitarias para las partes interesadas se centrarán en la actualización anual de la Ley de Servicios de Salud Mental (MHSA por sus siglas en inglés). Enfoque especial se colocará en compartir cómo MHSA se ha integrado en los servicios existentes y habrá discusión sobre el futuro de la política de salud mental y planificación de programas.

Fecha: Jueves, 10 de marzo del 2016
Localización: En línea evento "Adobe Connect"
Horario: 5:30 - 7:30 p.m.
Numero de Conferencia: US/CAN Toll Free: 1-877-820-7831
Contraseña: 947294
Para unirse a la reunión por favor utilice el siguiente enlace:
https://sbcdbh.adobeconnect.com/r35hc7la1ng/

Por favor note: esta será una sesión solamente en inglés. Para preguntas o dudas, por favor comuníquese con Aidery Hernandez al (909) 386-8223; marque el 7-1-1 si usted es usuario TTY; también puede ir a: Aidery.hernandez@dbh.sbcounty.gov.

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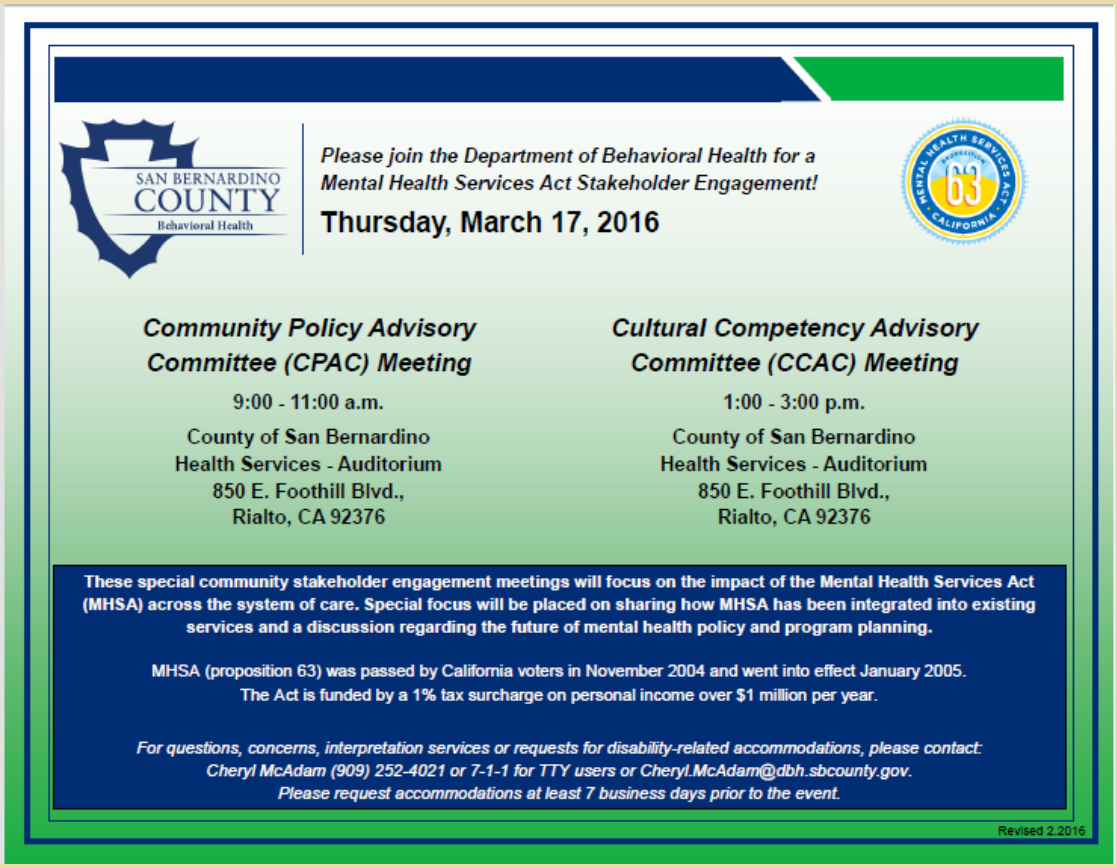
Overview of Stakeholder Process



SAN BERNARDINO COUNTY
Behavioral Health

Please join the Department of Behavioral Health for a Mental Health Services Act Stakeholder Engagement!

Thursday, March 17, 2016

Community Policy Advisory Committee (CPAC) Meeting

9:00 - 11:00 a.m.

County of San Bernardino
Health Services - Auditorium
850 E. Foothill Blvd.,
Rialto, CA 92376

Cultural Competency Advisory Committee (CCAC) Meeting

1:00 - 3:00 p.m.

County of San Bernardino
Health Services - Auditorium
850 E. Foothill Blvd.,
Rialto, CA 92376

These special community stakeholder engagement meetings will focus on the impact of the Mental Health Services Act (MHSA) across the system of care. Special focus will be placed on sharing how MHSA has been integrated into existing services and a discussion regarding the future of mental health policy and program planning.

MHSA (proposition 63) was passed by California voters in November 2004 and went into effect January 2005.
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Revised 2.2016

SAN BERNARDINO COUNTY
Behavioral Health

¡Únase al Departamento de Salud Mental (DBH por sus siglas en inglés) para reuniones comunitarias para partes interesadas sobre la Ley de Servicios de Salud Mental!

Jueves, 17 de marzo del 2016

Comité Asesor de Política Comunitaria (CPAC)

9:00 - 11:00 a.m.

County of San Bernardino
Health Services - Auditorio
850 E. Foothill Blvd.
Rialto, CA 92376

Comité Consultivo de Competencia Cultural (CCAC)

1:00 - 3:00 p.m.

County of San Bernardino
Health Services - Auditorio
850 E. Foothill Blvd.,
Rialto, CA 92376

Estas reuniones comunitarias, para partes interesadas, se centrarán en el impacto de La Ley de Servicios de Salud Mental (MHSA, por sus siglas en inglés) sobre el sistema de cuidado. Enfoque especial se colocará en compartir cómo MHSA se ha integrado en los servicios existentes y habrá discusión sobre el futuro de la política de salud mental y planificación de programas.

La Ley De Servicios de Salud Mental (Proposición 63) fue pasada por votantes de California en noviembre del 2004 para aumentar servicios de salud mental para niños y adultos. La Ley es financiada por un pago de impuesto de 1% en ingreso personal que sobrepasa un millón de dólares por año.

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Revised 2.2016

Overview of Stakeholder Process

The MHSA Administrative Manager and Component Leads, in conjunction with the offices of Cultural Competency and Ethnic Services (OCCES), and Community Outreach and Education (CORE), assumed responsibility for coordination and management of the CPP. This process was built upon existing stakeholder engagement components, mechanisms and collaborative networks within the mental health system and evolved out of the original CPP initiated in 2005. In many cases, meetings were held in the community at sites where consumers were already comfortable attending services, events and meetings. Participation of key groups of stakeholders included but were not limited to:

CCR Title 9 Section 3320 states that counties shall adopt the following standards in planning, implementing, and evaluating programs:

- Community collaboration.
- Cultural Competence.
- Client Driven.
- Wellness, recovery, and resilience focused.
- Integrated service experiences for clients and their families.

- Individuals with serious mental illness and/or serious emotional disturbance and/or their families.
- Providers of mental health and/or related services such as physical health care and/or social services.
- Educators and/or representatives of education.
- Representatives of law enforcement.
- Veteran/Military population of service organizations.
- Other organizations that represent the interests of individuals with serious mental illness and/or serious emotional disturbance and/or their families.

As listed in the schedule, five (**5**) special sessions of the Behavioral Health Commission's District Advisory Committee (DAC) meetings were conducted in each geographic region of the county. This schedule ensured representation and participation in each geographic region of San Bernardino County. To ensure participation of unserved, underserved, or inappropriately served cultural groups, the OCCES provided stakeholder engagement meetings for the Annual Update for each of their twelve (**12**) Cultural Competency Advisory subcommittees. DBH staff were able to host a discussion with diverse attendees about the background and intent of the MHSA, the approved Three-Year Integrated Plan and proposed updates as well as obtain feedback and recommendations for system improvement. To ensure that stakeholders could fully benefit from the community meetings, Office of Cultural Competency and Ethnic Services (OCCES) staff arranged for Spanish, American Sign Language and Vietnamese interpretation upon request at each meeting.

Group Discussion at stakeholder meeting

In order to increase opportunities for participation across the county, the department hosted an Adobe Connect© webinar the evening of March 10, 2016 from 5:30 p.m. to 6:00 p.m. This evening session allowed individuals living in remote areas of the county to participate via computer, smart phones, and other technological devices.

At the end of the presentation, the facilitator opened the phone line to encourage discussion, allow stakeholders to have questions answered, and provide input. Once the question and answer session concluded, participants were advised about additional opportunities to provide feedback. The link to the survey was provided in the presentation and participants were also provided information for alternative methods to provide input and feedback including the email address, phone number for the MHSA Coordinator, and a link to the MHSA Issue Resolution that can be accessed at http://www.sbcounty.gov/dbh/SPM/Manual_Docs/COM0947.pdf.

To further support this Community Planning Process (CPP) effort, a special session of the Community Policy Advisory Committee (CPAC) was hosted by the MHSA Administrative Manager on March 17, 2016. The session followed the format that had been established as a standard practice for all CPAC meetings. Attendees were seated in small groups, to allow for comfortable discussion opportunities, and provided the opportunity to provide written and verbal input after sections of information were presented. A subsequent special session of the Cultural Competency Advisory Committee was hosted by the DBH Cultural Competency Officer later in the afternoon on this same date, to ensure additional opportunities for stakeholders to interact with decision making staff. Attendees at all stakeholder engagement meetings were afforded the opportunity to provide feedback and input into the plan via verbal comment and a post survey in which stakeholders could provide written comments as well. Surveys were available in both English and Spanish and are included, along with a record of stakeholder comments received, for reference in the attachments section of this plan.

Group Discussion at stakeholder meeting

MHSA Summit

A highlight of the CPP process occurred On March 1, 2016, when the Department of Behavioral Health hosted a Mental Health Services Act (MHSA) Summit. Over **200** people attended this full day event that was held at a local university campus. The overarching goal of the Summit was to strategically advance MHSA communication and future planning with system partners, county residents and key stakeholders.

Specific Goals for the Summit included:

- Expanding awareness and education about local MHSA and system of care programs and their intersection with other systems.
- Strategically identifying areas where coordination can be improved, where existing strategies can be modified for improvement, and strategies that are working can be built upon.
- Supporting the development of strategic community networks that can assist in the ongoing evaluation and enhancement of the Public Mental Health continuum of care.
- Providing information to the public on how to stay informed and engaged in MHSA.

Summit attendees participated in several guided discussions and provided valuable feedback on specific topics and issues identified as of importance to our community. The topics for the Summit included:

MHSA 101

- A brief overview MHSA and the MHSA stakeholder engagement process. Included a description of the MHSA Community Planning Process and the importance of stakeholder participation.

Assisted Outpatient Engagement and Long Term Supports

- Participants learned about the RBEST Innovation project and the outcomes and milestones it has achieved thus far. There was an open discussion about the potential of the Department utilizing the strategies being tested in this project as an ongoing engagement strategy into medically necessary mental health services.
- In addition, the discussion included the utilization of peer staff as part of the service model.
- Attendees had an opportunity to provide feedback concerning the integration of the RBEST program into the Community Services and Supports (CSS) Component of the MHSA Plan and the larger system of care.

Crisis System of Care and Enhancements

- Participants learned about the current system of care within the Department of Behavioral Health (DBH). They had an opportunity to listen to a panel of DBH leadership directly involved in the administration and oversight of our crisis services and included an interactive question and answer session.

Supportive Housing or Housing Supports

- Participants learned about the housing continuum within MHSA programming and participated in a large group discussion on potential future housing program enhancements.

MHSA Program Changes

- Stakeholders learned about current innovative practices in the behavioral health field that can provide DBH with learning opportunities that could be used to enhance future service delivery models.
- A large group discussion occurred that highlighted some of the specific DBH programs that will be expanded to include some of the learning we have acquired as a result of our Innovation projects and other funding streams.

Overview of Stakeholder Process

NEW DATE

You Are Invited!

San Bernardino County Department of Behavioral Health
presents

Mental Health Services Act (MHSA) Summit: Educate• Participate • Integrate

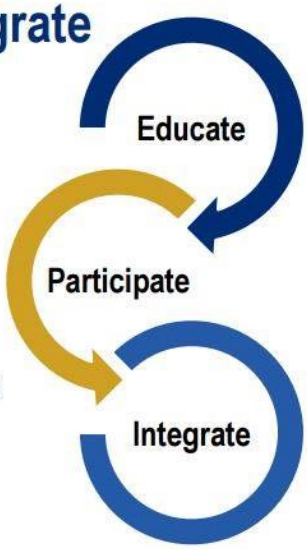
When: **March 1, 2016**
8:00 a.m. – 4:30 p.m.

Where: University of Redlands – Orton Center
1200 East Colton Avenue, Redlands, CA 92373

Who: Community stakeholders interested in MHSA programs and services.

Join us to learn, discuss and contribute to MHSA programming in San Bernardino County. Topic themes include:

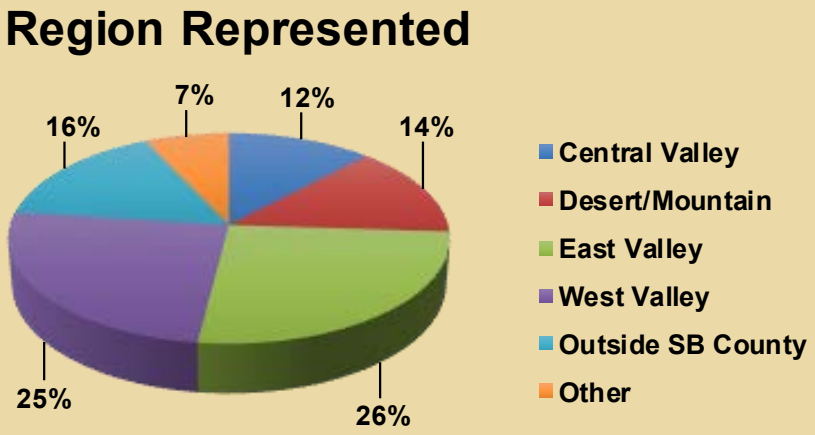
- MHSA Program Planning
- Crisis Management
- Innovating Practice
- Recovery and System Supports



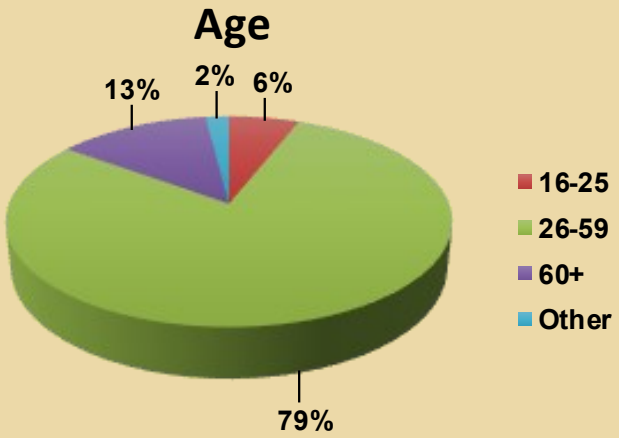
Group Discussion at MHSA Summit

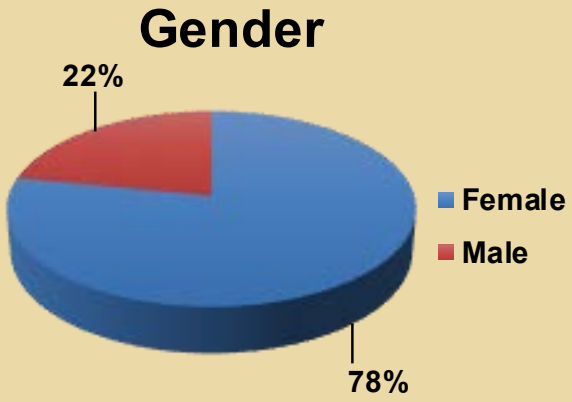
Overview of Stakeholder Process

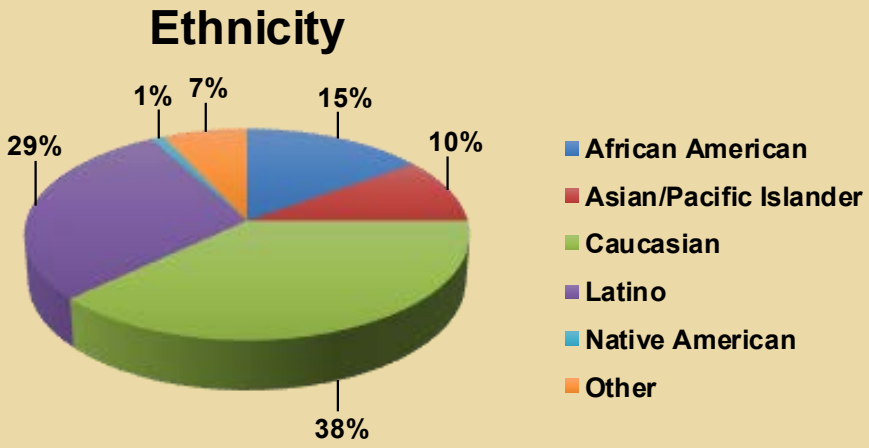
The overview of the individuals that participated in the MHSA Summit indicates that representatives were present from each region of the county.



The demographic breakdown of the **270** MHSA Summit participants that completed a survey is illustrated in the pie charts below. Please note that not every participant completed every section of every survey.







Overview of Stakeholder Process

During the stakeholder meetings for the Annual Update, several community members voiced their support and approval of the Update, as well as the enhanced community planning process that has occurred over the last year. Statements included in the meetings are reflected below.

CPP Participant Comments

"Before today I had never heard of RBEST, now I will be able to help refer patients and families to his resource."

"I was able to network with another provider that will enhance the services we provide."

"I learned about the STAY program and a great deal about the different programs that the county offers."

"It was a great resource to learn about new and innovative programs. These are potential great referrals."

"Lots of great ideas were discussed."

"There are resources to cover mental health."

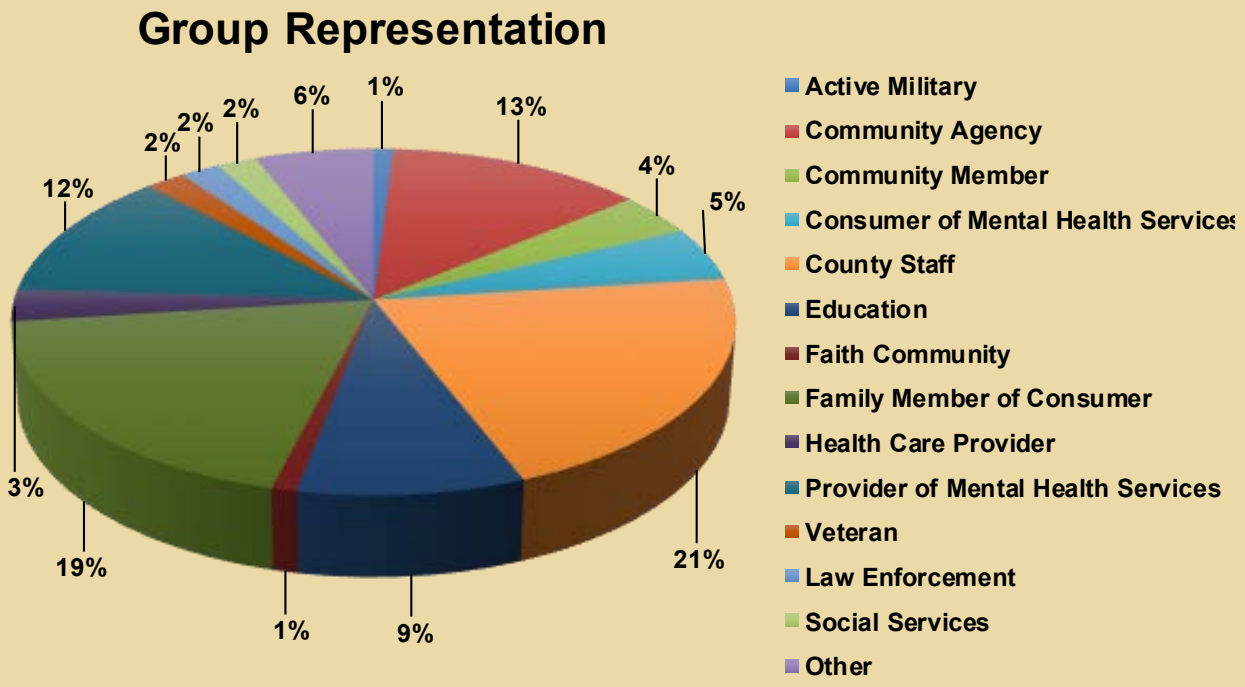
"There are a lot of resources within and throughout the county."

"It was my first time attending and I thought it was very informational."

Overview of Stakeholder Process

At each CPP meeting and at the MHSA Summit, participating stakeholders were provided with copies of the presentation materials and program resources. The DBH Public Information Office posted a copy of the presentation materials on the DBH website, allowing interested stakeholders the opportunity to download the materials at their own convenience. At the end of each meeting, diverse stakeholders were provided information concerning the planned Public Comment and Review time period (**April 1, 2016 through May 1, 2016**) as well as instructions about how to access the posted Annual Update (http://www.sbcounty.gov/dbh/mhsa/mhsa.asp#).

Approximately **270** stakeholders completed a stakeholder comment form in the MHSA Annual Update special community planning sessions held throughout February and March of 2016, with **300** individuals attending the meetings as documented by sign-in sheets. Each participant was asked to complete a comment form available in English and Spanish (see attachments for actual forms) that included questions regarding demographic information. Stakeholders that checked multiple boxes were counted in each category in which they identified. While not all attendees completed a stakeholder comment form, all attendees signed in on meeting sign-in sheets.



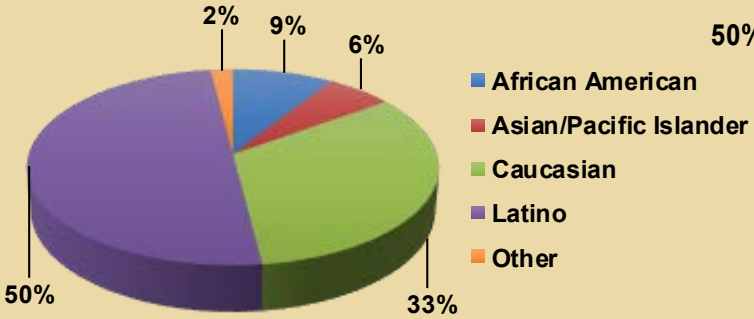
San Bernardino County is located in Southeastern California, approximately **60** miles inland from the Pacific Ocean. The County is the largest, in terms of land mass, in the continental United States, covering over **20,000** square miles. There are **24** cities in the County and multiple unincorporated and census designated places. Over **80%** of the land is owned by federal agencies (Federal Bureau of Land Management and the Department of Defense). According to the California Department of Finance, the estimated population for 2014 is **2,085,669**. Approximately **75%** of the County population resides in the Valley region of the County, which accounts for only **2.5%** of the land.

Overview of Stakeholder Process

The County has four (**4**) military bases, utilizing **14%** of the land, which include: Fort Irwin, Marine Corps Air Ground Combat Center Twentynine Palms, Marine Corps Logistics Base Barstow, and Twentynine Palms Strategic Expeditionary Landing Field.

San Bernardino County is the fifth largest county in the State of California in terms of population and ethnic diversity. The largest population in the county is Latino, with **50%**, followed by Caucasian, then African American, Asian/Pacific Islander, then Native American. The gender breakdown is even, with **50%** male and **50%** female.

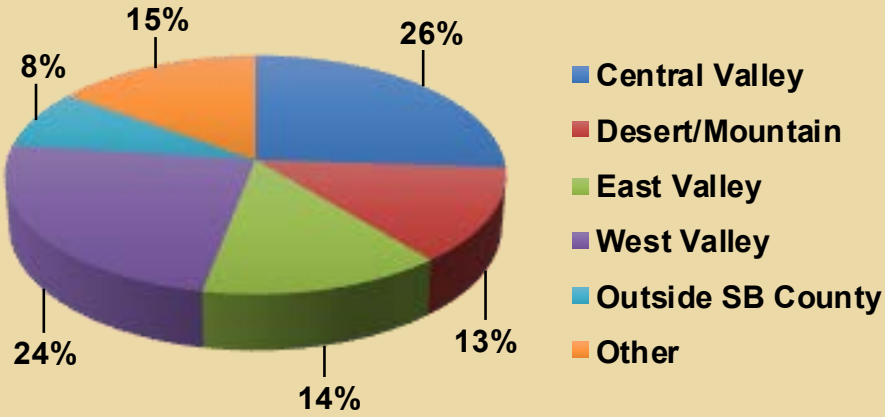
Countywide Ethnicity



Countywide Gender

The stakeholders completing the comment forms identified which region of the county they represented. The regions represented were the West Valley, the East Valley, the Central Valley, and the Desert/Mountain. Some of the stakeholders did not identify with a specific region.

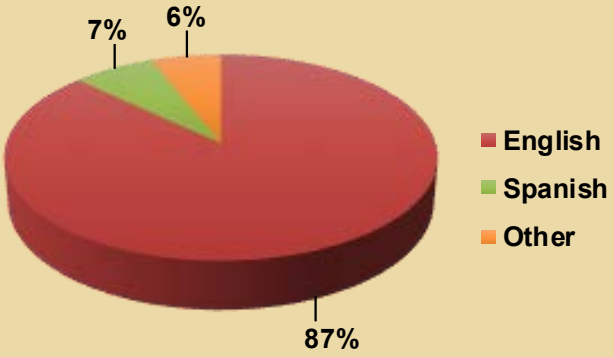
Regional Representation



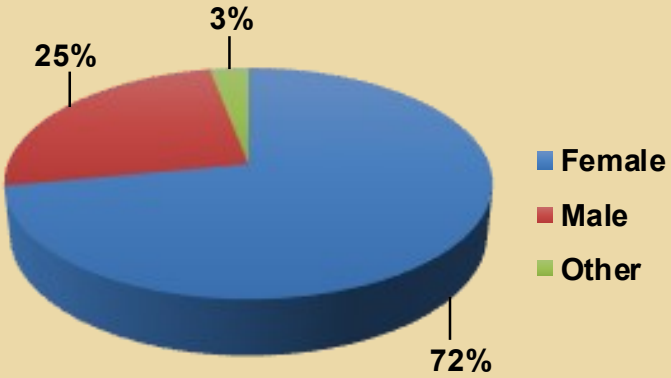
Overview of Stakeholder Process

The demographic breakdown of participants that completed a stakeholder comment form is illustrated below.

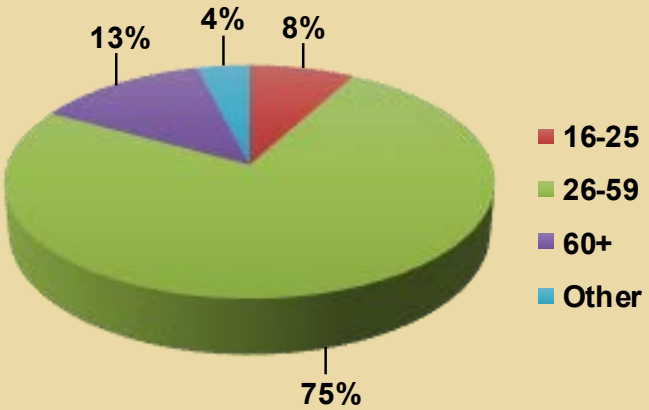
Primary Language



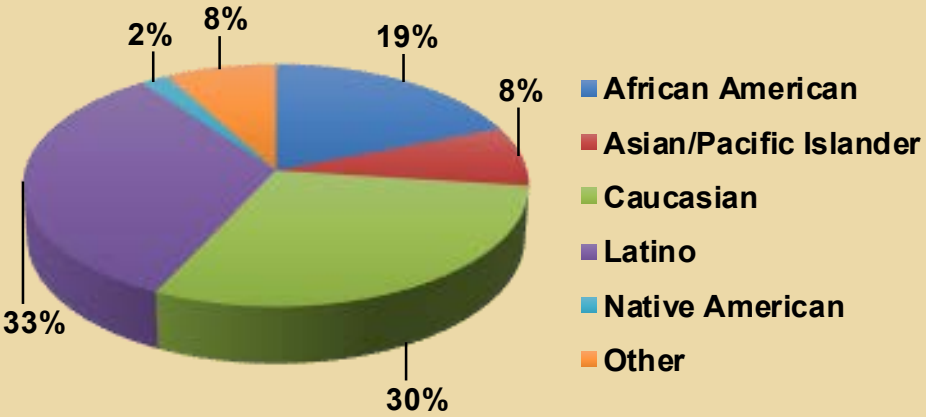
Gender



Age

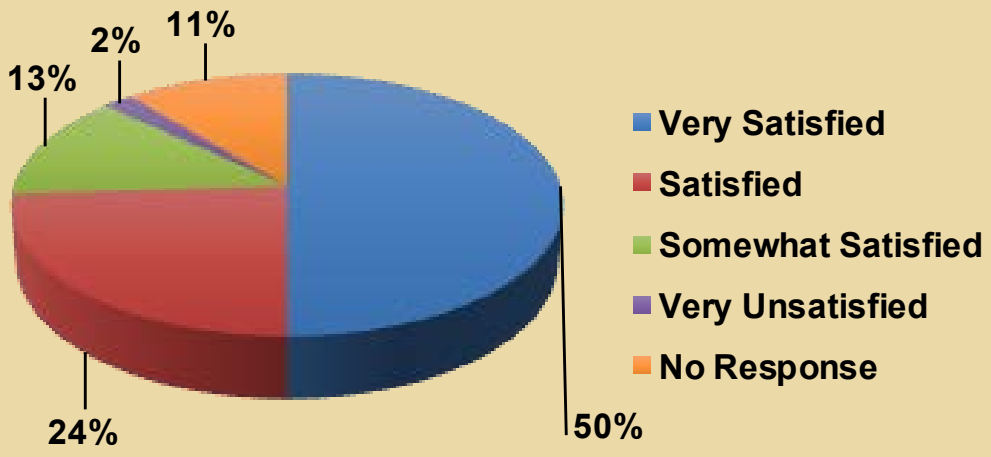


Ethnicity



Overview of Stakeholder Process

Participants completing the stakeholder comment form were asked to rate their satisfaction with the MHSA Annual Update to date. Overall results indicate that **87%** of participants reported being Very Satisfied, Satisfied or Somewhat Satisfied with the MHSA Annual Update while **11%** did not respond.



Summary of Program Changes

DBH has made a practice of planning for sustainable growth in the development and implementation of MHSA and system of care services. This Annual Update reflects stakeholder informed changes, expansion, and **includes new programs** that were identified as opportunities for growth in last years Annual Update that will be sustained under the Community Services and Supports (CSS) component.

With input from stakeholders, DBH has identified several program areas that require expansion of services beginning in Fiscal Year 2016/17. Because the expansion of programs would be for currently approved programs, DBH would not characterize increased activities as substantive changes. The service philosophy and array of services will not be changed, but rather extended and made accessible to more community members. This extension of services will also address the expanded requirements related to evaluation of program outcomes.

Expansion efforts as detailed below are contingent on MHSA funding estimates which are based on tax receipts and monthly cash projections. If cash projections change such that expansion is not feasible, program efforts detailed within this report will not be implemented as services provided under MHSA are contingent upon available funding. Cost per client and clients served estimates are included in the cost per client grids included with this report and are based on gross costs per Mental Health Oversight and Accountability Commission direction to counties in the current plan instructions. This means cost per client information includes both MHSA and other funding utilized to serve the clients in MHSA Integrated programs.

The following programs will continue to operate as currently approved in the MHSA Integrated Plan:

- **Community Services & Supports**
  - TAY-1: Transitional Age Youth (TAY) One Stop Centers
  - A-1: Clubhouse
  - A-3: Members Assertive Positive Solutions/Assertive Community Treatment
  - A-5: Psychiatric Triage Diversion Program
  - A-6: Community Crisis Response Team (CCRT)
  - A-8: Big Bear Full Service Partnership
  - A-9: Access, Coordination, and Enhancement (ACE)
  - OA-1: AgeWise - Circle of Care
  - OA-2: AgeWise - Mobile Response
- **Prevention and Early Intervention**
  - PEI SI-1: Student Assistance Program
  - PEI SI-2: Preschool Prevention and Early Intervention Program
  - PEI SI-3: Resilience Promotion in African American Children
  - PEI CI-1 Promotores de Salud/Community Health Workers
  - PEI CI-2 Family Resource Center
  - PEI CI-3: Native American Resource Center
  - PEI CI-4: National Curriculum and Training Institute (NCTI) Crossroads Education Program
  - PEI SE-2: Child and Youth Connection
  - PEI SE-3: Community Wholeness and Enrichment (CWE)
  - PEI SE-4: Military Services and Family Support
  - PEI SE-5: LIFT
  - PEI SE-6: Coalition Against Sexual Exploitation (CASE)
- **Innovation**
  - INN-06: Transitional Age Youth Behavioral Health Hostel
  - INN-07: Recovery Based Engagement Support Teams
- **Capital Facilities and Technological Needs**

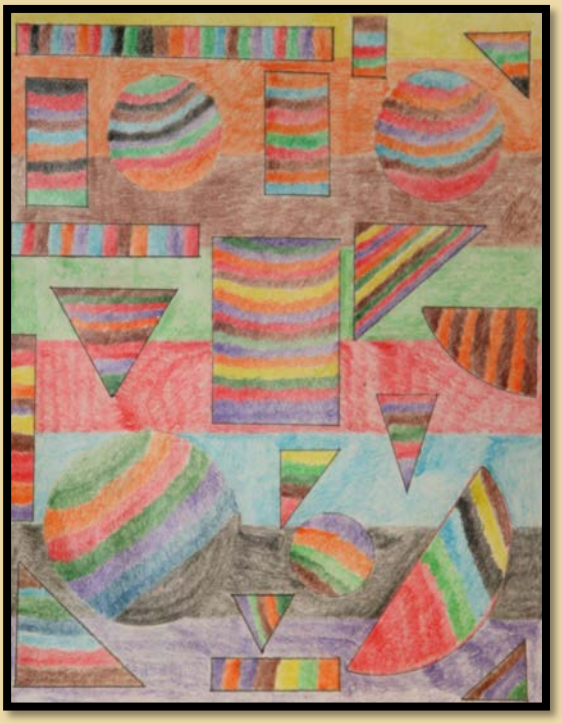
The following programs may be expanded per funding availability to meet consumer needs in FY 2016/17 and are consistent with stakeholder priority areas identified in past and current stakeholder processes.

Community Services and Supports (CSS)

C-1: Comprehensive Children and Family Support Program

The Comprehensive Children and Family Support Services (CCFSS) program is comprised of a continuum of services targeting three populations for Full Service Partnerships (FSP) to provide "Wraparound" services to diverse children and youth with emotional disturbances and co-occurring disorders. Wraparound has proven to be an effective means by which children and youth receive

assistance and avoid out-of-home placements or loss of current placements. Additionally, participants are helped in accomplishing appropriate goals and developing constructive relationships within their family and community.



Artwork by Gabriel Horn

In fiscal year (FY) 2015/16 this program was expanded by adding an outreach and engagement element to try to address the needs of children in congregate care. This was done to serve the dependents of the Core Practice Model (CPM) and facilitate access to three different types of Full Service Partnership services provided within the program. The successful work of the expansion has further highlighted the need for this outreach and engagement through the CPM, has illuminated the complex nature of serving children in this context, and has required a level of supervision that was unexpected. Additionally, the statewide implementation of the Continuum of Care Reform (CCR) and the passage of AB 403 is moving all congregate care away from Group Homes and more toward home based residences. System involved children and youth currently living in group homes may continue to be served for a short time within a Short Term Residential Treatment Center, necessitating continued efforts with these children. With more Dependents and Wards being provided a home based residence there is an increased need for the structure, support, and services offered and available through Full Service Partnerships. For these reasons, there will be an expansion of services for this program.

In this expansion, CCFS will continue the collaborative relationships that have been established with Children and Family Services (CFS) and will build on the existing relationship to serve an estimated **275** additional system involved children and youth. Clinical Therapists will be co-located at CFS regional offices in order to work closer with the CFS Social Workers caring for the children in placement. The clinical therapists will conduct mental health assessments at the group homes, providing ongoing Core Practice Model services as needed, and work toward the dependents being served by one of the three (**3**) existing CCFSS Programs. Children placed out of county and in need of an ongoing group home placement will be progressively linked to appropriate services. Children in group homes who are likely to be leaving congregate care in the next three months will be progressively linked to Wraparound or Success First/Early Wrap. These therapists will be in the field often and will require substantial team support from clerical staff and supervision.

The expansion will increase access to these already approved services thereby allowing the Department, along with our Children and Family Services department stakeholders, to serve an additional **275** system involved children.

A-2: Forensic Integrated Mental Health Services

The Forensic Integrated Mental Health Services is composed of two (**2**) main components. The first includes the Supervised Treatment After Release (STAR) and the Forensic Assertive Community

Treatment (FACT) programs, both which serve consumers who participate in the Mental Health Courts. The other component is the Crisis Intervention Training (CIT) program which focuses on training law enforcement personnel on ways to safely and effectively respond to consumers with mental health issues who are in crisis in the community. During the last year, and as described in the FY 2015/16 MHSA Annual Update, the STAR and FACT programs were expanded to provide additional treatment services for the reentry population as well as continue to serve consumers of the mental health court. As an and expansion and enhancement to these programs, Peer Mentoring for the re-entry population may be introduced and services will be expanded to the high desert region. The primary intent of the enhancement is to provide consumers with a Peer Support Specialist who has lived forensic experience through incarceration or probation and is also in active recovery. The purpose of pairing program participants with a Peer Support Specialist is to have the Peer Support Specialist act as a functional role model providing technical guidance and sharing their experience with successful reentry. With the consumers permission, the Peer Support Specialist will also function as a member of the program participant's care team, working collaboratively with clinicians and forensic staff. In addition, the Crisis Intervention Training (CIT) component will be expanded to provide education to additional groups such as firefighters and Probation staff. This sub-component will be referred to as Community Partners CIT.

A-4: Crisis Walk In Centers

The Crisis Walk-In Centers (CWIC) provide urgent mental health services to San Bernardino County residents located in the Morongo Basin, Victorville, and the Rialto. These centers conduct urgent psychiatric assessments and crisis stabilization for clients experiencing acute psychiatric distress, who are of possible danger to themselves or others. Centers are staffed by a multi-disciplinary team who focus on stabilizing clients and providing linkage to resources within the community for psychiatric follow-up. Services are provided up to **24** hours per day, **7** days a week in Victorville and Morongo Basin. The Central Valley CWIC operates Monday through Friday from 8:00 a.m. - 10:00 p.m. and Saturday 8:00 a.m. - 5:00 p.m. In collaboration with the Community Crisis Response Teams (CCRT), the CWICs work to reduce inappropriate hospitalizations and improve the quality of life for their clients.

Recently, DBH has been successful in applying for grants under the California Health Facilities Financing Authority. This opportunity will allow the Department to expand the Crisis Walk-in Centers program by including an additional Crisis Stabilization Unit (CSU). This additional short-term crisis assessment and treatment program will assist consumers during a mental health crisis who require a **23**-hour supervised crisis intervention services. The expanded program will work to stabilize the emotional, mental, and behavioral crisis of those seeking treatment and link them to mental health resources.

A-7: Homeless Intensive Case Management and Outreach Services

The Homeless Intensive Case Management and Outreach program is comprised of four (4) focus areas:

- Homeless Intensive Case Management and Outreach Services (HICMOS).
- Homeless Outreach Support Teams.
- Housing and Employment Program.
- Adult System of Care Full Service Partnerships.

The Full Service Partnership (FSP) is a vital component in DBH's Adult System of Care. The FSP is designed serve adults in San Bernardino County who are severely and mentally ill or who have untreated co-occurring disorders and who are in many cases, recently released from state hospitals and/or institutionalized care. These adults are at imminent risk of homelessness, incarceration, hospitalization or re-hospitalization. The FSP promotes the principles of recovery, wellness, and

resiliency to assist individuals to have lives that are more satisfying, hopeful, and fulfilling based on their own values and cultural framework. Services focus on the client's strengths and possibilities in order to move toward new levels of functioning in the community.
Individuals requiring this level of care are often unable to maintain independence in the community without the assistance of intensive case management support. The ratio of staff to clients is one **(1)** to **10**/**15** to allow for intense support of the clients **24** hours a day/**7**days a week.

The FSP offers a true one-stop shop of all available resources such as:

- Housing.
- Interim assistance.
- Medication support services.
- Intensive case management.

FSP service providers help individuals cope with the behavioral health challenges by linking them to community programs and agencies through direct, one-to-one support. This intense, interactive support from case managers and other community resources benefits FSP consumers and contributes to increased independence and reduced psychiatric hospitalization, thus enhancing the individual's quality of life.

The adult Full Service Partnership program component will begin to be expanded during fiscal year 2016/17. This vital component will be pulled out of the A-7: HICMOS work plan to create a “new,” stand-alone Regional Adult Full Service Partnership program (A-11). This administrative change will allow easier planning, tracking, and evaluation of this very important service provided under CSS.

In addition, use of CSS funding to expand the Housing and Employment component for mental health consumers have been identified for expansion, as allowable. Funding for this expansion could be utilized to continue the development of supportive and affordable housing for individuals living with serious mental illness and their families or to provide support services and other housing supports (i.e., rental subsidies, deposits, utilities, etc.) to those individuals living with serious mental illness who are or were homeless, and their families, and have or are in the process of transitioning into permanent housing.

Prevention and Early Intervention - Responding to Policy Change

On October 6, 2015, updated Prevention and Early Intervention (PEI) Component Regulations, designed by the Mental Health Services Oversight and Accountability Commission (MHSOAC), became effective. The updated regulations changed the framework and structure of the PEI component as compared to the guidance received from the Department of Mental Health in 2007 via Information Notice 07-19. The previous framework contained guidance concerning key mental health needs, priority populations, and was grounded in an internationally recognized construct, the Institute of Medicines (IOM) Framework. The IOM Framework, as related to PEI, describes a continuum of interventions that align with the severity of the population being served, ranging from activities targeted at groups with no known risk for the development of a behavioral health condition to those first experiencing the onset of a serious mental illness, including psychosis. In response, San Bernardino County and local stakeholders designed programs that fit within the construct. Programs and strategies within the framework were designed to reinforce collaboration with other systems and organizations, be provided in natural community settings, refer and link individuals in need of medically necessary care to appropriate services, be cognizant of the role of poverty, environmental and social factors that impact well-being, and implement strategies that reduce the stigma and discrimination associated with mental illness.

The new regulatory framework includes many of the concepts that guided the original design of PEI Component Programs. The majority of change relates to the guiding principles and concepts outlined

in the DMH-IN 07-19. The principles are now parceled out and defined as individual Programs described as "a stand-alone organized and planned work, action or approach that evidence indicates is likely to bring about positive mental health outcomes either for individuals and families with or at-risk of serious mental illness or for the mental health system (§3701 (b))." Under this new reporting construct, approved programs, services, or approaches utilized in the delivery of the PEI Component will remain consistent and are not considered substantively changed. Based on stakeholder informed feedback, a new reporting framework for the PEI Component was developed and will be utilized in future three-year plans and annual updates. A complete listing of this reporting structure can be found in the PEI section of this Annual Update.

Capital Facilities and Technological Needs

The goals of Capital Facilities and Technological Needs are to methodically achieve an integrated, modernized, information systems infrastructure; Improve the quality, access, equity and efficiency of care by using a fully integrated electronic health record system, personal health information systems, and telemedicine; and Improve or replace existing capital projects to meet program infrastructure needs.

Program updates related to this component include an update on the status of the project described in the FY 2015/16 MHSA Annual Update and describes an expansion. Construction of a total of three (**3**) new Crisis Residential Treatment (CRT) facilities and one (**1**) Crisis Stabilization Unit is planned. Development of one (**1**) CRT began last fiscal year and is expected to continue during FY 2016/17. The facility will be modeled after DBH's previous Capital Facilities project, the Transitional Age Youth One Stop Center/Crisis Residential center. Demolition of two uninhabitable county owned buildings occurred over the past fiscal year and construction of the newly designed structure on the site is beginning. These projects are funded through a state grant to support voluntary crisis services for adults and through transferring one-time Community Services and Supports (CSS) funding to leverage costs associated with the development of this future CSS program as described in this Annual Update.

Artwork by Jose Luis Mendez

Crisis Residential Treatment Program

New!

The Need for Crisis Residential Services in San Bernardino

The behavioral healthcare system in San Bernardino County is in need of alternatives to inpatient hospitalization, institutionalization and/or incarceration to address the complex needs of adult individuals experiencing a mental health crisis. In an effort to address this need, San Bernardino County Department of Behavioral Health (DBH) has developed a new Crisis Residential Treatment (CRT) program to strengthen the continuum of care. The CRTs will support the community by increasing access and capacity to efficiently and effectively serve the individualized needs of those in crisis who do not meet the criteria for inpatient hospitalization.

The county has experienced significant population growth and a steady increase in the volume of individuals experiencing a psychiatric crisis resulting in an increased demand for treatment resources and less restrictive services. For example, during fiscal year (FY) 13/14 approximately **18,893** consumers were assessed for crisis services by DBH mental health outpatient clinics. This is an average of **1,574** a month, or **363** each week. Overall, for FY 13/14, DBH provided mental health services to **42,280** unduplicated clients. This level of demand has had an adverse affect on law enforcement, hospital emergency departments, and has substantially impacted the availability of inpatient psychiatric beds which could otherwise be utilized in a more appropriate manner. Additionally, the implementation of the Affordable Care Act (ACA) in 2014, and the increasing behavioral health needs of the current population has made it necessary to proactively implement strategies that will expand access and capacity.

Artwork by Isabel Figueroa

The county currently has a crisis response system which provides services at several points of access where individuals experiencing a psychiatric crisis are located, including homes, schools, and hospital emergency departments. The county's current continuum of crisis services consists of the Community Crisis Response Teams (CCRTs), Crisis Walk-In Centers (CWICs), and the Psychiatric Triage Diversion program located in the County's Arrowhead Regional Medical Center (ARMC) Behavioral Health Triage Unit. All of these services were implemented in 2007 and have been sustained through the Mental Health Services Act (MHSA), Community Supports and Services (CSS) Funding. A review of the current continuum of care for crisis services for adults reveals the system is impeded due to a lack of appropriate levels and capacity for alternative destinations for stabilization and treatment to serve consumers in crisis, who often have little choice but to seek inpatient hospitalization.

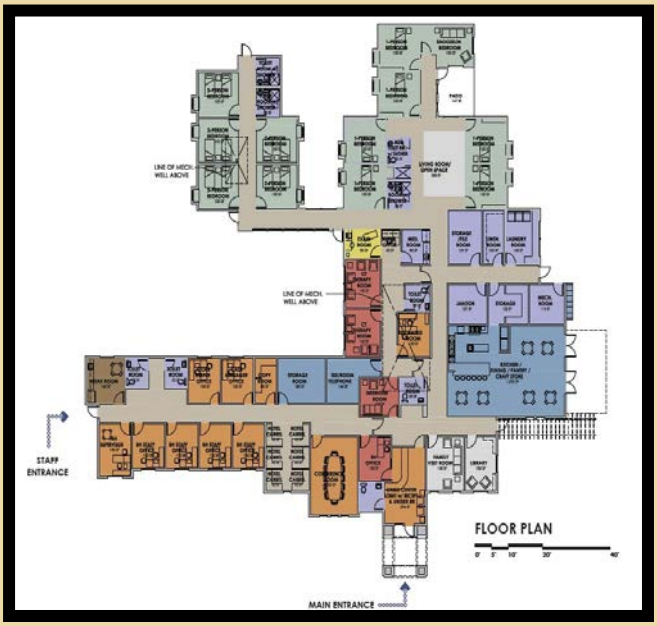
Accordingly, DBH is in the process of creating three CRTs that provide recovery based services and interventions as well as step down services from hospitalization or incarceration for adult individuals requiring a higher level of care than outpatient services. The three CRT facilities are unlocked, voluntary, short-term 16 bed crisis residential treatment centers for San Bernardino County residents. The additional beds at the three facilities will increase annual bed capacity by **17,520** bed days (**48** beds X **365** days = **17,520** bed days or **15,768** at a **90%** level of usage).

Description of New Crisis Residential Treatment Program and Services

The three CRTs in development will be **16**-bed crisis residential treatment facilities located in San Bernardino County. The CRT facilities will consist of a homelike environment that supports and promotes the individual's recovery, wellness and resiliency (RWR) in the community. Each facility will be designed to accommodate a living/common space area, family room, group rooms, separate interview rooms, bedrooms designed with separate living and visiting spaces, laundry, cooking facilities and outdoor patio and gardening areas. The CRT program is designed to empower and support diverse individuals in the process of stabilization and transition to outpatient services. The CRT program will provide the following structured recovery-based, enriched treatment services and activities:

Preliminary Architectural Plan of San Bernardino

- Housing.
- Psychiatric/medication support.
- Comprehensive clinical assessments and therapies.
- Life skills coaching.
- Peer and family support networks.
- Coping techniques.
- Recovery education.
- Community resource linkages.



Preliminary Floor Plan of CRT in San Bernardino

Additionally, the program will provide crisis intervention for individuals diagnosed with mental health and/or co-occurring substance use disorders. Services will be culturally and linguistically appropriate, allow for freedom of choice and will embrace recovery principles.

- All consumers will have a medical assessment within **24** hours of entering the program.
- Staff shall observe, monitor and document the consumer's status and develop an individualized service plan within **24** hours of admission into the program.
- The client service plan will be generated with the consumer's participation and identify specific goals and objectives.
- Consumers shall be actively involved in ongoing planning, review of progress towards goals, and evaluation of their treatment.

Overview of Stakeholder Process: New Programs

CRT Program Target Population

The CRT's target population will serve diverse county residents ages 18 and older, experiencing acute psychiatric crisis who will benefit from short-term crisis residential treatment services as an alternative to hospitalization or incarceration. This includes:

- Individuals who are at risk of danger to themselves and/or others.
- Individuals who normally seek inpatient hospitalization, but will in fact benefit from a lower, less restrictive level of care.
- Individuals who are acutely and Seriously Mentally Ill (SMI) who are unserved, underserved or inappropriately served and who do not receive the appropriate services to meet their specialized needs.

Target Population

- Adults

Projected Number to be Served FY 16/17

- 750 Adults

DBH estimates the impact to the target population (based on a two week length of stay) will be **1,251** new, individual admissions of crisis residential treatment annually, based on the **90%** usage. The program will take referrals and transfers directly from hospital emergency departments and from designated psychiatric hospitals when an individual does not need inpatient hospitalization. Referrals and admission will also be accepted from law enforcement, DBH's CCRTs, CWICs, Full Service Partnerships, Adult Systems of Care, as well as community based organizations, shelters and self-referrals.

MHSA Legislative Goals and Related Key Outcomes

- Increase Access to Services.
  - ◊ Increased number of clients served.
  - ◊ Increased penetration rate.

- Reduce the frequency of emergency room visits and unnecessary hospitalizations.
  - ◊ Reduced administrative hospital days.
  - ◊ Increased use of alternative crisis interventions.
  - ◊ Increase in number of individuals diverted from hospitalization.

Community and Stakeholder Involvement in CRT Program

In February 2012, DBH conducted a community planning process to obtain stakeholder feedback regarding the mental health needs to be addressed through Mental Health Services Act (MHSA) Prevention & Early Intervention (PEI) programs. Meetings were held in the High Desert, Central valley region, and the West Valley Region in which participants identified Access to Services as a significant need. Stakeholders expressed concern over the need for physical availability and accessibility of facilities, programs and services. Over the years, the need for, and access to, additional services, resources and supports in has continued to be a concern and a priority for stakeholders.

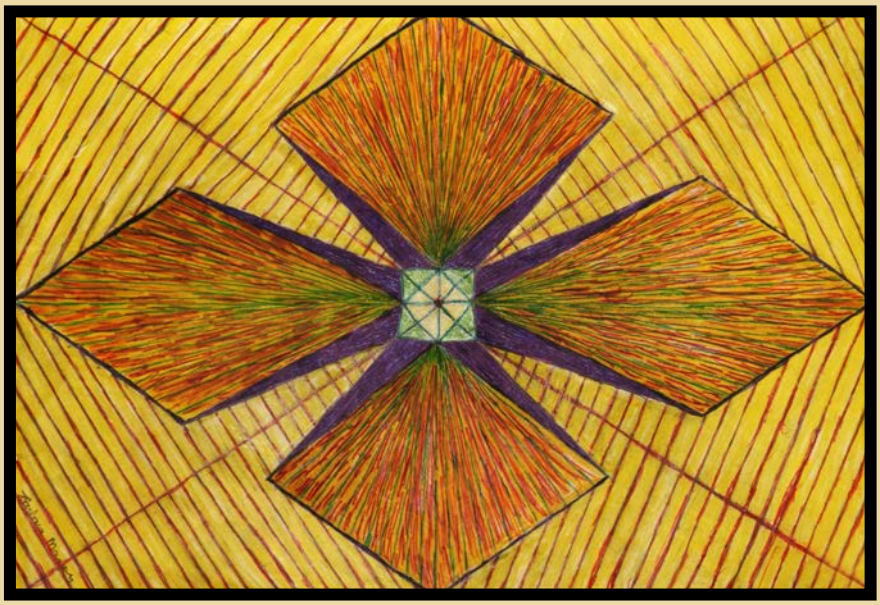
Artwork by Barbara Mason

Overview of Stakeholder Process: New Programs

In an effort to introduce individuals to this new CRT program, DBH has initiated its outreach proactively by working with respective County partners, cities and city officials and informing the DBH Commission, hospitals throughout the county, law enforcement and other stakeholders of the need and plans to expand access and capacity by developing a CRT program. As the program is established, extensive outreach services to the respective cities, local officials and residents of the cities of San Bernardino, Victorville, and Ontario will continue to be essential. Informational brochures and newsletters regarding CRT services will be created and distributed to hospital emergency departments, inpatient psychiatric hospitals, outpatient clinics, law enforcement briefings and posted on the San Bernardino County DBH websites, all county social media sites along with current crisis services information. Presentations will be conducted at relevant meetings such as Planning Department and neighborhood meetings. Community events in the area will be planned for residents in the neighborhood and community where the CRT facilities will be located.

Funding and Leveraging

In order to fund the construction of these facilities and leverage available funding for this new program, DBH has applied for grants through the California Health Facilities Financing Authority (CHFFA). CHFFA awarded DBH three grants to construct new **16-**bed CRT Program facilities. These grants will provide funding for the construction and furnishing of the CRT facilities. Ongoing CRT program activities will be sustained through a combination of Medi-Cal funding and MHSA CSS funding.



Artwork by Barbara Mason

DBH intends to leverage existing budgeted MHSA funding reserved and received for this proposed project to expand capacity and access to crisis services. DBH will leverage in-kind services from its Housing & Employment and Homeless Outreach Supportive Team (HOST) programs that will have staff made available to be on site to successfully link individuals to appropriate housing and employment in the community upon discharge. Space will also be made available for Transitional Assistance Department staff to aid individuals with accessing health benefits, training and employment and other appropriate state benefits. The establishment of benefits will facilitate full access to comprehensive integrated care. It will also enable DBH to generate revenue for services provided.

Regional Adult Full Services Partnership

New!

The Regional Adult Full Service Partnership (RAFSP) offers Full Service Partnership (FSP) programs in all clinics in every region of San Bernardino County. The RAFSP programs include intensive services that both assist individuals to step down to a lower level of care and services to assist at-risk individuals to receive services in the least restrictive setting possible.

Artwork by Michael Schertell

The Full Service Partnership (FSP) is a vital component of DBH and provides a broad array of integrated services and a supportive system of care for adults who are living with severe mental illness. Priorities identified for the program focused on the unengaged homeless, those with co-occurring disorders, and high users of crisis and hospital services. The Program serve those who are at imminent risk of homelessness, incarceration, hospitalization or re-hospitalization. The RAFSP seeks to serve those individuals with Serious Mental Illness (SMI) who are unserved, underserved or inappropriately served and who do not receive the appropriate services to meet their specialized needs. The strategies are recovery oriented and incorporate cultural competence and evidence-based practices.

The FSP promotes the principles of recovery, wellness, and resiliency to assist individuals to have lives that are more satisfying, hopeful, and fulfilling based on their own values and cultural framework. Mental health services provided at outpatient clinics focus on the client's strengths and possibilities so they can move toward new levels of functioning in the community.

Individuals requiring this level of care are often unable to maintain independence in the community without the assistance of intensive case management support. The ratio of staff to consumers is one (**1**) to ten (**10**) to allow for intense support of the consumers **24** hours a day/**7** days per week. The FSP offers a true one-stop shop of all available resources such as housing, interim assistance, medication support services, therapy, and intensive case management and care coordination. FSP service providers help individuals cope with the behavioral health challenges by linking them to community programs and agencies through direct, one-to-one support. Individuals in RAFSP treatment services include clinical assessments, risk assessments, housing placement, coordination of care with mental health and substance abuse outpatient clinics and physical healthcare physicians and insurance providers.

Those who have been homeless come into the program with many physical problems which intensive case managers support in getting resolved through linkage and transportation to community based healthcare providers. In addition, employment preparation and support services are provided to help the FSP reintegrate into the job market or aid the individual in obtaining entitlements such as Supplemental Security Income (SSI) as each individual's needs dictate.

Over view of Stakeholder Programs: New Programs

Description of New Regional Adult Full Service Partnership Services

The RAFSP encourages individualized decision making, focuses on the individual's abilities to make choices, and reinforces self-responsibility. Consumers shall be actively involved in ongoing planning, review of progress towards goals, and evaluation of their treatment. Additional services include activities that support consumers in their efforts to restore, maintain, and develop interpersonal and independent living skills

The FSP offers a true one-stop shop of all available resources such as housing, interim assistance, medication support services, therapy, and intensive case management. FSP service providers help individuals cope with behavioral health challenges by linking them to community programs and agencies through direct, one-to-one support. Individuals in RAFSP treatment services include clinical assessments, risk assessments, housing placement, coordination of care with mental health and substance use disorder services and physical healthcare physicians. Under this framework, Regional Adult FSPs can provide for the needs of individuals in need of intensive medication support, complex care coordination, such as eating disorders, or other voluntary medical interventions.

RAFSP Target Population

The RAFSPs target population will serve diverse county residents ages 18 and older, experiencing and/or living with serious mental illness who will benefit from wraparound treatment services.
This includes:

- The unengaged homeless.
- Individuals living with co-occurring disorders.
- High users of crisis and hospital services.
- Those who are at imminent risk of homelessness, incarceration, hospitalization or re-hospitalization.
- Underserved individuals who do not receive the appropriate services to meet their specialized needs.

Target Population:
- At Risk Adults

Projected Number to be Served FY 2015/2016:
- 451

MHSA Legislative Goals of CSS

- Reduce the Subjective suffering from serious mental illness for adults and serious emotional disorders for children and youth.
  - ◊ Improve life satisfaction
  - ◊ Decrease hopelessness
  - ◊ Increase resiliency
- Reduce homelessness and increase safe and permanent housing.
  - ◊ Decrease rate of homelessness for clients
- Increase access to treatment and services for co-occurring problems; substance abuse and health
  - ◊ Increase access to treatment and services for co-occurring problems; substance abuse and health
- Reduction in criminal and juvenile justice involvement
- Reduce the frequency of emergency room visits and unnecessary hospitalizations.
- Increase a network of community support services

Overview of Stakeholder Process

> ***WIC § 5848*** *states that an Annual Update shall be prepared and circulated for review and comment for at least 30 days to representative of stakeholder interests and any interested party who has requested a copy. Additionally the mental health board shall conduct a public hearing on the draft Annual Update at the close of the 30 day comment period.*

Public Review

The DBH MHSA Annual Update was posted on the department's website from **April 1, 2016 through May 1, 2016**, at www.sbcounty.gov/dbh. The Public Hearing to affirm the stakeholder process is scheduled to take place at the regularly scheduled Behavioral Health Commission Meeting on **May 5, 2015** which is held from **12:00 p.m. until 2:00 p.m.**

The Department invites you to review this and other plans and provide feedback or comments to the plan, not just during the **30** day comment period. Please see the next section of this report for detailed instructions on how to submit comments under the Substantive Comments/Recommendations section of this report.

Substantive Comments/Recommendations

An analysis of substantive recommendations is included in the Public Posting and Comment section of this final MHSA Annual Update for FY 2016/17. Comments/recommendations can be submitted via email to the DBH MHSA email box at MHSA@dbh.sbcounty.gov during the time the MHSA Annual Update draft is posted for public comment. Comments can be received anytime through the year but will not be included in the final plan. The plan is scheduled to be posted for 30-days per Welfare and Institutions code 5848 between **April 1, 2016 through May 1, 2016** at www.sbcounty.gov/dbh.

If you would like to request a comment form be sent to you please contact DBH at MHSA@dbh.sbcounty.gov or call **1-800-722-9866** for more information.

During the stakeholder meetings for this MHSA Annual Update community members asked how they might get additional information on what behavioral health services are available in the county. The County has an "Access Unit," that can be called for assistance in locating services and can be reached at **1-888-743-1478**. Service directories are also available online at http://www.sbcounty.gov/dbh/dos/template/Default.aspx.

During stakeholder meetings, it was noted that community members would like information about how to access funds related with MHSA programs for their areas. The department releases several Requests for Proposals (RFPs) every year through a procurement process. MHSA funds can be accessed by successful applicants who participate in the procurement process and are determined to meet criteria for RFPs.

RFP's may be accessed at the county website per the following link: http://www.sbcounty.gov/main/rfp.asp. More information on the department's RFP process will be provided over the course of the next year at the Regional District Advisory Committee meetings.

Overview of Stakeholder Process

District Advisory meeting dates may be found at the following link http://www.sbcounty.gov/dbh/mhcommission/mhcommission.asp#. For meetings in which RFPs are on the agenda, outreach will be done to inform interested community members of the time and dates of the meetings.

DBH encourages and supports community collaboration, particularly the involvement of stakeholders, in all aspects of the MHSA programs provided. To address concerns related to DBH MHSA program issues in the areas of access to mental health services, violations of statutes or regulations relating the use of MHSA funds, non-compliance with MHSA general standards, inconsistency between the approved MHSA Plan and its implementation, the local MHSA community program planning process, and supplantation, please refer to the MHSA Issue Resolution process located at http://www.sbcounty.gov/dbh/SPM/Manual_Docs/COM0947.pdf.

Community members do not have to wait for a meeting to provide feedback to the department. Feedback can be provided at any time via email or phone at MHSA@dbh.sbcounty.gov or by calling **1-800-722-9866**. As program data, outcomes, statistics and ongoing operations are discussed on a regular basis, regular attendance at one or more of the meetings listed above is encouraged. The Community Policy and Advisory Committee (CPAC) specifically addresses MHSA programs and occurs monthly. If you would like to be added to the invite list for CPAC's meetings, please email MHSA@dbh.sbcounty.gov.

As feedback is collected from the community, it is analyzed with county demographic information, prevalence and incidence rates for behavioral health services, specific treatment information collected by programs, clients served, number and types of services provided, geographic regions served by zip code, data provided to the department by state agencies evaluating access to county services, cultural and linguistic needs, poverty indexes, current program capacity and demonstrated needs in specific geographic regions and areas within the system of care (i.e., inpatient, residential, long term care, day treatment, intensive outpatient, general outpatient care), and program needs are considered.

Assistance for Disabled Individuals:

A good resource for finding services to support developmentally and physically disabled adults would be to the utilization of the **2-1-1** service. The **2-1-1** service is a free and confidential service, available 24-hours a day, providing information and resources for health and social services in San Bernardino County. Call **2-1-1** or visit the website at www.211sb.com, to find resources nearby.

Once the plan is written and posted, feedback is regularly solicited on the content of plans/programs while plans are posted for public review. Feedback/comments can be submitted via email or via the phone at MHSA@dbh.sbcounty.gov or **1-800-722-9866**. If feedback is received it may be incorporated into the new program plan, or if not incorporated, addressed in the final draft MHSA Annual Update FY 2016/17, as to why it was not incorporated.

Depending on the program proposal, services can be provided by DBH clinics or organizational contract providers. In many cases, programs are implemented using both DBH clinics and organizational contract providers working together to provide services in a system of care framework. For services provided by organizational providers, an RFP/procurement process is required. The RFP process can be accessed via the link above and is as follows http://www.sbcounty.gov/main/rfp.asp.

Additional information about past MHSA approved plans can be accessed at the following link http://www.sbcounty.gov/dbh/mhsa/mhsa.asp#. If you have any questions about MHSA programs in general or programs as detailed in this MHSA Annual Update, please email or call the department at MHSA@dbh.sbcounty.gov or **1-800-722-9866**.

During the stakeholder meetings, participants also mentioned specific topics for which they would like more information. In reviewing this feedback, DBH would like to respond that some of these areas are already being addressed within our current system of care or by other community resources.

Reduction of Discrimination and Stigma:

Prevention and Early Intervention (PEI) Programs focus on reducing stigma and discrimination. The programs are tailored to be culturally and linguistically competent and meet the identified needs of the communities they serve. Services offered include prevention services and leadership programs for children, youth, transitional age youth, adults and older adults, mental health education workshops, community counseling, adult skill-based education programs and parenting support. Additional information regarding PEI programs can be obtained by calling **1-800-722-9866**.

Support for Parents and Caregivers:

The Family Resource Centers (FRC) offer various programs that are tailored to be culturally and linguistically competent and meet the identified needs of the communities they serve, including parents and caregivers. Services offered include: prevention and leadership programs for children, youth, transitional age youth, adults and older adults; mental health education workshops; community counseling; adult skill-based education programs and parenting support. Additional information regarding FRC programs can be obtained by calling **1-800-722-9866.**

Innovation Projects:

Current Innovation projects are discussed in detail in the Innovation Project section of this report. To date, five (**5**) Innovation projects have ended and three (**3**) final reports have been published. Of the five projects, two (**2**) projects had final reports published in the MHSA Three-Year Integrated Plan, and one (**1**) project had the final report included in the Fiscal Year 2014-15 Annual Update. Of the two (**2**) remaining projects that have ended, both final reports are contained in this Annual Update, and are included in the Fiscal Year 2015-16 Annual Update, detailing project outcomes, successes and what practices will be continued based on learning during the project. Additional information regarding Innovation can be obtained at **1-800-722-9866**.

Shelter Beds and Homeless Assistance:

The Office of Homeless Services (OHS) plays a vital role in the San Bernardino County Homeless Partnership as the administrative support unit to the organization. OHS insures that the vision, mission and goals of the Partnership are carried into effect. Homeless services information and resources can be found at the San Bernardino County Homeless Partnership website: http://www.sbcounty.gov/dbh/sbchp/. The focus of the partnership is to develop a countywide public and private partnership and to coordinate services and resources to end homelessness in San Bernardino County.

The **2-1-1** website offers a guide available to homeless service providers and a list of homeless resource centers. For specific areas in need that may not be available on the websites resources there is the option of dialing **2-1-1** to access the most comprehensive database of free and low cost health and human services available in the county. Call **2-1-1** or visit the website at www.211sb.com, to find resources nearby.

In addition to the available resources from the OHS regarding homeless services, DBH provides services from the Community Crisis Response Team (CCRT) and the Crisis Walk-in Centers (CWIC) throughout San Bernardino County to reduce incidents of acute involuntary psychiatric hospitalization, reduce the amount of calls to law enforcement for psychiatric emergencies, reduce the number of psychiatric emergencies in hospital emergency departments, reduce the number of consumers seeking emergency psychiatric services form hospital emergency departments, reduce the amount of time a patient with a psychiatric emergency spends in hospital emergency departments and increase consumer access to services. Additional information regarding Community Crisis Response Team (CCRT) and Crisis Walk-in Centers (CWIC) can be obtained through the access unit hotline for 24-hour crisis and referral information which can be reached at **1-888 743-1478.**

Community Education and Resources:

Community Outreach and Education (CORE) provides outreach and education throughout San Bernardino County. It is a component found in many of our MHSA funded programs. In addition to providing education, resources, and linkages to services, it also assists with reducing stigma. The Community Outreach and Education (CORE) department within DBH attends and completes outreach to community events throughout the year. Additional information about CORE activities and obtaining information about department program and services can be obtained by calling **(909) 388-0938**.

Thank you for your participation in our county stakeholder processes. We greatly value your time and feedback as we work to serve the residents of San Bernardino County, as well as the opportunity to provide you this feedback on your requests for more information during the MHSA Annual Update stakeholder meetings.

Public Posting and Comment

DBH would like to thank those who participate in the public comment portion of the stakeholder process. During the thirty (**30**) day public posting of the MHSA Annual Update, DBH will continue to promote the thirty (**30**) day posting and provided overviews and information related to the MHSA Annual Update. All thirty-three (**33**) San Bernardino County Public Libraries receive a copy of the posted plan including instructions for submitting feedback. A press release, in English and Spanish, notifying the public of the posting will be sent to fifty- one (**51**) media outlets. A series of web blasts will be released to all DBH clinics, contracted provider agencies, the Community Policy Advisory Committee, the Cultural Competency Advisory Committee and all subcommittees, the Association of Community Based Organizations, the Behavioral Health Commission, will be included on all DBH sponsored social media sites, including Facebook and Twitter, and will be posted on the main San Bernardino County website. The MHSA Coordinator will make printed copies of the plan available, upon request, and will ensure printed copies are present in all DBH Clubhouses and ADS Recovery Centers. An Summary and Analysis of the thirty (30) day Public Review and Comment period will be included in the final report and will include any substantive changes to the draft. The next several pages are intentionally left blank as space holders for the final version of the plan.

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Public Hearing

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Artwork by Kathy Joy

Prevention and Early Intervention (PEI)

Introduction to Prevention and Early Intervention

Introduction

Prevention and Early Intervention (PEI) program services are intended to implement strategies to prevent mental illness from becoming severe and disabling, emphasizing improvement in timely access to services for underserved populations. Strategies and activities are implemented early on to deter the onset of mental health conditions or relapse among individuals and to change community conditions that contribute to risk factors for developing behavioral or mental health issues.

PEI incorporates the values of cultural competence, consumer and community empowerment, collaboration and inclusion in providing services that emphasize recovery, wellness and resiliency. As such, PEI programs continue to strive to meet the priority needs identified by local diverse community stakeholders, meet the key community and priority population needs outlined in the Mental Health Services Act (MHSA) PEI guidelines, and continue to transform the public mental health system. Services fall within three Institute of Medicine (IOM) categories: Universal, Selective, or Early Intervention. Universal services are targeted at an entire community not identified on the basis of individual risk; Selective services provide strategies to deter the onset of a mental illness among individuals and change community circumstances that contribute to behavioral health problems; Early Intervention services are directed toward individuals exhibiting early signs of a mental illness or early onset of mental illness or emotional disturbance with psychotic features.

Artwork by Greg Vander

MHSA Legislative Goals of PEI

The overall Mental Health Service Act (MHSA) goals of PEI include:

- Suicide reduction.
- Reduction of incarcerations.
- Reduction of school failure/dropout rates.
- Reduction of unemployment among mental health consumers.
- Reduction of prolonged suffering.
- Reduction of homelessness among consumers.
- Reduction of stigma and discrimination associated with mental illness.
- Reduction in the number of minor consumers removed from their home.

San Bernardino County's PEI Plan

In 2008, San Bernardino County (County), Department of Behavioral Health (DBH) and community stakeholders embarked on an extensive community planning process to identify priorities and strategies and to develop concepts to be included in the PEI Component Plan for approval by the State.

Introduction to Prevention and Early Intervention

DBH's PEI Plan was approved on September 25, 2008, which originally included twelve programs. A thirteenth program was added into the three year plan as the result of a successful Innovations project. All programs are categorized under three initiatives or "access points".

1. School Based Initiative.
2. Community Based Initiative.
3. System Enhancement Initiative.

School Based Initiative

The School-Based Initiative is designed to strengthen student health and wellness. The goal is to reduce risk factors, barriers and/or stressors that can contribute to mental illness while building protective factors and supports, and providing appropriate interventions at schools and after school programs. School-Based PEI programs include:

- Student Assistance Program (SAP).
- Preschool PEI Program (PPP).
- Resilience Promotion in African-American Children (RPiAAC).

Community Based Initiative

The goal of the Community-Based Initiative is to build and strengthen the capacity of communities to provide prevention and early intervention opportunities and community empowerment activities in natural settings. Community Based PEI programs include:

- Promotores de Salud/Community Health Workers (PdS/CHW).
- Family Resource Centers (FRC).
- Native American Resource Center.
- National Curriculum and Training Institutes (NCTI®) Crossroads Education Program.

Artwork by Judy Whiting

System Enhancement Initiative

The goal of the System Enhancement Initiative is to build and strengthen collaboration across public service organizations and work to implement efforts to promote wellness across all systems. System Enhancement PEI programs include:

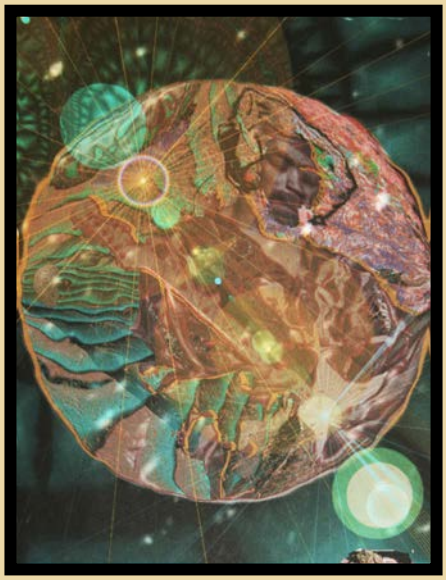
- Older Adult Community Services (OACS).
- Child and Youth Connection (CYC).
- Community Wholeness and Enrichment (CWE).
- Military Service and Family Support (MSFS).
- LIFT Home Visitation Program.
- Coalition Against Sexual Exploitation (CASE).

PEI Statewide Projects

In 2010, DBH PEI assigned one time funding to support implementation of PEI Statewide Projects intended to build PEI capacity across the state and locally via the California Mental Health Services Authority (CalMHSA). This effort was jointly initiated with other California counties, for the purpose of making a statewide and local impact.

The three statewide projects include:
1. Stigma and Discrimination Reduction.
2. Student Mental Health Initiative.
3. Suicide Prevention Program.

As part of the FY14/15-FY16/17 three year plan, the Department and its stakeholders reaffirmed the commitment to statewide PEI projects and contributed resources to support these continued efforts.



Artwork by Peter Millar

Stigma and Discrimination Reduction Initiative

GOAL: Strengthening schools (K-12) and higher education mental health programs, allowing these institutions the opportunity to develop/integrate/expand campus-based mental health services and supports.

ACTIVITIES:
- Networking and collaboration within and across educational institutions and/or other institutions addressing mental health issues.
- Informational/online resources.
- Training and educational programs for faculty, staff and students.

Student Mental Health Initiative

GOAL:
Eliminating stigma and discrimination against individuals with mental illness.

ACTIVITIES:
- Development of policies/protocols/procedures.
- Informational/online resources.
- Training and education.
- Media and social marketing campaigns.

Suicide Prevention Initiative

GOAL:
Support and coordinate with counties on the implementation of the California Strategic Plan on Suicide Prevention.

ACTIVITIES:
- Networking and collaboration activities.
- Trainings or educational programs for a broad range of audiences.
- Social marketing.
- Hotlines (web and text based crisis response services, and “warm lines”).

San Bernardino County Local Impact

Directing Change is a statewide contest that engages students in creating videos about suicide prevention and stigma and discrimination reduction. In 2015, **89** films were submitted from the following high schools from San Bernardino County: Granite Hills High School, Ruben S. Ayala High School, Etiwanda High School, Chino High School, Barstow High School, Ironwood Christian Academy, Apple Valley High School, Arroyo Valley High School and PAL Charter Academy. In addition, in 2015, **11** people from San Bernardino County judged films for the statewide contest and participated in a one-hour training on appropriate messaging about suicide prevention and mental health.

Artwork by Faith Forsey

In addition, San Bernardino County, in Collaboration with Riverside County hosted its second annual local screening and award ceremony on May 14th, 2015 at the Lewis Family Playhouse where local student winners were announced and recognized for their films. All participating schools were offered suicide prevention programs and an Ending the Silence presentation from NAMI California.

The **Walk In Our Shoes** campaign is an integrated communications campaign that reaches out to youth ages 9 – 13 to introduce the topic of mental health through a variety of mediums, such as an interactive website and musical school performance. The goal of this campaign is to educate youth about mental illness and promote understanding and empathy towards individuals experiencing a mental health challenge.

One of the ways in which this targeted age group was reached in San Bernardino County, was through a live school play that was produced and performed at 6 schools: Soar Charter Academy, Butterfield Ranch Elementary, Hidden Trails Elementary, Eagle Canyon Elementary, Martin Luther King Middle, and Country Springs Elementary. These performances reached **2,184** students and enabled them to learn about empathy towards people with mental health challenges and allowed for an interactive Question & Answer session to further strengthen their knowledge of mental health.

Artwork by Christopher Snyder

San Bernardino County organizations received **Each Mind Matters** community engagement mini-grants to combat stigma and discrimination related to mental illness. The University of the Redlands' Alliance for Community Transformation and Wellness, received a grant to reach university medical and healthcare students, faculty, and the general public of the Inland Empire with stigma and discrimination reduction efforts. African American faith centers and churches received a grant to support their with stigma and discrimination reduction efforts. San Bernardino Valley College's Mind and Matter Psychology Club and CSU San Bernardino's Active Minds Club each received a Lime Green Ribbon Partner School mini-grant to reach students and faculty with education and awareness activities for Mental Health Matters Month May 2015. Additionally three **(3)** high schools: Chino High School's NAMI On Campus Club, Fontana High School's NAMI On Campus Club, and Ayala High School's NAMI On Campus and Psychology Club - each received a Lime Green Ribbon Partner School mini-grant to reach students and faculty with education and awareness activities for Mental Health Matters Month May.

San Bernardino County Local Impact, continued

Also supported by **Each Mind Matters** campaign, San Bernardino County enhanced the use of statewide resources at the local level. Resources were directed toward various regions and included, one month of theater ads featuring a Directing Change film, advertisement at San Bernardino 66ers Stadium for **12** months and a Know the Signs website intro video played in English and Spanish as part of a **12** month Department of Motor Vehicles (High Desert Location) media buy.
The ***Know the Signs*** suicide prevention campaign informs Californians of three things: warning signs for suicide, how to talk to someone about suicide, and how to identify helpful resources. In FY 14/15, **63,169 Know the Signs** materials in English, Spanish, Chinese, Hmong, Lao, Tagalog, and Vietnamese were provided to **7** organizations. In addition, through ***Know the Signs*** suicide prevention efforts, **16** individuals participated in a train the trainer workshop and were trained to conduct one hour suicide prevention workshops in primary care clinics.

Applied Suicide intervention Skills Training (ASIST) is a training for caregivers who want to feel more confident and competent in helping to prevent the immediate risk of suicide of those at-risk for suicide. In San Bernardino County, **120** individuals were trained in *ASIST* due to an early investment allowing local individuals to become certified trainers.

safeTALK is a suicide alertness training that prepares caregivers, students, teachers, community volunteers, first responders, military personnel, police, public and private employees, and athletes to become suicide-alert helpers. In March of 2015, **30** Promotores de Salud (Community Health Workers) were trained in *safeTALK and how to use* El Rotafolio (flip chart) to conduct culturally competent presentations to the Latino communities.

Responding to Policy Change

Artwork by Isis Torres

On October 6, 2015, updated Prevention and Early Intervention (PEI) Component Regulations, designed by the Mental Health Services Oversight and Accountability Commission (MHSOAC), became effective. The updated regulations changed the framework and structure of the PEI component as compared to the guidance received via Department of Mental Health in 2007 from the Information Notice 07-19.
The majority of change relates to the guiding principles and concepts outlined in the DMH-IN 07-19. The principles are now parceled out and defined as individual Programs described as "a stand-alone organized and planned work, action or approach that evidence indicates is likely to bring about positive mental health outcomes either for individuals and families with or at-risk of serious mental illness or for the mental health system (§3701 (b))." A copy of the regulations can be located via the following link: http://mhsoac.ca.gov/Laws_Regs/docs/PEI_Final_Adopted_Oct_2015.pdf. The illustrations on the following pages provide a description of the State Programs as defined by the updated regulations.

Introduction to Prevention and Early Intervention

State Defined Prevention and Early Intervention Programs

Early Intervention

- Mental Health Treatment, including relapse prevention, intended to promote recovery and related functional outcomes for a mental illness early in its emergence.
- Length of Services:
  - 18 months
  - If individual is identified living with SMI with psychotic features, up to four years of service allowed
- Can be combined with Prevention Program

Outreach for Increasing Recognition of Early Signs of Mental Illness

- Process of engaging, educating, and/or training **potential responders** about ways to recognize and respond to early signs of potentially severe and disabling mental illness.
- Individuals who can identify early signs of severe and disabling mental illness to provide support, and/or refer individuals to treatment or other mental health services.
- Outreach may include reaching out to individuals with signs and symptoms of a mental illness, so they can respond to their own symptoms.

Prevention

- A set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors.
- The goal is to improve mental health for individuals/groups whose risk of developing a potentially serious mental illness is greater than average.
- Prevention services may include relapse prevention for individuals in recovery from a serious mental illness and population health prevention services.

Stigma and Discrimination Reduction

- Activities that reduce negative feelings, attitudes, beliefs, perceptions and/or discrimination related to being diagnosed with a mental illness or to seeking mental health services
- Activities increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and members of their families.
- Programs include approaches that are culturally congruent with the values of the populations for whom changes are intended.

Access and Linkage to Treatment

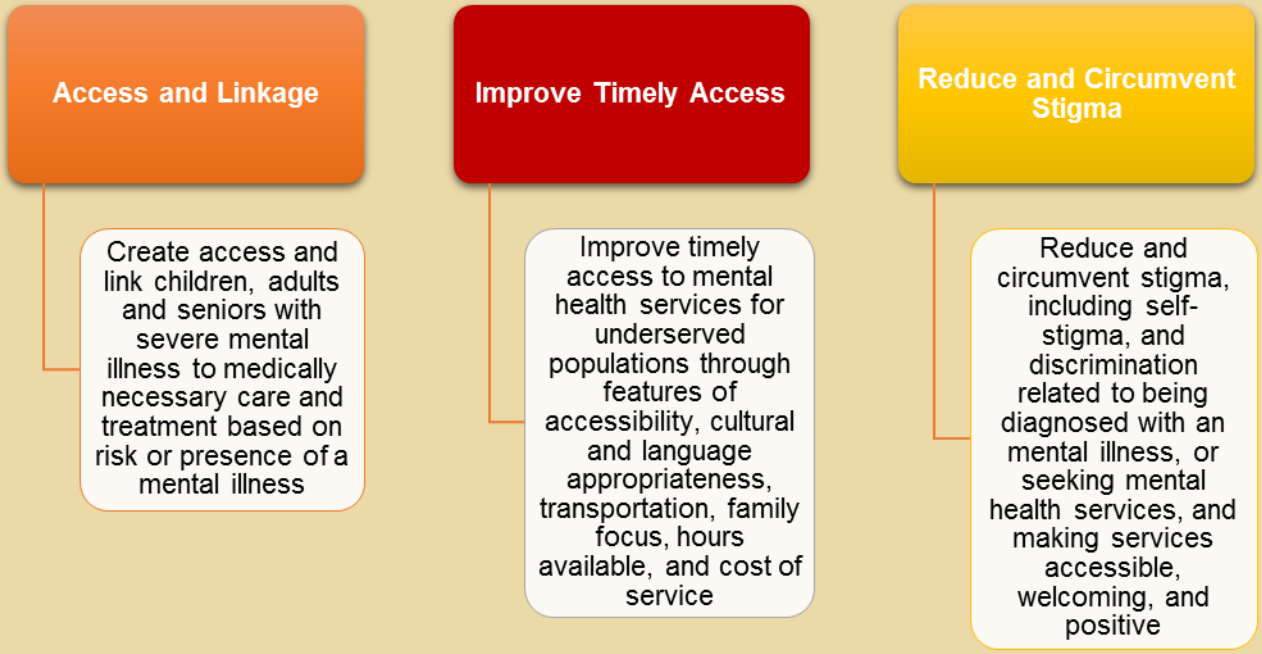
- Related activities to connect children, adults and seniors with severe mental illness as early in the onset as practicable, to medically necessary care and treatment.
- These types of programs can include but are not limited to screening, assessment, referral, telephone help lines, and mobile response.
- Includes targeted access and linkage activities for cultural populations

Suicide Prevention (Optional)

- Organized activities that the County undertakes to prevent suicide as a consequence of mental illness without focus on or intended outcomes for at-risk individuals
- These types of focused activities may be part of a prevention program or an early intervention program.
- This program is **optional**, includes, but is not limited to, strategies such as information campaigns, survivor-informed models, screenings, training, and education.

Responding to Policy Change, continued

In addition, all Programs described above, must include the three **(3)** strategies outlined in (§3735). Each of those three **(3)** Strategies is described below:



Operating Under a New Construct

Prior to the finalization of the PEI regulations, DBH consistently included the draft regulations as a topic of discussion at stakeholder meetings such as the Community Policy Advisory Committee (CPAC), the Association of Community-Based Organizations, the Prevention and Early Intervention (PEI) Network, the System-wide Performance Outcomes Committee, and the MHSA Executive Committee. Stakeholders and staff were provided updates on the process and the pending changes. During CPAC and PEI Network meetings, special sessions were held to engage stakeholders in the analysis of the current structure and framework of the PEI Component as compared to the new State Program categories, as defined in the updated regulations. The MHSA Coordinator presented the Programs and Strategies as defined in proposed, at the time, statute and subsequently presented the current MHSOAC approved PEI Component programs. Stakeholders, who were seated at tables in groups of 4-10, were given the information and asked to determine which new required program reporting category best aligned with the existing PEI programs and mark their selections on a form. They were also asked to determine if the required strategies were already contained within each program. Both stakeholder groups reached consensus that the existing PEI Component programs meet the Program and Strategy requirements of the new regulations. However, it was also determined that how the PEI Component Programs are presented, the reporting structure, fiscal and claiming process, data collection and evaluation, and all PEI business processes will be required to change in order to meet the administrative demands required, including the development of a new automated reporting system. Additional feedback noted that the amount of funding directed toward actual services may decrease to meet the new evaluation standards and administrative requirements and that several of the required evaluation indicators will be highly difficult to implement.

In collaboration with stakeholders, implementation of the PEI Component will move forward under the new reporting construct as illustrated on the following page.

Introduction to Prevention and Early Intervention

Prevention and Early Intervention (PEI) Reporting Structure

Both Prevention and Early Intervention	•Family Resource Center •Military Service and Family Support •Community Wholeness and Enrichment
Outreach for Increasing Recognition of Early Signs of Mental Illness	•Promotores de Salud •Community Health Workers
Stigma and Discrimination Reduction	•Native American Resource Center
Access and Linkage to Treatment	•Child and Youth Connection
Prevention Only	•Student Assistance Program •Preschool PEI Program •Resilience Promotion in African-American Children •NCTI® Crossroads Education Program •Older Adult Community Services •LIFT Program •Coalition Against Sexual Exploitation

Artwork by Grace Comisso

School-Based Initiatives

Student Assistance Program PEI SI-1

Artwork by Faith Forsey

The Student Assistance Program (SAP) is a school-based approach that focuses on services for diverse students (grades K-12) and their families who are in need of prevention education and early interventions for substance abuse, mental health, emotional and social issues. This program supports students and their families by connecting behavioral health professionals and educators to provide programs and services that create a network of supports between schools and community based organizations. The SAP program minimizes barriers to learning, supports students in developing academic and personal successes, and helps shorten the duration of untreated behavioral health concerns. The core component of the program consists of professionally trained teams that include school personnel and staff from community behavioral health agencies. SAP team members are trained to identify potential barriers to learning and make recommendations that will assist both the student and their families. The SAP team coordinates services that will improve student wellbeing, and provides follow-up services to ensure success. When the student requires services that fall past the scope of the program, the SAP team refers the student and their families to additional resources and services within the community.

The SAP team responds to all student and family concerns with respectful dialogue, individualized service, ongoing staff and parent training, community support, and referrals to appropriate school or community based services as needed.

SAP services utilize science or research based curriculum, programs and practices such as:

- Second Step.
- Project Alert.
- Social Skills Group Intervention (S.S.GRIN).

Evidence-based clinical interventions utilized in SAP include Trauma Focused Cognitive Behavioral Therapy, Dialectical Behavior Therapy, and Motivational Interviewing.

Target Populations:

- Children
- TAY
- Adults

Projected Number to be Served FY 2015/16:

- 21,250 Children
- 2,750 TAY
- 3,500 Adult

MHSA Legislative Goals and Related Key Outcomes

Reduce School Failure and Dropout Rates Related to Behavioral Health Concerns:

◊ Increased school attendance.
◊ Increased subjective school connectedness.
◊ Lower rate of school dropouts related to behavioral health issues.
◊ Lower rate of failing students.
◊ Decreased school behavioral problems.
◊ Decreased school achievement problems.

School-Based Initiatives

Positive Results

SAP providers use the Global Assessment of Functioning (GAF) scores to track the progress of early intervention participants. GAF scores measure an individual's overall ability to carry out daily living activities and psychological, social, and occupational functioning. Participants' scores are noted at case opening and case closing. The GAF scores shown below demonstrate a **17%** improvement in functioning after participating in SAP services.

Fiscal Year 2014/15 Average GAF Scores for SAP Providers		
At Case Intake	**At Case Discharge**	**Improvement**
58	**68**	**17%**

The 40 Developmental Assets is a research based framework used with youth to identify the necessary internal and external assets that often lead to academic and personal success. These assets include skills, behaviors, experiences, and supportive relationships as well as environmental supports. Some SAP providers use the Developmental Assets Survey Tool to measure the progress of students in defined domains such as Support, Empowerment, and Positive Identity. In each domain, the student's level of developmental assets are measured using the following spectrum: Challenged, Vulnerable, Adequate, and Thriving.

Pre and Post test data indicates that students who participated in SAP services increased their developmental assets. As a result, a higher number of students identified as Adequate and Thriving as part of their asset development evaluation. On average, students receiving SAP services increased their level of internal and external assets by **16%**.

Success Stories

"Maggie" participated in an anger management group and stated that the group has helped her stay out of trouble. She was experiencing anger management issues and was gaining a reputation as bully. Maggie learned communication skills and strategies in her SAP group. It has helped her deal with conflicts in a non-violent manner. Her success in the group earned her the recognition of the group leaders and they subsequently nominated her to become a Safe School Ambassador. She now serves as a positive role model for a safer school climate.

"[SAP] has helped me to solve problems on my own."

-2nd Grade Student

"Rick" was having difficulties with grief and loss after the death of his father. Rick's difficulties with his grief and loss was having a negative effect on his success in school. During sessions with the SAP counselor, the student opened up and completed some activities to help address his feelings and attitudes about the loss of his father. After receiving these services, Rick was able to identify healthy coping skills to deal with the loss of his father and learned how to be a support system for his family.

Challenges

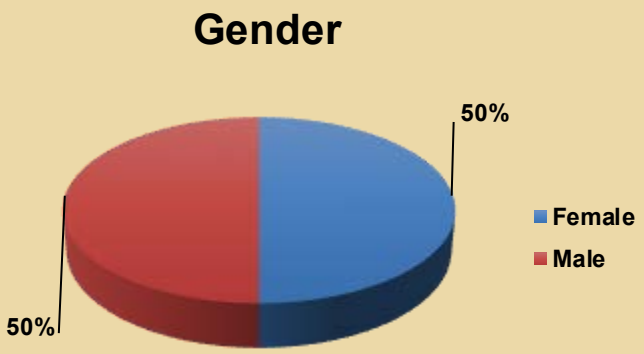
The SAP program providers encountered some challenges during the course of the year. Those challenges include a low number of referrals for early intervention services from May through September due to the school calendar year, difficulty obtaining permission slips from parents to participate in small group activities, and inconsistent group attendance by some students.

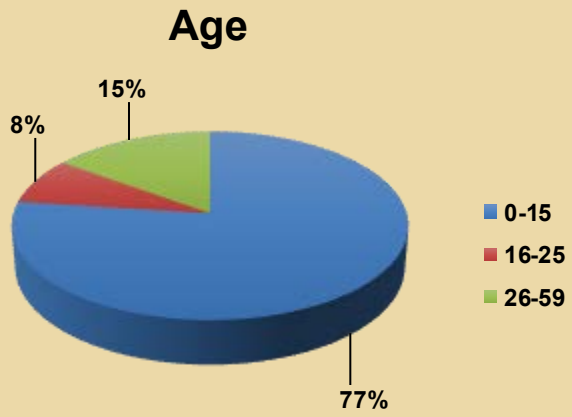
School-Based Initiatives

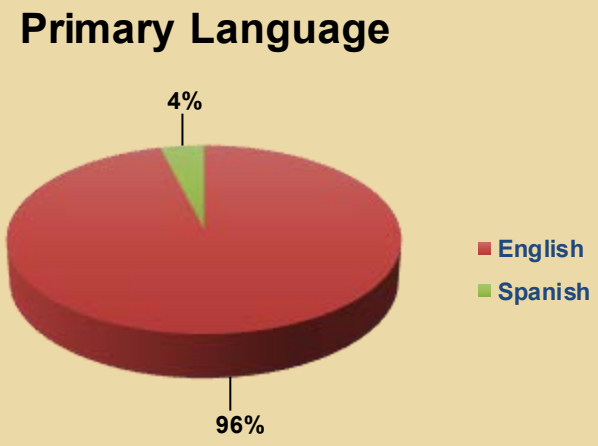
Solutions in Progress

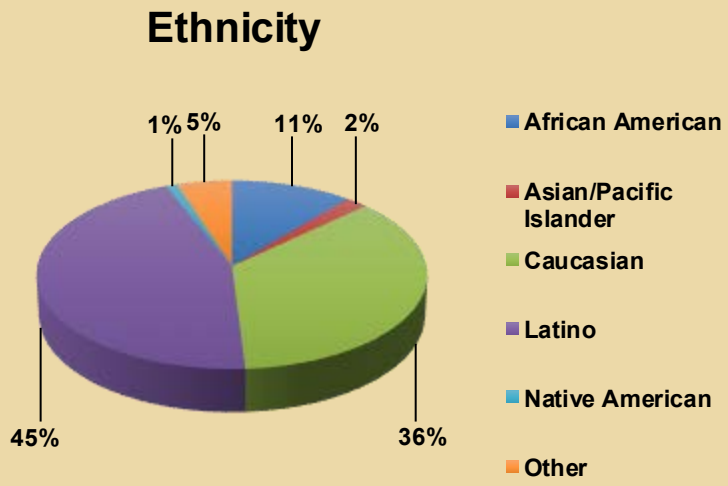
In an effort to overcome one of the main challenges with SAP, services have been established at schools that offer general summer programs and who are largely serving children who have been identified as being at risk. This allows for services to continue without interruption during the summer months when school is not typically in session. In addition, permission slips are now being distributed at the beginning of the year with enrollment paperwork and with individual student referrals to streamline the process for obtaining parent/guardian permission to participate in SAP services. Lastly, SAP program providers are working on improving their coordination and communication with school sites to ensure students attend groups regularly.

Fiscal Year 2014/2015 Program Demographics









Total Number Served/Unduplicated Count

Total Number Served	Unduplicated Count
82,889	39,321

School-Based Initiatives

Program Updates

In Fiscal Year 2016/17, there are no planned program changes or changes to the program budget.

Collaborative Partners

- Pacific Clinics.
- Reach Out West End.
- West End Family Counseling Services.
- Lutheran Social Services.
- Family Service Agency of San Bernardino.
- Desert/Mountain Children's Center.
- South Coast Community Services.
- Victor Community Support Services.
- Rim Family Services.
- San Bernardino County Superintendent of Schools.

Preschool PEI Program PEI SI-2

The Preschool PEI Program (PPP) provides supportive services for preschool children enrolled in the County's Head Start program and education for their parents and teachers. The goal is to prevent and reduce the occurrence of aggressive and oppositional behavior in preschool children. Doing so early in the child's life reduces problem behaviors later in life. The program is administered by the Preschool Services Department (PSD).

Artwork by Georgia Boniface

The program uses the Incredible Years curriculum that includes three components to train teachers, parents, and children. This evidence-based curriculum is designed to prevent, reduce, and treat conduct problems among preschool-aged children while increasing their social competence. The teacher component strengthens teaching and classroom management strategies to promote children's pro-social behaviors and school readiness. Some of those strategies include improving reading skills and reducing classroom aggression and non-cooperation with peers and teachers. The parent component provides techniques to help strengthen parenting competencies such as behavior monitoring and positive discipline. It also encourages increased parental involvement in a child's school experiences.

Additionally, PPP offers a bereavement and loss component referred to as Trauma, Loss, and Compassion, or TLC. Studies indicate that childhood trauma related to the loss of a close individual due to death, divorce, incarceration, or out-of-home placement is a risk factor for mental health issues. This program provides a safe and healthy outlet for both the child and the parent/caregiver to process grief and loss.

School-Based Initiatives

MHSA Legislative Goals and Related Key Outcomes

- Reducing School Failure and Dropout Rates:
  - ◊ Increased School Attendance.
  - ◊ Increased Subjective School Connectedness.
  - ◊ Lower Rate of School Dropouts.
  - ◊ Lower Rate of Failing Students.
  - ◊ Decreased School Behavioral Problems.
  - ◊ Decreased School Achievement Problems.

Target Populations:

- Children
- Adults

Projected Number to be Served FY 2016/17:

- 657 Children
- 243 Adults

Positive Results

The Preschool PEI program uses the Desired Results Development Profiles (DRDP), which is a science and research-based assessment and evaluation tool that measures a range of developmental domains in preschoolers. Each student receives a rating on their progress within a range of developmental levels. The ratings range from "Exploring" at the lowest point to "Integrating" at the highest point.

During Fiscal Year 2014/2015, Preschool Services Department (PSD) administered the DRDP on over **4,000** enrolled children. **238** of those children received Preschool PEI services. **12** developmental domains were measured and PSD identified **4** that were the most challenging for children in the program. The table below represents pre and post assessment results for students in the Preschool PEI program, on the **4** challenging domains. **The post scores indicate the percent increase in integrating positive behaviors** amongst children enrolled in Preschool PEI services.

DRDP Domain	Pre Score	Post Score	What "Integrating" Behavior Looks like in the Classroom
Impulse Control	**0%**	**4.99%**	Student consistently uses a variety of socially acceptable strategies to stop self from acting impulsively.
Conflict Negotiation	**0%**	**4.01%**	Student considers the needs and interests of another child when there is a conflict and accepts or suggests some mutually acceptable solutions.
Relationships with Adults	**0%**	**6.92%**	Student works cooperatively with an adult to plan and organize activities and to solve problems.
Cooperative Play with Peers	**0%**	**8.83%**	Student leads or participates in planning cooperative play with other children.

School-Based Initiatives

Success Story

"Glenn" had recently lost custody of his child "Judith" due to his challenges with substance use. He was living in a homeless shelter and Judith was placed in foster care. Glenn asked for assistance from the Preschool PEI program (PPP). Staff from the PPP linked Glenn to counseling services. In response to his request, he began to attend the "Nurturing Father" classes for drug rehabilitation through a local provider. After he successfully completed the classes, PPP provided him with career guidance by enrolling him in a Job Skills and Resume writing class. He was also able to enroll Judith in the Trauma, Loss, and Compassion (TLC) program. He recently regained custody Judith, is taking classes at a local college, and is living in permanent housing. He and Judith continue to attend ongoing counseling sessions. The PPP is currently working on coordinating similar support services for Judith's mother to help provide an ongoing stable environment for Judith.

Artwork by Mary Candelaria

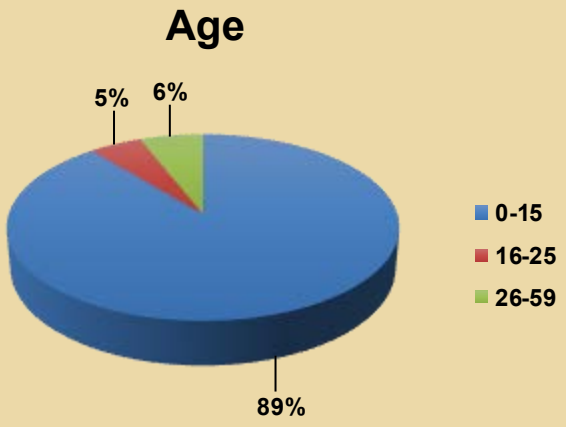
Challenges

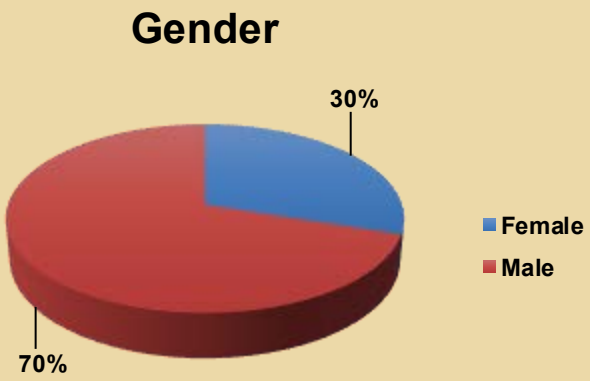
This program year, the PPP Interdisciplinary Team identified that approximately **4%** of children being managed by the PPP program are not effectively able to engage in services offered. The key factor hindering the successful delivery of service is the lack of family stability. Families are not engaging in services and, at times, appear to be overwhelmed by day to day challenges. Many families in their program are being negatively impacted by underdeveloped life skills and related coping abilities.

Solutions in Progress

Staff will continue to implement the use of the Life Skills Progression (LSP) Tool. The LSP Tool provides data on each families' life skills and identifies specific areas of need. The results assist staff in assigning appropriate interventions and supports to help stabilize families participating in the PPP program.

Fiscal Year 2014/2015 Program Demographics

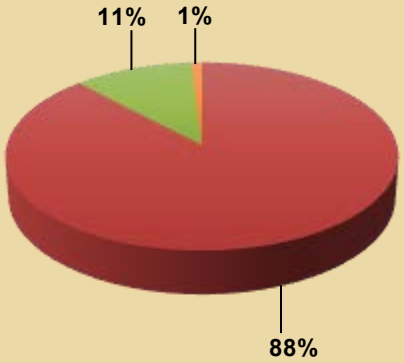




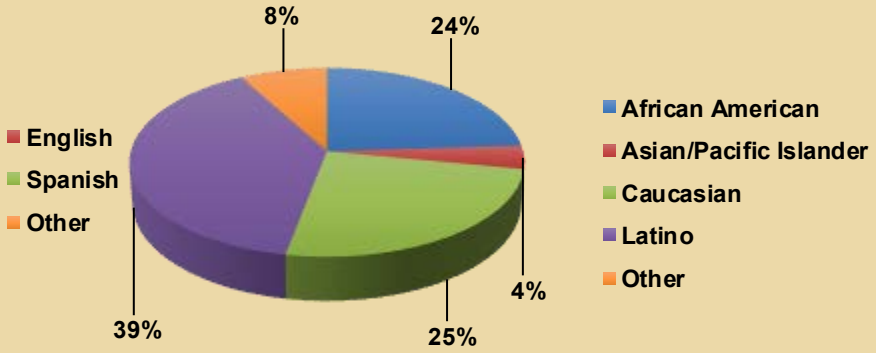
School-Based Initiatives

Fiscal Year 2014/2015 Program Demographics

Primary Language



Ethnicity



Total Number Served/Unduplicated Count

Total Number Served	Unduplicated Count
4,942	1,015

Program Updates

In Fiscal Year 2016/17, there are no planned program changes or changes to the program budget.

Collaborative Partners

- Preschool Services Department.

Resilience Promotion in African-American Children PEI S1-3

The Resilience Promotion in African-American Children (RPiAAC) program provides prevention and early intervention services to African American children/youth (ages 5-18) and their families. RPiAAC incorporates African American values, beliefs, and traditions into educational mental health programs. This program promotes resilience in African American children in order to reduce the development of mental health and/or substance use disorders. Outreach and education is delivered to diverse student populations to generate awareness regarding the importance of mental health and wellness for all students at a school site including African-American populations. The program includes curriculum-based education, cultural awareness activities, conflict resolution training, educational workshops, on-going weekly interventions, career-related presentations, parent support/education, individual and family therapy sessions, and linkage to additional resources.

School-Based Initiatives

MHSA Legislative Goals and Related Key Outcomes

- Reducing School Failure and Dropout Rates:
  - ◊ Increased School Attendance.
  - ◊ Increased Subjective School Connectedness.
  - ◊ Lower Rate of School Dropouts.
  - ◊ Lower Rate of Failing Students.
  - ◊ Decreased School Behavioral Problems.
  - ◊ Decreased School Achievement Problems.

- Reducing Incarceration:
  - ◊ Lower Rate of Incarcerations.
  - ◊ Decreased Delinquency Behaviors Which Increase Likelihood of Juvenile Detainment.

Target Populations:

- Children
- TAY
- Adults

Projected Number to be Served FY 2016/17:

- 4,036 Children
- 383 TAY
- 3,100 Adults

Positive Results

One unique component of the RPiAAC program is the Meet a Pro educational presentations. These presentations by African-American professionals provide positive role models to students to diminish negative self-perceptions. **95%** of participants who attended a Meet a Pro event valued the opportunity to meet African American professionals in their community. **95%** of participants valued the resiliency and confidence building skills learned in the program.

The Effective Black Parenting curriculum teaches healthy parenting strategies to help children develop self esteem and promote resilience. Post evaluation reports indicate that parents who participate in the Effective Black Parenting classes gain improved parenting skills, improved confidence in being an effective parent, and increased knowledge about parenting.

Artwork by Isis Torres

Success Story

During a program activity, RPiAAC staff noticed that “Andrea”, a 9-year-old girl in the group, was unhappy and writing negative comments on her paper about her appearance. The program staff recommended to Andrea’s family that she receive counseling. Later, Andrea divulged thoughts of suicide and the need for intervention services became more apparent. RPiAAC staff contacted her mother and the school counselor to address this concern. After receiving early intervention counseling services, Andrea has improved greatly. She is engaging with peers, beginning to develop positive friendships, and is no longer reporting that she wants to hurt herself. RPiAAC staff and school have noticed that the student is more helpful, respectful and pleasant to be around. Andrea’s mother was very grateful for the services provided and said, "I see the benefit of my daughter going to counseling. She is happy now."

School-Based Initiatives

Challenges

The RPiAAC program providers have identified some challenges in implementing the program services with the target population. Utilization of Early Intervention services has increased very slowly. Factors may include that the program is engaging a population that has perceived stigma associated with seeking with mental health services. Administratively, there has also been some delay in referrals for early intervention services between RPiAAC contract providers.

Sustaining participation in parenting classes has also been a challenge. Possible causes for the reduction in participation may be due to practical concerns such as the length of the training (15 weeks), individual perceptions about the need for parenting training, and logistical constraints (lack of transportation, basic needs, child care issues).

"I learned how to control my anger and how to respect people."

-RPiAAC Participant

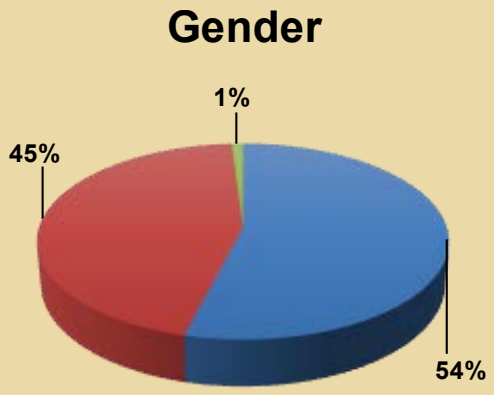
Solutions in Progress

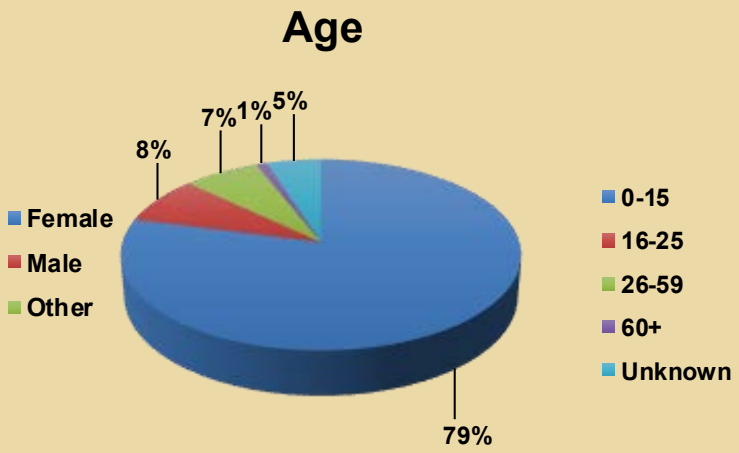
RPiAAC staff is actively looking for solutions to the engagement and retention issues that are occurring within the parenting classes and early intervention services. RPiAAC will be hosting strategic planning sessions with local African American academic programs and community consultants to determine more effective ways to engage and serve the target population. RPiAAC is working new ways to promote mental health awareness in a culturally relevant manner to reduce stigma and discrimination around mental health services. They are also exploring other avenues to increase parent participation such as offering families tangible assistance with practical concerns. Families entering the program will be offered increased assistance in locating resources to assist with transportation, housing, utilities, food, and other basic needs.

"This program, [RPiAAC], "inspired me and gave me motivation to try harder in school everyday."

-RPiAAC Participant

Fiscal Year 2014/2015 Program Demographics

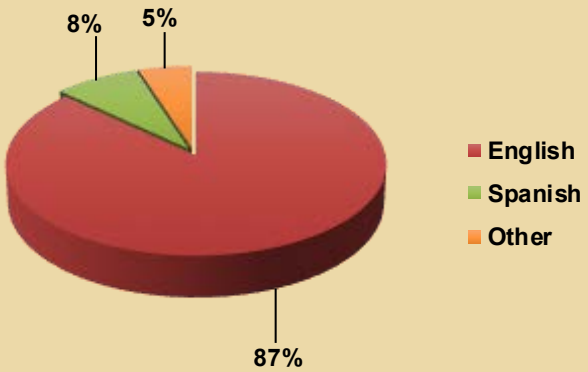




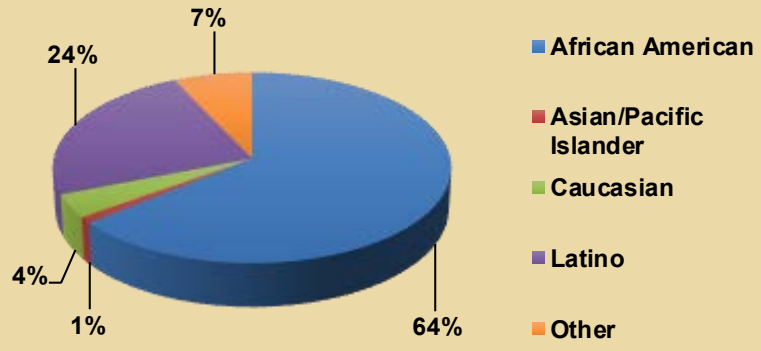
School-Based Initiatives

Program Demographics Fiscal Year 2014/2015

Primary Language



Ethnicity



Total Number Served/Unduplicated Count

Total Number Served	Unduplicated Count
13,677	5,737

Program Updates

In Fiscal Year 2016/17, there are no planned program changes or changes to the program budget.

Collaborative Partners

- Valley Star Children and Family Services.
- Young Visionaries.
- Act of Kindness Program.
- San Bernardino County Superintendent of Schools.
- Gaining Early Awareness and Readiness for Undergraduate Programs (GEAR UP) - California State University San Bernardino.
- San Bernardino City Unified School District.
- Black Voice News.
- Rialto Unified School District.
- San Bernardino County Probation Department.
- San Bernardino Valley College.

Promotores de Salud/Community Health Workers PEI CI-1

The Promotores de Salud/Community Health Workers program is designed to increase awareness and access to community-based prevention and mental health services without stigma or fear of discrimination. This program promotes mental health awareness, education, and available resources for members of various culturally-specific populations throughout the county. Services are offered in a culturally and linguistically appropriate manner. The program recruits and trains community members to become Community Health Workers, who provide regular outreach and mental health education presentations to large community, school, and church groups and also to smaller groups and families. Services are specifically targeted for unserved and underserved groups, including Latino and Spanish-speaking communities, African-American communities, Asian/Pacific Islander communities, and Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) communities.

Artwork by Isabel Figueroa

MHSA Legislative Goals and Related Key Outcomes

- Reduce Stigma and Discrimination Associated with Mental Illness:
  - ◊ Increased accurate knowledge about mental illness.
  - ◊ Increased intent to seek services, if needed.

- Reduce Prolonged Suffering:
  - ◊ Improved life satisfaction.
  - ◊ Decreased hopelessness/increased hope.
  - ◊ Increased resiliency.
  - ◊ Decreased impairment in general areas of life functioning.

Positive Results

In FY 2014/2015, the program served **30,698** unduplicated participants. Promotores de Salud/ Community Health Workers presented **1,381** educational presentations to over **10,000** new participants and also reached over **20,000** new participants through door-to-door contact and outreach efforts at several community events and health fairs.

Through the completion of pre and post tests, **95%** of the participants indicated that their knowledge about mental health and mental illness had increased as a result of the presentations.

Target Populations:

- Children
- TAY
- Adults
- Older Adults

Projected Number to be Served FY 2016/17:

- 600 Children
- 2,100 TAY
- 25,500 Adults
- 1,800 Older Adults

Community-Based Initiatives

Success Story

"Laura" the mother of a six year old child, noticed that her child was displaying some behavioral problems. She attended a mental health presentation facilitated by a Promotor. After the presentation, she stated that she felt more comfortable knowing that behavioral problems were not uncommon and there was help available. The Promotor assisted Laura by connecting her with a partner agency located near her home for additional assistance. The Promotor later followed up with Laura and learned that her child was receiving great services from the agency she was referred to. Laura said that the presentation she attended with the Promotor helped her understand that children can also suffer from mental health issues and felt more comfortable seeking services for her child.

Artwork by Linda James

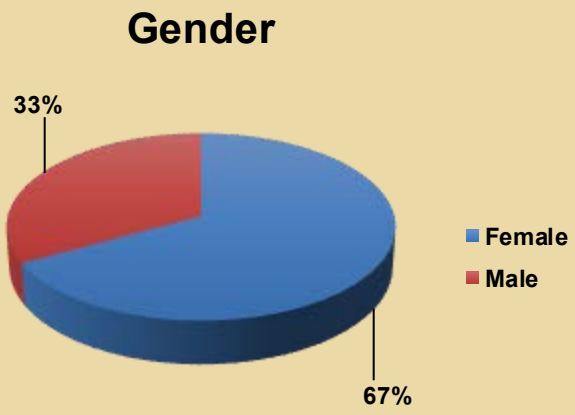
Challenges

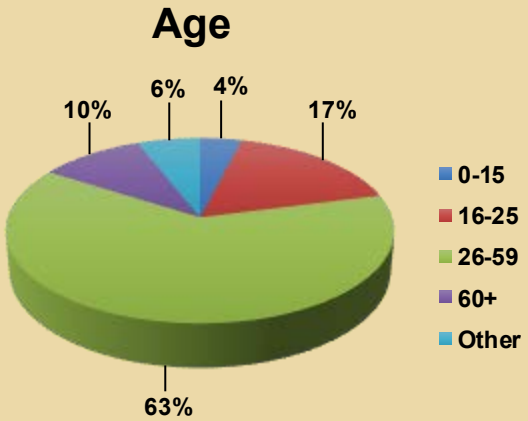
Retaining Promotores de Salud / Community Health Workers was a challenge this program year. Promotores de Salud / Community Health Workers who enter the program are volunteers. The program provides small stipends to the Promotores de Salud / Community Health Workers to help offset gas/fuel expenses incurred while providing services throughout the county. Some volunteers return to regular full or part-time work, leaving little time to continue their volunteer work as a Promotor de Salud/Community Health Worker with the program. Additionally, the program discovered that there are limited services available to Spanish-speaking individuals who do not have health insurance. This made linking clients to appropriate services a challenge.

Solutions in Progress

The Department of Behavioral Health is exploring the possibility of incorporating this program into existing PEI programs. By doing so, the Promotor de Salud / Community Health Worker position can be transitioned from a volunteer position to a paid full or part-time position within the program.
Staff are expanding their resource directory to locate more providers in their regions who can provide services to those without health insurance. They are improving the current referral process to include more access to services and follow up with clients to ensure appropriate and timely services are provided.

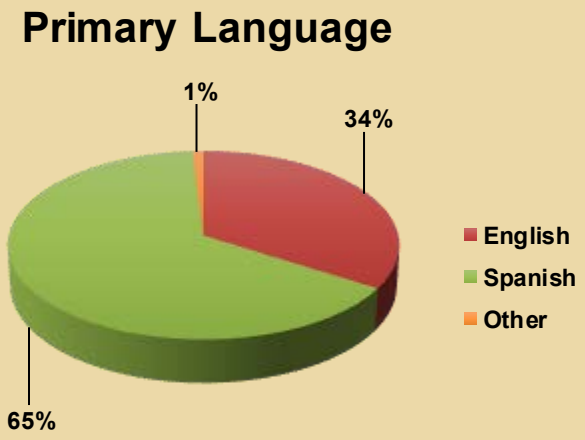
Fiscal Year 2014/2015 Program Demographics

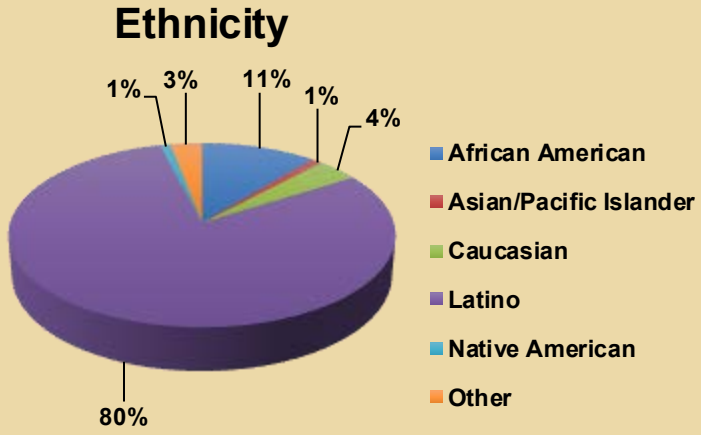




Community-Based Initiatives

Fiscal Year 2014/2015 Program Demographics





Total Number Served/Unduplicated Count

Total Number Served	Unduplicated Count
35,178	30,698

Program Updates

In fiscal year 2016/17 portions of the Promotores de Salud will be administered as part of the Family Resource Centers (FRC). Promotores de Salud/Community Health Workers will be part of the outreach and education services provided through some of the FRC sites and will also be maintained under a community outreach model.

Collaborative Partners

- Desert Mountain Children's Center.
- El Sol Neighborhood Education Center.
- Victor Community Support Services.
- Department of Behavioral Health.
- Loma Linda University.
- African American Mental Health Coalition.
- Healthy High Desert.
- Native American Resource Center.
- Asian American Resource Center.
- Rainbow Pride Youth Alliance.

Family Resource Centers PEI CI-2

Family Resource Centers (FRC) offer various culturally and linguistically competent services at fourteen **(14)** different FRC sites as well as out in their different communities. The locations of the FRC's increases the likelihood that community members will use the services while reducing stigmatizing attitudes associated with seeking behavioral health services. Services are tailored to meet the identified needs of the communities they serve. This program serves all ages and uses various Evidence-based, Promising Practices, and Community-based services which include:

Artwork by Barbara Mason

- Strengthening Families Program.
- Social Work Model.
- Communities that Care Model.
- Nurturing Parenting Program.
- NCTI® Crossroads© Education.
- Personal development activities.
- Parent/caregiver support and education.
- Behavioral health education workshops.
- After-school programs for children, youth, and transitional age youth.
- Promotores de Salud.
- Health education workshops.
- Adult skill-based education (e.g. education and employment assistance).
- Maternal mental health.
- Counseling and therapy activities for all ages and cultural backgrounds.

MHSA Legislative Goals and Related Key Outcomes

- Reduce Stigma and Discrimination Associated with Mental Illness:
  - ◊ Increased accurate knowledge about mental illness.
  - ◊ Increased intent to seek services if needed.

- Reduce Unemployment Among Consumers:
  - ◊ Lower rates of unemployment.
  - ◊ Increased employment-related skills/vocational strengths.

- Reduce Prolonged Suffering:
  - ◊ Improved life satisfaction.
  - ◊ Decreased hopelessness/increased hope.
  - ◊ Increased resiliency.
  - ◊ Decreased impairment in general areas of life functioning.

Target Population:

- Children
- TAY
- Adult
- Older Adult

Projected Number to Be Served FY 2016/17:

- 10,000 Children
- 2,700 TAY
- 8,000 Adult
- 1,300 Older Adult

Community-Based Initiatives

Positive Results

The FRCs served **151,994** participants in FY 2014/15. Of the total number of participants served, **45,566** were unduplicated participants. The cumulative goal for the FRCs was to serve **30,000** unduplicated participants in FY 2014/15. The goal was exceeded by **15,566** participants which is **51.9%** more participants than anticipated.

Artwork by Isis Torres

FRCs provided a variety of activities which included:

- Community outreach.
- Educational services.
- Promotional material dissemination.
- Individual and group counseling.
- Individual and family mentoring.
- Clinical assessments.
- Linkage and case management.
- Mental health treatment services.
- Multi-disciplinary collaboration.
- Mental health screenings.
- Stakeholder engagement meetings.
- Supportive activities.

The FRCs supported the community by providing **756** different sessions of the activities listed above.

During the past fiscal year, FRC providers utilized the Global Assessment of Functioning (GAF) scale as a tool to monitor outcomes. Providers tracked GAF scores of early intervention participants. GAF scores measure an individual's overall ability to carry out daily living activities and psychological, social, and occupational functioning. Participant's scores were noted at case opening and case closing. GAF results showed a **12%** overall improvement, as illustrated below.

Average GAF Scores for FRC Providers in FY 2014/15		
At Case Intake	**At Case Discharge**	**Improvement**
57	**64**	**12%**

Success Story

"Jose" signed up to take a Basic Computer Skills class offered at the FRC. He wanted to learn how to communicate via email with his family who lives in another country. Jose began the class apprehensively as he was unfamiliar with using a computer. As the weeks went by his confidence and skills grew tremendously. When he graduated not only did he know how to send an email but he was also able to browse the internet to find information, create simple presentations and spreadsheets, and design flyers. By learning these basic computer functions, he is now able to communicate with his family more frequently and keep in touch with his loved ones.

Challenges

The FRCs have reported an increased demand for early intervention and overall mental health services. Individuals struggled with having adequate transportation to access services which resulted in several missed early intervention appointments. In addition, stigma associated with seeking mental health services continues to be a factor especially amongst the military and veteran community.

Solutions in Progress

Group counseling sessions have been made available to individuals as well as individual counseling. When possible individuals are referred to a partnering local provider for early intervention services. FRC providers are working on securing bus passes so individuals will have transportation to and from services at the FRCs. Providers are also developing an improved communication system with participants in an effort to reduce the number of missed early intervention appointments.

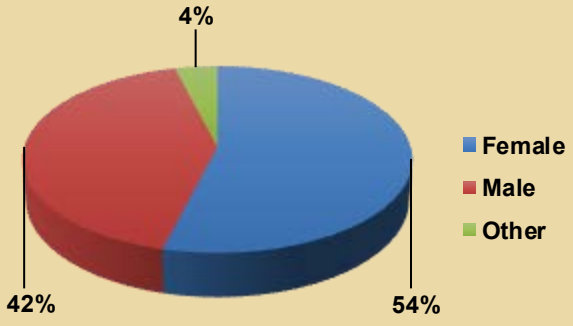
A collaboration with FRC's and the Military Services and Family Support Program was established. They are working together to find ways to reduce the stigma of military veterans seeking mental health services.

"Your services were the catalyst in my return to my Master's program and my consideration to work in the mental health field. I really enjoyed coming here and learning everything I learned. Thank you!"

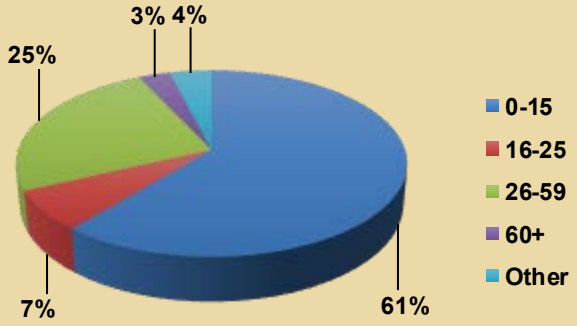
-FRC Client

Fiscal Year 2014/2015 Program Demographics

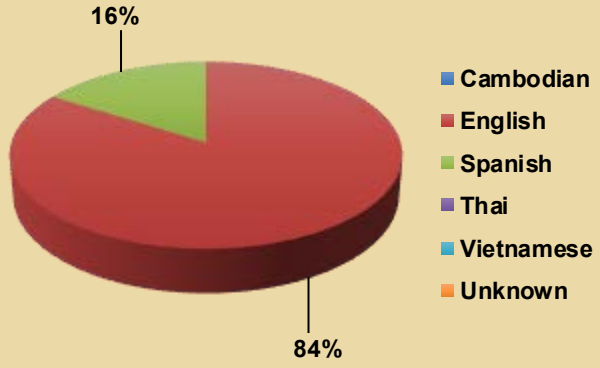
Gender



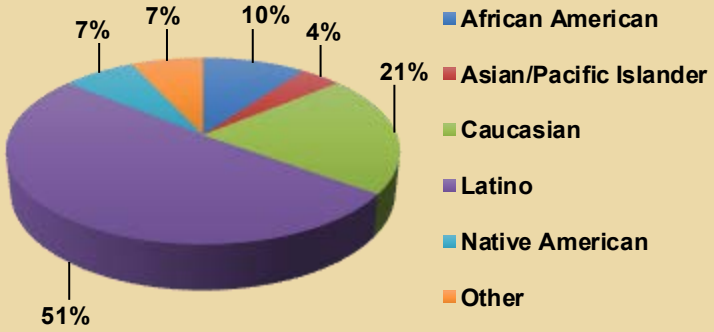
Age



Primary Language



Ethnicity



Community-Based Initiatives

Total Number Served/Unduplicated Count

Total Number Served	Unduplicated Count
151,994	**45,566**

Program Updates

The scope of work for some of the Family Resource Centers will been expanded to include the Promotores de Salud program component where appropriate. However, additional Promotores services may also be available outside of the FRC as provided by other community organizations. The Promotores de Salud model provides for individualized mental health resources and support for the Latino and Spanish-speaking communities. It is anticipated that the FRCs will serve approximately **17,500** additional community members through the expanded Promotores de Salud Program.

Collaborative Partners

- Building a Generation.
- Children and Family Services.
- Inland Empire Health Program.
- Ontario-Montclair School District.
- Pacific Clinics.
- Rim Family Services.
- Rim of the World Unified School District.
- Riverside-San Bernardino County Indian Health, Inc.
- Snowline Unified School District.
- Valley Star Behavioral Health, Inc.
- Victor Community Support Services, Inc.
- Victor Valley Unified School District.

Artwork by Chuck Ayala

Native American Resource Center PEI CI-3

The Native American Resource Center functions as a one-stop center offering several prevention and early intervention resources for Native American community members of all ages. The center provides services that use traditional, strength-based, Native American practices. Services include outreach and education, family support, parenting education, youth empowerment, healthy choice prevention activities, talking circles, drumming circles, employment development and education assistance. All services and supports are provided to the community in a culturally relevant context.

Community-Based Initiatives

MHSA Legislative Goals and Related Key Outcomes

- Reduce Prolonged Suffering:
  - ◊ Improved life satisfaction.
  - ◊ Decreased hopelessness / increased hope.
  - ◊ Increased Resiliency.
  - ◊ Decreased impairment in general areas of life functioning (e.g., health/self-care/housing, occupation/education, legal, managing money, interpersonal, social).

- Reduce Stigma and Discrimination Associated with Mental Illness:
  - ◊ Increased accurate knowledge about mental illness.
  - ◊ Increased intent to seek services if needed.

Target Populations:

- Children
- TAY
- Adults
- Older Adult

Projected Number to be Served FY 2016/17:

- 542 Children
- 509 TAY
- 538 Adult
- 162 Older Adult

Positive Results

The Native American Heritage event and the Redlands Pow Wow, provided cultural awareness to other ethnicities about the Native American heritage. Workshops included cultural story telling and song and dance as forms of communication. These communication strategies were showcased to help educate the community of alternative ways used by the Native American community. During the Family Conference and Healthy Heart Conference, the Native American Resource Center hosted an information booth to provide educational materials and information about local community resources.

The Native American Resource Center utilizes the Global Assessment of Functioning (GAF) scale as a tool to monitor outcomes. The center tracked GAF scores of early intervention participants. GAF scores measure an individual's overall ability to carry out activities of daily living and psychological, social, and occupational functioning. Participant's scores were noted at case opening and case closing. GAF results showed a **6%** overall improvement, as illustrated below. This change demonstrates an improvement in overall functioning from experiencing moderate symptoms to mild symptoms but functioning well.

Average GAF Scores for Native American Resource Center in FY 2014-2015		
At Case Intake	**At Case Discharge**	**Improvement**
58	**62**	**6%**

Success Story

Pow Wow-University of Redlands

The Native American Resource Center offers various classes that promote mental health/substance abuse awareness as well as cultural awareness. These holistic-centered activities focus on Physical, Spiritual, Emotional, and Mental wellness. On one occasion, a group of Native American elders visited the center and for the first time, participated in a group cultural activity. During the activity they made Native American regalia to later be used in ceremonies at local Native American cultural events. This was a powerful step for the group of elders who are not accustomed to visiting a resource center. The experience offered them an opportunity to make a contribution to the community and to share their cultural identity.

Talking Circles are one of the most impactful activities conducted at the annual Native American Family Conference. The Talking Circle activity gives families an opportunity to share their struggles with other Native American families. During this therapeutic activity individuals are able to offer each other support, prayers, and advice to help build a stronger and healthier Native American community.

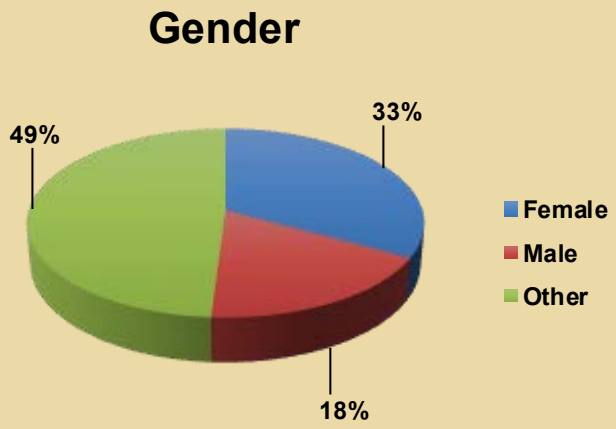
Challenges

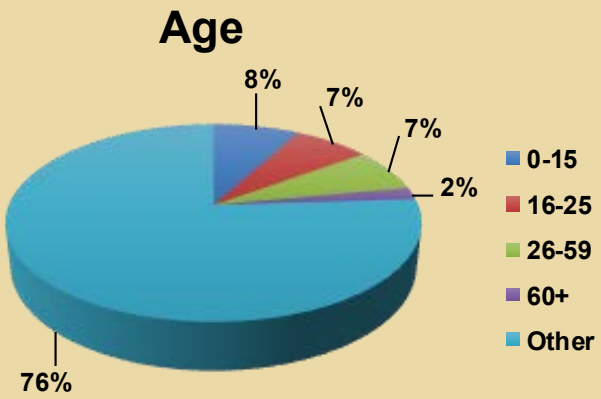
Over the last year, the Native American Resource Center relocated its service site. Simultaneously, staff has been more active and visible in the community, providing more outreach and education services. It is anticipated that the need for site based services will increase.

Solutions in Progress

The Native American Resource Center is addressing the need for site based services at the resource center by re-evaluating staffing patterns in order to provide adequate services both in and out of the resource center. As services increase, additional staffing may be required.

Fiscal Year 2014/2015 Program Demographics

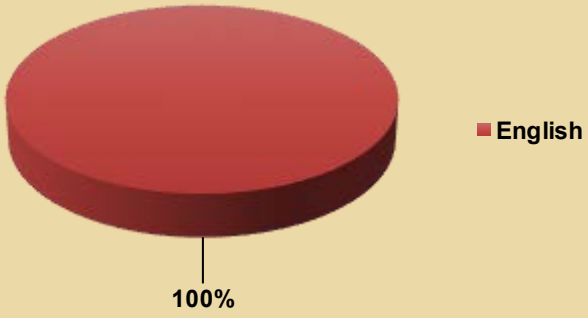




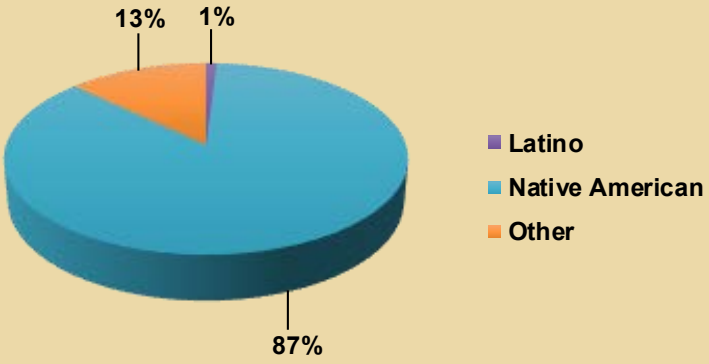
Community-Based Initiatives

Fiscal Year 2014/2015 Program Demographics

Primary Language



Ethnicity



Total Number Served/Unduplicated Count

Total Number Served	Unduplicated Count
12,448	11,591

Program Updates

In Fiscal Year 2016/17, there are no planned program changes or changes to the program budget.

Collaborative Partners

- Riverside-San Bernardino County Indian Health, Inc.
- San Bernardino County Department of Behavioral Health.
- San Manuel Band of Mission Indians Education Department.
- Morongo Band of Mission Indians TANF program.
- University of Redlands Native Student Program.
- California State University San Bernardino –Special Events & Guest Services.
- San Bernardino County Unified School District Title VII Program.
- Boys & Girls Club of San Bernardino.
- Healthy San Bernardino County Coalition.
- Molina Healthcare.
- Latino Health Collaborative.
- Reach Out West End.
- TAY One Stop Center.
- Juvenile Justice Program.
- Building A Generation.
- Housing Opportunities Collaborative- Inland Empire Hub.

National Curriculum and Training Institute® (NCTI) Crossroads Education© PEI CI-4

Artwork by Richard Cousin

The National Curriculum and Training Institute (NCTI) Crossroads® Education program is a curriculum-based education strategy that fosters positive, pro-social behavior in children (ages 10-15) and transitional age youth (TAY) (ages 16-25).This program employs a cognitive behavioral change model to teach pro-social behaviors through an interactive learning process.

Providers utilize the NCTI Crossroads® curricula and The Real Colors® Personality Instrument to focus on the relationship between values, attitudes, and behaviors, as they relate to the decision making process. Class topics include anger management, life skills, parent education, substance abuse prevention, gang involvement, truancy intervention, and graffiti prevention. Parenting classes are offered to the families of those participating in the program.

NCTI® providers collaborate with community and faith-based organizations and Family Resource Centers to provide services and promote a positive learning environment for the diverse populations throughout San Bernardino County.

MHSA Legislative Goals and Related Key Outcomes

- Reduce School Failure/Dropout Rates:
  - ◊ Increased school attendance.
  - ◊ Increased subjective school connectedness.
  - ◊ Lower rate of school dropouts.
  - ◊ Lower rate of failing students.
  - ◊ Decreased school behavioral problems.
  - ◊ Decreased school achievement problems.

- Reduce Incarcerations:
  - ◊ Lower rate of incarcerations.
  - ◊ Decreased delinquency behaviors which increase likelihood of juvenile detainment.

Target Population:

- Children
- TAY

Projected Number to Be Served FY 2016/17:

- 500 Children
- 4,000 TAY

Community-Based Initiatives

Positive Results

NCTI® Crossroads© has pre and post tests built into the curriculum. These tests measure the level of knowledge obtained by participants and the fidelity of the program implementation. The positive test data indicates that Crossroads© Education participants are gaining the pro-social skills and assets needed to make positive changes in their lives and validates that the program is being implemented effectively.

The table below explains the learning objectives for each Crossroads© Education course offered, and the increased rate of understanding students gained after completing each course in FY 2014/15.

The test data indicates that Crossroads© participants are gaining the pro-social skills and assets needed to make positive changes in their lives.

Crossroads Skills Progression		
Class Title	**Class Learning Objectives**	**Students' Increased Understanding of Course Content**
Youth Cognitive Life Skills 1	Learn how to overcome negative behaviors, become more productive and set goals	57%
Youth Anger Management Level 1	Understanding the influence that strong emotions have on behavior and gaining better control	56%
Youth Drugs & Alcohol Level 1	Identity skills and resources that help develop a healthy, positive lifestyle	58%
Shoplifting	Identify and take positive steps to change present behavior	93%

Success Story

"Sean" a student from a local high school was ready to graduate but did not have enough class credits. He was experiencing anger issues which resulted in frequent fights and suspensions from school. Sean began attending the Crossroads© Anger Management class. He completed the course without missing a class. Since the completion of the course, Sean is able to manage his anger. He has also successfully graduated from high school.

"Crossroads has helped me understand people and life more. Everyone has their own story. We're all different. We all make mistakes but that doesn't make us bad people."

-NCTI Participant

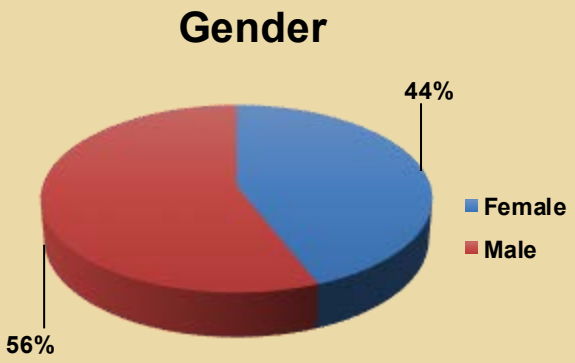
Challenges

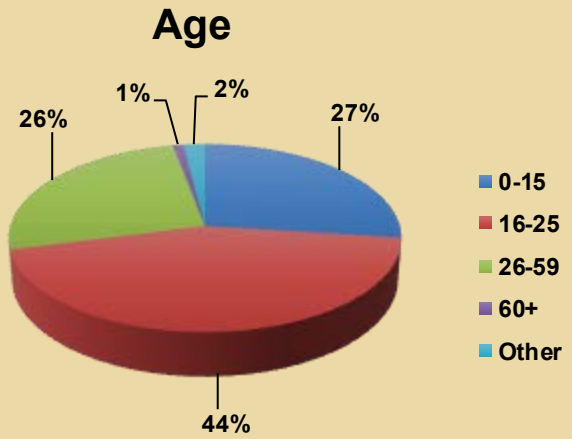
Consistent participation is a struggle that occurs in the NCTI® program. Participants will start a class and not complete the entire 6 to 8 week course. Collateral classes for caregivers are offered to increase understanding of the challenges that the youth participants may be experiencing. However, there has not been as much interest in these collateral classes as anticipated. An internal administrative challenge faced by providers is not having sufficient staff certified in NCTI® to accommodate staff absences and turnover.

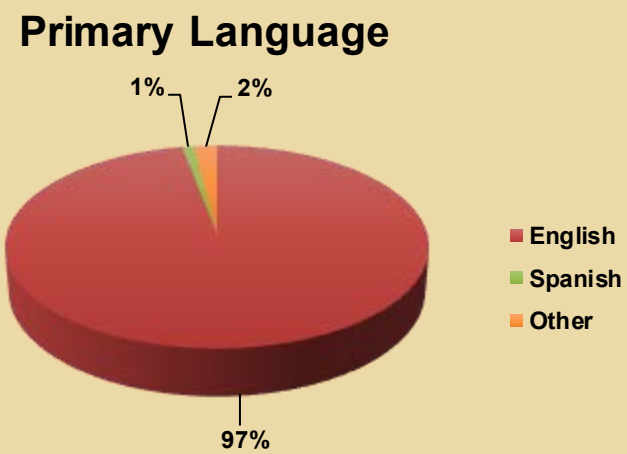
Solutions in Progress

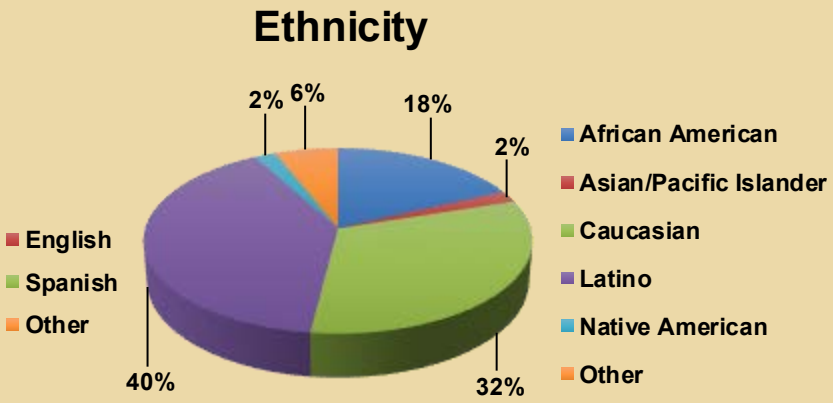
NCTI® providers continue to use proactive strategies to overcome the challenges they face. To improve attendance rates NCTI® is employing three strategies. First, the facilitators are making reminder phone calls and send reminder letters. Second, providers offered additional classes at more convenient times for families such as in the evening and on weekends. Lastly, providers will be actively recruiting additional staff to become NCTI® certified trainers.

Fiscal Year 2014/2015 Program Demographics









Community-Based Initiatives

Total Number Served/Unduplicated Count

Total Number Served	Unduplicated Count
11,126	5,473

Program Updates

In Fiscal Year 2016/17, there are no planned program changes or changes to the program budget.

Collaborative Partners

- Family Service Agency of San Bernardino.
- Inland Valley Drug and Alcohol and Recovery Services.
- Reach Out West End.
- Rim Family Services.

Artwork by Celina Castrejon

Older Adult Community Services PEI SE-1

The Older Adult Community Services (OACS) program is designed to promote a healthy aging process for older adults (ages 60+) by providing prevention and early intervention services to assist in maintaining positive mental health. Services focus on providing assistance to older adults before mental health issues develop and/or require a greater level of treatment. The OACS program is comprised of four components:

- **The Mobile Resources Unit** provides mental health and substance use screenings to older adults who are in geographically isolated or economically challenged areas. Screenings reduce risk factors for mental illness and substance use disorders by identifying possible concerns such as prolonged isolation, chronic medical conditions, severe trauma or loss, ongoing stress, and/or poverty.
- **Older Adult Wellness Services** delivers comprehensive services that includes assistance with securing transportation to medical appointments, basic life needs, and activities for older adults.
- The **Home Safety** component assists older adults in maintaining an appropriate level of personal and home safety. Older adults receive services and education in personal safety, home safety, preventing falls, and medication management.
- The **Suicide Prevention** component provides suicide prevention education, screenings, and direct support services. These services are provided in a culturally appropriate manner for the program target population.

Early intervention services are available for those exhibiting the onset of a mental illness and/or relapse episodes due to a pre-existing psychiatric condition. The program addresses specific causes and risk factors that can contribute to suicide and/or suicidal ideations and targets those who are exposed to trauma or are experience bereavement issues. The program also utilizes professionally trained Older Adult Peer Counselors to provide supportive listening and suicide prevention support to others.

MHSA Legislative Goals and Related Key Outcomes

- Reduce Prolonged Suffering:
  - ◊ Improved life satisfaction.
  - ◊ Decreased hopelessness/increased hope.
  - ◊ Increased resiliency.
  - ◊ Decreased impairment in general areas of life functioning (e.g., health/self-care/housing, occupation/education, legal, managing money, interpersonal, social).
- Reduce Suicide:
  - ◊ Decreased suicidal ideation.
  - ◊ Increased knowledge of suicide risk factors.
  - ◊ Increased knowledge of suicide prevention resources.
  - ◊ Decreased suicide risk, as measured by suicide and client assessments/outcome measures.
- Reduce Stigma and Discrimination Associated with Mental Illness:
  - ◊ Increased accurate knowledge about mental illness.
  - ◊ Increased intent to seek services if needed.

Target Population:

- Older Adults

Projected Number to be Served in FY 2016/17:

- 6,300 Older Adults

Positive Results

During FY 2014/15, a total of **6,615** unduplicated participants were provided with services and linkages to resources within their communities thereby reducing risk and increasing resiliency, coping skills, and social support networks.

Participants who received early intervention clinical services demonstrated an average improvement in the Global Assessment of Functioning (GAF) scores of **17%**, as illustrated in the table below. GAF scores measure the progress of participants receiving early intervention services and measures an individual's overall ability to carry out daily living activities and measures psychological, social, and occupational functioning. Participants' scores were collected at case opening and case closing.

Average GAF Scores for OACS Providers in FY 2014/15		
At Case Intake	**At Case Discharge**	**Improvement**
52	**63**	**17%**

The OACS also utilizes the Program to Encourage Active, Rewarding Lives for Seniors (PEARLS). PEARLS is an evidenced-based program providing treatment for depression in older adults. A PEARLS coordinator makes 9 home visits to participants to help them learn the signs of depression and provides them with problem solving skills. Participants of the PEARLS program complete a Patient Health Questionaire-9 (PHQ-9). The PHQ-9 consists of 9 questions that measure the frequency and severity of depression. PEARLS participants had an average pre test score of **15.57** and a post test score of **7.57** which translates to **51%** reduction in feelings of depression at program completion.

Results from client satisfaction surveys indicate that **100%** of the participants enjoy the benefits of the presentations, **88%** gained knowledge of programs/benefits, **75%** no longer feel isolated and alone, and **63%** indicate their everyday mood has brightened as well as feeling more confident.

Success Story

"Beth" attended a weekly support group. She suffered a severe stroke two years ago that tremendously impacted her speech, mobility and manual dexterity. Beth has also been struggling with suicidal thoughts as a result of the stroke. The OACS program was able to connect her to a speech therapist. Her speech is improving on a daily basis and she has a renewed hope in living a long healthy life. She recently expressed that since joining the group and receiving help, she has a better understanding of her feelings about death. Beth has become a regular member of the support group and looks forward to connecting with friends she has made in the group. She is also working on her dexterity by participating in the monthly craft classes offered to clients of the OACS program. With the help of the OACS, Beth is slowly returning to the vibrant and artistic person she was before the stroke.

Artwork by Brandi Hebel

System Enhancement Initiatives

Challenges

Transportation continues to be a challenge both to identifying potential participants in need of services and in transporting participants to OACS events and activities. OACS program providers do limited outreach to potential participants who live in extremely remote areas. Securing transportation for OACS sponsored events and activities has also been an ongoing issue and the program is not able to accommodate all the requests they receive.

Stigma and discrimination in seeking mental health services continues to be an obstacle for older adults and they are hesitant to accept mental health services offered to them. Also, some participants do not want to provide demographic information which is needed to capture required service data. They feel the information is too personal and unnecessary.

In addition, it has been difficult to recruit potential volunteers as well as to retain Older Adult Peer Counselors.

POEM by P.E.A.R.L.S. participant:

"There is a group, we've met for weeks
At the Club House in Twin Peaks
And on Wednesdays when we're able
We gather 'round our little table

We sit and talk of this and that
Mostly though is just chit chat
Marilynn, who leads our group
Keeps us informed of all the "scoop"

Like how to keep safe while living at home
Like how to keep active although alone
Like how we have value no matter our age
Her tips are timeless and really quite sage

Now we find we've all formed a bond
Of each other we've grown very fond
We learn, we share and continue to grow
Our lives are enriched with what we know."

-D.F. 03/24/2015

Solutions in Progress

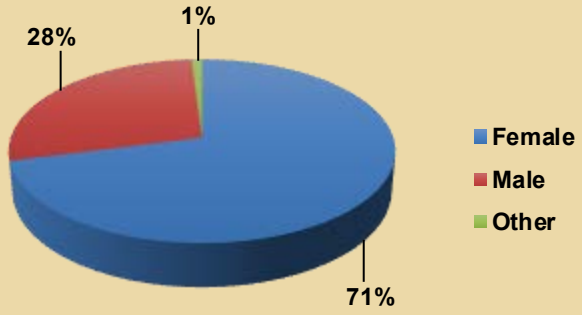
To alleviate some of the transportation barriers, OACS is providing assistance to participants on how to safely navigate the public transportation. They show participants what alternate methods of transportation they can access to be more independent and attend classes, events, and mental/physical health appointments. In order to increase capacity to identify isolated older adults who could benefit from OACS services, OACS providers are collaborating with In Home Support Services (IHSS). Through partnerships, they are developing a feasible process for referring potential participants. In an effort to reduce the stigma, providers have implemented fun and educational presentations to inform participants about mental health issues and about the importance of seeking treatment.

Attempts to recruit qualified Peer Counselors has been a challenge. Providers are contacting Marriage and Family Therapy students, who are also older adults, to volunteer as Peer Counselors. By volunteering, these students will gain valuable experience in working with the older adult community.

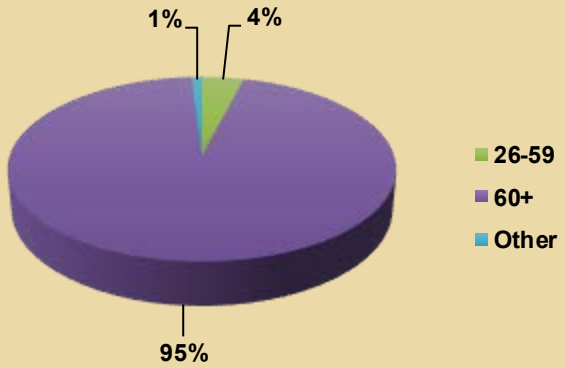
System Enhancement Initiatives

Fiscal Year 2014/2015 Program Demographics

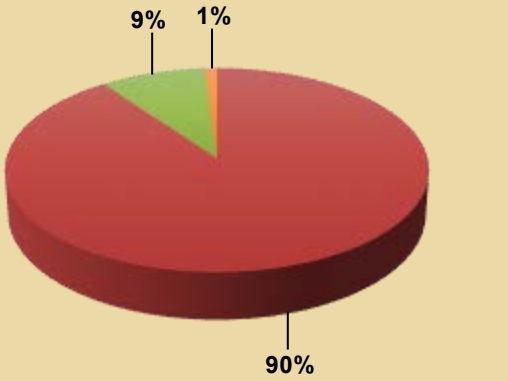
Gender



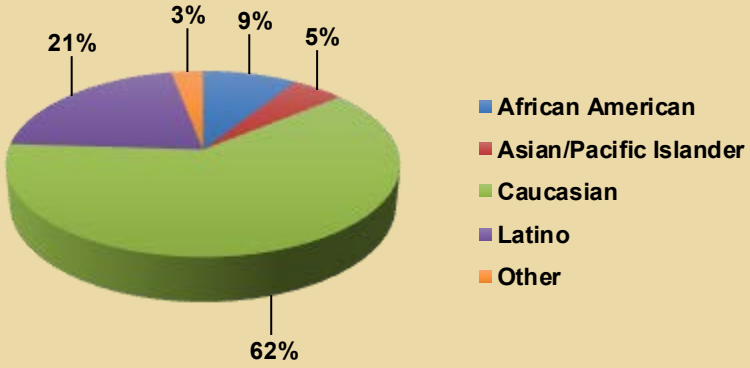
Age



Primary Language



Ethnicity



Total Number Served/Unduplicated Count

Total Number Served	Unduplicated Count
16,267	6,615

Program Updates

The OACS contract was finalized during the fiscal year for the period July 1, 2015 - June 30, 2018. Services will be provided throughout San Bernardino County and include four components: 1) Older Adult Mobile Resources, 2) Older Adult Wellness Services, 3) Older Adult Home Safety Program, and 4) Older Adult Suicide Prevention Program. These components were included to meet the goals of reducing prolonged suffering, reducing suicide, promoting linkage to resources, increasing connection to others, and treatment services.

Collaborative Partners

- San Bernardino County Department of Aging and Adult Services.
- Family Service Association.
- Lutheran Social Services.
- Rim Family Services.
- West End Family Counseling.

Child and Youth Connection PEI SE-2

The Child and Youth Connection (CYC) program provides prevention and early intervention services to children and transitional age youth involved in the foster care and juvenile justice systems. This program is a collaborative between the Department of Behavioral Health (DBH), the Juvenile Public Defender's Office, Children's Network, Child and Family Services (CFS), and local contract providers. Services include mental health screenings, alcohol and drug assessments, therapeutic interventions, and consultations regarding the mental health needs of minors. These services are used to facilitate the assignment of appropriate services and supports for system involved youth. Additionally, a Mentoring Resource Network is maintained where various agencies and stakeholders meet to conduct needs assessments and create mentoring opportunities for system involved youth.

The CYC includes a special component intended to improve social, developmental, cognitive, emotional, and behavioral functioning of young children. This component consists of Screening, Assessment, Referral and Treatment (SART) and Early Identification and Intervention Services (EIIS). SART is collaboration between DBH, CFS, Department of Public Health, First 5, and Children's Network, intended to identify young children at risk of developmental and mental health problems. SART provides comprehensive treatment services, including assessment, individual therapy, family therapy, rehabilitative services and intensive care coordination. EIIS provides services exclusively to children under the age of six who are not displaying appropriate interactions and attachment. Services include comprehensive treatment services, including assessment, individual therapy, family therapy, rehabilitative services, and intensive care coordination.

Artwork by Isis Torres

System Enhancement Initiatives

MHSA Legislative Goals and Related Key Outcomes

- Reduce Incarcerations:
  - ◊ Lower rate of incarcerations.
  - ◊ Decreased delinquency behaviors which increase likelihood of juvenile detainment.
- Reduce Prolonged Suffering:
  - ◊ Improved life satisfaction.
  - ◊ Decreased hopelessness / increased hope.
  - ◊ Increased Resiliency.
  - ◊ Decreased impairment in general areas of life functioning (e.g., health/self-care/housing, occupation/education, legal, managing money, interpersonal, social).
- Reduce Number of Minor Consumers Removed from their Home:
  - ◊ Increased family management skills.
  - ◊ Increase in ratio of minors maintained in the least restrictive environment necessary to meet their goals.
  - ◊ Increased residential stability for family.
  - ◊ Increase parental /caregiver knowledge of child's mental health condition and available services.
  - ◊ Increase relationship permanence for children at risk of removal.

Target Populations:

- Children
- TAY
- Adults

Projected Number to be Served FY 2016/17:

- 14,765 Children
- 1,735 TAY
- 4,625 Adults

Positive Results

One of the tools the CYC program uses for program monitoring and outcome measurement is the CANS-SB (Child and Adolescent Needs and Strengths Assessment– San Bernardino). The CANS-SB provides information regarding the impact services have on children participating in the SART and EIIS component of the CYC program. Typically children participating in SART/EIIS present with specific difficulties or needs. These needs can be categorized in various domains such as life functioning, behavioral and emotional problems, risk behaviors or issues specific to the 0-5 population. CANS-SB data allows analysis of individual scores for each domain to determine if there has been significant progress in working with the child. If a child's need is resolved in a domain it is an indication that the child may no longer require assistance with addressing that need. Data from the CANS-SB indicates positive results in a few key areas.

One of the MHSA Goals for CYC is to Reduce Incarcerations and Reduce Prolonged Suffering. Key outcome indicators that support those goals include decreasing delinquent behavior and decreasing impairment in general areas of life functioning. The CANS-SB data shows the following positive results:

CANS-SB Domain Item	Percent Resolved
Anger Control	**59%**
Oppositional Behavior	**57%**

System Enhancement Initiatives

Another MHSA Goal for CYC is to Reduce the Number of Minor Consumers Removed from their Home. The key outcome indicator that supports this goal is to increase relationship permanence for children at risk of removal. CANS data for the CYC SART program provides data on Maternal Availability. This domain addresses the physical and emotional availability of a child's caretaker which affects the emotional and physical well being of a child. The CANS data indicates that some participants needed assistance at intake with Maternal Availability. At discharge, the concern was resolved. This data below illustrates other domains that also contribute to increasing relation permanence for children and the percentage by which they were resolved.

CANS-SB Domain Item	Percent Resolved
Communication	**39%**
Regulatory Problems	**53%**
Affect Dysregulation	**58%**
Adaptability	**59%**

Success Story

"Scott" is five years old. He was experiencing severe behavioral issues induced by traumatic events since birth. He has been in the care of his legal guardian "Stacy" since the age of one. Scott was having trouble with attention and struggled with anger and aggression. He was not sleeping well and frequently had nightmares. The severity of some of these regulation difficulties he was presenting, were causing problems at home and school. Stacy contacted a SART provider and requested a referral to the SART program for Scott. The pediatrician and occupational therapist with the SART program conducted an evaluation. They found that although Scott had many risk factors, he was developing normally in most areas except speech and language. As part of their SART services, Scott and Stacy were enrolled in Parent-Child Interaction Therapy (PCIT) to assist with behaviors and trauma based needs. Sessions with Stacy focused on providing her with information on trauma and offering supportive services to assist her with implementing predictability and consistency in Scott's daily routines. Scott and Stacy recently celebrated their graduation from PCIT and SART services and continue to receive supportive services through other local resources coordinated by the SART program.

Challenges

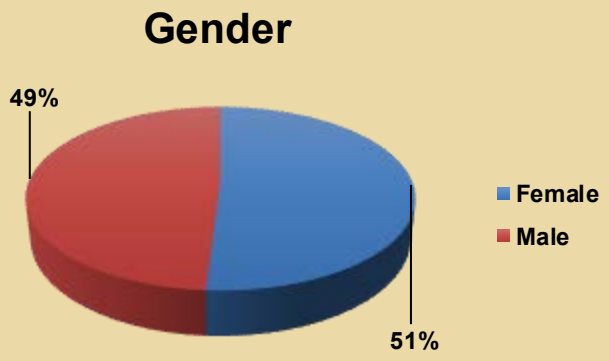
The CYC program has experienced difficulties in implementing a streamlined process for subcontract agencies to document the Non-Medical services they provide. In addition, recruiting and retaining qualified staff, especially Spanish speaking staff, has also been a challenge.

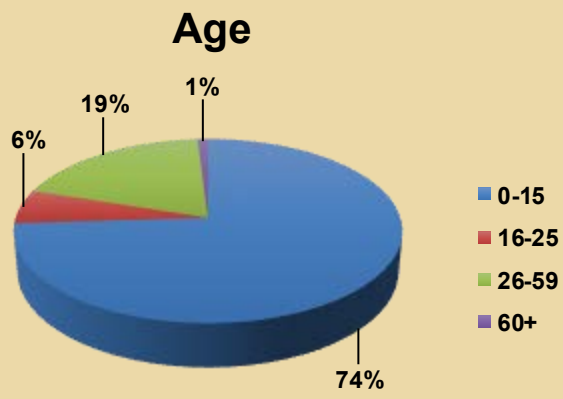
System Enhancement Initiatives

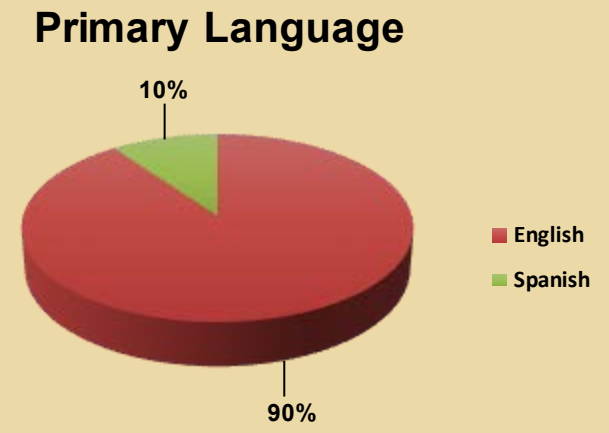
Solutions in Progress

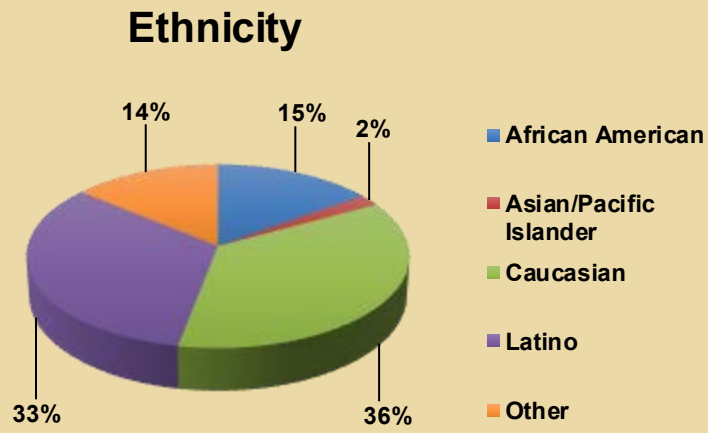
CYC staff has developed a business process that will allow subcontractors to effectively document non-billable services for reimbursement so that there is no interruption or delay in services. Providers are also increasing their recruitment efforts for clinician positions. They are focusing their search on bilingual staff. In particular those who can speak Spanish and English.

Fiscal Year 2014/2015 Program Demographics









Total Number Served/Unduplicated Count

Total Number Served	Unduplicated Count
71,142	24,006

Program Updates

In Fiscal Year 2016/17, there are no planned program changes or changes to the program budget.

Collaborative Partners

- Christian Counseling Service.
- Desert Mountain Children's Center.
- Hearts & Lives.
- Loma Linda University Medical Center.
- Lutheran Social Services.
- San Bernardino County Behavioral Health Children and Youth Collaborative Services.
- San Bernardino County Children and Family Services.
- San Bernardino County Children's Network.
- San Bernardino County Public Defender.
- Victor Community Support Services.
- West End Family Counseling.

Community Wholeness and Enrichment (PEI SE-3)

The Community Wholeness and Enrichment (CWE) program serves transition age youth (TAY (ages 16-25) and adults (ages 26-59) who are experiencing the initial onset of a mental or emotional illness and/or substance use problem. Services include screenings for risk of depression or substance, community mental health support and education, support groups (including bereavement and loss groups), and short-term mental health services. The primary level of early intervention services is delivered through a network of community-based organizations and two integrated primary health clinics.

MHSA Legislative Goals and Related Key Outcomes

- Reduce Suicide:
  - ◊ Decreased suicidal ideation.
  - ◊ Increased knowledge of suicide risk factors.
  - ◊ Increased knowledge of suicide prevention resources.
  - ◊ Decreased suicide risk, as measured by assessments and outcome measures.
- Reduce Prolonged Suffering:
  - ◊ Improved life satisfaction.
  - ◊ Decreased hopelessness/increased hope.
  - ◊ Increased resiliency.
  - ◊ Decreased impairment in general areas of life functioning (e.g., health, self-care, housing, occupation, education, legal, managing money, interpersonal, and social).
- Reduce Homelessness Among Consumers:
  - ◊ Decreased rate of homelessness.
  - ◊ Increased residence stability.
- Reduce Stigma and Discrimination Associated with Mental Illness:
  - ◊ Increased accurate knowledge about mental illness.
  - ◊ Increased intent to seek services, if needed.

Target Populations:

- TAY
- Adults

Projected Number to be Served FY 2016/17:

- 1,203 TAY
- 2,800 Adults

System Enhancement Initiatives

Positive Results

The CWE program uses a variety of evidence-based and promising practices such as Nurturing Parenting Program, Cognitive Life Skills, and Aggression Replacement Training. Current providers are using various evidence-based clinical interventions such as Trauma-Focused Cognitive Behavioral Therapy and Cognitive Life Skills in Behavioral Therapy.

Providers use the Patient Health Questionnaire 9 (PHQ-9) to screen, diagnose, monitor, and measure a client's severity of depression. It is a brief self-report tool that the client completes at intake and is scored by the provider. It is administered at varying intervals to measure the level of improvement with depression in response to treatment.

Another self-report questionnaire used is the Generalized Anxiety Disorder 7 (GAD-7). The GAD-7 is used to screen and measure the severity of generalized anxiety disorder (GAD). It has seven items, which measure the severity of various signs of GAD. The Assessment is indicated by the total score, which is made up by adding together the scores for all seven items. Higher GAD-7 scores are indicative of more severe symptoms while lower scores reflect mild to moderate severity.

Below are the results of the PHQ-9 and GAD-7 average assessment scores, which were administered to clients during the fiscal year. Both show an improvement in clients' post scores.

PHQ-9 Test Scores	
Pre Score	**Post Score**
27	**17**

37% Average Improvement

GAD-7 Test Scores	
Pre Score	**Post Score**
14	**9**

36% Average Improvement

Success Story

On the final day of our Women's Coping Skills group, members expressed truly enjoying the group and feeling somewhat sad that it was ending. One client verbalized that she was glad she decided to participate despite having initial reservations. She said that it was good to hear input from others and added that the group sessions also made her feel that she was helpful because she had an opportunity to offer suggestions and support to others as well. Another group member reported that she was eager to come to the weekly sessions to report on the progress she had made because she felt valued in the group. Several other members of her family have called to seek services after she shared her positive experiences and information with them.

Challenges

The CWE program providers identified challenges they faced during the course of the year. Through outreach and education, providers have attempted to increase awareness of supportive services available to those who are at risk of suicide or have loved ones they have lost to suicide. However, attendance continues to be scarce.

"Great information! In my group of friends, we never really talk about the topic [of suicide]. After receiving the training, I have a better understanding. I learned a lot!"

- safeTALK Participant

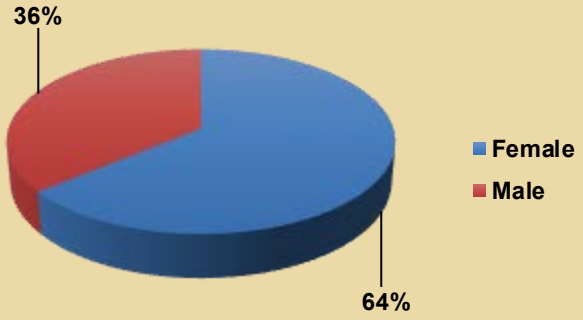
System Enhancement Initiatives

Solutions in Progress

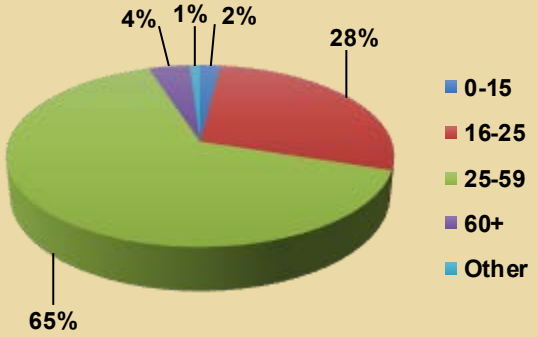
Providers are enhancing their outreach efforts in order to increase participation in suicide bereavement support groups. New strategies will be implemented that include a greater emphasis on reducing the stigma surrounding suicide and increasing mental health awareness.

Fiscal Year 2014/2015 Program Demographics

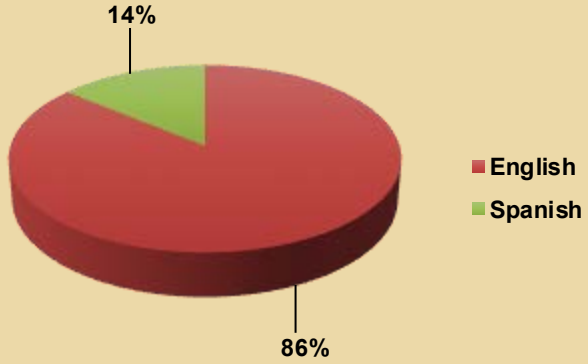
Gender



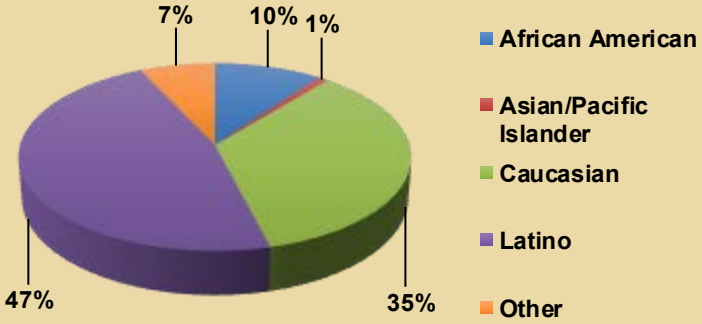
Age



Primary Language



Ethnicity



Total Number Served/Unduplicated Count

Total Number Served	Unduplicated Count
9,814	3,939

Program Updates

In Fiscal Year 2016/17, there are no planned program changes or changes to the program budget.

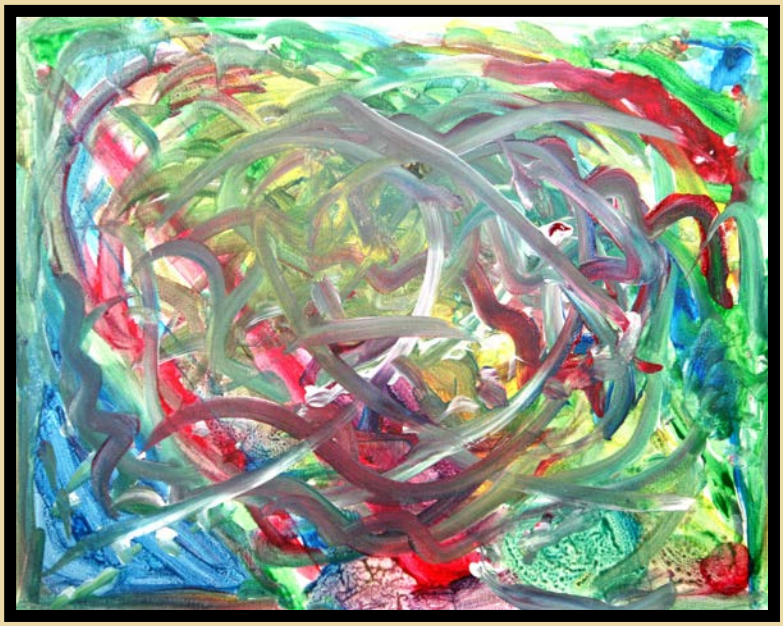
Collaborative Partners

- Bilingual Family Counseling Services, Inc.
- Rim Family Services, Inc.
- South Coast Community Services.
- Victor Community Support Services, Inc.
- McKee Family Health Center.
- Westside Family Health Center.

Military Services & Family Support Program (PEI SE-4)

The Military Services and Family Support (MSFS) Program provides free and confidential behavioral health services for military service members and their families in San Bernardino County. All active duty and retired military personnel, reservists or National Guard, who have served on or after September 11, 2001, and their families are eligible to receive services.

Men and women returning from active duty can carry emotional scars of prolonged battle fatigue and Post-Traumatic Stress Disorder (PTSD). Data analysis has shown that military personnel returning from active duty have a higher risk of suicide than that of the general population. Additionally, the diverse children and youth in these families face adjustment difficulties and vulnerabilities resulting from frequent moves, repeat deployments, and reintegration. Children and youth in these families may need support in coping with well-founded fears resulting from their parents' deployments.



Artwork by Kathy Joy

The MSFS program provides services that include, but are not limited to, behavioral health assessments, rehabilitative support, family services, case management services, screenings, educational classes, individual sessions, and in-home visits.

Portions of this program are offered in collaboration with San Bernardino County Department of Veterans Affairs. Offering multiple access options increases the likelihood military personnel will utilize services, while also reducing the occurrence of stigma and discrimination associated with obtaining behavioral health services.

System Enhancement Initiatives

MHSA Legislative Goals and Related Key Outcomes

- Reduce Prolonged Suffering.
  - ◊ Improved life satisfaction.
  - ◊ Decreased hopelessness/increased hope.
  - ◊ Increased resiliency.
  - ◊ Decreased impairment in general areas of life functioning, e.g., health, self-care, housing, occupation, education, legal, managing money, interpersonal, social.
- Reduce suicide.
  - ◊ Decreased suicidal ideation.
  - ◊ Increased knowledge of suicide risk factors.
  - ◊ Increased knowledge of suicide prevention resources.
  - ◊ Decreased suicide risk, as measured by suicide and client assessment/outcome measures.
- Reduce Stigma and Discrimination Associated with Mental Illness.
  - ◊ Increased accurate knowledge about mental illness.
  - ◊ Increased intent to seek services, if needed.

Target Populations:

- Children
- TAY
- Adults
- Older Adults

Projected Number to be Served FY 2016/17:

- 541 Children
- 934 TAY
- 2,509 Adults
- 203 Older Adults

Positive Results

There are two components included in the MSFS program. The first component is prevention, which provides screenings and assessments for individuals and their families. Support groups are also provided, which are designed to meet the unique needs of military families. The second component is intervention with services that include case management and referrals for individuals and families identified as needing mental health services. The intervention component also provides for individual, couples, and/or family counseling and therapy. Short-term mental health services are also available for participants experiencing the early onset of a mental illness.

For FY 2014/2015, the MSFS program served **7,233** unduplicated participants, which is **42%** over the projected number for the year. To measure outcomes and ensure goals are being met, the program utilizes the Beck Depression Inventory, the Beck Anxiety Inventory. Below are the results of those measure for the program year.

Beck Depression Inventory	
Pre Score	**Post Score**
28.8	**9.1**

68% Average Improvement

Beck Anxiety Inventory	
Pre Score	**Post Score**
21.4	**14.8**

31% Average Improvement

System Enhancement Initiatives

The Global Assessment of Functioning (GAF) is also used to measure outcomes. GAF scores measure an individual's overall ability to carry out daily living activities and psychological, social, and occupational functioning. Participant's scores were noted at case opening and case closing. GAF results showed a **24%** average improvement, as illustrated below.

GAF	
Pre Score	**Post Score**
48.7	**60.5**

24% Average Improvement

Success Story

"Daryl" observed his wife's behavior changing and was very concerned for her well-being. Daryl noticed that his wife, "Carol" was struggling with hostility and she also began isolating herself socially. This was impacting her relationships with Daryl, their family, and friends. Daryl and Carol's loved ones encouraged them to seek services from the Military Services and Family Support (MSFS) program. They engaged in services provided by the MSFS program. Daryl attended behavioral health education sessions and family support groups. Carol worked with counselors and learned how to express her thoughts and feelings appropriately and develop healthy coping skills. Carol has made tremendous progress by establishing goals, working on self-care, and improving relationships. The couple's relationship has improved tremendously and they continue to utilize MSFS program services when needed.

Challenges

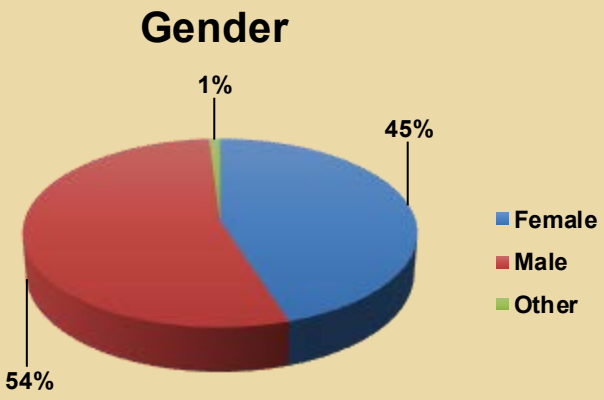
Due to the nature of the military environment, personnel on the bases rotate frequently. This can make it difficult to develop a consistent referral source. Additionally, military bases frequently experience base closures, which prevent MSFS program staff from gaining access on to the military bases.

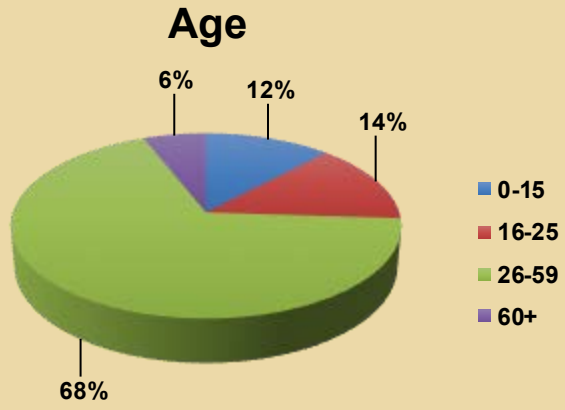
Solutions in Progress

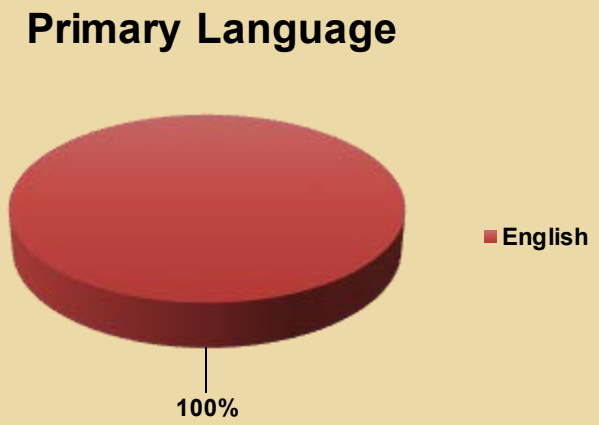
MSFS staff will continue to build on existing relationships with local military bases and establish new contacts when different personnel rotate to the bases. Program providers are working on developing a business process that will maintain the referral process between MSFS program providers and the military bases when staff is rotated at either site. Additionally, the MSFS staff continues to work with military bases to develop solutions to continue providing services in instances where the bases are on mandatory closure.

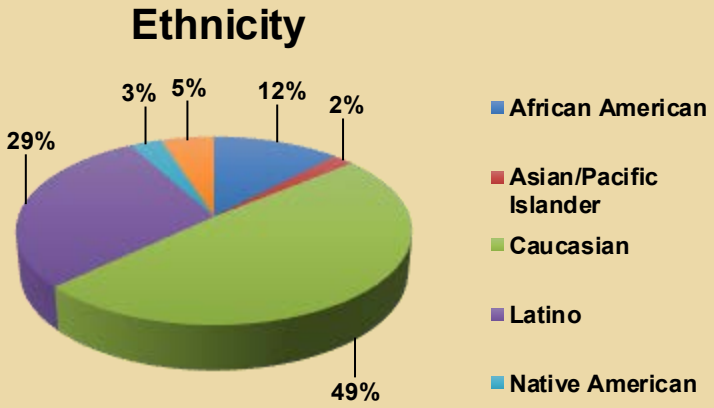
Artwork by Justin Seals

Fiscal Year 2014/2015 Program Demographics









Total Number Served/Unduplicated Count

Total Number Served	Unduplicated Count
13,042	7,233

Program Updates

In Fiscal Year 2016/17, there are no planned program changes or changes to the program budget.

Collaborative Partners

- Christian Counseling Service.
- Pacific Clinics.
- Victor Community Support Services.
- San Bernardino County Department of Veterans Affairs.

LIFT Program PEI SE-5

Artwork by Debra Medina

The LIFT program is a home visitation program for low-income mothers and their children. Services are delivered in the home by nurses who provide education and support from early pregnancy through the child's second birthday. Program nurses encourage the physical and emotional care of children by their mothers, family members, and caregivers and link them with needed physical and mental health services. Services include prenatal screenings, postpartum depression screenings, maternal attachment support, substance use screenings and support, parenting education and support, life and employment skills development, case management, and assistance with developmental milestones for the child.

The LIFT program uses the evidence-based curriculum Partners for a Health Baby. This curriculum stresses the importance of prenatal and early childhood development and the power of early family relationships.

MHSA Legislative Goals and Related Key Outcomes

- Reduce Prolonged Suffering:
  - ◊ Improved life satisfaction.
  - ◊ Decreased hopelessness/increased hope.
  - ◊ Increased resiliency.
  - ◊ Decreased impairment in general areas of life functioning.
- Reduce Stigma and Discrimination Associated with Mental Illness:
  - ◊ Increased accurate knowledge about mental illness.
  - ◊ Increased intent to seek services, if needed.
- Reduce School Failure and Dropout Rates:
  - ◊ Increased school attendance.
  - ◊ Increased subjective school connectedness.
  - ◊ Lower rate of school dropouts.
  - ◊ Lower rate of failing students.
  - ◊ Decreased school behavioral problems.
  - ◊ Decreased school achievement problems.
- Reduce Unemployment Among Consumers:
  - ◊ Lower rate of unemployment.
  - ◊ Increased employment-related skills/vocational strengths.

Target Populations:

- TAY
- Adults

Projected Number to be Served FY 2016/17:

- 54 TAY
- 66 Adults

System Enhancement Initiatives

Positive Results

In FY 2014/2015, the LIFT program served **88** unduplicated participants. The Life Skills Progression (LSP) assessment tool, which monitors an individual's strengths and needs, is administered every six months in the LIFT program and uses a rating scaled from 0-5 points with 0 indicating at most risk.

The table below represents pre and post results using the LSP during this program year. The data collected from participants indicate that they are gaining employment, receiving support in obtaining their educational goals, obtaining access to the health care system, increasing their relationships with family and friends, and acquiring basic essentials.

Categories	Pre Score	Post Score
Relationships with Family and Friends	4.4	4.5
Relationships with Children	3.6	3.7
Relationships with Supportive Resources	3.2	3.8
Education and Employment	2.4	2.9
Parent and Child Health	3.6	3.9
Basic Essentials	3.6	3.8

Success Story

PSD LIFT enrolled a pregnant mother that was starting to show unexplained signs of "sadness" as her delivery date approached. The RN had been discussing her need to complete high school and seek out a stable job. Up to this point the mother was resistant and although she was resistant the RN was eventually able to discuss the mother's unexplained "sadness". The mother confided that she was worried about being able to provide for her newborn. PSD has a component that provides job coaching and help identifying current employment opportunities. The new mother decided to participate in this program and shortly after delivery got a stable entry level job and returned to complete her high school diploma.

Artwork by Desiree Caudillo

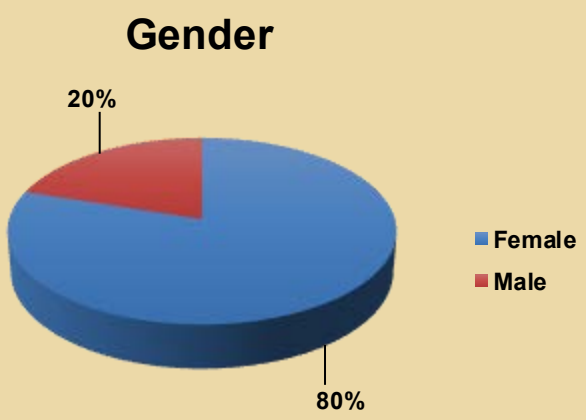
Challenges

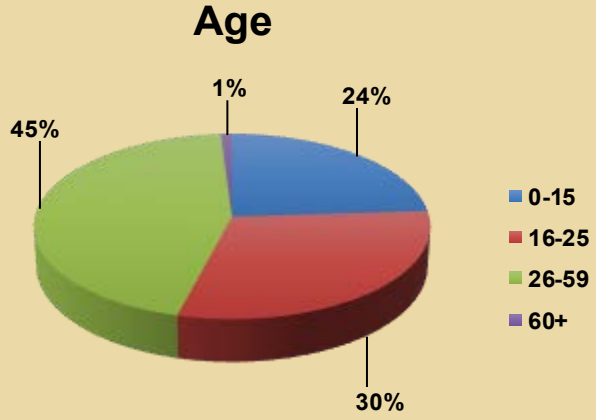
Recruitment issues for Registered Nurses are a challenge nationwide. The LIFT program started the year with only two Registered Nurses. This had an impact on the service capacity of the LIFT program. In the first part of the year. Services were limited until additional nurses could be recruited.

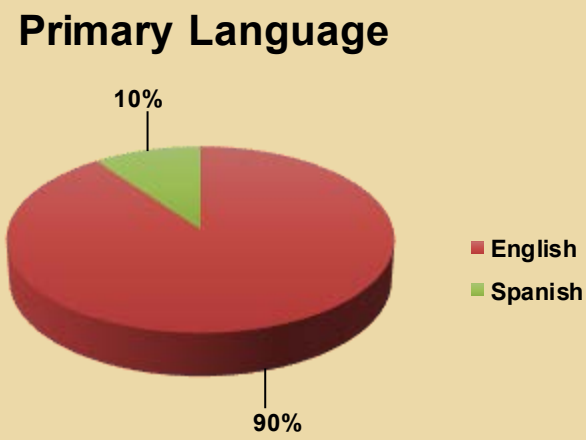
Solutions in Progress

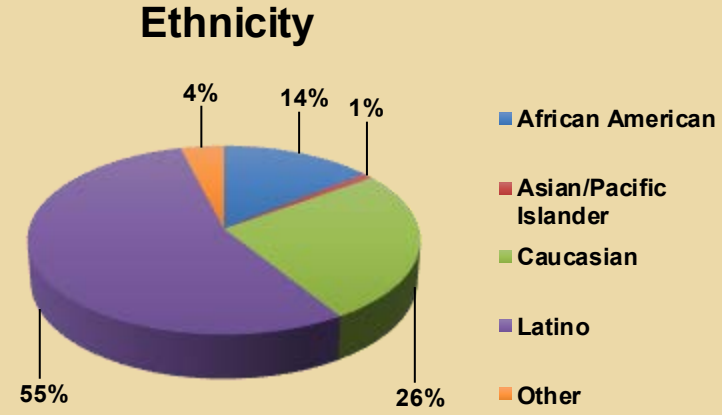
An additional nurse was added. The LIFT program is now fully staffed. The additional nurse increased recruitment and service delivery to pregnant mothers in need of supportive services. Additionally, Preschool Services Department will is collaborating with various agencies and implementing new strategies to create awareness in the community of the services offered by the LIFT program.

Fiscal Year 2014/2015 Program Demographics









Total Number Served/Unduplicated Count

Total Number Served	Unduplicated Count
841	88

Program Updates

In Fiscal Year 2016/17, there are no planned program changes or changes to the program budget.

Collaborative Partners

- Preschool Services Department.

Coalition Against Sexual Exploitation PEI SE-6

Artwork by Greg Vander-Haeghen

The Coalition Against Sexual Exploitation (CASE) program is a collaborative approach between ten public agencies that serve sexually exploited children (ages 12-15), Transitional Aged Youth (TAY) (ages 16-25), and those at risk for sexual exploitation through a centralized referral mechanism managed by the CASE Coordinator and multi-disciplinary team (MDT). The program coordinates community outreach and education as well as direct services. Services include mental health assessments, crisis intervention, case management, school enrollment assistance, therapeutic interventions, transportation, placement, and linkage/referral to community resources.

The CASE program was originally an Innovation project, introduced in 2010 through the approved MHSA Innovation component plan. The County conducted an extensive Community Program Planning (CPP) process involving a variety of community stakeholders. After careful review of the Innovation component intent, principles and priorities, CASE was identified as a project necessary to focus efforts on the sexually exploited population.

The initial intent was to develop a model of collaborative care that facilitated clinical rehabilitation for a specific group of children/youth who have been sexually exploited, and to develop approaches to mental health education that assist in the prevention of future exploitation. The long-term goal of the project is to make use of an innovative collaboration to strengthen clinical practice for systems that serve sexually exploited children/youth, by developing creative clinical strategies and combining best practices in trauma care with local-collaborative expertise.

MHSA Legislative Goals and Related Key Outcomes

- Reduce Prolonged Suffering:
  - ◊ Improved life satisfaction.
  - ◊ Decreased hopelessness / increased hope.
  - ◊ Increased Resiliency.
  - ◊ Decreased impairment in general areas of life functioning (e.g., health/self-care/housing, occupation/education, legal, managing money, interpersonal, social).

Target Populations:

- Children
- TAY
- Adults

Projected Number to be Served FY 2016/17:

- 50 Children
- 1,000 TAY
- 3,000 Adults *(Outreach)*

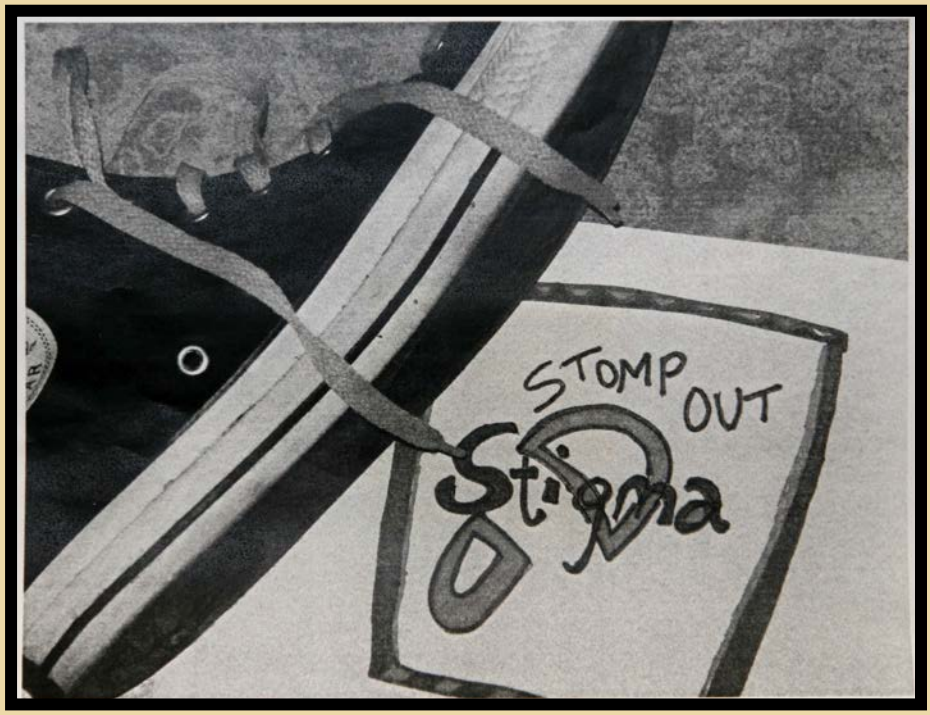
Positive Results

The Child and Adolescent Needs and Strength Assessment (CANS) is a tool being utilized by CASE program staff to measure the resiliency and functioning of children receiving supportive services through the program.

A score of **1** in this domain indicates that the "child's ability to recognize and use his/her strengths to support healthy development and/or to solve problems is limited." A score of **2** in the resiliency domain would indicate that there is evidence that the "child recognizes his/her strengths, but is not yet able to use them to support his or her healthy development or to solve problems and/or child is not conscious of the use of their strengths".

Using the Resiliency domain on the CANS Assessment, CASE participants were found to have a reduction in average score from **1.625** to **1.375**.

The minor reduction in average Resiliency scores is a result of the challenges in serving commercially sexually exploited children who tend to have instability in housing and placement, and consequently lack consistent access to supportive services that would increase resiliency.



Artwork by Stella Grosso

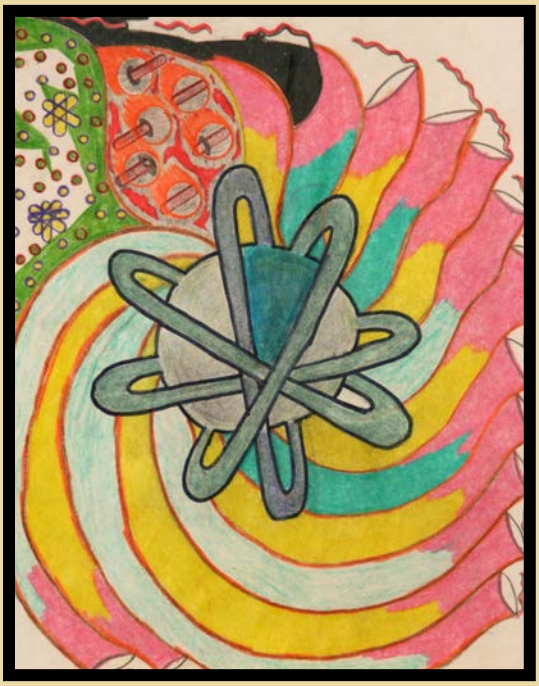
The CANS data on the children served through CASE confirms the need to continue to increase the awareness and capacity of local organizations to provide services to this extremely vulnerable population. With this in mind, CASE continues to provide education to community organizations and stakeholders. Over the past year, the CASE presentation, "*Identification & Assessment of Victims of Trafficking and Commercial Sexual Exploitation*," has been offered to law enforcement, probation officers, social workers, therapists, intake specialists, childcare workers, teachers, guidance counselors, school resource officers, first responders and community members.

A survey of participants was conducted at **13** training events. **99%** of the participants surveyed indicated that their "ability to identify and/or work with victims of human trafficking and sexual exploitation was improved" after receiving the training.

These positive training outcomes for potential responders may indicate an increased ability of systems and communities to identify and serve commercially sexually exploited children and youth, develop more stable placements and increase access to consistent services that in turn, may increase the resiliency of these children in the future.

Success Stories

"Mary" is a 16-year-old girl with a history of being commercially sexually exploited since age 14. She has been involved in the juvenile justice system in Orange, Los Angeles, and San Bernardino counties. She was connected with the CASE program where she worked with a social worker who provided case management services and coordinated supportive services for Mary and her family. Mary has successfully been attending school and therapy. The therapy sessions have helped her tremendously. She has asked to utilize her Victims of Crime benefits in order to meet with her therapist more frequently. She has also secured a job working part-time at a restaurant close to where she is living. Mary is no longer running away from home as she was in the past. She is working closely with Probation to ensure that she complies with her juvenile justice system requirements. Most importantly, she has a renewed sense of self worth and is committed to not returning to "the life" that caused her so much trauma.



Artwork by Isabel Figueroa

Challenges

The population of commercially sexually exploited children is a difficult population to serve for a variety of reasons including distrust of service providers, extensive histories of trauma, instability of housing/placement, frequency of running away, reluctance to engage in services, and unsupportive families.

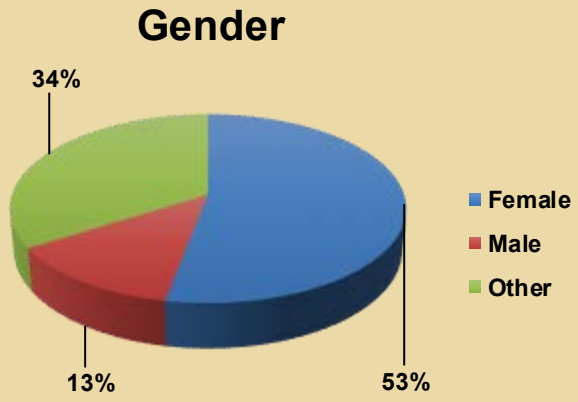
The most challenging barrier to the delivery of services to commercially sexually exploited youth is instability in housing/placement. For example, many of the youth in the CASE program do not stay in one place long enough to establish relationships with local service providers. They frequently run away from home or court-ordered placement and are not heard from again. In some cases, they are arrested and detained in a juvenile hall facility and ordered back to placement. Frequent placement changes and episodes of running away make delivery of behavioral health and other services a challenge. Because of the nature of the trauma, it is difficult to find appropriate housing or residential treatment facilities that can tailor services specifically for the complex and ever-changing needs of this target population.

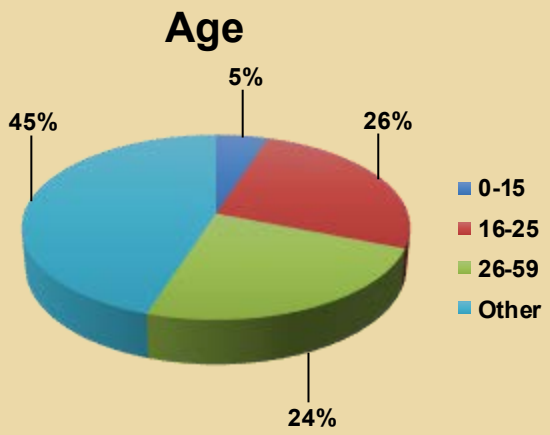
Solutions in Progress

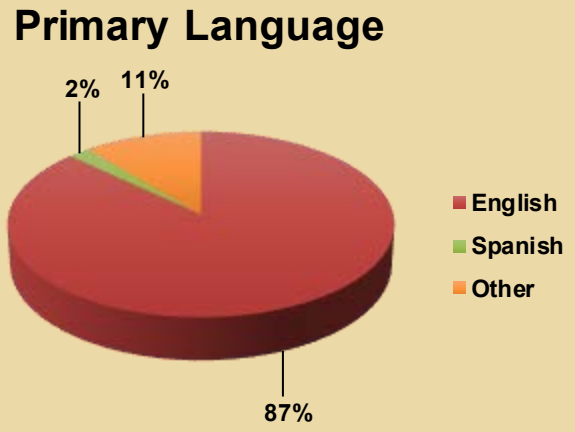
CASE provides ongoing training and education to community members and professionals working with children and families to provide them with tools and best practices to work with the population of commercially sexually exploited youth. CASE staff continue to advocate for safe and secure locations for survivors to be placed.

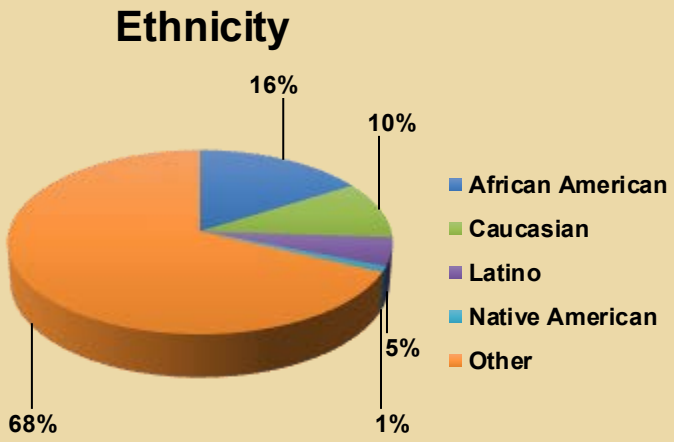
CASE staff members have also made efforts to establish and maintain good working relationships with professionals in the counties surrounding San Bernardino. This is accomplished by participating in regional meetings, conference calls and other events. A tightly-knit network of professionals who are familiar with the youth who have a history of being trafficked in the southern region counties will lead to increased and consistent service delivery for this population.

Fiscal Year 2014/2015 Program Demographics









Total Number Served/Unduplicated Count

Total Number Served	Unduplicated Count
6,275	5,022

Program Updates

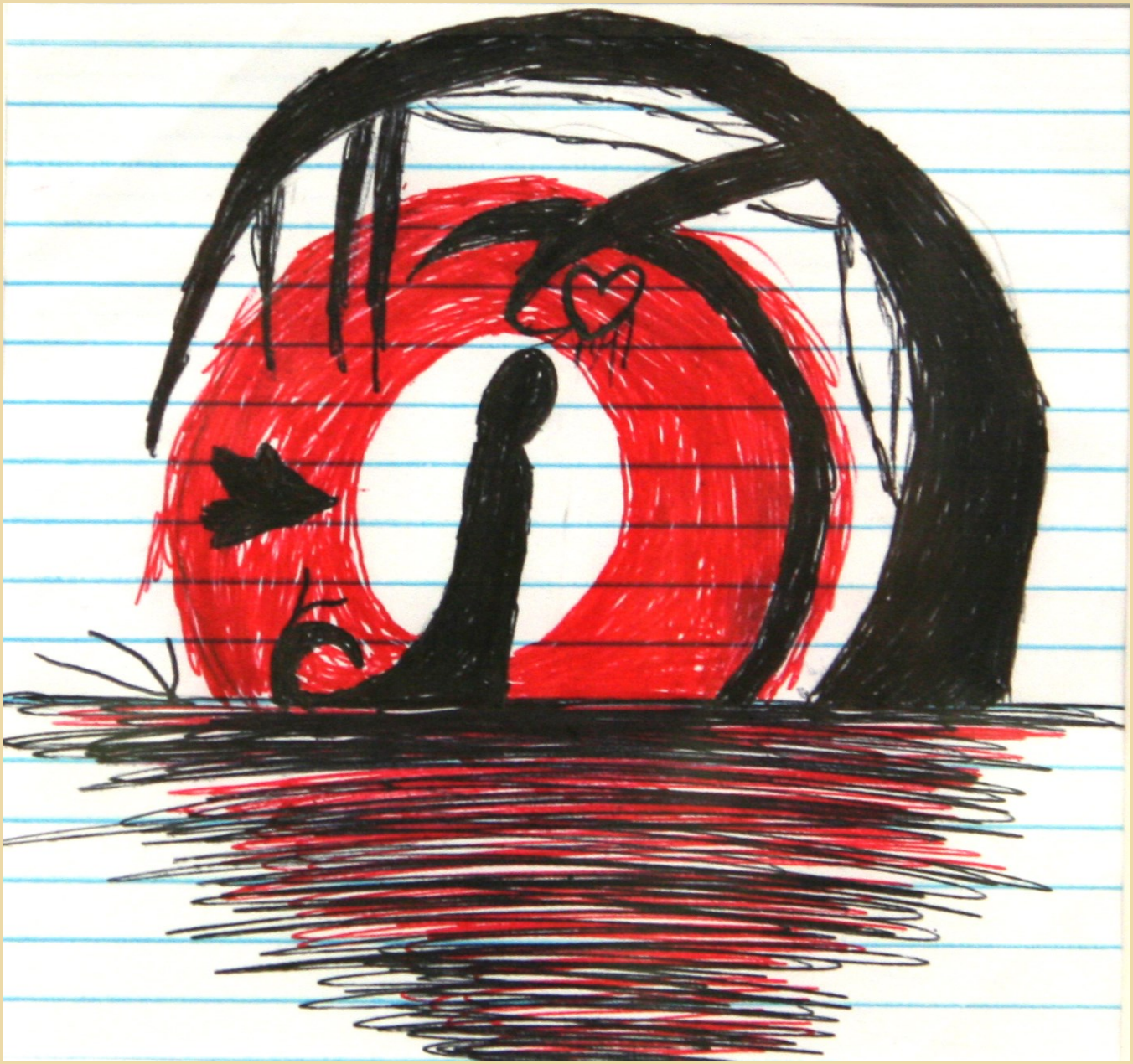
In Fiscal Year 2015/2016, the CASE program has added a Public Health Nurse to participate in multi-disciplinary team meetings and provide information related to reproductive and sexual health including access to contraceptives, Human Immunodeficiency Virus (HIV) prophylaxis and treatment for sexually transmitted infections and sexually transmitted diseases to the commercially sexually exploited children and youth.

System Enhancement Initiatives

Collaborative Partners

- San Bernardino County District Attorney's Office.
- San Bernardino County Behavioral Health.
- San Bernardino County Children and Family Services.
- San Bernardino County Children's Network.
- San Bernardino County Sheriff's Department.
- San Bernardino County Superintendent of Schools.
- San Bernardino County Probation Department.
- San Bernardino County Public Defender.
- San Bernardino County Public Health.
- Superior Court of California, Juvenile Court.

Artwork by Laverne Herbert



Artwork by Brandi Hebel

Community Services and Supports (CSS)

Community Services and Supports

Introduction

The Mental Health Services Act (MHSA) requires that services are consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers:

- To promote concepts key to the recovery for individuals who have mental illness; hope, personal empowerment, respect, social connections, responsibility, and self-determination.
- To promote consumer operated services as a way to support recovery.
- To reflect the cultural, ethnic, and racial diversity of mental health consumers.
- To plan for consumer's individual needs.

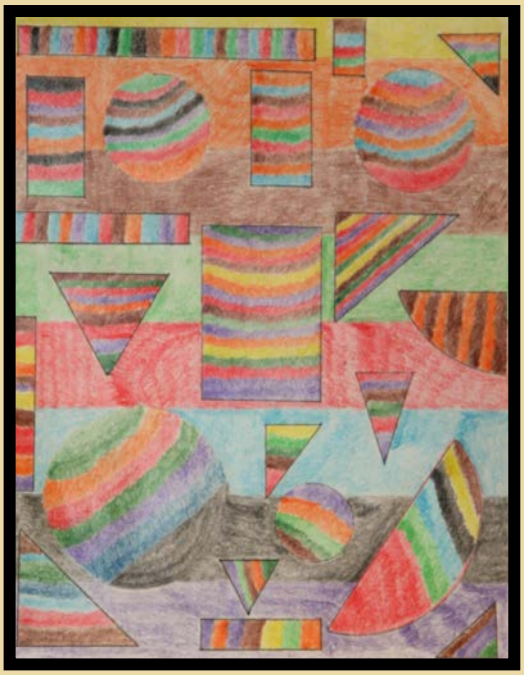
The majority of MHSA funding (80%) is mandated to be directed toward the Community Services and Supports (CSS) component. CSS provides access to mental health services through our previously approved programs and targets: Seriously Emotionally Disturbed (SED) children and youth and Seriously Mentally Ill populations. Seriously Emotionally Disturbed refers to children and youth with difficulty functioning in multiple life domains such as school, home, and/or community.

Serious Mental Illness (SMI) is a term defined by Federal regulations that describe mental disorders that significantly interfere with some area of functioning.

The CSS services component provides access to Full Service Partnerships (FSP). FSP's provide all necessary services and supports to help clients achieve their mental health goals and treatment plan. FSP services comprehensively address client and family needs and "do whatever it takes" to meet those needs, including intensive services and supports and strong connections to community resources with a focus on resilience and recovery.

MHSA Legislative Goals

- Reduce the subjective suffering from serious mental illness for adults and serious emotional disorders for children and youth.
- Reduce homelessness and increase safe and permanent housing.
- Increase in self-help and consumer/family involvement.
- Increase access to treatment and services for co-occurring problems; substance abuse and health.
- Reduction in disparities in racial and ethnic populations.
- Reduce the number of multiple out-of-home placements for foster care youth.
- Reduction in criminal and juvenile justice involvement.
- Reduce the frequency of emergency room visits and unnecessary hospitalizations.
- Increase a network of community support services.



Artwork by Gabriel Horne

Community Services and Support

This component has greatly contributed to the ongoing transformation of the public mental health system by:

- Augmenting existing services.
- Establishing a system of care for crisis services.
- Developing programming to address the needs of Transitional Age Youth (TAY).
- Developing supportive housing and maximizing MHSA funds for housing opportunities.
- Enhancing and expanding wraparound services to children.
- Expansion of adult FSP.

There are currently fourteen (**14**) CSS programs designed to serve all age groups. The programs are as follows:

- C-1: Comprehensive Children and Family Support Services (CCFSS)
- C-2: Integrated New Family Opportunities (INFO)
- TAY-1: Transitional Age Youth (TAY) One Stop Centers
- A-1: Clubhouse Expansion Program
- A-2: Forensic Integrated Mental Health Services (FACT, STAR and CIT)
- A-3: Members Assertive Positive Solutions/Assertive Community Treatment (MAPS/ACT)
- A-4: Crisis Walk-in Centers (CWIC)
- A-5: Psychiatric Triage Diversion Program
- A-6: Community Crisis Response Team (CCRT)
- A-7: Homeless Intensive Case Management and Outreach
- A-8: Big Bear Full Service Partnership
- A-9: Access, Coordination and Enhancement (ACE) of Quality Behavioral Health Services
- OA-1: AgeWise-Circle of Care
- OA-2: AgeWise-Mobile Response

Two additional programs have been added to the CSS component. The department has successfully been awarded by the California Health Facilities Financing Authority (CHFFA) to build three (3) facilities, which will house the new Crisis Residential Treatment (CRT) program, A-10. The CRT program will deliver much needed crisis residential treatment facilities to the residents of San Bernardino County.

The program will provide structured recovery-based, enriched treatment services and activities:

- Housing.
- Psychiatric/medication support.
- Comprehensive clinical assessments and therapies.
- Life skills coaching.
- Peer and family support networks.
- Coping techniques.
- Recovery education.
- Community resource linkages.

Additionally, in FY 2016/17, the Adult Full Service Partnership Program will be reorganized from within A-7, the Homeless Intensive Case Management and Outreach Services Program. As a new standalone program, the Regional Adult Full Service Partnership (RAFSP), A-11, offers Full Service Partnership (FSP) programs in all clinics in every region of San Bernardino County. The RAFSP programs include intensive services that both assist individuals to step down to a lower level of care and services to assist at-risk individuals to receive services in the least restrictive setting possible.

Comprehensive Children and Family Support Services (C-1)

Comprehensive Children and Family Support Services (CCFSS) program is comprised of a continuum of services targeting three (**3**) populations in Full Service Partnerships (FSP) to provide Wraparound services to diverse children and youth living with emotional disturbances and co-occurring disorders.

The Wraparound (SB 163) program helps develop plans to focus on individual strengths and needs of clients and families. The process provides individualized, comprehensive, community-based services and supports to children and families. Wraparound has proven to be an effective means by which children and youth receive assistance and avoid out-of-home placements or loss of current placements due to the severity of their emotional disturbance. Additionally, participants are helped in accomplishing appropriate goals and developing constructive relationships within their family and community.

Wraparound is a definable planning process that results in a unique set of community services and natural supports that are individualized for a child and family to achieve a positive set of outcomes. Services are "wrapped around" the child and family in their natural environments. Wraparound is community-based (using a balance of formal and informal supports), culturally relevant, flexible, and coordinated across agencies; it is outcome driven, and provides unconditional care (SAMHSA, 2008).

MHSA Legislative Goals and Related Key Outcomes

- Reduce the subjective suffering from serious mental illness for adults and serious emotional disorders for children and youth:
  - ◊ Decreased impairment in general areas of life functioning (e.g., health/self-care/housing, occupation/education, legal, managing money, interpersonal/social).
  - ◊ Decreased suffering from serious emotional difficulties.
  - ◊ Decreased hopelessness/increased hope
  - ◊ Increased resiliency.
- Reduce homelessness and increase safe and permanent housing:
  - ◊ Increased residential stability.
- Reduction in criminal and juvenile justice involvement:
  - ◊ Reduced delinquent behaviors which increase likelihood of juvenile justice involvement.

Target Population:
- Children

Projected Number to Be Served FY 2016/17:
- 2,081 Children

"Wraparound has helped to be calm and to tell the truth more often."
- Wraparound Participant

Positive Results

The Child and Adolescent Needs and Strengths (CANS) assessment tool is utilized within all CCFSS programs. The data from the CANS tool is analyzed in two ways: (1) Global Measurement and (2) Specific Area/Construct. The Global Measure analysis reviews specific items in a domain (e.g., Life Functioning) and compares scores from the beginning of services to the planned discharge. The Specific Area analysis considers only those children and youth who began services with a significant need for help on an item/construct and reports what percentage of those children and youth no longer needed help with the same item by the end of services or discharge.

Community Services and Supports Programs

Global Measurement of Life Functioning:

- **93.9%** of children and youth entering CCFSS Programs were scored as having at least one area of impaired life functioning.
- **66.3%** of these children and youth showed statistically significant improvements upon exiting the program.

Artwork by Brad Borrero

Specific Areas of Life Functioning:

- **Family Difficulties: 68%** of the children needed help with family difficulties, and of those, **63%** showed sufficient improvement in this area that no additional help was needed at the time of exiting the program.
- **Social Functioning: 53%** of the children needed help improving their social functioning, and of those, **68%** showed sufficient improvement in this area that no additional help was needed at the time of discharge.
- **Recreational: 35%** of the children needed help with positive recreational leisure time activities, and of those, **58%** showed sufficient improvement in this area that no additional help was needed at the time of exiting the program.
- **Sleep: 31%** of the children needed help with sleep disruption, and of those, **65%** showed sufficient improvement in this area that no additional help was needed at the time of exiting the program.
- **School Behavior: 43%** of the children needed help with behavior in school, and of those, **67%** showed sufficient improvement in this area that no additional help was needed at the time of exiting the program.
- **School Achievement: 47%** of the children needed help with academic achievement, and of those, **56%** showed sufficient improvement in this area that no additional help was needed at the time of exiting the program.
- **School Attendance: 13%** of the children needed help with school attendance, and of those, **67%** showed sufficient improvement in this area that no additional help was needed at the time of exiting the program.

Global Measurement of Behavioral and Emotional Needs:

- **94.8%** of children and youth entering CCFSS programs were scored as having at least one significant behavioral or emotional need.
- **62.7%** of these children showed statistically significant improvements upon exiting the program.

Specific Areas of Behavioral and Emotional Needs:

- **Impulsivity/Hyperactivity: 39%** of the children required treatment for difficulties related to impulsivity and/or hyperactivity, of those, **51%** showed sufficient improvement in this area that no additional help was needed at the time of exiting the program.
- **Depression: 43%** of the children required treatment for difficulties related to depression, and of those **60%** of them showed sufficient improvement in this area that no additional help was needed at the time of exiting the program.
- **Anxiety: 35%** of the children required treatment for difficulties related to anxiety, and of those, **57%** of them showed sufficient improvement in this area that no additional help was needed at the time of exiting the program.
- **Anger Control: 54%** of the children require treatment of anger control and of those, **64%** showed sufficient improvement in this area that no additional help was needed at the time of exiting the program.

- **Eating Disorders: 6%** of the children required treatment for eating disorders and of those, **64%** showed sufficient improvement in this area that no additional help was needed at the time of exiting the program.
- **Behavioral Regressions: 7%** of the children required treatment for regressions in behaviors, and of those, **53%** showed sufficient improvement in this area that no additional help was needed at the time of exiting the program.
- **Substance Use Disorder: 6%** of the children required treatment for substance use disorder, and of those, **38%** showed sufficient improvement in this area that no additional help was needed at the time of exiting the program.

Children coming into CCFSS programs are in a variety of situations regarding their residence. Some children live with biological families, some live in placement residences and have Child Welfare involvement, some are placed into families by Child Welfare, and others are placed in group homes. In addition to the basic question of residential stability for the caregiver, the key outcomes likely to increase residential stability for a child are (1) being with a caregiver likely to be involved once the child has grown, (2) how well the child is functioning within the family home, and (3) how involved and knowledgeable the caregiver is in regards to the needs of the child. These last items are indicative of a level of engagement from the caregiver and more engaged caregivers are more likely to provide positive supports for the child.

Artwork by Gary Bustin

Specific indicators likely to increase residential stability:

- **Caregiver's Residential Stability: 5%** of the caregivers involved in the CCFSS Programs indicated needing help in obtaining a more stable residence. **67%** of those needing this residential stability were able to obtain this by the end of services.
- **53%** of the children started a CCFSS Program needing help improving their functioning within their living situation. **70%** of these children were able to significantly improve on this item, indicating a decrease in conflict within the home.
- **8%** of the caregivers were significantly uninvolved with the mental health needs of their children at the time of admission, **84%** of these caregivers were seen as appropriately involved by the end of services.
- **52%** of the caregivers showed a detrimentally low level of knowledge regarding the child's mental health needs at the start of services. **71%** of these caregivers gained enough knowledge related to the child's needs that this was of no concern by the end of the program.
- **31%** of the caregivers showed a marked need for financial and social assets at the start of services. **74%** of these caregivers had necessary resources to address the child's major and basic needs by the end of services.

Of the children seen in CCFSS programs, **54.81%** needed help with issues that could easily lead to criminal or juvenile justice involvement; however, only **14%** had specific difficulties related to formal legal charges. Evaluating the effectiveness of CCFSS on reducing the likelihood of juvenile justice involvement focuses on the impact made on these specific issues which could lead to juvenile justice involvement.

Specific indicators likely to increase juvenile justice involvement:

- **Delinquency: 7%** of the children were engaging in delinquent type of behaviors that could result in an arrest at the start of services. **59%** of these children were no longer seen as needing help on this upon exiting the programs.
- **Danger to Others: 10%** of the children needed help to address the possibility that they would harm someone else. **74%** of these children were no longer considered to be at risk for harming others at the end of the program.
- **Runaway: 4%** of the children seen were engaging in runaway behaviors at the start of services. **56%** of them successfully managed to stop these behaviors by the end of services.
- **Conduct Disorder Behaviors: 12%** of the children displayed conduct disorder behaviors requiring intervention at the start of services. **59%** of these children improved to the point of not needing help with this issue upon discharge.
- **Oppositional Behaviors: 43%** of the children needed help with oppositional behaviors at the start of services. **59%** of these children improved to the point of not needing help with this issue upon discharge.

Success Story

Under the Wraparound model, services were provided to a five year old, 'Matthew' that presented with anxious episodes, fear of being taken from caregiver, nightmares, fear of being removed from the home, low frustration tolerance, anger outbursts, and irritability. He was quiet, cautious in forming personal relationships, and displayed a precise play style.

At the time of the referral to Wraparound, Matthew and his siblings were living with their maternal grandmother in family foster care while mother completed an in-patient treatment program. The Wrap team began the process of building rapport by engaging the family, including the mother after reunification, to focus on shared strengths and implement steps to create a healthy family future. The Wrap team modeled praise, reflect, imitate, describe, and enthusiasm (PRIDE) skills and encouraged parents to have one-on-one interaction with the child and to practice active listening skills. The PRIDE acronym is to support the parent-child interaction which means parents should describe the actions of their child, reflect what their child says, imitate the play of their child, praise their child's positive actions and try to enjoy the special time.

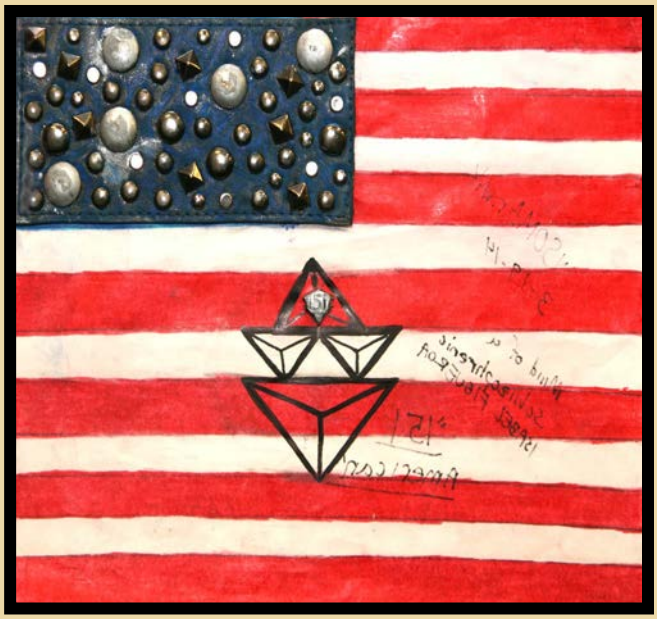
Artwork by Tona Epperson

Matthew reduced his difficult behaviors from five times per day to two times or less per week and increased assertive communication skills from zero times per day to the goal of two times per day. He formed good relationships with peers at school and with family members. He no longer has nightmares or is scared of the dark. He is no longer socially withdrawn and no longer physically strikes family members. He also no longer uses physical aggression to get his needs met. A loving and trusting relationship has been built with his mother, father, siblings, and extended family members.

Challenges

During the past year, one of the group home providers participating in the CCFSS program closed all Rate Classification Level (RCL) 14 group homes in San Bernardino County. and no longer operates any group homes in San Bernardino County. The agency communicated their intentions effectively and alternative placements were located for children. However, the loss of this placement option makes finding appropriate placements for youth more difficult.

The CCFSS program was one of the programs with the responsibility of implementing the Core Practice Model (CPM) as described by the California Department of Health Care Services (DHCS). The Core Practice Model was developed by the Department of Children and Family Services and the Department of Mental Health to identify common values, standards, and principles that promote effective working relationships and collaboration with all Community Partners to improve service for foster children. Since the core elements of a Full Service Partnership (FSP) support the CPM this was not difficult; however, monitoring the specific service requirements of the CPM was difficult to implement.



Artwork by Isabel Figueroa

Child Psychiatrists continue to be a limited resource in San Bernardino County, creating a difficulty in linking children and youth to resources for appropriate follow-up care. DBH, through the Workforce Education and Training Medical Education Program, is actively recruiting to meet this need.

Incorporating natural resources into the Child and Family Wraparound Teams for children and youth continues to be a challenge in our county. The FSP programs are attempting to address this for each family but this continues to be a challenge.

Collaboration with a local psychiatric hospital highlighted the difficulties families face in accessing care after hospitalization. The CCFSS programs are ideal to meet the needs of many children who have been hospitalized.

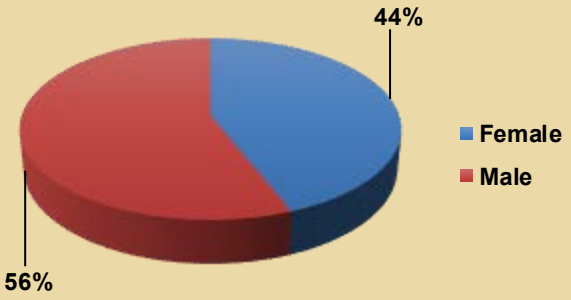
Solutions in Progress

To aid in the implementation of the CPM a multi-agency data sharing group was created. During FY 15/16, this group was able to develop consistent reports provided to the CCFSS programs that gave key indicators regarding the services provided to clients. The hope is that consistent information regarding the services provided this population will help facilitate a consistent implementation of the CPM.

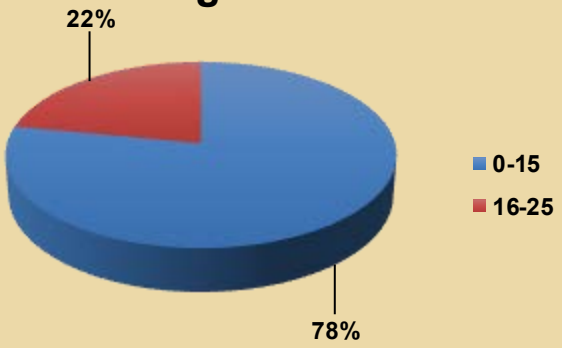
The high degree of collaboration with Children and Family Services (CFS) continues; however, the additional solution in progress is cross training provides in other programs regarding the value of CCFSS programs for foster youth. DBH staff co-located at the CFS regional offices have been more proactive in facilitating referrals to the CCFSS program.

Fiscal Year 2014/15 Program Demographics

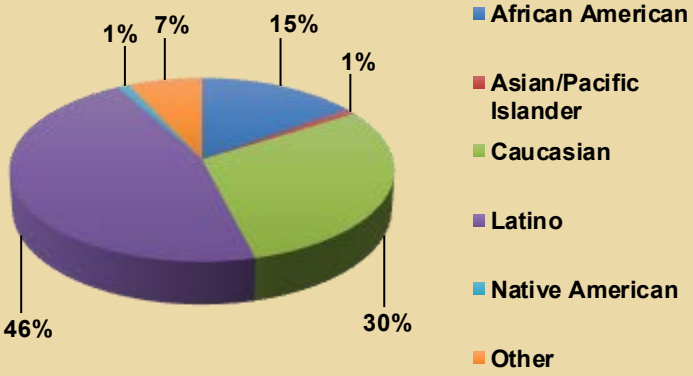
Gender



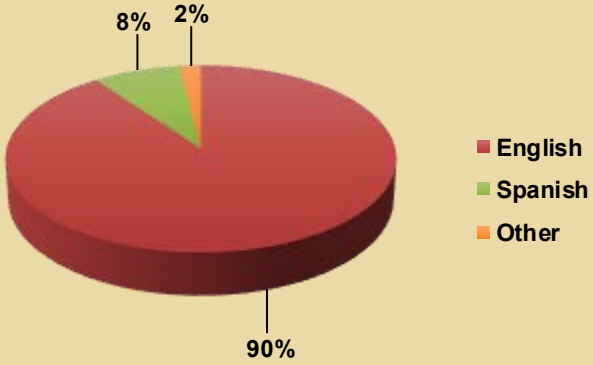
Age



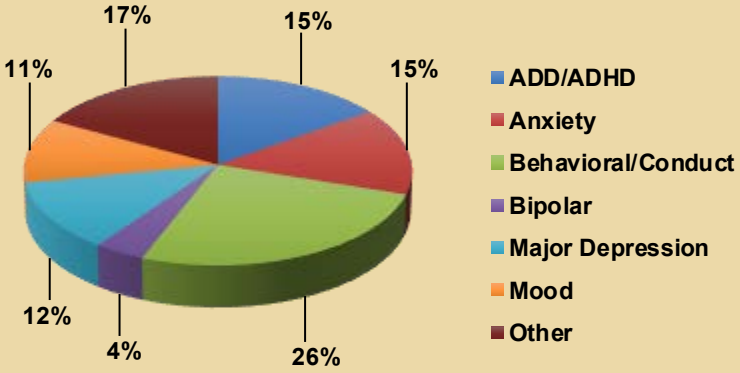
Ethnicity



Primary Language



Diagnostic Group



Program Updates

There was an increase in program funding in FY 16/17 due to CCFSS expanding to include an outreach and engagement element to try to address the needs of children in congregate care. This was done to serve these dependents through the Core Practice Model (CPM) and facilitate access to the three (**3**) different types of Full Service Partnerships within CCFSS. The successful work by these clinicians have furthered the need for this outreach and engagement through the CPM, illuminated the complex nature of serving children in this context, and required a level of supervision that was not expected. Additionally, the statewide implementation of the Continuum of Care Reform (CCR) and the passage of AB 403 is moving all congregate care away from Group Homes and more toward home based residences. System involved children and youth currently being maintained in a group home may continued to be served for a short time within a Short Term Residential Treatment Center (STRTC), so continued efforts with these children are needed. However, with more and more child/youth being provided a home based residence there is an increased need for the structure, support, and services inherent to the FSPs. For these two reasons (i.e. CPM and CCR) there will be an increase in the outreach and engagement portion of the CCFSS and the FSP portion of CCFSS that is designed to readily serve children in the home (i.e. Success First/Early Wrap and Wraparound).

Artwork by Gerard McDearmon

The increase will, in part, allow for expanded FSP services for children in home based residences. The current Success First/Early Wrap program was designed and funded to be a three to four month program. In the past year, while starting to serve more and more dependents, the typical length of the program has become extended to six months and some children require longer than a year of care before not requiring the FSP. The increase will allow for a shift in programming to expect these longer lengths of care, when needed.

The expansion of the CCFSS Outreach and Engagement effort is to serve dependents in congregate care, and will include the creation of positions to support growth efforts.

Some of the CCFSS Outreach and Engagement team will be co-located at CFS regional offices in order to work closer with the CFS Social Workers caring for the children in placement. The remaining CCFSS staff will work closely with existing CCFSS Full Service Partnership (FSP) providers to connect children to appropriate services. The clinical therapists will conduct mental health assessments at the group homes, provide on-going Core Practice Model (CPM) services as needed,

and work toward the child and youth being served by one of three existing CCFSS programs. The children in group homes who are likely to be leaving congregate care in the next three months will be progressively linked to Wraparound or Success First/Early Wrap. Therapists will be in the field often and will require substantial team support by the existing CCFSS clerical staff and supervision by the new CCFSS Clinical Therapist I and Clinical Therapist IIs.

There is a significant need for expansion given that Child and Family Services (CFS) has over **4,000** children with open child welfare cases at any point in time, with almost 2,000 placed in Foster Family Agencies (FFAs), and roughly **350** in group homes. CCR is expected to increase the number of children in FFAs while simultaneously increasing expectations for mental health services to be Provided. Separate from any MHSA program, the department has initiated a program for FFAs to provide mental health services directly to children placed within their agency; however, this is expected to only serve **15%** of the youth in foster homes and is not designed to provide the intensive structure of an FSP. Therefore, it is expected that there will be an increased need for home based FSP services and Success First/Early Warp is an ideal program to meet this need. Due to longer lengths of care being needed by this population (i.e. 6-12 months vs. 3-4 months), it is not expected that the same number of children may be served for the same cost as has been the case for SF/EW. For this reason, the plan is to increase the size of the program's funding while anticipating an increase of approximately **50%** in regards to the number of children served (i.e. increase by **275** children). This will allow for almost **15%** of the children currently placed in FFAs to be served through Success First/Early Wrap.

Collaborative Partners

- San Bernardino County Department of Children and Family Services.
- San Bernardino County Department of Probation.
- DBH Transitional Age Youth Centers.
- School Attendance Review Boards.
- School Districts.
- San Bernardino County First Five.
- Local Communities.
- David and Margaret Youth and Family Services.
- East Valley Children Have All Rights: Legal, Educational, and Emotional
- EMQ-Families First, Inc.
- Family Services Agency of San Bernardino.
- Lutheran Social Services.
- Mental Health Systems, Inc.
- South Coast Community Services.
- Victor Community Support Services.
- Victor Treatment Centers.

Integrated New Family Opportunities (C-2)

Integrated New Family Opportunities (INFO) is a NACo award-winning program using intensive probation supervision and evidence-based Functional Family Therapy (FFT). The goal is to provide and/or obtain services for children/youth and their families that are unserved or underserved. The program works with the juvenile justice population, ages 13-17, and their families. The services provided by the INFO program increase family stabilization, help families identify community supports, and encourage recovery, wellness, and resiliency.

Artwork by Tona Epperson

MHSA Legislative Goals and Related Key Outcomes

- Increase in self-help and consumer/family involvement:
  - ◊ Increase in number of encounters with collateral contacts, such as family members and informal supports.

- Reduction in criminal and juvenile justice involvement:
  - ◊ Decrease in jail days.
  - ◊ Decrease sustained allegations.
  - ◊ Reduced juvenile detention recidivism.

Positive Results

INFO continues to have successful results. For the Fiscal Year (FY) 2014/15:

- INFO provided services to **167** unduplicated participants.
- The INFO program has **100%** involvement of family members during the program.

Data is kept by the Probation Department regarding the youth in the INFO program on a system known as Probationer's Caseload Explorer. Using the time frame of 12 months prior to program entry and comparing it to 12 months after program completion, analysis of the data was focused on the following categories:

- Total number of custody days in San Bernardino County.
- Total combined number of misdemeanors, and felony allegations.

Youth that have successfully completed the program have experienced a:

- ◊ **3%** decrease in detention days.
- ◊ **80%** decrease in proven allegations.
- ◊ **51%** decrease in recidivism.

Target Population:

- Juvenile Justice Youth with mental health and substance use issues

Projected Number to be Served in FY 2016/17:

- 55 Transitional Age Youth

Success Stories

"Eric" came into the INFO program humble and grateful to have additional help for him and his family. This young man of 14 years seemed to have lived a lifetime. Eric was raised by his grandparents. Both grandparents were committed to helping Eric complete the necessary requirements of his probation. The grandfather would drive Eric to Moral Reconation Therapy (MRT) every week and would sit in the lobby, waiting for Eric to complete group therapy. Eric wanted to make his family proud. He stated in group that he wanted to be like his grandmother and grandfather. Eric stated he will be a hardworking man who loves and provides for his family. Eric completed FFT and MRT with perfect attendance.

Eric has continued to stay in school and has since been discharged from probation. Eric came back two months later for his graduation where he emotionally took the microphone and stated his sincere appreciation for all of the help he received along the way. At the same time, he motivated his peers to take their lives serious and to stay on track.

> ***"We struggle but we are doing a whole lot better than before!"***
> **- INFO Graduate Parent**

"Jennifer" came into the INFO program with strained family dynamics. She was adjusting to living with her father, whom she had not lived with for some time. Through Functional Family Therapy (FFT) sessions, Jennifer and her father were able to slowly build a trusting relationship. Jennifer became more focused. She attended the MRT group with the INFO program. When she started the program, Jennifer was attending probation school, but due to her positive progress, soon went back to traditional high school.

Jennifer and her father attended the INFO graduation in August 2015 and upon receiving their certificate of completion her father stated, "INFO and Probation saved my daughter's life." He went on to tell the story of a weekend that the INFO Probation staff made the decision to detain his daughter because of her continued curfew breaches. Today, Jennifer has since graduated high school and is enrolled in community college. She is the first female in the INFO program to go to college. This is a significant accomplishment!

Challenges

- Maintaining certified staff in order to remain in compliance with Functional Family Therapy (FFT) certification mandates.
- Support sustainability of new skills the participant families have learned while in treatment with the INFO program.

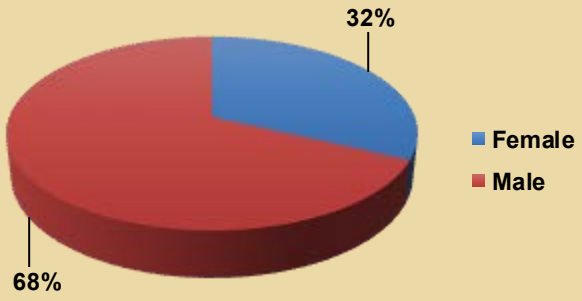
Solutions in Progress

- Department of Behavior Health (DBH) enhanced their employee recruitment process by adding targeted questions concerning experience working with the juvenile justice population.
- Enhance Generalization Phase (the final phase of FFT) activities which involve knowing the community, developing and maintain contacts, initiating clinical linkages, creating relapse prevention plans, and helping the family develop independence.

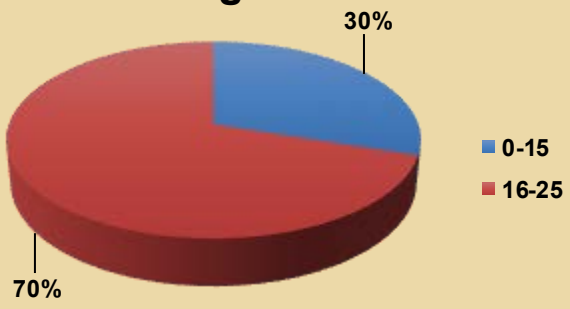
Community Services and Supports Programs

Fiscal Year 2014/15 Program Demographics

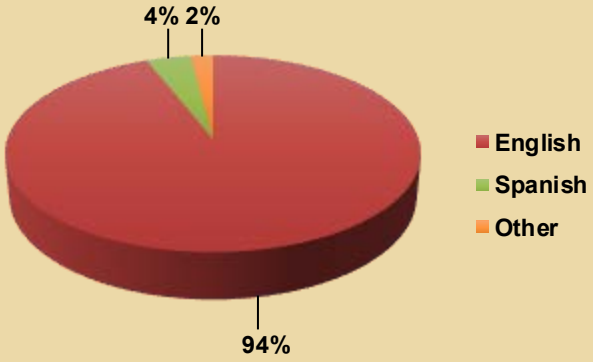
Gender



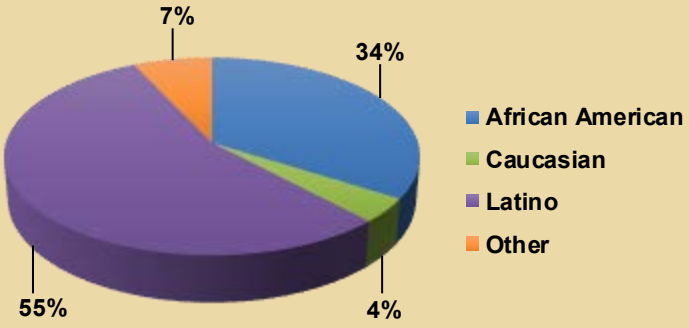
Age



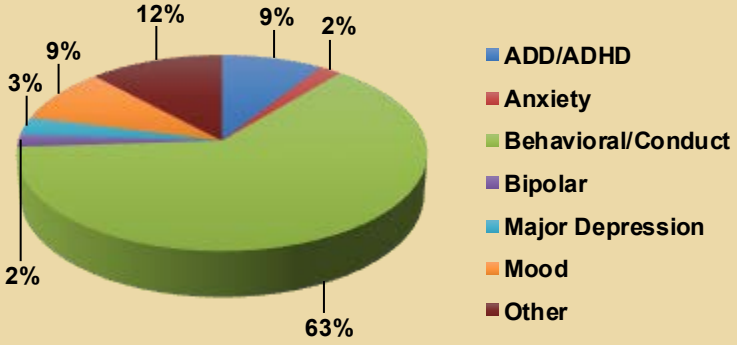
Primary Language



Ethnicity



Diagnostic Group



Program Updates

In FY 2016/17, the INFO program will continue to increase referrals to the program. Continued efforts will be made to hire clinical staff and maintain Functional Family Therapy (FFT) certification and fidelity to the FFT model. In order to reduce recidivism and support the families new learned skills, the INFO team will follow-up with families three, six and one-year after completing the program.

Collaborative Partners

San Bernardino County departments:

- Probation.
- Juvenile Court.
- District Attorney's Office.
- Public Defender's Office.
- Behavioral Health Administration.

Community agencies:

- National Alliance on Mental Illness (NAMI).
- Native American Resource Center - Riverside.
- San Bernardino County Indian Health Inc.
- Mary's Mercy Center.
- Catholic Charities.
- Children's Fund.
- North San Bernardino Jr. All-American Football & Cheer.
- Options for Youth.
- Fontana Unified School District.
- San Bernardino City Unified School District.
- Rialto Unified School District.
- Colton Joint Unified School District.
- San Bernardino County Superintendent of Schools - Youth Services Program.
- Community Action Partnership of San Bernardino.
- Salvation Army San Bernardino.
- Boys & Girls Club San Bernardino.
- San Bernardino County Museum.

"I graduated INFO, then high school, and will be graduating from Cal State San Bernardino next quarter [Spring 2015]."
- INFO Graduate

Artwork by Gary Bustin

One Stop Transitional Age Youth Centers (TAY-1)

The Department of Behavioral Health funds four (4) One Stop Transitional Age Youth (TAY) Centers, one in each region of the County. One Stop TAY Centers provide integrated services to the unserved, underserved and inappropriately served youth ages 16 to 25 in the County of San Bernardino. These individuals are at risk youth who may be:

- Emotionally disturbed.
- Severely and persistently mentally ill.
- High users of acute facilities.
- Homeless or at risk of homelessness caused by out of home placement.
- Suffering from co-occurring disorders.
- Individuals with a history of incarceration, institutionalization or recidivists with significant functional impairment.

The One Stop TAY Centers provide services to youth, ages 16-25, that are under 200% of the federal poverty level with, or at-risk of, mental health issues. Two of the targeted populations are Latino and African-American youth who are disproportionately over-represented in the justice system and out-of-home placements (foster care, group homes, and institutions).

The Centers are modeled as drop-in centers in efforts to improve TAY participation and allow TAY to (1) selectively utilize services needed to maximize their individual potential (Recovery, Wellness and Resiliency Model), while living in the community; and (2) to prepare them for re-entry into the community. The One Stop TAY Center in partnership with the San Bernardino County Department of Probation, Children and Family Services departments, and numerous other community partners assist TAY in achieving their goals of:

- Becoming independent.
- Staying out of the hospital or higher levels of care.
- Reducing involvement in the criminal justice system.
- Reducing homelessness.

Artwork by Laverne Herbert

The One Stop TAY Centers provide services that address the domains of mental and physical health, employment, educational opportunities, housing, and community life necessary for wellness, recovery and resilience of TAY.

In addition, the Centers provide Full Service Partnerships (FSP) services such as mental health outpatient services to seriously emotionally disturbed children, adolescents, and youth with serious mental disorders. Services include but are not limited to:

- Assessment.
- Evaluation.
- Targeted case management.
- Collateral.
- Crisis intervention.
- Medication support services
- Plan development (ISSP).
- Rehabilitative Activities of Daily Living.

- Therapy (Individual and group).
- Counseling.
- Substance use disorder and co-occurring services.
- Housing assistance.
- Employment assistance.
- Education assistance.
- Transportation assistance and much more.

FSPs operate under the "whatever it takes" mandate in providing the full spectrum of Community Services to assist clients achieve their goals.

TAY are also provided drop-in services that assist them, and when appropriate, their families with an array of services to address employment, educational opportunities, housing, mental health, physical well-being, drug and alcohol use, legal issues, trauma, domestic violence, and physical, emotional and sexual abuse to assist in achieving independence. Services include but are not limited to: peer support, peer driven groups/activities, shower and laundry facilities, resource room with computer and internet access, recreational activities, and access to co-located services and referrals to appropriate community based services. Drop-in services are available to TAY, FSP TAY and their families.

Outreach and Engagement Services and events are provided to unserved TAY and when appropriate their families to engage and educate them on the County's mental health system. Services include but are not limited to: Health Fairs, Job Fairs, Street Outreach and weekly orientations.

MHSA Legislative Goals and Related Key Outcomes

- Reduce the subjective suffering from serious mental illness for adults and serious emotional disorders for children and youth.
  - ◊ Decreased impairment in general areas of life functioning (e.g. health/self-care/housing /occupation/ education, legal, managing money, interpersonal/ social).
  - ◊ Increased Resiliency.
- Reduce homelessness and increase safe and permanent housing.
  - ◊ Decreased rate of homelessness for clients as defined in DCR.
  - ◊ Increased residence stability.
- Reduction in disparities in racial and ethnic populations.
  - ◊ Reduction in mental health and health care disparities.
- Increase a network of community support services.
  - ◊ Increase in number of collaborative partners.

Target Population:

- Transitional Age Youth (TAY) Ages 16-25

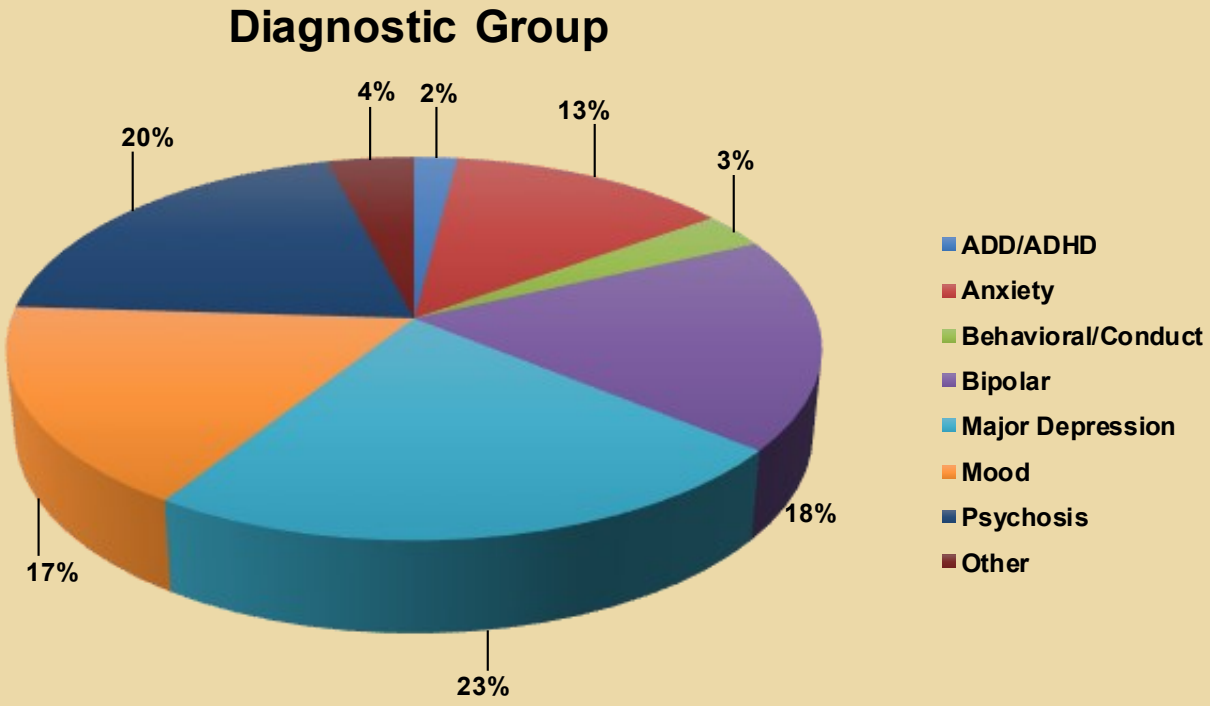
Projected number to be Served FY: 2016/17

- 1565 TAY

Positive Results

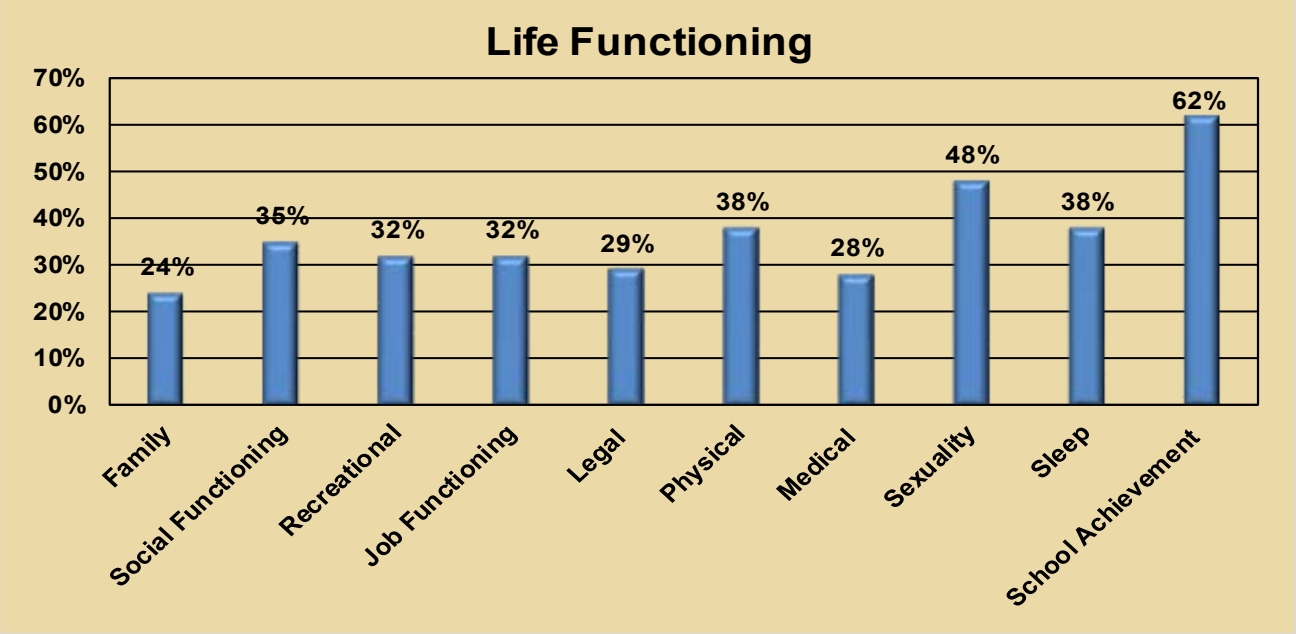
Increased Resiliency and decreased impairment in general areas of life functioning:
According to the Data Collection and Reporting System used to track outcomes for all Full Service Partners, the following data was tracked and analyzed:

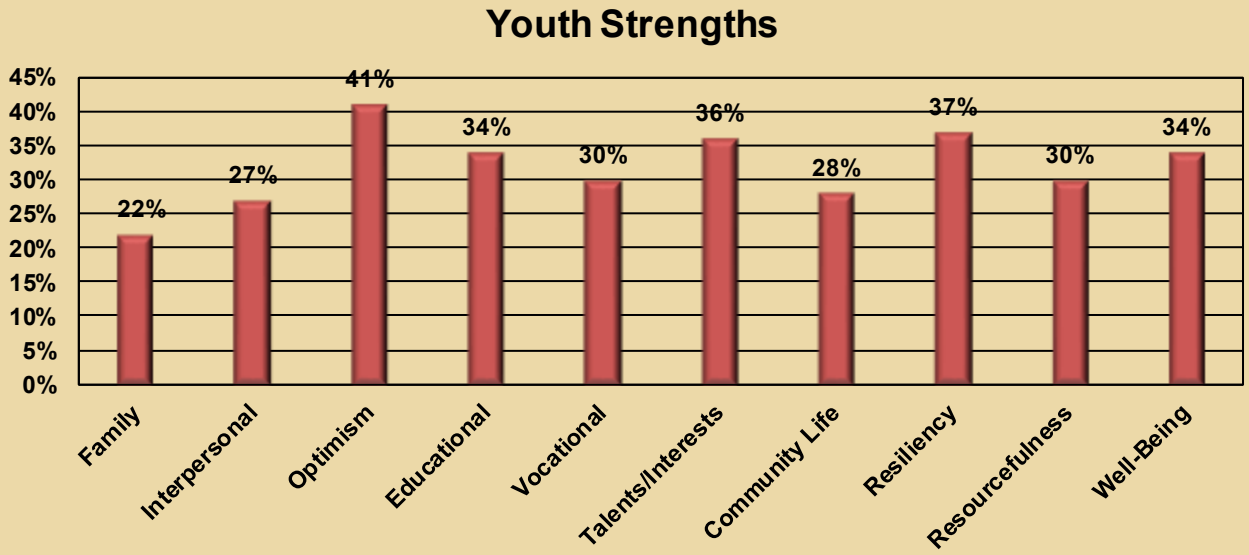
- **Hospitalization:**
  - ◊ **97%** of FSP TAY did not receive inpatient services and were able to maintain their mental wellness through outpatient FSP services in FY 2014/15.
- **Emergency Mental Health:**
  - ◊ **89%** of FSP TAY did not receive emergency mental health interventions in FY 2014/15.
  - ◊ **8%** of FSP TAY who reported a history of emergency mental health interventions prior to entering FSP services, did not receive any emergency mental health interventions in FY 2014/15 (Issue resolved).
- **Emergency Physical Health:**
  - ◊ **89%** of FSP TAY did not receive emergency physical health interventions in FY 2014/15.
  - ◊ **7%** of FSP TAY who reported a history of emergency physical health interventions prior to entering FSP services, did not receive any emergency mental health interventions in FY 2014/15 (Issue resolved).



Community Services and Supports Programs

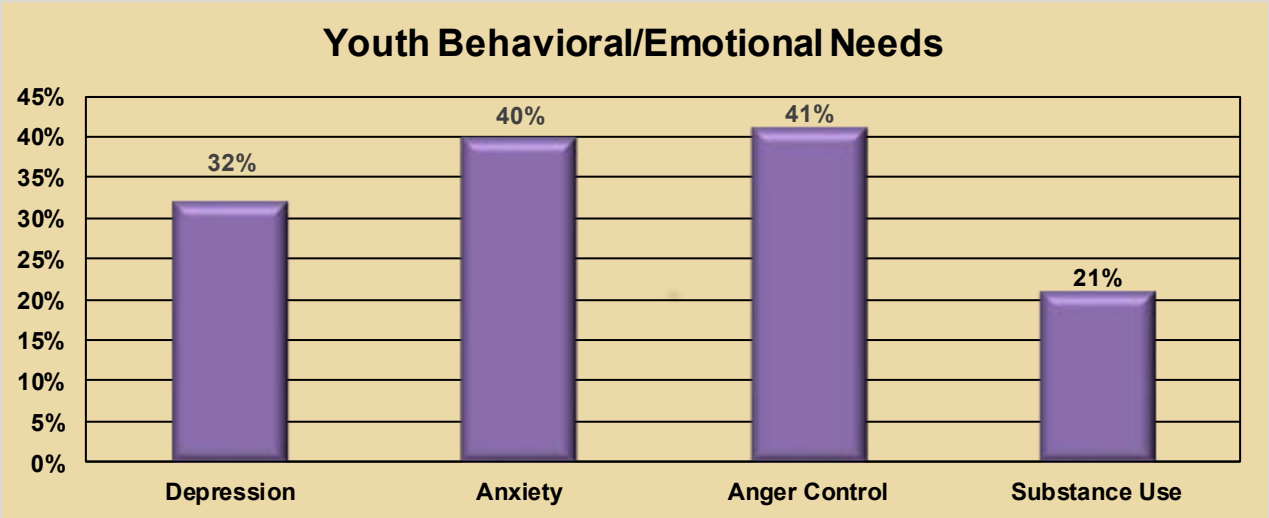
The graphs below represent the percentage of youth who presented with a significant issue on an item within the Life Functioning and Child/Youth Strengths domains of the Child and Adolescent and Needs and Strengths (CANS-SB), **and had this issue resolved by the completion of the program**.

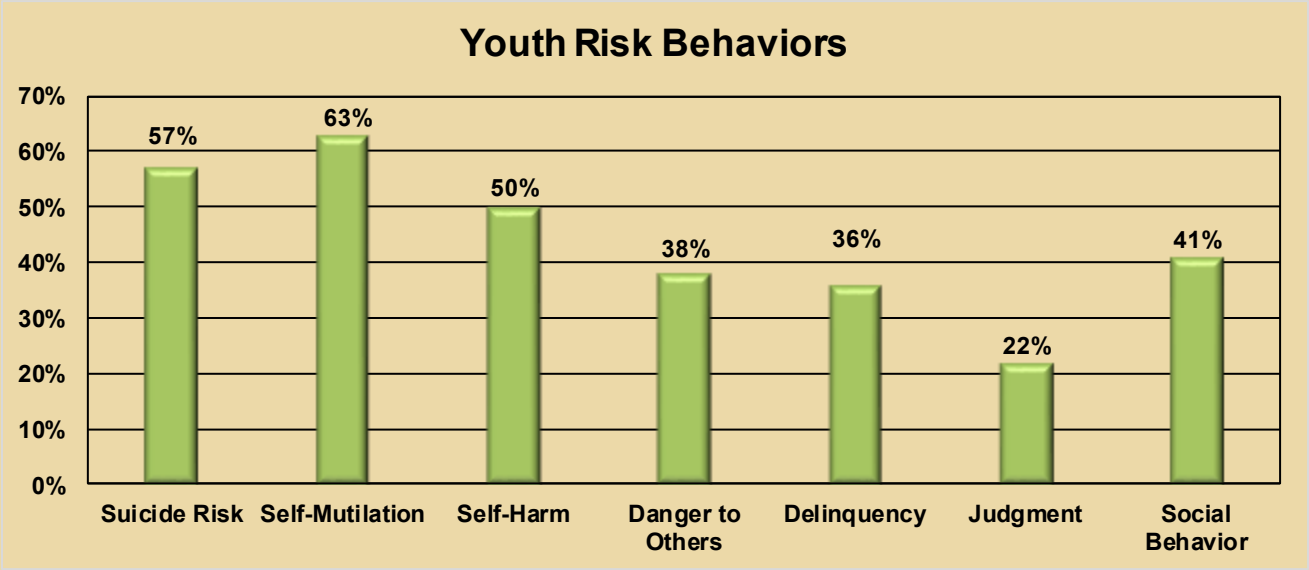




Community Services and Supports Programs

The graphs below represent the percentage of youth who presented with a significant issue on an item within the Behavioral/Emotional Needs and Youth Risk Behavior CANS-SB domains, and had **this issue resolved by the completion of the program**.





Positive Results, continued

Decreased rates of homelessness and increased residential stability:
Data collected and analyzed by DBH for FY 2014/15 indicates the following regarding the living situation of TAY:

- **82%** percent of TAY in FSP were not homeless prior to FY 2014/15, and remained that way during FY 2014/15. This shows that the TAY maintained a stable residence during FY 2014/15.
- **17%** of FSP TAY who were homeless prior to FY2014/15 where no longer homeless in FY 2014/15. FSP TAY were able to attain and maintain stable housing during the fiscal year.
- **85%** of youth who presented with a significant issue in their living situation had it improved/resolved by the completion of the program.

Reduction in mental health and health care disparities:

- In FY 2014/15 One Stop TAY Centers provided FSP services to **405** TAY.
- FSP services where provided to **185(45%)** Latino TAY and **77(19%)** African American TAY, both are priority populations for TAY programs due to their high rates of out of home placements and juvenile justice involvement.
- General System Development (GSD) services where provided to **536** TAY. Of the **536**, **173(32%)** identified as Latino and **127(24%)** as African American, both priority populations for TAY programs.

Increase collaborative partners:
In FY 2014/15 One Stop TAY Centers worked with 114 county programs and community based programs to assist TAY in integrating back into their communities and reaching their goals towards independence. Some county partners include:

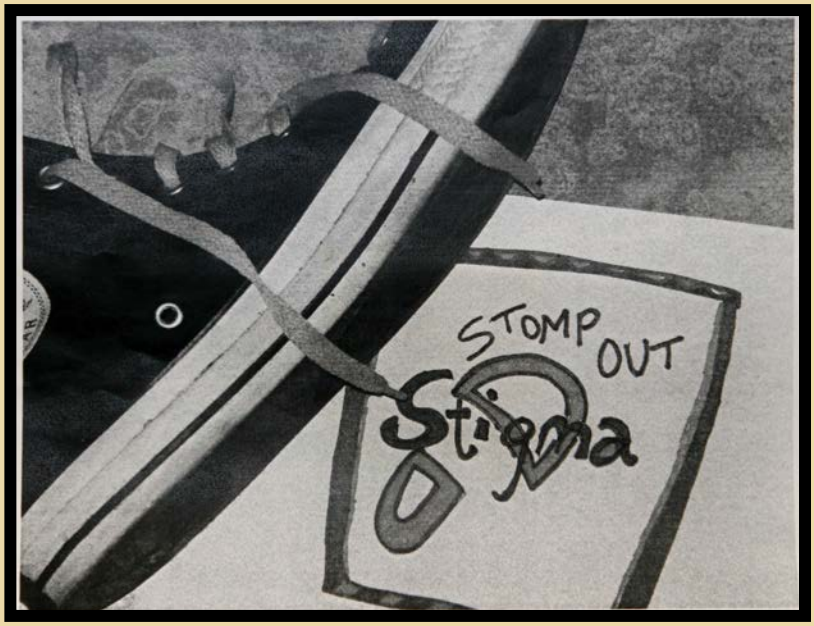
- Department of Children and Family Services.
- Department of Public Health.
- Department of Probation.
- Workforce Development Department.
- San Bernardino County Superintendent of Schools.

> ***"The TAY Center program has taught me confidence, how to deal with relationships, better eating habits, decreasing my anger and depression, and avoiding peer pressure."***
>
> ***- TAY client***

Success Stories

Yucca TAY Center
"Mark" 17 years of age, was brought to the TAY-Center by his mother for help with symptoms of depression. His mother reported that Mark was isolating himself from his friends, not attending school regularly, complaining of headaches, nausea and having suicidal thoughts. Mark's Case manager linked Mark & his mother to alternative educational outlets, which Mark thrived in. Mark participated in individual therapy sessions, and was able to address unresolved issues, underlying thoughts and feelings which decreased his depressive symptoms. Mark graduated and obtained his high school diploma in January 2015. Mark reported that he has developed a social network of friends that he speaks to daily, and his relationship with his mother has greatly improved. Mark is now enrolled in a nursing program offered by the local community college. He visits the TAY Center and reports he is doing well.

Rancho TAY Center
"Matt" came in to the TAY center experiencing auditory hallucinations and exhibited aggressive behavior, which was triggered in social situations. With the collaborative support of Therapist, Case Manager, medication staff, and family, Matt was able to stabilize on medication and showed significant relief of symptoms. He was able to participate in drop-in activities without becoming upset. He has registered to complete his high school diploma. Matt also began seeking employment and working on independence skills. Matt graduated with a high school diploma in June 2015 and is now employed.



Artwork by Stella Grosso

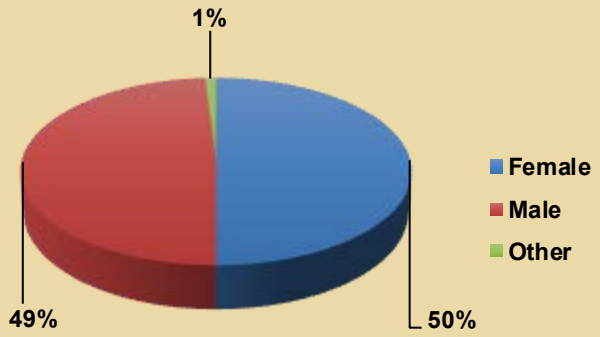
San Bernardino TAY Center
Four of our FSP youth obtained full time employment qualifying them for the Master Leasing Phoenix Project housing. They continue to maintain their employment and housing. Two of the youth have jobs in the mental health field as peer advocates.

"**The bonds you create here, friends, acquaintances...**
You become family."
- TAY client

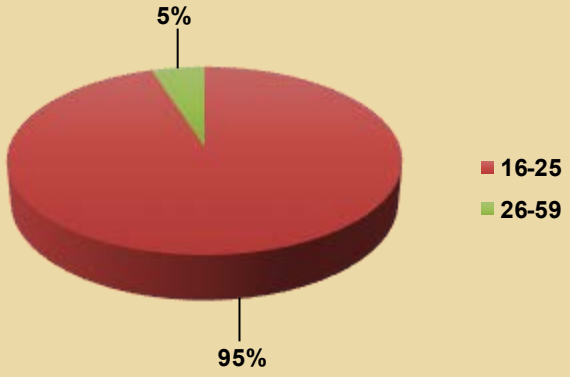
Community Services and Supports Programs

Fiscal Year 2014/15 Program Demographics

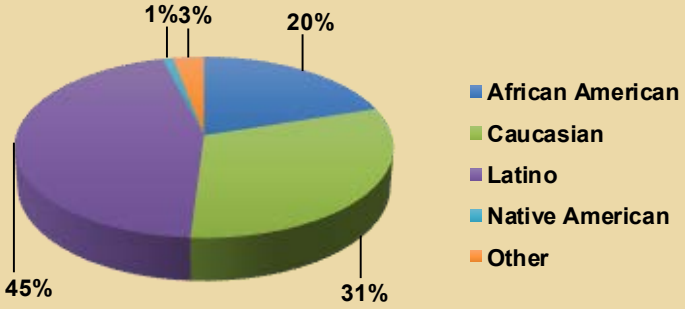
Gender



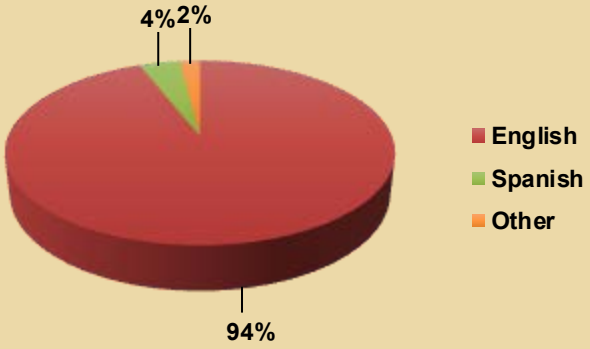
Age



Ethnicity



Primary Language



Challenges

Due to the geographic size of San Bernardino County, providing services to the TAY population continues to be a challenge.

Transportation

TAY population is facing difficulties in accessing services in the communities of Morongo Valley, Joshua Tree & 29 Palms. Due to the vast distances between cities, the local transit system is not ideal. TAY must travel long distances in order to find and search for employment opportunities.

Employment

Employment is a hurdle that TAY population face. There are limited employment opportunities for unskilled or entry level employment.

Housing

Housing continues to be the biggest challenge for the One Stop TAY program as there are few options for shelters or programs to assist with housing in the county. The importance of permanent housing and its impact on other areas of growth has continued to hinder some progress of TAY.

Basic Needs It has been challenging in FY 14/15 to get more community contacts for donations and to provide more options/services appropriate to the TAY population.

Outreach and Retention

Weekly orientation to TAY services are well attended. However, retention of potential TAY clients from weekly orientations is a challenge. Also, TAY attending high school had a difficult time attending new client orientation sessions at the centers scheduled times.

Enrichment Opportunities

While collaboration with volunteer services continues, there are limited volunteer sites for TAY in more rural areas of the county. Enrichment opportunities allow for TAY to give back to their communities and learn new skills.

"Thankful and blessed to have housing."

- TAY client

Solutions in Progress

Transportation

To help the TAY population get from place to place, the Eastern Desert TAY-Center developed an empowerment, goal orientated, and self-accountability system, which provided the consumers with a way to earn transportation privileges. FSP TAY were encouraged to provide documentation of enrollment into schooling, employment, doctor appointments, etc. and were provided with a monthly bus-pass. Drop-in consumers were provided a list of chores/duties to earn daily passes.

Employment

The Eastern Desert TAY-Center held weekly groups and role-playing exercises to help TAY consumers prepare for employment searches by developing their:

- skills in resume building.
- face-to-face interviewing.
- appropriate dress.
- and do's & don'ts for an interview.

Once a quarter, a local business owner would be contacted to do mock interviewing to assist consumers to experience the interviewing process. San Bernardino County's Department of Workforce Development presented at the TAY-Center semi-annually providing consumers with current & upcoming employment opportunities within the area.

> ***"TAY helped me to reconnect with my family, get my life back on track from drugs, and now I can be ready to start a family with my fiancé and our little one on the way"***
>
> ***-TAY client***

Housing

In FY 2014/15 the West Valley One Stop TAY Center reached out to different programs in the community who offer shelters and programs for clients to get them off the streets as well as helped TAY to work out differences with family members who could provide them shelter. Center staff continued to work with shelter bed providers to help clients be successful in the shelter bed placements.

The Central Valley One Stop TAY center continued recruitment for shelter bed providers (for parenting TAYs) and outreach to potential Board and Care providers.

The North Desert One Stop TAY Center increased the homeless pantry program to provide meals, provide access to showers, and laundry facility for homeless youth. They also provided linked clients to STAY program for housing needs.

Outreach and Retention
West Valley TAY Center staff increased outreach efforts to get more TAY enrolled in the TAY Center, as well as, reached out to businesses who donated items for TAY and for different events. The increased outreach efforts helped identify other programs that could help TAY with added resources such as school supplies, temporary housing and clothing donations.

Enrichment Opportunities
All Centers continue to educate community members and organizations on mental health issues, encouraging them to provide opportunities for TAY to volunteer and give back to their communities. Continue to partner with DBH Volunteer Services to identify opportunities.

Collaborative Partners

- Glesener Pharmacy.
- Our Lady of Guadalupe.
- County of San Bernardino Probation and Truancy Department.
- County of San Bernardino Forensic Adolescent Service Department.
- Chaffey Joint Unified School District.
- Chino Unified School District.
- Upland Unified School District.
- San Bernardino County Sheriff Department.
- County of San Bernardino Children and Family Services - Independent Living Program.
- Rancho Resource Center.
- Loma Linda Disability Expo.
- San Bernardino Reproductive Health Program.
- Mercy House.
- Mission Pointe Ministry.
- Chaffey College.
- American Career College.
- First Light Ministry.
- Starbucks.
- Terra Vista Theatres.
- San Bernardino County Welfare-Transitional Assistance Department.
- Motel 6.
- Options for Youth.
- Inland Valley Recovery.
- Salon Success.
- Upland Community Counseling Valley View.
- Continuation Growing Pains Program.
- Omni Public Transportation.
- Sweet Affair Barber Shop.
- West Valley Gang and Drug Task Force.
- Pomona Homeless Shelter.
- San Bernardino Homeless Shelter.
- Option House.
- San Bernardino Disaster Preparedness Program.
- Quest Diagnostic Lab.

Community Services and Supports Programs

- Dr. Robert Krishbaum Medical Offices.
- Department of Labor Job Corp.
- D&L Board and Care.
- PTL Home.
- Bienestar Gay and Lesbian Support Group Program.
- Department of Motor Vehicles.
- Social Security Administration.
- Housing Authority.
- Women, Infants and Children.
- Employment Development Department.
- Abundant Living Food Bank.
- Church of Christ Food Bank.
- Cross Light Church Food Bank.
- Echoes of Faith Food Bank.
- Water of Life Food Bank.
- Valley Star Behavioral Health, Inc. - The STAY (Youth Hostel) and Family Resource Center.
- New Hope School.
- Our lady of Lourdes.
- Department of Workforce Development.
- Department of Behavioral Health Mariposa Clinic.
- Department of Behavioral Health High Desert Clinic.
- Department of Behavioral Health Crisis Walk In Clinics (CWIC).
- County Crisis Response Team (CCRT).
- Vista Community Counseling.
- Department of Behavioral Health Clubhouses.
- Walden Family Services.
- Sachs Arrowhead Clinic.
- Living Word Harvest Center (Men and Women's homes).
- Community Action and Partnership.
- City Link – Water of Life.
- Reach Out.
- Sova.
- West End Family Counseling.
- Head Start.
- Kinship Care.
- Baldy View Regional Occupational Program.
- House of Ruth.
- Independent Living Program (ILP).
- Neighborhood Vineyard Church.
- Food for Life Ministries.
- Molding Hearts.
- Gabriel's House.
- County of San Bernardino Probation. Department, (Joshua Tree).
- Copper Mountain College.
- Student Attendance Review Board (SARB).
- "Rockin" Recovery.
- Hope Academy (Alternative Schooling).
- Morongo Unified School District.
- San Bernardino County Department of Workforce Development.
- United States Army Recruiting Center.
- Family Resource Center / Military Program.
- Santa Fe Social Club.
- Lutheran Social Services.
- New Horizons.
- Mary's Table.
- County of San Bernardino, Children's Network.
- County of San Bernardino, Children's Fund.
- Cedar House.
- Gibson House.
- St. John of God's.
- San Bernardino Valley College.
- San Bernardino Adult School.
- Department of Rehabilitation.
- Riverside-San Bernardino - Native American Resource Center.
- The WAY Outreach.
- Sunrise Community Church.
- Mission City Community Network.
- Victor Community Support Services - Family Resource Center.
- Victor Unified High School District.
- Victor Valley College.
- San Bernardino County Homeless Coalition.
- Victor Valley Transit Authority.
- Apple Valley School District Workforce Innovation and Opportunity Act (WIOA) program.

Clubhouse Expansion (A-1)

Clubhouses are recovery oriented centers that provide Wellness, Recovery, and Resilience model programs in stigma free environments for adult consumers living with serious Mental Illness. The main objective of the Clubhouse Program is to assist consumers in making their own choices and integrating into the community as contributing members, thereby achieving a satisfying and fulfilling life.

Artwork by Marisa Franklin

Clubhouses are primarily run by the adult consumers and have minimal support from department staff. In an effort to increase overall functioning and community integration, members are encouraged to provide input related to program and activity choices. Members often take ownership of the clubhouses and demonstrate an eagerness to participate in the various opportunities and activities.

Growth opportunities and activities for members include:

- Living skills.
- Volunteerism.
- Job skills.
- Community integration excursions.
- Canteen and clothing closet operations.
- Nutrition and cooking.
- Physical health.

The various growth opportunities and activities available to clubhouse members aid in increasing members ability to integrate and cope within the community. Clubhouses also sponsor regularly scheduled social and recreational activities, both in the community and on site, which thereby increases the members' ability to interact and develop skills that improve their ability to function in the community.

MHSA Legislative Goals and Related Key Outcomes

- Reduce the subjective suffering from serious mental illness for adults and serious emotional disorders for children and youth:
  - ◊ Improved life satisfaction.
  - ◊ Decreased hopelessness/increased hope.
  - ◊ Increased resiliency.
  - ◊ Decreased impairment in general areas of life functioning (e.g., health/self-care/housing, occupation/education, legal, managing money, interpersonal/social).

- Increase a network of community support services:
  - ◊ Increase in number of collaborative partners.

Target Population:

- Adults

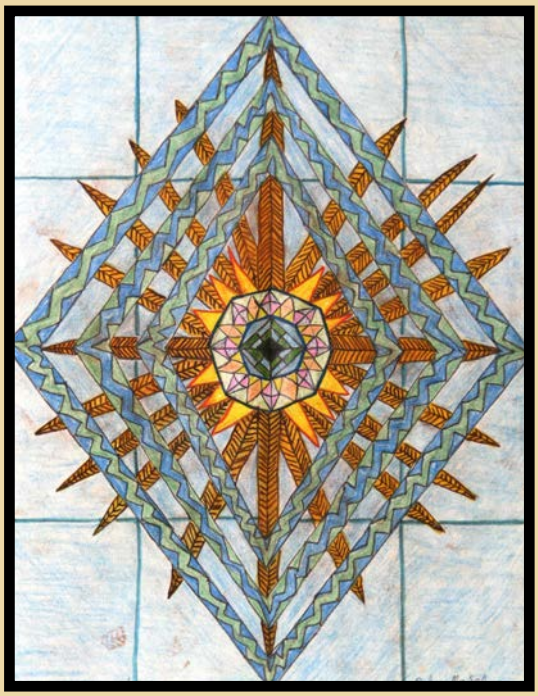
Projected Number to Be Served FY 2015/16:

- 5,871 Adults

- Increase in self-help and consumer/family involvement:
  - ◊ Increase in ratio of voluntary mental health services to involuntary mental health services.
  - ◊ Increase in number of encounters with collateral contact, such as family members and informal supports.
  - ◊ Increase in program attendance and frequency per consumer.
  - ◊ Increase in self-help/support/12-step group attendance and frequency per consumer

Positive Results

In Fiscal Year 2014/15, the Clubhouse Program served a total of **7,460** consumers, of which **2,109** were unduplicated. Clubhouse members had over **58** opportunities to explore various Behavioral Health oriented collateral and family supports through community integration excursions. Clubhouses also offered **92** different groups per month for increasing self-help skills. Over **90%** of the groups offered were facilitated by clubhouse members.



Artwork by Barbara Mason

California State University San Bernardino Nursing students conducted educational presentations on various health topics such as:

- Controlling blood sugar.
- Nutrition and hydration.
- How to eat well on a budget.
- Stress management.

Each clubhouse elected a board of peer members designated with the responsibility of making decisions related to activity planning and clubhouse operations. The board members for each clubhouse were included in all hiring decisions for new Clubhouse employees.

Clubhouses again saw a decrease in the amount of times that emergency services were accessed for physical health challenges due to an increase in education and linkages to physical health and nutrition resources.

Success Story

"Leticia" is a woman living with chronic and severe mental illness, enrolled as a member of the Clubhouse Program and was shy and withdrawn. She would sit by herself and not talk to anyone. She would not get involved in groups or engage with other members.

"The Clubhouse program helped me to find purpose for my life."
- Clubhouse member

Leticia recalls the day things changed for her; a Clubhouse staff member noticed her sitting alone and invited her to the kitchen to help prepare lunch for the day. She agreed to help and began learning how to prepare meals, measure ingredients, and store food according to health codes. After shadowing staff and other clubhouse members in the kitchen, she became a volunteer cook and began studying for the State Food Handlers Certification. She now spends her free time looking for new recipes to make for the members. She is the lead cook and responsible for delegating daily tasks, monthly meal planning, purchasing food in bulk, and shopping on a set budget. Leticia was

also elected as a board member and is involved in making decisions for the daily operations of the clubhouse activities. She credits the clubhouse for giving her a purpose in life and something to look forward to. She has made several friends at the clubhouse and exhibits a positive outlook on life. She describes herself as happy and is working to make everyday a success

Challenges

- Establishing consistent outcome measures for consumer-run programs.
- Access to transportation.
- Meeting the need for a higher demand for services in all clubhouses.

Solutions in Progress

- The Clubhouse Expansion Program is considering to pilot a Mental Health Outcomes Management System with the University of California San Diego Health Services Research Center in conjunction with the Life Satisfaction Survey.
- Clubhouses are offering shuttle-type pick-up for any community activities that are outside public transportation accommodations.
- All clubhouses have increased staff at each location. The Desert Stars Clubhouse in Barstow saw the most significant increase going from **1** part–time staff to **2** full-time staff and increased their days of service from **1** to **4** days per week. Clubhouses have also added staff that rotate between sites in order to provide optimum coverage levels and support.

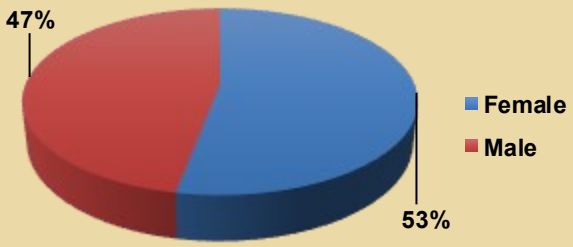
Outreach and Engagement

In Fiscal Year 2014/15, the Clubhouse Program organized and/or participated in the following outreach and engagement activities:

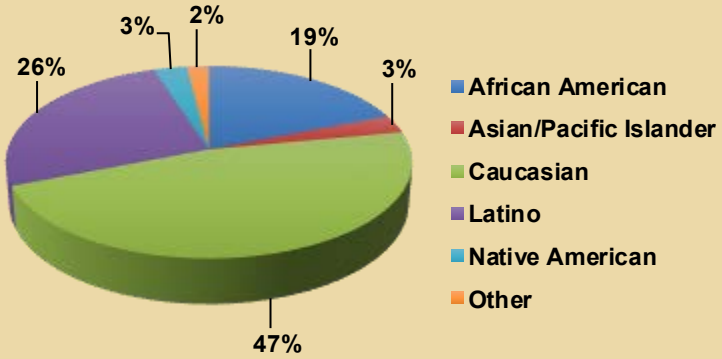
All Clubhouse Holiday Gatherings	650
Health Fairs	2,150
Community Service Activities	600
Community Presentations	675
Crisis Intervention Team Building	360
Behavioral Health Commission Presentations	75
Behavioral Health Wellness Triathlon	400
Evening With the Stars Education and Recognition Event	50
Clinic Appreciation Events	500
Community Food Distribution	1,200
Community Speakers	150
Mental Health Solidarity Day	365
TEAM House Outreach Day	100
Inter-Clubhouse Outreach Day	185
TOTAL	**7,460**

Fiscal Year 2014/15 Program Demographics

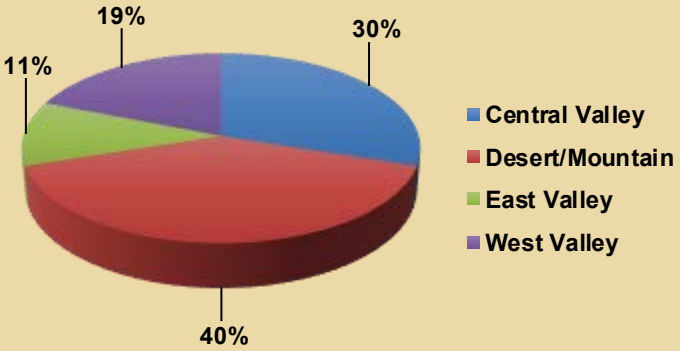
Gender



Ethnicity



Geographic Region



Community Services and Supports

Program Updates

Changes for FY 2016/17 include the introduction of a Peer Leadership Development Program in which consumers are able to apply for and take part in a 16 week leadership course which teaches workplace skills, assigns participants to Peer Mentors, and allows for job shadowing opportunities throughout the San Bernardino County. Additionally, the program will begin a Wellness on Wheels initiative which will bring wellness activities run by peers to locations throughout San Bernardino County. Lastly, the Clubhouse Expansion Program will coordinate and host a multi-county Peer Summit which will bring Clubhouses from multiple counties together for the sharing of successes, best practices, and collaboration.

Artwork by Brad Borrero

A additional support will be added to the High Desert to provide staff and consumers immediate access to a supervisor. This includes supervision of peer staff, immediate attention to the needs of the consumers and family members that are of a more complex nature and an ability to increase the network of referrals that consumers may access.

The cooking and nutrition program will be expanded at each Clubhouse site. Increased funding in the cooking and nutrition program will allow each clubhouse site to incorporate a higher percentage of fresh and healthy ingredients versus their frozen and/or less nutritious alternatives. This effort will familiarize consumers with the benefits of healthy eating as well as introduce ways to incorporate these foods into every day living and overall health.

Collaborative Partners

- San Bernardino County Sherriff's Deputies via Crisis Intervention Training.
- Housing and Employment Specialists.
- Brulte Senior Center.
- Hillside Community Church.
- The Rock Church.
- Salvation Army.
- Goodwill.
- National Alliance on Mental Illness.
- Ontario Reign.
- Native American Resource Center.
- Cal State San Bernardino Nursing students.
- Psychology Interns.
- Social Work Interns.
- Trauma Resource Institute.
- Starbucks.
- Upland Public Library.
- The Getty Museum.
- 24 Hour Fitness.
- City of Rialto Parks and Recreation Department.
- Loma Linda Behavioral Health.
- San Bernardino County Library.
- Recovery Based Engagement Services Team.
- Community Crisis Response Team.
- ABC Pharmacy.
- San Bernardino County Room and Board Coalition.
- Pacific Clinics.
- San Bernardino Valley College.
- Marciano's School of Beauty.
- Lion's Club.
- Chaffey Community College.
- Victor Valley Community College.

Forensic Integrated Mental Health Services (A-2)

Forensic Integrated Mental Health Services is composed of two components. The first component includes Supervised Treatment After Release (STAR) and Forensic Assertive Community Treatment (FACT) programs, which both serve consumers on formal supervision with Probation who voluntarily participate in one of the four Mental Health Courts located throughout San Bernardino County (Joshua Tree, Rancho Cucamonga, San Bernardino, and Victorville). Additionally, Hi-Desert Medical Center (HDMC) is the contracted vendor providing mental health service treatment services to consumers participating in the Joshua Tree Superior Mental Health Court located in the Morongo Basin. The second component is the Crisis Intervention Training (CIT) program that provides law enforcement personnel intensive training and certification as specialized first-line responders to crisis calls in the community that are identified or suspected of involving individuals presenting with behavioral health concerns.

Mental Health Courts

Beginning in the late 1990s, the establishment of Mental Health Courts throughout the United States began pursuant to federal legislation and funding. San Bernardino County was one of the first counties to have such a program which began in 1999. With the growing community concern for more effective treatment for mentally ill offenders, the Mental Health Court system continues to thrive, both nationally and at the local level. San Bernardino County currently has four Mental Health Courts located in the cities of San Bernardino, Rancho Cucamonga, Victorville and Joshua Tree which offer voluntary court-referred treatment programs for defendants living with severe and persistent mental illness who agree to make mental health treatment part of the terms and conditions of their probation. A multidisciplinary treatment team is located at each of the courts that consist of representatives from the STAR program, FACT program, Probation Department, Sheriff's Department, Mental Health Court, Public Defender's Office, and District Attorney's Office.

"I am glad to be part of STAR and happy that I have been given a second chance."
-STAR consumer

Supervised Treatment After Release (STAR) Program

The STAR program is a voluntary treatment program for individuals who suffer from severe and persistent mental illness (SPMI) along with a history of recidivism in the criminal justice system. Participants must be referred by the multidisciplinary team (MDT) from the Mental Health Courts and accept participation in this program as a condition of their probation. STAR is designed to reduce hospitalizations and incarcerations by assisting participants to re-enter into society. Through Day Treatment Rehabilitation or Intensive Outpatient modalities, participants receive individual and group therapy, psychiatric and medication support services and case management services, which include housing, medical, financial and vocational assistance. For substance use disorders, drug and alcohol treatment services are available such: as assessment, individual, family and group counseling, crisis intervention, follow-up, case management, drug education, and referral to aftercare services.

"The FACT program has given me back my dreams, hopes and inspirations."
- FACT consumer

Forensic Assertive Community Treatment (FACT) Program

The FACT program is a voluntary treatment program that provides mental health services to adults living with serious and persistent mental illness who, as a result of their mental illness, have had repeated arrests and contacts with the criminal justice system, are now under the supervision of the Mental Health Court, have difficulties linking with and remaining engaged in the traditional outpatient clinic model, and may also have a co-occuring

substance use disorder. These Full Service Partnerships are geared toward reducing recidivism in both jail and psychiatric hospitalization days and include community based, 24/7, intensive mental health and case management services to support recovery, self-management, and to increase public safety. Case management, mental health rehabilitation, individual and group counseling/therapy, crisis intervention, and medication support services are provided primarily in the community where the clients live, using a “whatever it takes” approach based on the member’s individualized treatment needs and the intensity of services is based on the member’s level of recovery, and may include in-home services. The FACT team also provides assistance with housing, social support, and outreach services to program participants. The FACT program is part of a multidisciplinary team that includes personnel from Mental Health Court, the Public Defender and District Attorney Offices, Sheriff and Probation Departments, and the STAR and Tenet Healthcare programs.

Artwork by Brandi Hebel

Since FACT services are approximately 75% community based, consumers who have trouble keeping appointments at outpatient clinics are referred to the FACT program across all four (4) courts. These consumers are seen at their homes weekly, which may include a home visit by a Psychiatrist for those who are not able to make it into the office.

Both programs provide intensive case management and clinical treatment, medication support, drug and alcohol treatment, residential placement/housing assistance, and periodic court reviews.

In 2015, the Community STAR and Community FACT programs were implemented as expansions of the STAR and FACT programs. They provide the same mental health services as STAR and FACT. Community STAR and Community FACT differ from STAR and FACT in that their consumers are no longer associated with the criminal justice system but remain in need of behavioral health services to reduce recidivism in the jails/prisons and the potential for psychiatric hospitalization.

Crisis Intervention Training (CIT) Program
Crisis Intervention Training (CIT) provides extensive training to law enforcement personnel as first-line responders to crisis calls in which mental health issues are identified or suspected. CIT has been embedded for the past three years in the completion requirements for all San Bernardino County Deputies who graduate from the Sheriff's Basic Academy. This training has resulted in increased law enforcement officer awareness of the stigma associated with mental illness and the ability to access appropriate community resources and an increase in law enforcement officer safety and the safety of individuals who are in crisis due to their mental illness.

MHSA Legislative Goals and Related Key Outcomes

- Reduce homelessness and increase safe housing:
  - ◊ Decreased rate of homelessness for consumers.
  - ◊ Increased residence stability.

Community Services and Supports Programs

- Increase access to treatment and services for co-occurring problems, substance abuse and mental health:
  - ◊ Increased encounters in specialty co-occurring and substance abuse interventions.
  - ◊ Increased encounters in integrated health clinics.
  - ◊ Increased transportation to co-occurring appointments.

- Reduction in criminal and juvenile justice involvement:
  - ◊ Decreased rate of incarcerations.
  - ◊ Decreased arrests.
  - ◊ Decreased jail bookings.
  - ◊ Decreased sustained allegations.
  - ◊ Reduced jail/prison recidivism.
  - ◊ Decrease in jail days.

- Reduce delinquent behaviors, which increase:
  - ◊ Likelihood of justice involvement .

- Reduce the frequency of emergency room visits and unnecessary hospitalizations:
  - ◊ Reduced number of emergency room visits for mental health concerns.
  - ◊ Reduced administrative hospital days.
  - ◊ Increased use of alternative crisis Interventions (e.g., Crisis Walk-In Center (CWIC), Community Crisis Response Team (CCRT), Crisis Stabilization Unit (CSU).
  - ◊ Increase in number of individuals diverted from hospitalization.

Positive Results

The Forensics Integrated Mental Health Services Program served a total of **427** consumers in FY 2014/15 and had very successful results for the year. The FACT program served **68** individuals and the STAR program served **136** individuals. Though the length of participation in the program is typically 1.5 to 2 years, homelessness for all participants decreased to nearly **0%** since both programs facilitate or provide housing for consumers.

In comparison to pre-enrollment levels, participants enrolled in the Mental Health Court programs have shown high rates of diversion from psychiatric hospitalization and incarceration. This has resulted in a decrease in unnecessary hospitalizations and jail beds each year. FACT had a decrease of **75%** in psychiatric hospital days and a reduction of **88%** in jail days. STAR had a decrease of **81%** in psychiatric hospital days and a reduction of **84%** in jail days.

Target Population:

- Adults
- Individuals with severe and persistent mental illness or co-occurring disorders
- Recidivists of the criminal justice system
- Individuals under the supervision of the Mental Health Courts (STAR & FACT only)

Projected Numbers to be Served FY 2016/17:

- 75 STAR
- 57 CSTAR
- 50 FACT
- 81 CFACT

Artwork by Judy Whiting

Specialty trainings were provided to staff to increase awareness of resources available for participants, such as Crisis Intervention Training (CIT), Seeking Safety, and Moral Recognition Therapy (MRT). Through the CIT program, five classes were held in FY 2014/15 with a total of **223** law enforcement officers trained. Also, staff are utilizing program transporters and bus passes to assist participants to fully engage in treatment programs.

"The program has helped me to become accountable."
- Forensics consumer

Success Stories

"Belinda" came to FACT with extensive emotional issues that resulted from a childhood trauma. By age 42, she had lived through two unsuccessful marriages and had three children, which she had not seen in years. Belinda suffered from auditory hallucinations, depression, mania, post-traumatic stress disorder (PTSD), and substance abuse. As a result of her untreated co-occurring disorder, she had moved from place to place with periods of homelessness and found herself hospitalized and incarcerated multiple times. Through the FACT program, she began receiving mental health and substance use treatment services and her journey to recovery began.

With the proper medication, Belinda was able to reduce some of her most distressing symptoms. Medication management and therapy has made it possible for Belinda to achieve and maintain sobriety, as well as stable housing. She continues to participate in the FACT program and is learning to manage her finances. Belinda graduated from FACT a year after enrollment and her future now looks bright. With only six more months of formal probation, she is now working toward being approved for permanent, low income housing and reuniting with her children.

Artwork by Erin Leonetti

Before enrolling in the FACT program, "Brian" suffered from auditory hallucinations, mood swings, a substance use disorder, paranoia and a learning disability and had been homeless for several months. Upon entering the FACT program, he was placed in sober living. Although he initially felt uncomfortable about living in a group setting and preferred being homeless, he has since adjusted and has been able to maintain his housing. The FACT psychiatrist and nurse worked closely with Brian to prescribe and manage his medication. Though it was difficult, Brian was able to stop his drug use and achieve and maintain sobriety by remaining consistent with his medication plan. He now participates in individual and group therapy in which he is learning and practicing the use of relaxation techniques and coping strategies to better manage his paranoia, agitation, and auditory hallucinations. Brian has progressed well and now proudly holds a part-time volunteer position. He is learning to manage his finances, is working toward completing the terms and conditions of his probation, and will graduate from Mental Health Court this year.

Challenges

STAR Program:

- Maintaining a resource base of accredited residential facilities (i.e. Room and Board, Licensed Board and Care) that assist program participants with residential needs.
- Participants are facing difficulties in applying for and obtaining entitlement benefits. Participants with co-occurring conditions are dealing with hurdles in being awarded other public benefits, which limits their ability to begin self-management of their finances and housing.
- Lack of employment opportunities for program participants due to their criminal background. In addition, the effects of co-occurring conditions may further limit a participant's capacity to engage in full-time employment.
- The reduction of some non-violent felonies to misdemeanors, as per newly passed legislation, may have a direct impact on the level of treatment available to individuals who were previously eligible to services offered through Mental Health Court.

FACT Program:

- Lack of adequate housing stock to meet the housing and living expense needs of FACT participants who have very limited or no source of income.
- Assisting FACT participants with securing and maintaining competitive employment due to probation status and criminal record.
- Securing affordable transitional and permanent housing in safe communities for participants who are dealing with co-occurring disorders. Permanent housing is a vital component to recovery, as participants seek independence and meaningful roles in the community.
- Recruitment of qualified clinical staff to fill vacant positions, specifically Clinical Therapist II positions. With the implementation of Community FACT, this is a major concern as additional staff will be required to manage the anticipated increase in program participation.

Artwork by Rachel Miller

CIT:

- There is a need for additional CIT instructors, as most CIT instructors are performing their CIT duties in addition to their full-time employment obligations.
- There is a need for additional volunteer law enforcement evaluators. These evaluators are experienced in both law enforcement and behavioral health and provide valuable feedback to trainees during participation in roleplay scenarios.

Solutions in Progress

STAR Program:

- During fiscal year 2014/15 contracts were secured with multiple housing vendors which resulted in **100** board and care beds for forensic consumers.
- One STAR staff member attended the SSI/SSDI Outreach, Access and Recovery (SOAR) training to increase their knowledge and skills in assisting consumers with completing and submitting thorough SSI/SSDI application packets.
- Consumers are encouraged to participate in the DBH Supportive Employment program to enhance their job seeking skills and secure employment. As a result, five (5) participants have secured part-time employment. STAR participants are also encouraged to enroll and assisted with enrolling into community college or vocational training programs to become more marketable.
- The STAR program has expanded with the implementation of Community STAR, which provides mental health and co-occurring treatment services to individuals with reduced sentences, as per new legislation passed in 2014, and are no longer involved in the criminal justice system

"It was very helpful to see/hear stories from the clients first hand. I was able to get another point of view and see their perspective."

- Forensics consumer

FACT Program:

- The implementation of the Community FACT program, which expands FACT to provide services to individuals no longer involved in the criminal justice system, has increased funding to cover participants' housing and living expenses.
- The FACT program continues to encourage and assist participants with enrolling into community college and vocational training programs to become more marketable, as well as pursuing volunteer opportunities that may lead to employment. The FACT program also attempts to identify employers who are willing to afford participants an opportunity to become employed.
- The FACT Program has been actively networking in the community to identify and build relationships with potential housing vendors that are willing to work with the forensic population and provide safe and satisfactory living conditions to them as residents. As a result, a number of new unlicensed sober living and board and care homes have been located and relationships have been rebuilt with licensed board and care homes that previously provided housing to FACT participants. FACT continues to assist participants with applying for low income or subsidized housing.
- FACT employment opportunity advertisements are specific and provide detailed job and program descriptions to attract job applicants who are interested in working with individuals living with a mental illness, as well as, individuals with a criminal justice background.

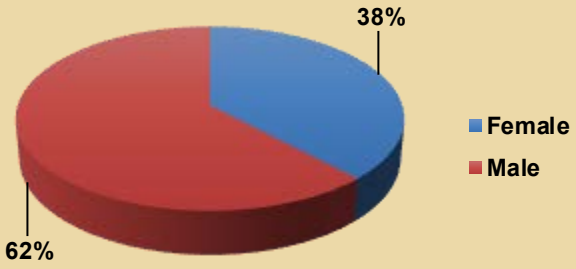
CIT:

- A log has been established identifying CIT presenters and backup instructors. The goal is to have a backup presenter for each presenter, as well as a backup presentation.
- A running list of past law enforcement evaluators is now kept and utilized to solicit volunteers. The Sheriff's Department Advance Office Training Unit is also collaborating with CIT to send out e-mails to stations throughout the County requesting officers to volunteer to be CIT evaluators.
- An additional strategy will be implemented this year to expand these services to include a Community Partners CIT sub-component. This will allow the Department to train additional partners such as Fire and Probation, as well as, fund officer related training positions with the CIT program.

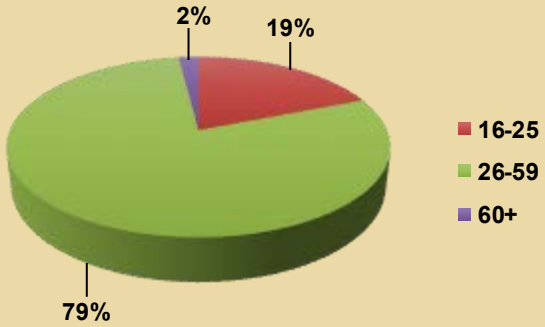
Community Services and Supports Programs

Fiscal Year 2014/15 Program Demographics

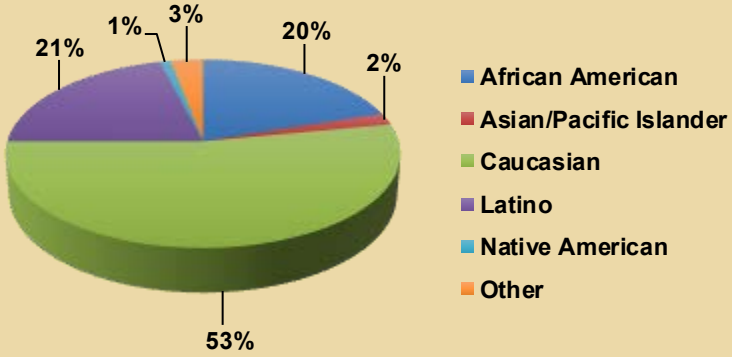
Gender



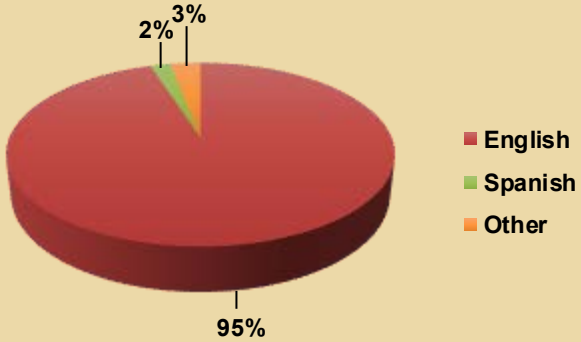
Age



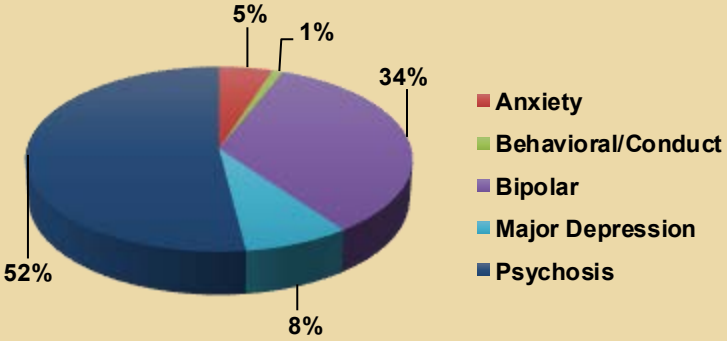
Ethnicity



Primary Language



Diagnostic Group



Community Services and Supports Programs

Program Changes

During the last year, and as described in the FY 2015/16 MHSA Annual Update, the STAR and FACT programs were expanded to provide additional treatment services for the reentry population as well as continue to serve consumers of the mental health court. As an and expansion and enhancement to these programs, Peer Mentoring for the re-entry population may be introduced and services will be expanded to the high desert region. The primary intent of the enhancement is to provide consumers with a Peer Support Navigator who has lived forensic experience through incarceration or probation and is also in active recovery. The purpose of pairing program participants with a Peer Support Navigator is to have the Peer Support Navigator act as a functional role model providing technical guidance and sharing their experience with successful reentry. With the consumers permission, the Peer Support navigator will also function as a member of the program participant's care team, working collaboratively with clinicians and forensic staff. In addition, the Crisis Intervention Training (CIT) component will be expanded to provide education to additional groups such as firefighters and Probation staff. This sub-component will be referred to as Community Partners CIT.

Artwork by Roger Stover

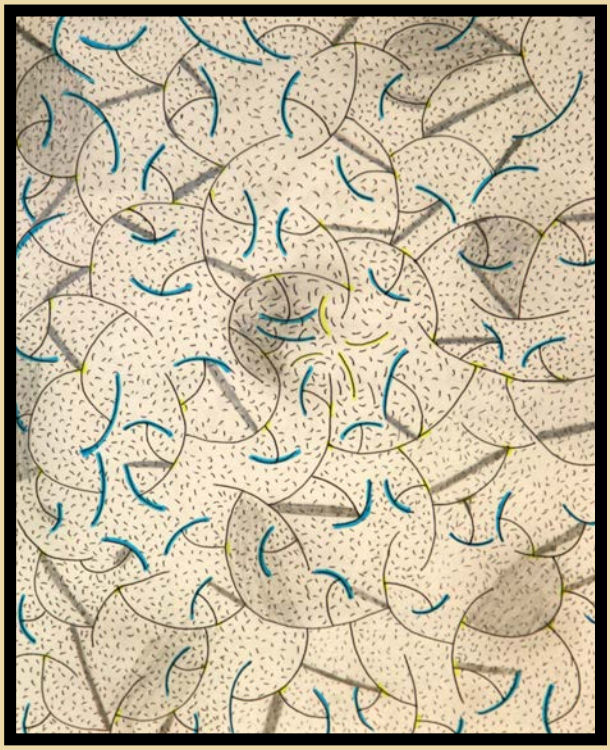
Outreach and Engagement Activities

- Mental Health Court Graduations.
- Art Contest Entry and Premier.
- DBH Recovery Happens.
- DBH Triathlon.
- Community Integration Outing.
- CIT Community Presentations.
- Cedar House Recovery Fair.
- Redlands Thanksgiving Celebration for Recovery.
- Community Resource Fair.
- Health Fair.

Collaborative Partners

- Alzheimer Association.
- Behavioral Health Commissioners.
- California State University of San Bernardino CARE Team.
- Cedar House Life Change Center.
- Coalition Against Sexual Exploitation (CASE).
- San Bernardino County Department of Behavioral Health presenters and guest speakers.
- County of San Bernardino Probation Department.
- County of San Bernardino Sheriff Department.
- Department of Aging and Adult Services.
- Department of Behavioral Health Clubhouse Members.
- Department of Behavioral Health Community Crisis Services.
- Department of Behavioral Health Peer and Family Advocates.
- Inland Empire Concerned African American Churches.
- Inland Regional Center.

Collaborative Partners (continued)



Artwork by Isabel Figueroa

- Inland Valley Recovery Services.
- Institute for Public Strategies.
- Loma Linda Veteran's Affairs Healthcare System.
- National Alliance on Mental Illness (NAMI).
- New Hope Missionary Baptist Church.
- Office of the District Attorney.
- Office of the Public Defender.
- Office of Veteran Affairs.
- Patton State Hospital.
- Rialto Kiwanis Club.
- San Bernardino City Police Department.
- San Bernardino County Superior Mental Health Courts.
- Shelter Services Housing Providers.
- The Counseling Team International.
- Veteran's Center of Colton.
- Westside Action Group.
- San Bernardino County Department of Behavioral Health Adult Forensic Services.
- Mental Health Court Treatment Teams of San Bernardino, Rancho Cucamonga, Victorville, and Joshua Tree Court.
- Residential facilities:
    - ◊ Residential substance use disorder treatment, such as:
        1. Gibson House for Men.
        2. Gibson House for Women.
        3. St. John of God Health Care Services.
        4. Inland Valley Recovery Services.
        5. Cedar House.
    - ◊ Licensed Board and Cares/Assisted Living Facilities, such as:
        1. Papa's Place.
        2. Redwood Guest Home.
        3. Shanti House Board and Care.
        4. Abria Del Cielo.
- Numerous unlicensed Room and Board and Sober Living Homes, such as:
    - ◊ American Surgical Pharmacy.
    - ◊ San Bernardino Adult Day Health Care Center.
    - ◊ Our Place Clubhouse (Redlands).
- Local community colleges and employment training programs (San Bernardino Valley College, Chaffey College and Center for Employment Training).
- Family members and other significant support persons of our FACT members.
- Gibson House.
- Crisis Walk-in Centers.

Members Assertive Positive Solutions / Assertive Community Treatment (A-3)

The **Members Assertive Positive Solutions (MAPS)** and **Assertive Community Treatment (ACT) –** Full service partnership programs are for individuals with Serious Mental Illness (SMI). These programs exist to help people live successfully in the community and helps clients to make strides toward achieving their personal recovery goals, while avoiding unnecessary psychiatric hospitalization. The programs serve San Bernardino County residents, ages 18 and up. The difference between the two programs is that ACT specializes in those who may be transitioning from institutional settings such as state hospitals, institutes of mental disease (IMDs), or locked psychiatric facilities. MAPS assists those who are high users of inpatient services and crisis services. These individuals may also have a history of co-occurring substance abuse or a history of being homeless. The MAPS program served **68** unique full service partners and ACT served **105** unique full service partners in **FY2014/15**.

Key components of the ACT model is treatment and support services that are individualized and guided by the individual's hopes, dreams and goals for behavioral health and overall wellness. The team members share responsibility for the individuals being served. Staff-to-consumer ratio is small (approximately 1-10) and the range of services are comprehensive and flexible. Most services are provided within the community where members live, work and socialize.

The Recovery Model used for both programs builds on traditional ACT standards. The Telecare Corporation has been contracted to provide MAPS/ACT services for individuals with serious mental illness and to create a recovery-centered experience for people served. Telecare's approach is based on a belief that "recovery can happen." The program and staff strive to create an environment where a person can recover. The program staff is a multidisciplinary team that include psychiatrists, nurses, Master's level prepared clinical managers, team leads, and personal service coordinators. Some staff may be consumers who are in recovery themselves.

Target Population:
- Adults

Projected Number to be served FY 2016/17:
- 100 Adults: ACT
- 85 Adults: MAPS

The services and support include a comprehensive assessment and treatment, crisis intervention and immediate support 24/7. Through these programs consumers have access to:

- Psychiatric assessment and treatment.
- Medication management and support.
- Risk focused assessment and intervention.
- Physical health screening.
- Care coordination and referral.
- Substance use disorder intervention.
- Counseling vocational services.
- Social skills building activities.
- Case management.
- Housing support.
- Benefits and entitlements assistance.
- Family support, education and life skills coaching.

Information and learning opportunities are provided to support individuals in their recovery. Staff support and consultation is available when members are hospitalized, and support upon discharge to aid their transition back to the community. All referrals are coordinated directly by Behavioral Health.

MHSA Legislative Goals and Related Key Outcomes

- Reduce the subjective suffering from serious mental illness for adults and serious emotional disorders for children and youth:
  - ◊ Improved life satisfaction.
  - ◊ Decreased hopelessness and increased hope.
  - ◊ Decreased impairment in general areas of life functioning.

- Reduce homelessness and increase safe and permanent housing:
  - ◊ Decreased rate of homelessness for clients related to their general living arrangement or in a supervised placement facility.

- Increase in self-help and consumer/family involvement:
  - ◊ Increased ratio of voluntary mental health services to involuntary mental health services.
  - ◊ Increased number of collaborative partners.

- Increase access to treatment and services for co-occurring problems; substance abuse and health:
  - ◊ Increased encounters in specialty co-occurring and substance abuse interventions.
  - ◊ Increased encounters in integrated health clinic.
  - ◊ Increased transportation to co-occurring appointments provided.

- Reduction in disparities in racial and ethnic populations:
  - ◊ Reduction in mental health and health care disparities.

- Reduce the frequency of emergency room visits and unnecessary hospitalizations:
  - ◊ Reduced number of emergency visits for behavioral health concerns.

- Increase a network of community support services.
  - ◊ Increased number of collaborative partners and increasing the coordination of care:

"Put your Heart and Soul into yourself and you will grow strong and beautiful in recovery."

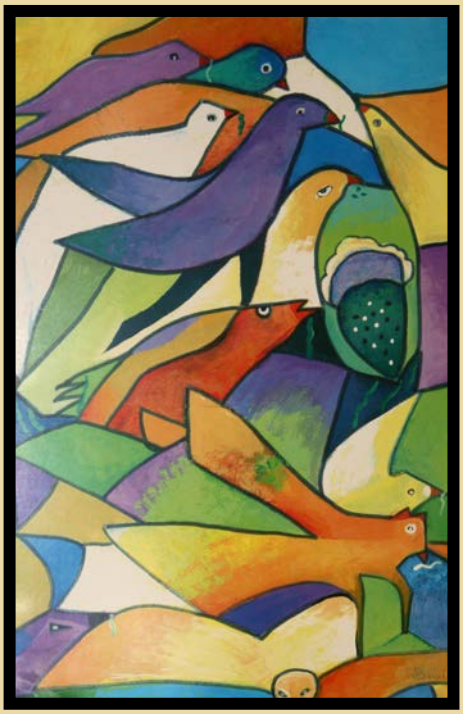
-MAPS/ACT consumer

Artwork by Gary Bustin

Community Services and Supports Programs

Outcome Tools Used to Reach Goals

- Global Assessment of Functioning (GAF) Scores.
- Key Event Tracking System (KETS).
- ACT Database.
- Simon.
- Data Collection and Reporting Outcome Tools.
- Discharge Information.



Artwork by Eneida Reboucas

Positive Results

MAPS

- **79%** decrease in homeless episodes when compared to clients year prior to enrollment in program.
- **95%** of the year, clients were housed in stable housing.
- **97%** or more of the consumers received voluntary mental health services through the MAPS program.
- Hospital episodes were reduced by **88%.**
- Unduplicated emergency room visits were reduced by **89%.**
- **2** members are working on their educational goals. One is seeking to obtain their High School diploma and the another is attending Community College.
- Increase in members use of community resources (clubhouses, adult school, community college, local libraries, etc.)

ACT

- There was a **50%** increase in number of clients moving into independent living in FY 14-15 compared to **FY 13-14**. This is often a indication of increased global functioning inclusive of an improved outlook on life and a decrease in hopelessness/suffering.
- **4%** of the members successfully terminated from conservatorship & maintained their independence in the community.
- **30%** of the target population was transitioned from Board and Care facilities into their own apartments or returned to live with family.
- **40%** reduction in the number of members that were hospitalized when compared to **FY 13/14**.

Success Stories

MAPS

Before “Tammy” met with Telecare MAPS she felt like it was really hard to get her head straight. She used to leave her home and sleep under the freeway bridges or in the park. She had spent a lot of time going in and out of the behavioral health hospital because she felt it was the safest place for her when she was homeless. She suffered from depression, loneliness, and other behavioral health issues. “Tammy” hasn’t been to the hospital in a years, since she enrolled in the MAPS program. While in the MAPS program Tammy attended a co-occurring group where she learned how addiction impacts her health. She attended another group that taught her how to be healthier, and how to relax and to better manage her anxiety. Tammy reports that she feels like she has support and a family with MAPS. She is glad she enrolled with MAPS. The program was able to help Tammy find a place to live, get her appropriate medication and help her resolve some court issues she was faced with. She doesn’t have much family but she feels she has the MAPS program because they’re always there.

"John" would drink, do drugs and run away from home before enrolling in the MAPS program. He often suffered from depression and feelings of worthlessness. When John was kicked out of his home he went to live in a board in care facility where his risky behavior worsened. He was in and out of the Behavioral Health unit at Arrowhead Regional Medical Center and was taken to Sierra Vista IMD. When he was there he was visited by Telecare who told him about the MAPS program. John decided to enroll in the program. He has learned how to develop stronger coping skills to help him manage his depression. MAPS has provided John with classes on how to stay healthy, on etiquette and has assisted John with keeping his doctors appointment and staying on track with his medication. John has made many friends in the program and finds they offer him good support.

ACT
"Betty" a 40 year old female was successful in terminating conservatorship due to zero hospitalizations in the last 2 years. She has been taking her medication regularly and attending support groups in the community independently.

Artwork by Sonia Stockton

"They are always available to talk even if it's at night. If I didn't have MAPS I wouldn't be here."

-MAPS/ACT consumer

Challenges & Solutions in Progress

MAPS
The MAPS programs face challenges with lack of affordable housing and co-occurring resources. The program works to address this issue by increasing and expanding its networking with local housing operators, apartment managers, assisted living programs, skilled nursing facilities, room and boards and
licensed board & care operators.

ACT
Community housing options for clients with criminal or substance abuse history and/or having a limited income is an ongoing challenge. To address this, the ACT program is continues to network with potential housing resources and offer co-occurring education.

Community Services and Supports Programs

Program Expansion

MAPS

There is a planned expansion that will increase the availability for this program. It is planned to expand this program by **25** additional client spaces. This expansion will accommodate referrals from the newly formed Recovery Based Support Teams (RBEST) project. This Innovations-funded project is providing outreach and engagement for the most difficult to activate clients in the community. As this project speaks to the spirit and intent of Assisted Outpatient Treatment (Laura's Law), this high level, Full Service Partnership level of care needs to be available. In the first two months of service delivery the RBEST project has already successfully referred clients into the MAPS program. Additionally, as DBH moves to include crisis residential treatment facilities in their treatment options, community-based, Full Service Partnership capacity needs to be available to provide a step-down component for discharge plans in order to provide a seamless, recovery based transition from the highest level of care (hospitalizations) to independent community living.

ACT

A **16** week psycho-education class about co-occurring disorders is planned for FY 2015/16 due to the lack of resources available in the community. The program changes will enhance the ability to connect and provide support for their sobriety. It will help those who have a dual diagnosis by providing a structured weekly class with **12** members and two **(2)** staff. This plan is to focus on the individual that may be ready for transition to a more independent style of living in the community.

Outreach and Engagement

MAPS

- Health Fair.
- Member Recognition.
- Community Celebrations.
- On-site Activities.
- National Alliance for the Mentally Ill (NAMI) Fundraiser.

"They are always available to help me."

-MAPS/ACT consumer

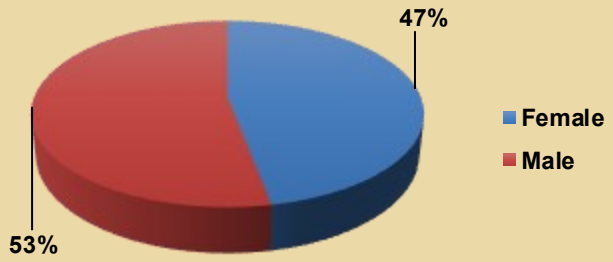
Collaborative Partners

- Board and Care Operators.
- Substance Use Disorder Treatment Programs.
- Clubhouses.
- Institutes for Mental Disease.
- Substance Use Disorder Treatment Programs.

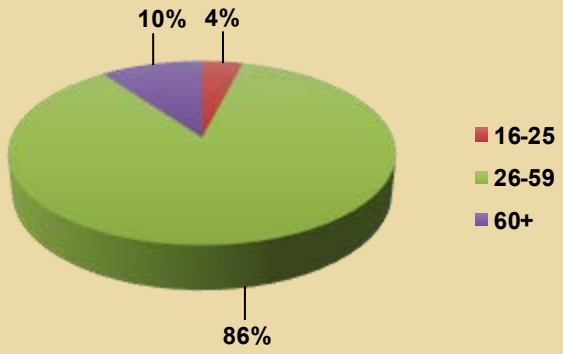
Community Services and Supports Programs

Fiscal Year 2014/15 Program Demographics

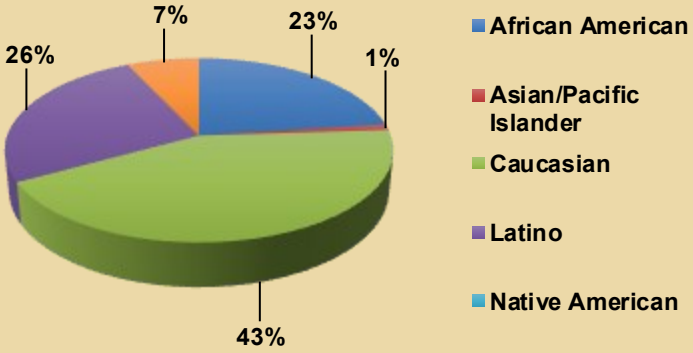
Gender



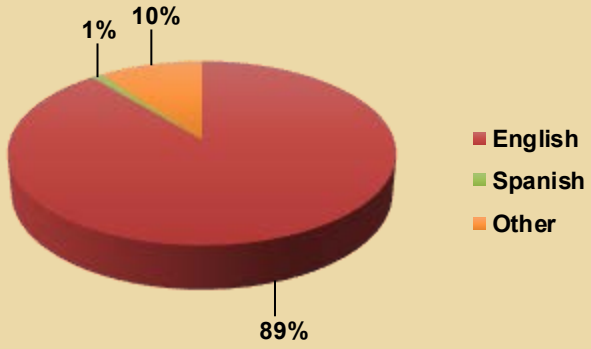
Age



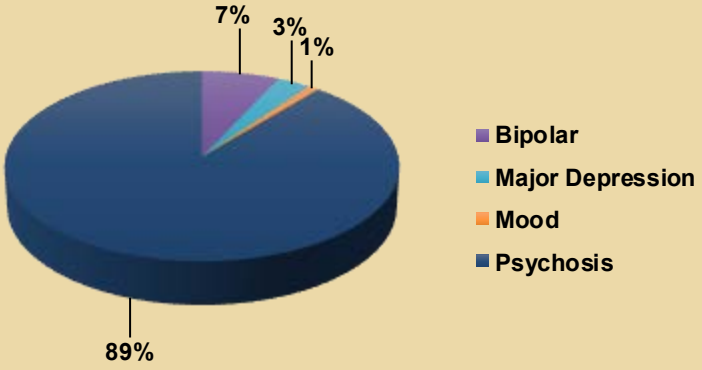
Ethnicity



Primary Language



Diagnostic Group



Crisis Walk-in Centers (A-4)

The Crisis Walk-In Centers (CWIC) provide urgent mental health services to San Bernardino County residents located in the Morongo Basin, Victorville, and the Rialto. These centers conduct urgent psychiatric assessments and crisis stabilization for clients experiencing acute psychiatric distress, who are of possible danger to themselves or others. Centers are staffed by a multi-disciplinary team who focus on stabilizing clients and providing linkage to resources within the community for psychiatric follow-up. Services are offered **24** hours per day, **7** days a week in Victorville and Morongo Basin. The Central Valley CWIC operates Monday through Friday from 8:00 am- 10:00 pm and Saturday 8:00 am - 5:00 pm. In collaboration with the Community Crisis Response Teams (CCRT), the CWICs work to reduce inappropriate hospitalizations and improve the quality of life for their clients.

Target Population:

- Children
- TAY
- Adult
- Older Adult

Projected Number to be Served FY 2016/17:

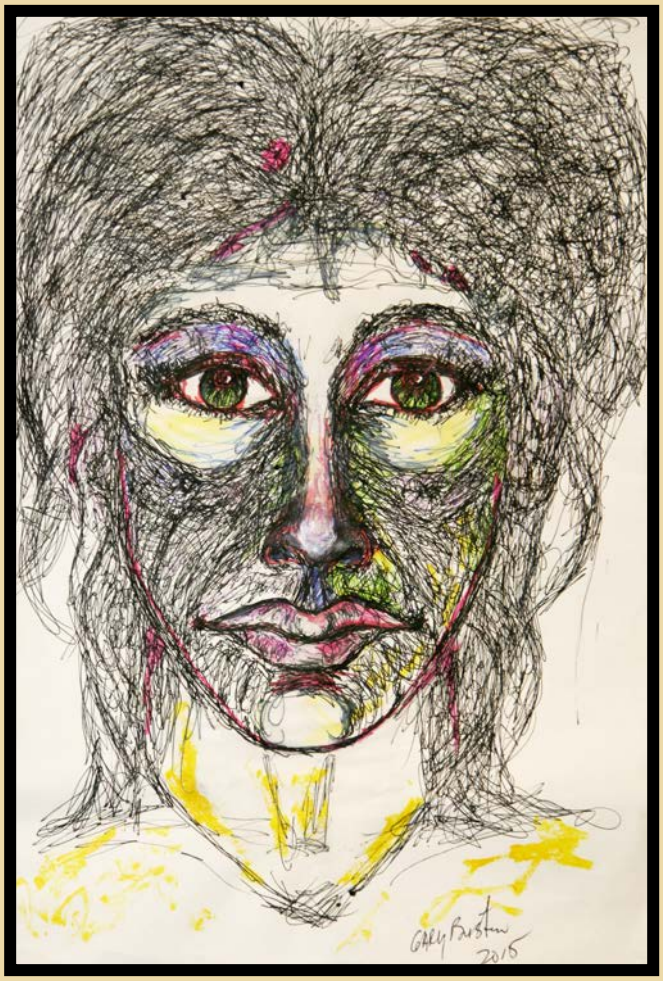
- 125 Children
- 700 TAY
- 1,900 Adults
- 100 Older Adults

MHSA Legislative Goals & Related Key Outcomes

- Reduce the frequency of emergency room visits and unnecessary hospitalizations:
  - ◊ Increased use of alternative crisis interventions.
  - ◊ Reduce the number of emergency room visits for Behavioral Health concerns.

Positive Results

The CWICs have provided much needed services to San Bernardino County residents to obtain emergency mental health and stabilization services while remaining within the community. Prior to the CWICs, the County's remote regions had no available options for emergency mental health services. They have provided an opportunity for family members and caregivers to become more involved in the care and treatment plan of their loved ones.



Artwork by Gary Bustin

Community Services and Supports Programs

Each client is given an evaluation to identify any psychiatric concerns that might be preventing their recovery. During the FY 2014/15, crisis stabilization interventions were provided by the CWIC which included medical, clinical, and psychiatric assessments.

Artwork by Marisa Franklin

Needs Assessments are completed on all clients to understanding of what community referrals are needed to assist with the overall goal of reducing emergency room visits and hospitalizations. Safety plans are developed to improve the client's ability to recognize triggers related to their current crisis and identify possible resources and coping strategies. **100%** of clients requesting community resources to assist with their crisis received referrals to appropriate levels of care. In addition, CWIC staff assist clients in getting appointments at local outpatient clinics for psychiatric support, and ongoing health care.

As a result of services provided, **92%** of clients seen in a CWIC were not hospitalized within 30 days after their visit. Clients determined to need hospitalization are transported to an inpatient psychiatric hospital within the county.

CWICs are a vital service in the department's efforts to reduce hospital emergency room encounters of individuals experiencing a mental health crisis. San Bernardino County hospital emergency rooms report **3.42%** of all emergency room encounters are due to a primary mental health diagnosis.
In the FY 2014/15, a total of **6,433** consumers were served for crisis services. Of those, **3,552, or 55%** received medications and **37%** received linkage to outpatient services. A total of **6,010 consumers, 93.4%,** were diverted from hospitalization and to less restrictive services.

Challenges

- Individuals who are not experiencing a mental health crisis but are referred for medication support only.
- Statewide shortage of psychiatrists, needed for medication support services.
- Homeless or at-risk individuals who are not experiencing a mental health crisis.

Solutions in Progress

- Continue to work collaboratively with community partners to provide ongoing education regarding appropriate referrals.
- Continue to work collaboratively with clinics and health plans to assist with client appointments.

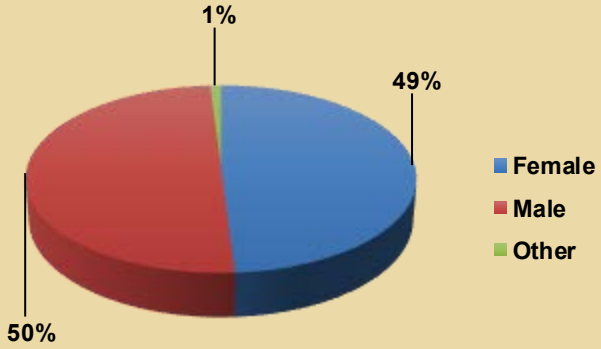
Collaborative Partners

- Inland Empire Health Plan.
- Arrowhead Regional Medical Center–Behavioral Health Unit.
- Community Clinic Association of San Bernardino County.
- Molina Health Care.
- DBH Diversion and CCRT Programs.
- Other designated 5150 (involuntary psychiatric hold) hospitals.

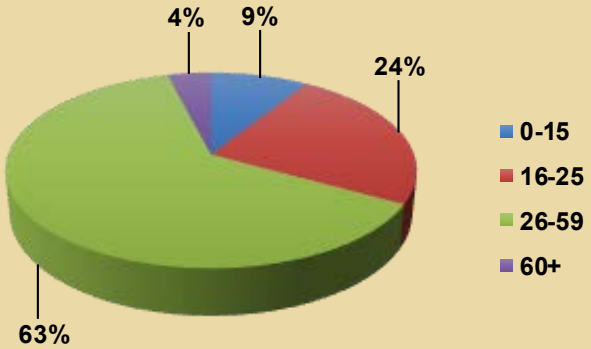
Community Services and Supports Programs

Fiscal Year 2014/15 Program Demographics

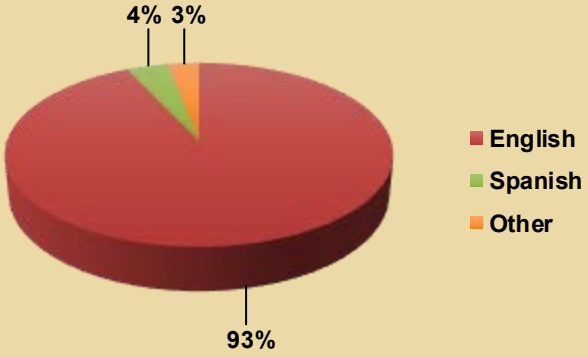
Gender



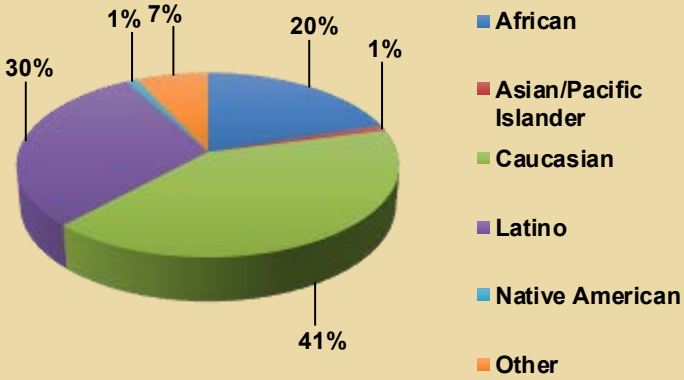
Age



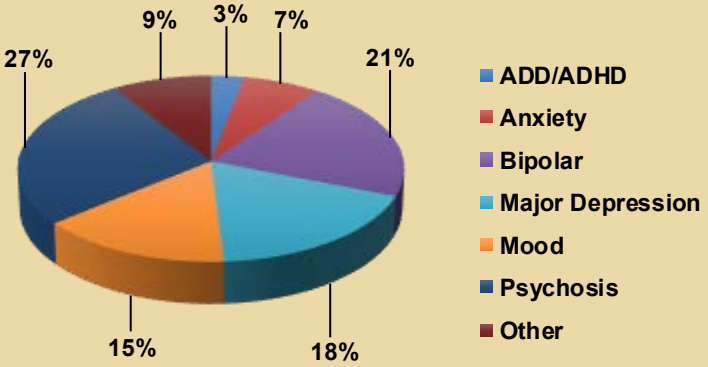
Primary Language



Ethnicity



Diagnostic Group



Psychiatric Triage Diversion Program (A-5)

Many individuals present to emergency rooms requesting mental health services that can be more effectively and efficiently met in an outpatient setting. This program was designed to screen these individuals to determine if their needs can be met in other settings outside of an inpatient treatment unit. There are many individuals who, after receiving a psychiatric assessment, do not meet the criteria for inpatient psychiatric treatment.

The Psychiatric Triage Diversion Program is located within the Psychiatric Emergency Room (ER) of the county hospital, Arrowhead Regional Medical Center (ARMC). The Diversion staff provides assessments of these individuals to determine how to best meet their needs outside of the hospital environment. Services provided include:

- Crisis assessment and intervention.
- Case management.
- Collateral contacts.
- Transportation assistance.
- Housing assistance.
- Linkage with outpatient resources and providers.
- Referrals to medical and social service agencies.
- Family and caretaker education.
- Client advocacy.

Artwork by Sonia Stockton

MHSA Legislative Goals and Related Key Outcomes

- Reduce the frequency of emergency room visits and unnecessary hospitalizations:
  - ◊ Decrease unnecessary and/or inappropriate inpatient psychiatric admissions.

Positive Results

Results show that **61%** of the **4,192** individuals who received services were successfully diverted from inpatient treatment to appropriate outpatient treatment options. Data was collected regarding each individual contact and included:

- Demographics.
- Insurance status.
- Homelessness.
- Medical conditions.
- Co-Occurring issues.
- Recent incarcerations.
- Outcomes of the encounters.
- Resources and referrals provided to the consumer.

Target Population:

- TAY
- Adults
- Older Adults

Projected Number to Be Served FY 2016/17:

- 500 TAY
- 2,000 Adults
- 500 Older Adults

Success Stories

"Tony" was discharged from various inpatient psychiatric units to his mother's home several times. At times he, came to the Psychiatric Triage Diversion unit but was not in need of inpatient treatment. The Diversion staff spent several hours with Tony to assess his outpatient treatment needs, which were
heavily centered on substance abuse.

"I feel like a new person"

-Consumer

Tony was at risk of homelessness, as his mother was frustrated with his lack of progress and unsure that she could continue to support him at home. The Diversion staff worked with Tony and located several appropriate treatment providers. Assistance was provided to Tony in completing applications, making phone calls, and appointments to various programs that would provide a comprehensive path towards recovery. Diversion staff also worked with Tony's mother to help her understand treatment options that would meet his needs. Tony was eventually accepted into a treatment program and was able to return home following treatment.

"I couldn't do it without your help"

-Consumer

Artwork by Gary Bustin

From 2009 to 2015, "Mary" was confined in psychiatric locked setting multiple times, as frequently as once every other week. While working with Mary, the Diversion staff changed the language and the tone of the crisis interactions by asking Mary, "What will make this better?" By partnering with the client in an unpressured and unconditionally accepting manner, the Diversion staff was able to help her understand her desires for her own future. She was able to accept an appropriate outpatient treatment plan from the Diversion staff that would help her actively participate in her own recovery journey. In addition to the outpatient appointments and referrals, the Diversion staff also linked her to the Recovery Based Engagement Support Team (RBEST) who were available to continue this partnership. RBEST was able to assist Mary with linkage to service providers and support her efforts to continue her life without requiring frequent inpatient treatment.

Community Services and Supports Programs

Challenges

As we continue with the implementation of the program and work to improve delivery of coordinated care for adults who have co-occurring physical health and behavioral healthcare needs, the program is challenged with seamless service delivery while diverting consumers from a hospital emergency room to an outpatient clinic or service provider.

Solutions in Progress

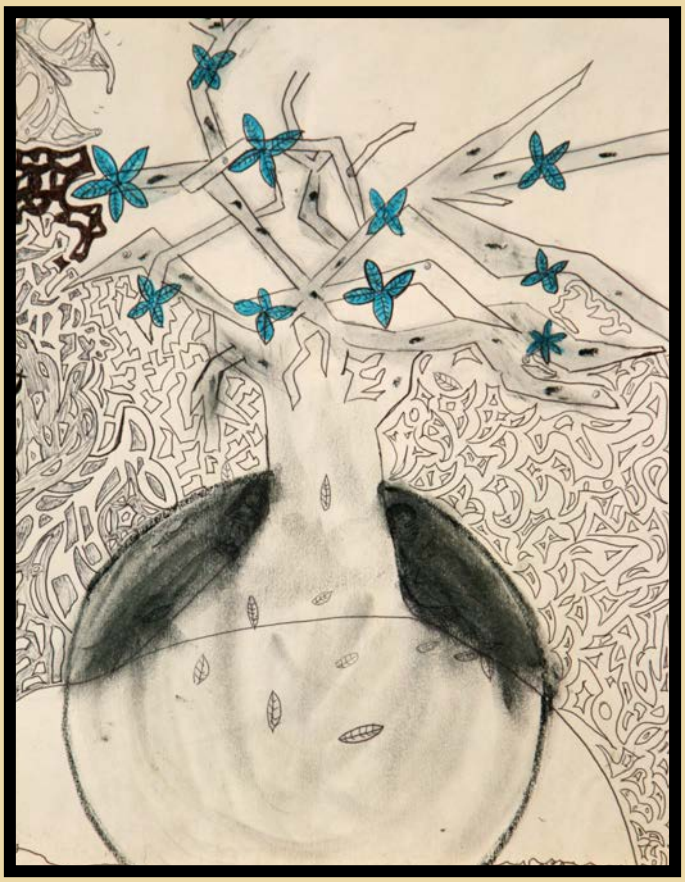
The Psychiatric Triage Diversion team continues to work collaboratively with partner agencies, outpatient clinics, community agencies, and Department of Behavioral Health Program to understand the needs of the clients served. The inclusion of regularly scheduled multidisciplinary meetings between the program and partner agencies have been instituted.

Additionally, collaborative meetings with ARMC nurse managers and administrative staff were instituted. As a result of the collaborative efforts with ARMC, the Psychiatric Triage Diversion team have monthly opportunities to discuss methods of improving seamless service delivery.

Artwork by Elisha Wheeler

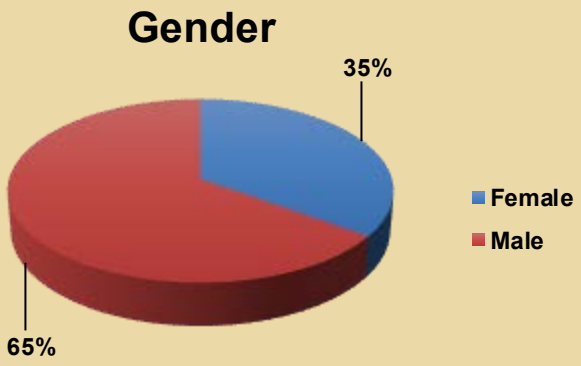
Collaborative Partners

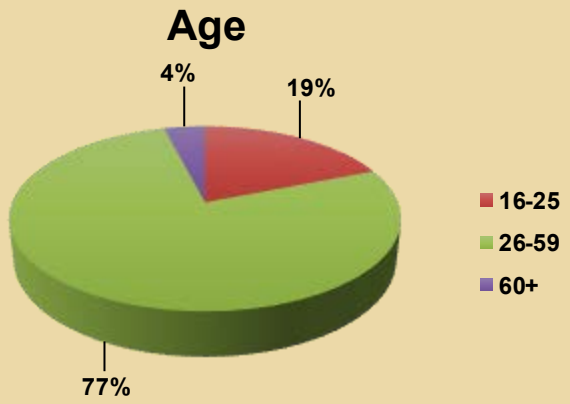
- Arrowhead Regional Medical Center.
- Law Enforcement agencies throughout the County of San Bernardino.
- Telecare Corporation.
- County Probation.
- State Parole.
- Public Guardian's Office.
- Department of Family Services.
- Department of Aging.
- Fee for Service Private Hospitals.
- Los Angeles County Department of Mental Health.
- Orange County Department of Mental Health.
- Riverside County Department of Mental Health.
- Contract Mental Health Providers.

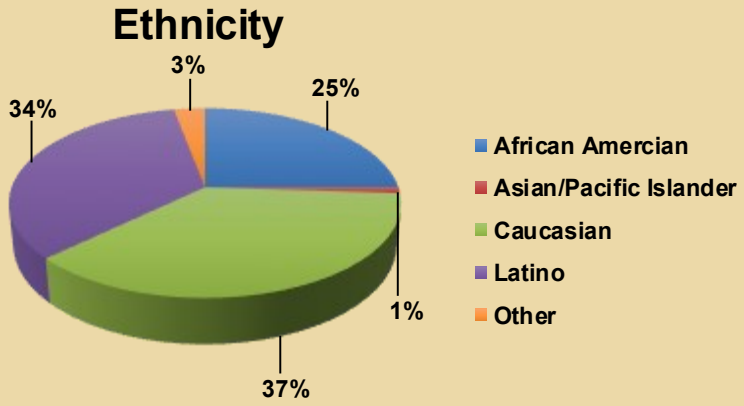


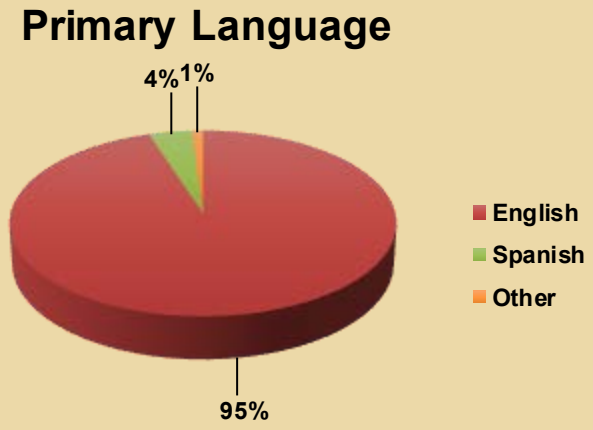
Artwork by Isabel Figueroa

Fiscal Year 2014/15 Program Demographics









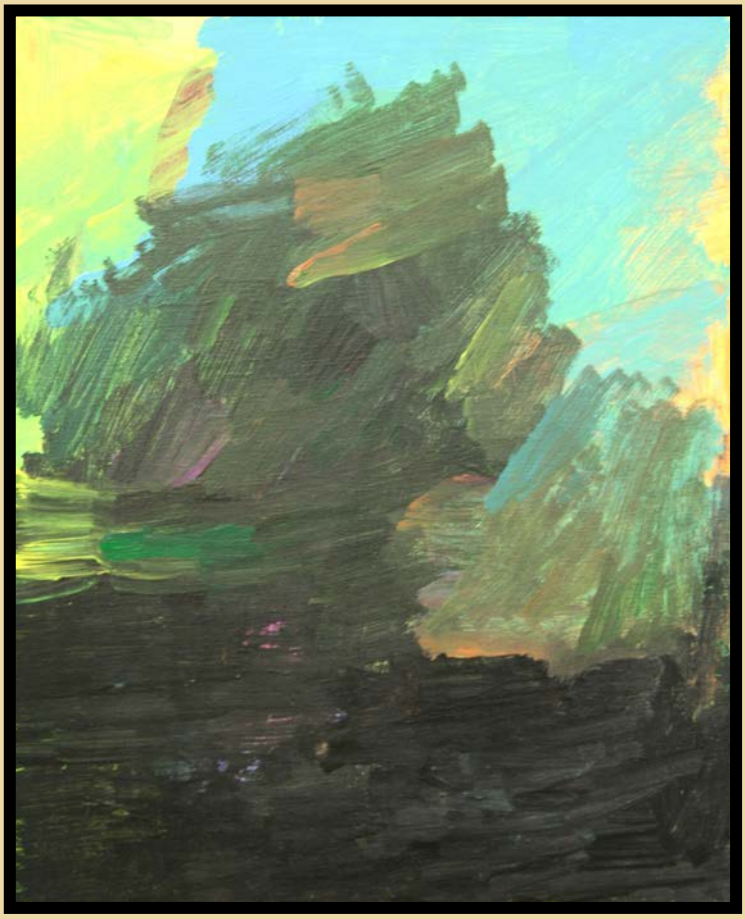
Community Crisis Response Teams (A-6)

The Crisis System of Care provides urgent mental health services to residents of San Bernardino County. The Community Crisis Response Teams (CCRT) utilize specially trained mobile crisis response teams to provide crisis interventions, assessments, case management, relapse prevention, and medication referrals. Additional services include linkage to resources through collaboration with law enforcement, hospitals, the San Bernardino Department of Children and Family Services, Adult Protective Services, schools, and other community organizations. CCRT teams are committed to assisting San Bernardino County consumers in the least restrictive manner, providing field responses and linkage to necessary and appropriate services.

MHSA Legislative Goals & Related Key Outcomes

Reduce the frequency of emergency room visits and unnecessary hospitalizations:

- ◊ Reduced number of emergency room visits for behavioral health concerns.
- ◊ Increased use of alternative crisis interventions.
- ◊ Increase in number of individuals diverted from hospitalization.



Artwork by Peter Vadnais

Target Population:

- Children
- TAY
- Adults
- Older Adults

Projected Number to Be Served FY 2016/17:

- 2,128 Children
- 872 TAY
- 2,288 Adult
- 294 Older Adult

Positive Results

In FY 2014/15, there were **3,986** crisis calls. Out of those **3,986** crisis calls, **2,136** (or **54%**) received services from Community Crisis Response Teams which resulted in clients diversion from unnecessary hospitalizations. The CCRT utilized Record of Intervention (R.O.I.) logs to measure program specific outcomes.

Success Stories

CCRT has several success stories from consumers and families that have been grateful for the immediate assistance provided during a psychiatric crisis.

- CCRT was contacted by a mother regarding her adult son who was not in mental health services and had stopped taking his medication. She arrived from another state to assist her son. CCRT staff assisted the young man to get to the Crisis Walk In Center and obtain necessary medication. The mother was grateful for CCRT assistance.

- A probation Officer called CCRT to come out and assess a Probationer that was having some mental health concerns. CCRT went out and provided an assessment and assisted the gentleman with getting services; preventing an unnecessary incarceration due to his mental health needs.

Challenges

The primary challenge CCRT faced this year was staffing shortages on all teams. Another challenge has been the staffing Standby shift during the night .

"CCRT really cared about my son and my family."

- Thankful Parent

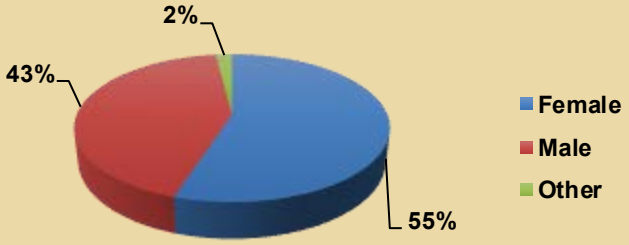
Solutions in Progress

During staffing shortages, teams pulled together to ensure all shifts were covered and all calls were responded to. These efforts fostered goodwill amongst staff and supported the development of teamwork. CCRT management is working with the Human Resource Department (HR) and the Office of Workforce Education and Training (WET) to fill vacant positions as quickly as possible.

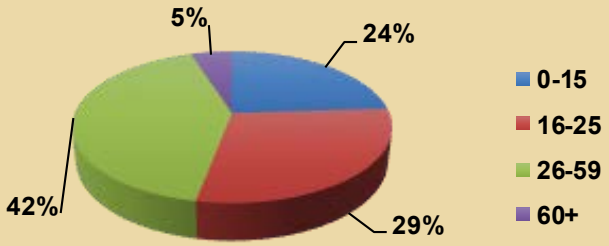
Artwork by Isabel Figueroa

Fiscal Year 2014/15 Program Demographics

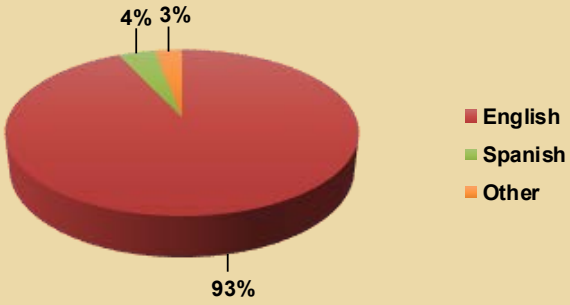
Gender



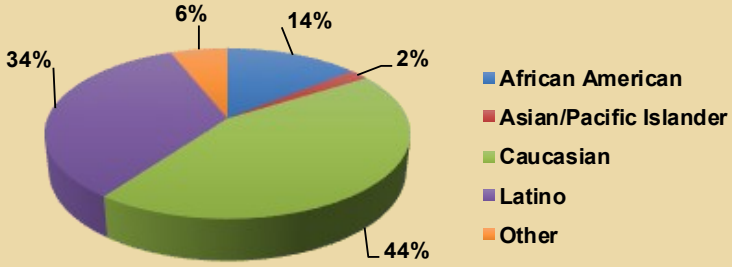
Age



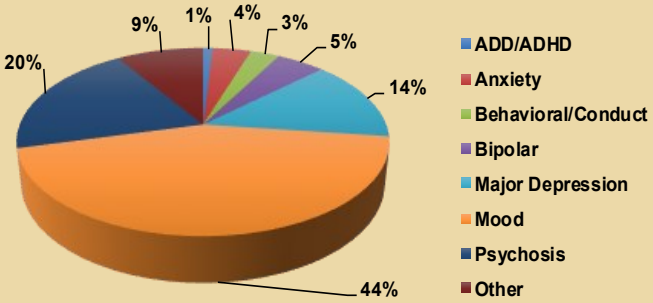
Primary Language



Ethnicity



Diagnostic Group



Outreach and Engagement

During the FY 2014/15, CCRT's participated in **110** Law Enforcement Briefings, presented at **5** hospitals, **8** conferences reaching **1,262** participants, **13** schools, and **30** community presentations or meetings. The combined number of participants from all activities totaled **10,165**.

Artwork by Gary Bustin

Program Updates

The Community Crisis Services will be expanding the program to include a graveyard shift for the Community Crisis Response Team (CCRT) in all three regions: East Valley, West Valley, and High Desert. This expansion will create a cost savings to the department by eliminating extended overtime. It will also eliminate the limited services that CCRT is able to provide during the hours of 10:00 p.m. to 7:00 a.m. The addition of this shift will will address resource issues thus increasing staff retention. This expansion is necessary for the CCRT program to continue to maintain its quality of services and keep up with the increase demands for services by community partners and consumers.

" My son will get the services he needs."

- CCRT Consumer

Collaborative Partners

- San Antonio Community Hospital.
- Arrowhead Regional Medical Center.
- St. Mary's Hospital.
- Victor Valley Hospital.
- Desert Valley Hospital.
- St. Bernardines Hospital.
- Community Hospital in San Bernardino.
- Redlands Community Hospital.
- Loma Linda Medical Center.
- Canyon Ridge Hospital.
- Behavioral Medical Center, Loma Linda.
- Mountains Hospital in Arrowhead.
- Bear Valley Hospital in Big Bear.
- High Desert Hospital in Morongo Basin.
- DBH Contract Agencies.
- Children's Intensive Case Management Services.
- Code Enforcement.
- Sheriff Stations throughout San Bernardino County.
- Local Police Departments throughout San Bernardino County.
- DBH Clinics.
- TAY Center.
- Probation, Adult and Juvenile.
- Elementary, Middle, High and Nonpublic Schools.
- Board and Care Facilities.
- Juvenile Group Homes.
- Kaiser ED and Outpatient Services.
- Private Providers, Medical and Psychiatric.
- Children's Foster Services.
- CWICs in three regions.
- Family Resource Centers.
- Coalition Against Sexual Exploitation.

Homeless Intensive Case Management and Outreach Services (A-7)

The Homeless Intensive Case Management and Outreach program is comprised of four (4) focus areas:

- Adult System of Care Full Service Partnerships.
- Homeless Intensive Case Management and Outreach Services (HICMOS).
- Homeless Outreach Support Teams.
- Housing and Employment Program.

Adult System of Care Full Service Partnerships

The Full Service Partnership (FSP) is a vital component in DBH's Adult System of Care that addresses individuals stepping down from State hospital institutions for mental health or conservators. The FSP is designed serve adults in San Bernardino County who are severely and mentally ill or who have untreated co-occurring disorders and who are in many cases, recently released from state hospitals and/or institutionalized care. These adults are at imminent risk of homelessness, incarceration, hospitalization or re-hospitalization if appropriate levels of care are not provided as part of transitional care and institutional discharge planning. The FSP promotes the principles of recovery, wellness, and resiliency to assist individuals to have lives that are more satisfying, hopeful, and fulfilling based on their own values and cultural framework. Services focus on the client's strengths and possibilities in order to move toward new levels of functioning in the community.

Artwork by Brad Borrero

Individuals requiring this level of care are often unable to maintain independence in the community without the assistance of intensive case management support. The ratio of staff to clients is one **1** to **15** to allow for intense support of the clients **24** hours a day/**7** days a week.

The FSP offers a true one-stop shop of all available resources such as

- Housing.
- Interim assistance.
- Medication support services.
- Intensive case management.

FSP service providers help individuals cope with the behavioral health challenges by linking them to community programs and agencies through direct, one-to-one support. This intense, interactive support from case managers and other community resources benefits FSP consumers and contributes to increased independence and reduced psychiatric hospitalization, thus enhancing the individual's quality of life.

This holistic approach meets the client's needs by providing coordination of care with mental health and substance abuse outpatient clinics as well as physical health care providers. Those who have been homeless often come into the FSP with many physical problems and are supported through linkage and transportation to community based health care providers. In addition, employment preparation and support services are provided to help the FSP clients to help them reintegrate into the job market or obtain entitlements such as SSI (Supplemental Security Income) as each individual's needs dictate.

Overall, the program promotes the principles of recovery, wellness, and resiliency to assist individuals to have lives that are more satisfying, hopeful, and fulfilling based on their own values and cultural framework. The focus of the services is on the client's strengths and possibilities in order to move toward new levels of functioning in the community. These are clients who lack access to community resources, are high-end users of emergency rooms, have possibly been in a psychiatric inpatient setting, and/or may have criminal/law enforcement contacts such as jail and the court systems. These services may include short-term placement in the emergency shelter level of care for up to 30 days, and an assigned a case manager. Individuals in need of short-term placement potentially face homelessness after being released or diverted from a higher level of care such as an acute inpatient psychiatric hospital. Shelter is needed while waiting for a substance abuse treatment program bed or for income entitlements. They are provided after placement help with their adjustment back into the community, eliminating re-hospitalizations and homelessness.

Homeless Intensive Came Management (HICMOS)
The Homeless Intensive Case Management and Outreach Services (HICMOS) program is designed to target provision of services to unserved, underserved, and inappropriately served adults in San Bernardino County who are living with chronic and severe mental illness, untreated co-occurring disorders and are homeless.

The program promotes the principles of recovery, wellness, and resilience to support individuals on the road to living more satisfying, hopeful, and fulfilling lives, based on their own personal values and cultural framework. Services focus on the client's strengths and abilities and assist with linkage to appropriate community resources in order to minimize unnecessary use or interaction with law enforcement, emergency rooms, and psychiatric inpatient facilities.

HICMOS clients are provided intensive case management services at various levels of care. Through the mental health assessment process, individual needs are identified and consumers are placed into one or more of the following program tracks:

- Employment Services Track – Consumers referred to this track are provided with an assessment for employment, group job skills training, and employment leads.
- Entitlements Track – The focus of the entitlements track is to assist the consumer in securing any entitlement programs they may be eligible to, such as Social Security Income.
- Groups Track – Consumers participating in this track attend groups to help cope with personal and mental health obstacles that have become barriers to meeting their goals.

In addition to the specific tracks previously mentioned, consumers are provided with ongoing intensive case management services which includes medical care coordination for mental and physical health care and linkages to community and county resources for:

- Clothing.
- Substance use treatment.
- DBH clubhouses and other entities as deemed individually appropriate.

The transitional level of care provides a long term structured case management program to assist consumers with overcoming obstacles to employment and obtaining permanent housing. Consumers agree to this level of care and engage in partnership with DBH to participate in an array of structured activities to enable them to move towards addressing their mental health and substance abuse issues as well as their medical, employment, and housing concerns.

The maintenance level of care provides continued case management to stabilize consumers living with mental illness and are preparing to transition to other housing programs, such as living in their own apartment, semi-independent living, and room and boards within the community. A major service provided by case managers at this juncture is relapse prevention and focus on consumer's recovery goals. Many clients continue ongoing aftercare with the DBH outpatient clinics to support continued stability once discharged from HICMOS.

Homeless Outreach Support Teams (HOST)
The Department of Behavioral Health's (DBH) Homeless Outreach Support Team (HOST) and Housing and Employment Programs, in collaboration with the Housing Authority of the County of San Bernardino (HACSB), receive funding from the Department of Housing and Urban Development (HUD) to assist homeless individuals with mental illness and their families into permanent supportive housing under the Homeless Assistance Shelter Plus Care grant. HACSB is the primary recipient of the HUD funding and provides the housing vouchers. DBH staff provide service match in the form of wrap around case management services. HOST is an outreach based program providing services in the field to engage those chronically homeless individuals with mental illness into permanent supportive housing. HOST collaborates with the Sheriff's Homeless Outreach Proactive Enforcement (HOPE) team to conduct outreach events, go out into the field, and engage the most difficult and hard to reach clients. HOST staff works with qualified individuals to complete the necessary applications and assessments in the field and, upon receipt of housing voucher, will assist the individual to locate and move into housing. HOST continues to offer recovery-based wrap around case management services to the individual to assist them to recover, gain wellness, and reintegrate into the community with the ultimate goal of independence and self-sufficiency.

Housing and Employment Program
Master Leasing (Emergency Housing) working in conjunction with the referring FSP, Housing and Employment staff would offer services to assist applicants to establish and maintain gainful employment and to establish an emergency tenant-based private residency. The goal is to assist consumers establish residential and economic stability so that they can be later transferred to the Shelter + Care housing program. Services include establishing and maintaining employment, referrals to the Department of Rehabilitation, finding an apartment, negotiating with potential landlords, transitioning into an apartment, gaining access to DBH drug and alcohol services, documentation and verification of sobriety (if needed) and other housing/employment related services. Clinical staff will be available to provide mental health services and substance abuse counseling. Additionally, employment staff assist the consumer to establish enrichment activities such as gainful employment, volunteer services, or enrollment in formal education.

Vintage at Kendall is a housing project located in the city of San Bernardino dedicated for the senior mentally ill individuals who are 55 years of age or older. There are **20** MHSA one-bedroom units reserved for the qualified consumers. As of July 2015, this project is at full capacity.

Magnolia at 9th is a housing project located in a different part of the city of San Bernardino dedicated for the senior mentally ill individuals who are 60 years of age or older. There are **10** MHSA one-bedroom units reserved for the qualified consumers. As of July 2015, this project is at full capacity.

Mountain Breeze Villas is a housing project located in the city of Highland dedicated for the adult mentally ill individuals who are 18 to 59 years old. There are **20** MHSA one-bedroom units reversed to the qualified consumers. As of July 2015, this project is at capacity.

Phoenix Apartment is a housing project located in the city of San Bernardino dedicated for the Transitional Age Youth and adult mentally ill individuals who are 18 to 60 years old. There are 8 MHSA units in this complex. As of July 2015, this project is at full capacity.

Community Services and Supports

MHSA Legislative Goals and Related Key Outcomes

- Reduce the subjective suffering from serious mental illness for adults and serious emotional disorders for children and youth:
  - ◊ Improved life satisfaction.
  - ◊ Decreased hopelessness/increased hope.
  - ◊ Increased resiliency.

- Reduce homelessness and increase safe and permanent housing:
  - ◊ Decrease rates of homelessness for clients.
  - ◊ Increased residence stability.

- Reduction in criminal and juvenile justice involvement:
  - ◊ Decreased rate of incarcerations.
  - ◊ Reduced jail/prison recidivism.

- Reduce the frequency of emergency room visits and unnecessary hospitalizations:
  - ◊ Reduced number of emergency room visits for mental health concerns.
  - ◊ Increased use of alternative crisis interventions.

- Increase network of community support services:
  - ◊ Increase in number of collaborative partners.

Target Population:

- TAY
- Adults
- Older Adults

Projected Number to be Served FY 16/17:

- 2 TAY
- 1,280 Adults
- 66 Older Adults

"I feel good knowing that I don't have to suffer from mental health problems. There is hope for me."

-Adult System of Care Full Service Partnerships Consumer

Positive Results

Adult System of Care Full Service Partnerships

- **98%** of this population, many of whom were recently released from long-term locked facilities, remained stable in a community setting.
- **96%** of the population did not require hospitalization for mental health issues.

" I am thankful for the HICMOS program. It got me off the streets and in a safe place."

- HICMOS Program Consumer

HICMOS

- In Fiscal Year 2014/15, **55%** of discharged consumers were discharged with a status, signifying they left the program for stable housing.
- Substance abuse treatment services were provided to **220** individuals. Mental Health services were provided to **176** individuals. **58** referrals were made to individuals for Primary Health Services with **56%** of consumers following through. As compared to FY 13/14, Substance Use treatment services provided to **61** individuals. Community Mental Health services were provided to **33** individuals, and **73** Primary Health referrals were provided with **41%** of persons following through.
- Based on the population served in FY 14/15, **75%** were identified as part of an underserved group. Of the **152** individuals, **78** were non-white individuals. **40** individuals reported as Hispanic/Latino which were included in the total number of white participants.
- In comparison to FY 13/14 there was only a slight increase in the frequency of emergency room visits from **5** in FY 13/14 to **8** in FY 14/15. There were **0** unnecessary hospitalizations.

HOST
In collaboration with the Housing and Employment program, HOST successfully engaged and placed **35** families into permanent supportive housing. Each of the families receive ongoing intensive case management, in an effort to assist them maintain their permanent supportive housing. HOST is currently managing a caseload of **200** families receiving permanent supportive housing.

> ***"This program has saved my life."***
>
> ***-HOST Program Consumer***

The HOST program was also recognized and awarded a National Association of Counties (NACo) award in June 2015.

Housing and Employment
The grand opening of the Magnolia at 9th St senior housing project, in the city of San Bernardino, occurred which consisted of a total of **119** total units, in which **10** units were set-aside for DBH FSP Age Wise Supportive Services.

> ***"I didn't feel safe and my PTSD was affecting me. I feel safe where I am now."***
>
> ***-Housing and Employment Consumer***

This program received a 2014 NACO award for this project.

The Grand Opening of the Mt. Breeze Villas adult/families housing project occurred in the city of Highland which consisted of a total of 168 units, in which **20** units were set-aside for DBH FSP Phoenix Clinic.

The program received a 2015 NACO award for this project.

The groundbreaking of the Siena Apartments in the city of Fontana occurred which consisted of a total of **55** units, in which **15** units set-aside for DBH FSP's Mesa and Mariposa Clinics for adults and families.

The groundbreaking of the Bloomington Intergenerational Apartments in the city of Bloomington also occurred during this fiscal year which consisted of a total of 106 units, in which 11 units set-aside for DBH FSP's Mesa (adults/families) and Age Wise Supportive Services (seniors).

Success Stories

Adult System of Care Full Service Partnerships
"Henry" transitioned from Patton State Hospital to a Board and Care in the County of San Bernardino. He increased his ability to recognize and understand his mental disorder of Schizophrenia, Paranoid Type. Henry collaborated with his intensive case manager and valued the outpatient medication support services provided to him. He reached his recovery goals within nine months and he expressed to his psychiatrist his readiness to transition into a room and board of his own choice. His psychiatrist concurred and agreed to continue to provide to him medication support services.

HICMOS
"Sam" came to the Homeless Program with some unique circumstances. He was previously a successful employee of the film industry, carrying a great deal of responsibility, and living in Beverly Hills. For years, he experienced intense highs and extreme lows in his career. He had had problems with substance abuse, and had completed numerous inpatient programs. He told his worker, "I went to the best of the best treatment centers. I would plan to dry out during the slow times, then pick back up working, partying non-stop, and binging on substances."

David also suffered from Bipolar Disorder, a behavioral health disorder that results in extreme highs and extremely depressed moods, as is the case with many individuals who suffer from co-occurring substance abuse and mental disorders, David's relationships suffered. "I lost the respect of

colleagues. My marriage dissolved, and my kids couldn't trust me," David added. "Other family members didn't want me around. I lost the career I loved, and I suffered financial ruin." After two DUI's and two suicide attempts, David was hospitalized and subsequently referred to the DBH TAP program, which provides residential substance abuse treatment while concurrently addressing the mental health issues of the participants by providing psychotherapy as well as coordinated psychiatric care. While in the residential program, David learned that his mother had died in the family home due to a house fire. In spite of learning such traumatic news, with the support of the TAP staff and the staff at the residential rehab center, he persevered and successfully completed the program.

Upon completion of treatment, David's family was still not ready to trust him. He was homeless and was referred to the HICMOS program. David worked with the HICMOS team who actively ensured that he received services from the DBH Outpatient Clinic, Employment Services, and the State Department of Rehabilitation. He increased his life skills and confidence. He obtained employment. During this time, he learned that his father also had a terminal illness. With the continued support of the HICMOS case managers and his outpatient service providers, David was able to maintain his mental health and sobriety through these difficult times. He eventually moved to a self-supported living arrangement in a sober living home located near his family. As he has continued his treatment for his mood disorder, and has maintained his sobriety, he has also continued to rebuild his relationships. He recently stopped by the HICMOS office and expressed appreciation for all the services he received.

HOST
"Harold" had a history of difficulty maintaining healthy relationships with his family. As a result, he burned bridges with his family and lacked social support. He was approached by the Sheriff's HOPE team however, due to his drug use, declined services. After several attempts at engagement and building a rapport, he addressed his drug use and began the process of housing assistance through a collaborative outreach event in Victorville with the Sheriff's HOPE team and DBH. The client is currently clean, works a full time job and is housed in an area where supportive services to maintain his sobriety are easily accessible.

Housing and Employment
A DBH client who has a long history of mental illness and was chronically homeless and had moved around and lived in different areas of Southern California including homeless shelter on Skid Row in Los Angeles. During the time of being homeless, the client was not able to seek the appropriate mental health treatment. Client was not able to take her medications to reduce her symptoms. This made her mental health condition become worse. The client never felt safe living in the shelters and on the street. Client was able to seek assistance from Phoenix Clinic, and was referred to an MHSA housing program was able to move in in September 2014. The client is doing much better having a stable place to live and continuing receive mental health treatment at Phoenix Clinic. She feels safe in her own place and follows through with her treatment plan. Her stress level has been reduced and she is stabilized with her medications.

Challenges

Adult System of Care Full Partnerships
Trying to find expanded modes of transportation or increasing DBH transportation to ensure FSP partners ready access to jobs, housing, integrated healthcare appointments, and other key destinations are ongoing priorities and challenges

HICMOs
Finding appropriate community level placements for our consumers to live on a long term basis, adjusting to an increase in the number of people entering the shelter with diagnosed serious medical problems and forming partnerships to delivery truly integrated services are the current challenges the HICMOS program face.

HOST
Funding/Resources:
Lack of availability of permanent housing stock and emergency shelter beds. Exclusive criteria for homeless shelter, which disqualifies candidates (i.e. single males lack resources for homeless shelters).
Funding/Support for client endeavors, such as books, school, etc.

Housing and Employment
One of the future MHSA housing projects for seniors called Horizons at Yucaipa has been delayed throughout the different stages of development of affordable housing.

Solutions in Progress

Adult System of Care Full Partnerships
Staff are being strategic by going out in teams to maximize vehicle usage and always placing client transport as priority when utilizing DBH vehicles.

HICMOS
We are working to increase case management staff to serve homeless consumers living with co-occurring disorders and complex medical issues as well as provide on-going training and education regarding integrated healthcare to assist the staff to navigate more effectively and ensure the consumers needs are being addressed timely and thoroughly.

HOST
Collaboration with Sheriff's HOPE program to identify and engage chronically homeless individuals. Staff attendance at the Homeless Provider Network and Interagency Council on Homelessness to gain education, keep abreast of and implement evidence based practices, as well as network and gain resources across the County. HOST gained approval to provide financial assistance with move-in costs for individuals in need. This includes assistance with holding deposits, application and credit check fees, utility deposits, and welcome home basic supplies.

Housing and Employment
Regular housing meetings and collaboration with various agencies and staying on top of key program dates as well as providing the necessary document to ensure that the approval process runs smoothly.

Outreach and Engagement

In Fiscal Year 2014/15, the HICMOS Program organized the following outreach and engagement activities:

Community Presentations	17
Community Outreach	112
TOTAL	**129**

In Fiscal Year 2014/15, the HOST Program organized the following outreach and engagement activities

Collaboration with Sheriff's HOPE Program	425
Health Fairs	180
Agency Presentations	200
TOTAL	**805**

In Fiscal Year 2014/15, the Housing and Employment Program organized the following outreach and engagement activities:

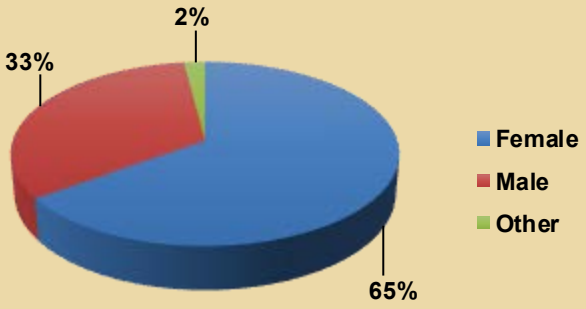
Project Connect/Homeless Resources Fair	200
Eight Annual Housing Institute	600
Monthly Cross Walk/Engagement meeting with MHSA housing project staff	40
Agency Presentations	105
TOTAL	**945**

:

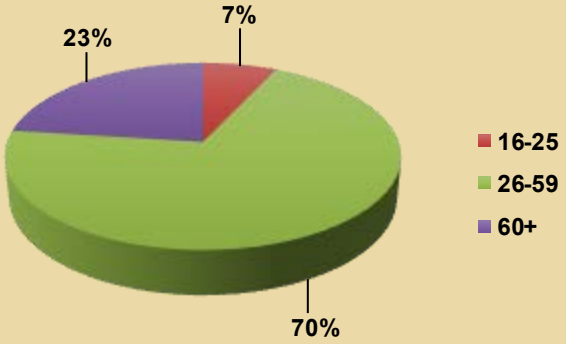
Community Services and Supports

Fiscal Year 2014/2015 Program Demographics

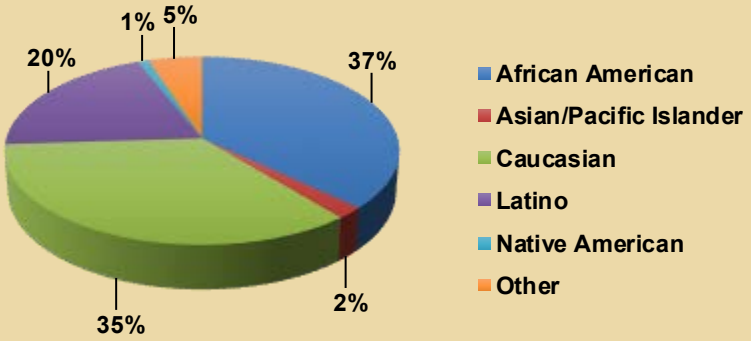
Gender



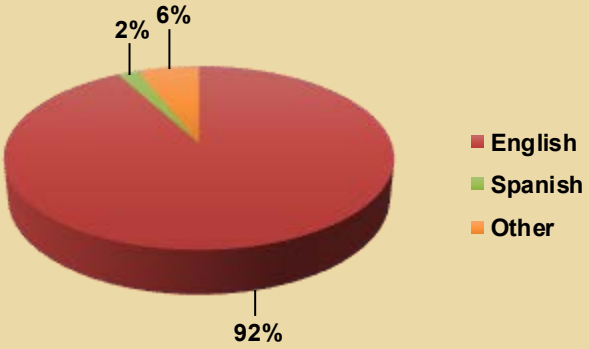
Age



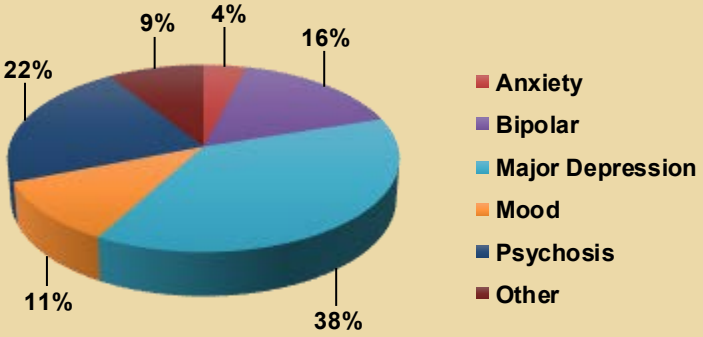
Ethnicity



Primary Language



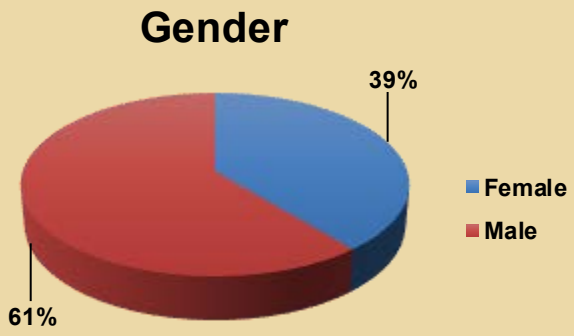
Diagnostic Group

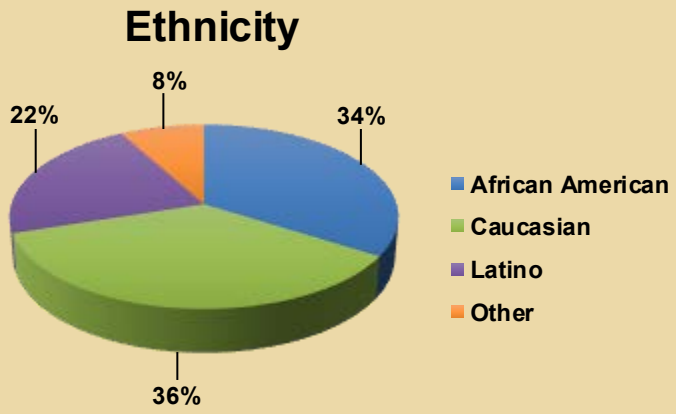


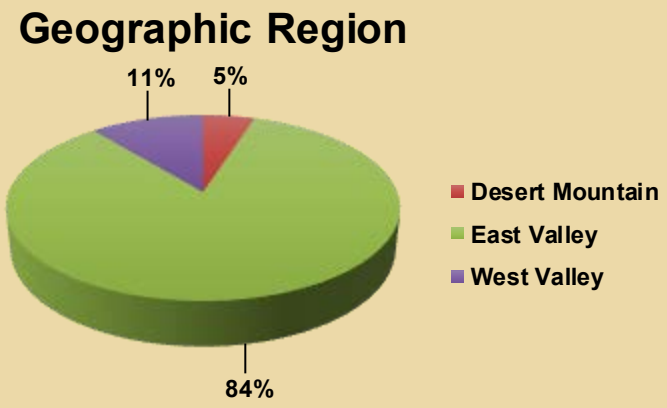
Focus Area	Total Number Served
Adult System of Care FSP	62
HOST	198
Housing & Employment	68
Total	**328**

Fiscal Year 2014/2015 Program Demographics

HICMOS







Program Updates

HOST

For FY 16/17 as there is an addition of additional staff resources to accommodate additional requests from law enforcement outreach and engagement.

Housing and Employment

The Housing and Employment program has added three **(3)** new projects: Bloomington Project, Siena Apartments, and Horizons at Yucaipa and Liberty Lane Apartments.

The Bloomington Project is a new construction complex in the city of Bloomington that includes **11** MHSA Project-based vouchers. It will house adults, families, and seniors and will have an on-site County Library and a senior center. This project is scheduled to be open in April 2016.

Siena Apartments is a new construction project in the city of Fontana which will provide **15** one bedroom apartments to MHSA tenants. The estimated move-in date is April 2016.

Liberty Lane Apartments is a tentative new construction project in the city of Redlands which will provide **15** MHSA project based vouchers to eligible veterans. The move-in date is estimated to be spring/summer 2018.

Horizons at Yucaipa is a new supportive housing project which will provide **50** units, in which **10** MHSA project-based vouchers will be for the DBH Agewise FSP.

Under AB 1929, DBH is requesting the release of the unencumbered funds of approximately $250,000. The unencumbered funds are to be used to assist the target population with rental assistance, security deposits, utility payments, or moving cost assistance. DBH will utilize these funds to provide assistance to DBH clients who meet the target population criteria for the MHSA Housing Program, which includes low income adults with serious mental health illness who are either homeless or at risk of homelessness.

Under the existing MHSA TAY Program, called the Phoenix Apartments, DBH amended the existing MOU between the developer, property management and added the Phoenix Clinic FSP along with the existing TAY FSP.

This upcoming year, the MHSA Housing Program will be presenting to the local stakeholders to address the issues of expansion and continuous funding for future affordable supporting permanent housing. Currently there is a request from the California Senate to address the issues of assisting local communities in preventing and addressing homelessness. The new initiative is called “No Place Like Home.” While this proposal is not yet approved, permanent built housing continues to be a consistent need for individuals living with behavioral health issues. One of the goals of DBH is to focus on the best practices of the MHSA Housing Program created under Proposition 63 and continues to participate in built housing projects using MHSA CSS funding.

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Collaborative Partners

- The Housing Authority of San Bernardino County
- Housing Partner I (Developer), non-profit entity of the Housing Authority
- Beacon Property Management (Property Management)
- USA San Bernardino 611, Inc. (Developer)
- Meta Housing Corporation (Developer)
- WCH Affordable II, LLC. c/o Western Community Housing, Inc.
- Mountain Breeze Villas, LP (Developer)
- Alliance Property Group, Inc. & Hearthstone Housing Foundation
- DBH: Phoenix Community Counseling FSP
- Mesa Community Counseling FSP
- Age Wise Supportive Services (AWSS)
- John Stewart (Property Management)
- Palm Communities
- ConAm Property Management
- Related Companies of California (Developer)
- DBH Housing & Employment
- DBH Adult Systems of Care
- DBH Recovery Based Engagement Support Teams
- San Bernardino County Sheriff's HOPE team
- San Bernardino County Homeless Partnership
- Vet Awareness
- Knowledge & Education for Your Success (KEYS)
- U.S. Vets
- Living Word Rehabilitative Home
- River's Edge Men's Ranch Rehabilitative Home
- Our Place Recovery Center
- Pathways to Recovery
- Team House
- Cataleya Day Treatment
- Mary's Mercy Center
- Casa de San Bernardino
- Goodwill Industries
- California Department of Rehabilitation
- Frazee Community Center
- Lutheran Mission
- Salvation Army
- Set Free Ministry
- Victoria Outreach
- Lutheran Mission
- Redlands Community Hospital
- San Bernardino Community Hospital
- Veterans Administration and Social Services
- Department of Vocational Rehabilitation
- Transitional Assistance Department (TAD)
- IEHP Community Resources
- Red Carnation Shelter Homes
- Housing Authority
- Employment Services
- Mary's Table
- Operation Grace

Big Bear Full Service Partnership (A-8)

The Big Bear Full Service Partnership (FSP) is an alliance of mental health service providers in the geographically isolated Big Bear Lake area that provides mental health services to children and adults. The partnership began in May 2009 to help a traditionally underserved area for mental health services. This FSP allows for consumers in this geographic region to access a continuum of needed mental health services including intensive case management, co-occurring treatment, and transportation services for low income and underserved clients in the Big Bear Valley. Having access to resources increases consumers ability to function within the community, within families, and schools. In addition, the partnership provides linkage to community resources and assists case management uninsured clients by assisting with applications to Medi-Cal. Psychotherapy medication services, and are also provided.

In Fiscal Year 2014/15, the Big Bear FSP served **99** participants, of which **84** were unduplicated, meaning the clients started services in the fiscal year.

MHSA Legislative Goals and Related Key Outcomes

- Increase access to treatment and services for Co -occurring problems; substance abuse and health:
  - ◊ Increased encounters in specialty co-occurring and substance abuse interventions.
- Reduce the frequency of emergency room visits and unnecessary hospitalizations:
  - ◊ Increase the number of individuals diverted from hospitalization.

Artwork by Roger Stover

Target Population:

- Adults
- Older Adults

Projected Number to be Served in FY 2015/16:

- 145

Positive Results

The approach of the Big Bear FSP is to provide co-occurring services for a mental disorder and substance abuse or dependence. The FSP provider coordinates services with the substance treatment program. If the FSP program does not have a built in co-occurring treatment program, then clients are connected to outpatient or residential treatment programs if client is ready to commit to sobriety. There has been an increase in the clients' willingness to accept substance abuse disorder treatment services because the client is aware of program supports in place during the treatment program and after the completion of the program.

Crisis intervention in the Big Bear Full Service Partnership has four **(4)** hospitalizations year-to-date as the FSP helps to link people with an outpatient clinic, which decreases the cost of services and provides a more consistent use of services.

Community Services and Supports Programs

Challenges

- The geographic location of the community makes accessing additional community supports available in more populated areas of the county difficult.
- Finding appropriately licensed or pre-licensed staff to work in the mountain area is a challenge.
- Public transportation resources have limited availability.
- Access to additional benefits or entitlements are limited.
- Clients may not engage in the full continuum of services and treatment options available.
- Engaging the Latino population residing in the mountain area.

"I am so glad I can get treatment here, I can't get off the hill"

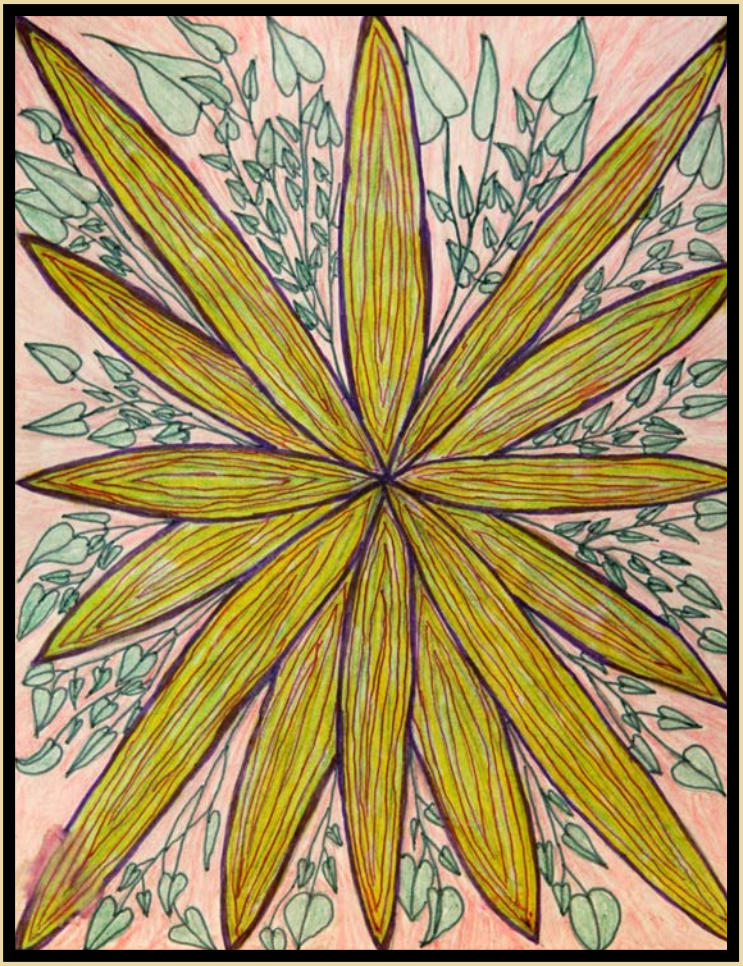
- Big Bear FSP Participant

Solutions in Progress

- Case managers are working with clients to help them sign up for Medi-Cal.
- Strategies to reach the Latino population include partnering with the school system and creating a partnership with the Community Health Worker/Promotores de Salud program to assist in relationship building and community education for the Latino population residing in the mountains.
- Case managers are also working with clients to facilitate movement to other insurance providers.
- There has been an increase in Activities of Daily Living (ADL) groups to provide increased functionality for clients who do not benefit from one-on-one therapy.

Collaborative Partners

- Bear Valley Community.
- Domestic Violence Education and Services (DOVES).
- Health Start.
- Healthcare District.

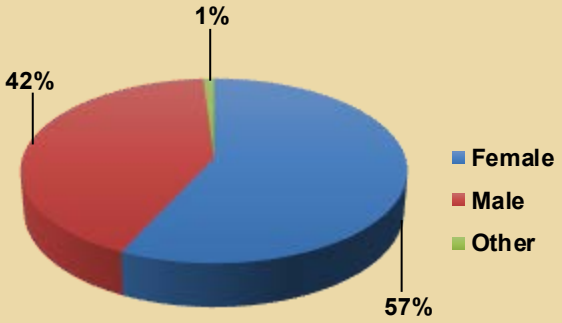


Artwork by Barbara Mason

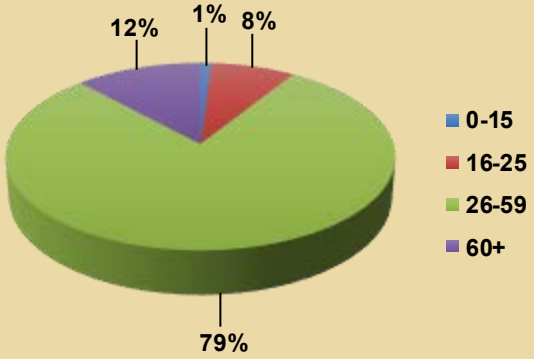
Community Services and Supports Programs

Fiscal Year 2014/15 Program Demographics

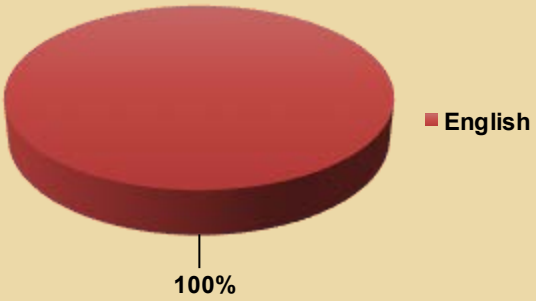
Gender



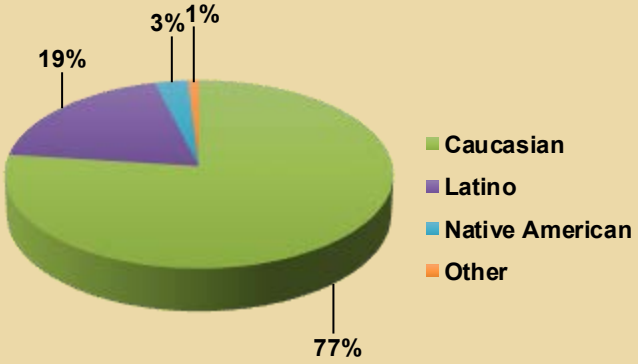
Age



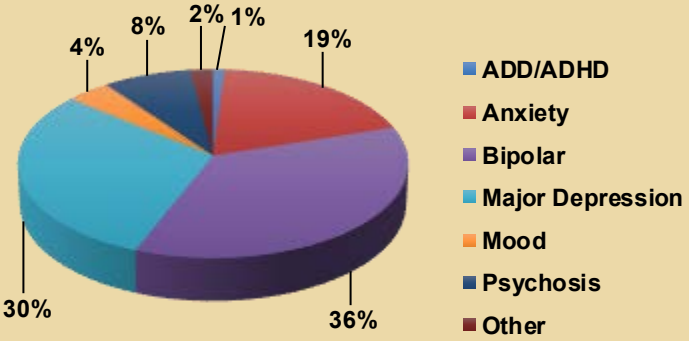
Primary Language



Ethnicity



Diagnostic Group



Access, Coordination, and Enhancement (A-9)

The Access Coordination and Enhancement (ACE) for Quality Behavioral Health Services program seeks to improve the timeliness of access to Department of Behavioral Health (DBH) outpatient services. The ACE program was implemented in the four large regional outpatient clinics - Phoenix, Mariposa, Mesa, Victor Valley and two rural outpatient clinics - Barstow and Needles specifically for assessments, hospital discharge, and care coordination.

Additionally, with the implementation of the Affordable Care Act and Medi-Cal expansion, the ACE program enhanced the redesign of the outpatient care system to ensure consumers receive the right services to meet their needs.

The ACE program increased staffing (administrative and clinical) necessary to perform initial screenings and intake assessments. ACE provides same day psychiatrist evaluations when medically necessary, reduces psychiatric wait times by expediting case openings, and allows for individuals, being discharged from a psychiatric hospital, ongoing clinic-based treatment.

Services provided through the ACE Program include:

- Mental Health Assessments.
- Psychiatric Evaluations.
- Substance Abuse Screenings.
- Referrals and Linkage.
- Access to appropriate services.

Artwork by Roger Stover

The ACE program operates at each clinic from 8:00 a.m. - 5:00 p.m. Monday through Friday. Individual consumers and families seeking mental health treatment can access services either by walking in without a scheduled appointment or calling the clinic to request an initial assessment appointment.

Additionally, DBH Access Unit, Local Health Care Plan Coordinators, such as IEHP and Molina, and psychiatric hospital discharge staff refer consumers to the clinics. Appointment priority is given to all patients discharging from a psychiatric hospital; they are given an appointment within **(7)** calendar days from discharge.

Consumers presenting for services are provided with an initial crisis screening. Results of the screening will determine the most appropriate service path for the consumer. Consumers determined to be in crisis, are referred to a Clinical Therapist for an immediate evaluation. All other individuals are provided with intake documentation to complete and set up for a clinical assessment

Clinical Therapists conduct initial assessments and determine if the consumer meets medical necessity for Specialty Mental Health Services and consults with the Psychiatrist regarding the need for medication. Additionally, a Licensed Vocational Nurse can assist the psychiatrist by taking vital signs, contacting pharmacies, securing medical records, and linking the consumer to the local Health Plans for primary medical care.

Consumers that do not meet medical necessity for Specialty Mental Health Services, are assigned to a case manager for:

- Local Health Plan referrals (IEHP/Molina).
- Entitlement programs (Social Security Disability Income, Veterans Assistance, etc.).
- Transitional assistance programs (Medi-Cal, Cal-Fresh, etc.).
- Temporary or Permanent Housing assistance programs.
- Transportation assistance.
- Charitable organizations for other needs.

Artwork by Peter Millar

MHSA Legislative Goals and Related Key Outcomes

- Increase access to treatment and services for co-occurring problems; substance abuse and health:
  - ◊ Increased encounters in integrated health clinic and/or with primary care/health specialist providers.

- Reduce the frequency of emergency room visits and unnecessary hospitalizations:
  - ◊ Reduced number of emergency room visits for behavioral health concerns.

Positive Results

The implementation of the ACE program has been a progressive process and the careful planning has spanned across several fiscal years (FY). Since it's inception, DBH has worked diligently on hiring and establishing business processes for this program.

Target Population:

- Children
- Transitional Age Youth (TAY)
- Adults
- Older Adults

Projected Number to be Served FY 2016/17:

- 1,908 Hospital Referrals

Community Services and Supports Programs

FY 2014/15 is the first complete year for results for this program.

- There were a total of **1,817** referrals to the ACE program.
- Of the **1,817** referrals received by the ACE program**, 79% (1,430)** were scheduled for an appointment within **7** days of discharge from the hospital and **94% (1,709)** of the referrals had an appointment within **14** days of discharge.
- From the total of appointments made,**1,817, 25**% (**454**) of the consumers attended their initial appointment.

Challenges

- The recruiting, retaining, and hiring of qualified staff for the ACE positions.
- Improving the client discharge coordination with the DBH outpatient clinics
- Arranging a psychiatric service within **7** days to provide timely medication support services to hospital discharged clients.

Solutions in Progress

DBH continues to improve access to the Health Information Exchange from Arrowhead Regional Medical Center for patient records.

Collaborative Partners

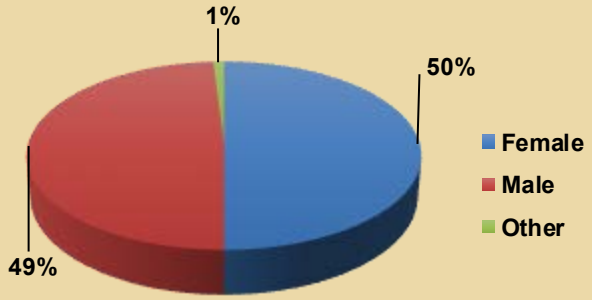
- Inland Empire Health Plan.
- Molina Healthcare.
- Arrowhead Regional Medical Center - Behavioral Health Unit.
- DBH Diversion Program.
- Recovery Based Engagement Support Team (RBEST).
- Crisis Walk-In Clinic (CWIC).
- Community Crisis Response Team (CCRT).
- Association of Community Based Organizations.
- Other Designated 5150 Hospitals.

Artwork by Quirina VanDerVeen

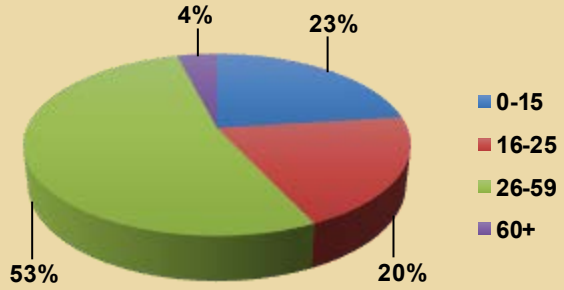
Community Services and Supports Programs

Fiscal Year 2014/15 Clinic Demographics

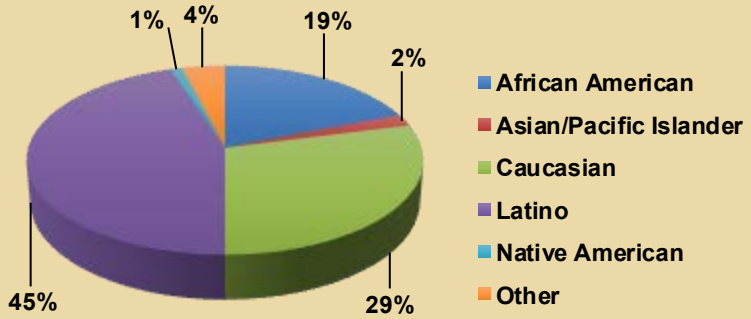
Gender



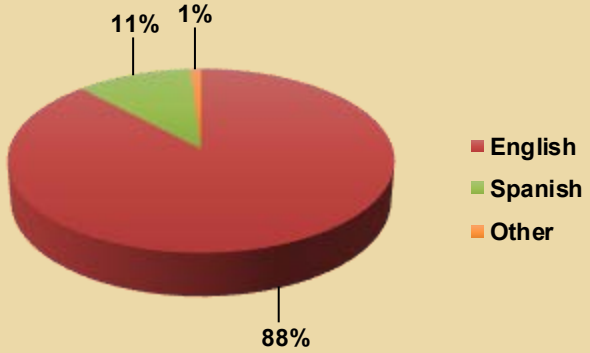
Age



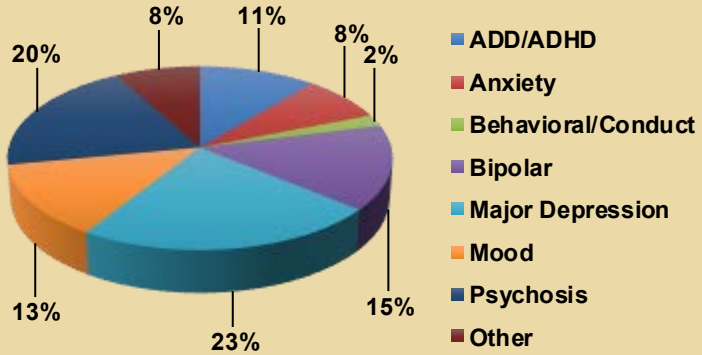
Ethnicity



Primary Language



Diagnostic Group



AgeWise Circle of Care Program (OA-1)

The AgeWise Circle of Care program provides access to mental health, substance use disorder, and case management services throughout San Bernardino County to adults, age 59 and older, living with mental illness and co-occurring disorders. It works to increase access to services for the older adult community, and decrease the stigma that is associated with mental illness within the older adult community. AgeWise builds capacity through collaboration with community and government agencies that serve older adults. Research shows older adults are especially vulnerable to the difficulties of accessing available services due to stigma, lack of mental health education, and many other factors, such as limited funds and transportation. The AgeWise Circle of Care program addresses these vulnerabilities by providing therapy and case management in the home, therefore offering older adults a more accessible form of care. Through the provision of culturally competent services, access has been further expanded by providing bilingual staff to work with monolingual Spanish speaking older adults, and by utilizing interpretation as needed for other languages.

Artwork by Tona Epperson

Target Population:
- Older Adults (age 59+)

Projected Number to be Served in FY 2016/17:
- 190 Older Adults

To facilitate the goals of attaining housing and preventing homelessness of mentally ill older adults, DBH has enhanced the focus on wellness and recovery. This focus assists older adults in remaining independent and active in their communities for as long as possible. This is a capacity building component in which collaborative partnerships have been developed between staff and community agencies, including Adult Protective Services, the Department of Aging and Adult Services, the Social Security Administration and other public agencies. These agencies work with older adults to aid in obtaining needed support, including entitlements. The program continues to work with the MHSA Housing program to develop senior apartments and create stable housing complexes for older adults experiencing mental illness. The AgeWise staff work with the apartment management to develop beneficial activities and programs that help keep participants engaged and in stable living.

The program focuses on helping unserved, underserved and inappropriately served older adults develop integrated care with respect to their physical and mental health needs. A major goal is to outreach to the primary care physician providing resources, education and services to identify and treat older adults with depression and other mental health issues. Additionally, this program provides outreach and engagement activities in the community to educate agencies and the public about the mental health needs of the older adult population.

MHSA Legislative Goals and Related Key Outcomes

- Reducing homelessness and increase safe and permanent housing.
  - ◊ Decreased rate of homelessness.
- Increase access to treatment and services for co-occurring problems; substance abuse and health.
  - ◊ Increase in encounters in integrated health clinics.
- Reduction in disparities in racial and ethnic populations.
  - ◊ Reduction in mental health and health care disparities.
- Increase a network of community support services.
  - ◊ Increase in number of collaborative partners.

Positive Results

- **9** homeless older adults were placed in safe and permanent subsidized housing.
- **100%** of clients were linked to Primary Care Providers.
- **54%** of open cases were for underserved cultural populations indicating the program is addressing disparities in racial and ethnic populations.
- Collaborative partners have increased by **32%.**

Success Story

"Shaun" came to the Agewise program in August 2013. Due to the severity of his illness, he had difficulty managing his medication, was hospitalized numerous times over several years and was unable to return to his family. He did not have a consistent source of income and needed additional resources. Shaun was paired with a DBH Psychiatrist who worked with him for over a year. During that time, Shaun showed improvement in his hygiene, managing his medications, and overall wellbeing. AgeWise staff provided him with assistance in securing additional resources such as Supplemental Security Income (SSI). Shaun is now doing well and has secured stable housing. He is now receiving SSI and is working with AgeWise staff to secure housing closer to his family so he can visit with them on a regular basis.

Challenges

Building a trusting relationship between program staff and the client is a challenge as older adults living with a mental illness or a co-occurring disorder who are homeless, at risk of being homeless, incarcerated or hospitalized, are often very distrusting of services provided by government agencies.

Accessing services due to many factors such as stigma associated with mental illness and lack of mental health education, limited funds and transportation, cultural issues, identity theft, retirement and pension benefit problems, and social security concerns are challenges that continue to affect the older adult population.

A lack of staffing such as clinicians who are bi-lingual and Peer and Family Advocates has been a challenge for the program as it impacts the programs ability to provide Outreach and Engagement Services.

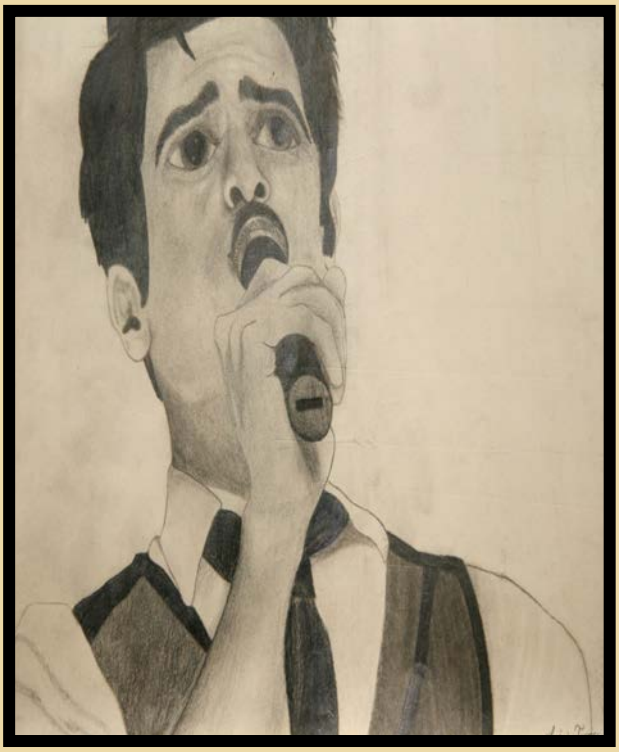
Solutions in Progress

Age Wise I has hired more bi-lingual Clinical Therapists and a Mental Health Specialist and are now working on designating a staff to provide Outreach and Engagement services.

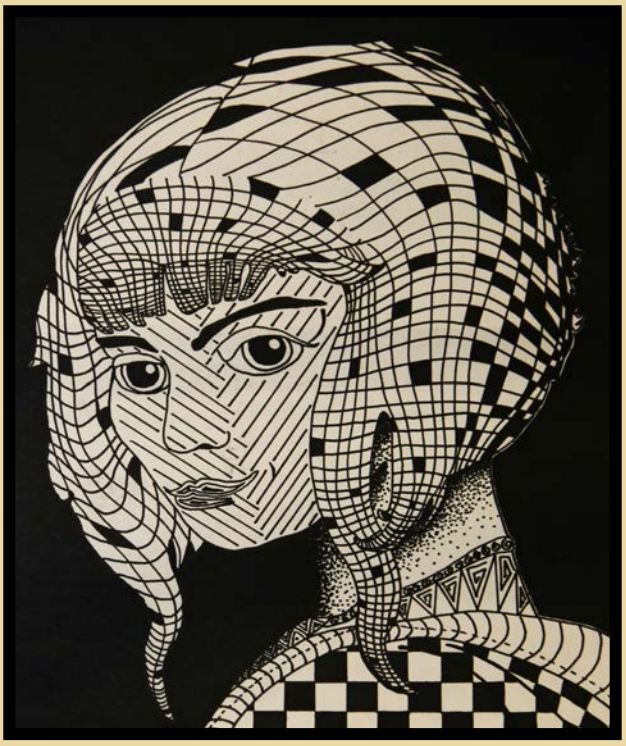
Outreach and engagement activities are making an impact among older adults targeted by this program. As education expands and is provided, participants are exhibiting better attendance and involvement with community resources.

The Affordable Care Act has increased access to services for the treatment of medical and mental health issues.

By providing in-home therapy and case management services, older adults are able to access needed care. Access is further expanded through the provision of culturally competent services. For example, this program provides bilingual Spanish-speaking staff to work with the monolingual older adults and utilizes interpreter services for other language encounters.



Artwork by Isis Torres



Artwork by Isis Torres

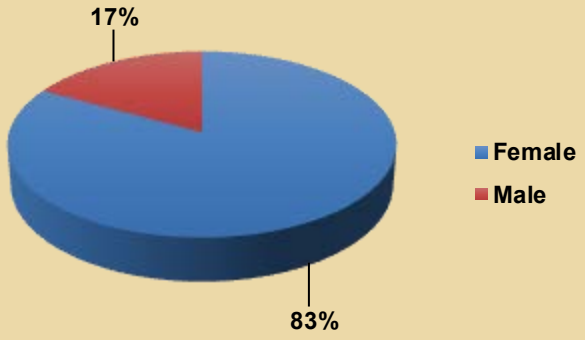
Collaborative Partners

- DBH MHSA Housing and Employment Program.
- Adult Protective Services.
- Adult Residential Services.
- Department of Aging and Adult Services.
- In Home Supportive Services (IHSS).
- San Bernardino Community Action Partnerships.
- Home Energy Assistance Program.
- Catholic Charities.
- Habitat for Humanity.
- The Humane Society.
- Mary's Table.
- Home of Neighborly Services.

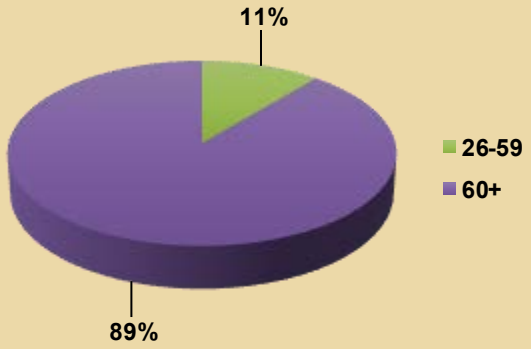
Community Services and Supports Programs

Fiscal Year 2014/15 Program Demographics

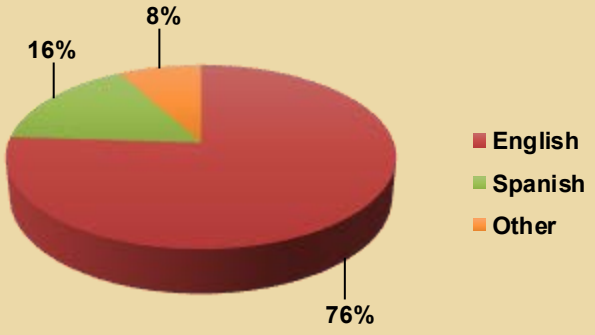
Gender



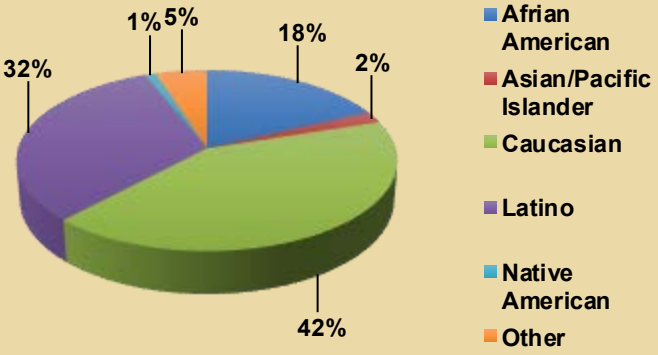
Age



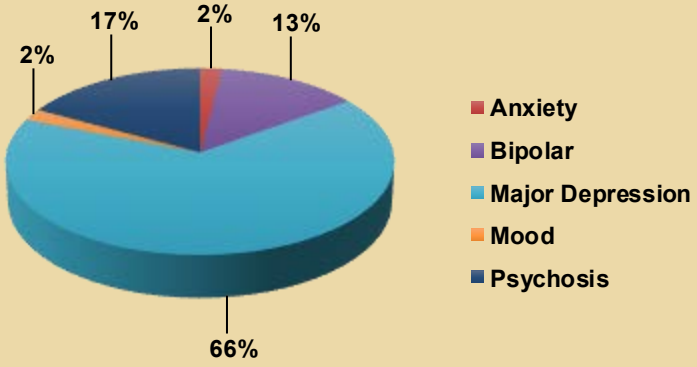
Primary Language



Ethnicity



Diagnostic Group



Mobile Outreach and Intensive Case Management (OA-2)

The Mobile Outreach and Intensive Care program's target population is older adults (age 59+) who are homeless or at risk of being homeless, high users of emergency room and acute psychiatric inpatient services or those having the most difficulty accessing care due to multiple barriers.

The Circle of Care program is composed of two distinct components: Mobile Outreach and Intensive Case Management. The Mobile Outreach collaborates with agencies that serve the older adult population. Collaborative partners are: the Department of Aging and Adult Services, Adult Protective Services, Alzheimer's Association and Inland Care Givers' Resource Center.

Part of the Intensive Case Management of AgeWise is providing short term, solutions and linking to long term supports, such as transportation, which supports the client maintaining at the least restrictive level of care. Services are provided through outreach to isolated seniors in their homes, to the homeless older adults in the community, and those that are at risk of being homeless. The outreach team participates in community multidisciplinary treatment team meetings that review older adult cases and coordinate services to assist with their needs.

The multidisciplinary treatment team goes to the churches, nutrition centers, senior centers and other community settings to offer services and help the community become aware of these services. The program staff provides these services to outlying cities such as Barstow, Phelan, Newberry Springs and Lucerne Valley.

The services the Mobile Outreach provides are:

- Comprehensive mental health and substance abuse services.
- Integrated assessment including the physical health of the individual and its effect on their mental health.
- Assistance in acquisition of entitlements.
- Linkages and referrals for clients, their families and caregivers.
- Transportation services to mental health, physical health, and other services.

Target Population:

- Older Adults (59+)

Projected Number to Be Served FY 2016/17:

- 150 Older Adults

Intensive Case Management is provided through Full Service Partnerships (FSP) with clients in need of high level case management services, mental health therapy and medication support services. The FSP seeks to increase access to care, reduce episodic institutionalization, and assist the client with their ability to manage themselves in the community.

Some of the services provided are:

- **24/7** mental health services through after hours phone coverage.
- Housing or placement in the least restrictive level of care.
- Assist in developing participant's self-care skills and daily living skills.
- Coordination of mental health and physical health care with primary care physicians through an integrated service system of care.

All services of the Intensive Case Management/FSP program are geared toward assisting seniors to remain:

- In their own homes, or appropriate housing.
- Active in their communities.
- In pursuit of individualized goals to initiate and maintain their recovery.

MHSA Legislative Goals and Related Key Outcomes

- Reduce the subjective suffering from serious mental illness for adults and serious emotional disorders for children and youth:
  - ◊ Improve life satisfaction.
  - ◊ Decrease hopelessness/increase hope.
- Reduce homelessness and increase safe and permanent housing:
  - ◊ Decrease rate of homelessness for clients.
- Increase in self-help and consumer/family involvement:
  - ◊ Increase in ratio of voluntary mental health services to involuntary mental health services.
  - ◊ Increase in number of encounters with collateral contacts such as family members and informal supports.
- Increase access to treatment and services for co-occurring problems, substance abuse, and health:
  - ◊ Increased encounters in specialty co-occurring and substance abuse intervention.
  - ◊ Increase number of encounters in integrated health clinic.
- Reduction in disparities in racial and ethnic populations:
  - ◊ Reduction in mental health and health care disparities.
- Reduce the frequency of emergency room visits and unnecessary hospitalizations:
  - ◊ Reduce number of emergency room visits for mental health concerns.
  - ◊ Increased use of alternative crisis interventions (e.g., CSIC, CCRT, and CSU).
- Increase a network of community support services:
  - ◊ Increase in number of collaborative partners.

Artwork by Isabel Figueroa

Community Services and Supports Programs

Positive Results

- **86%** of clients have maintained low or reduced risk of subjective suffering.
- **100%** of clients have remained in stable housing.
  - ◊ **11%** of such individuals were formerly homeless and have since been placed in shelters.
  - ◊ **25%** are placed in Board and Care (B&C).
- **61%** of clients are able to seek outside help and locate their own resources.
- **100%** of the **28** FSP clients serviced by AgeWise II are linked to community agencies.
- **25%** of clients represent underserved cultural populations.
- Of the clients serviced by Mobile Outreach and Intensive Management program, five **(5)** consumers are high users of emergency CWIC services.

Artwork by Judy Whiting

Success Story

"Stephen" arrived at AgeWise after his release from a seven year incarceration. While with AgeWise, "Stephen" has had therapeutic intervention and case management. His Clinician continued the recovery plan and assisted the client to locate housing and encouraged the client to integrate into the community. The client subsequently stabilized and adjusted to his environment while simultaneously abstaining from criminal activity. During his treatment, "Stephen" learned how to navigate through the community with the public transit system. He has now reacquired his drivers license and vehicle. With limited income, "Stephen" has found suitable housing. He has learned how to manage his finances and how to locate resources to support his current daily needs (e.g., food, clothing, etc). Today, he has successfully demonstrated he is able to manage himself without returning to criminal actives. With family support keeping him on track, self-regulation, and compliance with his medication and psychiatric appointments, "Stephen" is living independently and utilizing the tools provided by program name.

Challenges

- Building a trusting relationship between program staff and the client can be a challenge. Older adults with a mental illness or a co-occurring disorder who are homeless, at risk of being homeless, incarcerated or hospitalized, are often very distrusting of services provided by government agencies.
- Accessing services due to many factors such as stigma and lack of mental health education, limited funds and transportation; immigration issues; identity theft; retirement and pension benefit problems; and social security concerns are challenges that continue to affect the older adult population.

- The shortage of clinical bi-lingual staff to provide outreach and services to the monolingual Spanish speaking community.

Community Services and Supports Programs

Solutions in Progress

- Outreach and engagement activities are making an impact among older adults targeted by this program. As education is provided, participants are exhibiting better attendance and involvement with community resources.

- The Affordable Care Act has helped to increased access to services for the treatment of physical and mental health issues through primary care providers.

- Programs such as Senior Peer Counseling provide increased opportunities to make resources available to older adults in the community living with a mental health and co-occurring disorders, who may also have physical health concerns.

- The program continues its efforts to recruit and retain Spanish speaking clinical staff.

Outreach and Engagement

The AgeWise Mobile Outreach and Intensive Case Management continues to increase community presentations to expand its client base and reach unserved older adults in the community.

Collaborative Partners

- Department of Aging and Adult Services.
- Adult Protective Services.
- Salvation Army.
- Victor Valley Behavioral Health.
- Probation.
- Community Action Partnership.
- Catholic Charities.
- Community Churches.

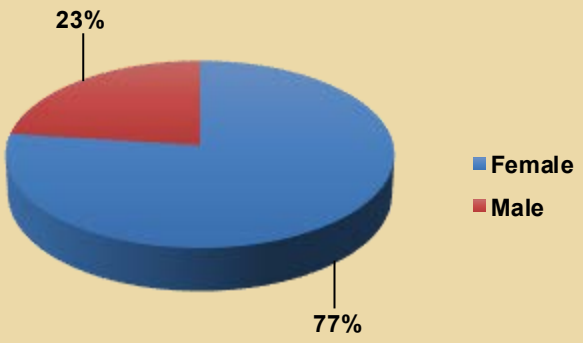
" I appreciate all of your help. I could not have done this without the help."
-AgeWise Consumer

Artwork by Gabriel Horne

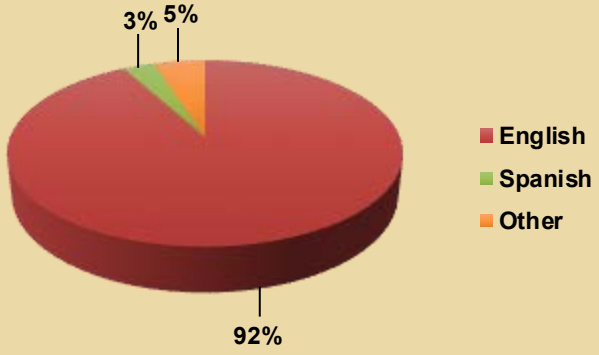
Community Services and Supports Programs

Fiscal Year 2014/15 Program Demographics

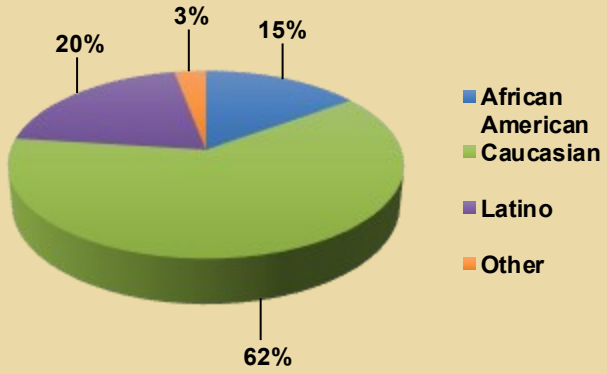
Gender



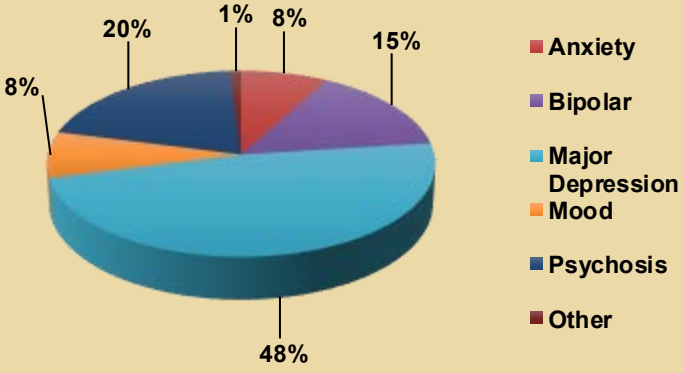
Primary Language



Ethnicity



Diagnostic Group



Artwork by Amie Stover

Innovation (INN)

Introduction to Innovation

The goal of the Innovation component of the Mental Health Services Act (MHSA) is to test methods that adequately address the mental health needs of unserved and underserved populations by expanding or developing services and supports that produce successful outcomes, are considered to be innovative, novel, creative, and/or ingenious mental health practices that contribute to learning rather than a primary focus on providing services.

Innovation projects will form an environment for the development of new and effective practices and/or approaches in the field of mental health. Innovation projects are time-limited, must contribute to learning, and be developed through a process that is inclusive and representative, especially of unserved, underserved, and inappropriately served populations.

Innovation projects are designed to support and learn about new approaches to mental health care
by doing one of the following:

- Introduce a mental health practice or approach that is new to the overall mental health system, including, but not limited to, prevention and early intervention.
- Make a change to an existing practice in the field of mental health, including, but not limited to, application to a different population.
- Apply to the mental health system a promising community-driven practice or an approach that has been successful in non-mental health context or settings.

The purpose of Innovation funded projects is to design, pilot, and evaluate the efficacy of new or changed mental health approaches. Thus, this component is unique, as it focuses on research and learning that can be utilized to improve the overall public behavioral health system. All Innovation projects must be reviewed and approved by the Mental Health Services Oversight and Accountability

MHSA Legislative Goals

The overall MHSA goal of the Innovation component is to implement and test time-limited, novel, creative, or ingenious mental health approaches that are expected to contribute to learning, transformation, and integration of the mental health system.

Every Innovation project must identify one of the following primary purposes:

- **Increase** access to mental health services to underserved groups.
- **Increase** the quality of mental health services, including measurable outcomes.
- **Increase** access to mental health services.
- **Promote** interagency and community collaboration related to mental health services or supports or outcomes.

Introduction to Innovation

Innovation Final Legislative Requirements

Previous Innovation Guidelines originated in 2009 from the Department of Mental Health (DMH) Info Notice #90-02. The Mental Health Services Oversight and Accountability Commission (MHSOAC) issued new Innovative Project Regulations effective October 1, 2015 as a replacement to Info Notice #90-02. The new guidelines are still in the process of being fully implemented through on an ongoing series of MHSOAC stakeholder discussion meetings occurring statewide, however some notable distinctions in the newly enacted regulations that will impact the way Innovation Projects are designed and implemented include:

- A refined description of the elements necessary in any Innovation project.
- A well defined breakdown of demographic data to be collected for individuals served by the project.
- A clear distinction that Innovation projects are to be considered time-limited pilot projects and should have an end date that is not more than five (**5**) years from the start date of the project.
- Successful parts of the project may continue under a different funding source or be incorporated into existing services.
- Projects may be terminated prior to planned end date.
- There is an increased focus on outcomes and evaluation.
- The inclusion of a preliminary plan regarding how it will be decided if the project will continue when Innovation funding ends.
- Defined reporting requirements and timeframes.

As of the time of this report, all information presented is in accordance to Info-Notice #90-02 as the reporting period is prior to the new regulations being enacted.

Artwork by Cindy Messer

Transitional Age Youth Behavioral Health Hostel (INN - 06)

The Transitional Age Youth (TAY) Behavioral Health Hostel, named The STAY by its advisory board, is a short-term, **14**-bed, crisis residential treatment program for the Transitional Age Youth (TAY) population between the ages of **18** to **25**, who are experiencing an acute psychiatric episode or crisis, and are in need of a higher level of care than board and care residential, but a lower level of care than psychiatric hospitalization. Services are designed to be culturally and linguistically appropriate crisis stabilization services, with particular emphasis on diverse (African American, Latino, LGBTQ youth, etc.) former system-involved youth. The STAY is designed to be **80%** peer run, by individuals representing the County's diverse ethnic communities and cultures. The program is currently contracted and services are being provided by Valley Star Behavioral Health, Inc. (Valley Star). The primary purpose of The STAY is to ***increase access to mental health services to underserved groups***.

Valley Star has developed a psychiatric rehabilitation program for The STAY that is comprehensive and multidisciplinary/ interdisciplinary, designed to meet the following objectives:

- Improve residents' adaptive functioning through their acquisition of skills essential for successful independent or semi-independent living in the community (less restrictive environment).
- Prevent residents' regression to a lower level of functioning through their acquisition of skills essential to their recovery.

Artwork by Peter Millar

Services include therapeutic and psycho-educational groups, and activities that include focuses on daily living skills-training, behavioral intervention/modification training, individual and group counseling, crisis intervention, medication support, substance use disorder counseling/referrals, recreational therapy, educational assistance, and pre-release and discharge preparation and planning.

The program bases itself within a structured, consistent, therapeutic milieu designed to enhance the self-images of the residents and to promote health, and supportive interactions among the residents and staff. The multidisciplinary design includes diverse input from the psychiatric, nursing, social service, vocational, and recreational activity disciplines.

Target Populations:

- African American
- Latino
- LGBTQ
- Former system involved youth

Projected Number to be Served FY 2016/17:

- 72 youth

MHSA Legislative Goals and Related Key Outcomes

- Increase access to mental health services to underserved groups:
  - ◊ Increase rates of underserved participating in the program.

- Increase the quality of services, including measurable outcomes:
  - ◊ Regular collection, analysis, and reporting of data to improve the program.
  - ◊ Improved year-over-year outcomes.

- Promote interagency and community collaboration related to mental health services, or supports, or outcomes:
  - ◊ Increase collaboration by two or more agencies.

- Increase access to mental health services:
  - ◊ Increase number of clients served.

"Being at The STAY has been a reliever, because I can express myself and this is a place where I can start healing."

- STAY resident

Project Learning Goals

The following learning goals were identified in the project description which was approved by the Mental Health Oversight and Accountability Commission (MHSOAC):

1. Learn about and evaluate the effectiveness of having a TAY Behavioral Health Hostel run primarily by diverse peers.
2. Learn if the innovative application of culturally specific crisis stabilization services is an effective model.
3. Learn what type of support and training is needed for diverse peer staff to effectively provide a culturally & linguistically appropriate peer run Behavioral Health Hostel.
4. Evaluate if these new approaches, in addition to the Peer Advisory Board, leads to increased access to services and better outcomes with regards to crisis stabilization.
5. Determine if the high percentage of culturally diverse peers along with the availability of resources to local providers, fosters a more diverse environment in which multiple cultures within the TAY population can be served appropriately and concurrently out of one location with both western and traditional healing methods.
6. Determine if our unserved, underserved, and inappropriately served TAY populations have better outcomes while seeking crisis stabilization services in a Behavioral Health Hostel where the community determines the services offered, the majority of employees are peers, and where the County provides minimal direction.
7. Assess the benefits of joining multiple consumer, stakeholder, cultural groups into one community-driven setting to establish relevant peer support networks, resources, and linkages around their distinct resources and needs.
8. Learn if the identification and implementation of models to address issues of grief, loss, identity, and environmental trauma help to facilitate crisis stabilization with former system involved youth.
9. Learn if new innovative policies and procedures around the housing of LGBTQ TAY can help facilitate the crisis stabilization process for these TAY.
10. Learn the impacts of innovative policies and procedures around the housing of LGBTQ TAY on TAY who do not identify as LGBTQ.

Positive Results

The STAY is the only project of its kind and it has increased access to Crisis Residential Treatment (CRT) services to **94** unduplicated, underserved TAY county residents in FY 2014/15 and serves as a model for future CRT's.

Increase Access to Mental Health Services and Increase Access to Mental Health Services to Underserved Groups

Since the project's inception in FY2012/13, The STAY has successfully increased access to crisis residential treatment services to the underserved TAY population. In FY 2014/15, The STAY specifically continued to provide services to youth who identify as African American, Latino, or LGBTQ, and youth in or at-risk of involvement in the juvenile justice or foster care systems.

Of the **94** unduplicated TAY youth served, **28** were African American youth, **27** were Hispanic youth, **20** youth self-identified as LGTBQ, and **38** were system involved youth. Of the **38** system involved youth, there were **19** CFS, **16** CFS and Probation, and **3** Probation only.

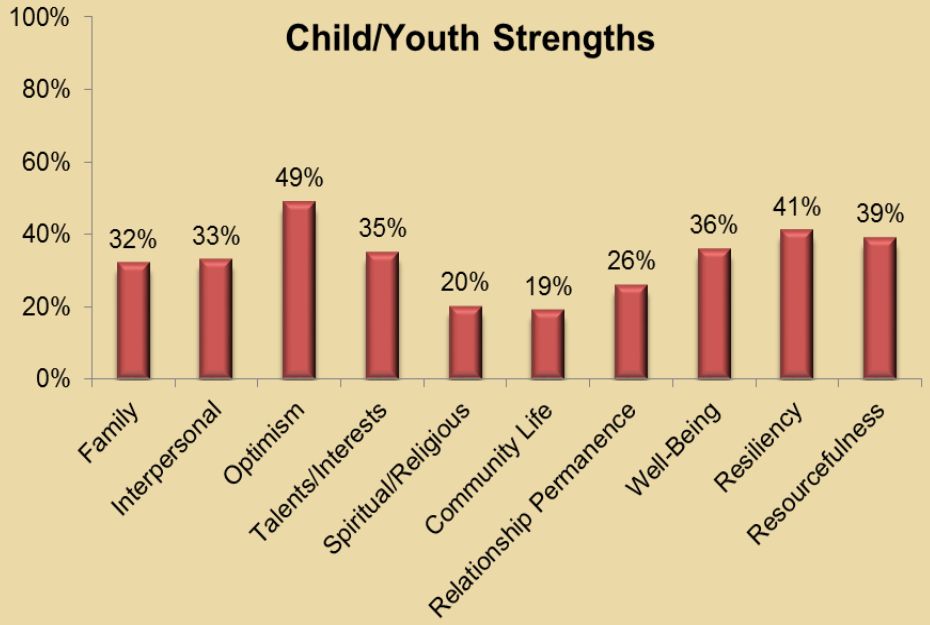
Promote Interagency and Community Collaboration Related to Mental Health Services or Supports or Outcomes

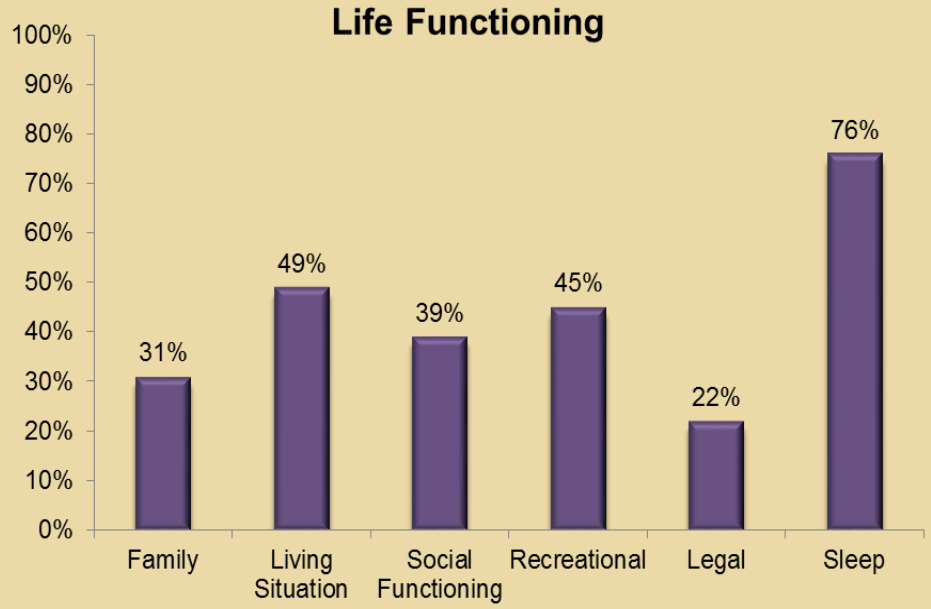
The STAY worked with **20** collaborative partners during FY 2014/15 to address the needs of youth enrolled in The STAY. As a result of the collaborations, The STAY has more resources to assist their residents in transitioning to lower levels of care, appropriate care (i.e. substance abuse treatment) and reintegrating back into the community.

Example: The San Bernardino One Stop TAY center collaborates with The STAY in linking and referring residents with co-occurring disorders to Residential Substance Use Disorder Treatment Services (i.e. Cedar House, DBH contractor) ensuring clients get the most appropriate care.

Increase Quality of Services, Including Measurable Outcomes
All of the residents at The STAY complete a Child and Adolescent Needs and Strengths (CANS-SB) assessment at time of enrollment and discharge from The STAY. The assessment identifies the youth's difficulties, needs, and strengths.

The graph to the right represents the percentage of youth who presented with a significant issue on an item within the *Child/Youth Strengths* domain, and had this issue resolved by the completion of the program.

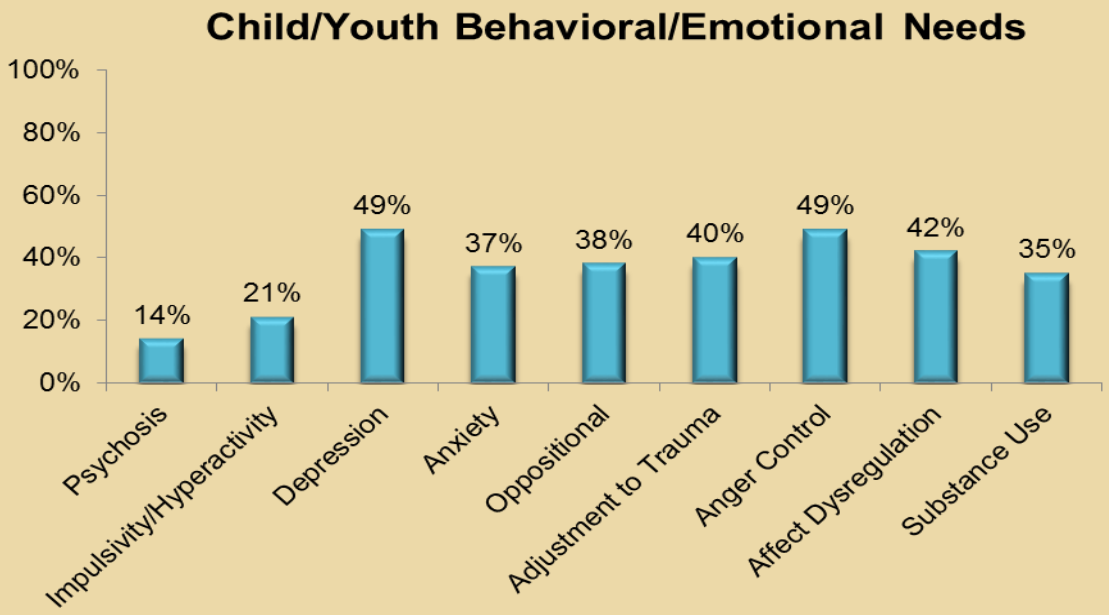




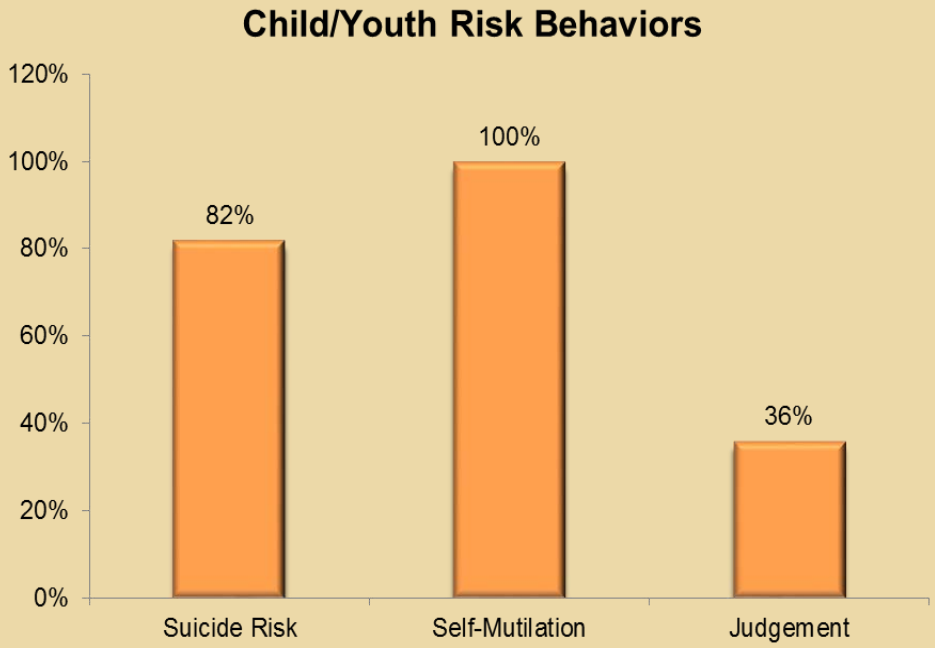
The graph to the left represents the percentage of youth who presented with a significant issue on an item within the *Life Functioning* domain, and had this issue resolved by the completion of the program.

Innovation Projects

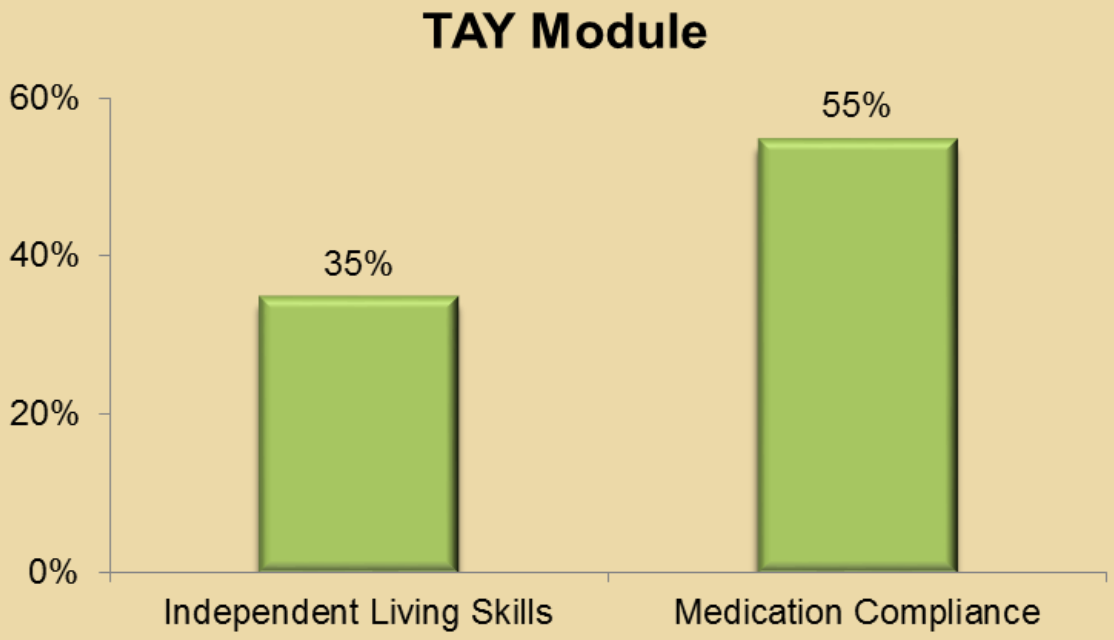
The graph below represents the percentage of youth who presented with a significant issue on an item within the Child/Youth *Behavioral/Emotional Needs* domain and had this issue resolved by the completion of the program.



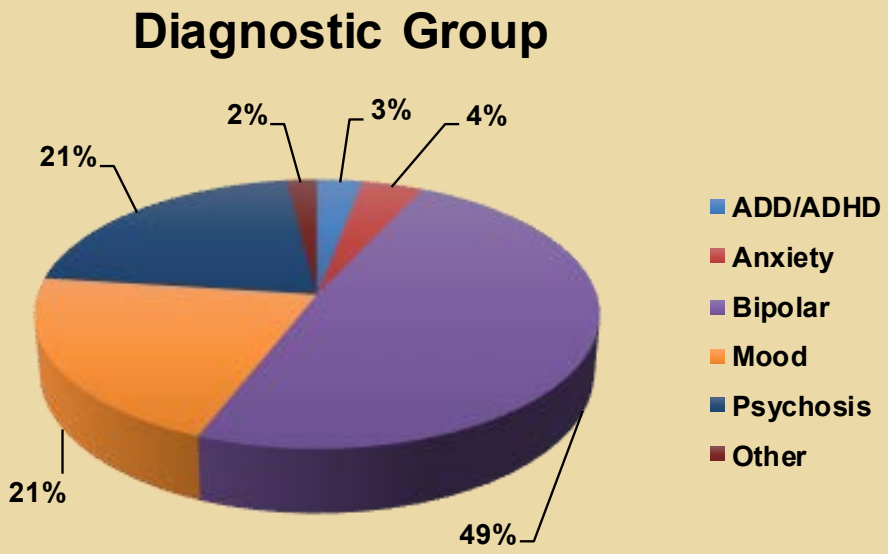
The graph to the right represents the percentage of youth who presented with a significant issue on an item within the Child/ Youth *Risk Behaviors* domain, and had this issue resolved by the completion of the program.



The graph below represents the percentage of youth who presented with a significant issue on an item within the TAY module, and had this issue resolved by the completion of the program.



The graph below identifies the diagnosis of TAY obtained by the completion of the program.



Success Story

My name is B, when I first began my time at The STAY I was very upset. I really didn't know I was going to live there. I was very hard headed. Over and over again I got into trouble. I really didn't like anybody and I didn't like to go to groups. Then one day I tried going to my first group and really enjoyed it. Afterwards, I started going to all my groups and life started getting better. Things started to get easier for me and I really enjoyed it. We had very good times here and I started to love others and they started love me. It was the first time in a long time I really felt real love for people I didn't know. They started to teach me how to use good coping skills and how to work on my wellness. I love them so much for that, and I respect them more today because of it.

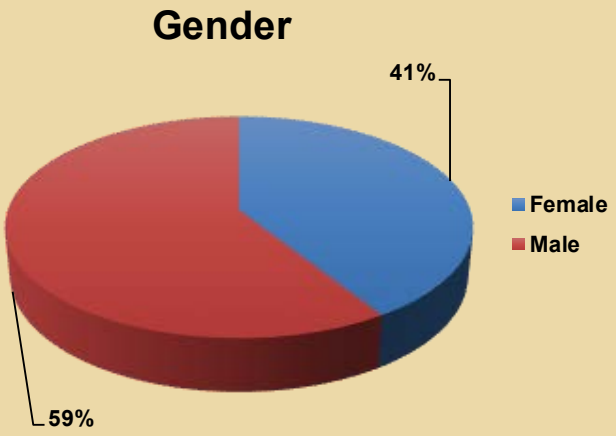
As the days went by, I felt stronger as a person and closer in my relationship with staff. I started to see they wouldn't judge me for whatever I did in my life. They didn't care about my past life and they showed me who I really am. I'm thankful for all the people in The STAY. I know it may seem hard in the beginning, but trust me it's easy. The people here really care about you and you will start to care about them the same way. Even when you have bad days, they are still going to be there for you no matter what happens. God is very good and everyone at The STAY is an angel. I love all the staff here and the residents here, no matter what background you come from. Trust me, they get it. They are not going to leave you no matter what. You can get the help you really need. The Stay will feed you, supply you with clothes, and assign you a nurse to help you with things. They will get you anything you want and need, and wont second guess it.

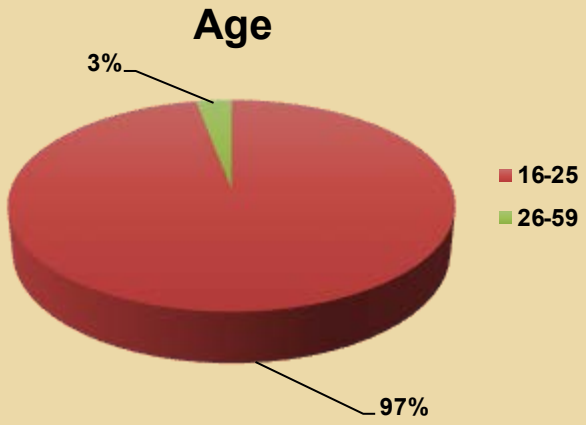
No matter what happens they will protect you from drugs and harm. They will not let you be homeless at all and are here if you need a shoulder to cry on.

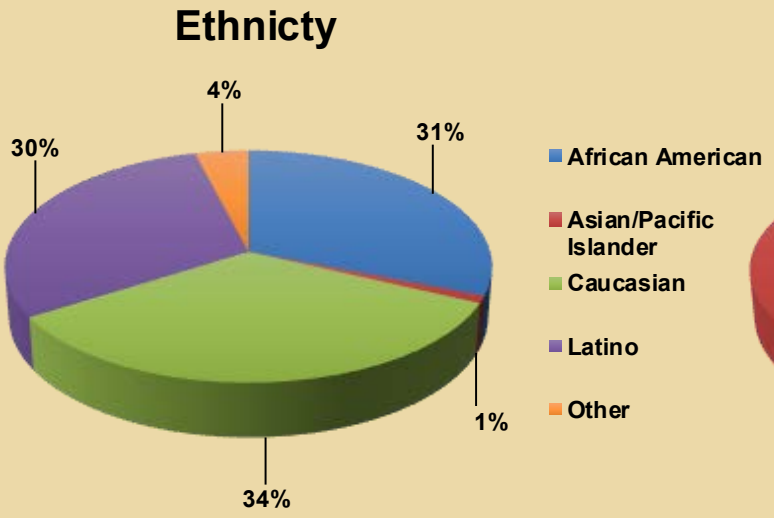
Artwork by Raymond Geisel

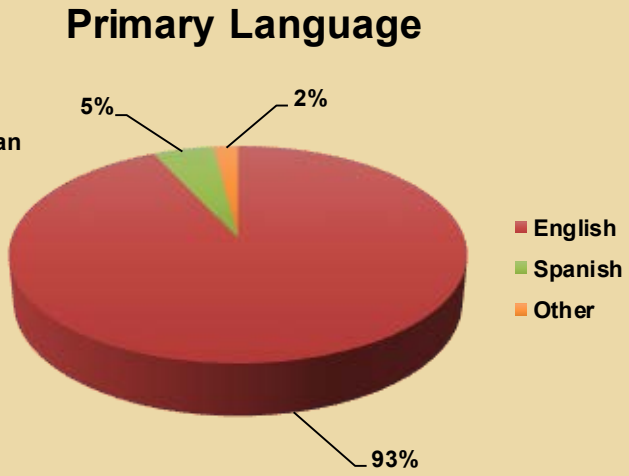
Innovation Projects

Fiscal Year 2014/15 Project Demographics









Challenges

- Referrals for housing only, not mental health crisis, continues to be an area of concern.
- Lack of housing for consumers after program completion continues to be a challenge. Due to the volume of consumers served by DBH Transitional Age Youth programs, The STAY consumers do not always have access to TAY housing at the time of discharge. This is also a larger countywide issue attributed to available and affordable housing stock.

Solutions in Progress

- The STAY Clinical Manager and Program Manager continue to educate referral sources on admission process and the requirements in order to meet criteria to enter the program including providing information on housing and resources for individuals not meeting admission criteria.
- The STAY clinical staff continues to work hand in hand with DBH TAY clinical staff on a weekly basis to address housing issues and appropriate placements.

Planned Ending and Future Programming

Learning from an Innovation project is experienced throughout the process. The uniqueness of have a project end date makes implementation more challenging than other programs, as planning for the transition of successful parts of each project may be continued under a different funding source or implemented into existing services for improvement. Innovation funding is projected through March 31, 2017.

Collaborative Partners

The following agencies are the collaborative partners for The STAY project:

County of San Bernardino

- Arrowhead Regional Medical Center (ARMC).
- Community Crisis Response Team (CCRT).
- Crisis Walk-in Clinics (CWIC).
- Department of Behavioral Health (DBH).
- Department of Children and Family Services (CFS): Child Protective Services.
- Homeless Program.
- Mesa Clinic.
- Recovery Based Engagement Support Teams (RBEST).
- San Bernardino One Stop TAY Center.

Community Partners

- ASPIRANET.
- Canyon Ridge Hospital.
- Cedar House.
- Clinica Medica.
- Job Core.
- Loma Linda Behavior Medicine Center.
- Red Carnation.
- ROP Redlands.
- San Bernardino Community Hospital.
- Unlimited Resource Network.
- Valley Star Non-Public School in Mentone.

"I have gained the strength and confidence to walk the path of sobriety."

- STAY resident

Recovery Based Engagement Support Teams (INN - 07)

The Recovery Based Engagement Support Team (RBEST) project provides community (field-based) services in the form of outreach, engagement, case management, family education, support, and therapy for the most challenging diverse adult clients in the community who suffer from untreated mental illness in an effort to "activate" the individual into the mental health system to receive appropriate services. The multi-disciplinary nature of the engagement teams presents a holistic approach to the needs of the individuals. The program is "non-clinical" in its orientation, in that it will focus on the needs and goals of the consumer and helping that individual meet those goals and eliminate obstacles through appropriate mental health treatment.

It is the goal of the RBEST project to serve clients in the least intrusive, restrictive and disruptive way in order to promote client-resiliency and recovery, as well as to preserve and maintain the individual's dignity and self-worth, while linking them to appropriate mental health services.

RBEST is a resource for adults, families, and local community agencies and organizations. The team's primary function is to take a supportive role in the facilitation, linking, and building of the client's support network. RBEST is to be utilized in conjunction with the individual's support system to assist in the management of the person's behaviors, so that the client's system will not be overwhelmed. The primary purpose of the RBEST project is to ***increase the quality of services, including better outcomes*** along with increasing access to underserved groups.

RBEST targets individuals who repeatedly access treatment at points in the mental health system that do not deliver effective care in meeting the psychiatric needs of that individual. This may include those who are repeatedly hospitalized, but do not follow up with recommended outpatient care. Also included in this effort are those individuals unknown to the public behavioral health system who have been cared for in private residences by families and loved ones without the assistance of effective behavioral health supports.

"I am really happy with what RBEST has done. You have been such a positive influence on [Client]. He really needed someone on his side and you guys were on his side."

-RBEST family member

Target Population

- Adults

Projected Number to be Served FY 2016/17

- 300 Adults

MHSA Legislative Goals and Related Key Outcomes

- To increase the quality of services, including measurable outcomes:
  - ◊ Regular collection, analysis, and reporting of data to improve the program.
  - ◊ Improved outcomes compared to standard services.

- To increase to mental health services to underserved groups:
  - ◊ Increase rates of underserved groups participating in the project.

Project Learning Goals

The following learning goals were identified in the INN project description approved by the Mental Health Oversight and Accountability Commission (MHSOAC):

1. Disruption of the existing system will occur through utilizing engagement and outreach strategies that traditionally target individuals who are currently activated in psychiatric care, to instead target the non-compliant and individuals resistant to treatment.
2. Identified individuals who are high users of inpatient services will have fewer inpatient admissions and/or fewer psychiatric hospital days and/or more frequent activation in psychiatric interventions following the offering of an incentive.
3. Families of individuals with a mental illness will acknowledge having increased understanding and knowledge regarding mental illness, as well as improved and increased strategies to care for their mentally ill loved ones as a result of care provider initiated activation strategies.

"I'm so blessed to have you guys in my life. I don't know where I would be if you hadn't helped me."

-RBEST consumer

Addressing the Spirit of Laura's Law (AB 1421)

The RBEST project was designed to address the spirit and intent of Assembly Bill 1421, also known as Laura's Law. Enacted in 2002, Laura's Law gives counties the option to mandate clients into outpatient treatment through an order of the court.

RBEST works with individuals that are non-compliant or resistant to treatment in order to ***voluntarily*** engage in appropriate and necessary outpatient treatment.

Positive Results

In its first year of implementation, RBEST has already shown excellent results in meeting the objectives and goals of the project. RBEST has succeeded in voluntarily engaging individuals who have been inappropriately served, underserved, or unserved and who suffer from untreated, severe chronic and persistent mental illness. Through RBEST's innovative approach and by providing services and education in the individual's living environment, awareness and relationships are built, and trust is gained. Individuals who have been traditionally have not followed and/or are resistant to treatment or an "unknown to the system" client for most of their lives have been able to gain the necessary and appropriate treatment to sustain in the community.

As a result of the efforts of the RBEST project, the following results have taken place:

- **77** individuals have been successfully linked to necessary treatment services.
- Individuals who had over-utilized law enforcement and psychiatric hospitalization services have significantly reduced their utilization.
- Families have gained education and support, as well as a willingness to assist their loved ones.
- Human suffering has been reduced.
- Family tension has been reduced.
- Utilization of high cost services has been reduced.

Artwork by Isabel Figueroa

Increase the quality of services, including measurable outcomes.
Since implementation of services began in October 2014, which represents **fifteen** months (Fiscal Year (FY) **2014-15** and FY **2015-16**) of providing services, the RBEST staff has:

- Received **571** referrals.
- Opened **364** cases.
- Provided **4,166** engagement encounters.

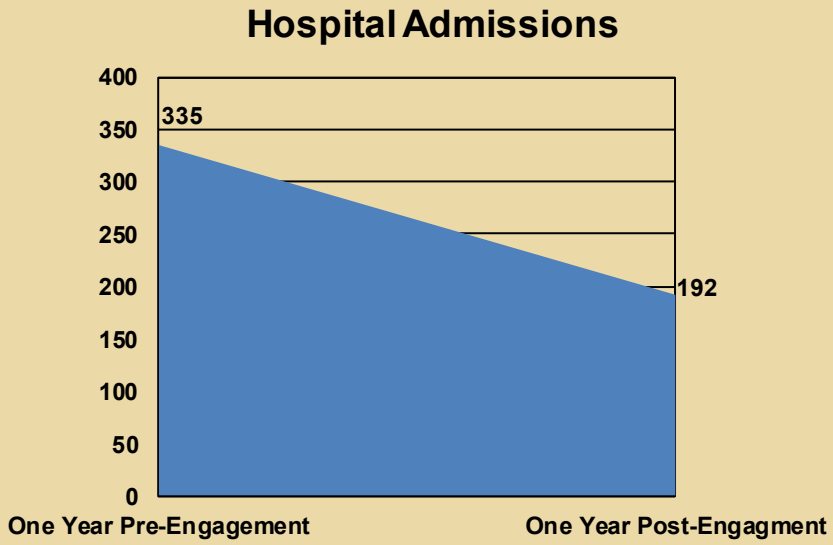
This far exceeds projections that RBEST would make **300** contacts and hold a caseload of **100** on a yearly basis.

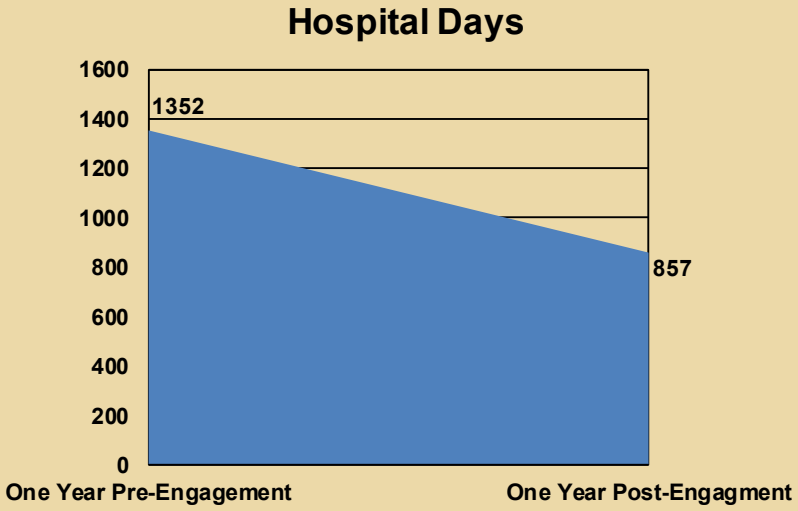
The program is "non-clinical" in its origin, in that it focuses on the needs and goals of the consumer and helping that individual meet those goals and eliminate obstacles through appropriate mental health treatment. The Countywide average for outpatient services within **7** days of hospital discharge is **20-25%**. Before being engaged by RBEST, the **364** individuals served by RBEST received an outpatient service within **7** days of hospital discharge **38%** of the time. For hospitalizations within the

first **30** days of initial RBEST engagement, **96%** received an outpatient service within seven (**7**) days of the hospital discharge. The data marks a significant increase in access to care especially lower cost of outpatient service, when actively engaged with RBEST. Of all consumers engaged by RBEST, **24** individuals started engagement over one (**1**) year ago (reporting period would span across multiple Fiscal Years (FY) **2013-14**, **2014-15**, and **2015-16**) with the following long-term outcomes:

- Non-crisis outpatient services increased **288%**.
- Collateral services (services for a support person) increased **217%**.
- Individual therapy increased **500%**.
- Linkage and consultation increased **700%**.
- Medication services increased **300%**.
- Rehabilitation services increased **590%**.
- Day treatment increased **300%**.

A primary goal for RBEST is to reduce unnecessary psychiatric hospitalizations. Of the **24** individuals who started engagement over one (**1**) year ago, review of hospital admissions prior to engagement in comparison to post engagement indicate a **43%** reduction in hospital admissions. This also demonstrates a **58%** reduction in total hospital days.

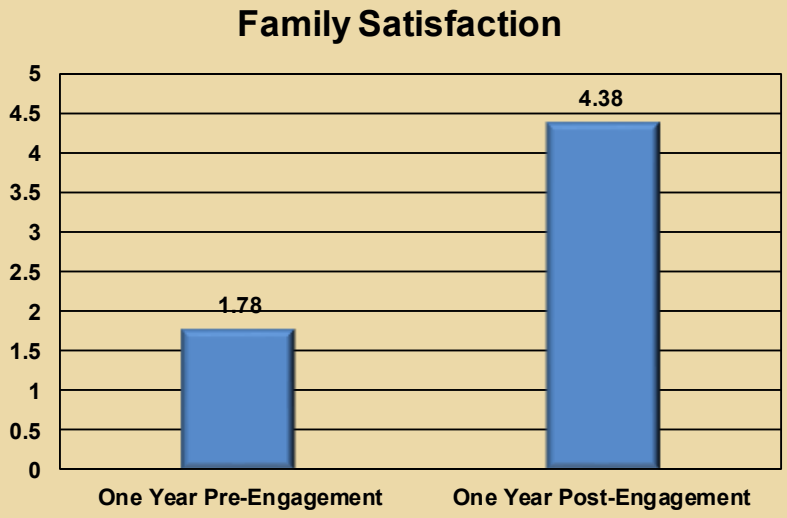




Empowering Families and Support Systems

Empowering families and support systems has been a key component to successfully link and engage consumers into treatment. RBEST families have indicated a willingness to accept and enter into education even when the consumer refuses treatment. Satisfaction with these services is one indicator of someone's understanding and knowledge regarding mental illness. Therefore, family members were asked about satisfaction with behavioral health services in general, according to a five point satisfaction scale where five is most satisfied. For those whose families have engaged with RBEST during project implementation (10/2014) through January 2016 , initially family members reported an average score of **1.78** satisfaction with behavioral health services in general. Upon ending RBEST engagement, family members reported an average score of **4.38** on the same item. The increase in satisfaction indicates RBEST had an impact on whole person health, not just behavioral health concerns. Family members also reported being significantly less worried about the family member's physical health and/or financial situation at discharge than during early engagement. Helping families has led to consumers accepting treatment referrals and reduced out of home placement. Additionally, family members are educated and better equipped to assist their loved one in leading meaningful and productive lives within the community.

See Attachment 2: RBEST Data Charts for additional information.



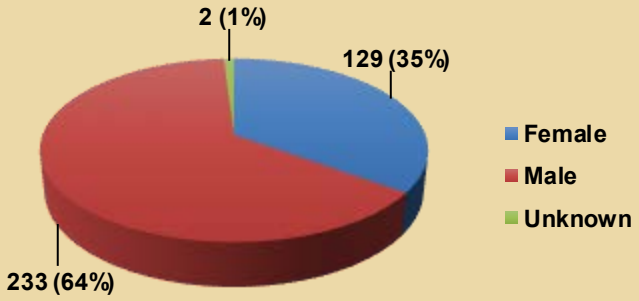
Increase access to mental health services to underserved groups

One of the goals of the RBEST project was to increase access to underserved groups. During the initial **fifteen (15)** months of providing services, the project has received **571** referrals. This includes **73** African American adults and **125** Latino adults. Additional information regarding the demographics of the consumers served by the RBEST project are provided later in this section.

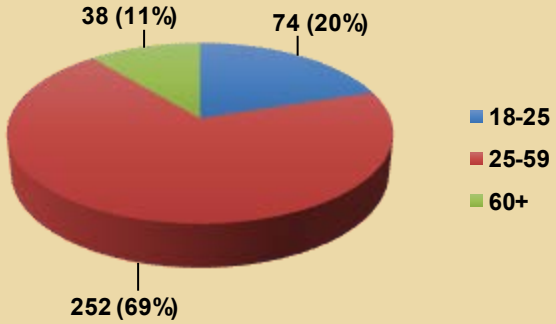
Project Demographics

The charts below provide RBEST Project demographics for a fifteen month period that spans across FY 2014-15 and 2015-16.

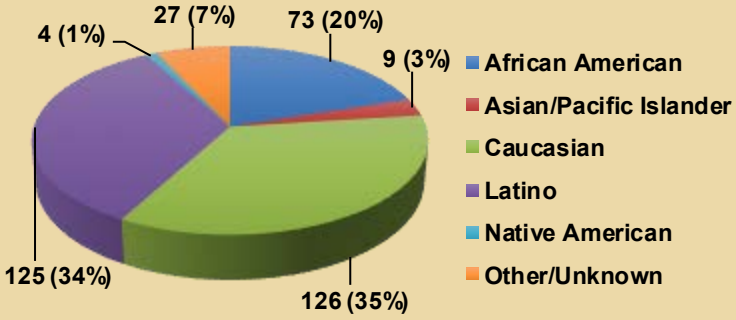
Gender
N=364



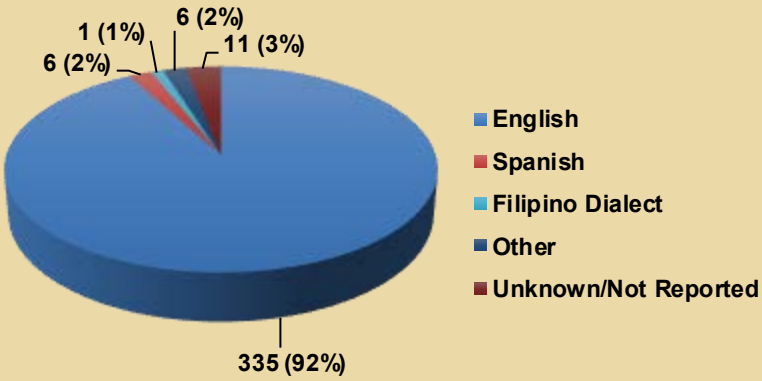
Age
N=364



Ethnicity
N=364



Primary Language



Success Stories

- M, a male referred to RBEST was exhibiting symptoms of paranoia, psychosis, agitation, and isolation. There also existed a strained relationship between him, his mother and sister. Mother was extremely frustrated as she was unable to receive help from other resources. RBEST staff provided engagement and psycho-education to the family members. Staff utilized the Listening, Empathizing, Agreeing, and Partnering (LEAP) model to empower M and his family, teaching them to set limits and boundaries in an effective manner. M was successfully linked to treatment services and is now stable on medication, attending the Intensive Outpatient Program (IOP) through a private treatment provider. The significant reduction in tension throughout the home facilitated the linkage to the outpatient services.
- J is a client referred to RBEST, who was utilizing psychiatric hospital based services 2-3 times per month. Prior to RBEST engagement J was severely depressed and isolating. J is not yet participating in traditional clinic-based services; however there have been no psychiatric hospitalization since RBEST intervention

Artwork by Isis Torres

- L is a male utilizing psychiatric and medical hospitalization for depression and health issues 5-7 times per week. L is chronically homeless and a high user of psychiatric emergency services. Through RBEST engagement, L has accepted linkage to a Full Service Partnership (FSP), gained housing, has his medical care coordinated and has reduced his hospitalizations significantly. During the final engagement, L, who had grown attached to RBEST staff, attempted to continue his RBEST services asking if he can still continue receiving RBEST engagement services. RBEST continues to be an ongoing support and available to L as he receives mental and medical health services.

Challenges

Challenges that were experienced with the startup and implementation phase of the RBEST project are mostly associated with issues regarding starting a new service delivery project from scratch:

- The time that it takes to recruit and hire qualified personnel.
- The process of obtaining necessary equipment to operate a field-based team, including vehicles.
- Securing the necessary office space at selected sites.
- Establishing collaborative relationships with hospital staff, and ensuring that appropriate discharge plans are developed to create easy “hand off” to RBEST.
- Working with individuals who have access to private insurance, yet struggle with navigating the system to find appropriate treatment options.
- Discovering that the Family Experiences Interview Schedule (FEIS) survey tool was too lengthy and difficult to administer in its entirety.
- Finding that regionalizing teams did not meet the needs of the individual consumer and workload size.
- The majority of consumers identified as high users of psychiatric inpatient services also having a co-occurring disorder, yet very few consumers were receiving treatment for Substance Use Disorder (SUD).
- Finding a greater number of consumers to have co-existing medical conditions than anticipated.
- Bus passes and prepaid phone cards were not necessary as incentives to treatment.
- Many consumers thrive with assistance with basic needs including food, shelter, utilities, and transportation, and the current resources aimed at providing these services are insufficient.
- A small subset of individuals, approximately **25,** are experiencing severe symptoms related to their mental illness and are in need of much higher levels of navigational support.

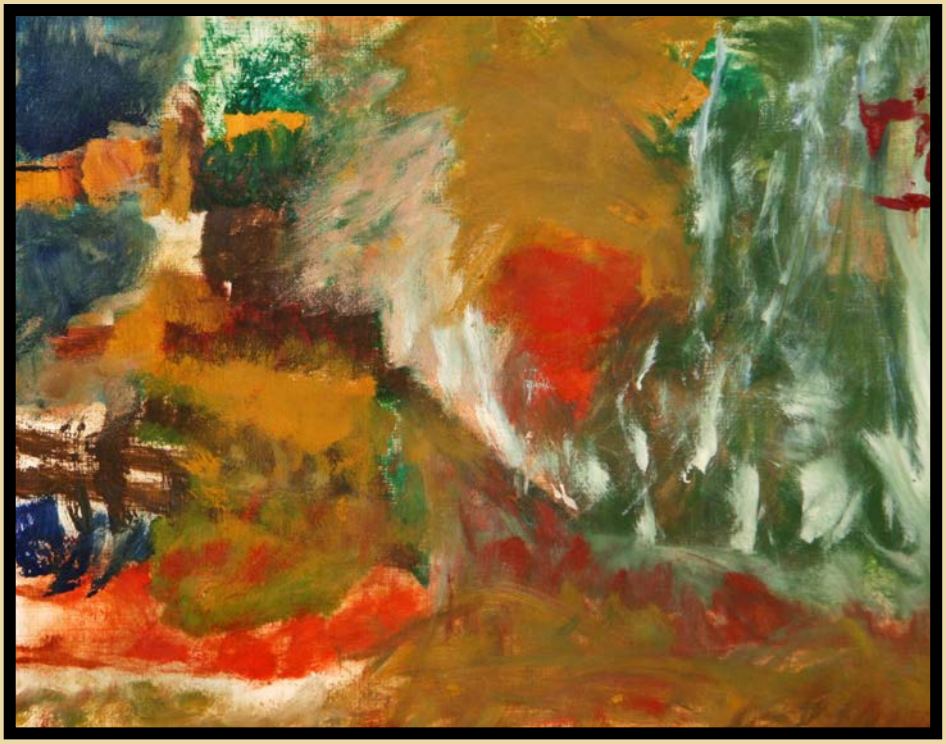
“I want everyone in DBH to know just how much you all have truly helped my brother. It is about time a program like this existed for the mentally ill."

-RBEST family member

Solutions in Progress

Solutions including RBEST project modifications are expected to continue as time learning occurs:

- Working with human resources to quickly recruit qualified staff. All efforts are made to utilize the existing staff as effectively as possible.
- Plans have been approved for the build-out of a now vacant office space. Plans have been implemented to allow staff to use the Supervisor's and Program Manager's offices whenever possible. Plans have been discussed to share work space in other DBH clinics when teams are assigned to that area.
- Modifying the FEIS survey tool allowed for teams to focus on more relevant issues and capturing more information from families.



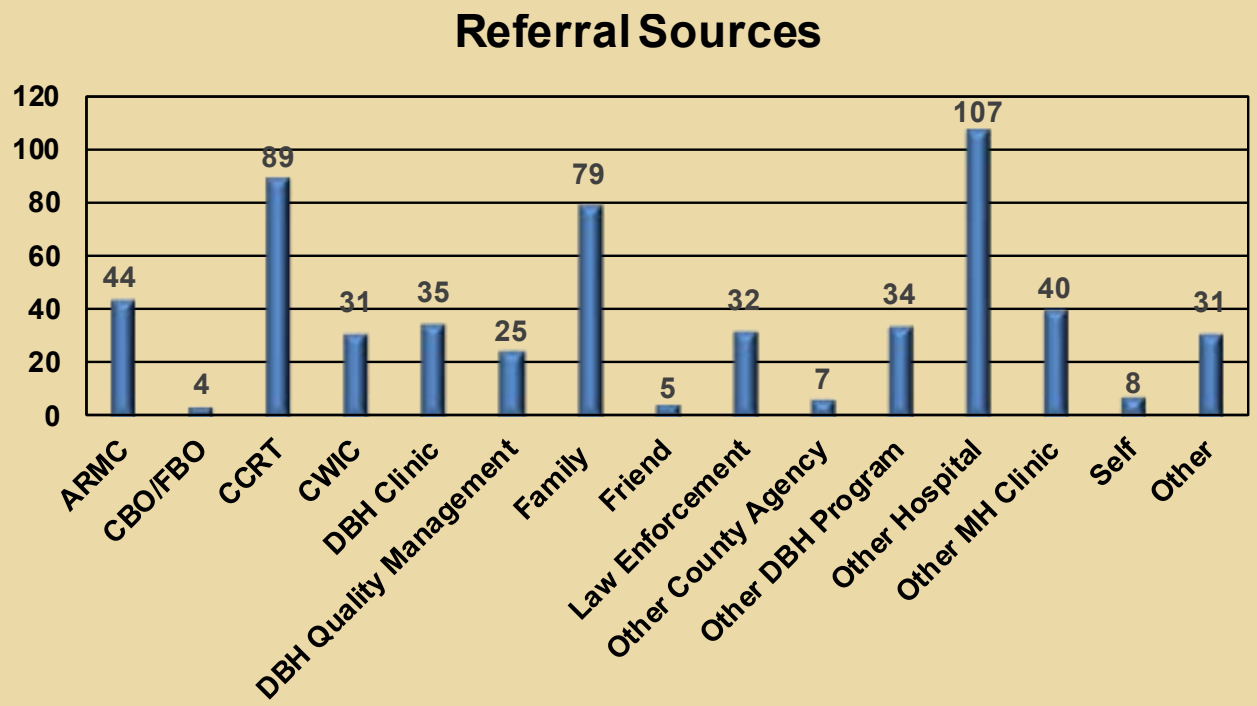
Artwork by Linda James

- Non-regionalization of teams allowed for greater flexibility in the make up of engagement teams to meet the needs of the consumer and sharing of resources.
- Inclusion of Licensed Vocational Nurses (LVNs) on initial engagements provides consultation, education, linkage, and advocacy to address medical needs of consumers immediately.
- Helping families has led to consumers accepting treatment referrals and reduced out of home placement.
- Providing incentives, which included bus passes and phone cards, for the purposes of encouragement into engaging in outpatient care were not found to be barriers to treatment.
- Providing consistent case management and relational based follow up seems to be the key to engagement in outpatient care.
- Develop additional methods and tracking to measure impact in-home education has on families and their ability to assist loved ones.
- Begin to create a description of the consumers who are being referred to the project, including individuals experiencing severe symptoms related to their mental illness and are in need of much higher levels of navigational support.

Collaborative Partners

The RBEST project was planned to operate on a referral system. Outreach was conducted throughout San Bernardino County, and the RBEST project receives referrals from all over the county.

The identification and tracking of referring agencies is important to gain insight concerning which agencies may have a higher need as well as to identify gaps in outreach. The following graph illustrates the agencies and collaborative partners that have worked with the RBEST project to serve the consumers of San Bernardino County.



Key:

- ARMC - Arrowhead Regional Medical Center.
- CBO/FBO - Community Based Organization/Faith Based Organization
- CCRT - DBH Community Crisis Response Teams.
- CWIC - DBH Crisis Walk-In Clinics.

Holistic Campus (INN - 04) Final Report

The Holistic Campus was an innovative project conceived in San Bernardino County with a unique focus on providing enhanced access to behavioral health and wellness services in non-traditional settings. The services of the Holistic Campus were provided using a distinctive cultural and holistic approach that artfully integrated community defined wellness practices and conventional behavioral health care services into a neutral, non-clinical setting. The hypothesis was to test whether non-traditional services would be a more appropriate gateway into the larger behavioral health system of care, resulting in increased access to the behavioral health system of care for groups who have been typically underserved. The services, design, and operation of the Holistic Campus were guided through an ongoing, diverse, culturally and linguistically competent community stakeholders and peers.

On September 27, 2011, the San Bernardino County Board of Supervisors approved contracts for Holistic Campus services with three (**3**) community based organizations, for the contract period of October 1, 2011 through September 30, 2014. The approved contract amount for each campus was $2,749,560 ($807,672 per year). The total project budget for the contract period of the Holistic Campus Project was $8,248,680.

Project Description and Summary of the Priority Issue

One of the most pressing issues facing the public mental health system in California is the disparity in access and utilization of behavioral health services by cultural groups and other historically underserved communities. Locally, the challenges faced by ethnic/cultural communities, geographically isolated and under-resourced communities, and specialty populations in San Bernardino County are continually highlighted by stakeholders involved in the Mental Health Services Act (MHSA) Community Program Planning (CPP) process. African-American, Latino, Native American, and Asian/Pacific Islander populations in the County are typically underserved, lack access to services, or underutilize behavioral health services. Some key issues for these cultural groups include: service appropriateness, relevance and accessibility of behavioral health resources, and services. For the Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ) population, access is affected by location, service array, relevance, and appropriateness. While there are unique and targeted services for military veterans and family members in our County, access is greatly affected by issues of stigma and knowledge of military culture.

Artwork by STRIVE Holistic Campus

Innovation Projects

While there are unique differences, resources, strengths, and skills amongst these populations, the common challenge can be categorized as access to service. Throughout the MHSA CPP process, stakeholders expressed an interest to test other access points to behavioral health care that were considered non-traditional in order to improve access to care.

The intent of this Innovative project was to address the priority issue identified by local stakeholders and increase access to underserved groups by creating a Holistic Campus that was both community driven and culturally informed. Consumers, family members, and cultural brokers from underserved or inappropriately served ethnic and cultural groups as well as the specialty populations provided input into the programs and services offered, operated the campus, and were part of the ongoing evaluation of the project.

This project was designed to bring together a diverse group of stakeholders to create their own resource networks and strategies by blending their diverse cultural strengths and wellness practices with traditional behavioral health entities taking a more subtle, readily accessible, and supportive role within the program design. This focus was also intended to provide behavioral health services and integrated treatment in a single setting for consumers identified with co-occurring disorders. The design and activities of the Holistic Campus were intended to test innovative ways to increase access to services for underserved groups by addressing the following questions:

- Will a unique, community friendly setting in which services are provided by peers and cultural groups with ties to both community resources and traditional behavioral health resources increase access and use of services and contribute to wellness, resilience and recovery?
- Is it possible to create a setting in which participants and partners can frame cultural differences as learning sources for each other and the mental health system?
- By offering services specifically requested by the community and welcoming all to the Holistic Campus, will diverse consumers request and receive behavioral health information and services as needed without stigma?

In order to address these questions, the Holistic Campus project included several unique components. One requirement for the Holistic Campus was that at least **80%** of the services were to be peer-led by community members and cultural brokers, including individuals representing cultural and ethnic communities, the LGBTQ community, and military veterans and their families. In this setting, Holistic Campus staff were given the opportunity to establish collaborative relationships with physical health providers and community based organizations that provide linkage to housing, employment,

Victorville Holistic Campus Advisory Board

education, and benefits issues, as well as provide art therapy and culturally specific healing strategies. It was up to the cultural brokers and the Holistic Campus Advisory Board of Directors (HCAB) to decide which culturally specific healing strategies were needed, desired, and found to be most effective by the community at improving access to the behavioral health system of care. The Holistic Campus facilities were located in the community in a neutral and non-clinical setting. Services provided at the Holistic Campus sites were categorized by three **(3)** levels:

- Outreach activities were a core innovative component of the Holistic Campus project, allowing each site to develop and implement a wide variety of engagement strategies to help improve access to behavioral health care. Sites were encouraged to test new strategies that they believed might encourage people to seek appropriate behavioral health services. These strategies included trainings and presentations, cultural fairs and festivals, health fairs, and street outreach.
- Wellness activities were geared toward increasing an individuals' quality of life by focusing on specific health components. These services are considered less intensive than therapeutic activities offered at each site. Some examples of wellness activities offered at various sites included: zumba, nutrition, crafts, and family game night.
- Therapeutic services referred to behavioral health services that individuals would access in traditional behavioral health settings. Therapeutic activities also referred to services that cater to individuals requiring a higher level of intense behavioral health care. Some examples of therapeutic activities include: individual therapy, Equine-Assisted Therapy, and services offered by Department of Behavioral Health.

- One local community-based organization took the lead responsibility for the campus, and with input from the community, cultural brokers, and the Advisory Board of Directors, invited others, such as traditional healers and culturally specific providers to participate and provide culturally and ethnically appropriate services.

  This project introduced a new mental health practice/approach to San Bernardino County. Convening community members from diverse cultures and ethnicities as one decision-making body to develop and run a Holistic Campus serving all was an innovative concept. Individually these cultures and ethnicities expressed a shared sense of challenge in accessing services. This innovative project incorporated the six (**6**) standards applicable to all Mental Health Services Act (MHSA) activities:
- **Community Collaboration** – Community collaboration was key to the development of this project. Each peer, cultural broker, and service provider brought a unique perspective on the needs of their community to the conversation. The County's existing Cultural Coalitions and Cultural Competence Advisory Workgroups were invited to provide input into the development, implementation, and evaluation of the project and to ensure that all services provided were appropriate to the community being served.
- **Cultural Competence** – Stakeholders from San Bernardino County's diverse cultural communities including LGBTQ individuals, military veterans and their families as well as existing Cultural Coalitions and Cultural Competence Advisory Workgroups participated in developing and operating the Holistic Campus working together to evaluate the effectiveness of melding diverse cultural wellness practices together to address common needs.
- **Client/Family Driven Mental Health System** – Diverse consumers as well as their family members were represented at every step in the development and operation of the Holistic Campus. Consumers and their family members were recruited as employees of the Holistic Campus. These staff positions were modeled on the San Bernardino County Peer and Family Advocate (PFA) classifications. As planned, at least **80%** of the positions were staffed by peers.

- **Wellness, Recovery and Resilience** –The focus of the Holistic Campus was 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 sought to tap into the resiliencies of a broad and diverse community of participants. It was expected that this innovative learning partnership would facilitate an integration of these strengths, skills and resources into transforming the mental health system.
- **Integrated Service Experience** – The Holistic Campus brought together many different community members, mental health service providers, culturally specific healers, and others, in a singular location in a true expression of an integrated service experience.

Changes Made to the Innovative Project During Implementation

East Valley Region services ceased operations on July 16, 2012. The County released a Request for Proposals for Holistic Campus services and on July 9, 2013 a new contract was awarded to a new community based organization to provide services in the East Valley region through June 30, 2015. As a result of this administrative change, Holistic Campus services in the East Valley region were provided for less time than originally proposed. This change may have impacted the overall number of unduplicated participants served.

On December 1, 2013, the County awarded a contract to EVALCORP, research consultant, to develop an evaluation framework for all existing Innovative projects for the purpose of measuring and demonstrating project effectiveness through uniform data collection and continued evaluation. The contract period was through November 30, 2014. This change was made to address the data collection variations, varied level of evaluation capacity amongst providers, and to inform future Innovative project design. On September 23, 2014, the County extended the contract to the providers serving the West Valley and High Desert regions for nine (**9**) months solely for evaluation purposes extending the total contract period of October 1, 2011 through June 30, 2015. When the Innovation Plan was drafted in 2010 by DBH, the resources and time required to perform the evaluation of the project by Providers was underestimated. This change allowed agencies to validate their current data, enter collected data manually into an electronic system, analyze the data, and perform a comprehensive outcome and performance evaluation.

Program Information Collected during the Reporting Period

The current Innovation Project regulations were issued July 2015 and effective October 2015, and require the Final Innovative Project Report to include demographic information regarding individuals served during the reporting period as specified in Section 3580.010, subdivision (a)(4). While demographic information on the individuals served through the Holistic Campus Project was collected, the available data differs from some of the requirements of the Innovation Projection regulations. This variance in data collection can be attributed to two main causes:

1) The Holistic Campus Project activities concluded on September 30, 2014, for the West Valley and High Desert regions and June 30, 2015, for the East Valley region, prior to the issuing of the new Innovation Project regulations in October 2015. Data was collected according to the requirements of previous Innovation Project guidelines for reporting.

> ***"Holistic Campus strength is serving the underserved"***
>
> ***-CPAC Participant***

2) The contract agencies providing services under Holistic Campus Project had variances in their data collection methodologies as well as variations in collecting demographic data from all individuals served. For example, contract agencies providing Holistic Campus services would ask individuals served about their race, ethnicity, or sexual orientation, but the responses lacked the specificity required in the newly enacted Innovation Project regulations. In an analysis of the data collected, it was also found that contract agencies did not universally ask all of the demographic questions to all of the individuals served upon entry into the program. The providers shared that the organic nature of the program didn't lend itself to asking some of the demographic questions, as they were trying to establish relationships and rapport.

Artwork by Cathy Giblin

One of the lessons we learned from this project was that we could collect these points of information later on in the process once a relationship had been established. However, the challenge with this was being unable to predict at what point it would be appropriate to revisit, or alternatively, at what point the consumer would exit the program. This is an area of learning we are still exploring, particularly around informing our current practices for collecting information required by the newly enacted regulations. The available program information collected during the Implementation period is provided in this Final Report. As applicable, notations have been made regarding variations in data collection or how reporting on various demographic elements has been derived.

Evaluation Methodology

The primary purpose of the Holistic Campus project was to increase access to underserved groups. In the original Innovation Work Plan for the Holistic Campus project (**11/13/2009**), the Department of Behavioral Health (DBH) indicated that the project would be reviewed and assessed by measuring community participation. Specifically, the evaluation activities would assess the range of services accessed by users of the Holistic Campus including mental health education and treatment. In order to conduct this evaluation, DBH planned to conduct the following activities:

- Collect basic demographic information of participants.
- Develop participant surveys to gather information from consumers on their initial visit as well as any follow up visits to a Holistic Campus site. These surveys would be informed by surveys used in DBH's utilization consumer clubhouses and programs.
- Track requests for traditional mental health services from those consumers who come to the Holistic Campus.

Accordingly, this planned approach guided the evaluation methodology during the implementation phase of the Innovative Project. During the course of implementing the Holistic Campus sites, basic demographic information was collected for participants served. The demographic information collected illustrates the rate of utilization of Holistic Campus services by various underserved groups. The term "underserved" included participants who were underserved, unserved, or inappropriately served.

Innovation Projects

In December 2013, DBH contracted the services of an independent evaluator, EVALCORP, to assist with the process of developing participant surveys and evaluating outcomes. In alignment with the Work Plan, EVALCORP developed a Holistic Campus Participant Survey as well as a supplemental Provider Survey to gathering more complete data on achievement of learning goals. DBH and EVALCORP developed a logic model (see Appendix Attachment L(1): Holistic Campus Logic Model) to illustrate how the Holistic Campus' primary purpose and learning goals connect, how they relate to the project strategies, and how the outcomes are measured.

These logic models were created near the end of the Holistic Campus project implementation and were designed to accurately represent what had been done during the implementation phase. One of the primary lessons learned was the significant importance of including evaluation design, including logic model construction, in the planning phase of projects before implementation even starts, instead of midway or closer to the completion of projects. Another lesson learned regarding evaluation is the importance of incorporating evaluation into the life cycle of the project, so projects are able to perform real- time continuous process improvement, along with developmental evaluative efforts to inform, guide, and support the direction of the project.

While exploring the demographics and numbers of people served in various ways at the Holistic Campus sites is important to see if people were engaged in general, further analysis was needed to explore whether non-traditional activities helped to increase access to behavioral health services. Therefore, DBH and the Providers examined how many people of all those served through the Holistic Campus received therapeutic services, both at the Holistic Campus sites as well as in the larger behavioral health system of care.

"Holistic Campus has been a great help"

-CPAC Participant

"Holistic Campus are in areas where services are free. Services are helpful"

-CPAC Participant

"These preventive programs are very helpful"

-CPAC Participant

"To have good mental health, one must have nutrition and exercise"

-CPAC Participant

Final Evaluation Results

This evaluation section is comprised of two (**2**) parts. The first section will describe the demographics of Holistic Campus participants. Initially, this will review collective demographic information across all Holistic Campus sites and all types of services. This will then move into more detailed review by site. For ethnicity, LGBTQ, and military veterans, detailed demographics will be reviewed for each level of service provided at the Holistic Campus (outreach, wellness, and therapeutic). This type of analysis helps evaluate whether the targeted populations were represented in each level of service as hypothesized, thereby letting us know if the innovative strategies were effective to increase access to behavioral health care.

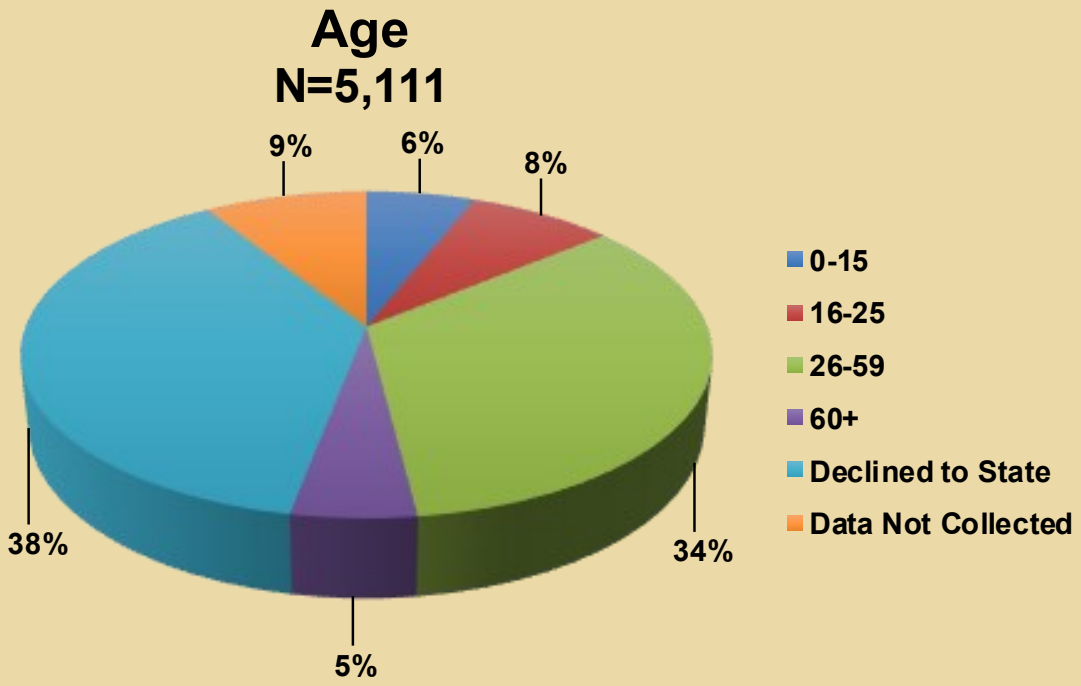
The second section will review analysis of the rate at which Holistic Campus participants accessed behavioral health care both at the Holistic Campus sites and in the larger behavioral health system of care. This was the ultimate goal and hypothesis of this Innovative project.

Demographics of Holistic Campus Participants

Collective Demographics

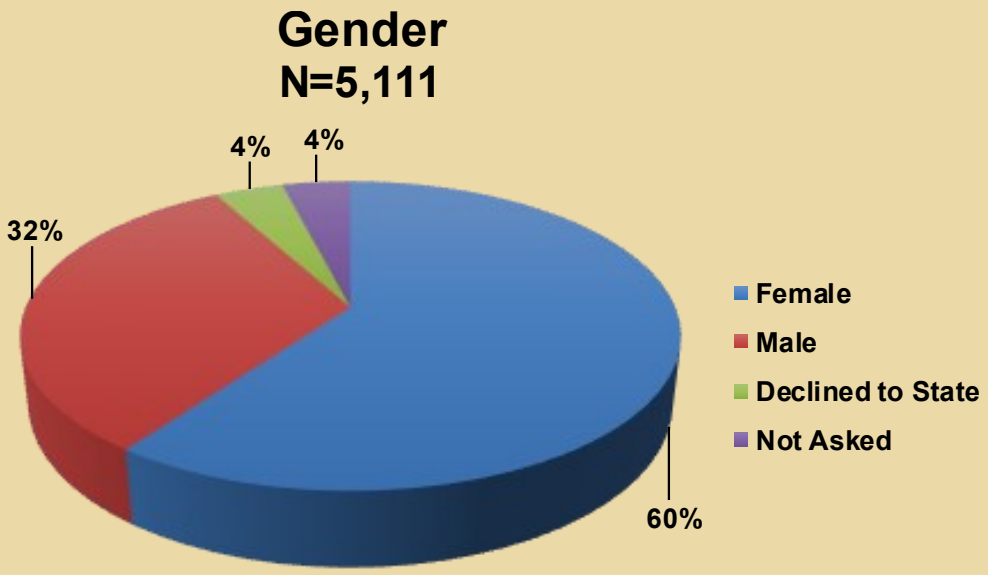
As unserved, underserved, and inappropriately served demographic groups were of particular focus in this project, exploring the rates of these groups' participation in the different levels of services is important in evaluating whether the Holistic Campus project increased access to the behavioral health system of care for the target populations.

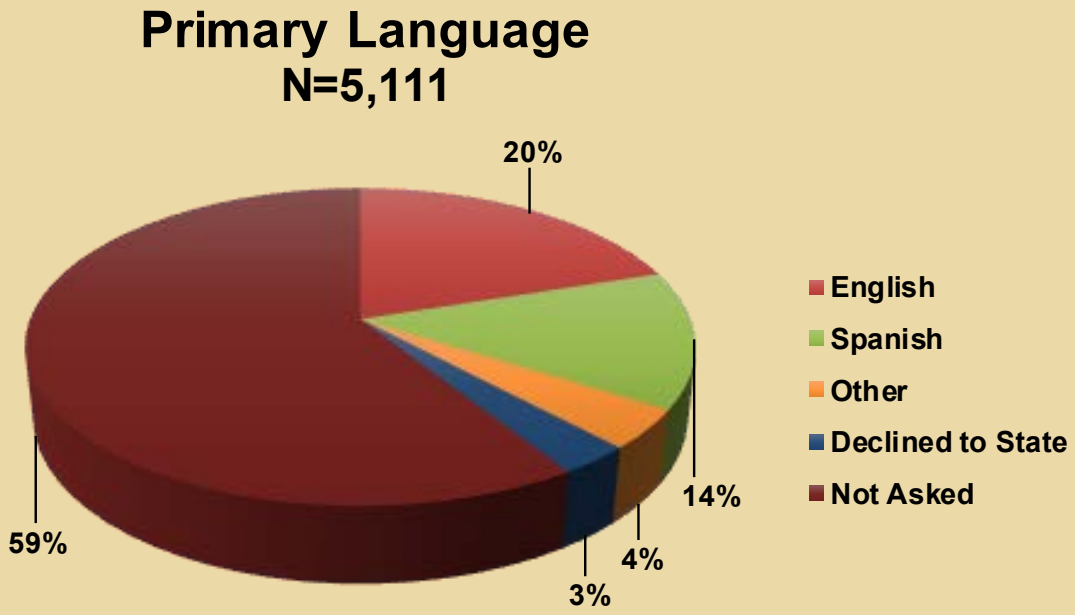
The following charts illustrate the collective demographic information for participants served by all of the providers through the duration of their contract. Nearly half (**47%**) of the individuals served were asked but did not provide an age or the provider did not collect data regarding the individual's age. The data below indicates that the majority of individuals served (**34%**) were between **26-59** years of age.



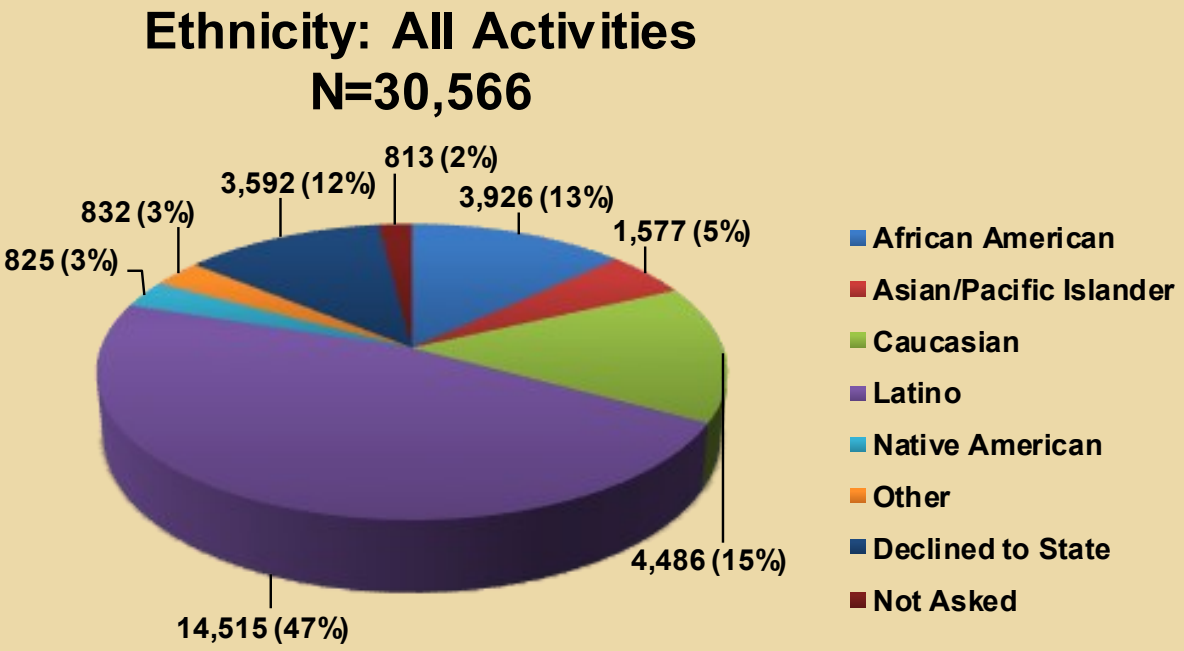
Innovation Projects

The following charts illustrate the collective demographic information for participants served by all of the providers through the duration of their contract. Of those asked, the majority of individuals (**60%**) were female, **32%** served identified English as their Primary Language, and **59%** of individuals were not asked about their primary language.





The chart below illustrates the shows the ethnic breakdown of all Holistic Campus participants engaged in any Holistic activity (outreach, wellness, and therapeutic). These counts are duplicated across activities as unduplicated was not always possible to collect based on the nature of the services being delivered. The majority of individuals served were Latino (**47%**) followed by Caucasian (**15%**).

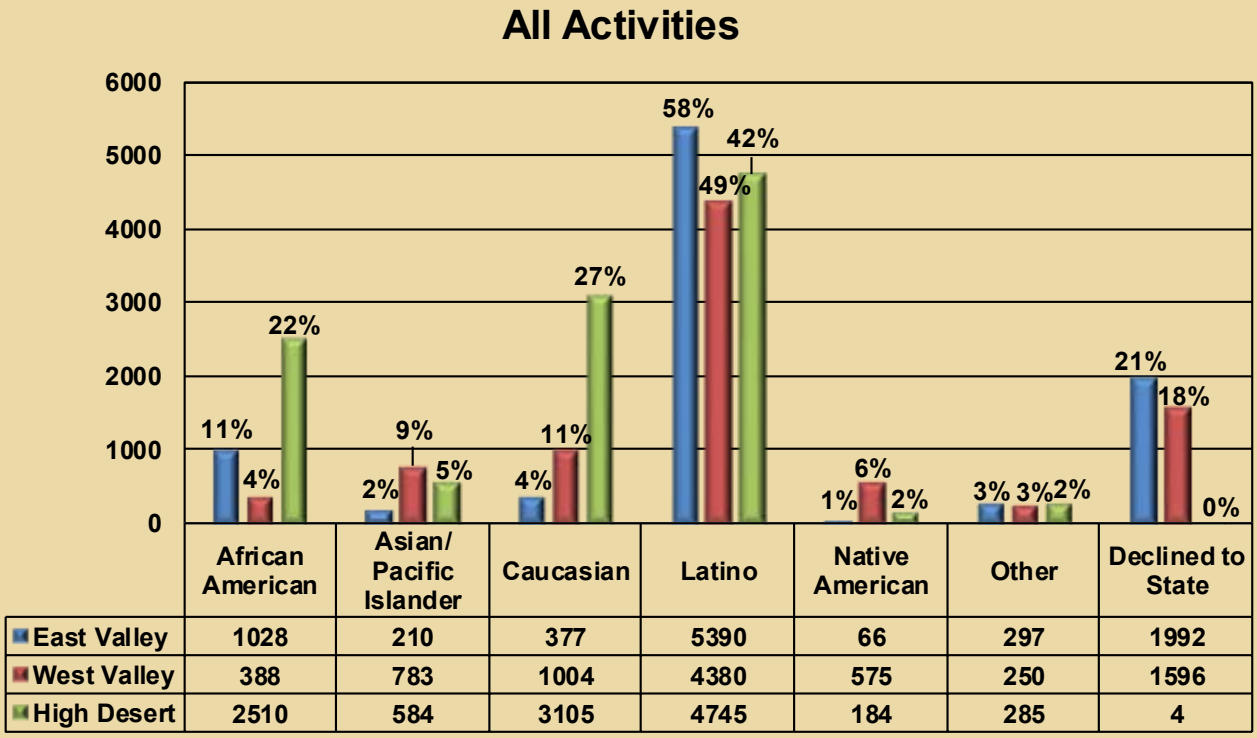


S.T.R.I.V.E. Holistic Campus Staff at a DBH Outreach Event

Demographics by Site and Activity: Ethnicity

As mentioned in an earlier section of the report, with an analysis of the data collected, it was also found that contract agencies did not universally ask all of the demographic questions to all of the individuals served upon entry into the program. The providers shared that the organic nature of the program did not lend itself to asking some of the demographic questions, as they were trying to establish relationships and rapport. For the purposes of this report, Figures (1, 2, 3, and 4) presented in this section of the report refers to individuals who were asked about their demographic information. Of the individuals who were asked, **Figure 1** below shows that the highest participation in services was for the Latino population at **14,515** (**47%**). Of those served**, 4,486** (**15%**) self-reported as Caucasian, **3,926** (**13%**) of participants were African American, **1,577** (**5%**) were Asian/Pacific Islander, **820** (**3%**) were Native American and **825** (**3%**) identified their ethnicity as Other. Of those served**, 3,592**(**12%**) declined to state their ethnicity

Figure 1 provides the ethnic breakdown of all activities for individuals who engaged in Holistic Campuses serving the East Valley, West Valley, and/or High Desert regions.



	African American	Asian/ Pacific Islander	Caucasian	Latino	Native American	Other	Declined to State
East Valley	1028	210	377	5390	66	297	1992
West Valley	388	783	1004	4380	575	250	1596
High Desert	2510	584	3105	4745	184	285	4

Service Engagement and Utilization

As outlined in the Work Plan, the service data collected during the project implementation period also included the number of participants from underserved groups who engaged in traditional behavioral health/therapeutic services. Participant service and demographic data was collected through a combination of monthly service reports during the implementation period, and Participant and Provider Surveys administered and collected during Fiscal Year (FY) 2013-14. In order to determine whether access to underserved groups increased through the Holistic Campus project, the data evaluation and analysis focused on three essential indicators:

1) Availability of services;
2) Service participation; and
3) Help-seeking behaviors and attitudes.

These indicators provide the framework for evaluating the outcomes of this Innovative Project. Through the Holistic Campus project, a variety of activities (Outreach, Wellness, and Therapeutic) were offered and provided to priority populations from underserved groups. Conducting outreach activities was a key factor in engaging members of underserved groups in available services. Typically, outreach activities were socially interactive events or activities that were aimed at informing the general public, community-based organizations (CBOs), and/or stakeholders about Holistic Campus services. Basic demographic information collected during these outreach activities indicates engagement with underserved groups.

A total of **22,477** people were reached through outreach activities. Each Holistic Campus reached underserved groups using unique methods. The highest engagement for the Latino population was in the East Valley region, even though Holistic Campus services were provided for a shorter time period in this region than in the other regions. There are several factors that can be attributed to this higher engagement for the Latino population. The Holistic Campus in the East Valley employed a door-to-door outreach strategy, using Community Health Workers (also called Promotores de Salud) to canvas neighborhoods inviting community members to attend services at the Holistic Campus. The provider agency in this region was also well known in the community for offering an array of services to the Latino community.

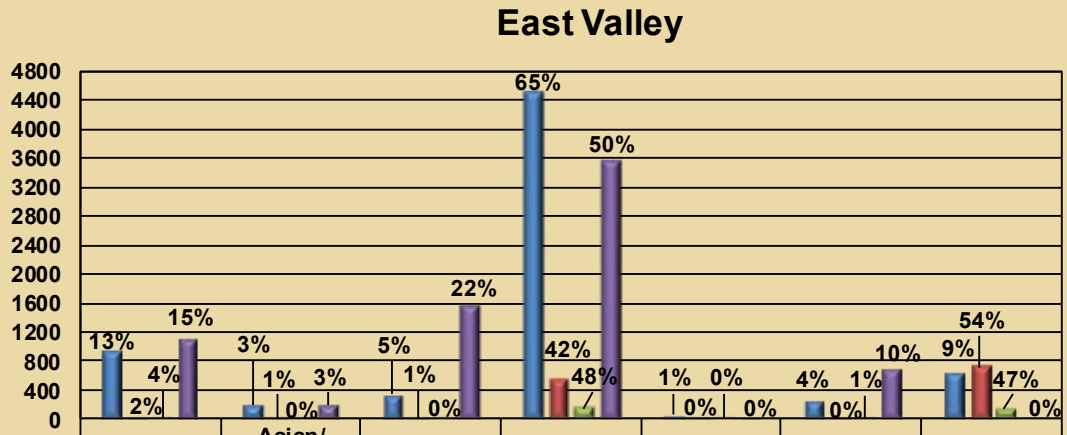
The outreach strategy utilized in the West Valley region included targeting specific underserved groups such as Native Americans and Asian/Pacific Islander (API) communities through community cultural events. Targeted outreach at an annual Powwow reached **545** Native American participants. Through a relationship that the Holistic Campus Advisory Board (HCAB) members had with the API community, staff were invited to participate in a communal meal at a local Buddhist Temple to celebrate the Lunar New Year, which drew **738** attendees.

In the High Desert region, there was more diverse engagement in outreach efforts, particularly for the Latino (**40%**), Caucasian (**27%**), and African American (**22%**) populations. This can be attributed to their holistic approach and strategy of networking with CBO's in holding their Annual Health Fairs at the Holistic Campus site.

The figures on the next page show the ethnic breakdown of Holistic Campus participants by site. Each bar represents the type of Holistic Campus activity (outreach, wellness, and therapeutic), with the final bar showing the ethnic breakdown represented by existing DBH services in that region. This provides a comparison to determine if the Holistic Campuses increased access for the underserved groups over the access existing services provide.

Figure 2 below provides the ethnic breakdown of all Holistic Campus participants who engaged in outreach, wellness, and therapeutic activities in the East Valley region compared to individuals accessing DBH existing services.

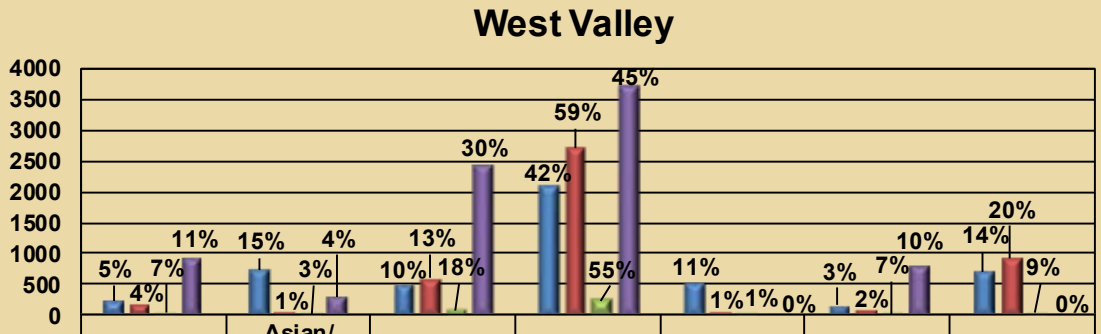
Figure 2:



	African American	Asian/ Pacific Islander	Caucasian	Latino	Native American	Other	Declined to State
Outreach	954	193	344	4517	59	263	653
Wellness	28	6	8	549	4	6	717
Therapeutic	10	1	1	144	1	3	139
Existing DBH Services	1119	196	1577	3560	30	690	0

Figure 3 below provides the ethnic breakdown of all Holistic Campus participants who engaged in outreach, wellness, and therapeutic activities in the West Valley region compared to individuals accessing DBH existing services.

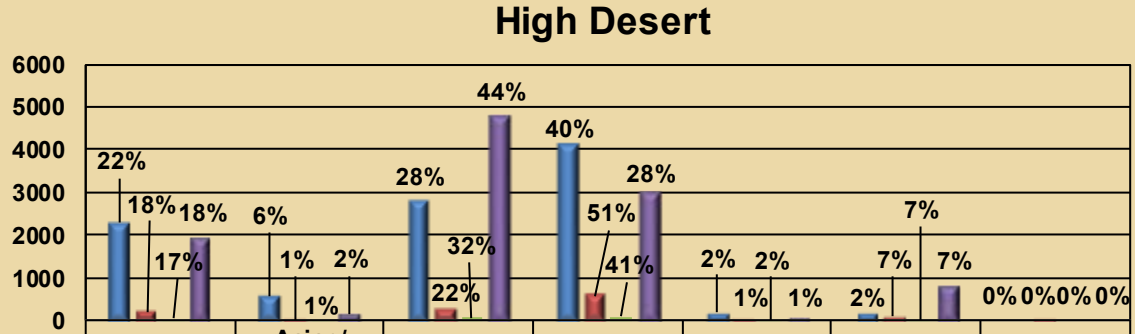
Figure 3:



	African American	Asian/ Pacific Islander	Caucasian	Latino	Native American	Other	Declined to State
Outreach	240	738	503	2102	545	160	710
Wellness	178	48	601	2709	51	80	928
Therapeutic	30	14	77	235	4	27	39
Existing DBH Services	935	311	2437	3732	39	807	0

Figure 3 below provides the ethnic breakdown of all Holistic Campus participants who engaged in outreach, wellness, and therapeutic activities in the East Valley region compared to individuals accessing DBH existing services.

Figure 3:



	African American	Asian/ Pacific Islander	Caucasian	Latino	Native American	Other	Declined to State
Outreach	2273	572	2784	4083	170	186	0
Wellness	203	10	257	580	10	84	4
Therapeutic	34	2	64	82	4	15	0
Existing DBH Services	1948	166	4773	3034	74	813	0

W.I.S.E Holistic Campus, Victorville CA

Demographics by Site and Activity: LGBTQ

Although there were several outreach events and activities that targeted the Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) community, efforts to engage this underserved group were less successful than efforts to reach culturally underserved groups. The bars presented in Figures (5, 6, 7, and 8) in this section of the report are represented by those who self-identify as LGBTQ, those who did not self-Identify as LGTBQ, and those who declined to state whether they belonged to the LGBTQ community or not. Of those asked, **Figure 5** below provides the breakdown of all activities targeting the LGBTQ community. Of those asked, **Figure 6** below provides the breakdown of Outreach activities targeting LGBTQ community resulting in a total of **9,038** individuals being reached, with **147** (**2%**) of those who self-identify as LGBTQ; **7,433** (**82%**) of those who did not self-Identify as LGTBQ; and **1,458** of those who declined to state whether they belonged to the LGBTQ community or not.

Figure 5:

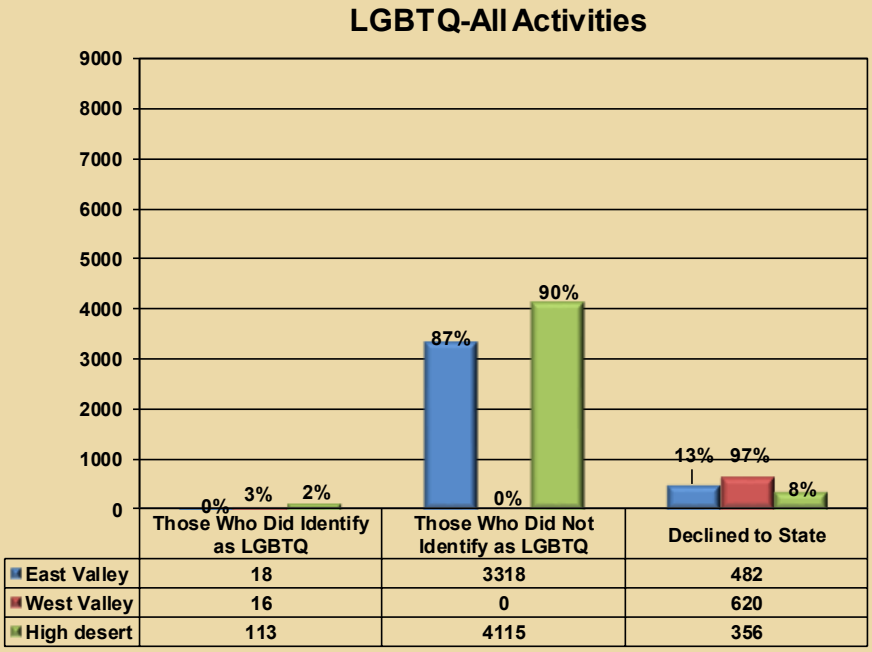
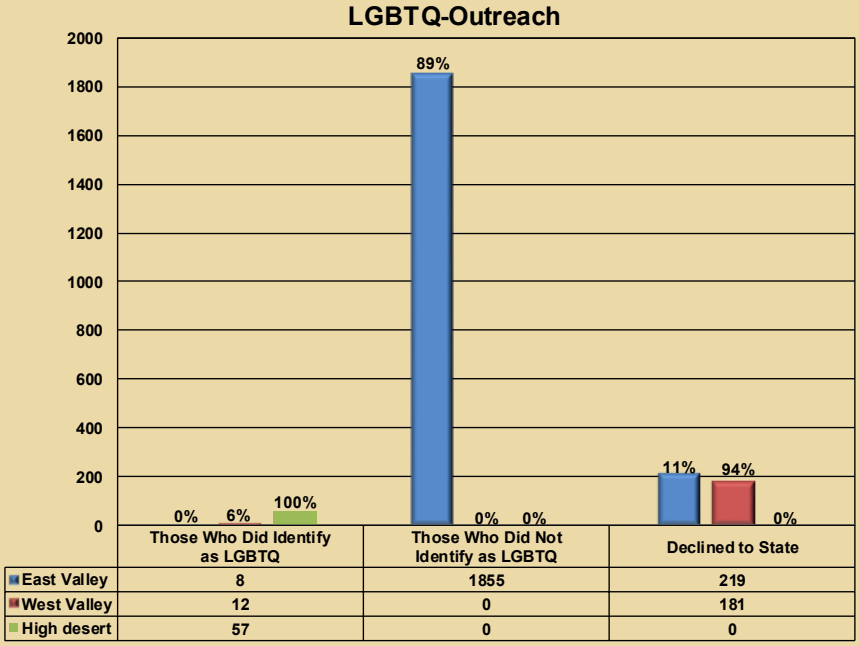
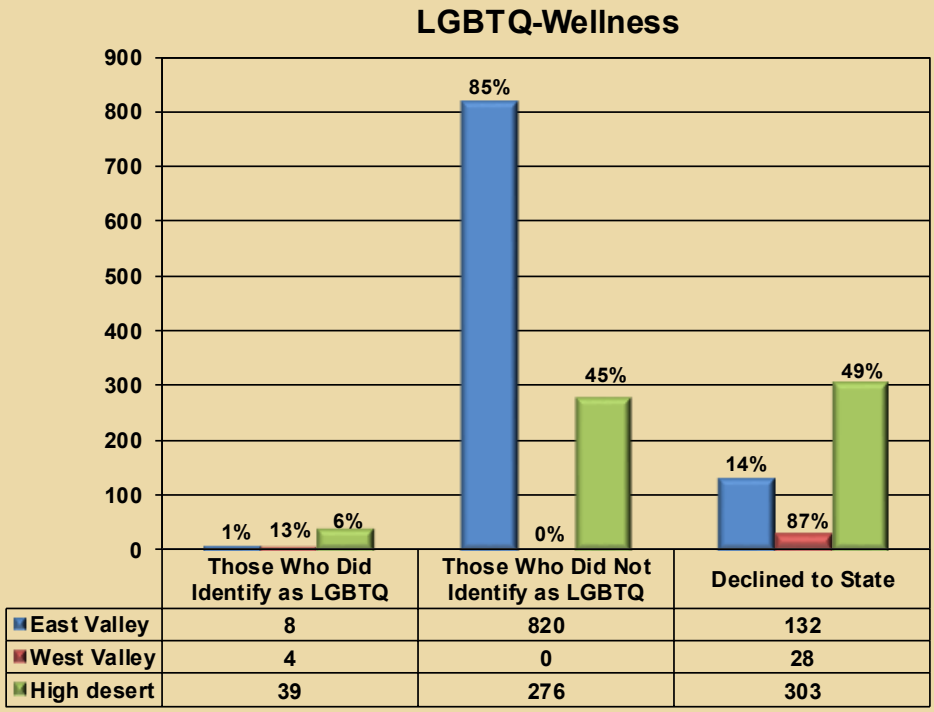


Figure 6:



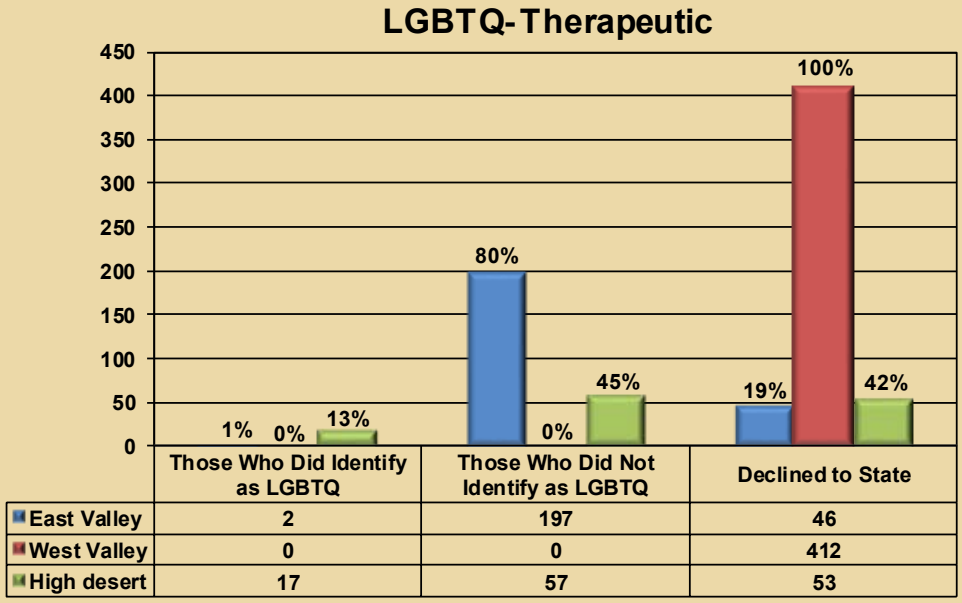
Of the individuals who were asked, **Figure 7** below provides the breakdown of all Holistic Campus participants who engaged in Wellness activities targeting LGBTQ community.

Figure 7:



Of the individuals who were asked, **Figure 8** below provides the breakdown of all Holistic Campus participants who engaged in Therapeutic activities targeting LGBTQ community.

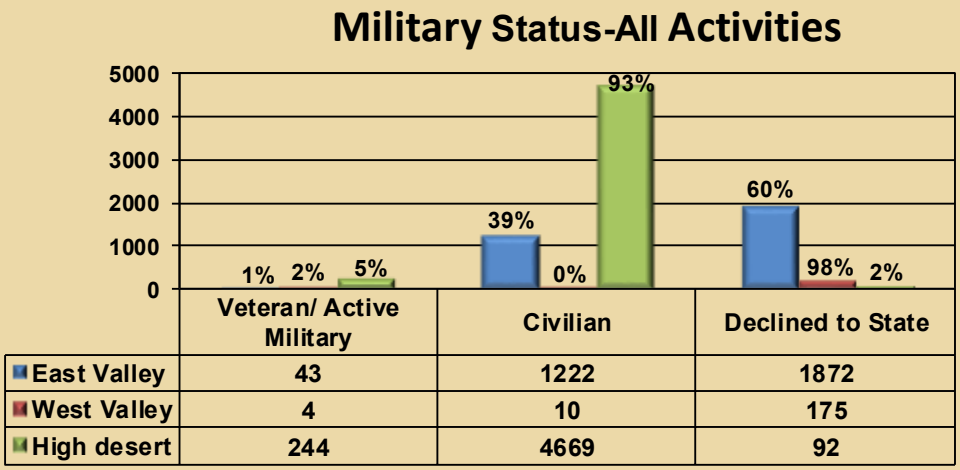
Figure 8:



There may be several factors that contributed to this outcome. A lack of adequate staff training in engaging the LGBTQ community may have been a factor in the amount of people either not asked their sexual orientation (**15**,**079**), or people who were asked and did not answer (**1,458**). Research indicates, being trained on how to ask about sexual orientation and gender identity in a sensitive and culturally competent manner is very important when providing health care services to LGBTQ individuals (Rutherford, et al, 2012). Although staff from the Holistic Campus received training on LGBTQ issues, as well as LGBTQ Ally training, this may not have been adequate for assisting in obtaining this type of sensitive information in a community setting. Research indicates many times the lack of LGBTQ knowledge, or a level of discomfort with this topic can lead interviewers to avoid asking questions related to sexual orientation or gender identity, or it can lead the interviewers to ask in an inappropriate way that may not illicit a response (Rutherford, et al, 2012). Staff from one (**1**) Holistic Campus site stated that they felt it was intrusive to ask about an individual's sexual orientation or gender identity on a demographic form in public without having trust established between provider and responder. The staff's perception about this issue may have led to the low number of responses. They also stated not having a staff peer from the LGBTQ community may have increased their challenge of reaching this cultural group. Research however, indicates that health care providers can offer "supportive, appropriate care for LGBTQ individuals" without the presence of LGBTQ staff (Rutherford, et al, 2012).The lack of data collection regarding this LGBTQ underserved population was inconclusive, but may be explained (as stated previously) by a lack of training or discomfort around asking about sexual orientation or gender identity in community settings. Thus, another key learning from the project is that enhanced training on LGBTQ culture would be beneficial. Like the ethnic groups and LGBTQ populations, the Holistic Campus sites intentionally built strategies to reach out to veterans and active military residents of their region.

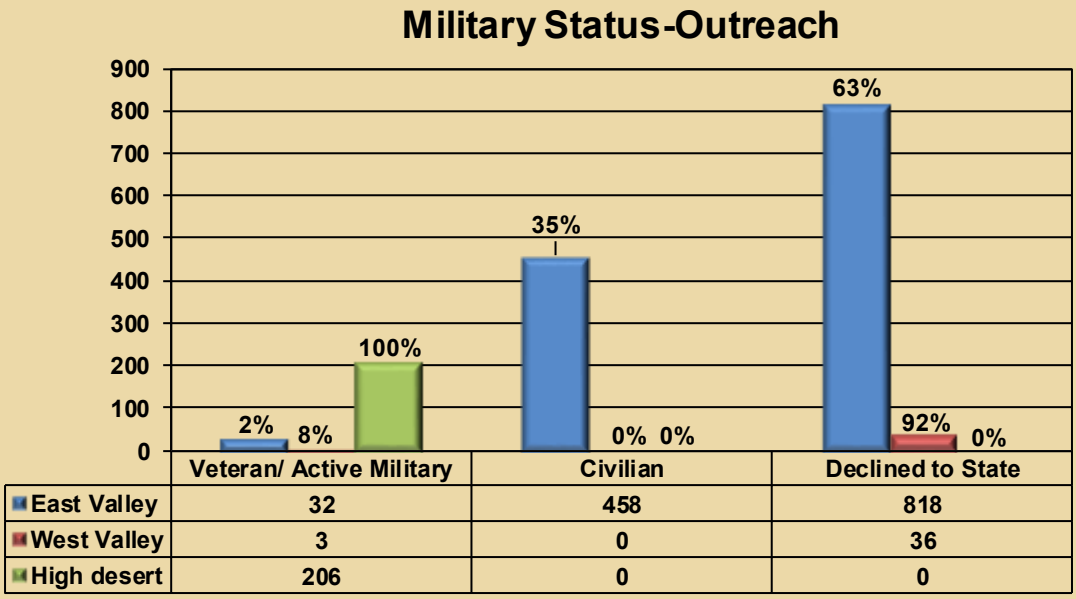
Similarly, there was some difficulty in conducting outreach activities to military veterans and their families. For the purposes of the Figures (9,10,11, and 12) presented in this section of the report, Veteran/Active Military refers to individuals who self-identified as having a Veteran and/or Active Military status, Civilian refers to individuals who self-identified as not having a Veteran and/or Active Military status, and Declined to State refers to Individuals who were asked about their military status and did not respond. Of those asked about their military status, in **Figure 9** below, **291** (**3.4%)** Holistic Campus participants identified as being a veteran or active military.

Figure 9:



Of the individuals asked, in **Figure 10** below, of those **241** (**2%**) self-identified themselves as Veterans/Active Military; **458** (**3%**), self-identified as Non-Veteran/Active Military; and **854** (**5%**) declined to provide their military status.

Figure 10:



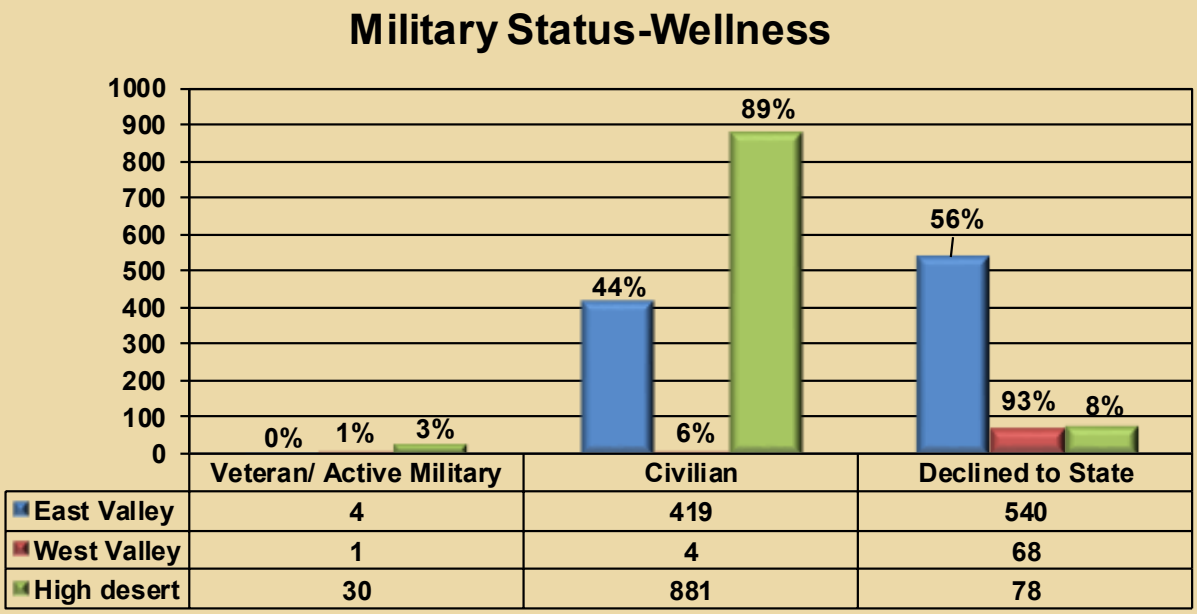
One veteran from the Holistic Campus Advisory Board (HCAB) stated that “mental health stigma is high and help-seeking behavior is low in the military community” which may account for low participation.

As illustrated in **Figure 10** above, the outreach activities in the High Desert region were more successful in engaging military veterans and their families. **206** (**85%**) of participants who identified as Veterans or Active Military were identified in the High Desert region. This outcome may be a combination of the outreach strategies employed as well as the presence of two military installations in the region, and a higher percentage of the general population with military status or background. One of the outreach strategies included a collaborative effort to provide a Veterans Resource and Job Fair for the community. In addition, this contractor also holds a staff knowledge and a separate PEI contract to work with military population and their families. Therefore, training may be enhanced for this provider.

Overall, outreach activities to increase access to available services was successful in reaching targeted underserved cultural groups. This outcome is supported by the number of participants reached from underserved groups, particularly Latinos. Though smaller in number, outreach efforts were successful to Asian/Pacific Islanders, Native Americans and African Americans.

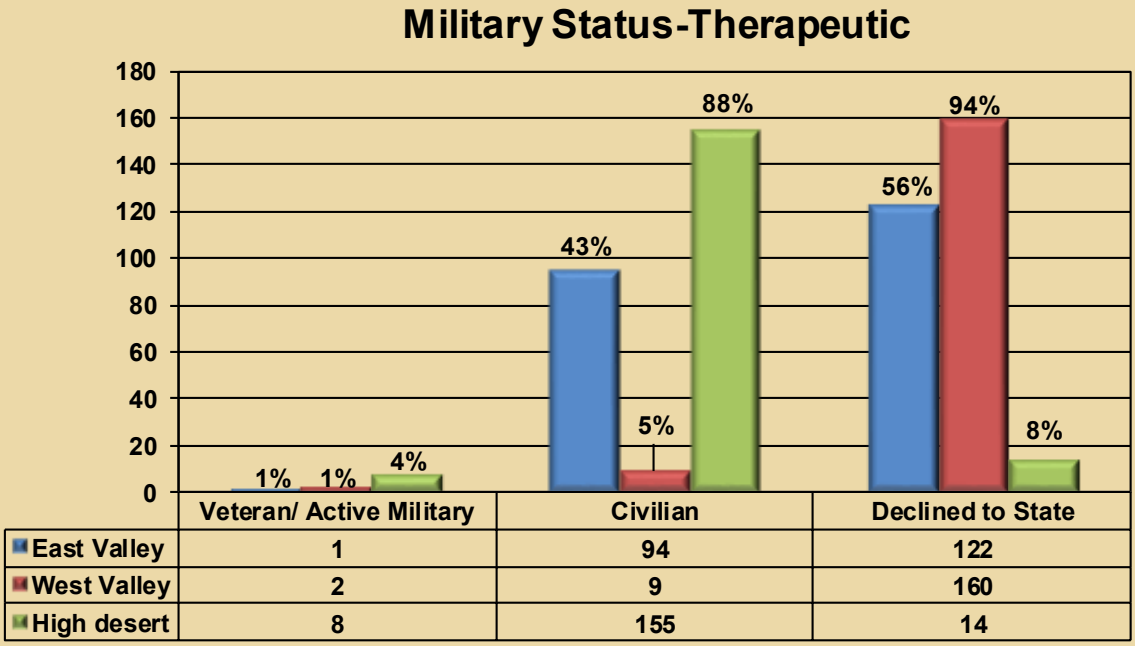
In **Figure 11** provides the breakdown by Military status for Wellness activities.

Figure 11:



In **Figure 12** provides the breakdown by Military status for Therapeutic activities.

Figure 12:



Access to the Behavioral Health System of Care

As previously discussed, the primary purpose of the Holistic Campus project was to increase access to underserved groups. The prior evaluation section explored how different strategies were able to reach underserved groups. This section investigates the ability of different strategies to increase access to the larger behavioral health system of care regardless of target population. The therapeutic group of services provided at the Holistic Campus were similar to traditional behavioral health services in DBH's larger system of care, except they were located in a non-clinical setting. The Holistic Campus locations made significant efforts to create a non-traditional setting that would be more welcoming to diverse populations who might not otherwise seek traditional behavioral health services. Looking at how frequently people entered therapy services at the Holistic Campus sites is an evaluation of whether different strategies at the wellness level were an effective "front door" to the behavioral health system of care. **Figure 13** below examines this rate. Outreach activities were often unable to be tracked at an individual level due the nature of activities.

Figure 13:

Holistic Campus Participants Accessing Therapy Services at the Holistic Campus			
	Central Valley	**West Valley**	**High Desert**
Total Holistic Campus Clients (Wellness & Therapy)	2,381	9,427	2,052
Therapy Clients at Holistic Campus	185	437	209
% Receiving Therapy	7.77%	4.64%	10.19%

These results suggests that large amounts of resources are needed to reach and engage people into basic behavioral health services. While the Holistic Campus providers put in significant efforts to engage individuals in behavioral health services it did not appear to be a greater "doorway" into therapeutic services as compared to current penetration rates, with the exception of the High Desert Holistic Campus site.

The next level of analysis was exploring how many Holistic Campus participants entered into the larger DBH system of care, determining whether the Holistic Campus innovative strategies acted as a "front door" to the DBH system of care. The figure below examines how many of the Holistic Campus participants entered the DBH system of care after receiving services at the Holistic Campus. The analysis of Holistic Campus services only include wellness and therapy services (excluding outreach activities) because these are the only services where individual data was able to be tracked.

Figure 14:

Holistic Campus Participants Accessing Therapy Services in the DBH System of Care			
	Central Valley	**West Valley**	**High Desert**
Total Holistic Campus Clients (Wellness & Therapy)	2,381	9,427	2,052
Total Clients in DBH	4	4	29
% Clients in DBH	0.17%	0.04%	1.41%

While the activities provided at the Holistic Campus are meaningful community services, they do not appear to significantly increase utilization of behavioral health services beyond current penetration rates. In examining the practices that were successful in engaging individuals into therapeutic care, peer counseling emerged as a promising practice and will be integrated along with the Promotores de Salud in other areas of DBH programming. While these findings are not innovative, both practices of peer counseling and Promotores de Salud are successful community defined practices that should be utilized in other parts of the DBH system of care. Additionally, exploration of the benefits of Equine-Assisted Therapy (EAP) as utilized by the High Desert site will be reviewed.

Addressing Learning Goals

In addition to the primary purpose of increasing access to underserved groups, the Holistic Campus Innovation project included ten (**10**) learning goals. These were areas identified by stakeholders as being helpful in achieving the primary purpose as well as enhancing the overall learning from the project. This section explores what was discovered related to each learning goal. The Participant and Provider Surveys, mentioned earlier in this report, were the primary tools used to evaluate the learning goals.

Innovation Projects

1. 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.

The unique design of the Holistic Campus project required at least **80%** of the services to be operated by peers including community members and cultural brokers. The Holistic Campus also welcomed local providers who specialized in culturally diverse services and as a result, became the catalyst for improving clients' sustained well-being through a comprehensive and collaborative means. Staff were employed who could identify with the community served and may have had personal or family experiences with recovery from substance use disorders and mental illness. Staff also mirrored the diversity of the communities served.

The impact of diverse, peer operated services at the Holistic Campus sites appears to have been significant on the experience of participants. The Holistic Campus serving the West Valley region noted that Peer and Family Advocates (PFA) "shared their personal success stories with members to motivate them in seeking their own recovery," which "often produced a sense of belonging for the members within the community." While meeting with a PFA was not a requirement for receiving services, it was highly valued according to the Participant Survey results. At the East Valley campus, consumers participated in both traditional behavioral health services with a therapist and peer-to-peer support. These responses seem to emphasize the importance of relationship on engagement. This is a critical reminder to all health care services that building a strong relationship with potential consumers can make a significant difference in their engagement.

The Providers emphasized the value of peers in the operation of the Holistic Campuses, but also recognized the value of specialized training that behavioral health providers could provide. They recommended a partnership of peers along with behavioral health providers, each providing a skill set that would complement the other. The PFAs provide an important function of the Holistic Campus and partnership with mental health staff is ideal.

W.I.S.E Holistic Campus Reception Area

2. Understand and define what partnership means and what can be accomplished from a program perspective.

Through the collaboration with community partners, Holistic Campus sites were able to offer a variety of services while expanding their reach into other areas of the community. These partnerships were mutually beneficial, reciprocal relationships that helped to promote Holistic Campus services, while fostering a sense of community. Partnership in this project meant more than referring people to one another's services, but sharing physical resources to be able to enhance and promote each organization's work. This helped to minimize duplication of efforts, while also providing access to resources in the community's regular environment rather than forcing them to go somewhere new.

For example, the Holistic Campus in the West Valley region did not initially have a physical building and rented space from a local YMCA. The YMCA was able to contribute to the array of Holistic Campus services, by not only offering physical space, but also by providing an instructor for a Tai Chi class. The classes and activities provided by the Holistic Campus staff in turn, enhanced the services available to YMCA members. During this same period, staff developed a relationship with a local pastor in another area of the city. This church became like an extension campus in which the Holistic Campus staff were able to provide English as a Second Language (ESL) classes for a predominately Latino population. In turn, the pastor partnering with the Holistic Campus was able to assist in providing food to members of the Holistic Campus who were in need. In some instances, the Holistic Campus site was able to provide transportation for mentoring and high school completion programs. These mutually beneficial partnerships greatly expanded the ability of staff to provide services to underserved groups. At the West Valley site, **7.6%** of referrals for services came from other community agencies. Approximately **67%** of Holistic Campus ESL classes were provided at partner agency sites expanding the reach of the Holistic Campus, and providing an opportunity to inform the community about additional services on campus. Some of the ways the Holistic Campus sites partnered with other agencies is represented in the chart below, counting the number of agencies with which the Holistic Campuses partnered.

Activity	# of Organizations and Agencies Across Sites
Provided outreach and/or materials	77
Received referrals from the agency	71
Made referrals to the agency	67
Co-hosted an event	61
Provided training and/or presentation	59
Provided space	57
Co-managed cases	3
Other Collaborative Activity Written in by Respondent	34
TOTAL	**429**

3. How to respectfully use community resources.
The community partnerships formed through the Holistic Campus created many opportunities to share space and resources with existing organizations. During the implementation period, it was important for Holistic Campus providers to employ these resources in a respectful, collaborative manner.

Holistic Campus staff often made referrals to other community resources, such as housing programs that required an application process. For this type of referral, respecting the resource meant assisting the client in the application process and understanding the requirements, to reduce the impact on the partner agency providing the resource. The Holistic Campus staff did not request special treatment and were responsive when additional information was needed. Respectfully using community resources also required Holistic Campus staff to be flexible in partnering with other organizations and their scheduling needs rather than dictating the terms of the partnership. When partnering with faith-based organizations, it also meant being respectful of sacred space and using language and content that would be respectful of the beliefs of partner organizations.

Holistic staff were also encouraged to model respectful behavior towards one another and towards clients. Staff often coached clients to use community resources respectfully while providing a warm hand off. This coaching ensured that clients were not misusing or using community resources in excess, so that others in need would have the opportunity to access such resources.

4. What type of support and training is needed by peer cultural brokers as well as the small percentage of clinical staff?
Some of the providers reported that as the Holistic Campus project proceeded, they increasingly recognized the need for specialized training in order to meet the needs of people coming to their sites. This relates to their observations about the benefits and challenges of peer-run organizations. Peer-run work is highly valuable and specialized training was found to be useful. Training became an important component used to enhance all staff skills and better equip them to provide appropriate services to consumers. Continuous feedback from the Holistic Campus Advisory Board (HCAB), stakeholders, and analysis of client participation helped shape the direction of trainings for the respective campuses. Some of the needed trainings included:

- Cultural Competency.
- Trainings around mental illness/ mental health.
- Peer Family Advocate/peer to peer support.
- Gender Responsiveness.
- LGBTQ Ally training.
- Crisis Intervention.
- Post-Traumatic Stress Disorder and Post Traumatic growth.
- Motivational Interviewing.

5. What underrepresented cultures and ethnicities can learn from each other and how they work together.
Staff members shared cultural knowledge with each other to help build the others' cultural competency. Ongoing daily contact with each other provided ongoing opportunities for cultural learning. Staff members spent time regularly helping each other learn how to speak specific important points of information in each other's languages. They provided opportunities for comparing and contrasting important points regarding cultural events and practices. Perhaps more importantly, perhaps most importantly, they learned how to work effectively together despite cultural differences.

One of the consistent themes regarding learning from others from other underrepresented groups was that people learned that those that were culturally different were really more like each other than originally thought. As one individual put it, "I learned that people who looked very different, people I had been afraid of, were the same as me. We liked the same things and want the same things in our lives." One Community Advocate shared that people's efforts to connect with others were recognized and rewarded.

Artwork by STRIVE Holistic Campus

Outreach Events designed to encourage cultural learning included, Latino Health Fair, Powwow, Native American Heritage Celebration, The Mix and 12 Step Community Dance, Veterans Resource Fair are just a few examples of the learning environments that were created by the Holistic Campus project. These Outreach events usually had a focused theme that was connected to an ethnic or relational culture. Going to one of these events meant exposure to learning about other cultures. The Resiliency, Wellness, and Recovery (RWR) approach promoted a collaborative relationship with clients, along with their families and their other support systems, to encourage continuous involvement in clients' own efforts to increase their quality of life. Therefore, the Holistic Campus depended on relationships to make connections with all unserved, underserved and underrepresented cultural groups.

The different cultural groups attending the Holistic Campus observed the collaboration among the culturally diverse staff that was providing the services. Each participant felt represented at the campus, which cultivated a family-like atmosphere. Staff role-modeled for clients how to work together, support each other and to celebrate cultural, ethnic and religious differences. Participants realized that they can learn more while having support from other ethnic and religious groups. These learnings emphasize the importance of relationship, as noted from learning goal 1, as well. The power of relationship impacts individuals' daily interactions in their communities, as well as with health care providers. Feeling a welcoming, warm, safe connection enhances people's engagement in care.

6. 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.

The Holistic Campus offered participants the opportunity to learn about a multitude of different services and work on different life dimensions all in one location. Often times, participants would attend the Holistic Campus for a specific class or service, and would learn of other services which could enhance other areas of their lives. The Holistic Campus was a one-stop, centralized location that treated clients as a whole person. The ways in which wellness and recreational activities were provided in one centralized location was extremely beneficial, especially when serving families. It was commonplace for each individual family member to disperse to their respective groups while getting each of their individual needs met. This became extremely convenient for parents because they were not required to drive to multiple locations to get the wellness and recreational activities that they needed for themselves and their children.

The benefits of joining multiple participant, stakeholder, and cultural groups into one centralized setting were also beneficial, due to the sharing of resources in one location. Because the Holistic Campus was seen as a safe place for clients of diverse cultural backgrounds, clients were comfortable in talking about the things that they either liked or did not like about their cultural group. These conversations enabled clients to learn about others' cultures, and increasing greater cultural awareness. Participants made connections with staff/peers and with other participants. Clients also learned about various resources from others. When clients had the opportunity to get to know each other in supportive groups settings, the benefits of social connection and fellowship were apparent. Clients' decreased reluctance of reaching out to others was supported by the social modeling of staff/peers who exhibited help-seeking and prosocial behavior in wellness groups. It was common to have participants exchange contact information and resources at the Holistic Campus. Joining multiple participant, stakeholder, and cultural groups into one community-driven setting helped to establish an informal peer support network focusing on empowerment.

Inspire Holistic Campus Mural

Inspire Holistic Campus Signage

7. 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.
Partnerships were often initiated as a result of the collaboration that took place between the members of Holistic Campus Advisory Board (HCAB). By bringing diverse community members and cultural brokers together in one advisory group, members who represented local community organizations met together to discuss the ways in which the Holistic Campus could address the needs of the community.

The funding and programmatic structure of some mental health programs requires that individuals meet certain eligibility requirements and often these programs serve a group of people with similar needs through prescribed interventions. The flexibility of the Holistic Campus project to determine the needs of individuals and add services and/or interventions accordingly that may be unique to that site or community was a helpful approach to reaching underserved groups. Wellness classes and other non-traditional services increased the overall wellness of participants who were socially isolated and disconnected from their community, by creating a space for connection. In some cases, offering these wellness services (such as zumba classes) may also have been instrumental in increasing access to these participants who were not necessarily seeking traditional mental health services. This suggests that the Holistic Campus project provided some needed community services, but not therapeutic services within the scope of DBH.

Reducing stigma is a core interest of DBH and behavioral health nationwide, and promising practices as identified in this report will continue to be applied in the DBH system of care.

8. 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.
The Holistic Campus fostered an all-inclusive, diverse environment that welcomed all. Most of groups and workshops were designed by peers with the guidance of the Clinical Supervisor or Program Managers. There were services designed for LGBTQ and veterans specifically. Rather than separating based on group membership, culturally relevant services were integrated in every service that was offered, where staff were diligent about adapting services for each client's individual needs while taking into consideration their culture. Discussions concerning diverse inclusion was constant throughout the life of the project. Cultural conversations were embedded in every service that was provided. Clients were able to freely express their frustrations and/or positive things about their cultural background, increasing cultural awareness among Holistic Campus clients. Holistic Campus services were provided by peers who identified in a diverse number of ethnic and cultural groups. Some examples include: African-American, Latina, Arab-American, Caucasian, Asian/Pacific Islander, Veteran, and LGBTQ. HCAB members were also diverse and represented many cultural and ethnic groups, including: African-American, Latino, Native-American, LGBTQ and Veteran, and Asian/Pacific Islander. This diverse group of individuals informed and shaped how services were implemented.

9. 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.
The Holistic Campus was designed to create a comfortable, welcoming environment with culturally directed services and activities to increase access to underserved groups. This intention shaped the array of available services, the inclusion of cultural brokers and HCAB in ongoing decision making and changes, the location of the campus in the community, the décor and artwork in the buildings, the hours services were provided, and the staff utilized to provide services.

Of all of the aspects of the Holistic Campus, the staffing may have been the most significant strategy in creating a comfortable environment that helped to increase access to underserved groups. Peers often share lived experience with community members and may be understanding and emphatic to the struggles of Holistic Campus participants. The use of peers in the staffing may have encouraged some community members to utilize services to a greater degree than if services were exclusively provided by licensed professionals in a clinical setting.

Additionally, ongoing feedback loops were established between Holistic Campus participants and staff to ensure they were comfortable with receiving services. This feedback was typically provided when participants expressed their concerns about the traditional ways in which scheduling of wellness and therapeutic groups took place.

Overwhelmingly, feedback from clients has mentioned that Holistic Campus was a comfortable, flexible setting where receiving services was safe and targeted toward individual wellness. However, as identified earlier in the report, those accessing therapeutic services at the Holistic Campus locations were not in greater numbers than current penetration rate. Enhancement of access based on environment could be applied to clinic locations in effort to make them feel more welcoming.

10. Determine if this setting reduces stigma associated with behavioral health
Holistic Campus providers indicated that the services provided were effective in reducing the stigma attached to seeking behavioral health services. For example, some community advocates reported that they felt that the Holistic Campus provided behavioral health services that were perceived as less threatening. Quantitative data collected at the East Valley site indicated that Peer to Peer Support and Therapeutic Services in the context of a community center was effective in increasing willingness to seek help with regard to mental health issues. Data analyzed does not provide evidence that Wellness activities distinct from Peer to Peer Support was effective in decreasing stigma attached to mental health issues. Based on this information, peer support may have been key in reducing stigma for traditionally underserved groups.

These findings continue to reinforce the learning from earlier goals of the importance of building a strong relationship and the power of peers to do so. This can be important learning that could be applied to other areas of the behavioral health system of care.

Activities and Elements Contributing to Successful Outcomes

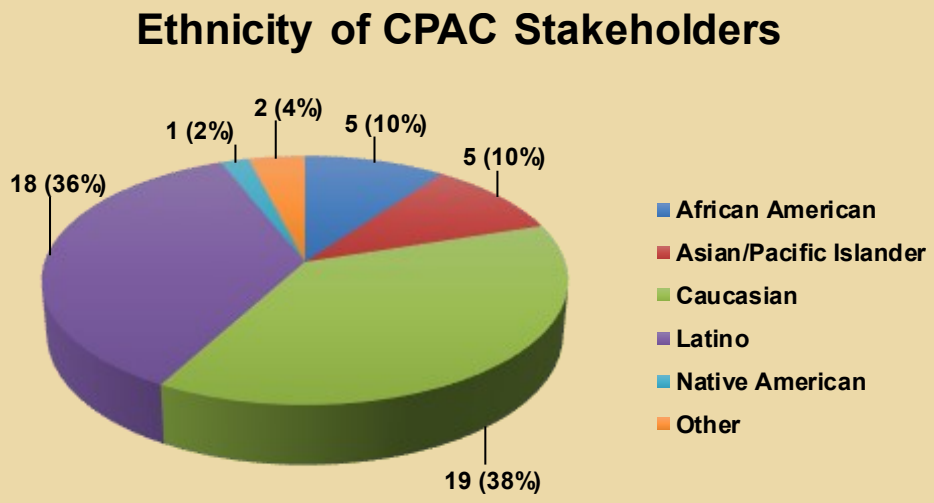
Of all of the engagement strategies and wellness activities aimed at increasing access to services for underserved groups, we did see a trend of people being drawn to services that involved one on one personal time with a peer advocate. At the East Valley site, their peer to peer counseling drew **321** participants, **62 (19%)** of which went on to access individual therapy through the Holistic Campus. In the West Valley, 480 people accessed case management services from a peer and family advocate. **90 (19%)** of these went on to access individual therapy at the Holistic Campus. In the High Desert region the one on one services were somewhat different in that their peer to peer activity was in the form of an orientation for their Equine Assisted Program (EAP), which **159** people accessed and **93 (58%)** of those went on to participate in the EAP therapy.

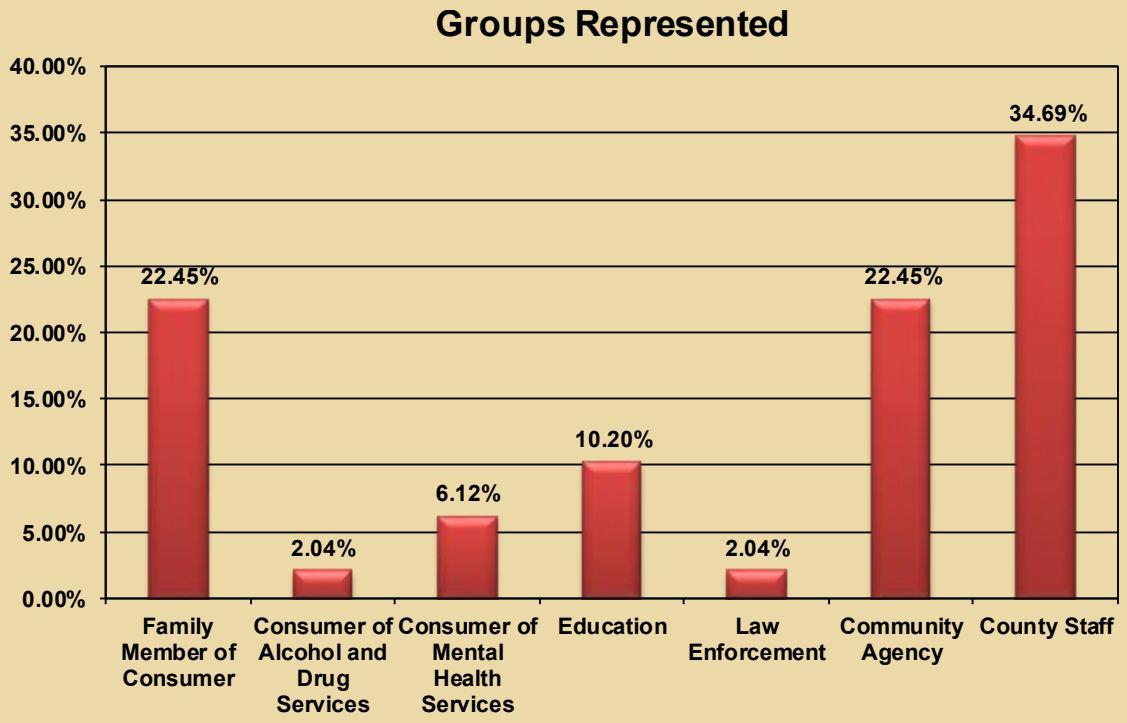
Peer support is defined as “social emotional support, frequently coupled with instrumental support that is mutually offered or provided by persons having a mental health condition to others sharing a similar mental health condition to bring about a desired social or personal change” (Solomon, 2004). Some people who have a mistrust for the mental health system due to dissatisfaction due to prior experiences, may prefer the peer support approach, as opposed to the traditional psychotherapy and/or psychiatric interventions.

Artwork by STRIVE Holistic Campus

Stakeholder Contribution

In February of 2015, a local stakeholder meeting was held at the monthly Community Policy Advisory Committee (CPAC) where the Holistic Campus preliminary outcomes were presented. Several underserved populations and diverse ethnic groups were represented at this meeting, as well a variety of stakeholder groups. Stakeholders had opportunities to provide feedback regarding the preliminary outcomes presented.



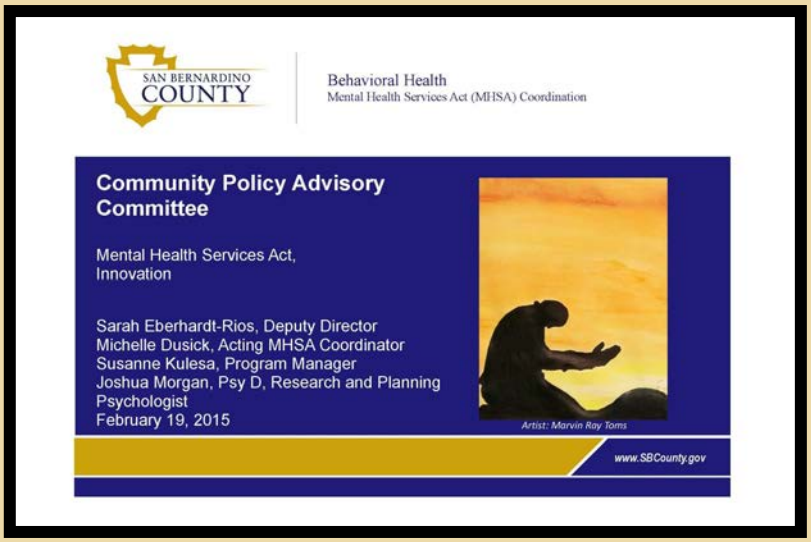


Holistic Campus Conclusions

The Holistic Campus was one of DBH's first contracted innovation projects to end. Managing discussions of whether to continue the Holistic Campuses as they were designed under innovation influenced additional learning. Historically, funding sources for services provided long-term sustainable funding. However, Innovation funding is, by definition and regulation, short-term in order to test new strategies and learn from them. Substantial time was spent in both internal and external stakeholder meetings discussing the central purpose of Innovation being learning. Innovation projects always have a planned end date with learning applied to other parts of the system. In some cases, portions or all of the programming may be continued in other parts of the system of care based on learning. A central learning from this process is the importance of very clearly setting these expectations for consumers, community partners, and staff that innovation projects are short-term projects.

From the Innovation framework of learning, the Holistic Campus was highly successful. The Providers engaged in many novel activities and strategies to engage the community and improve access to behavioral health care to underserved groups. There were some parts of these strategies that were partially effective at improving access.

In considering whether to continue the Holistic Campuses as stand-alone programs, the learnings from all the Providers provided valuable insights:
To increase access to more traditionally based behavioral health services, it seems that the provider/ agency/implementer must also have easy access to programs and services that span the entire continuum of care. For example, a provider who offers additional services/programs beyond those offered at the Holistic Campus can easily transition a client to a higher level of care within its own network. This same principle can also hold true for a provider who may have a well-established and built network of formal and informal supports outside of their agency, such as business agreements that allow for referral and payment, memoranda of understanding (MOUs) with or without funding, etc.



February 2015 Community Policy Advisory Committee Meeting: Holistic Campus Outcomes

Culturally-specific outreach strategies are successful to engage underserved/inappropriately served populations and bring them to a welcoming, non-clinical setting/service site. The most likely services people will engage in these contexts appear to be prevention and wellness activities. When it comes to increasing access to prevention/early intervention services for these populations, incorporating culturally-specific outreach strategies will likely increase the probability that these target populations will be served. Family Resource Centers (FRC) function in a very similar way to the Holistic Campus model, providing life skills education, parenting, employment support, wellness and recovery groups, and early intervention services.

Another learning to consider is how cultural groups may define and access services. One Holistic Campus site offered peer counseling services in addition to their wellness and outreach activities. The use of peers from specific cultural groups was found to be useful. This strategy will be included as a required service offered as part of the PEI Promotores de Salud program in future implementation efforts.

Discussion of these learnings and potential applications was discussed on an ongoing basis through DBH's Community Program Planning process, and the decision was made to not continue the Holistic Campuses, but rather apply their learnings to other areas of the existing system. DBH worked with the Providers to ensure services were not abruptly stopped, but rather tapered down, with participants referred to appropriate services, as necessary. The community was made aware of the "ramping down" of the services before the end of the contract and DBH worked with the providers to successfully conclude this innovation project.

W.I.S.E Holistic Campus Reception Area

Materials Developed to Communicate Lessons Learned and Project Results

Throughout the project period, documents have been created to provide updates for the stakeholders of San Bernardino County and other entities regarding the Holistic Campus project. Examples of these documents include the Mental Health Services Act (MHSA) Annual Update Reports, MHSA Three-Year Integrated Plan, MHSA Innovation Plan, and Power Point presentations provided at various stakeholder meetings. Two (2) examples include a presentations conducted by Innovation staff at the Community Policy Advisory Committee (CPAC) for San Bernardino County stakeholders in May 2014 and February 2015.

Links to some of the documents containing updates regarding the Holistic Campus Project are provided below:

MHSA Innovation Plan 2010
http://www.sbcounty.gov/dbh/Announcments/2010/Innovation_Plan_Final_2-8-10.pdf

MHSA Annual Update FY 2010-11
http://www.sbcounty.gov/dbh/mhsa/CSS/MHSA_Three_Year_Plan/9_CSS_FY_10-11_Plan_Update_Resubmission_II_6.11.10.pdf

MHSA Annual Update FY 2011-2012
http://www.sbcounty.gov/dbh/mhsa/CSS/MHSA_Three_Year_Plan/10_CSS_FY_11-12_Plan_Update_4.11.11.pdf

MHSA Annual Update FY 2012-2013
http://www.sbcounty.gov/dbh/mhsa/CSS/MHSA_Three_Year_Plan/11_CSS_FY_12-13_Plan_Update_6.21.12.pdf

MHSA Annual Update FY 2013-2014
http://www.sbcounty.gov/dbh/mhsa/MHSA_Annual_Update_FY_2013-14_06072013_FINAL.pdf

MHSA Innovation Plan 2014
http://www.sbcounty.gov/dbh/mhsa/Innovation_Plan/2014/index.html

MHSA Integrated Three-Year Plan FY 2014/2015 – 2016/2017
http://www.sbcounty.gov/dbh/Announcments/2014/MHSA_Integrated_Plan_070114.pdf

MHSA Annual Update FY 2015-16
http://www.sbcounty.gov/dbh/mhsa/2015/MHSA_Annual_Update_FY15-16_BoS_Approved-071515.pdf

Please see the **ATTACHMENT** section of this report for the following Holistic Campus related attachments:
Attachment G(1)– Holistic Campus Logic Model
Attachment G(2)– Strive Brochure
Attachment G(3)– Wise Brochure
Attachment G(4)– Inspire Brochure
Attachment G(5)– Community Policy Advisory Committee (CPAC) presentation May 2014
Attachment G(6)– Community Policy Advisory Committee (CPAC) presentation February 2015

Interagency Youth Resiliency Team (INN - 05) Final Report

The Interagency Youth Resiliency Team (IYRT) is an innovation project created by San Bernardino County with a focus to pair system involved youth with supportive adults/mentors that help them develop life skills intended to increase their ability to successfully transition into adulthood. This project aimed to reach out to youth across multiple systems of care, including foster care, the probation system, and youth at risk of becoming victims of their environment. Once in the project, youth were matched with mentors who taught them life skills for coping with grief, trauma, violence, and loss. The services of the IYRT are a product of ongoing, diverse, culturally and linguistically competent community stakeholder meetings.

The (IYRT) project was submitted as part of San Bernardino County's Innovation Plan for Fiscal Year 2010-11. The Mental Health Services Oversight and Accountability Commission (MHSOAC) approved the project on June 24, 2010.

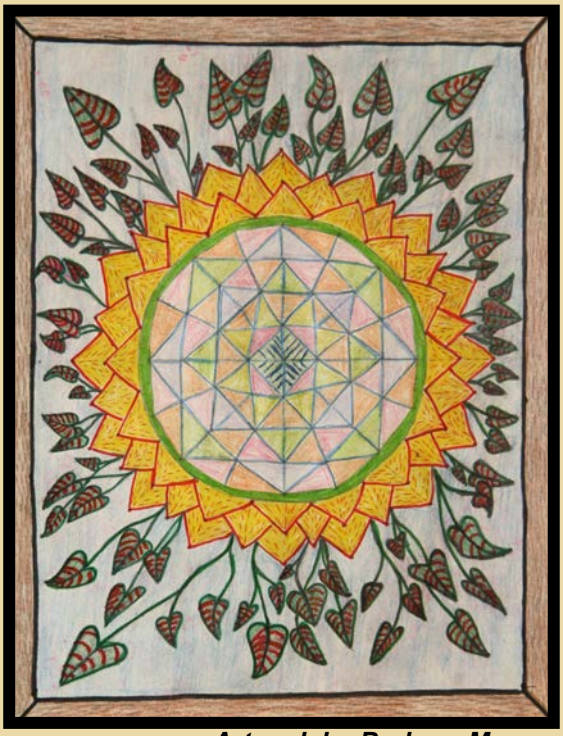
Project Description

The Interagency Youth Resiliency Team (IYRT) is an innovation project created by San Bernardino County with a focus to pair system involved youth with supportive adults/mentors that help them develop life skills intended to increase their ability to successfully transition into adulthood. This project aimed to reach out to youth across multiple systems of care, including foster care, the probation system, and youth at risk of becoming victims of their environment. Once in the project, youth were matched with mentors who taught them life skills for coping with grief, trauma, violence, and loss. The services of the IYRT are a product of ongoing, diverse, culturally and linguistically competent community stakeholder meetings.

The (IYRT) project was submitted as part of San Bernardino County's Innovation Plan for Fiscal Year 2010-11. The Mental Health Services Oversight and Accountability Commission (MHSOAC) approved the project on June 24, 2010. The project addresses:

- Unresolved grief and loss issues,
- Effects of environmental trauma, and
- Unresolved issues stemming from exposure to violence and gangs.

The target population for this project was all County of San Bernardino dependents and wards of the court in out-of-home placement that were not likely to return to their biological families, as well as, youth who were wards of the court being supervised by the Probation Department.



Artwork by Barbara Mason

The innovative design and approach for the IYRT project was developed to answer the following questions:

- What happens with youth and their resource providers/caregivers when they have received mentoring from diverse peer counselors vs. youth and their resource providers/caregivers that have not received mentoring?
- What strategies are most effective for a team mentoring youth and their resource/providers who are dealing with grief, trauma, and loss?
- In what way will a mentoring project such as IYRT make a difference in the community? Will it improve the youth's transition into adulthood?

To address these concerns the project introduced a new mental health approach to San Bernardino County. The IYRT project sought to reach out to adults that have previously been involved in the foster care or probation system ("aged out youth), to involve them in the planning, implementation, and evaluation of services provided to youth and their resource providers/caregivers within the target population. The idea behind seeking involvement from "aged out youth" was to include individuals with "lived experience" in the "system" who would provide invaluable expertise in an area most professionals cannot. The IYRT project was designed to bring together the knowledge, expertise, and experiences of diverse professionals from the mental health system, the child welfare system, the Probation Department, the courts, foster youth agencies, resource providers and former dependent and wards. The goal of the project is to provide skills for youth to develop permanency readiness, sustain positive relations, and resolve grief, loss, and trauma; so that they may live successful and productive lives when they age-out of the foster care system. The IYRT project consisted of five (**5**) innovative components:

- Development of an innovative train-the-trainer protocol and peer counseling model for peer counselors that provide information, tools and resources that can be used to address the issues of grief, loss, environmental trauma, and exposure to violence and gangs.
- Identification and recruitment of diverse peer counselors to act as mentors for youth and their caregivers who are served by this project.
- Establishment of the Interagency Youth Resiliency Team (IYRT) that would serve collaboratively across department lines.
- Delivery of the training to the (IYR) team and other professional staff working with the target population.
- Implementation of the train-the-trainer protocol by culturally and linguistically diverse peer counselors in their interactions and work with youth and their caregivers.

Changes Made to the Innovation Project During Implementation

One of the changes made to the IYRT project allowed each of the 3 providers implementing the project to design their own curricula and shape their process around how mentoring services were delivered. Although this was a change to the original Innovation plan, it does have some overlap with one of the learning goals, which is to learn if the provision of mentorship, and/or what types of mentorship help these youth address their unresolved issues. By each provider administering a unique combination of curricula and mentoring process, we were able to compare results to learn if some types of mentorship had more success than others.

On December 1, 2013, the County awarded a contract to EVALCORP, research consultant, to develop an evaluation framework for all existing Innovative projects for the purpose of measuring and demonstrating project effectiveness through uniform data collection and continued evaluation. The contract period was through November 30, 2014 for a total of $97,772. This change was made to address the data collection variations, varied level of evaluation capacity amongst providers, and to inform future Innovative project design.

"I enjoyed being part of Reach Out's mentoring program because it helped me to learn that I am not alone. I was surrounded by kids who had similar experiences. It also exposed me to great resources that I can use. My favorite part was going to camp because we did team building and it helped me build character."

–Youth Mentee

Final Evaluation results including the Evaluation Methodology

The primary goal for the Interagency Youth Resiliency Team (IYRT) innovation project was to make changes and enhance an existing mental health approach that would increase access to services for underserved groups. The following key learning goals were identified for this project in the description of the work plan submitted for the project approval.

- To increase the understanding of the impact of grief and loss, exposure to violence and environmental trauma in diverse youth.
- To learn if the innovative application of a model that addresses the issues of grief, loss, trauma and exposure to violence in a culturally inclusive manner allows us to identify and address behaviors that manifest themselves in diverse youth at an earlier point in the youth's exposure to the "system".
- To learn if the reality of being part of the dependency/ward "system" is a contributing factor and/or exacerbates youth's issues of grief, loss and trauma.
- To learn if a team that includes three major county departments (Department of Behavioral Health (DBH), Children Family Services (CFS), and Probation), and countless youth serving programs succeeds in addressing the issues of grief, loss, exposure to violence and environmental trauma experienced by these children.
- To learn if the provision of mentorship, and/or what types of mentorship help these youth address their unresolved issues.
- To learn if the identification of a model for collaboration to address grief and loss issues, exposure to violence, and environmental trauma help build connections for diverse youth served by the project.
- To learn if the application of techniques addressing grief and loss, exposure to violence, and trauma help the youth build positive relationships with resource providers and peer counselors.
- To develop methods and skill sets necessary for resource providers and for identified youth to address unresolved grief and loss as well as environmental trauma in a culturally inclusive manner.
- To learn if Peer Counselors and other professional staff who receive the training can engage youth as well as their resource providers to use the skills and information obtained from the training.
- To learn if the above model for collaboration, methods and skills for intervention and strategies for interaction with youth effectively addresses the impacts of grief, loss, trauma on youth outcomes.

The IYRT Work Plan (June 4, 2010) indicates that the measurable success of the project would be reflected by: the effectiveness of the training sessions, whether the training sessions provided the necessary skills for the mentor to successfully interact with the youth and resource provider/caregiver, and whether the tools and skills taught helped the youth develop better relationships with the peer counselors and the resource providers and aided the youth with transitioning successfully into adulthood.

"My mentor has supported me when I was on track, and hasn't judged the mistakes I have made, but gave me the tools I needed to get back where I needed to be."

–Youth Mentee

For this project DBH contracted with three providers: EMQ FamiliesFirst, Reach Out, and Valley Star. Each provider created their own curricula and process for delivering services for IYRT. Initially the department was going to design and provide the curriculum to the providers. However, the decision was made to have each provider design their own curriculum created to meet the specific needs of their respective regions. They were allowed to use their own curriculum providing it met the goals of the general program. Collectively, the IYRT project utilized various evaluation tools to collect data and to complete the evaluation of the project. The following tools were used by all three (**3**) contracted agencies:

- Child and Adolescent Needs and Strengths (CANS-SB) tool were administered when the youth entered into the project and again at discharge from the project.

- EVALCORP Surveys & Excel Spreadsheets – were used by the contracted agencies to capture information such as demographics of the youth, mentors, and caregivers. This information was utilized to ensure the targeted population identified in the original work plan was served.

In December 2013, DBH contracted the services of an independent Evaluator, EVALCORP, to help with the process of developing participant surveys and evaluating the project outcomes. Collaboratively, DBH and EVALCORP developed the Interagency Youth Resiliency Team logic model (see appendix) as a guide and illustration of how the project goals and objectives connect to the strategies and the outcome measurements of the project. As well as, to ensure the project measured outcomes according to the goals identified in the IYRT Work Plan. The learning goals of the project address three (3) separate evaluation domains :

1. Increase Access to Underserved Groups

    a. To increase the understanding of the impact of grief and loss, exposure to violence and environmental trauma in diverse youth.
    b. To learn if the innovative application of a model that addresses the issues of grief, loss, trauma and exposure to violence in a culturally inclusive manner allows us to identify and address behaviors that manifest themselves in diverse youth at an earlier point in the youth's exposure to the "system".
    c. To develop methods and skill sets necessary for resource providers and for identified youth to address unresolved grief and loss as well as environmental trauma in a culturally inclusive manner.

2. Improve Service Effectiveness by Increasing Quality of Services, Including Better Outcomes

    a. To learn if the reality of being part of the dependency/ward "system" is a contributing factor and/or exacerbates youth's issues of grief, loss and trauma.
    b. To learn if the provision of mentorship, and/or what types of mentorship help these youth address their unresolved issues.
    c. To learn if the application of techniques addressing grief and loss, exposure to violence, and trauma help the youth build positive relationships with resource providers and peer counselors.
    d. To learn if Peer Counselors and other professional staff who receive the training can engage youth as well as their resource providers to use the skills and information obtained from the training.

3. Provide Linkages & Promote Interagency Collaboration

a. To learn if a team that includes three major county departments (Department of Behavioral Health (DBH), Children Family Services (CFS), and Probation), and countless youth serving programs succeeds in addressing the issues of grief, loss, exposure to violence and environmental trauma experienced by these children.
b. To learn if the identification of a model for collaboration to address grief and loss issues, exposure to violence, and environmental trauma help build connections for diverse youth served by the project.
c. To learn if the above model for collaboration, methods and skills for intervention and strategies for interaction with youth effectively addresses the impacts of grief, loss, trauma on youth outcomes.

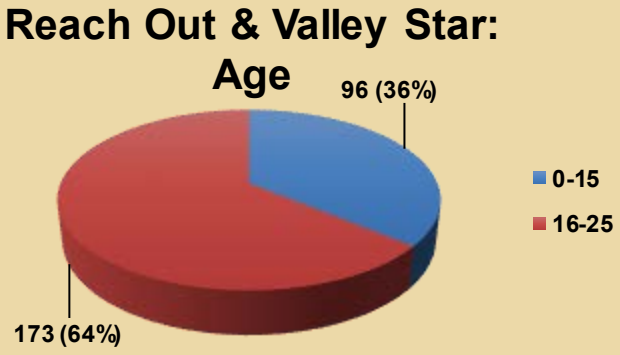
Program Information Collected during the Reporting Period

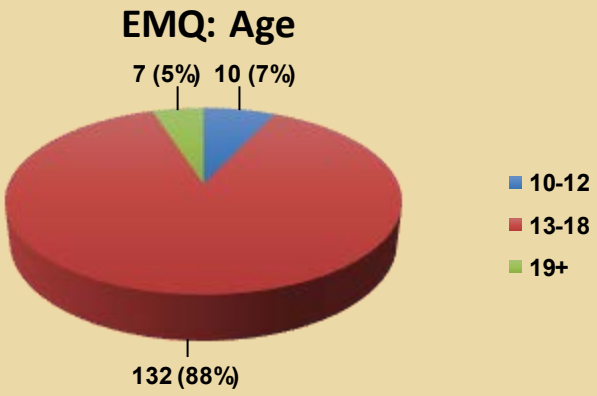
The current Innovation Project regulations were issued July 2015 and require the Final Innovative Project Report to include demographic information regarding individuals served during the reporting period as specified in Section 3580.010, subdivision (a)(4).

While demographic information on the individuals served through the Interagency Youth Resiliency Team (IYRT) project was collected, the available data differs from some of the requirements of the new Innovation Projection regulations.

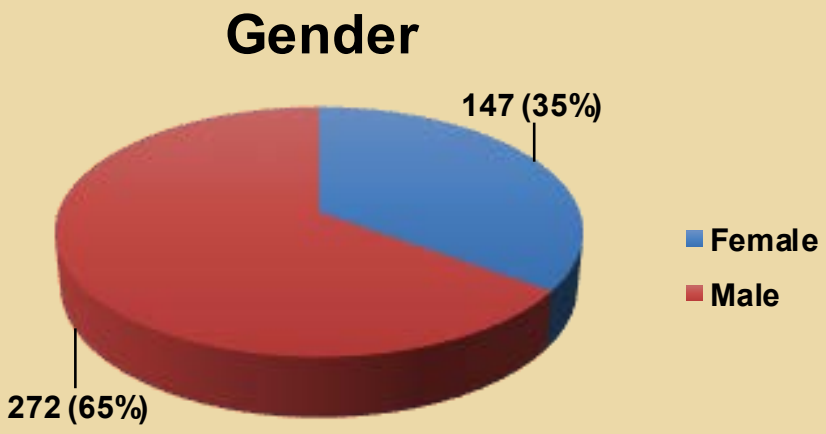
The available program information collected during the implementation period is provided in this Final Report.

The following charts illustrate the collective demographic information for participants served by the three **(3)** providers throughout the duration of the project. The majority of youth served were within Transition Age Youth age range, 16-25.

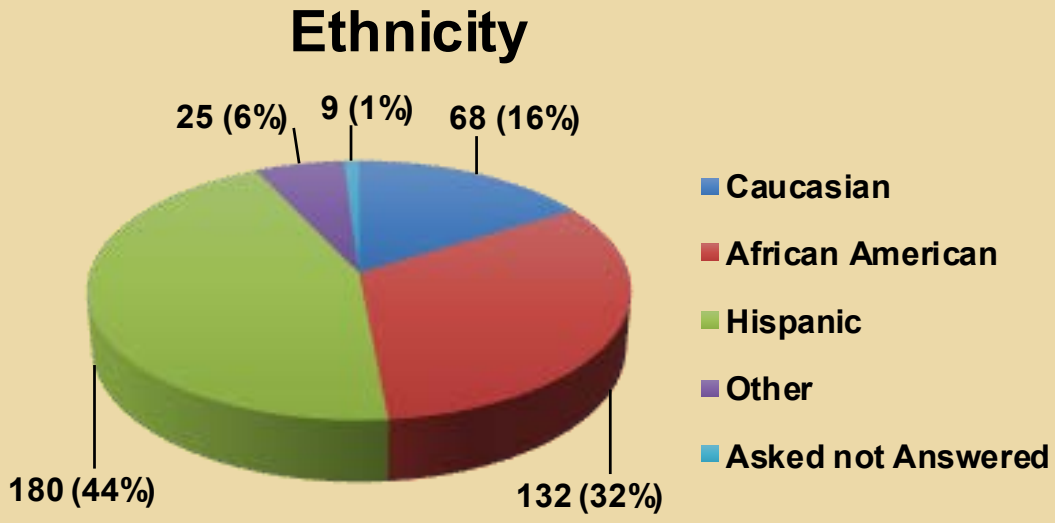




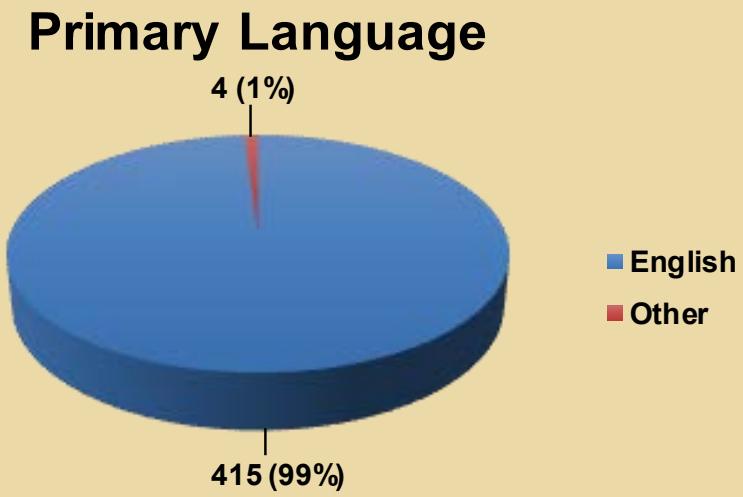
The chart below indicates that the majority of youth served identified as male **(65%)** and female made up **35%**.

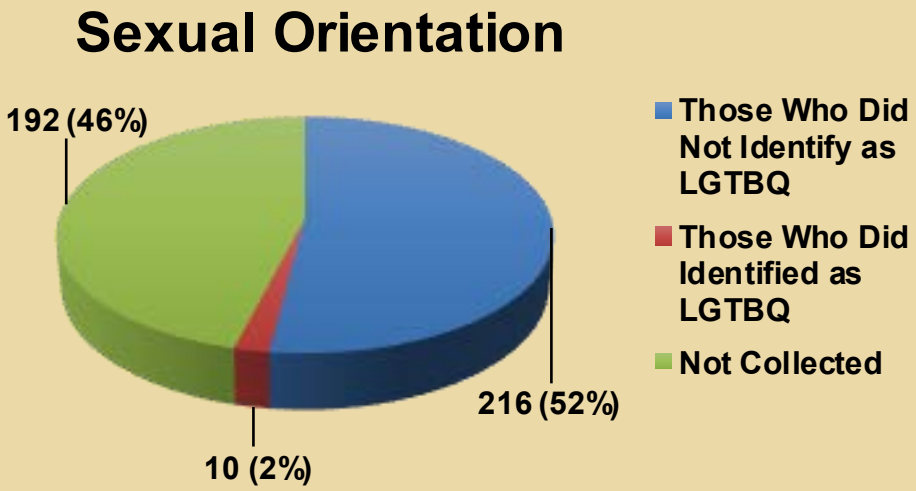


In the chart below, this demographic chart is an indication that the project has reached and provided services to its targeted underserved and underrepresented demographic population.



In the chart below, the vast majority of youth served reported English as their preferred language. Sexual orientation was not consistently collected until approximately midway through the project, accounting for such high numbers in the 'Unknown' category. Ten **(10)** of the youth identified as LGBTQ. Demographic data regarding participants military and veteran's status was not collected.





Access to Services

One of the primary goals of the IYRT project was to increase access to underserved groups. To accomplish this, the project focused on increasing the understanding of the impact of grief and loss, exposure to violence, and environmental trauma in diverse youth, and addressing the question as to whether an innovation project that focused on grief, loss, trauma, and exposure to violence would allow for earlier identification of behavioral and emotional problems in youth in the system. Each service provider created their own unique trainings, workshops, and meetings based on their ability to address the learning goals. Some of the trainings included:

- **3-5-7 Model Training**
  The 3-5-7 Model is a strengths-based approach that supports the process of children, youth, and families grieving their losses and rebuilding their relationships towards the goals of well-being, safety, and permanency.
- **Transition to Independence Process (TIP) Model**
  The TIP Model is an evidence-supported practice based on published studies that demonstrate improvements in real-life outcomes for youth and young adults with emotional/behavioral difficulties.
- **Attachment, Self-Regulation, and Competency (ARC)**
  ARC is a framework for intervention with youth and families who have experienced multiple and/or prolonged traumatic stress.
- **Caring for Children Who Have Experienced Trauma**
  Caring for Children Who Have Experienced Trauma is a training curriculum focused on traumatic stress in foster children and parents, and is designed to be taught by a mental health professional with foster parents as co-facilitators.
- **Mentoring Training**
  Provided mentors understanding of the program and mentor roles and expectations, explored the benefits of being a mentor.

Throughout the five (**5**) year term of the IYRT project, the three (**3**) providers collectively conducted over **60** trainings with more than **1,171** attendees receiving training regarding the impact of grief, loss, and trauma, and how to address these issues. With these culturally and linguistically competent trainings, the IYRT mentors, mentees, caregivers and professionals gained an understanding of what trauma is and the effect trauma can have on an individual's life. Specifically, they addressed what trauma looks like in youth behaviors, how trauma affects development, and how to address personal trauma.

In addition to the educational outreach workshops and trainings provided, youth and caregivers were able to participate in one-on-one mentoring, group mentoring and were provided with phone support.

The degree to which the workshops, trainings, and one-on-one meetings met the project goal of increasing access to underserved groups was measured by EVALCORP developed surveys – the IYRT Youth Participant Survey, Caregiver Participant Survey, and Provider Survey.

> ***"The training was amazing. I feel like you guys are changing my life. I know this program is for the youth in the program, but I feel like you guys are also challenging us to grow and become better too."***
>
> ***– Youth Mentee***

Innovation Projects

The table below provides demographics of participants who completed the EVALCORP survey during survey period FY 2013/2014.

EVALCORP Participant Question	% Youth Who Accessed Service N=73	% Caregivers Who Accessed Service N=57
Gender	**N=72**	**N=54**
Female	46%	80%
Male	54%	19%
Other	0%	1%
Age	**N=73**	**N=54**
11-15 years old	41%	0%
16-25 years old	58%	2%
26-59 years old	1%	85%
60 years old and older	0%	13%
Race/Ethnicity	**N=72**	**N=57**
Asian or Pacific Islander	1%	0%
African American	26%	30%
Latino	32%	40%
Native American	3%	0%
Caucasian	24%	21%
Other	14%	9%
How actively do you participate in this project?	**N=72**	**N=57**
A lot	67%	49%
Some	26%	37%
A little	7%	7%
Rarely	0%	7%
How long have you been participating in this project?	**N=73**	**N=55**
Less than a month	1%	2%
1-3 months	6%	5%
4-6 months	18%	13%
7-9 months	23%	2%
10-12 months	13%	11%
Over a year	39%	67%
I have used mental health services.	**N=59**	**N=50**
Yes	56%	50%
No	44%	50%

This table indicates that during the survey period the project was reaching its underserved target populations, with **32%** for youth and **40%** for caregivers identifying as Hispanic**, 26%** for youth, and **30%** for caregivers as Black or African American. **56%** of youth and **50%** of caregivers reported having gained access to and used mental health services.

The table below indicates youth were accessing the services provided by the IYRT providers during the survey period. Out of the **73** youth that were surveyed, youth were most likely to access the One-on-One meetings, with **86%** of the population accessing the mentoring sessions. They also attended group mentoring sessions at a high rate, with **71%** accessing these services. They were less likely to access the linkage services and the education and training services.

Caregivers were, for the most part, utilizing all five services equally. The services with the highest percentage of participation by caregivers was group mentoring at **58%** use by participants. Education and training was the second most accessed service by caregivers with **54%** participation.

IYRT Services received by Youth and Caregivers

Services Clients Participated In	% Who Selected Service	
	% of Youth Who accessed Service N=73	% of Caregivers Who accessed Service N=57
One-on-One Meeting	86%	47%
Phone Support	NA	42%
Group Mentoring	71%	58%
Education/training	49%	54%
Linkage to Other Services	19%	47%
Monthly Newsletter	NA	28%
Email Support	NA	16%

Evaluation Domains, Learning Goals and Outcomes

Presented here is a summary of the findings for each learning goal that within the framework of our 3 evaluation domains.

Evaluation Domain 1: Increasing Access to Underserved Groups

Learning Goal 1A: To increase the understanding of the impact of grief and loss, exposure to violence and environmental trauma in diverse youth.

Has understanding of the impact of grief and loss, exposure to violence and environmental trauma in diverse youth increased?

Over **50+** training sessions were offered with over **1,000** attendees, and pre/post surveys were administered. The results of the surveys indicate that over **80%** of the participants reported that their knowledge of the impact of grief, loss and trauma on developing relationships, maintaining relationships, and child/youth self-identification increased after attending the training.

Learning Goal 1B: To learn if the innovative application of a model that addresses the Issues of grief, loss, trauma and exposure to violence in a culturally inclusive manner allows us to identify and address behaviors that manifest themselves in diverse youth at an earlier point in the youth's exposure to the "system."

Did the innovative application of a model that addresses the issues of grief, loss, trauma and exposure to violence in a culturally inclusive manner allow us to identify and address behaviors that manifest themselves in diverse youth at an earlier point in the youth's exposure to the system?

Literature shows that youth who have a history of multiple level system involvement go on to experience issues of incomplete educational achievement, joblessness, increased drug use, isolation and lack of supportive connections throughout their adult life. The results below, which are a combination of the Participant Survey and CANS-SB show that as a result of the IYRT project:

- **26%** of youth struggling with education achievement saw an improvement over the duration of the project.
- **97%** of youth reported planning to get a college education.
- **86%** of youth reported that they try harder in school.
- **39%** of youth struggling with vocational challenges saw an improvement over the duration of the project.
- **90%** of youth reported planning to get or currently having a job.
- **33%** of youth struggling with issues of substance use saw an improvement over the duration of the project.
- **30%** of the youth struggling with relationship permanence saw an improvement over the duration of the project.
- **47%** of the youth struggling with community life saw an improvement over the duration of the project.
- **94%** of youth reported having more relationships with adults that are positive.
- **83%** of youth reported getting along better with family.
- **50%** of the youth struggling with well-being saw an improvement over the duration of the project.

Learning Goal 1C: To develop methods and skill sets necessary for resource providers and for identified youth to address unresolved grief and loss as well as environmental trauma in a culturally inclusive manner.

Did the project develop methods and skill sets necessary for resource providers and for identified youth to address unresolved grief and loss as well as environmental trauma in a culturally inclusive manner?

Mentee reports, "It helped me control my anger. Everyone has shown me the right path to go down."

Mentee is currently enrolled in college to become a nurse.

– Youth Mentee

To assess whether youth and caregivers obtained the knowledge and skills needed to address their own issues, youth and caregivers were provided with a survey. Education was a key component in building skill sets necessary for resource providers in these areas. Again, over **50+** training sessions were offered on these topics with over **1,000** attendees, and pre/post surveys were administered. The results of the surveys indicate that over **80%** of the participants reported that their knowledge of the impact of grief, loss and trauma on developing relationships, maintaining relationships, and child/youth self-identification increased after attending the training.

- A significant part of building skill sets necessary for youth and caregivers to be able to address unresolved grief and loss as well as environmental trauma centers on the ability to, and attitudes toward, seeking help. As a result of the IYRT project:**76%** of youth and **86%** of caregivers strongly agreed or agreed that treatment can help people with mental illness.
- **90%** of youth and **89%** of caregivers strongly agreed or agreed that getting help makes it easier to cope with problems.
- **89%** of youth and **90%** of caregivers strongly agreed or agreed to knowing where to get help for personal or emotional problems.
- **76%** of youth and **89%** of caregivers strongly agreed or agreed that they felt better about asking a counselor or other mental health professional for help.
- **85%** of youth and **77%** of caregivers strongly agreed or agreed that they felt better about asking a friend or relative for help with a personal or emotional problem.

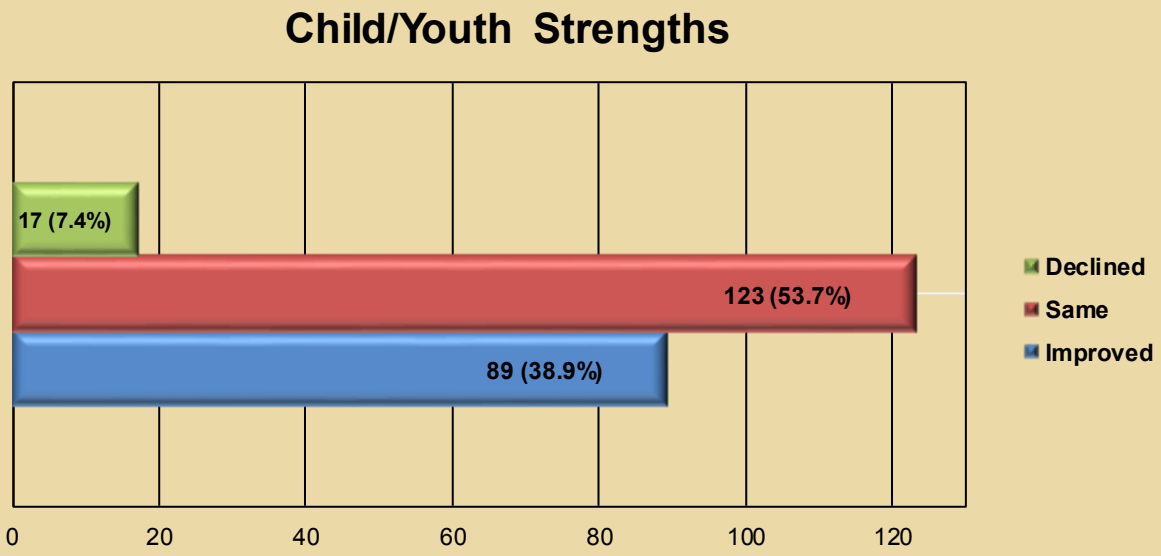
Establishing an active caregiver role in a youth's life is an important part of building necessary skill sets for the youth to be able to address these areas. Caregivers were given a survey at the completion of their participation in the IYRT project. Outcome results for caregivers reveal that between **72%** and **95%** of IYRT caregivers "strongly agree" or "agree" with all of the project-specific outcomes listed below. The most highly rated outcome indicates that as a result of their participation in the IYRT, caregivers are more likely to discuss difficult issues with their youth, which is a likely indicator that the youth will be better able to address difficult issues such as grief, loss, trauma and exposure to violence. Further, caregivers "strongly agree" or "agree" that as a result of this project they:

- Communicate more effectively with youth **(89%)**.
- Have built a better attachment with youth **(88%)**.
- Access community resources more **(86%)**.
- Do more to help youth achieve their permanency plans **(86%)**.
- Help youth address issues of trauma more **(84%)**.
- Are more knowledgeable about the negative effect of grief, loss, and trauma on youth **(83%)**.
- Get support from other caregivers **(79%)**.
- Help youth with emancipation plans **(73%)**.
- Help youth find and connect with existing relatives more **(72%)**.

"It helped me because it gave me someone to talk to when I had a problem. It also gave me the opportunity to have a lot of fun. And to learn about the different housing programs that are there to help."

– Youth Mentee

Another significant part of building skill sets necessary for youth and caregivers to be able to address unresolved grief and loss as well as environmental trauma is the development of strengths. The CANS-SB was administered to youth at the beginning and end of their participation in IYRT. The below figure demonstrates that strengths among IYRT participants increased by **38.9%**. The Strengths domain measures areas such as resiliency, resourcefulness, optimism, hope, relationship permanence, family, interpersonal skills and spirituality. In a strengths-based framework, building strengths is an important part of the process in addressing the issues of grief, loss and exposure to violence and trauma. Resiliency in particular is paramount in being able to address significant issues around grief, loss, and exposure to violence and trauma, and among those participants who came in with low scores in resiliency, **49%** left with improved resiliency, and **43%** left with resiliency as a 'centerpiece strength', meaning it is a significant and functional strength.



- The IYRT project also provided trainings on these areas for youth and caregivers. The IYRT project offered accessible services to the underserved groups by providing **60+ t**rainings with **1,171** willing participants. Over **50%** of the project participants indicated that the tools and techniques they learned through mentoring and training provided by IYRT would assist them with dealing with life challenges.
- There were high participation rates among the underserved population with the project services being utilized by **32%** African American population and **42%** Hispanic or Latino population.

" When I first joined the TEAM program, I lacked the confidence needed to do well in job interviews. However, after going to the mentee trainings on employment and advice from my mentor, I finally was able to do well during interviews, and now I have my first job!"

– Youth Mentee

Evaluation Domain 2: Improve Service Effectiveness by Increasing Quality of Services, Including Better Outcomes.

Learning Goal 2A: To learn if the reality of being part of the dependency/ward "system" is a contributing factor and/or exacerbates youth's issues of grief, loss and trauma.

Does being a dependent or ward of the court in the "system" contribute/exacerbate youth's issues with grief, loss, and trauma?

Research has shown that **50%** of adults who were in the foster care system experience homelessness, incomplete educational achievement, joblessness, incarceration, increased drug use, gang affiliation, and exposure to violence. Many of these adults reported that their early adulthood years are marked by isolation, loss of childhood relationships, unhappiness and lack of supportive connections and help in times of stress and crisis (IYRT Work Plan 2010). Indeed, nearly 1/3 of the IYRT youth reported not having even one single stable permanent relationship in their life.

Providers distributed questionnaires to youth participants and used mentor feedback to further evaluate the goal. Many youth reported difficulties that accompany being removed from their homes and loved ones, and having to develop relationships with new caregivers, only to be moved and placed in another home soon after. It was reported that it was difficult for the youth to engage with caregivers and providers as they would experience a form of grief and loss when they would be placed in different placement home. They were expected to build relationships with various people (foster families, social workers, therapist, etc.) only for them to leave or be reassigned.

To address the question "Does being part of the dependency/ward "system" contribute to and worsen youth issues of grief and trauma?," the service provider Reach Out, engaged youth in discussions with mentors, group activities, and provided other casual activities in which youth had opportunities to express themselves freely. Reach Out learned from their youth that though being part of the "system" prevented additional trauma or harm from occurring; at the same time, separation from their biological family or never even meeting their biological parent was a significant stressor as well.

To address the same question, Valley Star used CANS-SB data, feedback from the mentors, internal surveys, and self-reporting from the youth. They found that being "system-involved" does contribute to issues of grief, loss, and trauma for many of the youth.

Based on the findings from the provider reports, being part of the "system" is a contributing factor to "system" involved youth's grief, loss, and trauma.

Learning Goal 2B: To learn if the provision of mentorship, and/or what types of mentorship help these youth address their unresolved issues.

Does the provision of mentorship help "system" involved youth address their unresolved issues? What types of mentoring help?

All three providers reported significant success with their respective mentorship approach.

Providers discovered that one-on-one mentoring combined with group mentoring worked well to move youth forward on a positive path.

To evaluate the success of the mentoring component, a survey was administered to project youth. The survey asked youth to rank which project activities were most useful to least useful in improving their resiliency. The following eight (**8**) activities were included: 1) one-on-one youth mentoring, 2) group sessions, 3) assessments, 4) collateral, 5) urgent mentoring, 6) planning, 7) training, 8) linkage and consultation contributed to improved trauma and resiliency and community functioning for youth.

Findings included:

- The majority of youth felt that all of the activities were either helpful, or very helpful in improving their resiliency.
- The majority of the participants ranked one-to-one-mentoring and group mentoring as the two most useful activities in helping to improve their resiliency (**86%** and **71%** respectively).
- Half of the participants ranked urgent mentoring as the least helpful in improving resiliency with assessment and collateral tied for the second least useful activity.

Overall, youth indicate that mentoring activities were very helpful in helping them resolve unresolved behavioral and emotional issues by increasing their strengths, specifically by improving their resiliency.

Learning Goal 2C: To learn if the application of techniques addressing grief and loss, exposure to violence, and trauma help the youth build positive relationships with resource providers and peer counselors.

Does the application of learned techniques help youth with addressing grief and loss, exposure to violence and trauma, and build positive relationships with resources providers and peer counselors?

To discover if youth had built positive relationships with resource providers and peer counselors, these types of questions were included in a Service Quality Participant Survey that was distributed to the IYRT youth. The table indicates that out of the **129** participants that were surveyed during this survey period the majority of the participants strongly agreed that the IYRT project is valuable.

- **98%** of youth and **89-93%** of caregivers felt that the people who work in IYRT care about them and listened to what they had to say, thereby demonstrating that the youth built positive relationships with their IYRT resource provider.
- **92%** of the youth participants indicated they would recommend this project to friends and family, and **90%** of the caregivers agreed.
- Additionally, **97%** of youth reported they would use the skills and tools they learned in the future and **88%** of the caregivers agreed.

As a result of this project…	Youth N=72			Caregivers N=57		
	% Strongly Agree or Agree	% Strongly Disagree or Disagree	% Not Sure	% Strongly Agree or Agree	% Strongly Disagree or Disagree	% Not Sure
I have learned something from this project.	97%	0%	3%	91%	4%	5%
I plan to use the things I learned in this project.	97%	0%	3%	88%	5%	7%
The people who work in this project care about me.	98%	1%	1%	89%	4%	7%
The people who work in this project listen to what I have to say.	98%	1%	1%	93%	7%	0%
Overall, I like this project.	99%	0%	1%	90%	6%	4%
I would recommend this project to friends and family.	92%	0%	8%	90%	5%	5%

During the survey period (FY 2013-2014), when evaluating quality of services over time in the project there was no significant change with participant's satisfaction. The table below provides survey responses based on participants time involved in the program.

Service Quality	Youth		Caregivers	
As a result of this project…	9 Months or Less N=35	More than 9 Months N=37	1 Year or Less N=18	More than 1 Year N=37
	% Strongly Agree or Agree	% Strongly Agree or Agree	% Strongly Agree or Agree	% Strongly Agree or Agree
I have learned something from this project.	98%	97%	100%	87%
I plan to use the things I learned in this project.	97%	97%	89%	87%
The people who work in this project care about me.	100%	94%	95%	86%
The people who work in this project listen to what I have to say.	100%	96%	100%	92%
Overall, I like this project.	100%	97%	100%	84%
I would recommend this project to friends and family.	94%	89%	100%	84%

As shown in the table above, when the participant surveys were separated and evaluated based on their length of stay in the project, the length of stay in the project does not significantly change the participant satisfaction for youth. However, there is change in satisfaction for caregivers. When comparing the responses between youth in the project for less than 9 months with the youth in the project for over 9 months for the question, "Overall, I like this project," there is a **3%** difference in a survey population of **72.** When comparing the responses between caregivers in the project for less than 9 month with caregivers in the project for over 9 month for the same question, there is a **16%** difference in a survey population of **55**. The decrease in project satisfaction among caregivers could be due to many factors. They might feel the project is no longer relevant to their relationship with the youth. Or, they see their youth attending the project but see no improvements in their behavior or emotions. Another reason for the drop in satisfaction for caregivers could be related to the time it takes to be involved in the trainings, workshops and mentoring meetings.

"I can say that without the TEAM mentoring program and the support of my mentor I could not have easily overcome the obstacles of life that were thrown at me growing up in foster care.

My mentor believed in me…"

–Youth Mentee

To address this learning goal, IYRT also surveyed project youth, youth mentors and resource providers to assess the elements that facilitate a positive relationship between mentee, mentor and resource provider. Overall findings found the following:

- The majority of youth felt that participation in the IYRT project has been helpful or very helpful in helping them build positive relationships.
- Youth ranked the IYRT Mentor, Other Adult, and Other Family as the top three areas that the project has helped them in building positive relationships.

Mentors were asked how much they feel that participation in the IYRT project has helped youth building positive relationships with caregivers, parents, other family, mentor, other adult, same-sex friend, and opposite-sex friend.

- The majority of mentor respondents felt that participation in the IYRT project has been helpful or very helpful in helping youth build positive relationships.
- Mentors ranked Caregiver, Other Adult, and Other family as the top three areas that the project has helped youth in building positive relationships.

Artwork by Jessica Ponce

Learning Goal 2D: To learn if Peer Counselors and other professional staff who receive the training can engage youth as well as their resource providers to use the skills and information obtained from the training .

Does training and using the skills and information obtained during training help Peer Counselors and other professional staff better engage with youth and their resource providers?

Evaluation Domain 3: Provide Linkages & Promote Interagency Collaboration.

Learning Goal 3A: To learn if a team that includes three major county departments (Department of Behavioral Health (DBH), Children Family Services (CFS), and Probation), and countless youth serving programs succeeds in addressing the issues of grief, loss, exposure to violence and environmental trauma experienced by these children.

Learning Goal 3B: To learn if the above model for collaboration, methods and skills for intervention and strategies for interaction with youth effectively addresses the impacts of grief, loss, trauma on youth outcomes.

The model encouraged collaboration with County Departments and community partners to address grief & loss and trauma. Project data indicates that the trainings/workshops in the community were effective in engaging the target population and providing them with necessary coping skill to address grief, loss and trauma. By implementing a collaborative model the IYRT project was able to gain access to the target youth population and their resource providers.

Providers found that the model of collaboration was effective in that the model supported collaboration between providers and different partners. They worked to be part of the community and get involved with activities throughout the life of the project. The IYRT contract provider routinely had a booth/table at County and community resource fairs, which allowed for the promotion of the project to reach the youth throughout the County.

The multi-disciplinary approach had been successful in addressing issues of grief, loss, and exposure to trauma for youth. Bringing all interested parties to the same table has made it possible for all parties to learn from each other and work as a team to better the situation for our combined youth. Due to open communication between the major County departments and service providers, providers have been able to address its needs sooner and enter into service quicker.

IYRT providers were provided with a Collaborative Survey developed through collaboration with EVALCORP and the County of San Bernardino. The survey reported the different collaborative activities conducted in fiscal year 2013-14.The IYRT project collaborated with major San Bernardino County Departments, such as San Bernardino Department of Behavioral Health (DBH), Child and Family Services (CFS), and the Probation Department on trainings/workshops, community outreach, and curriculum. The project received referrals for the IYRT mentoring program from its collaborative partners. Some of the programs serving youth include, but are not limited to:

- Independent Living Program through CFS and Probation.
- Foster Family Agencies.
- School Districts.
- Group Homes.
- San Bernardino County Superintendent of Schools.
- CASE Task force.

Activity	# Organizations/ Agencies			
	Across Sites	EMQ	Reach Out	Valley Star
Provided outreach and/or materials	35	15	15	5
Provided training and/or presentation	35	10	14	11
Received referrals from the agency	34	10	13	11
Made referrals to the agency	27	4	3	20
Provided space	19	8	9	2
Co-hosted an event	13	2	7	4
Co-managed cases	13	9	4	0
Other	16	4	12	0
TOTAL	**192**	**62**	**77**	**53**

As shown above, across eight collaborative categories, a total of **192** collaboration activities took place across the three IYRT providers. Collaboration activities were conducted for every category by two of the three IYRT sites—EMQ and Reach Out. The largest collaboration efforts across sites focused on:

- providing outreach materials (**35** collaborative activities),
- providing training and/or presentations (**35** collaborative activities)
- receiving referrals (**34** collaborative activities).

Valley Star was successful at making referrals with a high of **20** collaborative activities; whereas EMQ and Reach Out were very successful at providing outreach and materials with **15** collaborative activities.

To assess whether a multi-department team and if the above model for collaboration, methods and skills for invention and strategies for interaction with youth was successful in effectively addressing issues of grief, loss, exposure to violence and environmental trauma experienced by these youth, a combination of survey results and CANS-SB pre/post scores were evaluated. Participant surveys reported that as a result of the IYRT project:

- **85%** of youth improved their emotional well-being.
- **85%** are better able to cope when things go wrong.
- **85%** handle feelings of grief and loss better.
- **97%** feel more hopeful about their future.
- **90%** of youth are proud of themselves.
- **95%** of youth make better decisions.

Various domains across the CANS-SB, as well as individual items within the domains were evaluated to assess if IYRT was successful in effectively addressing issues of grief, loss, exposure to violence and environmental trauma experienced by "system-involved" youth.

Figure 1 shows that in a testing population of **228,** youth that participated in IYRT through 2012-2015 exhibited a **38.9%** increase in the strengths domain of the CANS, demonstrating that IYRT was successful in building areas of strengths in over 1/3 of the youth exposed to the system The Strengths domain measures areas such as resiliency, resourcefulness, optimism, hope, relationship permanence, family, interpersonal skills and spirituality. In a strengths-based framework, building strengths is an important part of the process in addressing the issues of grief, loss and exposure to violence and trauma. In the strengths domain:

- **56%** of youth who had little to no talents/interests improved in this area throughout the duration of the project, and **52%** completed the project with talents/interests as a centerpiece strength.
- **50%** of youth who presented with issues around well-being improved throughout the duration of the project, and **46%** completed the project with well-being as a centerpiece strength.
- **49%** of youth who reported little to no resiliency improved in this area throughout the duration of the project, and **43%** completed the project with resiliency as a centerpiece strength.
- **51%** of youth who reported little to no resourcefulness improved in this area throughout the duration of the project, and **46%** completed the project with resiliency as a centerpiece strength.

Figure 1

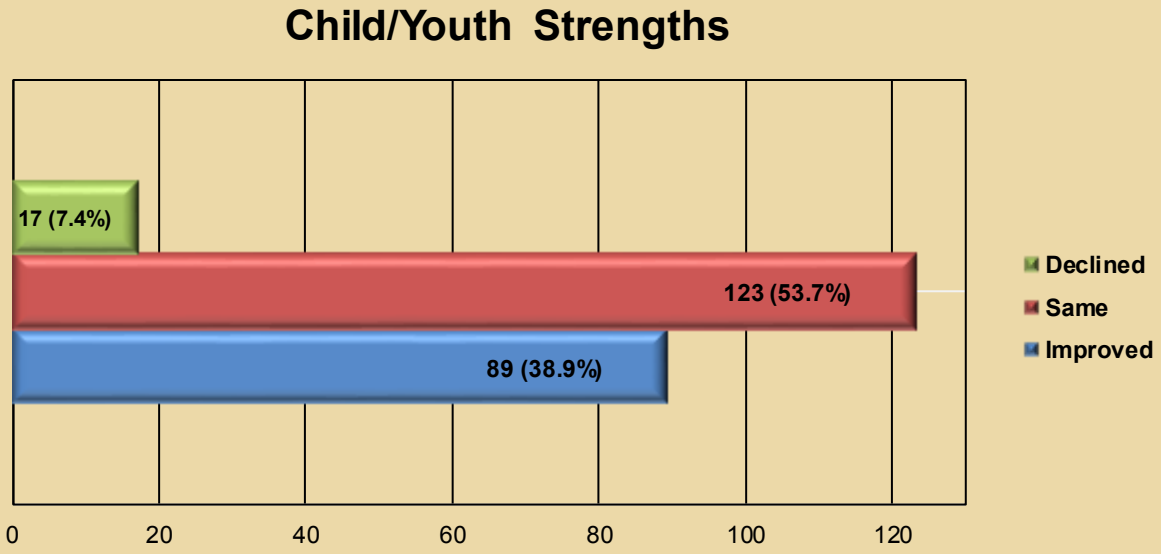
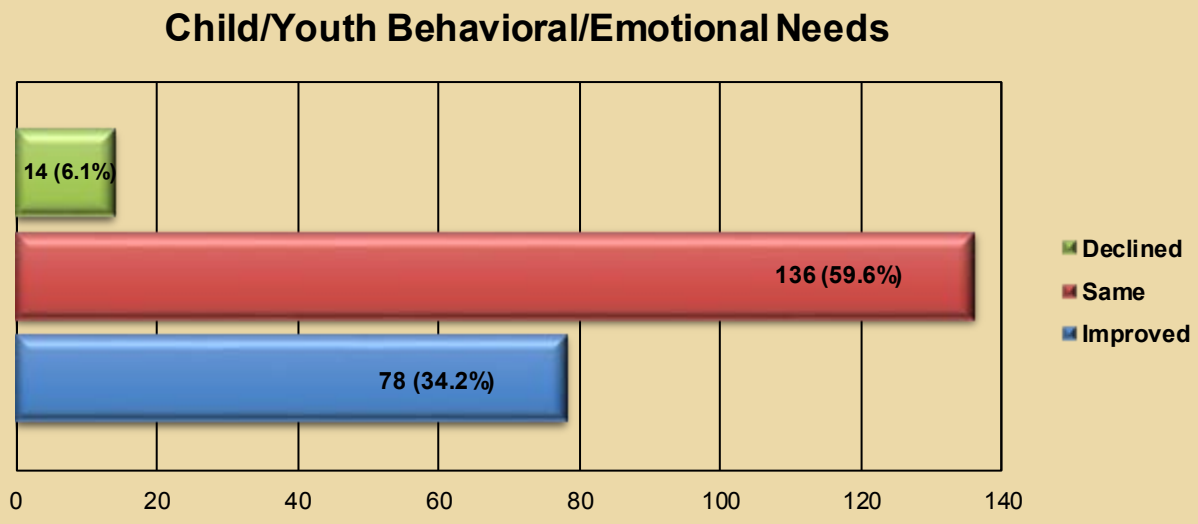


Figure 2 illustrates that in a testing population of **228**, youth that participated in the program through 2012-2015 exhibited a **34.2%** increase in the Behavioral/Emotional Needs domain of the CANS, demonstrating that IYRT was successful in addressing behaviors that manifest themselves in youth exposed to the system in over 1/3 of the youth. The Behavioral/Emotional Needs domain measures areas such as depression, anxiety, opposition, trauma, and substance use. In this domain,

- **54%** of youth who presented with significant adjustment to trauma difficulties demonstrated improvement and **48%** reported that these difficulties had resolved by the end of the project
- **75%** of youth who presented with psychosis demonstrated improvement by the end of the project
- **45%** of youth who presented with impulsivity/hyperactivity demonstrated improvement by the end of the project
- **46%** of youth who presented with depression demonstrated improvement by the end of the project.
- **59%** of youth who presented with anxiety demonstrated improvement by the end of the project.
- **33%** of youth who presented with oppositional challenges demonstrated improvement by the end of the project
- **29%** of youth who presented with conduct issues demonstrated improvement by the end of the project
- **39%** of youth who presented with anger control demonstrated improvement by the end of the project.
- **57%** of youth who presented with eating disturbances demonstrated improvement by the end of the project
- **36%** of youth who presented with affect dysregulation demonstrated improvement by the end of the project.
- **44%** of youth who presented with behavioral regressions demonstrated improvement by the end of the project.

Figure 2

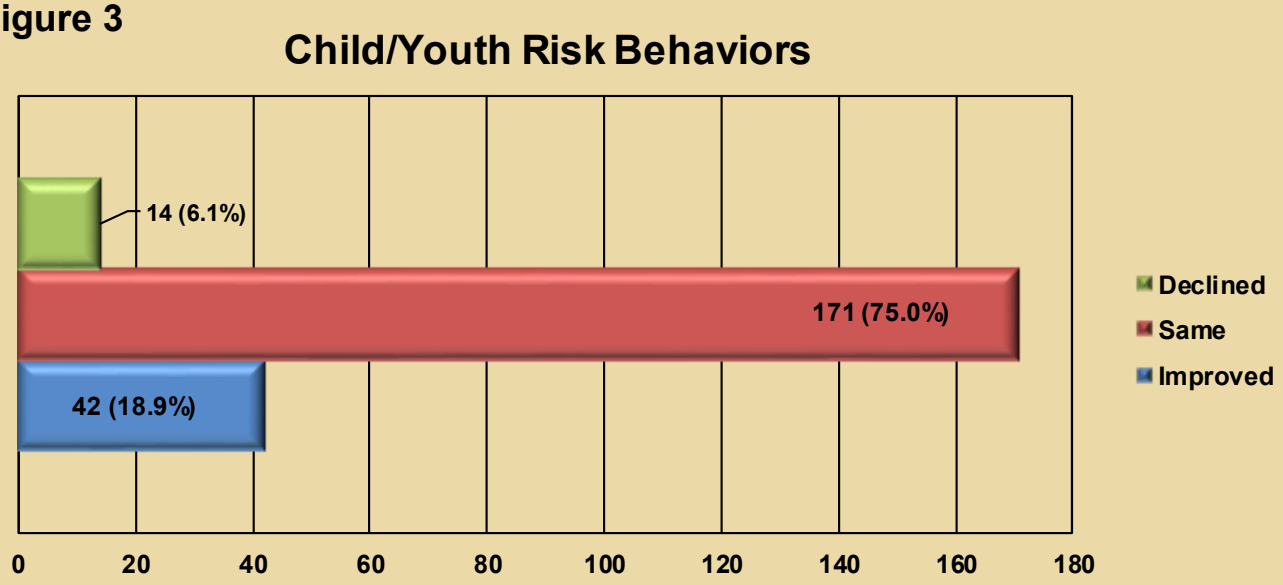


Additionally, **18%** of youth with grief and loss showed an improvement in this area. The CANS-SB has items that are within core domains and items that are within modules. The core domains are always completed, and the modules are only completed if there is a high enough score on an item within the core domain to trigger the module for completion. Grief and loss is an item within the Permanence Module. The Permanence Module is only completed if the Relationship Permanence item within the Core Strengths domain indicates this is an issue for the client. So a high score on Relationship Permanence item (indicating relationship permanence is an issue), prompts the administrator to complete the Permanence module, where the item Grief and Loss is found. As a result of this, if a youth left the program with improvement in the area of Relationship Permanence, the Permanence module would not be completed, therefore we would not collect a score on the Grief and Loss item. Therefore, the **18%** improvement around the area of Grief and Loss is likely much higher given the above explanation.

Figure 3 represents the youth's improvement in Risk/Behaviors in the CAN-SB assessment tool. Out of a testing size of **228**, **18.9%** of the youth showed improvement in their risk behaviors. However, **75.0%** of the youth remained the same and **6.1%** declined.

While there was significant improvement in the domains listed above, a great percentage of the youth remained the same (**75.0%** youth remained the same) – experiencing no change. This can be attributed to the fact that though these youth are being provided with mentoring services and trainings to address their grief and loss, they are often still living in the environment/system that exacerbate risk factors. In this domain:

Figure 3



Learning Goal 3B: To learn if the identification of a model for collaboration to address grief and loss issues, exposure to violence, and environmental trauma help build connections for diverse youth served by the project.

In accordance with the collaboration learning goals of the IYRT project, the San Bernardino County Workforce Investment Board (SBWIB) partnered with DBH and the innovative IYRT project in a Youth Employment and Preparation Program (YEPP), to provide training and employment services, career guidance, skill assessments, case management, supportive services and classroom and on-the-job training opportunities to **298** diverse youths, ages **18** to **25.** The term of the Memorandum of Understanding (MOU) between DBH and WDD for these services was for the period of April 1, 2012 to June 30, 2012. Participating youth were Transitional Age Youth (TAY) and all were "system-involved" participants of the IYRT project. WDD contracted with eight **(8)** providers to provide the training and employment opportunities for the youth. As a result of this collaborative partnership:

- **298** youth were able to be enrolled in the program.
- **78.86%** of the youth obtained a positive outcome, defined as one of the following:
  - ◊ **80** youth returned to high school or enrolled in college.
  - ◊ **71** youth continued participation in the WDD year-round program.
  - ◊ **84** youth were hired on by their worksite.

This program collaboration was successful in assisting system-involved youth obtain readiness skills and obtain meaningful employment, which addressed the stakeholder identified stressors associated with employment difficulties with IYRT youth. DBH met this need by collaborating with WDD to address these stressors and traumas that impacts youth ability to overcome and succeed into adulthood.

Final Thoughts

Overall, the IYRT project did demonstrate that the mentoring service model used to deliver services can help current foster and probation youth to understand and begin to address their grief, loss and violence issues.

Things to consider in the future: The outcomes for the project were difficult to capture due to the varying data collection tools and methodologies among the three providers. To ensure data quality and for more accurate comparisons of outcomes, a standardized assessment measurement tool and procedure should be used for all project providers upon project implementation. Though the Department sought to address this issue in December 2013 when they contracted with EVALCORP, there were still inadequacies in the data collected by providers.

Another data challenge for this project was the intervals at which the CANS-SB was administered to the youth. The CANS-SB was administered at 6-month intervals and did not collect data for the participants who discontinued the project prior to the 6-month mark. Administering assessments in shorter intervals may help account for missing data causes by participants that do not continue through the project duration.

Will the County continue the IYRT innovation project?

In August of 2014, a presentation was conducted at the San Bernardino County Community Policy Advisory Committee (CPAC) meeting to provide stakeholders with an update on the progress of the IYRT project.

The Department of Behavioral Health and its stakeholders elected to discontinue the IYRT project after funding under MHSA Innovation ended. The project was not able to leverage resources and obtain continued funding for project sustainability.

While the IYRT project showed that the mentoring project could help youth overcome their grief, loss and trauma, the services provided can be found in other mentoring programs provided by some of DBH's collaborative partners. The CFS and Probation departments both have peer-mentoring programs that offer the youth similar services the IYRT project provided. Therefore, the learning noted under this project could be applied to similar services.

Materials Developed to Communicate Lessons Learned and Project Results

Throughout the project period, documents have been created to provide updates for the stakeholders of San Bernardino County and other entities regarding the Interagency Youth Resiliency Team project. Examples of these documents include the Mental Health Services Act (MHSA) Annual Update Reports, MHSA Three-Year Integrated Plan, and Power Point presentations provided at various stakeholder meetings. An example include a presentation conducted by Innovation staff at the Community Policy Advisory Committee (CPAC) for San Bernardino County stakeholders in May 2014.

Links to some of the documents containing updates regarding the Holistic Campus Project are provided below:

MHSA Innovation Plan 2010
http://www.sbcounty.gov/dbh/Announcments/2010/Innovation_Plan_Final_2-8-10.pdf

MHSA Annual Update FY 2010-11
http://www.sbcounty.gov/dbh/mhsa/CSS/MHSA_Three_Year_Plan/9_CSS_FY_10-11_Plan_Update_Resubmission_II_6.11.10.pdf

MHSA Annual Update FY 2011-2012
http://www.sbcounty.gov/dbh/mhsa/CSS/MHSA_Three_Year_Plan/10_CSS_FY_11-12_Plan_Update_4.11.11.pdf

MHSA Annual Update FY 2012-2013
http://www.sbcounty.gov/dbh/mhsa/CSS/MHSA_Three_Year_Plan/11_CSS_FY_12-13_Plan_Update_6.21.12.pdf

MHSA Annual Update FY 2013-2014
http://www.sbcounty.gov/dbh/mhsa/MHSA_Annual_Update_FY_2013-14_06072013_FINAL.pdf

MHSA Innovation Plan 2014
http://www.sbcounty.gov/dbh/mhsa/Innovation_Plan/2014/index.html

MHSA Integrated Three-Year Plan FY 2014/2015 – 2016/2017
http://www.sbcounty.gov/dbh/Announcments/2014/MHSA_Integrated_Plan_070114.pdf

MHSA Annual Update FY 2015-16
http://www.sbcounty.gov/dbh/mhsa/2015/MHSA_Annual_Update_FY15-16_BoS_Approved-071515.pdf

Please see the **ATTACHMENT** section of this report for the following IYRT relatedattachments:
Attachment G(5) – Community Policy Advisory Committee (CPAC) presentation 2014
Attachment G(6) – Community Policy Advisory Committee (CPAC) presentation 2015
Attachment G(7) – Interagency Youth Resiliency Team Logic Model
Attachment G(8) – IYRT Flyer
Attachment G(9) – 357 Model Training Flyer
Attachment G(10) – TEAM Flyer

Artwork by Jose Mendez

Workforce Education and Training (WET)

Workforce Education and Training

Introduction

The passage of Proposition 63, which established the Mental Health Services Act (MHSA) in November 2004, provided a unique opportunity, and funding, to increase staffing and other resources that support public mental health programs. MHSA funds also increased access to much-needed services, and progress toward statewide goals for serving children, Transition Age Youth (TAY), adults, and older adults and their families. California's public mental health system has suffered from a shortage of public mental health workers, misdistribution of certain public mental health occupational classifications, a recognized lack of diversity in the workforce, and under-representation of professionals with consumer and family member experience, and of racial, ethnic, and cultural communities in the provision of services and support. To address the public mental health workforce issues, the MHSA included a component for Mental Health Workforce Education and Training (WET) programs.

WET carries forth the vision of the MHSA to create a transformed, culturally-competent system that promotes wellness, recovery and resilience across the lifespan of age groups such as infants, children, adolescents, TAY, and older adults.

MHSA Legislative Goals and Related Key Outcomes

The MHSA Legislative Goals of WET and related key outcomes are:

- Address workforce shortages and deficits identified in the workforce needs assessment:
  - ◊ Increase in the number of employees hired in identified needs assessment areas.
  - ◊ Increase in pre-licensed to licensed clinical staff.
  - ◊ Increase in the number of qualified applications received for clinical positions.
  - ◊ Increase in DBH pre-licensed clinicians hired (interns vs. non interns).

- Designate a WET Coordinator:
  - ◊ WET Coordinator Designated.

- Educate the workforce on incorporating the general standards:
  - ◊ Trainings documented addressing these standards.
  - ◊ Training evaluations.

- Increase the number of clients and family members of clients employed in the public mental health system:
  - ◊ Increased number of Peer and Family Advocates (PFAs) hired.

Workforce Education and Training

- Conduct focused outreach and recruitment to provide equal employment opportunities in the public mental health system for individuals who share the racial/ethnic, cultural and/or linguistic characteristics of clients, family members of clients and others in the community who have serious mental illness and/or serious emotional disturbance:
  - ◊ Documented efforts that target the identified populations.
  - ◊ Documented Career Fairs including locations.

- Recruit, employ and support the employment of individuals in the public mental health system who are culturally and linguistically competent or, at a minimum, are educated and trained in cultural competence:
  - ◊ Documented efforts that target the identified populations.
  - ◊ Adherence to cultural competency training requirement.
  - ◊ Increase in hiring of culturally competent staff.
  - ◊ Increase in the number of bilingual staff, bilingual applicants, and bilingual interns.

- Provide financial incentives to recruit or retain employees within the public mental health system:
  - ◊ Financial incentives implemented.
  - ◊ Tracking for Employee Scholarship applicants.
  - ◊ License Exam Prep Program statistics.

Artwork by George Davis

- Incorporate the input of clients and family members of clients, and when possible utilize them as trainers and consultants in public mental health WET programs and/or activities:
  - ◊ Documented meetings with clients and family members.
  - ◊ Documented trainings facilitated by clients and family members.

- Incorporate the input of diverse racial/ethnic populations that reflect California's general population into WET programs and/or activities:
  - ◊ Documented meetings with diverse racial/ethnic populations.

- Establish regional partnerships:
  - ◊ Partnerships with other counties established.

- Coordinate WET programs and/or activities:
  - ◊ Coordinated WET program/activities.

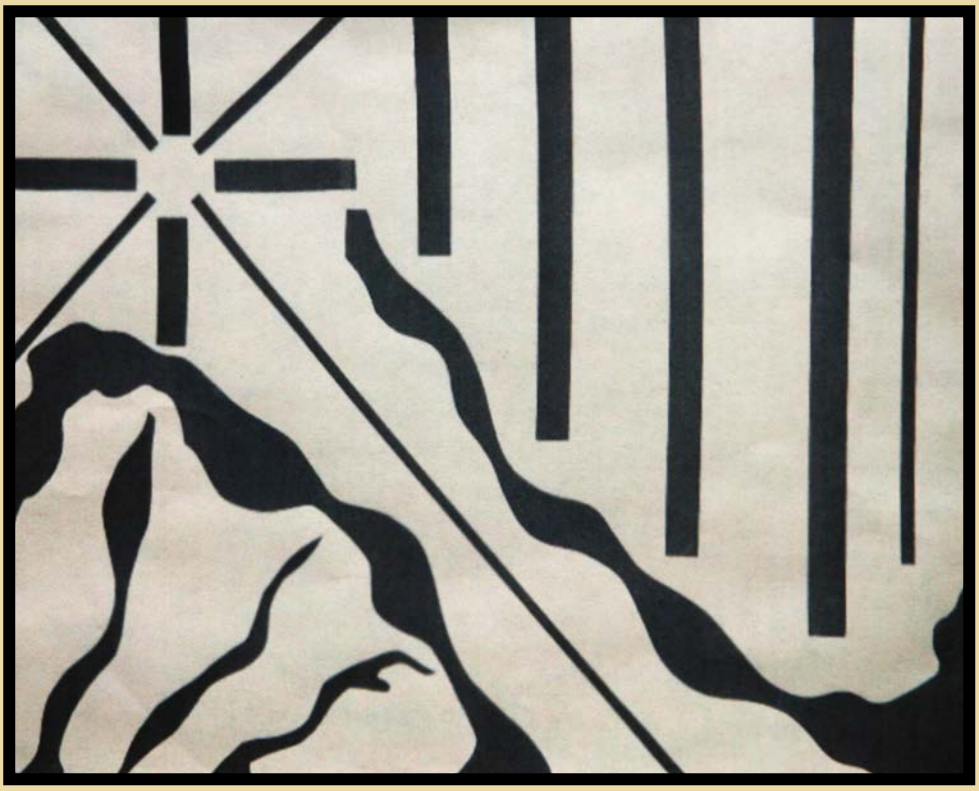
Positive Results

To meet the Legislative Goal, *Address workforce shortages and deficits identified in the workforce needs assessment*, a needs assessment was completed in 2008. Psychiatrists, Child Psychiatrists, Licensed Clinical Therapists, and Internists were identified as hard-to-retain and hard-to-recruit positions in the County. A new needs assessment was completed in July 2013 again identifying Child Psychiatrists and Psychiatrists as hard-to-fill and hard-to-retain positions.

Through collaboration with Human Resources, DBH is working to address the recruitment shortages. The tools utilized to address the recruitment shortages include:

- EMACS.
- NEOGOV.
- License Exam Prep Program Tracking Log.
- JobsinSoCal.com.
- Clinical Therapist I (CT I) Hiring Fair.

The progress made in San Bernardino County in the occupational shortage areas and in other clinical positions is a credit to the various WET programs in place. However, more progress is needed as there are still occupational shortages, particularly for licensed staff, that must be addressed in order to adequately equip the DBH workforce to serve an ever growing and diverse population within San Bernardino County.



Artwork by Alexandra Bear

Workforce Education and Training

As seen in the table below, there is a significant shortage of qualified applications received for licensed positions in FY 2014/15.

Number of Qualified Applications Received for DBH Positions per Fiscal Year (FY)							
Job Title	**FY 08/09**	**FY 09/10**	**FY 10/11**	**FY 11/12**	**FY 12/13**	**FY 13/14**	**FY 14/15**
Alcohol and Drug Counselor	N/A	N/A	43	44	27	N/A	39
Child Psychiatrist	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Clinic Assistant	N/A	N/A	N/A	N/A	N/A	N/A	47
Clinic Supervisor	14	10	57	N/A	N/A	30	37
Clinical Therapist, LCSW	N/A	3	5	12	3	6	3
Clinical Therapist, MFT	N/A	6	5	12	10	8	9
Clinical Therapist, Psychology	N/A	1	3	5	1	N/A	1
Clinical Therapist II	N/A	8	12	32	N/A	54	44
Licensed Vocational Nurse (LVN)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Mental Health Education Consultant	N/A	N/A	24	20	N/A	N/A	77
Mental Health Nurse II	2	8	4	7	N/A	29	32
Mental Health Specialist	72	15	13	120	N/A	90	70
Nurse Manager	N/A	N/A	N/A	N/A	N/A	N/A	6
Nurse Supervisor	4	6	N/A	10	N/A	N/A	N/A
Peer and Family Advocate I	N/A	N/A	N/A	96	279	187	141
Peer and Family Advocate II	N/A	N/A	N/A	32	0	52	35
Peer and Family Advocate III	N/A	N/A	N/A	N/A	0	53	31
Pre-Licensed Clinical Therapist, LCSW	37	50	65	92	81	105	69
Pre-Licensed Clinical Therapist, MFT	92	82	86	109	112	128	90
Pre-Licensed Clinical Therapist, Psychology	27	22	21	23	21	20	43
Pre-Licensed Clinical Therapist, LPCC	N/A	N/A	N/A	N/A	14	2	17
Program Manager I	75	N/A	N/A	38	N/A	20	38
Program Manager II	6	11	8	6	N/A	6	18
Psychiatric Technician I	N/A	43	54	66	59	N/A	46
Psychiatrist	N/A	N/A	N/A	1	6	9	8
Research and Planning Psychologist	N/A	N/A	N/A	3	N/A	N/A	N/A

Table 1

Workforce Education and Training

Another program that WET oversees is the License Exam Prep Program (LEPP). LEPP was created to help pre-licensed clinicians become licensed. The table below illustrates the progress that LEPP has had to help staff get licensed for their discipline.

County of San Bernardino DBH WET License Exam Prep Program (LEPP) 09/15 YTD Statistics				
Program	Date Materials Received	# of Participants	# Licensed	% Licensed
LEPP 1	July 2009	60	41	68%
LEPP 2	Jan. 2011	38	24	63%
LEPP 3	Jan. 2012	32	19	59%
LEPP 4	FY 2013/14	18	7	39%
LEPP 5	FY 2014/15	41	6	15%
Totals		189	97	51%

Table 2

As seen in ***Table 2*** above, for LEPP 1-5, there has been, on average, approximately **51%** licensure rate among the participants.

DBH expects the percentage of pre-licensed to licensed Clinician I's (CTI'S) to continue to increase with the benefit of LEPP.

	Prior to LEPP (2008)	After LEPP (2009-2015)
Licensed	84	109
Pre-licensed	127	176
% Licensed	39.8%	38.2%

Table 3

Workforce Education and Training

With the passage of the MHSA and the creation of WET, DBH was able to consolidate and expand the Internship Program. WET coordinates all aspects of the internships and practicums placed within DBH. Currently, the Internship Program trains students who are enrolled in bachelor and graduate programs in:

- Social Work.
- Marriage and Family Therapy.
- Psychology.

Depending on their discipline, interns can be placed in the Internship Program for **12** to **18** months. During that time, interns learn to provide clinical services in a public community mental health setting. DBH is committed to hiring applicants that were previously interns. As seen in the following table, the number of new pre-licensed CT I's hired increased between FY 2013/14 and FY 2014/15.

Pre-licensed Clinicians Hired	FY 2011/12	FY 2012/13	FY 2013/14	FY 2014/15
Total Number of Interns Hired	13	18	13	18
Total Number of Non-Interns Hired	11	9	16	22
% of Interns Hired	54%	67%	45%	45%

Table 4

In 1995, the Board of Supervisors created the MSW Assist Program, which later became known as the DBH Employee Educational Internship Program. This program was created to support current DBH staff in pursuing their Master of Social Work (MSW) or Marriage and Family Therapy (MFT) degrees, by allowing them to intern for up to **20** hours per week in a DBH program as part of their degree program requirements.

In 2015, WET expanded to build a more skilled workforce by "growing their own" qualified staff to fulfill the identified clinical shortages within the department to be able to serve the community and offer quality services to consumers seeking services within our county.

This program has increased in popularity since its implementation, and recently added Alcohol and Drug Counselor (AOD) and Bachelor of Social Work (BSW) as intern career path options in April 2015.

"Please pass along my appreciation to Ms. Thomas and all those who orchestrated the hiring fair. I was truly impressed. I have never attended anything similar to the event and it was a seamless and very innovative experience."

— Sophia Morelli, MSW - CT I Hiring Fair Attendee

To meet the Legislative Goal, Designate a WET Coordinator, DBH continues to support and employ an Administrative Manager for Workforce Education and Training.

Workforce Education and Training

To meet the Legislative Goal of *Educate the Workforce on Incorporating the General Standards*, DBH continues to incorporate them in trainings: Wellness, Recovery, and Resilience Model.

The General Standards set by the Mental Health Services Act (MHSA) are wellness, recovery and a resilience model, that are culturally competent, that support the philosophy of a client/family driven mental health system, integrates services and includes community collaboration. Among the **108** trainings provided in FY 2014/15, the following trainings are examples that incorporate the General Standards set by MHSA:

- Motivational Interviewing.
- Recovery, Resilience, and Transformation.
- Substance Abuse Treatment for Special Populations.
- Spirituality 101: Addressing the Spiritual and Cultural Needs of African Americans in Behavioral Health Care Setting.
- Info Mapping.
- MRT (Moral Recognition Therapy).
- Play Therapy.
- Introduction to Spirituality in Behavioral Health Treatment.
- Trauma Resiliency Model (TRM).
- Evidence Based Practice in Behavioral Health Services.

The table below provides more information regarding trainings provided by WET in FY 2014/15.

Fiscal Year	Attendance	Classes	CEUs	Evaluation (Avg)
FY 10/11	2,723	176	696.25	4.6
FY 11/12	2,460	211	1,938.55	4.53
FY 12/13	1,948	176	1,288	3.8
FY 13/14	3,095	136	939.45	4.6
FY 14/15	3,524	108	703	4.6

Table 5

The table above also indicates the overall average evaluation of the trainings in FY 2014/15 is **4.6** out of **5**, which reflects consistency in trainee satisfaction as that is the same evaluation rating from FY 2013/14. There was also a **13%** increase in training attendance in FY 2014/15 from FY 2013/14.

Workforce Education and Training

To meet the Legislative Goal, *Increase the number of clients and family members of clients employed in the public mental health system*, Peer and Family Advocates (PFA) are mental health consumers and/or their family members who provide crisis response services, peer counseling, and linkages to services and supports for consumers of DBH services. PFA's
also assist with the implementation, facilitation and on-going coordination of activities of the CSS plan, in compliance with MHSA requirements, and perform related duties as required.

As seen in the table below, there has been a significant increase in PFAs hired in DBH. As of September 21, 2015, there are **29** PFA positions in DBH. Furthermore, there are eight (**8**) more newly created, vacant PFA positions that are in the process of being filled. This is largely due to increasing knowledge and evidence of the benefits resulting from the inclusion of PFAs in many DBH programs, and the positive outcomes it has yielded on the consumers served by these programs. PFA's with lived experience are highly integrated in program planning and evaluation in all levels of the organization. DBH strives to continue to increase the number of PFAs hired and on staff in DBH programs and hosts an open recruitment for PFA levels I, II and III annually, which includes advertising on social media, via flyers and emails circulated throughout the community, and postings on JobsinSoCal.com. This exposure greatly increases the knowledge of the PFA position, as well as increases the number of qualified applicants applying for these vacancies each year.

	FY 05/06	FY 06/07	FY 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12	FY 12/13	FY 13/14	FY 14/15
DBH	4	19	24	24	21	20	24	25	23	29

Table 6

Once a PFA starts working for DBH, they are encouraged to develop professionally and promote to a higher classification. Table 7 (below) shows the number of DBH PFAs promoted since 2008.

	FY 2007/08	FY 2011/12	FY 2012/13	FY 2013/14	FY 2014/15
PFA's Promoted	3	1	1	4	3

Table 7

The contract agencies that work with DBH are required to employ PFAs as well, although they may be given different working titles. The number of PFAs employed with DBH contract agencies continues to increase as more programs are choosing to utilize the benefits presented by incorporating peer support and advocacy into their practices.

Not all contract agencies use the PFA title. A few other titles they use are:

- Family Partner.
- Youth Partner.
- Peer Partner.
- Parent Partner.
- Family Support Partner.
- Parent Family Advocate.

Workforce Education and Training

To meet the Legislative Goal, *Conduct focused outreach and recruitment to provide equal employment opportunities in the public mental health system for individuals who share the racial/ ethnic, cultural and/or linguistic characteristics of clients, family members of clients and others in the community who have serious mental illness and/or serious emotional disturbance*, the Volunteer Services Coordinator participates in career fairs throughout the County, from Barstow to San Bernardino to Morongo. As seen in the table below, the coordinator has increased her outreach efforts by more than **1,000** additional people in FY 2014/15.

	FY 2011/12	FY 2012/13	FY 2013/14	FY 2014/15	Total
Number of Schools Visited	13	16	23	35	87
Number of Participants	2,470	2,479	1,706	2,770	9,425

Table 8

To help reach the Spanish speaking community, the coordinator has partnered with a bilingual co-presenter and translated her presentations and handouts into Spanish. The co-presenter also helps to explain Behavioral Health career opportunities to monolingual parents that may not have a full understanding of what kind of career options there may be for their children.

To meet the Legislative Goal, *Recruit, employ and support the employment of individuals in the public mental health system who are culturally and linguistically competent or, at a minimum, are educated and trained in cultural competence*, DBH strives to have staff that provide culturally and linguistically competent services to consumers. To ensure that, all staff are required to take either online or live cultural competency trainings (2 hours for non-clinicians and 4 hours for clinicians, annually).

To help ensure that DBH staff provides culturally and linguistically competent services to the diverse populations of San Bernardino County, DBH continually seeks new employees that represents them, as can be seen in ***Chart 1***.

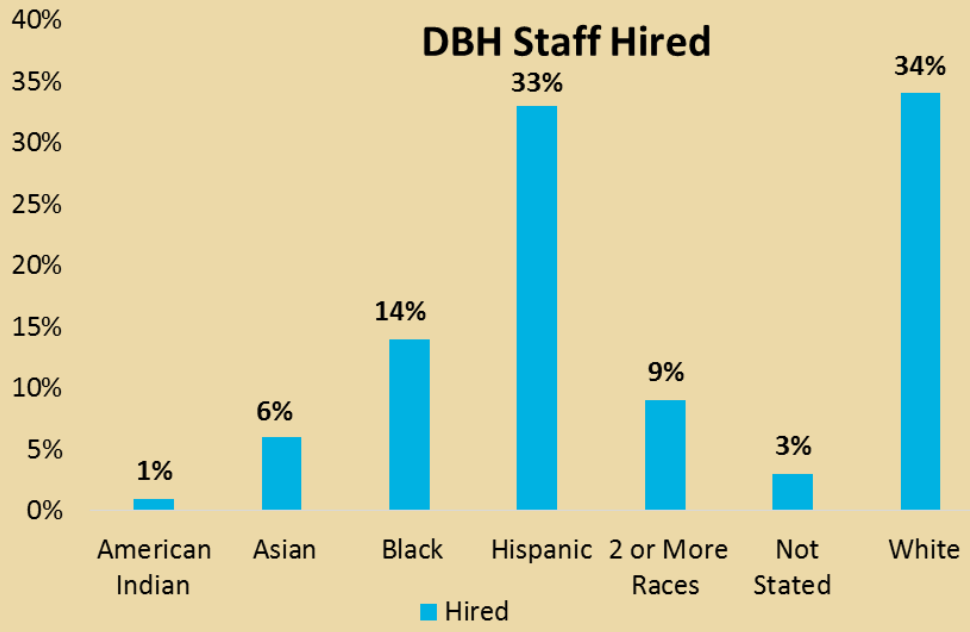


Chart 1

Workforce Education and Training

To help provide culturally and linguistically competent services to consumers, DBH actively recruits applicants that are bilingual and bicultural. As can be seen below, there is a slight decrease in the number of bilingual staff that work at DBH in FY 2014/15, however it remains a top priority of the department to continue to recruit and retain bilingual staff.

	FY 2012/13	FY 2013/14	FY 2014/15
# of Bilingual Staff	150	165	162

Table 9

The majority of bilingual staff speak Spanish, but other languages include:

- Tagalog.
- Vietnamese.
- French.
- Armenian.

WET has actively recruited bilingual interns to help provide services in other languages. Since FY 2008/09, on average **30%** of interns are bilingual. Of the bilingual interns, nearly **80%** are Spanish speakers.

Number of Bilingual Interns	FY 2008/09	FY 2009/10	FY 2010/11	FY 2011/12	FY 2012/13	FY 2013/14	FY 2014/15	Total
BSW	3	3	2	0	3	3	5	14
MSW	5	3	9	5	5	8	6	35
MFT	6	3	6	2	5	1	2	23
Psychology	2	1	1	1	0	2	3	7
Total Interns	39	46	41	44	47	51	43	311
Total – Bilingual	**16**	**10**	**18**	**8**	**13**	**14**	**16**	**95**
Total Percentage	**41%**	**22%**	**44%**	**18%**	**28%**	**27%**	**37%**	**30%**

Table 10

Workforce Education and Training

To meet the Legislative Goal, *Provide financial incentives to recruit or retain employees within the public mental health system*, the Employee Scholarship Program (ESP) was piloted in 2013. $25,000 in funds is budgeted per year to be distributed among the awardees. The funding for ESP has been allocated to provide scholarships designed to pay student tuition (not to include books, travel or other expenses) for employees who are working to earn a clinical or non-clinical Certificate, Associate or Bachelor's degree, or a non-clinical Master's or Doctorate degree. This opportunity is expressly designed to promote the development of a strong, stable and diverse workforce within DBH. The majority of scholarship funding will be aimed at entry level employees to assist them in moving up the career ladder.

In FY 2012/13, **12** awardees were selected, in FY 2013/14, **11** awardees were selected, and in FY 2014/15 eight (**8**) awardees were selected. The table below provides a breakdown of what degrees the awardees were working on.

Degrees	FY 2012/13	FY 2013/14	FY 2014/15
Associates	2	0	0
Bachelors	5	5	4
Masters	5	6	3
Certificate	0	0	1
Total Recipients	12	11	8

Table 11

Additionally, one (**1**) of the FY 2012/13 awardees has promoted, and two (**2**) each from the FY 2013/14 and FY 2014/15 have also promoted.

As seen in the License Exam Prep Program (LEPP) table below, there have been **189** total participants, with approximately **51%** of the participants getting licensed in their discipline.

County of San Bernardino DBH WET
License Exam Prep Program (LEPP) 9/15 YTD Statistics

Program	Date Materials Received	# of Participants	# Licensed	% Licensed
LEPP 1	July 2009	60	41	68%
LEPP 2	Jan. 2011	38	24	63%
LEPP 3	Jan. 2012	32	19	59%
LEPP 4	FY 2013/14	18	7	39%
LEPP 5	FY 2014/15	41	6	15%
Totals		189	97	51%

Table 12

Workforce Education and Training

To meet the Legislative Goal, *Incorporate the input of clients and family members of clients, and when possible utilize them as trainers and consultants in public mental health WET programs and/or activities*, the Office of Consumer and Family Affairs (OCFA) are invited to the Workforce Development Discussion (WDD) meeting. The purpose of the WDD is to provide input on the implementation of the MHSA WET Plan components.

Peer and Family Advocates (PFAs) train in collaboration with the Training and Development Specialists (TDS) at WET. As part of the Crisis Intervention Training (CIT), PFAs also conduct the Shaken Tree training which is an award-winning documentary film that illuminates, through a collection of stories, the journey families experience when one of its members has chronic, persistent mental illness. Addressing their journey of pain, grief, feeling of helplessness, despair, and stigma associated with mental illness, while giving the viewer hope and ways to survive and live life fully while sharing it with someone who has a mental illness. After the documentary is viewed, the PFA leads a discussion regarding the film, and connects their own experiences with mental illness as a person in recovery of a mental illness, and a family member of someone with a mental illness, respectively.

As of FY 2014/15 the Shaken Tree training is shown in DBH New Employee Orientation in order to familiarize all new staff with the perspective of family members of consumers battling mental illness. PFAs also participated in the "Get Psyched" conference to encourage youth to consider careers in the mental health field.

Artwork by Kathy Joy

The PFAs are also part of the Trauma Resiliency Model (TRM) training team. TRM training is a 3-day course designed to teach skills to stabilize ones nervous system to reduce and/or prevent the symptoms of traumatic stress.

This model has been used successfully with adults and children and is being utilized at Juvenile Hall, triage, Community Crisis Response Team (CCRT), disaster response, Full Service Partnership (FSP), outpatient therapy, and Crisis Walk-In Clinic (CWIC). TRM is an integrative mind-body approach, which focuses on the biological foundation of trauma and the reflexive, defensive ways the body responds to threat and fear. Although this training does not directly address alcohol and drug treatment, trauma often results in substance use/ abuse. TRM promotes healing of mind and body in adults and children around the globe suffering from trauma and thereby creates a healthier and safer world.

Workforce Education and Training

To meet the Legislative Goal, *Incorporate the input of diverse racial/ethnic populations that reflect California's general population into WET programs and/or activities*, DBH uses multiple methods. DBH uses the Workforce Development Discussion (WDD) meeting and partners with the Office of Cultural Competency and Ethnic Services (OCCES) to help maximize the ability of the existing and potential workforce, contract agencies, and Fee-For-Service providers, to provide culturally and linguistically appropriate services to County residents by:

- Providing Cultural Competence training to all staff.
- Developing policies that clarify the usage of bilingual staff for interpretation services, as well as provide guidelines on providing appropriate services for diverse cultural groups.
- Providing interpreter training to all bilingual staff.
- Recruiting and retaining multilingual and multicultural staff.
- Working with the communities we serve to address the cultural needs of the community.

OCCES also works closely with the Workforce Development Discussion (WDD) committee to ensure the needs of the diverse racial/ethnic populations of San Bernardino County are being met.

To meet the Legislative Goal, *Establish regional partnerships*, the Southern Counties Regional Partnership (SCRP) was created in 2009. SCRP is a collaborative effort between ten (**10**) Southern California counties. The Partnership's goals are to coordinate regional education programs, disseminate information and strategies throughout the region, develop common training opportunities and share programs that increase diversity of the public mental health system workforce when those programs are more easily coordinated at a regional level. The ten (**10**) member counties include:

- Kern.
- Imperial.
- Orange.
- Riverside.
- San Bernardino.
- San Diego.
- San Luis Obispo.
- Santa Barbara.
- Tri Cities.
- Ventura.

San Bernardino County was the fiscal agent of SCRP until June 30, 2014. Santa Barbara County assumed responsibility as the fiscal agent during FY 2014/15. San Bernardino continues to participate in SCRP as a member county.

To meet the Legislative Goal, *Coordinate WET programs and/or activities*, the WET staff continues to coordinate all WET programs/activities.

Outreach and Engagement Activities

Workforce Education and Training (WET) continues to conduct outreach and engagement activities throughout San Bernardino County. The table below identifies the activities conducted in FY 2014/15:

Activity Type	Number of Activities	Number of Participants
College and Career Fairs	17	1,480
Classroom Presentation = School Sites	8	630
Mock Interviews = Colton-Redlands-Yucaipa Regional Occupational Program (CRY-ROP)	2	30
Career Expo = CSUSB	1	50
Career Fairs = CBU Nursing	1	60
Career Fairs = CSUSB BSW/MSW	1	60
Career Fairs = LLUMC Public Health	1	100
Career Fairs = Western University	1	100
Career Fairs = Community	2	60
University of Redlands = Foster Youth	1	200
Totals	**35**	**2,770**

Table 13

"Thank you for this opportunity and for allowing our students to truly gain a deeper understanding and appreciation for the community around them. My students too came back with positive feedback and an excitement about the event and the people it serviced. Thanks for this opportunity!"

— Jose Quintero, Chaffey High School AVID Coordinator - Recovery Happens Attendee

Success Story

Benjamin Knisley, former intern, obtained his Bachelor's of Science in Applied Statistical Analysis. He is now a DBH Business System Analysis I with Research and Evaluations.

"As a student I have learned that opportunities present themselves, but it requires a lot of support, effort, and encouragement to recognize and act on them. Going into the internship program I knew there were challenges here at DBH that would push me even harder not just to learn routine procedures, but how to transform our results into a fast-paced reproducible product. The experience has been humbling and if it was not for the many talented, experienced, and invaluable staff members that have not only contributed to my work but supported all of my efforts, I could not have succeeded during my internship. So it came as a huge shock that during my internship that I was offered a position. When my wife heard the news she literally jumped up and down ecstatic to hear that we would be able to stay and invest our energy into this wonderful department.

Artwork by Gerard McDearmon

I cannot tell you how appreciative we are to be here and to give our best to such a wide array of generous, kind, and talented people. It has been an honor to invest our time here and we are looking forward to many more challenges where each of us continues to build and encourage one another to excel still more."

Workforce Education and Training

Challenges

- Difficulty retaining licensed clinical staff due to challenges presented by recent MOU negotiations within the Professional bargaining unit.
- Loss of Psychiatrists. DBH continues to lose Psychiatrists to retirement or to other employers that can offer higher wages or better benefits.
- High vacancy rates in clinical positions that are higher than the hiring rate.

Solutions in Progress

The department is working closely with County Human Resources to develop creative solutions to address the issue of retaining qualified licensed clinicians.

Program Updates

For FY 2016/17, WET is continuing the expansion of the Psychiatry Residency Program in an effort to address the Psychiatrist shortage in the County. The department is also expanding the License Exam Prep Program (LEPP) guidelines to include non-clinical professionals.

Artwork by Faith Forsey

Workforce Education and Training

Collaborative Partners

- Alder School of Professional Psychology.
- American Career College.
- Argosy University.
- Arrowhead Regional Medical Center (ARMC).
- Azusa Pacific University.
- Brandman University.
- California Baptist University.
- California State Polytechnic University, Pomona.
- California State University, Fullerton.
- California State University, Long Beach.
- California State University, Northridge.
- California State University, San Bernardino.
- Center for Information Systems and Technology – Claremont Graduate University.
- Chapman University.
- Chicago School of Professional Psychology.
- Colton-Redlands-Yucaipa Regional Occupational Program (CRY-ROP).
- Hope International University.
- Inland Coalition.
- Intercoast College.
- ITT Technical Institute.
- La Sierra University.
- Loma Linda University – School of Behavioral Health (LLUSBH).
- Loma Linda University Medical Center (LLUMC).
- Loma Linda University School of Medicine (LLUSM).
- Mount St. Mary's.
- National University.
- Pacifica Graduate University.
- Pomona Valley Hospital Medical Center (PVHMC).
- San Bernardino County Superintendent of Schools Regional Occupational Program.
- Summit Career College.
- Touro University College of Osteopathic Medicine (TUCOM).
- UEI College.
- University of California, Riverside.
- University of La Verne.
- University of Redlands.
- University of Southern California.
- Western University of Health (WUH).

Artwork by Rachel Miller

Artwork by Gerald McDearmon

Capital Facilities and Technological Needs (CFTN)

Capital Facilities and Technological Needs

Introduction

Each County's Capital Facilities and Technological Needs Component must support the goals of the Mental Health Services Act (MHSA) and the provision of MHSA services. The planned use of the Capital Facilities and Technological Needs funds produces long- term impacts with lasting benefits that support the mental health system movement towards the goals of wellness, recovery, resiliency, cultural competence, help first, and expansion of opportunities for accessible community-based services for consumers and their families.

These efforts include the development of a variety of technology uses and strategies and/or community-based facilities which support integrated service experiences that are culturally and linguistically appropriate. Funds may also be used to support an increase in peer-support and consumer-run facilities, development of community-based, less restrictive settings that will reduce the need for incarceration or institutionalization, and the development of a technological infrastructure for the public mental health system to facilitate high quality, cost-effective services and supports for consumers and their families.

Artwork by Jason Baldridge

The San Bernardino County Department of Behavioral Health (DBH) has embraced the transformational concepts inherent to MHSA to develop a community driven, culturally competent, wellness focused Capital Facilities and Technology needs component that supports the public mental health system and infrastructure to improve the delivery of services across the county.

MHSA Legislative Goals and Related Key Outcomes

- Expansion of the capacity/access of existing services or the provision of new services:
  - ◊ Increased capacity.
  - ◊ Increased access to services.
  - ◊ Increased provision of new services.

- Increase the county mental health infrastructure on a permanent basis:
  - ◊ Permanent capital asset obtained.

- Modernize and transform clinical and administrative information systems to ensure quality of care, parity, operational efficiency, and cost effectiveness:
  - ◊ Implement, maintain, and improve the Electronic Heath Records.

Capital Facilities

Existing County-Owned Structure and Surrounding Area

Works in Progress
DBH has four (**4**) Capital Facilities projects, in various stages, for the expansion of crisis services. All of the projects are part of DBH's grant application to the California Health Facilities Financing Authority (CHFFA), for capital funding for construction of crisis residential treatment facilities, and a crisis stabilization unit.

Three (**3**) of these new projects are Crisis Residential Treatment (CRT) facilities that will be located in the Central, West Valley, and High Desert regions throughout San Bernardino County. The fourth (**4th**) project is a Crisis Stabilization Unit (CSU) that will be located in the Central Valley Region of San Bernardino County. These proposed plans are highly contingent upon the availability of real estate stock in the various regions of the County and may be subject to change.

The Crisis Residential Treatment (CRT)

The first of the CRTs to be completed will be located in the city of San Bernardino. The timeline for the process is:

- Board approved DBH's request to apply for the CHFFA grant on 9/9/14.
- DBH applied for the grant.
- Letter of initial approval was received on 11/5/14.
- Final approval was received on 12/4/14.
- San Bernardino Board of Supervisors approved DBH's request to accept the grant was on 3/3/15.

Preliminary Architectural Plan of San Bernardino site

The project will demolish two (**2**) uninhabitable buildings, and replace with a newly designed structure that will meet the needs for one new CRT facility. The CRT will contain **16** beds, and specialize in providing crisis intervention for individuals diagnosed with co-occurring substance use disorders and mental health disorders.

Construction of the new facility is currently in progress and the ground breaking ceremony occurred on 11/5/15. The facility is estimated to be open for services by 9/1/16.

The second Crisis Residential Treatment (CRT) facility is planned to be located within San Bernardino County, potentially in the high desert region. The timeline for the process for the high desert CRT facility is:

- DBH's request to apply for the CHFFA grant was presented/approved by the board on 3/17/15.
- The application was submitted to CHFFA on 3/25/15.
- Letter of initial approval was received on 5/15/15.
- DBH has presented a request to the San Bernardino County Board of Supervisors to purchase property in Victorville and this was approved on 10/6/15.

Unlike the CRT in San Bernardino, this project will not require a demolition of any existing buildings, as the proposed site is vacant land containing needed infrastructure including gas, electricity, water and telephone. The CRT will contain **16** beds and specialize in providing crisis intervention for individuals diagnosed with co-occurring substance use and mental health disorders. Construction is estimated to commence in FY 2015/2016 and to be open for services sometime in FY 2016/2017.

As with all site based projects, these proposed plans are subject to change based on the availability of real estate stock in the various regions of the County.

Preliminary Architectural Plan of High Desert CRT

Capital Facilities and Technological Needs

The third Crisis Residential Treatment (CRT) facility is planed to be located within San Bernardino County, potentially in the central valley, and is in early planning stage. Just like the other two (**2**) CRTs, the process for the central valley CRT facility started with a request to the Board of Supervisors to approve a request to apply for the CHFFA grant that would be the major source of funding for this project. The timeline for the process of this central valley facility is:

- DBH's request to apply for the CHFFA grant was approved by the board on 9/1/15.
- DBH submitted the grant application on 9/4/15.
- The letter of initial approval was received on 10/28/15.
- Final letter of approval was received 12/18/15.

Construction is estimated to begin FY 2016/2017 and to be open for services sometime in FY 2017/2018. As with any site based project, these proposed plans are subject to change based on availability of real estate stock in the various regions of the County.

Preliminary Architectural Plan of Proposed CRT in Fontana

The new CRT facilities will be modeled after DBH's previously approved Capital Facilities project, the Transitional Age Youth (STAY) One Stop Center/Crisis Residential. The CRTs will be unlocked, voluntary, short-term crisis residential programs for San Bernardino residents ages 18 and older.

The programs, supported under the Community Services and Supports component, will provide structured recovery-based, enriched treatment services and activities. Services for these facilities will include, but will not be limited to:

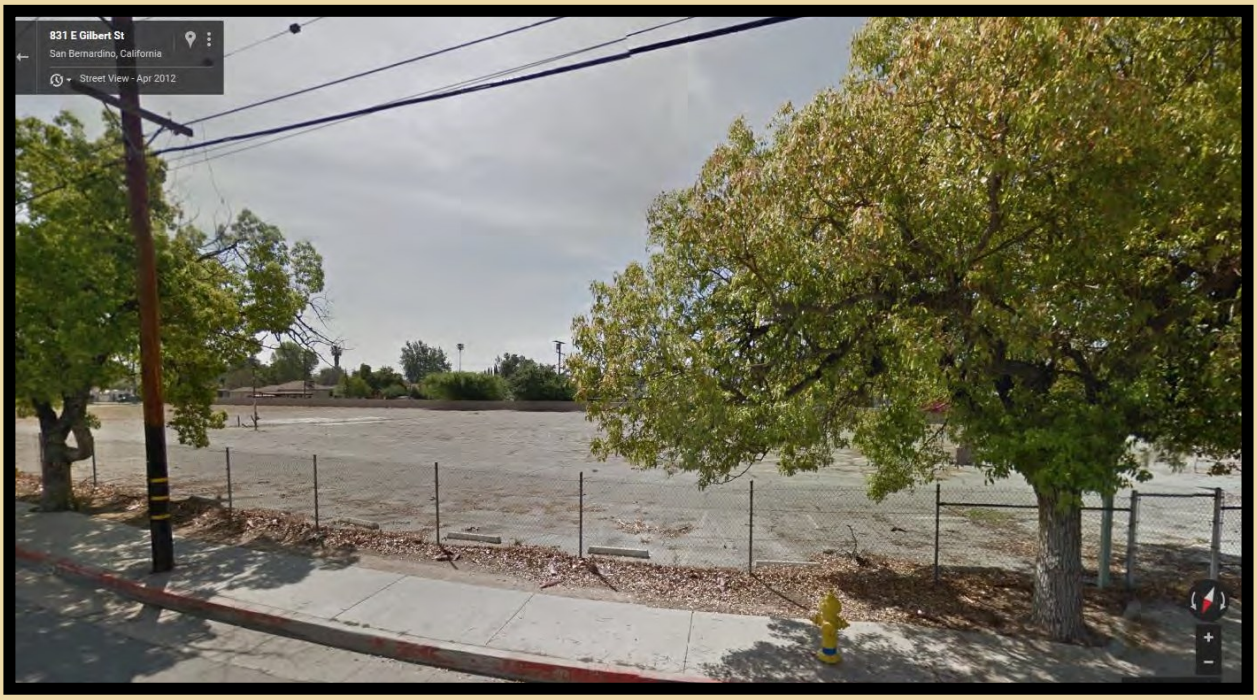
- Assessments.
- Treatment plan development.
- Collateral services.
- Crisis intervention.
- Medication support services.
- Individual and group therapy.
- Case management.

The Crisis Stabilization Unit

The Crisis Stabilization Unit (CSU) will be located within San Bernardino County, potentially in the Central Valley Region of San Bernardino County, and is in the early planning stages. The process, just like the CRTs, started with the following timeline:

- DBH's request to apply for the CHFFA grant was presented to and approved by the San Bernardino County Board of Supervisors on 9/1/15.
- The application for the grant was subsequently submitted to CHFAA on 9/4/15.
- DBH received the initial approval for the grant on 10/28/15.

The proposed site for the CSU program is proposed in the city of San Bernardino on county–owned land. The CSU will be a 23-hour psychiatric urgent care center where individuals experiencing a mental health crisis can be assessed for stabilization services, have medication evaluated, or assessed for hospitalization if necessary. The CSU will be an unlocked voluntary facility with **20** beds to serve **16** adults ages 18 and older and four (**4**) adolescents ages 13 to 17. Construction is anticipated to begin in FY2016/17 with occupation and commencement of services in 2017.



Proposed Site for Crisis Stabilization Unit in San Bernardino

Capital Facilities and Technological Needs

Technological Needs

The overarching goal of the technology portion of the Capital Facilities and Technological Needs Components is to support the modernization of information systems and to increase consumer/family empowerment by providing the tools for secure access to health and wellness information. These projects will result in improvements in the quality of care, operational efficiency, coordination of care, and cost effectiveness.

Behavioral Health Management Information Systems (BHMIS) Replacement – Electronic Health Record (EHR)

Replacement of the Department of Behavioral Health's (DBH) **22**-year-old information system that is used to track clients as they progress through treatment system by implementing a new Behavioral Health Management information System (BHMIS) that incorporates an integrated Electronic Health Records (HER) system to improve technological efficiencies will allow DBH to meet changing state requirements. DBH is working on implementing an Electronic Health Record System that would allow information to be securely accessed and exchanged.

The purpose of the electronic health record is to provide a well-designed system to support better information capture, allowing clinicians to fully document care in a manner that fosters client and family interactions, enables highly functional reporting and data aggregation, as well as enhances coordination of care between internal and external providers.

Data Warehouse

The purpose of a data warehouse is to bring information together from different sources so overall services and trends can be analyzed to help improve overall service delivery. The data warehouse is a repository of information collected from a variety of data systems, including the department's current billing system, the hospitalization tracking system, pharmacy data, and the Full Service Partnership Data Collection and Reporting system. This data will expand to include more clinical information from the upcoming electronic health record and other outcomes systems.

The data warehouse has been updated to the latest technology, allowing for a more robust and efficient data analysis, focused on improving service delivery to consumers and family members. The warehouse is also being prepared to accept new data, from changes to our diagnostic system, new outcome measure systems, as well as the new electronic health record. These additional data elements will allow the department to better analyze the efficacy of services across multiple domains.

Reports and analyses generated from data in the warehouse have helped drive evaluation of, and decision making around, program planning across the system of care and has been central to current and upcoming conversations about program development. This data was also foundational for the department's successful Senate Bill 82 (SB82) grant proposals.

Success Stories

Electronic Health Records (EHR)

- Gained overwhelming support from clinical staff for enterprise-wide implementation of e-prescribing (Dr. First) solution.
- Increased staffing to provide adequate support for the BHMIS project.
- Increased network infrastructure to support the BHMIS project.
- Implemented system infrastructure hardware enhancements/upgrades in support of the BHMIS project.
- Analyzed and updated business processes.

Data Warehouse

- Developed first draft of new interactive dashboards from warehouse data, which provide more accessible data to influence decision making.
- Developed access studies to explore geographic and service access to behavioral health care for adult mental health, substance use disorder, and EPSDT consumers.
- Expanded program evaluation reports for children's programs to include new metrics.
- Provided internship opportunities for students to work with real-world data warehouses. This resulted in one student being hired, expanding the County workforce and sustainable knowledgebase.
- Upgrade the data warehouse to a new version of software.

Artwork by Barbara Mason

Capital Facilities and Technological Needs

Challenges

DBH continues to move forward with updating the department's technology in regards to the EHR system and the data warehouse. Some of the challenges encountered include:

Electronic Health Records (EHR)

- Time constraints.
- Changes at the State and Federal level as it pertains to requirements for billing and claiming affecting current business processes.
- Retention of knowledgebase due to staff attrition.
- Transforming the business process.
- Data conversion.

Data Warehouse

- Changes in data sources that feed into the data warehouse.
- Retention of technical staff knowledgeable about maintaining local support for the warehouse.

Solutions in Progress

Solutions identified by the implementation team include:

Electronic Health Records (EHR)

- Implement Phase II of e-prescribing (Dr. First) solution.
- Revision of the implementation schedule based on the assessment of the Business Process Group.
- Continuing data integrity checks and data preparation for data conversion.
- Scheduling Dr. First training for in-house staff.

Data Warehouse

- Revision of the upgrade schedule based on changes to other data sources.
- Focus on integrating data from the Transformation Collaborative Outcomes Management measures.
- Additional technical training from the vendor on supporting the warehouse.
- Additional consulting time from the vendor to ensure smooth operations when problems arise.

Collaborative Partners

The following agencies are collaborative partners for the CFTN component:

County of San Bernardino Partners

- Information Services Department (ISD).
- Arrowhead Regional Medical Center (ARMC).
- Department of Behavioral Health (DBH) staff.
- County Counsel.
- Purchasing Department.
- County Administrative Office (CAO).

Community Partners

- Contracted Service Providers.
- Contracted Vendor.
- Local Universities.

Artwork by Raymond Geisel

Fiscal

Estimated Cost Per Client Fiscal Year 2016-2017
County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Annual Update FY 2016-2017

PREVENTION AND EARLY INTERVENTION

Program Name		Abbreviation	Estimated Total Mental Health Expenditures	Estimated Clients Served by Age Group				Estimated Number of Clients	Estimated Cost Per Client
				Children/ Youth (0-15)	TAY (16-25)	Adult (26-59)	Older Adult (60+)		
PEI SI-1	Student Assistance Program	SAP	$ 3,147,677	21,250	2,750	3,500		27,500	$ 114
PEI SI-2	Preschool PEI Program	PPP	$ 425,000	657		243		900	$ 472
PEI SI-3	Resilience Promotion in African American Children	RPiAAC	$ 672,477	4,036	383	3,100		7,519	$ 89
PEI CI-1	Promotores de Salud	PdS	$ 1,148,630	600	2,100	25,500	1,800	30,000	$ 38
PEI CI-2	Family Resource Centers	FRC	$ 3,350,000	10,000	2,700	8,000	1,300	22,000	$ 152
PEI CI-3	Native American Resource Center	NARC	$ 500,000	542	509	538	162	1,751	$ 286
PEI CI-4	National Crossroads Training Institute Crossroads Education	NCTI	$ 530,000	500	4,000			4,500	$ 118
PEI SE-1	Older Adult Community Services	OACS	$ 963,818				6,300	6,300	$ 153
PEI SE-2	Child and Youth Connection	CYC	$ 16,112,051	14,765	1,735	4,625		21,125	$ 763
PEI SE-3	Community Wholeness and Enrichment	CWE	$ 1,643,755		1,203	2,800		4,003	$ 411
PEI-SE-4	Military Services and Family Support	MSFS	$ 725,000	541	934	2,509	203	4,187	$ 173
PEI SE-5	Lift - Home Nurse Visitation Program	Lift	$ 396,000		54	66		120	$ 3,300
PEI SE-6	Coalition Against Sexual Exploitation	CASE	$ 311,498	50	1,000	3,000		4,050	$ 77
	Total Program Costs		$ 29,925,906					133,955	$ 223
	PEI Administration		$ 3,532,065						
	PEI Total		$ 33,457,971						

Total Clients Served = 133,955 or $223 per person

Estimated Cost Per Client Fiscal Year 2016-2017
County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Annual Update FY 2016-2017

COMMUNITY SERVICES AND SUPPORTS

Program Name		Abbreviation	Estimated Total Mental Health Expenditures	Estimated Clients Served by Age Group				Estimated Number of Clients	Estimated Cost Per Client
				Children/ Youth (0-15)	TAY (16-25)	Adult (26-59)	Older Adult (60+)		
A-1	Clubhouse Expansion Program		$ 2,925,739			5,871		5,871	**$ 498**
A-2	Forensic Integrated Mental Health Services	CIT/HDMC/FACT/STAR	$ 9,127,589			263		263	**$ 34,771**
A-3	Members Assertive Positive Solutions/Assertive Community Treatment	ACT/MAPS	$ 5,871,090			185		185	**$ 31,736**
A-4	Crisis Walk-in Centers/Crisis Stabilization Unit	CWIC	$ 8,495,216	125	700	1,900	100	2,825	**$ 3,007**
A-5	Psychiatric Triage Diversion Program		$ 3,101,928		500	2,000	500	3,000	**$ 1,034**
A-6	Community Crisis Response Team	CCRT	$ 8,327,774	2,128	872	2,288	294	5,582	**$ 1,492**
A-7	Homeless Intensive Case Management and Outreach Services	HICMOS	$ 9,439,460		2	1,280	66	1,348	**$ 7,003**
A-8	Big Bear Full Service Partnership		$ 370,000			73	72	145	**$ 2,562**
A-9	Access, Coordination and Service Enhancement of Quality Behavioral Health Services	ACE	$ 2,515,962	477	477	477	477	1,908	**$ 1,319**
A-10	Crisis Residential Treatment Program		$ 1,250,000			750		750	**$ 1,667**
A-11	Regional Adult FSP		$ 8,381,519			534		534	**$ 15,702**
C-1	Comprehensive Children and Family Support Services	CCFSS	$ 23,420,516	2,081				2,081	**$ 11,256**
C-2	Integrated New Family Opportunities	INFO	$ 1,357,290		55			55	**$ 24,678**
OA-1	Agewise - Circle of Care: General System Development		$ 1,722,206				190	190	**$ 9,064**
OA-2	Agewise - Circle of Care: Mobile Outreach and Intensive Case Management		$ 573,203				150	150	**$ 3,821**
TAY-1	Transitional Age Youth One Stop Centers	TAY	$ 5,781,754		1,565			1,565	**$ 3,694**
	Total Program Costs		$ 92,661,246					26,451	$ 3,503
	CSS Administration		$ 14,629,942						
	CSS Total		$ 107,291,188						

Total Clients Served = 26,451 or $3,503 per person

Estimated Cost Per Client Fiscal Year 2016-2017
County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Annual Update FY 2016-2017

INNOVATION

Program Name	Abbreviation	Estimated Total Mental Health Expenditures	Estimated Clients Served by Age Group				Estimated Number of Clients	Estimated Cost Per Client
			Children/ Youth (0-15)	TAY (16-25)	Adult (26-59)	Older Adult (60+)		
Transitional Age Youth Behavioral Health Hostel	The STAY	$ 1,875,000		72			72	$ 26,042
Recovery Based Engagement Support Teams	RBEST	$ 1,509,502			300		300	$ 5,032
Total Program Costs		$ 3,384,502					372	$ 9,098
INN Administration		$ 846,927						
INN Total		$ 4,231,429						

Total Clients Served = 372 or $9,098 per person

FY 2016/17 Mental Health Services Act Annual Update
Funding Summary

County: San Bernardino

Date: 3/31/16

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2016/17 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	67,958,630	18,780,871	5,099,386	941,327	12,153,389	
2. Estimated New FY 2016/17 Funding	74,759,933	18,689,983	4,917,864			
3. Transfer in FY 2016/17a/	(12,388,748)			2,639,178	9,749,570	
4. Access Local Prudent Reserve in FY 2016/17						0
5. Estimated Available Funding for FY 2016/17	130,329,815	37,470,854	10,017,250	3,580,505	21,902,959	
B. Estimated FY 2016/17 MHSA Expenditures	69,338,268	17,719,029	2,920,110	3,580,505	20,958,367	
G. Estimated FY 2016/17 Unspent Fund Balance	60,991,547	19,751,825	7,097,140	0	944,592	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2016	22,152,363
2. Contributions to the Local Prudent Reserve in FY 2016/17	0
3. Distributions from the Local Prudent Reserve in FY 2016/17	0
4. Estimated Local Prudent Reserve Balance on June 30, 2017	22,152,363

a/ Pursuant to Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five

FY 2016/17 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding

County: San Bernardino

Date: 3/29/16

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. SI-1 Student Assistance Prgm	3,147,677	3,147,677				
2. SI-2 Preschool Program	425,000	425,000				
3. SI-3 Resilience in African-Amr Children	672,477	672,477				
4. CI-1 Promotores de Salud/Comm Health Worker	1,148,630	1,148,630				
5. CI-4 National Crossroads Education Institute Training	530,000	530,000				
6. SE-1 Older Adult Community Services	963,818	963,818				
7. SE-4 Military Services & Family Support	725,000	725,000				
8. SE-5 LIFT	396,000	396,000				
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. CI-2 Family Resource Centers	3,350,000	3,350,000				
12. CI-3 Native American Resource Centers	500,000	500,000				
13. SE-2 Child and Youth Connection	16,112,051	1,163,056	4,808,055		5,115,504	5,025,436
14. SE-3 Community Wholeness and Enrichment	1,643,755	1,643,755				
15. SE-6 Coalition Against Sexual Exploitation (CASE)	311,498	311,498				
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	3,532,065	2,742,118	789,947			
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	33,457,971	17,719,029	5,598,002	0	5,115,504	5,025,436

FY 2016/17 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding

County: San Bernardino

Date: 3/31/16

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. C-1 Comprehensive Child and Family Support System	23,420,516	11,205,530	6,475,270		5,239,716	500,000
2. C-2 Integrated New Family Opportunity Prog	1,357,290	1,124,816	85,687		146,787	
3. TAY - One Stop Center	5,781,754	3,968,491	1,445,595		327,535	40,133
4. A-2 Forensic Integrated Mental Health Srv	9,127,589	5,587,988	2,937,981		21,643	579,977
5. A-3 Members Assertive Positive Solutions/ Assertive Community Treatment	5,871,090	3,778,751	2,056,565		222	35,552
6. A-7 Homeless Intensive Case Mgmt & Outreach	9,439,460	7,865,337	976,720			597,403
7. A-8 Big Bear Full Services Partnership	370,000	254,922	107,010		5,839	2,229
8. OA-2 Older Adult Case Management	573,203	285,272	287,931			
9. A-11 Regional Adult	8,381,519	6,030,647	2,350,872			
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. A-1 Clubhouse	2,925,739	2,925,739				
2. A-4 Crisis Walk-In Center/Crisis Stabilization Unit	8,495,216	3,524,363	4,003,273		826,233	141,347
3. A-5 Psych Diversion Team at ARMC	3,101,928	2,186,858	744,322		50,176	120,572
4. A-6 Community Crisis Response Team	8,327,774	3,631,739	2,798,675		1,851,357	46,003
5. OA-1 Circle of Care	1,722,206	1,348,984	346,889			26,333
6. A-9 Assessment, Coordination & Enhancement	2,515,962	2,515,962				
7. A-10 Crisis Residential Treatmen Program	1,250,000	1,250,000				
8.		0				
9.		0				
10.		0				
11.		0				
12.		0				
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS Administration	14,629,942	11,852,869	1,577,053			1,200,020
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	107,291,188	69,338,268	26,193,843	0	8,469,508	3,289,569
FSP Programs as Percent of Total	60.0%					

FY 2016/17 Mental Health Services Act Annual Update
Innovations (INN) Funding

County: San Bernardino

Date: 3/29/16

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Youth Hostel	1,875,000	563,681	1,177,493		16,970	116,856
2. Recovery Based Engagement Supp Team	1,509,502	1,509,502				
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	846,927	846,927				
Total INN Program Estimated Expenditures	4,231,429	2,920,110	1,177,493	0	16,970	116,856

FY 2016/17 Mental Health Services Act Annual Update
Workforce, Education and Training (WET) Funding

County: San Bernardino

Date: 3/29/16

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Workforce Staffing and Support	1,421,691	1,421,691				
2. Training and Technical Assistance	286,400	286,400				
3. Mental Health Career Pathways Program	27,500	27,500				
4. Residency and Internship Program	1,913,603	1,667,499	246,104			
5. Financial Incentive Program	75,000	75,000				
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	102,416	102,416				
Total WET Program Estimated Expenditures	3,826,609	3,580,505	246,104	0	0	0

FY 2016/17 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Funding

County: San Bernardino

Date: 3/29/16

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. CHFFA 2	5,519,446	1,573,540				3,945,906
2. CHFFA 3	5,018,238	1,964,144				3,054,094
3. CHFFA 4 CSUEV	5,332,508	2,632,508				2,700,000
4. CHFFA 4 CRWV	4,887,265	999,080				3,888,185
5. CHFFA 5 CSUF	6,984,645	3,934,645				3,050,000
6. CHFFA 5 CRMR	5,605,681	1,000,000				4,605,681
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11. Data Warehouse Continuation Project	1,772,814	1,772,814				
12. Empowered Communication/Sharepoint Proj	7,877	7,877				
13. Virtual Infrastructure Project	30,240	30,240				
14. Electronic Health Record Project	1,788,279	1,788,279				
15. BHMIS Replacement Proj	4,347,433	4,347,433				
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	907,807	907,807				
Total CFTN Program Estimated Expenditures	42,202,233	20,958,367	0	0	0	21,243,866

Attachments

Behavioral Health

Aimara Freeman, Media Specialist
(909) 383-3952
Aimara.Freeman@dbh.sbcounty.gov
(Contact information for media use only, not for publication)

February 3, 2016

Public invited to learn more about County mental health services

The San Bernardino County Department of Behavioral Health (DBH) invites members of the community to attend an annual stakeholder engagement meeting to learn more about the public mental health service delivery system in San Bernardino County.

These public stakeholder meetings will promote community conversation and participation regarding the Mental Health Services Act (MHSA) Annual Update for Fiscal Year 2016/17, in addition to a facilitated discussion regarding the future of mental health policy and program planning in San Bernardino County.

The MHSA (Prop 63) was passed by California voters in November 2004 to expand mental health services for children and adults. The Act is funded by a 1 percent tax surcharge on personal income over $1 million, per year.

"Participation in the stakeholder process is important because it gives residents both the opportunity to learn more about public services and their ability to influence those services," stated Michelle Dusick, MHSA Administrative Manager. "We encourage all community members to attend."

Stakeholder meetings will take place at locations throughout the county. For a complete list of dates, times and locations, please view the attached list. For more information, interpretation services or requests for disability-related accommodations, please call Aidery Hernandez at (909) 386-8223 (7-1-1 for TTY users.)

DBH, through the MHSA, is supporting the Countywide Vision by providing behavioral health and alcohol and drug services that promote wellness, recovery and resiliency in the community. Information on the Countywide Vision and the Department of Behavioral Health can be found at www.sbcounty.gov.

Mental Health Services Act (MHSA) Annual Update
Community Program Planning meeting dates, hours and locations.
(TTY users, please dial 7-1-1 for all phone numbers listed.)

Community Policy Advisory Committee (CPAC) and Cultural Competency Advisory Committee (CCAC) Meetings		
Meeting Date/Time		**Meeting Location**
Community Policy Advisory Committee (CPAC)	Thursday, March 17, 2016 9:00a.m. - 11:00a.m.	CSBHS – Auditorium 850 E. Foothill Blvd., Rialto, CA 92376 Contact Cheryl McAdam (909)252-4021
Cultural Competency Advisory Committee (CCAC)	Thursday, March 17, 2016 1:00 - 3:00p.m.	CSBHS - Auditorium 850 E. Foothill Blvd., Rialto, CA 92376 Contact Aidery Hernandez (909)386-8223

District Advisory Committees (DAC) Meetings		
Meeting Date/Time		**Meeting Location**
1ST District Advisory Committee (DAC)	Wednesday, February 17, 2016 11:00 a.m. - 12:00 p.m.	Victor Community Support Services 15400 Cholame Rd. Victorville, CA 92392 Contact: Chris Croteau (760)995-8313
2nd/ 4th District Advisory Committee (DAC)	Thursday, February 25, 2016 2:00 to 3:30 p.m.	Mariposa Community Counseling 2940 Inland Empire Blvd, Room 168 Ontario, CA 91764 Contact Karina Esparza (909)458-1381
3rd District Advisory Committee (DAC)	Tuesday, February 16, 2016 11:00 a.m. – 12:00 p.m.	Phoenix Community Counseling Center 820 E. Gilbert Street, Room 153 San Bernardino, CA 92415 Contact: Margaret Hernandez (909)387-7607
5th District Advisory Committee (DAC)	Monday, February 22, 2016 5:30-7:30 p.m.	New Hope Family Life Center – Auditorium 1505 W. Highland Ave. San Bernardino, CA 92411 Contact: Crista Wentworth (909)421-4606

Special Sessions		
Meeting Date/Time		**Meeting Location**
Adobe Connect	Thursday, March 10, 2016 5:30-7:30 p.m.	Training Institute – Vai Sa Room 1950 S. Sunwest Lane, Suite 200 San Bernardino, CA 92415 Contact: Cheryl McAdam (909)252-4021
Spanish Session	Thursday, March 10, 2016 10:00a.m. – 12:00 p.m.	Consulate of Mexico in San Bernardino 293 North D Street San Bernardino, CA 92401

Cultural Competency Advisory Committee Subcommittee Meetings		
Meeting Date/Time		**Meeting Location**
Spirituality Awareness Subcommittee	February 9, 2016 1:00-2:30 p.m.	DBH Administration – Room 106 303 E. Vanderbilt Way San Bernardino, CA 92415
Asian Pacific Islander Awareness Subcommittee	Friday, February 12, 2016 10:00-11:30 p.m.	Asian American Resource Center 1115 S. E Street San Bernardino, CA 92408
Native American Awareness Subcommittee	February 16, 2016 2:00-3:30 p.m.	Native American Resource Center 11980 Mt. Vernon Ave. Grand Terrace, CA 92313
Disabilities Awareness Subcommittee	February 17, 2016 3:00-4:30 p.m.	DBH Administration – Room 106 303 E. Vanderbilt Way San Bernardino, CA 92415
Transitional Age Youth	February 17, 2016 11:00 a.m.-12:30 p.m.	One Stop TAY Center 780 Gilbert St. San Bernardino, CA 92404
Co-Occurring and Substance Abuse Subcommittee	February 18, 2016 3:00-4:30 p.m.	EMQ Families First 572 North Arrowhead Ave., San Bernardino, CA 92401 3:00-4:00 p.m.
Consumer and Family Member Awareness Subcommittee	February 22, 2016 2:00-3:30 p.m.	Pathways to Recovery Clubhouse 850 E. Foothill Blvd., Rialto, CA 92376 2:00-3:30 p.m.
LGBTQ Awareness Subcommittee	February 23, 2016 12:00-1:30 p.m.	DBH Administration – Room 109 A 303 E. Vanderbilt Way San Bernardino, CA 92415
Women's Awareness Subcommittee	February 24, 2016 1:00-2:30 p.m.	DBH Administration – Room 109 A 303 E. Vanderbilt Way San Bernardino, CA 92415
Veteran's Awareness Subcommittee	March 7, 2016 3:00-4:00 p.m.	DBH Administration – Room 109 A 303 E. Vanderbilt Way San Bernardino, CA 92415
Latino Health Awareness Sub Committee	March 10, 2016 10:00 a.m.-12:00 p.m.	Consulate of Mexico in San Bernardino – Lobby 293 North D Street San Bernardino, CA 92401
African American Awareness Subcommittee	March 14, 2016 2:00-3:30 p.m.	Young Visionaries 1580 N. Waterman Ave. San Bernardino, CA 92404
Contact: Aidery Hernandez (909)386-8223		

-30-

Behavioral Health

Aimara Freeman, Media Specialist
(909) 383-3952
Aimara.Freeman@dbh.sbcounty.gov
(Contacto information for media use only, not for publication)

3 de febrero del 2016

Público invitado para aprender más sobre servicios de salud mental del Condado

El Departamento de Salud Mental del Condado de San Bernardino invita a los miembros de la comunidad interesados a asistir una reunión anual para aprender sobre el sistema de prestación de servicios de salud mental en el Condado de San Bernardino.

Esta serie de reuniones públicas promueven la conversación comunitaria y participación en cuanto a la Actualización Anual de la Ley de Servicios de Salud Mental (MHSA, por sus siglas en inglés), correspondiente al año fiscal 2016/17, y para conversar sobre el futuro de la política de salud mental y planificación de programas en el Condado de San Bernardino

La Ley de Servicios de Salud Mental (también conocida como Proposición 63) fue aprobada por los electores de California en noviembre del 2004 para ampliar los servicios de salud mental para niños y adultos. La Ley es financiada por un impuesto adicional de 1% para aquellos cuyos ingresos personales son más de un millón de dólares al año.

"Participación en el proceso de personas interesadas es importante porque da a los residentes la oportunidad de aprender más sobre los servicios públicos y capacidad para influir en esos servicios," dijo Michelle Dusick, Gerente Administrativo de la MHSA. "Animamos a todos los miembros de la comunidad a asistir."

Estas reuniones para personas interesadas se llevarán a cabo en localizaciones a través del condado. Para una lista completa de fechas, tiempos y lugares, favor de ver la lista que sigue. Para más información, servicios de interpretación o las solicitudes de alojamiento relacionados con la discapacidad, por favor llame Aidery Hernandez al (909) 386-8223 (7-1-1 para los usuarios de TTY.)

DBH, a través de la MHSA, apoya la visión del Condado proporcionando servicios de salud mental y servicios de alcohol y drogas que promueven el bienestar, la recuperación y la resiliencia de la comunidad. Información sobre la Visión del Condado y del Departamento de Salud Mental puede encontrarse en www.sbcounty.gov.

Actualización Anual de la Ley de Servicios De Salud Mental
Fechas y horarios y lugares de Reuniones de Planificación de Programas Comunitarios
(Los usuarios de TTY, por favor marque 7-1-1 para todos los números de teléfono indicados.)

Reuniones de Comité Asesor de Política Comunitaria (CPAC por sus siglas en inglés) y Comité Consultivo de Competencia Cultural (CCAC por sus siglas en inglés)		
Fecha/Hora		**Lugar de Reunión**
Comité Asesor de Política Comunitaria (CPAC por sus siglas en inglés	Jueves, 17 de marzo del 2016 9:00 a.m. - 11:00 a.m.	CSBHS – Auditorio 850 E. Foothill Blvd., Rialto, CA 92376 Contacto Cheryl McAdam (909)252-4021
Comité Consultivo de Competencia Cultural (CCAC por sus siglas en inglés)	Jueves, 17 de marzo del 2016 1:00 - 3:00 p.m.	CSBHS - Auditorio 850 E. Foothill Blvd., Rialto, CA 92376 Contacto Aidery Hernandez (909)386-8223

Reuniones de Comité Consultivo de Distrito (DAC)		
Fecha/Hora		**Lugar de Reunión**
Primer Distrito	Miércoles, 17 de febrero del 2016 11:00 a.m. - 12:00 p.m.	Victor Community Support Services 15400 Cholame Rd. Victorville, CA 92392 Contacto: Chris Croteau (760)995-8313
Segundo y Cuarto Distrito	Jueves, 25 de febrero del 2016 2:00 – 3:30 p.m.	Mariposa Community Counseling 2940 Inland Empire Blvd., Cuarto 168 Ontario, CA 91764 Contacto Karina Esparza (909)458-1381
Tercer Distrito	Martes, 16 de febrero del 2016 11:00 a.m. – 12:00 p.m.	Phoenix Community Counseling Center 820 E. Gilbert Street, Room 153 San Bernardino, CA 92415 Contacto: Margaret Hernandez (909)387-7607
Quinto Distrito	Lunes, 22 de febrero del 2016 5:30-7:30 p.m.	New Hope Family Life Center – Auditorio 1505 W. Highland Ave. San Bernardino, CA 92411 Contacto: Crista Wentworth (909)421-4606

Sesiones Especiales		
Fecha/Hora		**Lugar de Reunión**
Adobe Connect – Sesión en Línea	Jueves, 10 de marzo del 2016 5:30-7:30 p.m.	Training Institute – Cuarto Vai Sa 1950 S. Sunwest Lane, Suite 200 San Bernardino, CA 92415 Contacto: Cheryl McAdam (909)252-4021
Sesión en Español	Jueves, 10 de marzo del 2016 10:00a.m. – 12:00 p.m.	Consulado de México en San Bernardino 293 North D Street San Bernardino, CA 92401

Coaliciones y Subcomités del Comité Consultivo de Competencia Cultural		
	Fecha/Hora	**Lugar de Reunión**
Subcomité de Concientización de Espiritualidad	Martes, 9 de febrero del 2016 1:00-2:30 p.m.	DBH Administration – Cuarto 106 303 E. Vanderbilt Way San Bernardino, CA 92415
Subcomité de Concientización de Asiáticos/Isleños del Pacifico	Viernes, 12 de febrero del 2016 10:00-11:30 p.m.	Asian American Resource Center 1115 S. E Street San Bernardino, CA 92408
Subcomité de Concientización de Nativos Americanos	Martes, 16 de febrero del 2016 2:00-3:30 p.m.	Native American Resource Center 11980 Mt. Vernon Ave. Grand Terrace, CA 92313
Subcomité de Concientización de Discapacidades	Miércoles, 17 de febrero del 2016 3:00-4:30 p.m.	DBH Administration – Room 106 303 E. Vanderbilt Way San Bernardino, CA 92415
Subcomité de Concientización de Jóvenes en Edad de Transición	Miércoles, 17 de febrero del 2016 11:00 a.m.-12:30 p.m.	One Stop TAY Center 780 Gilbert St. San Bernardino, CA 92404
Subcomité de Concientización de Diagnostico Dual y Drogadicción	Jueves, 18 de febrero del 2016 3:00-4:30 p.m.	EMQ Families First 572 North Arrowhead Ave., San Bernardino, CA 92401 3:00-4:00 p.m.
Subcomité de Concientización de Consumidores y Miembros de Familias	Lunes, 22 de febrero del 2016 2:00-3:30 p.m.	Pathways to Recovery Clubhouse 850 E. Foothill Blvd., Rialto, CA 92376 2:00-3:30 p.m.
Subcomité de Concientización de LGBTQ	Martes, 23 de febrero del 2016 12:00-1:30 p.m.	DBH Administration – Room 109 A 303 E. Vanderbilt Way San Bernardino, CA 92415
Subcomité de Concientización de Mujeres	Miércoles, 24 de febrero del 2016 1:00-2:30 p.m.	DBH Administration – Room 109 A 303 E. Vanderbilt Way San Bernardino, CA 92415
Subcomité de Concientización de Veteranos	Lunes, 7 de marzo del 2016 3:00-4:00 p.m.	DBH Administration – Room 109 A 303 E. Vanderbilt Way San Bernardino, CA 92415
Subcomité de Concientización Latino	Jueves, 10 de marzo del 2016 10:00 a.m.-12:00 p.m.	Consulate of Mexico in San Bernardino – Lobby 293 North D Street San Bernardino, CA 92401
African American Subcomité de Concientización de Afroamericanos	Lunes, 14 de marzo del 2016 2:00-3:30 p.m.	Young Visionaries 1580 N. Waterman Ave. San Bernardino, CA 92404
Contacto: Aidery Hernandez (909)386-8223		

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Please join the Department of Behavioral Health for a Mental Health Services Act Stakeholder Engagement!

Special Online After-Hours Event

Participate from the comfort of your own home!

This community stakeholder engagement will focus on the Mental Health Services Act (MHSA) Annual Update. Special focus will be placed on sharing how MHSA has been integrated into existing services and a discussion regarding the future of mental health policy and program planning.

When: Thursday, March 10, 2016
Where: Online Adobe Connect Event
Time: 5:30 - 7:30 p.m.
Conference Number: US/CAN Toll Free: 1-877-820-7831
Passcode: 947294
To join the meeting please use the link below:
https://sbcdbh.adobeconnect.com/r35hc7la1ng/

Please note: This will be an English language session. For questions or concerns, please contact: Cheryl McAdam (909) 252-4021 or 7-1-1 for TTY users or Cheryl.McAdam@dbh.sbcounty.gov.

MHSA (Proposition 63) was passed by California voters in November 2004 to expand mental health services for children and adults. The Act is funded by a 1% tax surcharge on personal income over $1 million per year.

SAN BERNARDINO COUNTY
Behavioral Health

***¡Únase al Departamento de Salud Mental** (DBH por sus siglas en inglés) para reuniones comunitarias para partes interesadas sobre la Ley de Servicios de Salud Mental!*

Sesión en Línea por la Tarde

Estas reuniones comunitarias para las partes interesadas se centrarán en la actualización anual de la Ley de Servicios de Salud Mental (MHSA por sus siglas en inglés). Enfoque especial se colocará en compartir cómo MHSA se ha integrado en los servicios existentes y habrá discusión sobre el futuro de la política de salud mental y planificación de programas.

Fecha: Jueves, 10 de marzo del 2016
Localización: En línea evento "Adobe Connect"
Horario: 5:30 - 7:30 p.m.
Numero de Conferencia: US/CAN Toll Free: 1-877-820-7831
Contraseña: 947294
Para unirse a la reunión por favor utilice el siguiente enlace:
https://sbcdbh.adobeconnect.com/r35hc7la1ng/

Por favor note: esta será una sesión solamente en inglés. Para preguntas o dudas, por favor comuníquese con Aidery Hernandez al (909) 386-8223; marque el 7-1-1 si usted es usuario TTY; también puede ir a: Aidery.hernandez@dbh.sbcounty.gov.

La Ley de Servicios de Salud Mental (Proposición 63) fue pasado por votantes de California en noviembre de 2004 para aumentar servicios de salud mental para niños y adultos. El Acta es financiada por un pago de impuesto de 1% en ingreso personal que sobrepasa un millón de dólares por año.

Please join the Department of Behavioral Health for a Mental Health Services Act Stakeholder Engagement!

Cultural Competency Advisory Committee Subcommittee Meetings

These community stakeholder engagements will focus on the Mental Health Services Act (MHSA) Annual Update. Special focus will be placed on sharing how MHSA has been integrated into existing services and a discussion regarding the future of mental health policy and program planning.

Spirituality Awareness Subcommittee **February 9, 2016** Department of Behavioral Health Administration, Rm 106 303 E. Vanderbilt Way, San Bernardino, CA 92415 1:00 - 2:30 p.m.	**Asian Pacific Islander Awareness Subcommittee** **February 12, 2016** Asian American Resource Center 1115 S. E Street, San Bernardino, CA 92408 10:00 - 11:30 a.m.	**Native American Awareness Subcommittee** **February 16, 2016** Native American Resource Center 11980 Mt. Vernon Ave., Grand Terrace, CA 92313 2:00 - 3:30 p.m.
Transitional Age Youth Awareness Subcommittee **February 17, 2016** One Stop TAY Center 780 E. Gilbert St., San Bernardino, CA 92404 11:00 a.m. - 12:30 p.m.	**Disabilities Awareness Subcommittee** **February 17, 2016** Department of Behavioral Health Administration, Rm 106 303 E. Vanderbilt Way, San Bernardino, CA 92415 3:00 - 4:30 p.m.	**Co-Occurring and Substance Abuse Subcommittee** **February 18, 2016** EMQ Families First 572 North Arrowhead Ave., San Bernardino, CA 92401 3:00 - 4:00 p.m.
Consumer & Family Member Awareness Subcommittee **February 22, 2016** Pathways to Recovery Clubhouse 850 E. Foothill Blvd., Rialto, CA 92376 2:00 - 3:30 p.m.	**LGBTQ Awareness Subcommittee** **February 23, 2016** Department of Behavioral Health Administration, Rm 109 A 303 E. Vanderbilt Way, San Bernardino, CA 92415 12:00 - 1:30 p.m.	**Women's Awareness Subcommittee** **February 24, 2016** Department of Behavioral Health Administration, Rm 109 A 303 E. Vanderbilt Way, San Bernardino, CA 92415 1:00 - 2:30 p.m.
Veteran's Awareness Subcommittee **March 7, 2016** Department of Behavioral Health Administration, Rm 109 A 303 E. Vanderbilt Way, San Bernardino, CA 92415 3:00 - 4:00 p.m.	**Latino Health Awareness Subcommittee** **March 10, 2016** Consulate of Mexico in San Bernardino — Lobby 293 North D Street, San Bernardino, CA 92401 10:00 a.m. - 12:00 p.m.	**African American Awareness Subcommittee** **March 14, 2016** Young Visionaries 1580 N. Waterman Ave., San Bernardino, CA 92404, 2:00 - 3:30 p.m.

For questions, concerns, interpretation services or requests for disability-related accommodations, please contact: Aidery Hernandez at (909) 386-8223 or 7-1-1 for TTY users or Aidery.hernandez@dbh.sbcounty.gov. Please request accommodations at least 7 business days prior to the event.

MHSA (Proposition 63) was passed by California voters in November 2004 to expand mental health services for children and adults.

The Act is funded by a 1% tax surcharge on personal income over $1 million per year.

SAN BERNARDINO COUNTY
Behavioral Health

¡Únase al Departamento de Salud Mental (DBH por sus siglas en inglés) para reuniones comunitarias para partes interesadas sobre la Ley de Servicios de Salud Mental!

Coaliciones y Subcomités del Comité Consultivo de Competencia Cultural

Estas reuniones comunitarias para las partes interesadas se centrarán en la actualización anual de la Ley de Servicios de Salud Mental (MHSA por sus siglas en inglés). Enfoque especial se colocará en compartir cómo MHSA se ha integrado en los servicios existentes y habrá discusión sobre el futuro de la política de salud mental y planificación de programas.

Subcomité de Concientización de Espiritualidad **9 de febrero del 2016** Administración de DBH— Cuarto 106 303 E. Vanderbilt Way, San Bernardino, CA 92415 1:00 - 2:30 p.m.	**Subcomité de Concientización de Asiáticos/Isleños del Pacifico** **12 de febrero del 2016** Asian American Resource Center 1115 S. E Street, San Bernardino, CA 92408 10:00 - 11:30 a.m.	**Subcomité de Concientizacion de Nativos Americanos** **16 de febrero del 2016** Native American Resource Center 11980 Mt. Vernon Ave., Grand Terrace, CA 92313 2:00 - 3:30 p.m.
Subcomité de Concientización de Jóvenes en Edad de Transición **17 de febrero del 2016** One Stop TAY Center 780 E. Gilbert St., San Bernardino, CA 92404 11:00 a.m. - 12:30 p.m.	**Subcomité de Concientización de Discapacidades** **17 de febrero del 2016** Administración de DBH - Cuarto 106 303 E. Vanderbilt Way, San Bernardino, CA 92415 3:00 - 4:30 p.m.	**Subcomité de Concientización de Diagnostico Dual y Drogadicción** **18 de febrero del 2016** EMQ Families First 572 North Arrowhead Ave., San Bernardino, CA 92401 3:00 - 4:30 p.m.
Subcomité de Concientización de Consumidores y Miembros de Familias **22 de febrero del 2016** Pathways to Recovery Clubhouse 850 E. Foothill Blvd., Rialto, CA 92376 2:00 - 3:30 p.m.	**Subcomité de Concientización de LGBTQ** **23 de febrero del 2016** Administración de DBH - Cuarto 109 A 303 E. Vanderbilt Way, San Bernardino, CA 92415 12:00 - 1:30 p.m.	**Subcomité de Concientización de Mujeres** **24 de febrero del 2016** Administración de DBH - Cuarto 109 A 303 E. Vanderbilt Way, San Bernardino, CA 92415 1:00 - 2:30 p.m.
Subcomité de Concientización de Veteranos **7 de marzo del 2016** Administración de DBH - Cuarto 109 A 303 E. Vanderbilt Way, San Bernardino, CA 92415 3:00 - 4:00 p.m.	**Subcomité de Concientización Latino** **10 de marzo del 2016** Consulado de México en San Bernardino - Sala de Espera 293 North D Street, San Bernardino, CA 92401 10:00 a.m. - 12:00 p.m.	**Subcomité de Concientización de Afroamericanos** **14 de marzo del 2016** Young Visionaries 1580 N. Waterman Ave., San Bernardino, CA 92408 2:00 - 3:30 p.m.

Para preguntas, dudas, servicios de interpretación o solicitudes de acomodos especiales por razones de incapacidad, por favor comuníquese con Aidery Hernandez al (909) 386-8223; marque el 7-1-1 si usted es usuario TTY; también puede mandar un correo electrónico a: Aidery.hernandez@dbh.sbcounty.gov. Por favor solicite estos acomodos por lo menos 7 días laborales previos al evento. La Ley de Servicios de Salud Mental (Proposición 63) fue pasada por votantes de California en noviembre del 2004 para aumentar servicios de salud mental para niños e adultos. La Ley es financiada por un pago de impuesto de 1% en ingresos personal que sobrepasa un millón de dólares por año.

Join the community forum in Spanish regarding the Mental Health Services Act

Consulate of Mexico in San Bernardino

Topic: Mental Health Services Act (MHSA)

Invited by: San Bernardino County, Department of Behavioral Health

Location: Consulate of Mexico in San Bernardino

293 North D Street, San Bernardino, CA 92401

Date: Thursday, March 10, 2016

Time: 10:00 a.m. - 12:00 p.m.

For questions, concerns, interpretation services or requests for disability-related accommodations, please contact:
Aidery Hernandez at (909) 386-8223, 7-1-1 for TTY users or aidery.hernandez@dbh.sbcounty.gov.
Please request accommodations at least 7 business days prior to the event.

MHSA (Proposition 63) was passed by California voters in November 2004 to expand mental health services for children and adults.
The Act is funded by a 1% tax surcharge on personal income over $1 million per year.

Participe en el foro comunitario en español sobre
La Ley de Servicios de Salud Mental

Consulado de México en San Bernardino

Temas: Ley de Servicios de Salud Mental (MHSA)

Invita: Condado de San Bernardino Departamento de Salud Mental

Lugar: Consulado de México en San Bernardino

293 North D Street, San Bernardino, CA 92401

Fecha: 10 de marzo del 2016

Horario: 10:00 a.m - 12:00 p.m.

Para preguntas, dudas, servicios de interpretación o solicitudes de acomodos especiales por razones de incapacidad, por favor comuníquese con Aidery Hernandez al (909) 386-8223; marque el 7-1-1 si usted es TTY; también puede comunicarse al: aidery.hernandez@dbh.sbcounty.gov.
Por favor solicite estos acomodos por lo menos 7 días laborales previos al evento.

La Ley de Servicios de Salud Mental (Proposición 63) fue pasado por votantes de California en noviembre del 2004 para aumentar servicios de salud mental para niños e adultos. La Ley es financiada por un pago de impuesto de 1% en ingreso personal que sobrepasa un millón de dólares por año.

Please join the Department of Behavioral Health for a Mental Health Services Act Stakeholder Engagement!

Thursday, March 17, 2016

Community Policy Advisory Committee (CPAC) Meeting

9:00 - 11:00 a.m.

County of San Bernardino
Health Services - Auditorium
850 E. Foothill Blvd.,
Rialto, CA 92376

Cultural Competency Advisory Committee (CCAC) Meeting

1:00 - 3:00 p.m.

County of San Bernardino
Health Services - Auditorium
850 E. Foothill Blvd.,
Rialto, CA 92376

These special community stakeholder engagement meetings will focus on the impact of the Mental Health Services Act (MHSA) across the system of care. Special focus will be placed on sharing how MHSA has been integrated into existing services and a discussion regarding the future of mental health policy and program planning.

MHSA (proposition 63) was passed by California voters in November 2004 and went into effect January 2005.
The Act is funded by a 1% tax surcharge on personal income over $1 million per year.

For questions, concerns, interpretation services or requests for disability-related accommodations, please contact:
Cheryl McAdam (909) 252-4021 or 7-1-1 for TTY users or Cheryl.McAdam@dbh.sbcounty.gov.
Please request accommodations at least 7 business days prior to the event.

¡Únase al Departamento de Salud Mental (DBH por sus siglas en inglés) para reuniones comunitarias para partes interesadas sobre la Ley de Servicios de Salud Mental!

Jueves, 17 de marzo del 2016

Comité Asesor de Política Comunitaria (CPAC)

9:00 - 11:00 a.m.

County of San Bernardino
Health Services - Auditorio
850 E. Foothill Blvd.
Rialto, CA 92376

Comité Consultivo de Competencia Cultural (CCAC)

1:00 - 3:00 p.m.

County of San Bernardino
Health Services - Auditorio
850 E. Foothill Blvd.,
Rialto, CA 92376

Estas reuniones comunitarias, para partes interesadas, se centrarán en el impacto de La Ley de Servicios de Salud Mental (MHSA, por sus siglas en inglés) sobre el sistema de cuidado. Enfoque especial se colocará en compartir cómo MHSA se ha integrado en los servicios existentes y habrá discusión sobre el futuro de la política de salud mental y planificación de programas.

La Ley De Servicios de Salud Mental (Proposición 63) fue pasada por votantes de California en noviembre del 2004 para aumentar servicios de salud mental para niños y adultos. La Ley es financiada por un pago de impuesto de 1% en ingreso personal que sobrepasa un millón de dólares por año.

Para preguntas, dudas, servicios de interpretación o solicitudes de acomodos especiales por razones de incapacidad, por favor comuníquese con Aidery Hernandez al (909) 386-8223; marque el 7-1-1 si usted es usuarios TTY; también puede ir a: Aidery.hernandez@dbh.sbcounty.gov. Por favor solicite estos acomodos por lo menos 7 días laborales previos al evento.

Please join the Department of Behavioral Health for a Mental Health Services Act Stakeholder Engagement!

District Advisory Committee Meetings

These community stakeholder engagements will focus on the Mental Health Services Act (MHSA) Annual Update. Special focus will be placed on sharing how MHSA has been integrated into existing services and a discussion regarding the future of mental health policy and program planning.

First District

Wednesday, February 17, 2016
11:00 a.m. - 12:00 p.m.
Victor Community Support Services
15400 Cholame Road
Victorville, CA 92392
Contact: Chris Croteau (760) 955-8313

Second District

Thursday, February 25, 2016
2:00 - 3:30 p.m.
Mariposa Community Counseling
2940 Inland Empire Blvd., Room 168
Ontario, CA 91764
Contact: Karina Esparza (909) 458-1381

Third District

Tuesday, February 16, 2016
11:00 a.m. - 12:00 p.m.
Phoenix Community Counseling Center
820 E. Gilbert Street, Room 153
San Bernardino, CA 92415
Contact: Margaret Hernandez (909) 387-7607

Fourth District

Thursday, February 25, 2016
2:00 - 3:30 p.m.
Mariposa Community Counseling
2940 Inland Empire Blvd., Room 168
Ontario, CA 91764
Contact: Karina Esparza (909) 458-1381

Fifth District

Monday, February 22, 2016
5:30 - 7:30 p.m.
New Hope Family Life Center - Auditorium
1505 W. Highland Avenue
San Bernardino, CA 92411
Contact: Crista Wentworth (909) 421-4606

For questions, concerns, interpretation services or requests for disability-related accommodations, please contact:
Cheryl McAdam (909) 252-4021 or 7-1-1 for TTY users or Cheryl.McAdam@dbh.sbcounty.gov. Please request accommodations at least 7 business days prior to the event.

MHSA (Proposition 63) was passed by California voters in November 2004 to expand mental health services for children and adults.
The Act is funded by a 1% tax surcharge on personal income over $1 million per year.

¡Únase al Departamento de Salud Mental (DBH por sus siglas en inglés) para reuniones comunitarias para partes interesadas sobre la Ley de Servicios de Salud Mental!

Reunión de Comité Consultiva de Distrito

Estas reuniones comunitarias para las partes interesadas se centrarán en la actualización anual de la Ley de Servicios de Salud Mental (MHSA por sus siglas en inglés). Enfoque especial se colocará en compartir cómo MHSA se ha integrado en los servicios existentes y habrá discusión sobre el futuro de la política de salud mental y planificación de programas.

Primer Distrito

Miércoles, 17 de febrero del 2016
11:00 a.m. - 12:00 p.m.
Victor Community Support Services
15400 Cholame Road
Victorville, CA 92392
Contacto: Chris Croteau (760) 955-8313

Segundo Distrito

Jueves, 25 de febrero del 2016
2:00 - 3:30 p.m.
Mariposa Community Counseling
2940 Inland Empire Blvd., Room 168
Ontario, CA 91764
Contacto: Karina Esparza (909) 458-1381

Tercer Distrito

Martes, 16 de febrero del 2016
11:00 a.m. - 12:00 p.m.
Phoenix Community Counseling Center
820 E. Gilbert Street, Room 153
San Bernardino, CA 92415
Contacto: Margaret Hernandez (909) 387-7607

Cuarto Distrito

Jueves, 25 de febrero del 2016
2:00 - 3:30 p.m.
Mariposa Community Counseling
2940 Inland Empire Blvd., Room 168
Ontario, CA 91764
Contacto: Karina Esparza (909) 458-1381

Quinto Distrito

Lunes, 22 de febrero del 2016
5:30 - 7:30 p.m.
New Hope Family Life Center - Auditorium
1505 W. Highland Avenue
San Bernardino, CA 92411
Contacto: Crista Wentworth (909) 421-4606

Para preguntas, dudas, servicios de interpretación o solicitudes de acomodos especiales por razones de incapacidad, por favor comuníquese con Aidery Hernandez al (909) 386-8223; marque el 7-1-1 si usted es usuario TTY; también puede ir a: Aidery.hernandez@dbh.sbcounty.gov. Por favor solicite estos acomodos por lo menos 7 días laborales previos al evento.

La Ley de Servicios de Salud Mental (Proposición 63) fue pasado por votantes de California en noviembre de 2004 para aumentar servicios de salud mental para niños y adultos. El Acta es financiada por un pago de impuesto de 1% en ingreso personal que sobrepasa un millón de dólares por año.

SAN BERNARDINO COUNTY
Behavioral Health

Mental Health Services Act (MHSA)

Fiscal Year 2016/17 Annual Update

Stakeholder Comment Form

What is your age? ☐ 0-15 yrs ☐ 26-59 yrs ☐ 16-25 yrs ☐ 60+ yrs	**What is your gender?** ☐ Female ☐ Male ☐ Other: _____
What region do you live in? ☐ Central Valley Region ☐ Desert/Mountain Region ☐ East Valley Region ☐ West Valley Region	
What group(s) do you represent? ☐ Family member of consumer ☐ Social Services Agency ☐ Consumer of Mental Health Services ☐ Health Care Provider ☐ Consumer of Alcohol and Drug Services ☐ Community Member ☐ Law Enforcement ☐ Active Military ☐ Education ☐ Veteran ☐ Community Agency ☐ Representative from Veterans Organization ☐ Faith Community ☐ Provider of Mental Health Services ☐ County Staff ☐ Provider of Alcohol and Drug Services	
What is your Ethnicity? ☐ African American/Black ☐ Asian/Pacific Islander ☐ Latino/Hispanic ☐ American Indian/Native American ☐ Caucasian/White ☐ Other:_____	
What is your primary language? ☐ English ☐ Spanish ☐ Vietnamese ☐ Other:_____	
What is your general feeling about the MHSA Annual Update in San Bernardino County? ☐Very Satisfied ☐Somewhat Satisfied ☐Satisfied ☐ Unsatisfied ☐Very Unsatisfied	

Do you have other concerns not addressed in this discussion?

_____

_____

_____

What did you learn about the MHSA Annual Update?

_____

_____

_____

What else would you like to learn about the MHSA process?

_____

_____

_____

Thank you again for taking the time to review and provide input on the MHSA Annual Update in San Bernardino County.

SAN BERNARDINO COUNTY
Behavioral Health

Ley de Servicios de Salud Mental

(MHSA por sus siglas en inglés)

Actualización Anual del Año Fiscal 2016/17

Formulario de Comentarios para Personas Interesadas

¿Cuál es su edad? ☐0-15 años ☐26-59 años ☐16-25 años ☐60 + años	**¿Cuál es su género?** ☐Femenino ☐Masculino ☐Otro: _____
¿En cuál región vive usted? ☐Región de Valle Central ☐ Región de Desierto/Montañas ☐ Región al este del Valle ☐ Región al oeste del Valle	
¿Qué grupo(s) representa usted? ☐ Familiar del consumidor ☐Agencia de Servicios Sociales ☐Consumidor de Servicios de Salud Mental ☐Proveedor de Atención Médica ☐Consumidor de Servicios de Alcohol y Drogas ☐Miembro de la Comunidad ☐Autoridad Policial ☐En el Servicio Militar Activo ☐Educación ☐Veterano del Servicio Militar ☐Agencia Comunitaria ☐Represente de Organización de Veteranos ☐ Comunidad Religiosa ☐Proveedor de Servicios de Salud Mental ☐Personal del Condado ☐Proveedor de Servicios de Alcohol y Drogas	
¿Cuál es su Grupo Étnico? ☐Afroamericano ☐Asiático/Islas del Pacífico ☐Latino/Hispano ☐Amerindio/Nativo Americano ☐Caucásico/Blanco ☐Otro:_____	
¿Cuál es su idioma principal? ☐Inglés ☐Español ☐Vietnamita ☐Otro:_____	
¿Cuál es su opinión general sobre la Actualización Anual del MHSA en el Condado de San Bernardino? ☐Muy Satisfecho ☐Algo Satisfecho ☐ Satisfecho ☐Insatisfecho ☐Muy insatisfecho	

¿Tiene alguna otra duda que no haya sido hablada en esta junta?

_____

_____

_____

¿Qué aprendió sobre la Actualización Anual de la MHSA?

_____

_____

_____

¿Qué más le gustaría aprender sobre el proceso de la MHSA?

_____

_____

_____

Gracias de nuevo por tomar el tiempo de revisar y proveer su opinión en el proceso de la Actualización Anual de la MHSA en el Condado de San Bernardino.

Behavioral Health

Aimara Freeman, Media Specialist
(909) 383-3952
Aimara.Freeman@dbh.sbcounty.gov
(Contact information for media use only, not for publication)

April 1, 2016

Public input sought for Behavioral Health report

San Bernardino County Department of Behavioral Health (DBH) invites members of the public to review and comment on the Mental Health Services Act (MHSA, Prop. 63) Annual Update. The Update is a comprehensive report that illustrates the recent progress made by DBH and its contracted partners in addressing the behavioral health needs of the community and addresses proposed changes in MHSA components in the upcoming fiscal year.

The MHSA Annual Update and comment forms will be posted, in English and in Spanish, from April 1 – May 1, 2016 on www.sbcounty.gov/dbh.

"I encourage all interested parties to participate in this community planning process by reviewing the MHSA Annual Update and submitting comments as preferred," said DBH Director CaSonya Thomas. "All feedback is reviewed and assists DBH and our community partners in designing behavioral health services that best meet the needs of San Bernardino County residents."

The MHSA was passed by the California voters in November 2004 and is funded by a 1 percent tax surcharge on personal income over $1 million per year.

DBH, through the MHSA, is supporting the Countywide Vision by providing behavioral health services and ensuring residents have the resources they need to promote wellness, recovery and resilience in the community. Information on the Countywide Vision and on DBH can be found at www.sbcounty.gov.

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Behavioral Health

Aimara Freeman, Media Specialist
(909) 383-3952
Aimara.Freeman@dbh.sbcounty.gov
(Contacto information for media use only, not for publication)

1 de abril de 2016

Se solicita la opinión del público para el informe de Salud Mental

El Condado de San Bernardino, Departamento de Salud Mental (DBH por sus siglas en inglés) invita a los miembros del público a revisar y comentar sobre el borrador de la Actualización Anual de La Ley de Servicios de Salud Mental (MHSA, Proposición 63). La Actualización es un amplio informe que ilustra los avances recientes del Departamento de Salud Mental y sus socios contratados para hacer frente a las necesidades de salud mental de la comunidad y afrontar los cambios propuestos en componentes de la MHSA en el próximo año fiscal.

El borrador de la Actualización Anual de la Ley de Servicios de Salud Mental y formas de comentarios se publicarán en inglés y en español, del 1 de abril – 1 de mayo de 2016 en www.sbcounty.gov/dbh.

"Invito a todas las partes interesadas a participar en este proceso de planificación comunitaria para revisar el borrador de la Actualización Anual de la Ley de Salud Mental y presentar comentarios," dijo la Directora del Departamento de Salud Mental, CaSonya Thomas. "Todos los comentarios se repasan y asisten a DBH y nuestros socios comunitarios en diseñar servicios de salud mental que mejor satisfacen las necesidades de los residentes del Condado de San Bernardino."

La MHSA fue aprobada por los votantes de California en noviembre de 2004 y es financiado por un recargo de impuesto del 1 por ciento de ingresos personales sobre $1 millón al año.

DBH, a través de la MHSA, está apoyando la visión del Condado proporcionado servicios de salud mental y asegurando que los residentes tengan los recursos necesarios para promover el bienestar, la recuperación y la resiliencia en la comunidad. Información sobre la visión del Condado y DBH puede encontrarse en www.sbcounty.gov.

-30-

SAN BERNARDINO COUNTY

Behavioral Health

Press Release Media Outlet List

ABC News
Albert Morrissette
Apple Valley News
Associated Press
Barb Stanton
Big Bear Grizzly
Black Voice News
Bloomberg BNA
CBS News
CBS Radio
Chino Champion
City News Group
City News Service
Daily Journal
Desert Dispatch
Desert Trail News
ET News
Fontana Herald
Fox 11 News
Hi-Desert Star
High Desert Daily
Highland Community News
Highland News
Homeless Times
Inland Empire Business Journal
Inland Empire Community Newspaper
Inland Empire Hispanic News
Inland Empire Magazine
Inland Newspaper
Inland Empire News Radio
Inland News Today
KBHR 93.3 FM
KCAL9 News
KCDZ 107.7 FM
KESQ News
KFI News
KFRG 95.1FM and 92.9 FM
KNX News Radio
KPCC 89.3 AM
KTIE/KRLA
KTLA News
KVVBTV High Desert
La Prensa
Los Ángeles News Group
Los Angeles Times
Lucerne Valley Leader
Mountain News
NBC News
NBC Universal/Telemundo
Needles Desert Star
News Line
News Mirror
News Radio
Precinct Reporter
Press Enterprise
San Bernardino American News
San Bernardino City News
San Bernardino Sun
Senior News/Desert News Post
SoCal News
The Alpenhorn News
Tri-Community NewsPlus - Phelan/Wrightwood/Pinon Hills
Univision KMEX 34
Victorville Daily Press
Westside Story Newspaper
Yucaipa/Calimesa News Mirror

Measurement and Assessment Tools

Adult Needs & Strengths Assessment (ANSA): A comprehensive assessment of psychological and social factors for use in treatment planning. ANSA is an assessment strategy and communication process with the consumer and family, in addition to a multi-purpose tool developed for adult services to: support decision making (level of care, service planning), facilitate quality improvement initiatives, and monitor the outcomes of services. The measure is based on research findings that optimally effective treatment should include both efforts to reduce symptomatology and efforts to use and build upon strengths.

Alcohol Use Disorders Identification Test (AUDIT): A 10-item questionnaire that screens for hazardous or harmful alcohol consumption. Developed by the World Health Organization, the test correctly classifies 95% of people into either alcoholics or non-alcoholics.

Beck Anxiety Inventory (BAI): A 21 item self-report questionnaire that assesses anxiety severity. It was specifically designed to reduce the overlap between depression and anxiety scales by measuring anxiety symptoms shared minimally with those of depression. Both physiological and cognitive components of anxiety are addressed in this scale.

Beck Depression Inventory (BDI): A 21 item self-report questionnaire that assesses severity of depression.

Beck Suicide Scale: A brief assessment to help identify individuals at risk for suicide. There are 5 screening items and 21 assessment items. Items on this measure assess the respondents' suicidal plans, deterrents to suicide, and the level of openness to revealing suicidal thoughts.

Behavior and Symptom Identification Scales (BASIS-24): A 24 item self-report measure that identifies a wide range of symptoms that occur across the diagnostic spectrum. It gives an overall score and scores for six subscales for the following domains of psychiatric and substance abuse symptoms and functioning including: Depression and Functioning, Relationships, Self-Harm, Emotional Liability, Psychosis, and Substance Abuse.

Brief Symptom Inventory – 18 (BSI-18): A brief inventory of participants' depression, anxiety, and somatization symptoms. This short version of the BSI questionnaire is composed of 18 Likert-type items, which are rated on the basis of distress over the last 7 days on a 5-point scale from 0 (not at all) to 4 (extremely).

Burns Depression Checklist: A 25 item tool used in evaluating symptoms of depression, and in providing an assessment of depression severity.

Center for Epidemiologic Studies Depression Scale (CES-D): A 20-item measure that asks caregivers to rate how often over the past week they experienced symptoms associated with depression, such as restless sleep, poor appetite, and feeling lonely.

Child & Adolescent Needs & Strengths Assessment (CANS): A comprehensive assessment of psychological and social factors for use in treatment planning. CANS is an assessment strategy and communication process with the youth and family, in addition to a multi-purpose tool developed for children's services to: support decision making (level of care, service planning), facilitate quality improvement initiatives, and monitor the outcomes of services. The measure is based on research findings that optimally effective treatment of children and youth should include both efforts to reduce symptomatology and efforts to use and build upon strengths.

Client Service Information (CSI): A collection of client information on all mental health services provided through DBH and contract agencies. Timely and accurate reporting of this data to the State is mandated. The California Department of Health Care Services requires that CSI data be collected for all services (MHSA and non-MHSA) and for all consumers. CSI data is collected from client registration information, episode, periodic, and service entry documentation.

Promotores Community Pre/Post Survey: A survey developed by the Latino Health Collaborative, Loma Linda University, and the Department of Public Health to capture knowledge gained through mental health presentations, attitudes toward mental health services and intention to use mental health services among community members. Surveys are given to participants both before and after mental health presentations to measure the level of change in knowledge, attitude, and intention.

Correctional Offender Management Profiling for Alternative Sanctions (COMPAS): A system used within juvenile justice settings and is an automated risk and needs assessment and unified case planning system. This actuarial risk assessment system contains offender information specifically designed to determine their risk and needs and inform dynamic case plans that will guide them throughout his or her lifecycle in the criminal justice system.

National Curriculum and Training Institute (NCTI) Crossroads Education Pre/Post Test: A set of pre- and post-tests which are used to measure the participant's increase in learning for each course and allow program managers to ensure facilitator effectiveness, as well as measure program fidelity.

Data Collection and Reporting Repository (DCR): A data collection system maintained by the California Department of Health Care Services, containing Full Service Partnership data elements across counties, regions, and the state. Use of the system is required for Full Service Partnerships.

DBH Clinic Assessment: A tool used to assess an individual's level of impaired functioning related to a mental health disorder in the five global areas: health/self-care, occupation/academic, legal/community, financial, and interpersonal/family.

It includes an assessment of the individual's presenting problems, level of risk (danger to himself or others), substance abuse, and medication history.

Desired Results Developmental Profile (DRDP): The primary objective of the desired results system and measures is to measure and encourage child development programs' progress toward the achievement of desired results by providing information and technical assistance to improve program quality.

Developmental Assets Survey: A tool for youth that measures internal strengths and external supports and their growth in these key areas over time.

Family Experiences Interview Schedule (FEIS): A semi-structured interview for family members of consumers to assess their experiences with their loved one and behavioral health treatment. This interview includes the family members' understanding of mental illness, ability to provide support for their loved one, and satisfaction with behavioral health treatment. MAYSI 2 Massachusetts Youth Screening Instrument is a brief screening instrument designed to identify potential mental health needs of adolescents involved in the juvenile justice system. It uses 7 scales to assess the youth including alcohol and drug use, mood disturbances (angry, irritable; depressed, anxious), somatic complaints, suicide ideation, thought disturbance and traumatic experiences.

Generalized Anxiety Disorder Screener (GAD-7): A brief 7-item measure that assesses generalized anxiety disorder. It is a self-report questionnaire for screening and severity measuring of generalized anxiety disorder.

Geriatric Depression Scale (GDS): A 30-item self-report assessment used to identify depression in older adults (Age 60+).

Global Assessment of Functioning (GAF): A scale from the Diagnostic and Statistical Manual of Mental Disorders that provides a measure of a consumer's overall functioning.

Homeless Information Management System (HMIS): An information technology system mandated by the federal government used to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness.

Housing Authority of the County of San Bernardino Monthly Report: Tracks increase in permanent supportive housing vouchers in San Bernardino County as well as stability in the program/length of stay.

INSPIRE – Psychological Empowerment Scale (INSPIRE-PES): A tool designed to assess subscales of psychological empowerment: sociopolitical skills, motivation to influence, participatory behavior, and perceived control specifically with regard to the INSPIRE Holistic Campus, a potential initial setting for empowerment practice. No psychometric data yet exists for this version.

Key Event Tracking System (KETS): Database used by DBH provider, Telecare, to track client demographics, as well as information related to emergency room visits, hospitalizations, incarcerations, disenrollment, change of address, and any report of the client being unaccounted for or missing.

Life Skills Progression (LSP): For use with at-risk families of children from birth to 3 years of age, this tool generates a broad, accurate portrait of the behaviors, attitudes, and skills of both parents and children and helps professional establish baseline client profiles, identify strengths and needs, plan interventions, and monitor outcomes to determine if interventions are working.

Massachusetts Youth Screening Instrument (MAYSI): A brief screening instrument designed to identify potential mental health needs of adolescents involved in the juvenile justice system. It uses 7 scales to assess the youth including alcohol and drug use, mood disturbances (angry, irritable; depressed, anxious), somatic complaints, suicide ideation, thought disturbance and traumatic experiences.

Outcomes Questionnaire (OQ – Adult & Youth): A 45 item self-report scale used to evaluate behavioral health problems at the outset and over the course of treatment. It measures symptomatic distress, quality of life, and interpersonal relationships.

Patient Health Questionnaire for Depression (PHQ9): A multipurpose instrument for screening, diagnosing, monitoring, and measuring the severity of depression. The tool incorporates depression diagnostic criteria from the Diagnostic and Statistical Manual of Mental Disorders into a brief self-report tool.

Point in Time Count: A count of homeless persons both in shelter and non-sheltered at a certain point in time. This count is done biannually by the County.

Psychological Empowerment Scale – Revised (PES-R): A 25 item scale designed to assess subscales of psychological empowerment: sociopolitical skills, motivation to influence, participatory behavior, and perceived control in youth.

San Bernardino Information Management Online Network - SIMON: DBH's billing system, which maintains a variety of data elements required for billing and some reporting.

Satisfaction Survey: This Survey is for the participants to evaluate the satisfaction with their experience at INSPIRE Multicultural Holistic Campus. These evaluations help Inspire know how to improve the service and the professional development of the staff.

Severity measure for Generalized Anxiety Disorder (GAD): A 10 item measure that assesses the severity of generalized anxiety disorder in individuals age 18 or older. Each item on the measure is rated on a 5-point scale.

Social Support Inventory (SSI): An 18 item measure of participants' degree of social support.

World Health Organization Quality of Life (WHOQOL): A 26 item subset of the World Health Organization Quality of Life measure. This assessment asks how a person feels about their quality of life, health, or other areas of their life. The WHOQOL makes use of different five-point Likert type scales based on the way the questions are worded.

Table 26. Holistic Campus Logic Model

MHSA-Defined INN Purposes	INN Project Learning Goals	Strategies	Learning Goal Outcomes	Learning Goal Evaluation Method	INN Purpose Outcomes	INN Purpose Evaluation Method
Increase Access to Underserved Groups (Primary Purpose)	Understand and define what partnership means and what can be accomplished from a project perspective.	Targeted outreach; Center is 80% peer run by community members and cultural broker	• Provider reported understanding and definition of partnership and potential accomplishments	• Provider Survey (both quantitative endorsement of objective met and qualitative responses)	Increased rates of Underserved participating in the project in comparison to standard services	Participant demographic and utilization data on levels of service within the Holistic Campus and larger system of care
	How to respectfully use community resources.		• Provider reported understanding of respectful use of community resources	• Provider Survey (both quantitative endorsement of objective met and qualitative responses)		
	What type of support and training is needed by peer cultural brokers as well as the small percentage of clinical staff?		• Provider reported understanding of needed support and training by peer cultural brokers as well as the small percentage of clinical staff	• Provider Survey (both quantitative endorsement of objective met and qualitative responses)		
	What can underrepresented cultures and ethnicities learn from each other and how they work together?		• Provider reported understanding of what underrepresented cultures and ethnicities can learn from each other and how they work together	• Provider Survey (both quantitative endorsement of objective met and qualitative responses)		
	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.		• Provider reported belief if the new approaches, in addition to the Advisory Board of Directors led to increased access to services from those that would not normally seek mental health services due to stigma and other cultural considerations	• Provider Survey (both quantitative endorsement of objective met and qualitative responses)		

MHSA-Defined INN Purposes	INN Project Learning Goals	Strategies	Learning Goal Outcomes	Learning Goal Evaluation Method	INN Purpose Outcomes	INN Purpose Evaluation Method
Increase Access to Underserved Groups (Primary Purpose)	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.	Targeted outreach; Center is 80% peer run by community members and cultural broker	• Provider reported belief if the 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	• Provider Survey (both quantitative endorsement of objective met and qualitative responses)	Increased rates of Underserved participating in the project in comparison to standard services	Participant demographic and utilization data on levels of service within the Holistic Campus and larger system of care
	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.		• Provider reported belief that 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 • Participant report of comfort at Holistic Campus site v. traditional DBH location(s)	• Provider Survey (both quantitative endorsement of objective met and qualitative responses)		
	Determine if this setting reduces stigma.		• By end of each year, at least 50 percent of participants will report a decrease in stigma surrounding mental health illnesses as measured by pre- and post-test questionnaires. (from El Sol) • Provider reported belief that the setting reduces stigma • Increased participant willingness to seek mental health assistance	• Provider Survey (both quantitative endorsement of objective met and qualitative responses)		

MHSA-Defined INN Purposes	INN Project Learning Goals	Strategies	Learning Goal Outcomes	Learning Goal Evaluation Method	INN Purpose Outcomes	INN Purpose Evaluation Method
Promote Interagency Collaboration	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.	Promote program to other agencies; Health fair; partnerships	• Agency reports interagency collaboration occurs; community capacity building improves	• Provider Survey (both quantitative endorsement of objective met and qualitative responses)	Increased collaboration by two or more agencies	Provider Collaboration Survey (End of fiscal year)
	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.		• By June 30, 2014, 85 percent of participants in need will report having received assistance with referrals and service linkages and will receive at least one follow-up call to verify participant accessed service, as documented and measured by participant surveys (from El Sol) • Agency reports interagency collaboration occurs; community capacity building improves	• Provider Survey (both quantitative endorsement of objective met and qualitative responses)		
	Learn how the Holistic Campus, its services, service delivery approach, and consumers fit into the overall health and behavioral health care systems.		• By June 30, 2014, 75 percent of participants in need will have examined eligibility for health insurance, identified available community health resources, and where possible, selected a primary community health clinic for ongoing care coordination (i.e. medical home) as measured by participant report and referral logs (from El Sol) • Agency reports interagency collaboration occurs; community capacity building improves	• Provider Survey (both quantitative endorsement of objective met and qualitative responses)		

What is the STRIVE Holistic Campus?

Our STRIVE Holistic Campus is an innovative program that assists members of the community living with mental illness, as well as assisting their families. Previously our members have not had access to adequate services. Our campus is designed to remedy this by providing both traditional services and culturally relevant nontraditional services in a safe, warm, and accepting environment. Working in the community with campus members, we focus on three areas:

- Assessing those we serve and assisting them in acquiring physical and behavioral health benefits
- Acting as a hub for referrals to other community resources and agencies willing and able to help
- Creating a series of nontraditional approaches to healing for those we serve

Mental Health Systems is a non-profit agency founded in 1978 to improve the lives of individuals, families and communities facing substance abuse and behavioral health challenges.

mhs MENTAL HEALTH SYSTEMS

mhsinc.org

STRIVE Holistic Campus
316 E "E" Street,
Ontario, CA 91764
P (909) 983-4466 | F (909) 872-1686

Funded by the Mental Health Services Act, Proposition 63

MHS is a 501(c)(3) non-profit corporation.
© Mental Health Systems

mhs MENTAL HEALTH SYSTEMS

STRIVE Holistic Campus

How Can STRIVE Holistic Campus Help?

Our STRIVE Holistic Campus is guided by an advisory board of cultural, spiritual, and diverse members, who continually suggest new nontraditional healing activities that would be helpful to the community members they represent. In response to the advisory board's suggestions, we find partners from the community to provide advised activities to best help our members. The help offered by the campus also includes traditional services, such as groups and assessments.

What Are Our Services?

Our STRIVE Holistic Campus provides traditional services, such as:

- Peer-led support groups
- Clinically led recovery and specialty groups
- Crisis interventions
- Assessments, evaluation and treatment planning

As well as nontraditional activities, such as:

- Yoga and Tai Chi
- Massage and acupressure
- Drum circles
- Anger management
- English as a second language classes
- Art therapy, photo walks, and more

Who Do We Serve?

We serve community members living with a mental illness, as well as serving their family members. Those we serve reside in the western end of San Bernardino County and have previously been under-served.

How Do We Get Our Referrals?

Referrals to our STRIVE Holistic Campus come from more traditional mental health settings, licensed professionals, cultural and spiritual organizations and groups, family members, friends, and other campus members. In short, they come from the community.

Servicios de Apoyo de la Comunidad Víctor Presenta:

Campo Holístico

Servicios de Apoyo de la Comunidad Víctor (VCSS) departamento de consejo del Campo Holístico (HCAB) junto con la comunidad y con otros profesionales y una gran variedad de diversas empresas, en el desierto alto serán unido para asegurar los servicios mas apropiados son ofrecidos al público.

Este programa ofrece servicios que no son tradicional y cicatrización específicas estrategias cultural.

TRADICIONAL * DIVERSO *
SERVICIOS ALTERNATIVOS

*Adapted from SAMHSA's
Eight Dimensions of Wellness

Que es un Campo Holístico?

El Campo Holístico en Victorville es una instalación que ofrecerá un nivel avanzado de las terapias alternativas profesionales. Este programa se enfoca en culturas diversas y etnias, incluyendo LGBT, veteranos militares y sus familias. El Campo Holístico proporcionará el acceso a la salud y el servicios de bienestar, en forma gratuita, en un ambiente acogedor.

8 Dimensiones de la Salud y Bienestar

Físico, Emocional, Espiritual, Social/Relacional, Profesional, Financiero, Intelectual, Medioambiental y Cultura

Para mas información favor de hablar a (760) 245-4695

O para alojamiento especial favor de hablar a 711 para TTY

Victor Community Support Services-Victorville Campus
15400 Cholame Rd.
Victorville, CA 92392
(760) 245-4695

El Campo Holístico es patrocinado por la ley de Servicios de Salud Mental (Proposición 63)
Condado de San Bernardino Departamento de Salud del Comportamiento oficina de Innovación

Holistic Campus

Victor Community Support Services

Victor Community Support Services (VCSS) and the Holistic Campus Advisory Board (HCAB) are partnering with the community, alternative practitioners and a host of diverse businesses within the High Desert to assure the most appropriate integrated services are offered to the public.

This program offers non-traditional services and culturally specific healing strategies.

TRADITIONAL * DIVERSE * ALTERNATIVE SERVICES

Focusing on the Eight Dimensions of Health and Wellness

Physical, Emotional, Spiritual, Social/Relational, Occupational, Financial, Intellectual, Environmental

For more information:

Jenna at JSanders@victor.org

(760) 780-4750 or 7-1-1 for TTY users

What is a Holistic Campus?

The Holistic Campus in Victorville is a facility that offers an advanced level of professional alternative therapies. This program focuses on diverse cultures and ethnicities, including LGBTQ, military veterans and their families.
The Holistic campus provides access to health and wellbeing services, free of charge, in a welcoming environment.

Victor Community Support Services
15400 Cholame Road
Victorville, CA 92392
(760) 245-4695 or 7-1-1 for TTY users

The Holistic Campus is sponsored by the Mental Health Services Act (Proposition 63)
County of San Bernardino Department of Behavioral Health, Office of Innovation.

Description of Services

Wellness Class ● Mental Health Workshop covering common mental illness such as Depression, Anxiety and Schizophrenia
ESL ● English as a Second Language class
Sabores-LGBTQ ● Support Group for Lesbian, Gay, Bisexual, Transgender, Questioning individuals and their families
Mano a Mano ● HIV Positive Support Group for individuals and their families
Dream Act ● Development, Relief, and Education for Alien Minors Application Workshop
Nutrition Class ● Educational class to learn how to make healthier decisions when purchasing, preparing and eating food
Zumba ● Dance Fitness Class
Aerobics ● Physical activity workout focus on cardiovascular fitness and muscular strength
Exercise/Yoga ● Physical activity class for seniors (50+)
Therapy ● Peer-to-Peer counseling, Individual, Group and Family Therapy

Descripción de Servicios

Clase De Salud Mental ● Clases educativas de diferentes tópicos como Ansiedad, Depresión y Bipolaridad
Clase de Violencia Domestica e Intrafamiliar ● Clase de información y crecimiento acerca de lo que es y que hacer cuando hay violencia domestica
Clase de Nutrición ● Clase educativa para aprender a tomar decisiones mas saludables al comprar, preparar y consumir alimentos
Clase de (Bullying) Intimidación ● Clase informativa y educativa de que hacer y como detectar casos de intimidación/bullying
12 Pasos ● Grupo de apoyo para padres afectados por el uso de alcohol, drogas o pandillas
Padres Ayudando A Padres ● Curso educativo para padres de 26 semanas con diferentes tópicos como: Relación de Pareja, Siendo Padres, Creando una familia, Disciplina Con Amor y Sin Violencia, Comunicación Saludable en la Familia y Debilitamiento familiar
ESL ● Clase de Inglés como Segundo Idioma
Sabores-LGBTQ ● Grupo de apoyo para Lesbianas, Gays (Homosexuales) , Bisexuales, Transexuales y sus familiares
Zumba ● Clase de actividad física con baile
Mano a Mano ● Grupo de apoyo para personas VIH positivas y sus familiares
Clase de Aerobics ● Clase de actividad física enfocada en el área cardiovascular y en fortalecimiento de los músculos
Dream Act ● Taller para ayudar a estudiantes extranjeros con la solicitud
Ejercicios/Yoga ● Clase de actividad física para personas de la tercera edad (50+)
NAMI ● Grupo de apoyo para familiares de personas que viven con el diagnostico de alguna enfermedad mental
Terapia ● Consejería Informal, Terapia Individual y Familiar

Services provided in collaboration with the County of San Bernardino, Department of Behavioral Health and funded by the Mental Health Services Act (Prop. 63).
Servicios provistos en colaboración con el Departamento de Salud Mental del Condado de San Bernardino y financiado por la Ley de Servicios de Salud Mental (Prop. 63).

Brought to you By: El Sol Neighborhood Educational

Activity Calendar
Calendario de Actividades
April/Abril 2014

Inspire
MULTICULTURAL HOLISTIC CAMPUS
Empowering body, mind, and soul

The Inspire Multicultural Holistic Campus is here to assist community members and families by providing traditional and nontraditional culturally and linguistically appropriate approaches to healing, resiliency, recovery, overall wellness and linkages to services.

El Campus Holístico Multicultural Inspire está aquí para ayudar a los miembros de la comunidad y a sus familias con métodos tradicionales y no-tradicionales que son lingüística y culturalmente apropiados para la curación, resiliencia, recuperación, bienestar general y enlaces a los servicios.

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Inspire Multicultural Holistic Campus
766 North Waterman Ave., San Bernardino, CA 92410
Phone: (909) 386-3500 Fax: (909) 386-3602
www.inspiremc.org

LUNES	**Clase de Aerobics** 9:00 a.m.-10:00 a.m. **Clase de Violencia Domestica e Intrafamiliar** 10:00 -11:00 a.m. **ESL** (Primer Nivel) 5:00-7:00 p.m. **Sabores-LGBTQ** (primer y tercer lunes de cada mes) 5:00-7:00p.m.
MARTES	**Clase de Aerobics** 9:00 -10:00 a.m. **Clase de Nutrición** (por registración solamente) 10:00a.m.-12:00p.m. **Clase De Salud Mental** 4:00-5:00p.m. **Ejercicios/Yoga para personas de la tercera edad (50+)** 5:00-6:00p.m. **Zumba** 6:00-7:00p.m **NAMI** (Grupo de apoyo segundo martes de cada mes) 6:00-9:00p.m.
MIERCOLES	**Clase de Aerobics** 9:00 -10:00 a.m. **Clase de Violencia Domestica e Intrafamiliar** 4:00-5:00p.m. **ESL** (Primer Nivel) 5:00-7:00p.m. **Mano a Mano** (Grupo de Apoyo) 6:00-9:00p.m
JUEVES	**Clase de Aerobics** 9:00 -10:00 a.m. **Clase de (Bullying) Intimidación** 4:00-5:00p.m. **Ejercicios/Yoga para personas de la tercera edad (50+)** 5:00-6:00p.m. **Zumba** 6:00-7:00p.m. **Padres Ayudando A Padres** (Clase de 26 semanas) 7:00-9:00p.m. **12 Pasos** (Grupo de Apoyo) 7:00-9:00p.m.
VIERNES	**Clase de Salud Mental** 4:00-5:00p.m. **Ejercicios/Yoga para personas de la tercera edad (50+)** 5:00-6:00p.m.
SABADO	**Ofrecemos Clases CON REGISTRATION SOLAMENTE**

MONDAY	**Aerobics Class** 9:00-10:00 a.m. **Wellness Class** 11:00 a.m. - 12:00p.m. **ESL** (beginners) 5:00-7:00 p.m. **Sabores-LGBTQ** (first and third Monday of the month) 5:00-7:00 p.m.
TUESDAY	**Aerobics Class** 9:00 - 10:00 a.m. **Nutrition Classes (by registration only)** 10:00a.m.-12:00p.m. **Wellness Class** 4:00-5:00p.m. **Exercise/Yoga for Seniors (50+)** 5:00-6:00p.m. **Zumba** 6:00-7:00p.m.
WEDNESDAY	**Aerobics Class** 9:00 - 10:00 a.m. **Wellness Class** 11:00 a.m.-12:00p.m. **ESL** (beginners) 5:00-7:00p.m. **Mano a Mano (**Support Group) 6:00-9:00p.m
THURSDAY	**Aerobics Class** 9:00 -10:00 a.m. **Wellness Class** 2:00-3:00p.m. **Exercise/Yoga for Seniors (50+)** 5:00-6:00p.m. **Zumba** 6:00-7:00p.m.
FRIDAY	**Wellness Class** 4:00-5:00p.m. **Exercise/Yoga for Seniors (50+)** 5:00-6:00p.m.
SATURDAY	**Classes offered BY REGISTRATION ONLY**

Computer Lab is available from Monday - Thursday 2:00 - 7:00 p.m.
Computadoras disponibles de lunes a jueves 2:00 - 7:00 p.m.

Therapy offered by appointment only.
Terapia disponible solo por citas.

INNOVATION:

Pathway to Learning

Community Policy Advisory Committee (CPAC)
May 15, 2014

Presentation Objectives

- Review Innovation (INN) legislative requirements
- Overview of Evaluation Approach
- Review of current INN projects
  - CASE
  - Holistic Campus
- Future CPAC Meetings
  - IYRT
  - STAY
  - RBEST

2

INNOVACIÓN:

Camino al Aprendizaje

Comité Consultivo de Políticas Comunitarias (CPAC)
15 de mayo de 2014

1

Objetivos de la Presentación

- Revisar los requisitos legislativos de Innovación (INN)
- Visión general del enfoque evaluativo
- Revisar los proyectos actuales de INN
  - CASE
  - Holistic Campus

Reuniones futuras de CPAC
  - IYRT
  - STAY
  - RBEST

2

INN LEGISLATIVE REQUIREMENTS
WIC 5830, Part 3.2

Address one of the following learning purposes as its primary purpose:

(1) To increase access to underserved groups.

(2) To increase the quality of services, including better outcomes.

(3) To promote interagency collaboration.

(4) To increase access to services.

3

INN LEGISLATIVE REQUIREMENTS
WIC 5830, Part 3.2

Support innovative approaches by doing one of the following:

(A) Introducing new mental health practices or approaches, including, but not limited to, prevention and early intervention.

(B) Making a change to an existing mental health practice or approach, including, but not limited to, adaptation for a new setting or community.

(C) Introducing a new application to the mental health system of a promising community-driven practice or an approach that has been successful in non-mental health contexts or settings.

4

REQUISITOS LEGISLATIVOS DE INN
WIC 5830, Parte 3.2

Enfóquese en uno de los siguientes propósitos de aprendizaje como su objetivo principal:

(1) Para aumentar el acceso a los grupos que son atendidos de manera insuficiente.

(2) Para aumentar la calidad de los servicios, incluyendo mejores resultados.

(3) Para promover la colaboración entre agencias.

(4) Para aumentar el acceso a los servicios.

3

REQUISITOS LEGISLATIVOS DE INN
WIC 5830, Parte 3.2

Apoyar los enfoques innovadores realizando uno de las siguientes actividades:

(A) Introducir nuevas prácticas o enfoques de salud mental, incluyendo pero sin limitarse a prevención e intervención temprana.

(B) Hacer un cambio a una práctica o enfoque existente de salud mental, incluyendo pero sin limitarse a una adecuación a un nuevo entorno o comunidad.

(C) Introducir una nueva característica al sistema de salud mental de una práctica promisoria impulsada por la comunidad o un enfoque que haya tenido éxito en los contextos o entornos no relacionados con la salud mental.

4

INN LEGISLATIVE REQUIREMENTS
WIC 5830, Part 3.2

- An Innovation project is defined, for purposes of these guidelines, as one that contributes to learning rather than a primary focus on providing a service.
- County mental health programs shall expend funds for their innovation programs upon approval by the Mental Health Services Oversight and Accountability Commission.

5

EVALUATION APPROACH
Mental Health Services Oversight and Accountability Commission (MHSOAC)

- From Innovation Evaluation RFP:
  - Purpose is "designing, piloting, and evaluating the efficacy of new or changed mental health approaches"
  - Evaluation is at the core of all Innovative Projects

6

REQUISITOS LEGISLATIVOS DE INN
WIC 5830, Parte 3.2

- Un proyecto de Innovación se define, para los propósitos de estas normas, como un proyecto que contribuye al aprendizaje, más allá de enfocarse a prestar un servicio exclusivamente.
- Los programas de salud mental del condado destinarán fondos a sus programas de Innovación una vez que sean aprobados por la Comisión de Supervisión y Rendición de Cuentas de Servicios de Salud Mental.

5

ENFOQUE EVALUATIVO
Comisión de Supervisión y Rendición de Cuentas de Servicios de Salud Mental (MHSOAC)

- De la Evaluación de Innovación RFP:
  - El propósito es "diseñar, poner a prueba, y evaluar la eficacia de enfoques nuevos o cambiantes sobre la salud mental"
  - La evaluación es la parte esencial de todos los Proyectos Innovadores

6

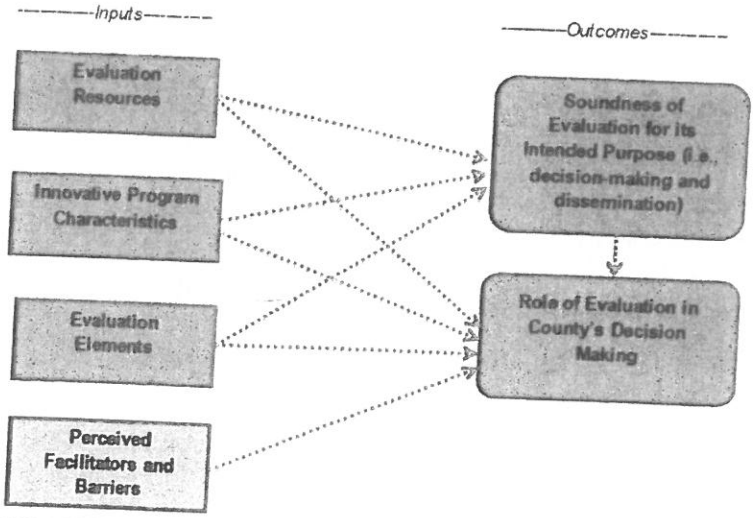
EVALUATION APPROACH
MHSOAC

- Overall trend of increased oversight, especially with regard to evaluation activities
- CiMH contract: Evaluation of Innovation Evaluation
  - Inventory of evaluation approaches
  - Evaluation of the efficacy of the evaluation approaches

7

EVALUATION APPROACH
CiMH INN Evaluation Logic Model

Figure 1: OVERALL RESEARCH FRAMEWORK



8

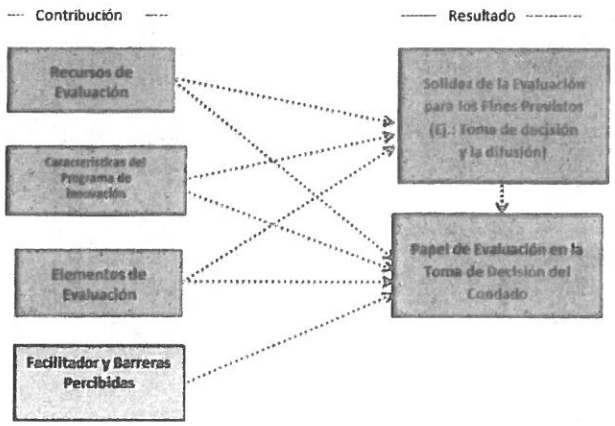
ENFOQUE EVALUATIVO
MHSOAC

- Tendencia general de una mayor supervisión, especialmente en cuanto a actividades de evaluación
- Contrato CiMH: Evaluación sobre la Evaluación de Innovación
  - Inventario de los enfoques evaluativos.
  - Evaluación de la eficacia de los enfoques evaluativos.

7

ENFOQUE EVALUATIVO
Evaluación del Modelo Lógico de CiMH INN

Figura 1: INFRAESTRUCTURA GENERAL DE INVESTIGACIÓN



8

EVALUATION APPROACH
Pending Regulations

- MHSOAC is preparing proposed regulations for Innovation, per AB 82
- Regulations will be outcomes-focused
  - Emphasis on research, testing, and learning
- Language moving from "program" to "project"

*All information on this slide is proposed and subject to change as proposed legislation goes through legislative review.

9

EVALUATION APPROACH
Pending Regulations

Time-limited Pilot Project
- Maximum of 4 years from the start date of the project
- Successful parts of the project may continue under a different funding source or be incorporated into existing services
- Projects may be terminated prior to planned end date

*All information on this slide is proposed and subject to change as proposed legislation goes through legislative review.

10

ENFOQUE EVALUATIVO
Reglamentos Pendientes

- La Comisión MHSOAC está preparando los reglamentos propuestos para Innovación, de acuerdo a AB 82.
- Los reglamentos estarán enfocados en los resultados.
  - Énfasis en: investigación, evaluaciones y aprendizaje
- Cambio de términos, de "programa" a "proyecto"

*Toda la información en esta diapositiva es solo una propuesta y como tal esta ta siendo propuesta y esta sujeta a cambiar a medida que cambie la legislación propuesta a través de revisiones legislativas.

9

ENFOQUE DE EVALUACIÓN
Reglamentos Pendientes

Proyecto Piloto de Duración Limitada
- Máximo de 4 años a partir de la fecha de inicio del proyecto
- Las partes exitosas del proyecto pueden continuar bajo una fuente diferente de financiamiento, o, ser incorporada a los servicios existentes
- Los proyectos pueden ser terminados antes de la fecha de finalización prevista

* Toda la información en esta página/diapositiva es una propuesta y está sujeta a cambios en la medida en dicha propuesta pase por el proceso de revisión legislativa.

10

Innovation Presentations to Date

(CPAC April 17, 2014)

- INN -01 Online Diverse Communities Experiences (ODCE)
  - Budget: $94,500
  - Concluded June 2013
  - Facebook and Twitter is being maintained by DBH, as part of Public Information Office duties
- INN -03 Community Resiliency Model (CRM)
  - Budget: $885,288
  - Concluded Dec 2013
  - CRM Skills training will be offered through the DBH outreach and education as part of community education efforts.

Be sure to attend CPAC and other DBH stakeholder meetings to get updated information!

11

INN 02 – Coalition Against Sexual Exploitation (CASE)

Michael Schertell, Deputy Director
Department of Behavioral Health
County of San Bernardino

12

Presentaciones de Innovación a la fecha (CPAC de 17 de abril de 2014)

- CommuniINN -01 Experiencias de Comunidades Diversas en Línea (ODCE)
  - **Presupuesto: $94,500**
  - **Concluyó en junio del 2013**
  - **DBH está dando mantenimiento a las pagina de Facebook y Twitter, como parte de las tareas de la Oficina de Información Pública**
- INN -03 Modelo de Resiliencia Comunitaria (CRM)
  - **Presupuesto: $885,288**
  - **Concluyó en diciembre del 2013**
  - **Las capacitaciones de habilidades CRM serán ofrecidas a través de alcance y educación de DBH como parte de los esfuerzos de educación comunitaria.**

¡Asegúrese de estar presente en reuniones de partes interesadas de DBH para recibir información actualizada!

11

INN 02 – Coalición en Contra de la Explotación Sexual (CASE)

Michael Schertell, Subdirector
Departamento de Salud Mental
Condado de San Bernardino

12

Overview

- Background/History/Learning Goals
- CASE Steering Committee
- CASE Project
- Specialty/Unique Population
- Successes and Outcomes
- Transition to Prevention and Early Intervention

13

Background/History/Learning Goals

- Inspired by District Attorney and Board of Supervisors during CASE Summit of 2009
- Originally a project of the 2010 MHSA Innovation Component Plan
- Broad Goals:
  - Develop model of collaborative care for this unique, **unserved** population
  - Strengthen practices for systems that serve sexually exploited children/youth
  - Combine best practices in trauma care with local-collaborative expertise

14

Visión General

- Antedecentes/historia/metas de aprendizaje
- Comité Directivo de CASE
- Proyecto de CASE
- Especialidad/población única
- Logros y resultados
- Transición a Prevención e Intervención Temprana

13

Antecedentes/Historia/Metas de Aprendizaje

- Concebida por la Oficia de la Fiscalía y la Junta de Supervisores y durante la Reunión Cumbre CASE de 2009.
- Un proyecto original que fue parte de Componente del Plan de Innovación de MHSA de 2010.
- Metas generales:
  - Desarrollar un modelo de cuidados de colaboración para esta población única que carece de servicios.
  - Fortalecer las prácticas para los sistemas que dan servicio a niños/jóvenes que son explotados sexualmente.
  - Combinar las mejores prácticas de atención sobre traumas con la colaboración de expertos locales.

14

Learning Goals, cont'd.

- Increase understanding of impact of sexual exploitation, risk factors and a means of effective identification, intervention and treatment.
- Develop a means for identifying diverse children/youth entering juvenile justice system on non-sexual exploitation charges.
- Develop a training and education module for effective interaction with this unique population.
- Develop psychometric tools for identifying and monitoring this unique population.

15

CASE Steering committee

A collaborative effort made up of ten child/youth-serving agencies:

- Department of Behavioral Health
- Children and Family Services
- Children's Network
- District Attorney's Office
- Public Defender
- Probation Department
- Sheriff's Department
- Department of Public Health
- San Bernardino County Superintendent of Schools
- San Bernardino County Superior Court – Juvenile Dependency Division

16

Metas de Aprendizaje, cont

- Aumentar el entendimiento sobre el impacto de la explotación sexual, los factores de riesgo y medios efectivos de identificación, intervención y tratamiento.
- Desarrollar un medio para identificar los niños/jóvenes que se involucran en el sistema judicial juvenil por acusaciones que no tienen que ver con explotación no sexual.
- Desarrollar un módulo de capacitación y educación para interactuar eficazmente con esta población única.
- Desarrollar herramientas psicométricas para identificar y monitorear esta población única.

15

Comité Directivo de CASE

Un esfuerzo conjunto compuesto de diez agencias que sirven a los niños/jóvenes:

- Departamento de Salud Mental
- Servicios para Niños y Familias
- Children's Network
- Oficina de la Fiscalía
- Oficia de Defensoría Pública
- Departamento de Libertad Probatoria
- Departamento de los Alguaciles
- Departamento de Salud Pública
- Superintendente Escolar del Condado de San Bernardino
- Tribunal Superior del Condado de San Bernardino – División de Dependencia Juvenil

16

CASE Project

Prior to the creation of the CASE:

- There were no services tailored specifically for survivors of commercial sexual exploitation in San Bernardino County.
- There was no training available to professionals or community members regarding these issues.
- Coordination of services for commercially sexually exploited children was minimal in most cases.
- There were no performance outcomes or statistical tools for this unique population.

17

Specialty/Unique Population

- Commercially Sexually Exploited Children (CSEC) often have many levels of trauma—interpersonal violence, family violence, systemic violence, societal violence, racism, sexism, etc.
- Many CSEC are involved in multiple child-serving departments/agencies. These entities have not always communicated with each other in coordination of services/case planning.
  - Resulting in many youth "falling through the cracks" and not being identified as victims.

18

Proyecto de CASE

Antes de la creación de CASE:

- No existían servicios adaptados específicamente a sobrevivientes de la explotación sexual comercial en el Condado de San Bernardino.
- No había capacitación relacionada con estos temas que estuviera disponible para profesionales o miembros de la comunidad.
- La coordinación de servicios para niños víctimas de explotación sexual comercial era mínima en la mayoría de los casos.
- No había resultados de rendimiento o herramientas estadísticas para esta población única.

17

Población Única/Especializada

- Niños Víctimas de Explotación Sexual Comercial (CSEC) con frecuencia tienen muchos niveles de trauma—violencia interpersonal, violencia en familia, violencia sistémica, violencia social, racismo, sexismo, etc.
- Muchos CSEC están involucrados en múltiples departamentos/agencias sirviendo a la niñez. Estas entidades no siempre se han comunicado entre sí para coordinar servicios o planear casos.
  - Causando que muchos jóvenes "caigan vacíos" y no sean identificados como víctimas.

18

Successes and Outcomes

- Strengthened collaborative efforts between all child/youth serving agencies.
- Formation of a Multi-Disciplinary Team.
- Development of a centralized referral mechanism.
- Appointment of a CASE Coordinator to oversee and coordinate program efforts.
- Training, outreach and education to 3,000-4,400 individuals per year from FY 2010/11 – FY 2012/13

19

Successes and Outcomes, cont'd.

- Standardized use of the Child and Adolescent Needs and Strengths (CANS) as a tool to develop a comprehensive treatment plan that can be utilized across multiple systems.
- Utilization of the CANS to track progress, gains in functionality, increased resiliency, and reduction in symptoms.
- Development of a unique CSEC module for monitoring impact of services provided.

20

Logros y Resultados

- Esfuerzos conjuntos fortalecidos entre todas las agencias que sirven a la niñez/jóvenes.
- Formación de un Equipo Multi-Disciplinario.
- Desarrollo de un mecanismo centralizado de referencias.
- Nombramiento de Coordinador de CASE para supervisar y coordinar los escuerzos del programa.
- Capacitación, difusión y educación de 3,000 a 4,400 personas por año (del año fiscal 2010/11 al año fiscal 2012/13).

19

Logros y Resultados, cont.

- Uso uniforme de las Necesidades y Fortalezas de Niños y Adolescentes (CANS) como herramienta para desarrollar un plan integral de tratamiento que se pueda usar en múltiples sistemas.
- Utilización de CANS para rastrear progreso, avances en funcionalidad, aumento de resiliencia y reducción en los síntomas.
- Desarrollo de un módulo CSEC único para monitorear el impacto de los servicios brindados.

20

Successes and Outcomes, cont'd.

Utilization of the Massachusetts Youth Screening Instrument - Second Version (MAYSI-II)

- Development of a means of identifying juvenile justice youth as possible victims of sexual exploitation.

21

Transition to Prevention and Early Intervention

- MHSA legislative goal: Reducing Prolonged Suffering
- Service population is a unique group with limited-targeted resources
- Inherently at risk of developing a behavioral health condition
  - Underserved cultural populations
  - Trauma exposed
  - At risk of/or experiencing juvenile justice involvement
- Disparate proportion are from underserved cultural populations

22

Logros y Resultados, cont.

Uso del Instrumento de Detección Juvenil de Massachusetts - Segunda Versión (MAYSI-II)

- Desarrollo de un medio para identificar a jóvenes en el sistema de justicia juvenil como posibles víctimas de explotación sexual.

21

Transición a Prevención e Intervención Temprana

- Meta legislativa de MHSA: reducir el sufrimiento prolongado.
- La población a servir es un grupo único con recursos identificados y limitados.
- En riesgo inherente de desarrollar una condición de salud mental
- Poblaciones culturales desatendidas
  - Expuesto al trauma
  - En riesgo de/involucrándose en el sistema de justicia juvenil
- La disparidad proporcional proviene de poblaciones culturales atendidas insuficientemente

22

Transition to Prevention and Early Intervention, cont'd.

- 80% Early Intervention services
  - Clinical assessment
  - Mental health treatment services
  - Alcohol and drug counseling
- 20% Selective services
  - Outreach and engagement
  - Screening, case management, multi-disciplinary collaboration
  - Educational services

23

Transition to Prevention and Early Intervention, cont'd.

- The annual budgeted cost under Innovation was approximately $900,000.
- Sustainability of services are dependent on leveraged resources.
  - Probation and CFS will assume funding support for staffing commitments to this effort.
  - Budget has been reduced by 55% since the inception of the project, which includes the reduction of MOU pool funds for all partners for auxiliary services/supplies.
- The annual budgeted cost now, under PEI, is approximately $400,000.

24

Transición a la Prevención e Intervención Temprana, cont.

- 80% de servicios de Intervención Temprana
  - Evaluaciones clínicas
  - Servicios de tratamiento de salud mental
  - Consejería sobre alcohol y drogas
- 20% de servicios selectivos
  - Alcance comunitario y participación
  - Detección, gestión de caso, colaboración multidisciplinaria
  - Servicios educativos

23

Transición a la Prevención e Intervención Temprana, cont.

- El costo presupuestado anual bajo Innovación era de aproximadamente $900,000.
- La continuidad de servicios depende de los recursos que se aseguren.
  - Probatoria y CFS asumirán apoyo de fondos para dedicar personal a este esfuerzo.
  - El presupuesto ha sido reducido en un 55% desde el inicio del proyecto, que incluye la reducción de fondos comunes MOU para todos los socios para los servicios/suministros auxiliares.
- El costo presupuestado anual ahora, bajo PEI, es de aproximadamente $400,000.

24

INN 04 – Holistic Campus

Sarah Eberhardt-Rios, Deputy Director
Department of Behavioral Health
County of San Bernardino

25

Background/History

- Originally a project of the 2010 MHSA Innovation Component Plan
- 10 Learning Goals to determine if community-based, non-mental health context would achieve the following MHSA legislative purposes:
  - Increased Access to Underserved Groups (primary purpose)
  - Increased Interagency Collaboration (secondary purpose)

26

INN 04 – Campo Holístico

Sarah Eberhardt-Rios, Subdirectora
Departamento de Salud Mental
Condado de San Bernardino

25

Antecedentes/Historia

- Un proyecto original del Componente de Innovación del Plan de MHSA de 2010
- 10 metas de aprendizaje para determinar si el contexto de base comunitaria y no de salud mental, podría alcanzar los siguientes propósitos legislativos de MHSA:
  - Aumento del acceso a grupos atendidos insuficientemente (propósito principal)
  - Aumento de la colaboración entre agencias (propósito secundario)

26

Project Status

Three contracts became effective for different regions as of October 2011:

- High Desert Area - Victor Community Support Services (VCSS) - WISE
- West Valley - Mental Health Systems (MHS) - STRIVE
- East Valley/Metro – Original contract was terminated in 2012. Project went out for bid and was awarded to El Sol Neighborhood (INSPIRE) to run from July 2013 through June 2015

27

Target Population

Primary population to be served include the underserved populations of San Bernardino County:

- African American
- Asian / Pacific Islander
- Latino
- Native American

Along with LGBTQ and Veterans and their families.

28

Estado del Proyecto

Tres contratos entraron en vigor para diferentes regiones desde octubre del 2011:

- High Desert Area - Victor Community Support Services (VCSS) - WISE
- West Valley - Mental Health Systems (MHS) - STRIVE
- East Valley/Metro – El contrato original terminó en el 2012. El proyecto se publicó para su licitación y se otorgó a El Sol Neighborhood (INSPIRE) para que operara de julio 2013 hasta junio 2015.

27

Población Destinataria

La población principal a servir incluye las poblaciones atendidas insuficientemente del Condado de San Bernardino:

- Afroamericanos
- Asiáticos / Isleños del Pacífico
- Latinos
- Indígenas Americanos
- Junto con LGBTQ y Veteranos y sus familias.

28

Outreach and Engagement Strategies

- Strategies to engage these identified populations vary by campus and are driven by the Holistic Campus Advisory Board (HCAB) at each.
- The HCAB is designed to work collaboratively with the contractor to establish the needs of the community; identify and propose culturally competent and relevant activates, programs, and events to meet those needs.

29

El Sol- INSPIRE

Not in the same place in their implementation as the other two campuses.

- Contract Start date July 2013
- Services began January 2014
- Annual Program Review will take place Summer 2014

30

Estrategias de Alcance Comunitario y Participación

- Las estrategias para que estas poblaciones identificadas se hagan partícipes varían de campus a campus y son impulsadas por la Junta Consultiva del Campo Holístico (HCAB) con el que cada uno cuenta.
- HCAB está diseñada para trabajar en colaboración con el contratista a efecto de establecer las necesidades de la comunidad; identificar y proponer actividades culturalmente competentes y relevantes, programas y eventos para satisfacer esas necesidades.

29

El Sol- INSPIRE

No en el mismo lugar en su implementación como en los otros dos campus.

- Fecha de inicio de contrato julio de 2013
- Servicios iniciaron en enero de 2014
- Revisión Anual del Programa será en el verano del 2014

30

Outreach & Engagement Strategies
VCSS – WISE – High Desert

- Volunteer program for LGBTQ and Veteran engagement
- Increased training efforts in order to equip staff in providing appropriate linkage, support, and services and engagement
- Community Resiliency Model (CRM)
- LGBTQ Ally Training
- Mental Health First Aid
- Crisis intervention training for staff
- Question, Persuade & Refer (Suicide Prevention)

31

Outreach & Engagement Strategies
MHS – STRIVE – West Valley

- Community Education
- Health and Wellness Fairs
- LGBTQ "Safe Zone"
- Veterans Resource Fair
- Gender Responsive Training
- Recovery Sober Dance
- Health fairs- provide health screenings at local supermarkets
- Veterans Barbeque
- Annual Pow Wow

32

Estrategias de Alcance Comunitario y Participación *VCSS – WISE – High Desert*

- Programa de voluntarios para participación de LGBTQ y Veteranos
- Aumento de esfuerzos de capacitación para poder equipar al personal para que ofrezcan enlaces, apoyos y servicios; así como participación apropiada
- Modelo de Resiliencia Comunitaria (CRM)
- Entrenamiento de Alianza LGBTQ
- Primeros Auxilios de Salud Mental
- Capacitación al personal para intervención de crisis
- Preguntar, Persuadir y Recomendar (Prevención de Suicidio)

31

Estrategias de Alcance Comunitario y Participación *MHS – STRIVE – West Valley*

- Educación Comunitaria
- Ferias de Salud y Bienestar
- "Zona Segura" LGBTQ
- Feria de Recursos para Veteranos
- Capacitación con enfoque de género
- Baile de Sobriedad y Recuperación
- Ferias de salud- realizan evaluaciones médicas en los supermercados locales
- Barbeque para Veteranos
- Pow Wow anual

32

Behavioral Health Services
VCSS – WISE – High Desert

- Adult Sand Tray
- Discover Your Wise Mind
- Equine Assisted Therapy
- LGBTQ Context in Film (Insight Through Cinema)
- Manage the Mood
- Living Authentically
- Music Therapy

33

Behavioral Health Services
MHS – STRIVE – West Valley

- Individual Therapy
- Couples Therapy
- Family Therapy

34

Servicios de Salud Mental
VCSS – WISE – High Desert

- Adult Sand Tray
- Descubra su Mente Sabia
- Terapia Equina Asistida
- Contexto LGBTQ en Film (Visión a través del Cine)
- Maneje el Humor
- Vivir Auténticamente
- Terapia con Música

33

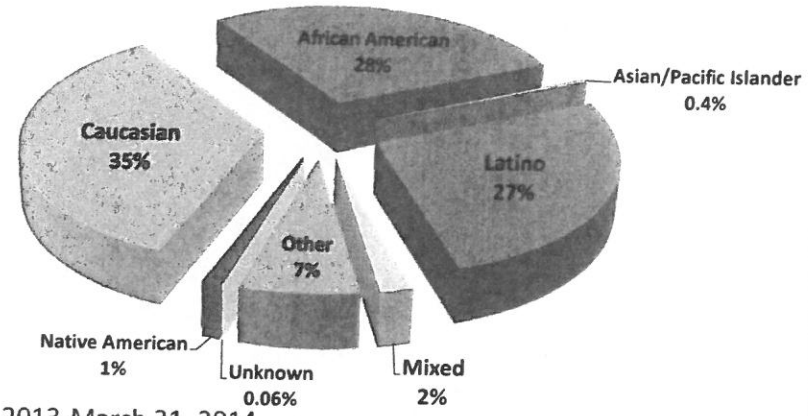
Servicios de Salud Mental
MHS – STRIVE – West Valley

- Terapia Individual
- Terapia de Parejas
- Terapia de Familias

34

Increased Access to Underserved Groups : Total Individuals Engaged
VCSS – WISE – High Desert

2061 individuals engaged*

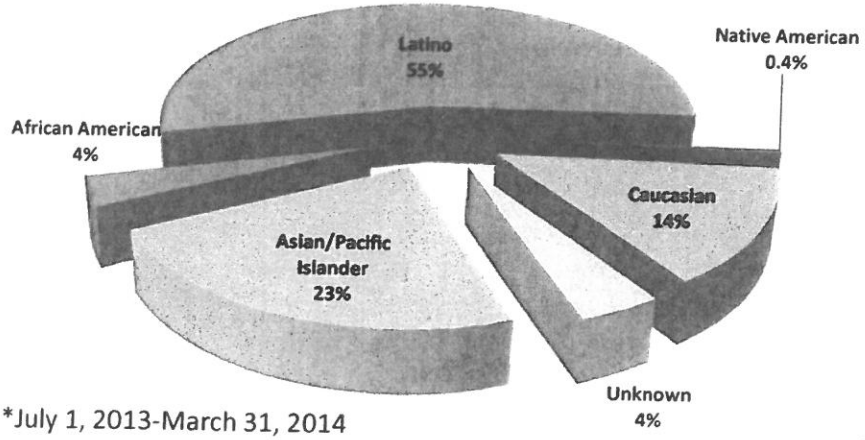


*July 1, 2013-March 31, 2014

35

Increased Access to Underserved Groups : Total Individuals Engaged
MHS – STRIVE – West Valley

2374 individuals engaged*



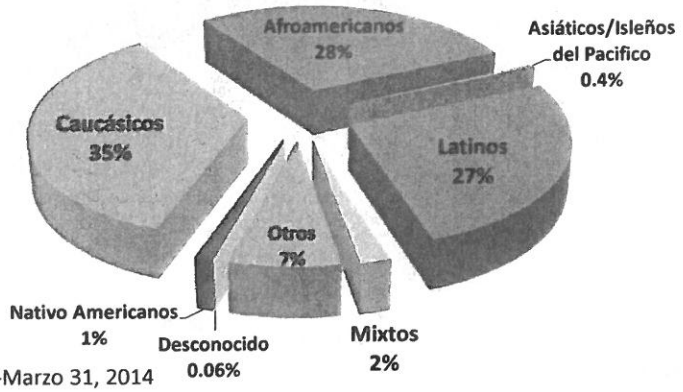
*July 1, 2013-March 31, 2014

36

Aumento de Acceso a Grupos Desatendidos : Total de Personas Participando

VCSS – WISE – High Desert

2061 personas participando*



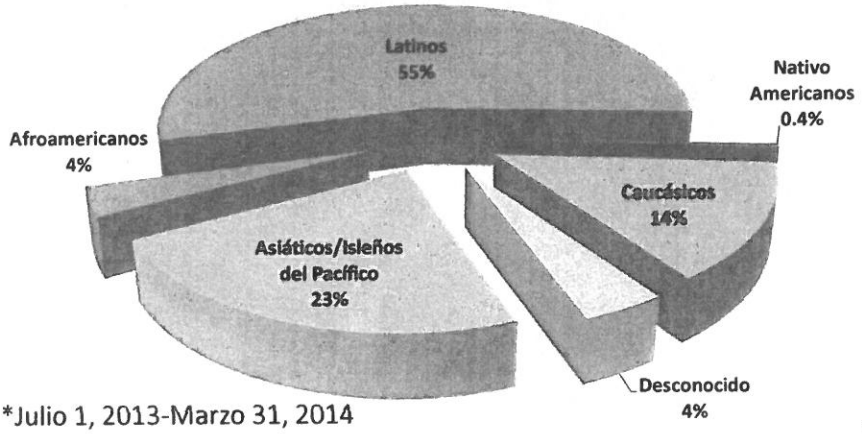
*Julio 1, 2013-Marzo 31, 2014

35

Aumento de acceso a grupos atendidos insuficientemente : total de personas participando

MHS – STRIVE – West Valley

2374 personas participando*



*Julio 1, 2013-Marzo 31, 2014

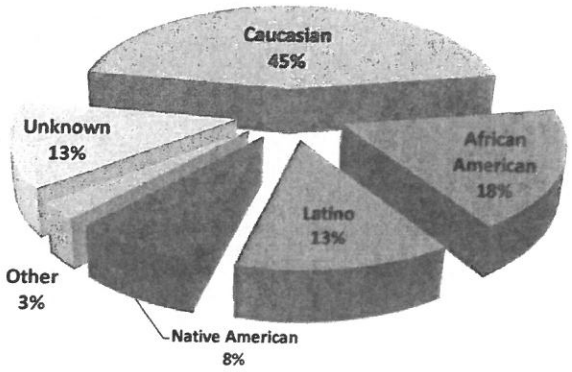
36

Increased Access to Underserved Groups: Receiving Mental Health Services

VCSS – WISE – High Desert

40 individuals provided mental health services at HC*

- 1.94% of total engaged
- 70% were Medi-Cal beneficiaries



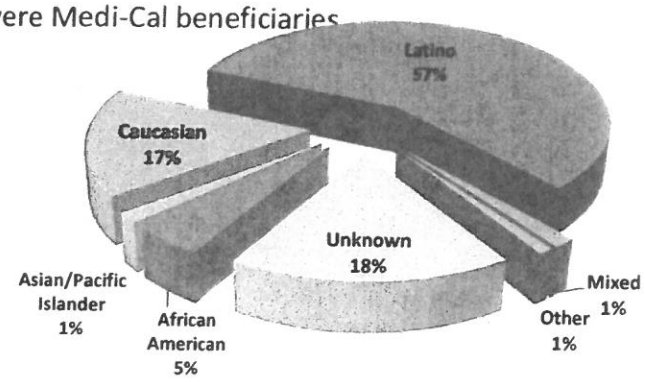
37

Increased Access to Underserved Groups: Receiving Mental Health Services

MHS – STRIVE – West Valley

193 individuals provided mental health services at HC*

- 8.1% of total engaged
- 21.24% were Medi-Cal beneficiaries

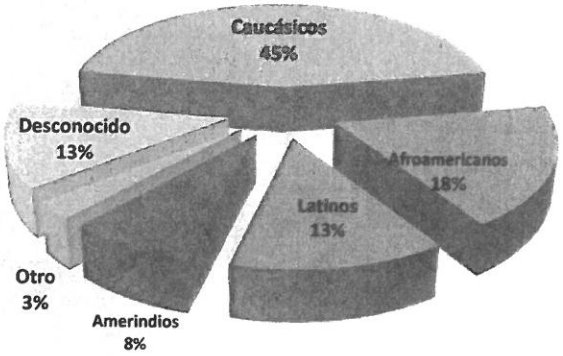


38

Aumento de acceso a grupos atendidos insuficientemente: recibiendo servicios de salud mental *VCSS – WISE – High Desert*

Se brindó servicios de salud mental a 40 personas en HC*

- 1.94% del total participando
- 70% eran beneficiarios de Medi-Cal



*Julio 1, 2013-Marzo 31, 2014

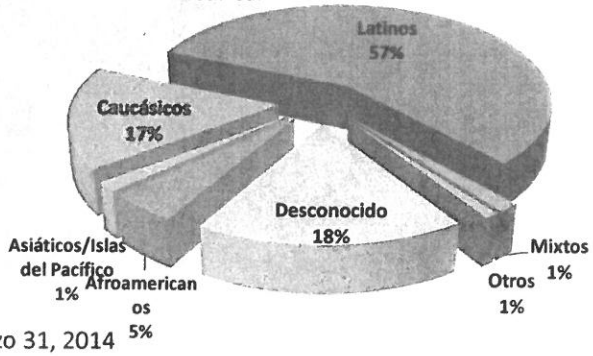
37

Aumento de acceso a grupos atendidos insuficientemente: recibiendo servicios de salud mental

MHS – STRIVE – West Valley

193 personas recibieron servicios de salud mental en HC*

- 8.1% del total participando
- 21.24% eran beneficiarios de Medi-Cal



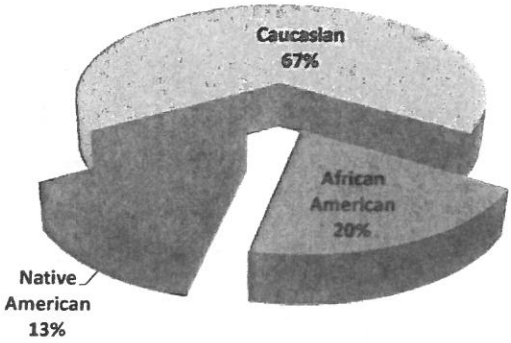
*Julio 1, 2013-Marzo 31, 2014

38

Increased Access to DBH System of Care
VCSS – WISE - High Desert

15 individuals* engaged in DBH system of care

- 0.7% of total engaged
- 93.33% were Medi-Cal beneficiaries



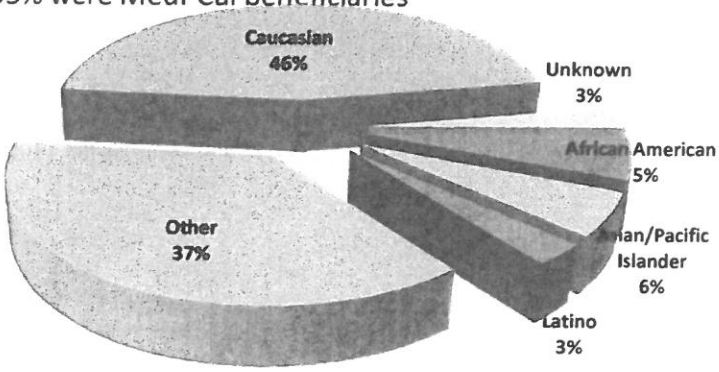
*Individuals who received mental health services at WISE
July 1, 2013-March 31, 2014

39

Increased Access to DBH System of Care
MHS– STRIVE - West Valley

30 individuals* engaged in DBH system of care

- 1.3% of total engaged
- 63.33% were Medi-Cal beneficiaries



40

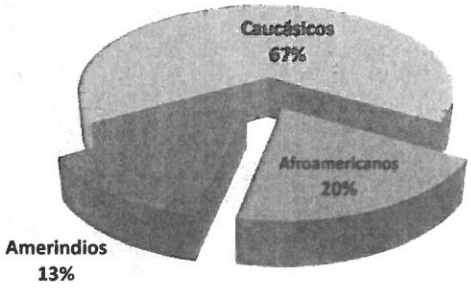
*Individuals who received mental health services at STRIVE

Aumento de acceso al Sistema de Atención de DBH

VCSS – WISE - High Desert

15 personas* participando en el sistema de atención de DBH

- 0.7% del total participando
- 93.33% eran beneficiarios de Medi-Cal



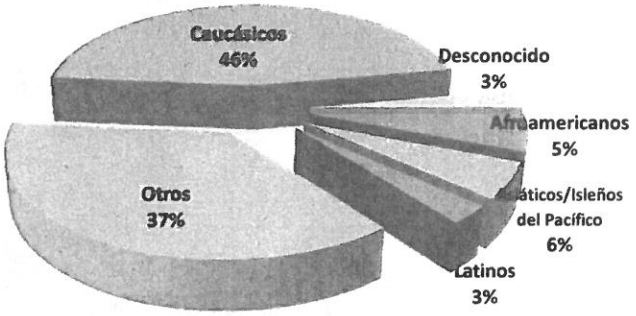
*Personas que recibieron servicios de salud mental en WISE Julio 1, 2013-Marzo 31, 2014

39

Aumento de Acceso al Sistema de Atención de DBH *MHS– STRIVE - West Valley*

30 personas* participando en el sistema de atención de DBH

- 1.3% del total participando
- 63.33% eran beneficiarios de Medi-Cal



*Personas que recibieron servicios de salud mental en STRIVE Julio 1, 2013-Marzo 31, 2014

40

Increased Interagency Collaboration

- Community training, education, and fairs
- Central location for culturally diverse activities
- Work toward increasing collaboration efforts with organizations and agencies, currently providing services, where holistic members are referred

41

VCSS – WISE
High Desert

WISE Holistic Campus-VCSS 15400 Cholame Rd. Victorville, CA. 92392	Family Resource Center-VCSS 15400 Cholame Rd. Victorville, CA. 92392	Hospitality Center-SJOG 15534 Sixth St. Victorville, CA. 92393 3.9 miles	CWE-VCSS 15095 Amargosa, Victorville, CA 92395 1.7 miles	Military Service and Family Support VCSS Ft. Irwin Barstow
Wellness Activities				
Zumba Youth Yoga Family Game Night Nutrition Ready, Set, Go Creative Families Couponing Craft Club Healthy Lifestyles	After School Activities After School Workshops	Social Activities/ Seasonal		
Mental Health Education/Peer Support				
Relapse Prevention Spirituality Women's support Men's support LGBTQ (Family & Friends) CRM Words of Wisdom (Book Club)	Personal development Parent support Family Education MH workshops Adult skills education Counseling Services Parenting	12 step meetings Drug Ed/Awareness Life Skills Job Seeking Making Decisions Stress Management Computer Lab Parenting Counseling for Aftercare ADS groups-aftercare	Case Management Risk Screenings Depression/Substance Abuse Screenings MH First Aid Assist/SafeTalk Bereavement and Loss	Women's support Men's support
Therapeutic				
Adult Sand Tray Discover Your Wise Mind Equine Assisted Therapy LGBTQ Context in Film (Insight Through Cinema) Manage the Mood Living Authentically Music Therapy	Evidence Based Therapy		Individual Therapy Group Therapy	Trauma Focused Care Family Functional Treatment Child Interventions PTSD Screening Evidence Based Therapy Equine Assisted Therapy

Aumento de Colaboración entre Agencias

- Capacitación, educación y ferias comunitarias
- Ubicación centralizada para actividades diversas culturales
- Trabajar para aumentar los esfuerzos de colaboración con organizaciones y agencias que actualmente brindan servicios a donde a los miembros holísticos son referidos

41

VCSS – WISE
High Desert

Campo HolisticoWISE -VCSS 15400 Cholame Rd. Victorville, CA. 92392	Family Resource Center-VCSS 15400 Cholame Rd. Victorville, CA. 92392	Hospitality Center-SJOG 15534 Sixth St. Victorville, CA. 92393 3.9 millas	CM/E-VCSS 15095 Amargosa, Victorville, CA 92395 1.7 millas	Servicio Militar y Apoyo Familiar VCSS Ft. Irwin Barstow
Actividades de Bienestar				
Zumba Yoga para jóvenes Noche de juegos familiares Nutrición En sus marcas, listos, Fuera Familias Creativas Cupones Club de artes Estilos de vida sana	Actividades después del horario escolar Talleres después del horario escolar	Actividades Sociales/ por época		
Educación de Salud Mental/Apoyo de Compañeros				
Prevención a recaídas Espiritualidad Apoyo para mujeres Apoyo para hombres LGBTQ (Familia y amigos) CRM Palabras Sabias (club del libro)	Desarrollo personal Apoyo de padres Educación familiar Talleres de salud mental Capacitación de habilidades adultas Servicios de consejería Progenitura	Reuniones de 12 pasos Educ /Conciencia de drogas Habilidades de la vida Búsqueda de empleo Tomar decisiones Manejo de estrés Lab de Computación Progenitura Consejos postratamiento Postratamiento grupos ADS	Gestión de caso Detección de riesgos Detección de Depresión /Abuso de sustancia Primeros auxilios de salud mental Asistencia/Pláticas Duelo y pérdida	Apoyo para mujeres Apoyo para hombres
Terapéutico				
Adult Sand Tray Descubra su mente sabia Terapia asistida por caballos Contexto LGBTQ en Film (Visión a través del Cine) Maneje el humor Vida auténtica Terapia con música	Terapia basada en evidencia		Terapia individual Terapia en grupo	Cuidado enfocado al trauma Tratamiento funcional familiar Intervenciones de niños Detección PTSD Terapia basada en evidencia Terapia asistida por caballos

MHS – STRIVE West Valley

STRIVE Holistic Campus Mental Health Systems 316 East E Street Ontario, CA 91764	Family Resource Center Linda Vista Ontario Montclair Unified 1556 S. Sultana Ave Ontario CA. 91761 1.7 miles	Upland Recovery Center 934 N. Mountain Ave Upland, CA. 91786 IVRS 3.9 miles	CWE Bilingual Family Counseling 317 West F Street Ontario, CA. 91762 0.5 miles
Wellness Activities			
Yoga Kick Boxing Zumba Native American Beading Loom Knitting Power Pilates Arts Therapy Health Screenings	After School Activities After School Workshops	Karaoke Rock Band Bingo Movie night	
Mental Health Education/Peer Support			
English Second Language Citizenship Class Computer Skills GED Training Life Skills Anger Management Relapse Prevention Financial Workshop Women's Group Parenting (S) 12 step/self help	Personal development Parent Support/Education MH workshops Adult Skills Education Parenting English Second Language Financial Workshop Citizenship Class	Job Skills Daily Living Skills Anger Management Domestic Violence Money Management Men/Women 12 step Parenting 12 step/self help Relapse Prevention	Case Management Risk Screenings Depression/Substance Abuse Screenings MH First Aid Assist/SafeTalk Bereavement and Loss
Therapeutic			
Individual Therapy Couples Therapy Family Therapy	Evidence Based Therapy Individual, Group, and couples Counseling	Counseling Group Counseling	Individual Therapy Group Therapy

Evaluation and Review

- Evaluation of the Holistic Campus project is on-going, as the project has not yet been completed.
- Evaluation of project as a whole.
- Evaluation of outreach and therapeutic services separately.
- Evaluation of outcome and engagement services as compared to other current engagement strategies used in DBH.
- Evaluation of locality.
- Continuity of care planning for therapeutic services and outreach services.

44

MHS – STRIVE
West Valley

STRIVE Campo Holístico Mental Health Systems 316 East E Street Ontario, CA 91764	Family Resource Center Linda Vista Ontario Montclair Unified 1556 S. Sultana Ave Ontario CA. 91761 1.7 millas	Upland Recovery Center 934 N. Mountain Ave Upland, CA. 91786 IVRS 3.9 millas	CWE Bilingual Family Consejería 317 West F Street Ontario, CA. 91762 0.5 millas
Actividades de Bienestar			
Yoga Kick Boxing Zumba Rebordeados amerindios Tejido Pilates Terapia de artes Detección de Salud	Actividades después del horario escolar Talleres después del horario escolar	Karaoke Banda de rock Bingo Noche de película	
Educación de Salud Mental/Apoyo de Compañeros			
Inglés como segundo idioma Clase de ciudadanía Habilidades de computación Entrenamiento para GED Habilidades de vida Control de ira Prevención a recaídas Taller de finanzas Grupo para mujeres Progenitura (S) Auto ayuda en 12 pasos	Desarrollo personal Apoyo/educación de padres Talleres de salud mental Educ. de habil. p/adultos Progenitura Inglés como segundo idioma Taller de finanzas Clase de ciudadanía	Habilidades para empleo Habilidades de vida diaria Control de ira Violencia Doméstica Money Management 12 pasos hombres/mujeres Progenitura Auto ayuda en 12 pasos Prevención a recaídas	Gestión de casis Detección de riesgos Depresión/Abuso de sustancia Detecciones Primeros auxilios de salud mental Asist/Ayuda del habla Duelo y la pérdida
Terapéutica			
Terapia individual Terapia de parejas Terapia de familia	Terapia basada en evidencia Consejos para individuos, grupo y parejas	Consejería Consejería de grupo	Terapia individual Terapia de grupo

Evaluación y Revisión

- La evaluación del proyecto Campo Holístico es continuo, ya que el proyecto no ha sido completado aún.
- Evaluación del proyecto en su totalidad.
- Evaluación de los servicios de alcance comunitario y servicios terapéutico por separado.
- Evaluación de resultados y servicios de participación comparado con otras estrategias actuales de participación usadas en DBH.
- Evaluación de localidad.
- Continuidad de planificación de cuidados para servicios terapéuticos y servicios de proyección.

44

Sustainability

- Comparison of local services being offered that are similar to Holistic Campus services within 4 mile radius of High Desert and West Valley campuses.
- Identified existing programs that could potentially continue to provide these services, with a possible modified scope of work, on an ongoing basis under alternative funding.
- Consideration for ongoing care, i.e. clients receiving therapeutic services.

45

Sustainability

- Consideration of types of therapeutic interventions being provided and their relationship to the mental health benefit expansion under Medi-Cal.
- Consideration of the types of outreach activities and other stakeholder in the community that provide similar activities but are not behavioral health, or health providers.

46

Sostenibilidad

- Comparación de los servicios locales que se ofrecen y que son similares a los servicios de Campo Holístico dentro de un radio de 4 millas de los campus High Desert y West Valley.
- Se identificaron programas existentes que podrían potencialmente continuar brindando estos servicios, con un ámbito de trabajo posiblemente modificado, en una base continua bajo financiamiento alternativo.
- Consideración de cuidados continuos por ejemplo: clientes que reciben servicios terapéuticos.

45

Sostenibilidad

- Consideración de tipos de intervenciones terapéuticas que se brindan y su relación con el beneficio de expansión de salud mental bajo Medi-Cal.
- Consideración de los tipos de actividades de alcance comunitario y otros colaboradores en la comunidad que brindan actividades similares pero que no son de salud mental ni proveedores de salud.

46

Fiscal Impact

- VCSS and MHS (serving the High Desert and West Valley areas)
  - Contract amount for each $2,749,560
  - Annual budget for each $807,672
  - Contracts expire on September 30, 2014
- El Sol (serving Central Valley/Metro areas)
  - Contract amount was $1,848,418
  - Contract expires June 30, 2015

47

Next Steps

- Utilize the learning and implement in to the DBH system of care where applicable.
- Identify next steps for holistic campuses with contract end dates in September 2014.
- Continue to evaluate the holistic campus project.
  - Apply learning to date to the third campus (El Sol).
  - Apply learning within the system as a whole.

48

Impacto Fiscal

- VCSS y MHS (sirviendo las áreas de High Desert y West Valley)
  - Cantidad de contrato por cada una $2,749,560
  - Presupuesto anual por cada una $807,672
  - Los contratos se vencen el 30 de septiembre de 2014
- El Sol (sirviendo las áreas de Central Valley/Metro)
  - Cantidad de contrato fue de $1,848,418
  - El contrato caduca el 30 de junio de 2015

47

Siguientes Pasos

- Utilice el aprendizaje e impleméntelo en el sistema de atención DBH donde sea aplicable.
- Identifique los siguientes pasos para los campos holísticos con fechas de finalización de contrato en septiembre del 2014.
- Siga evaluando el proyecto de campo holístico.
  - Aplique lo que aprendió a la fecha al tercer campo (El Sol).
  - Aplique el aprendizaje dentro del sistema en su totalidad.

48

Future CPAC Meetings

Presentations regarding other INN projects include:

- INN-05: Interagency Youth Resiliency Teams (IYRT)
- INN-06: Behavioral Health Youth Hostel – The STAY
- INN-07: Recovery Based Engagement Services Teams (RBEST)

49

Questions....

50

Reuniones Futuras de CPAC

Las presentaciones relacionadas con otros proyectos INN incluyen:

- INN-05: Equipos Juveniles Interagenciales de Resiliencia (IYRT)
- INN-06: Hostel Juvenil de Salud de Mental – The STAY
- INN-07: Equipos de Recuperación Basados en Servicios de Participación (RBEST)

49

Preguntas....

50

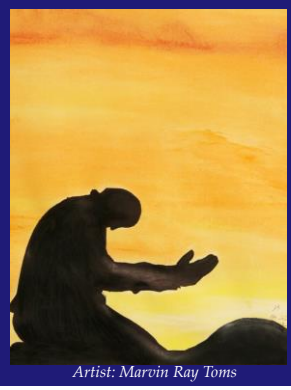
SAN BERNARDINO COUNTY

Behavioral Health
Mental Health Services Act (MHSA) Coordination

Community Policy Advisory Committee

Mental Health Services Act,
Innovation

Sarah Eberhardt-Rios, Deputy Director
Michelle Dusick, Acting MHSA Coordinator
Susanne Kulesa, Program Manager
Joshua Morgan, Psy D, Research and Planning Psychologist
February 19, 2015



Artist: Marvin Ray Toms

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Mental Health Services Act

- The Mental Health Services Act (MHSA), Prop 63, was passed by California voters November 2004 and went into effect in January 2005.
- The MHSA provides increased funding for mental health programs across the State.
- The MHSA is funded by a 1% tax surcharge on personal income over $1 million per year.
- As these taxes are paid, fluctuations impact fiscal projections and available funding.

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Mental Health Services Act

WIC § 5848 states that counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on:

- Mental Health Policy
- Program Planning
- Implementation
- Monitoring
- Quality Improvement
- Evaluation
- Budget Allocations

Components of MHSA

- Community Services and Supports
- Prevention and Early Intervention
- **Innovation (INN)**
- Workforce Education and Training
- Capital Facilities and Technological Needs
- Community Program Planning

Goals of Innovation Component

Address one of the following learning purposes as its primary purpose:

(1) To increase access to underserved groups.
(2) To increase the quality of services, including better outcomes.
(3) To promote interagency collaboration.
(4) To increase access to services.

Goals of Innovation Component, cont'd.

Support innovative approaches by doing one of the following:

(A) Introducing new mental health practices or approaches, including, but not limited to, prevention and early intervention.

(B) Making a change to an existing mental health practice or approach, including, but not limited to, adaptation for a new setting or community.

(C) Introducing a new application to the mental health system of a promising community-driven practice or an approach that has been successful in non-mental health contexts or settings.

Innovation Legislative Requirements
WIC 5830, Part 3.2

- An Innovation project is defined, for purposes of these guidelines, as one that contributes to learning rather than a primary focus on providing a service.
- County mental health programs shall expend funds for their innovation programs upon approval by the Mental Health Services Oversight and Accountability Commission.

Innovation Pending Legislative Requirements

Time-limited Pilot Project

- Maximum of 4 years from the start date of the project.
- Successful parts of the project may continue under a different funding source or be incorporated into existing services.
- Projects may be terminated prior to planned end date.

*All information on this slide is proposed and subject to change as proposed legislation goes through legislative review.

Innovation Projects in Transition

Two Innovation Projects are coming to a foreseen end in June 2015:

- Holistic Campus
- Interagency Youth Resiliency Teams (IYRT)

Interagency Youth Resiliency Teams (IYRT)

Project end date is 6/30/2015:

- Data & Outcome information to date discussed at CPAC meeting on 8/21/14.
- Services to be transitioned and end by 5/31/2015.
- Youth will receive a "warm handoff" to ensure the continuation of services currently being received.
- Evaluation efforts well underway.
- Contractors to provide final reports early FY 15/16.

Innovation Projects in Transition

Our goal today is to spend this meeting discussing:

Holistic Campus

Holistic Campus Goals

Legislated Goal:

- Increase Access to Underserved Groups

Learning Purpose:

- Determine if this high percentage of culturally diverse peers, along with the availability of resources to local providers, fosters a more diverse environment and concurrently out of one location with both culturally specific and traditional healing methods.

- Determine if our underserved, unserved and inappropriately served populations are more comfortable seeking services within a holistic campus setting, where the community determines the services offered, the majority of employees are peers and cultural brokers, and where DBH provides maximum flexibility.

Holistic Campus Goals, cont'd.

Project Timelines

- Two campuses stopped direct services in September 2014.
- Third campus end date is June 30, 2015.

Note: The variance in end dates is the result of separate contracts and start dates.

Preliminary Outcomes

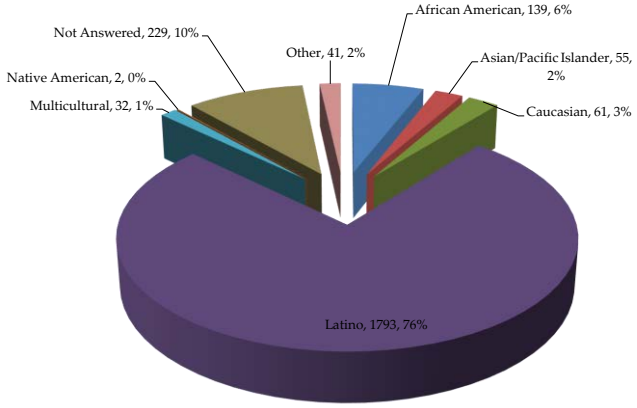
Who we served:

Fiscal Year	Central Valley	West Valley	High Desert	Total
2012/13	*0	3924	4614	8538
2013/14	1434	3592	4272	9298

*Central Valley did not provide services for FY 2012/13 due to a later contract start date.

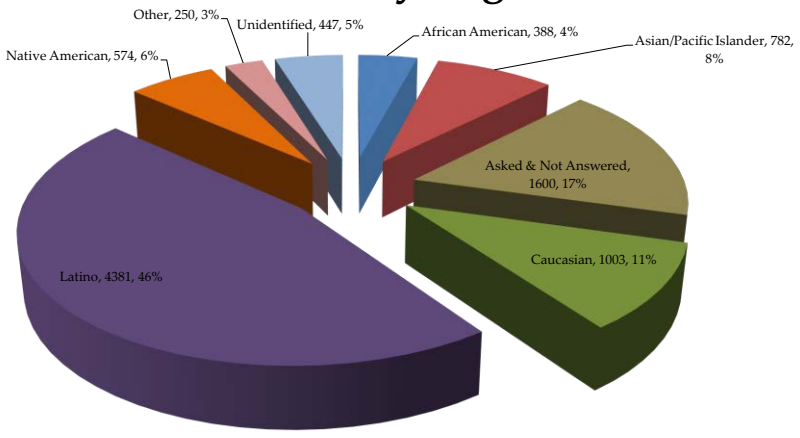
Preliminary Outcomes, cont'd.

Central Valley Region



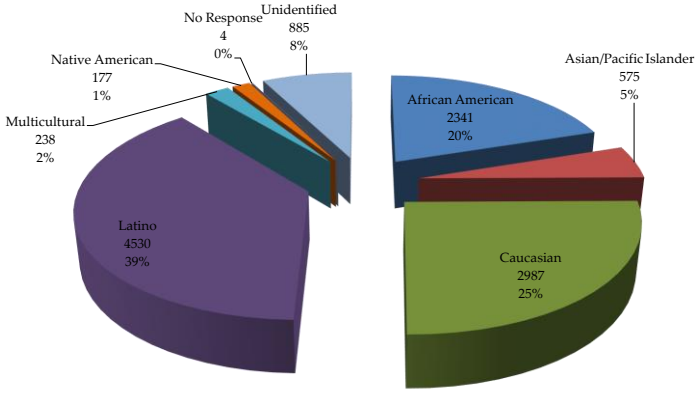
Preliminary Outcomes, cont'd.

West Valley Region



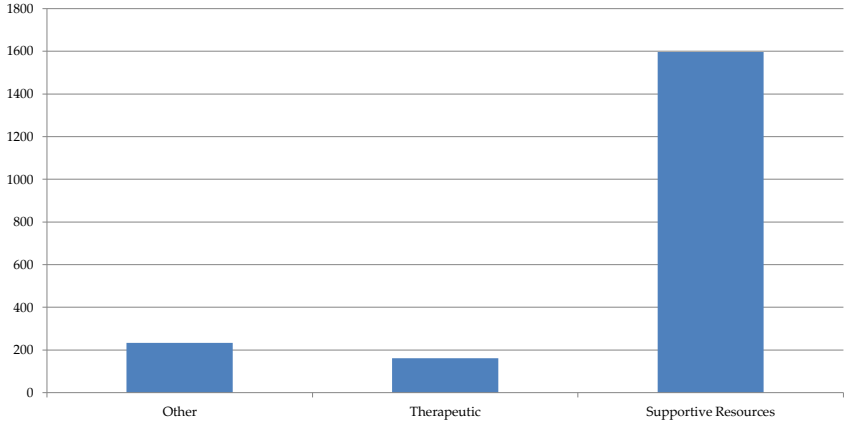
Preliminary Outcomes, cont'd.

Desert/Mountain Region

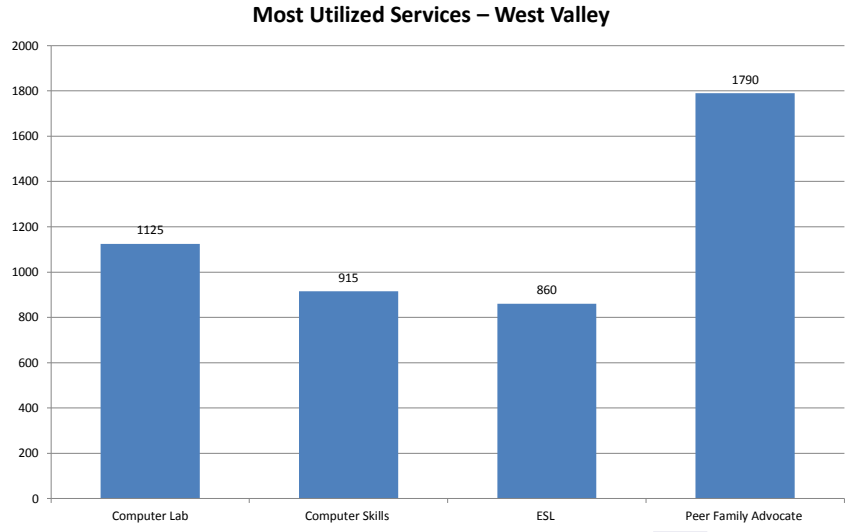


Preliminary Outcomes, cont'd.

Most Utilized Services – Central Valley



Preliminary Outcomes, cont'd.



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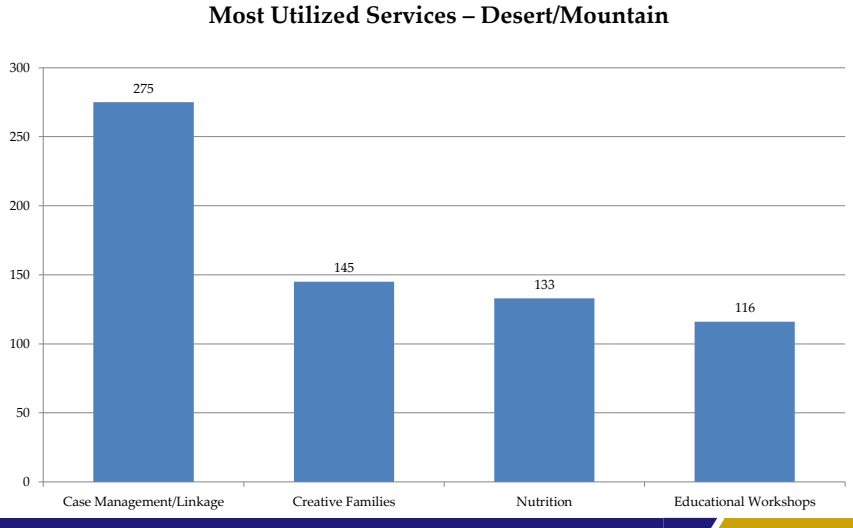
Preliminary Outcomes, cont'd.



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Discussion

How do we apply what we have learned?

- Evaluate what worked in this project.
- Determine if "what worked" is happening anywhere else.
- Talk about how we can apply "what worked" in the rest of the DBH system of care.

Definitions

Outreach Activities - Activities and events aimed at disseminating information regarding the services that are offered at the holistic campus. Examples included health fairs, job fairs, Powwow, 12 step events, cultural specific activities.

Wellness Activities - Activities that are aimed at improving the overall wellness of the individual. The activities are based on SAMHSA's eight dimensions of wellness (emotional, environmental, financial, intellectual, occupational, physical, social, and spiritual). Peer Counseling was a significant wellness activity, which included individual counseling from a Peer Family Advocate (PFA), Peer Partner, Parent Partner, or Community Health Worker covering basic life issues, offering encouragement and support to the individual. Other examples include yoga, Zumba, art therapy, computer classes, ESL, GED, life skills, nutrition, parenting, anger management, and other self-help or peer run activities.

Therapeutic Activities - Individual, family, or group counseling facilitated by a clinician.

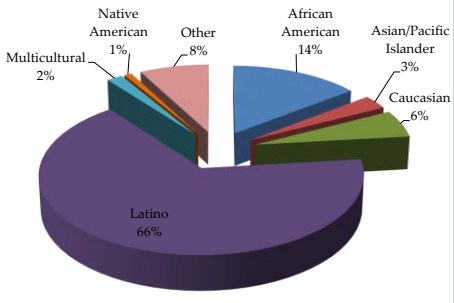
* See FAQ/Definition Handout

Group Discussion

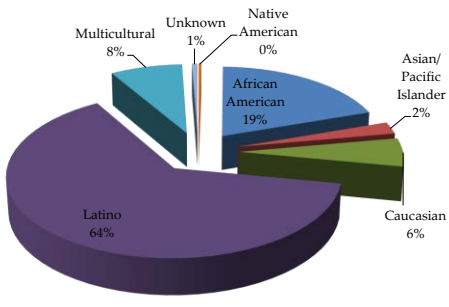
Section I

Outreach Comparison Ethnicity

Central Valley Holistic Campus



Central Valley Family Resource Center



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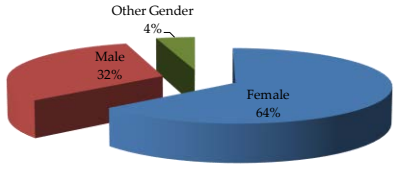
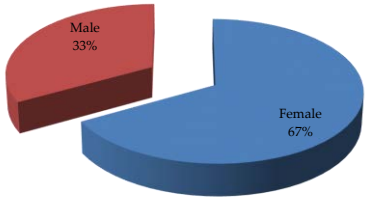
Outreach Comparison Gender

Central Valley Holistic Campus



Central Valley Family Resource Center



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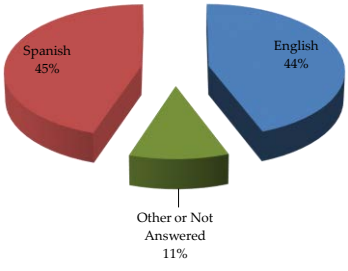
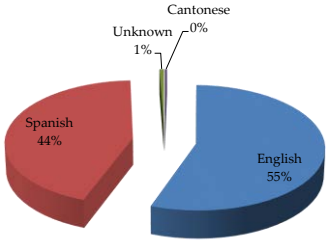
Outreach Comparison Language

Central Valley Holistic Campus



Central Valley Family Resource Center



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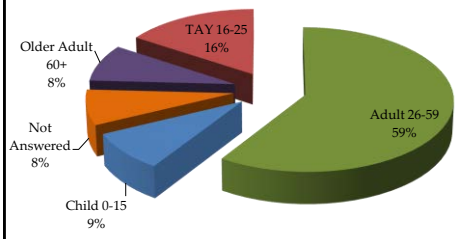
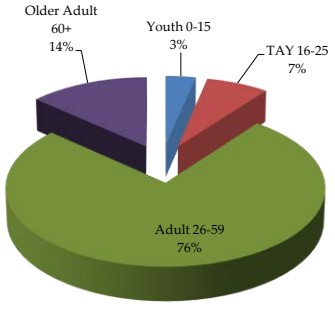
Outreach Comparison Age

Central Valley Holistic Campus



Central Valley Family Resource Center



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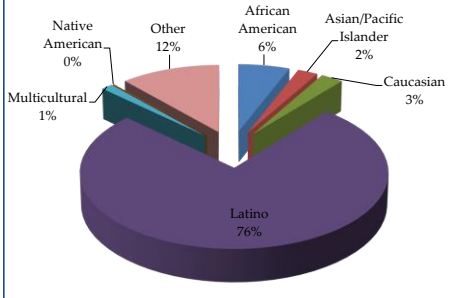
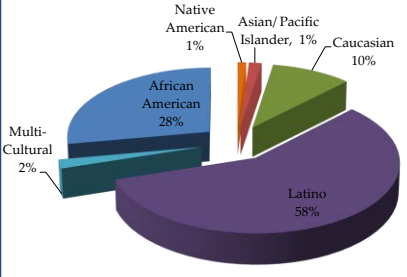
Wellness Comparison Ethnicity

Central Valley Holistic Campus



Central Valley Family Resource Center



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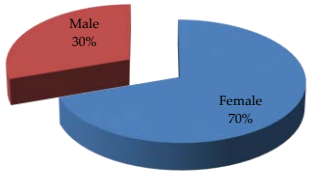
Wellness Comparison Gender

Central Valley Holistic Campus



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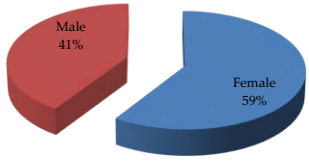

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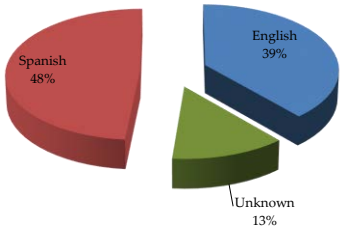
Wellness Comparison Language

Central Valley Holistic Campus



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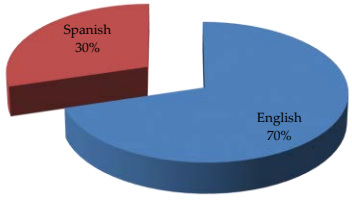

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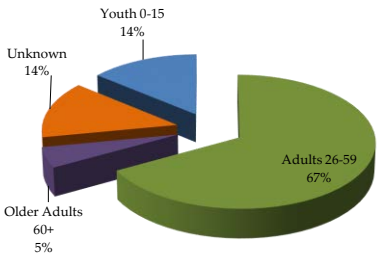
Wellness Comparison Age

Central Valley Holistic Campus



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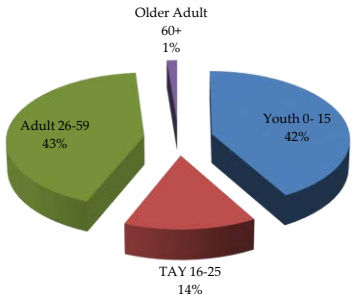

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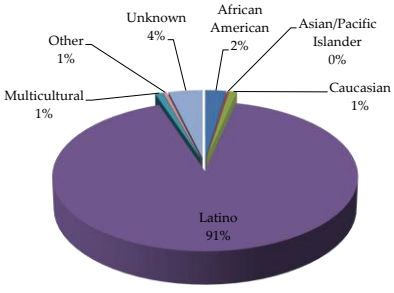
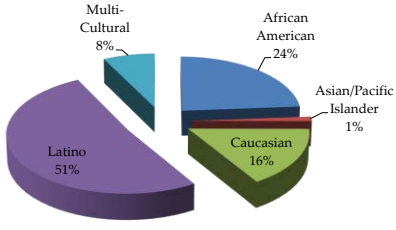
Therapy Comparison Ethnicity

Central Valley Holistic Campus



Central Valley Family Resource Center



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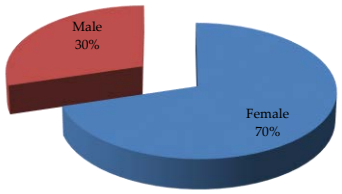
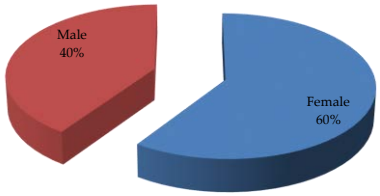
Therapy Comparison Gender

Central Valley Holistic Campus



Central Valley Family Resource Center



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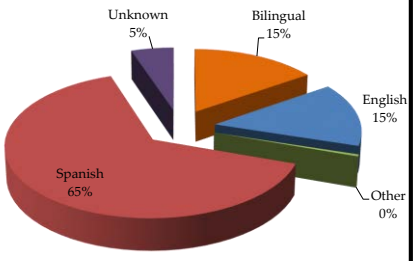
Therapy Comparison Language

Central Valley Holistic Campus



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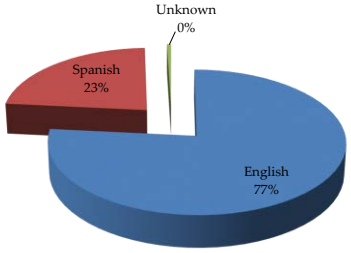

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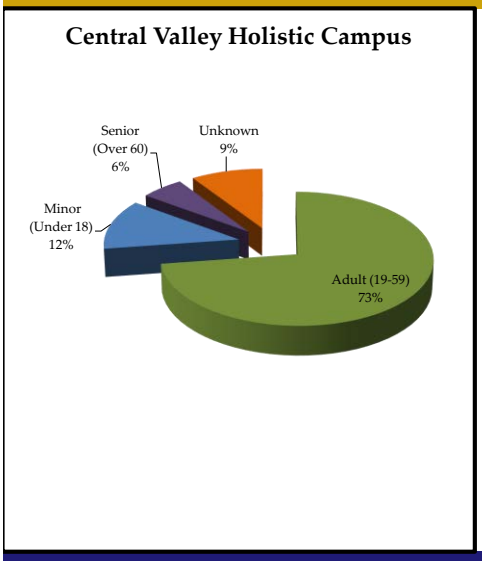
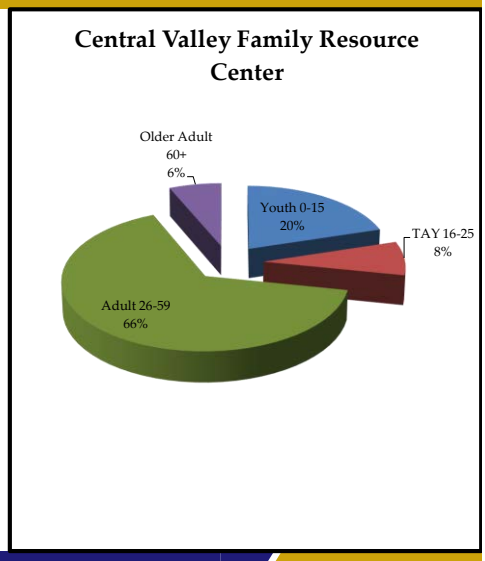
Therapy Comparison Age





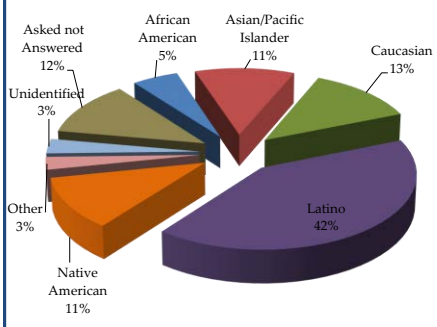
Group Discussion

Discussion Section I

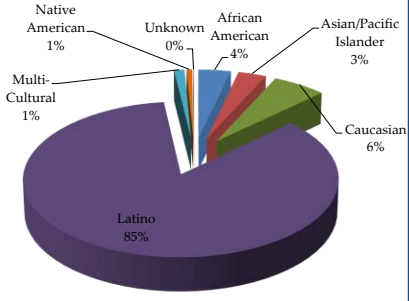
Section II

Outreach Comparison Ethnicity

West Valley Holistic Campus



West Valley Family Resource Center



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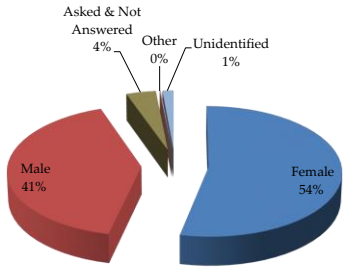
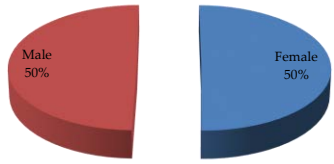
Outreach Comparison Gender

West Valley Holistic Campus



West Valley Family Resource Center



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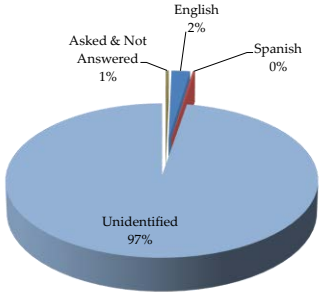
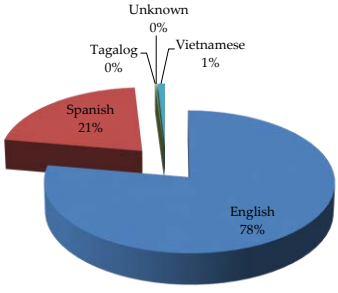
Outreach Comparison Language

West Valley Holistic Campus



West Valley Family Resource Center



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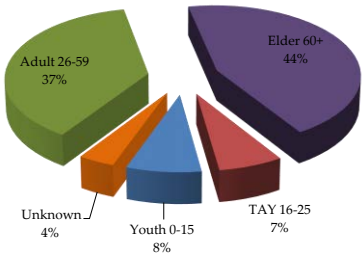
Outreach Comparison Age

West Valley Holistic Campus



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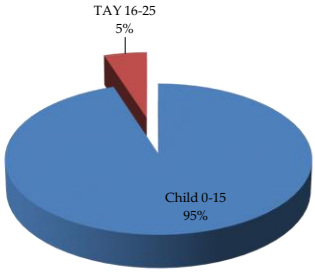

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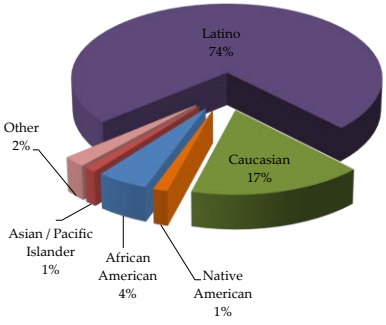
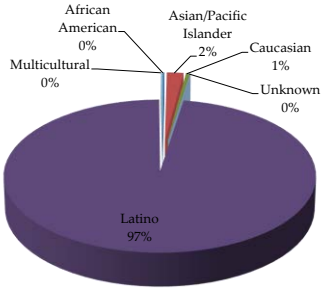
Wellness Comparison Ethnicity

West Valley Holistic Campus



West Valley Family Resource Center



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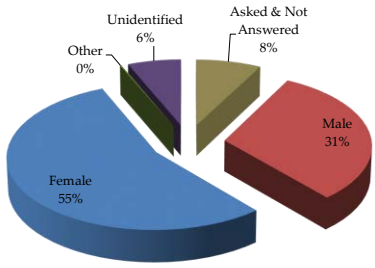
Wellness Comparison Gender

West Valley Holistic Campus



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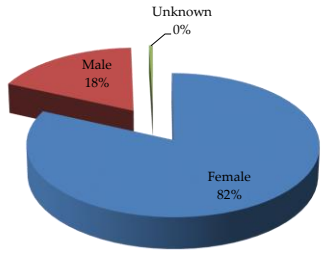

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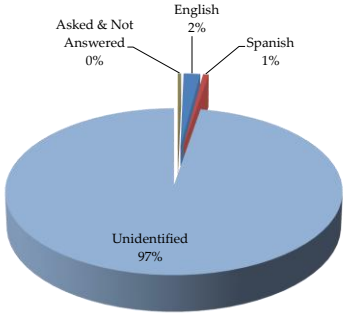
Wellness Comparison Language

West Valley Holistic Campus



West Valley Family Resource Center

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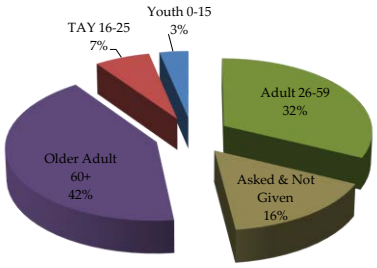
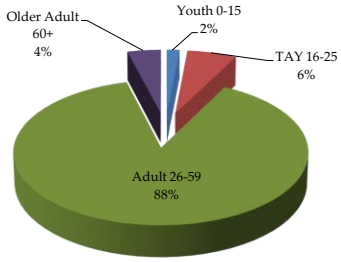
Wellness Comparison Age

West Valley Holistic Campus

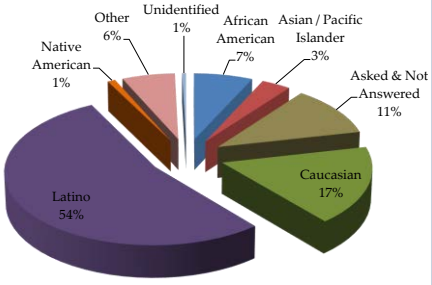


West Valley Family Resource Center

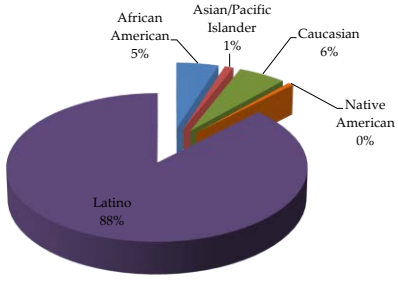


Therapy Comparison Ethnicity

West Valley Holistic Campus

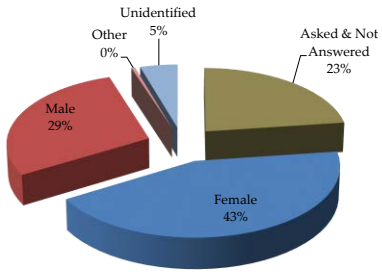


West Valley Family Resource Center



Therapy Comparison Gender

West Valley Holistic Campus



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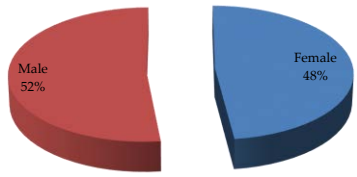

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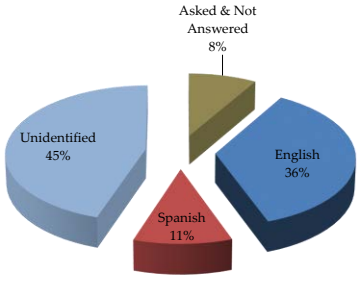
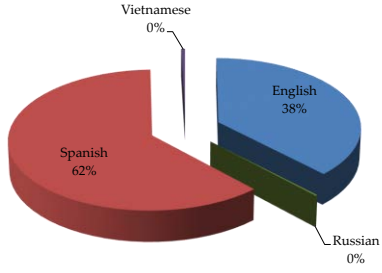
Therapy Comparison Language

West Valley Holistic Campus



West Valley Family Resource Center



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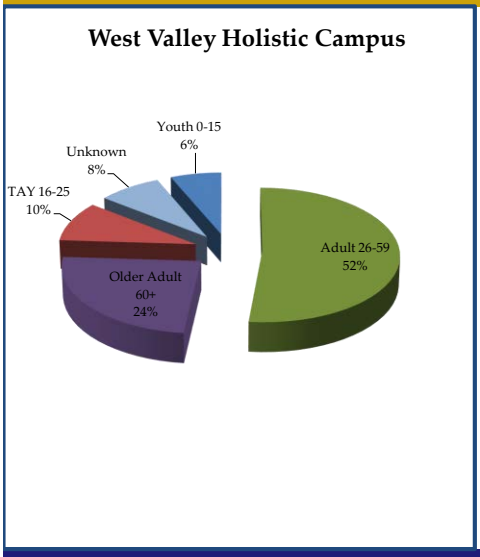
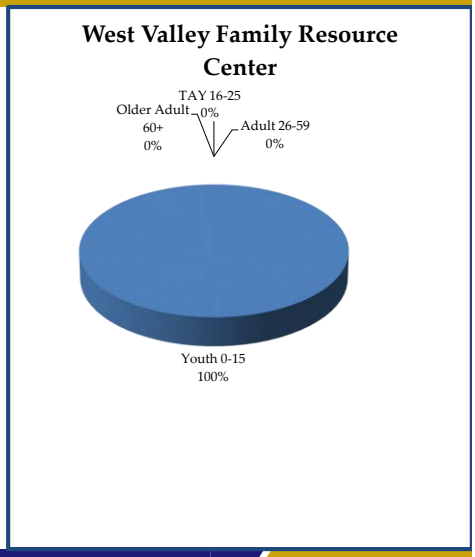
Therapy Comparison Age





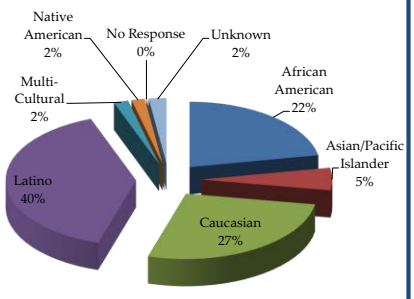
Group Discussion

Discussion
Section II

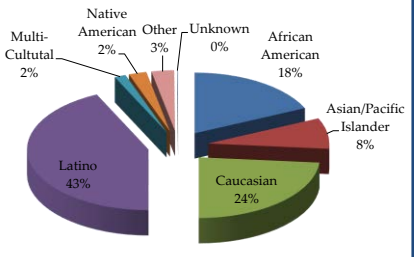
Section III

Outreach Comparison Ethnicity

Desert/Mountain Holistic Campus



Desert/Mountain Family Resource Center



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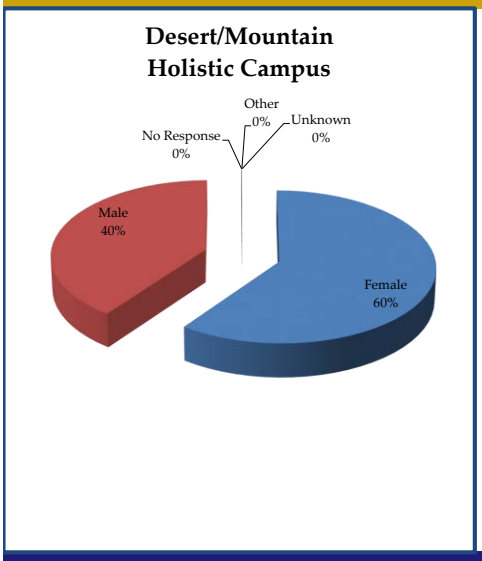
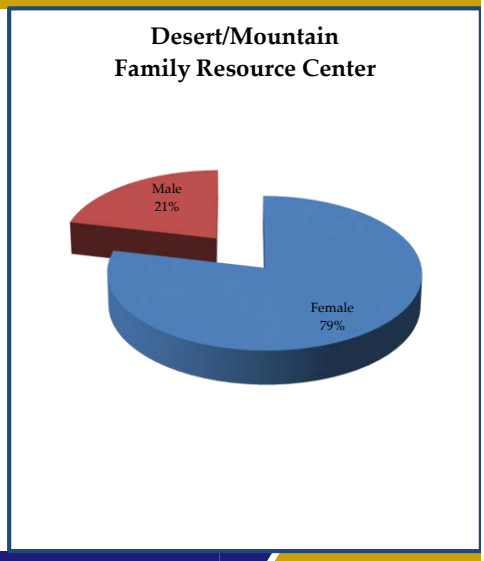
Outreach Comparison Gender





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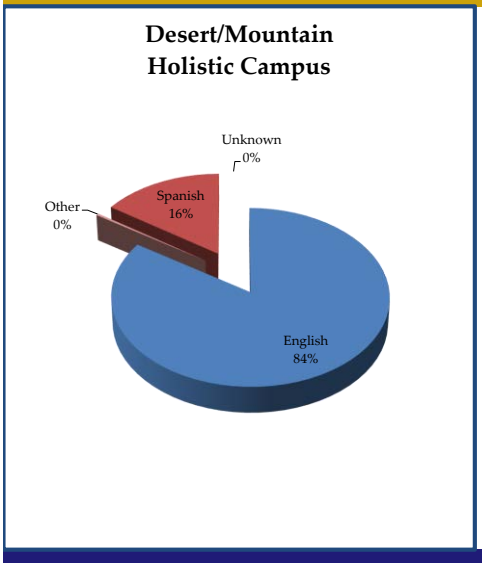
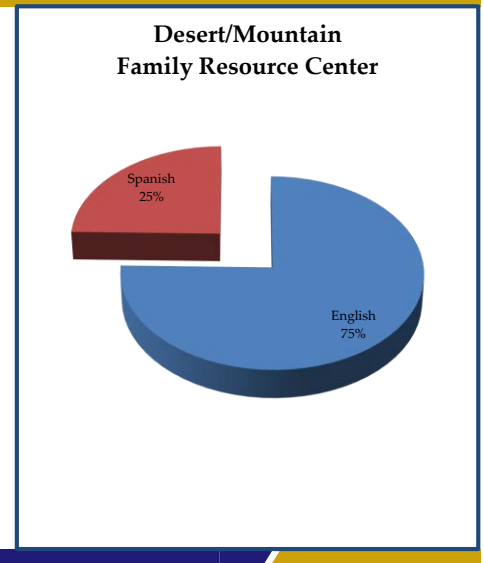
Outreach Comparison Language





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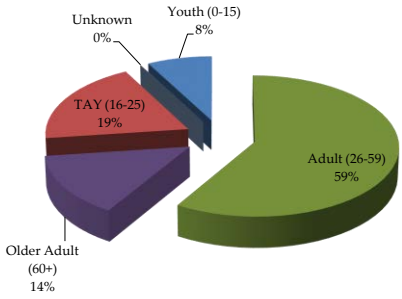
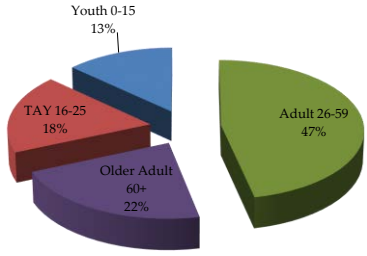
Outreach Comparison Age

Desert/Mountain Holistic Campus



Desert/Mountain Family Resource Center



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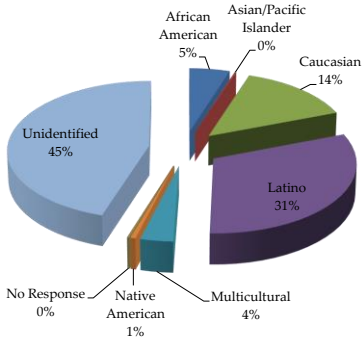
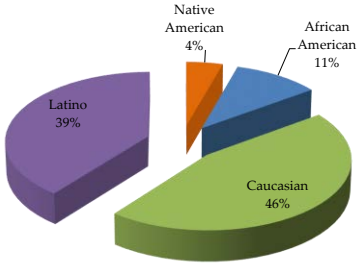
Wellness Comparison Ethnicity

Desert/Mountain Holistic Campus



Desert/Mountain Family Resource Center



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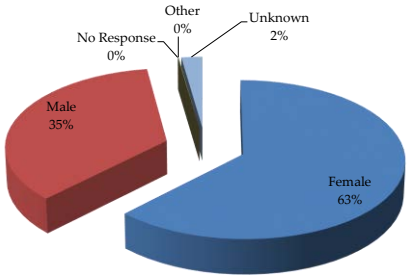
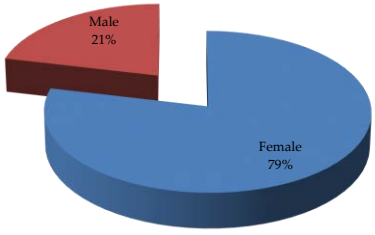
Wellness Comparison Gender

Desert/Mountain Holistic Campus



Desert/Mountain Family Resource Center



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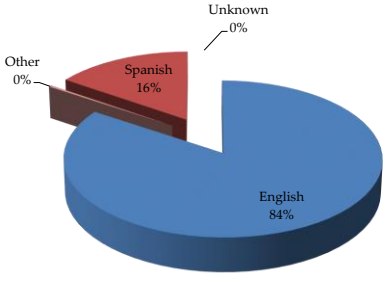
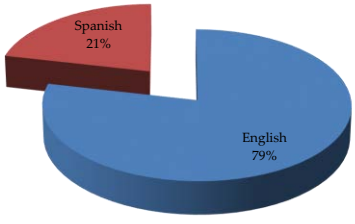
Wellness Comparison Language

Desert/Mountain Holistic Campus



Desert/Mountain Family Resource Center



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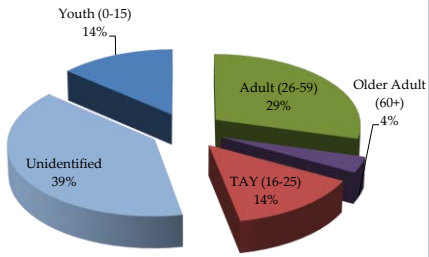
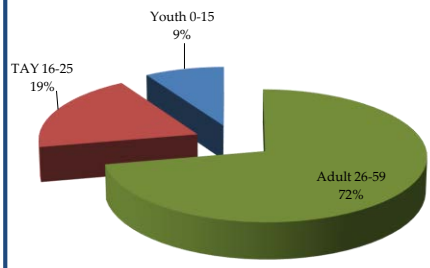
Wellness Comparison Age

Desert/Mountain Holistic Campus



Desert/Mountain Family Resource Center



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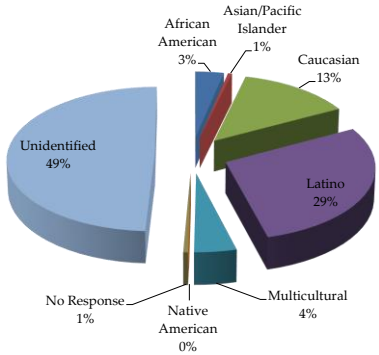
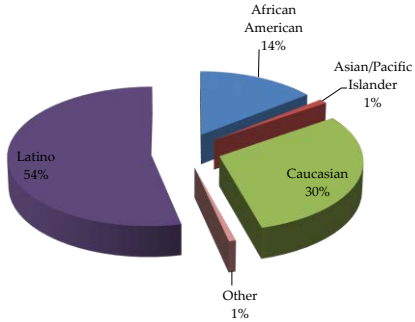
Therapy Comparison Ethnicity

Desert/Mountain Holistic Campus



Desert/Mountain Family Resource Center



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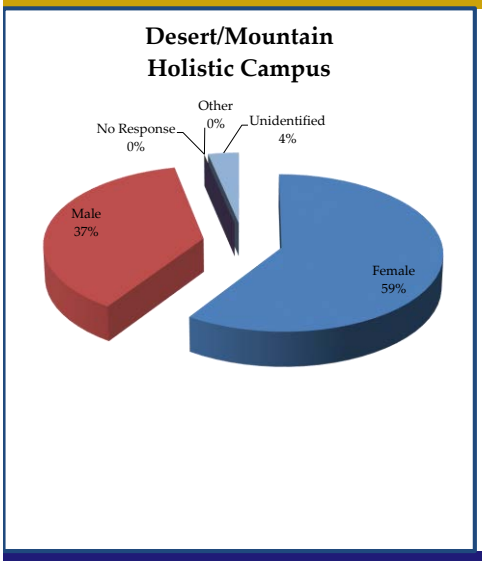
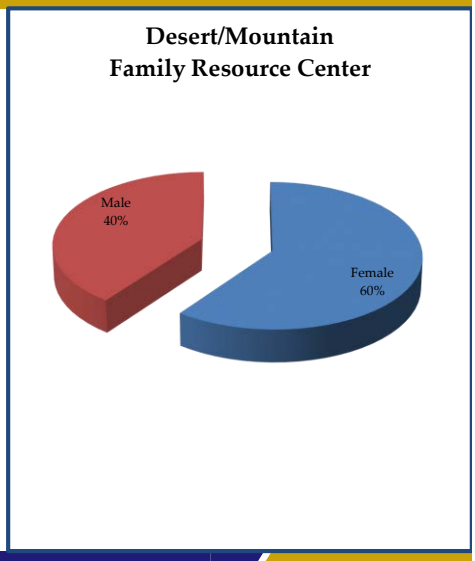
Therapy Comparison Gender





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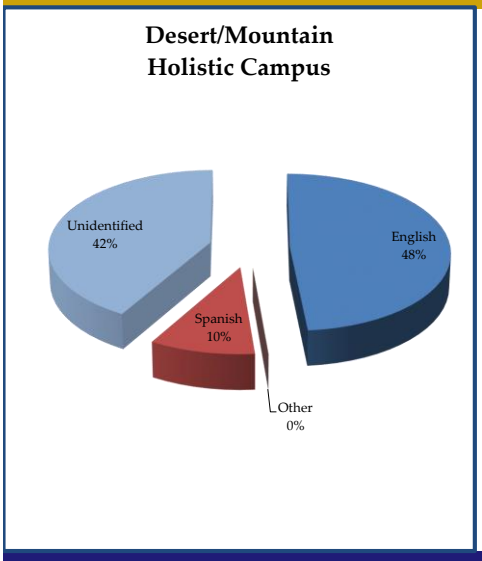
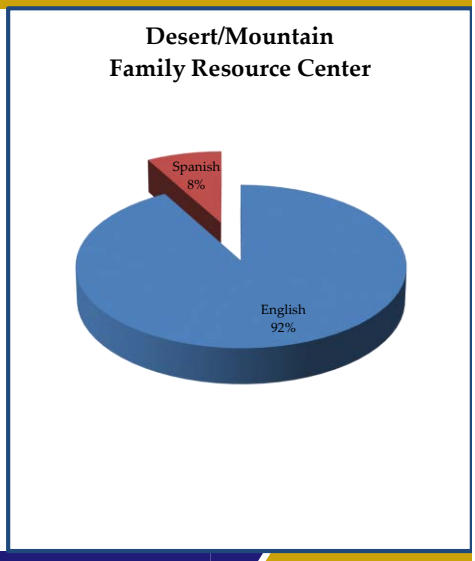
Therapy Comparison Language





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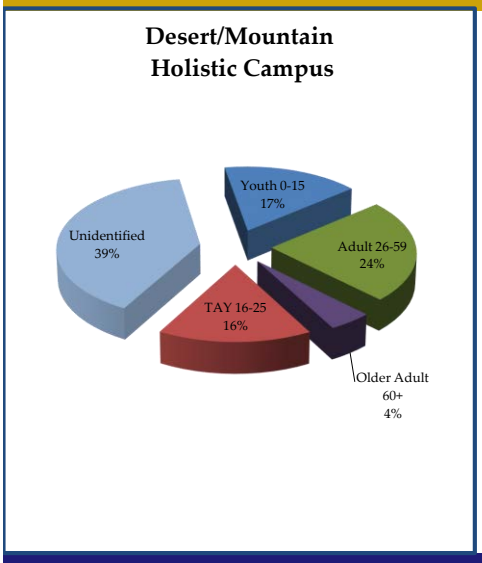
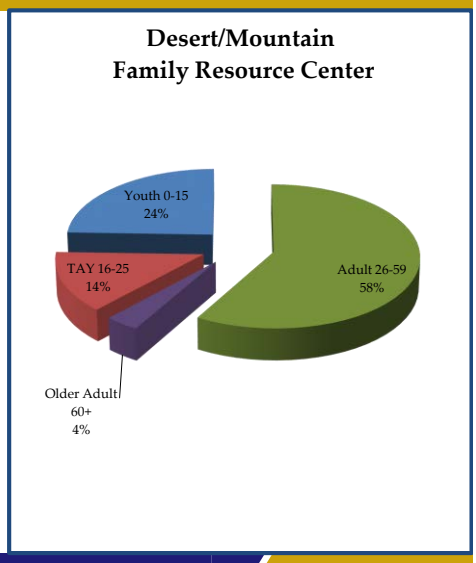
Therapy Comparison Age





Group Discussion

Discussion
Section III

Section IV

Consideration Points

Did the cultural and outreach strategies used work?

Ethnicity for Outreach Activities			
	Central Valley	West Valley	High Desert
African American	14.55%	5.31%	2.75%
Latino/Hispanic	66.34%	41.54%	49.51%
Asian/Pacific Islander	2.95%	11.44%	6.94%
Native American	1.79%	11.35%	2.06%
Caucasian	5.73%	12.57%	33.76%
Mixed/Other	0.85%	0.00%	2.26%
No Response	0.00%	2.76%	0.00%
Unknown/Not Asked	7.79%	15.02%	2.72%
Grand Total	100.00%	100.00%	100.00%

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Consideration Points, cont'd.

Did the outreach strategies increase access to mental health services (therapy) at the holistic campus?

Holistic campus participants accessing therapy services at the holistic campus			
	Central Valley	West Valley	High Desert
Total holistic campus Clients (Wellness & Therapy)	2381	9427	2022
Therapy Clients at holistic campus	185	437	209
% Receiving Therapy	7.77%	4.64%	10.34%

Consideration Points, cont'd.

Did the outreach strategies lead to increased access to mental health services in the DBH system of care?

Holistic campus participants accessing mental health services in the DBH system of care			
	Central Valley	West Valley	High Desert
Total holistic campus Clients (Wellness & Therapy)	2381	9427	2022
Total Clients in DBH	39	51	332
% Clients in DBH	1.64%	0.54%	16.42%

Group Discussion

Discussion
Section IV

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Project Conclusions

Next Steps

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Project Conclusions

Final Reports

- Includes analyses of project learning goals in comparison to project implementation.
- Identification of successful strategies.
- Recommendations to improve the system of care.
- Final report on the projects will be written and included in the FY 2016/2017 MHSA Annual Update.

Closing

Thank you for your thoughtful participation!

March CPAC will focus on MHSA Annual Update 2015/16

Your feedback is important to us.
Please ensure you have completed your surveys.

Contact Information

For questions or comments, please contact

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Program Manager, Innovation
skulesa@dbh.sbcounty.gov
(909) 252-4068

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Salud Mental
Coordinación de la Ley de Servicios de Salud Mental (MHSA)

Comité Consultivo de Políticas Comunitarias

Ley de Servicios de Salud Mental, Innovación

Sarah Eberhardt-Rios, Directora Adjunta
Michelle Dusick, Coordinadora Interina de MHSA
Susanne Kulesa, Manejadora de Programa
Joshua Morgan, PsyD., Psicólogo de Investigación y Planificación
19 de febrero 2015

Artista: Marvin Ray Toms

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Ley de Servicios de Salud Mental

- La Proposición 63 de la Ley de Servicios de Salud Mental (MHSA), fue aprobada por los electores de California en noviembre 2004 y entró en efecto en enero 2005.
- MHSA ofrece un aumento de financiación para los programas de salud mental por todo el estado.
- MHSA está financiado por 1% de recargo de impuestos en ingresos personales mayores de $1 millón anual.
- A medida que se pagan estos impuestos, las fluctuaciones impactan las proyecciones fiscales y los fondos disponibles.

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Ley de Servicios de Salud Mental

WIC § 5848 establece que los condados deben demostrar una asociación con los componentes y las partes interesadas durante todo el proceso que incluya participación significativa de las partes interesadas en:

- Política de Salud Mental
- Planificación del Programa
- Implementación
- Monitoreo
- Mejora de la Calidad
- **Evaluación**
- Asignaciones Presupuestarias

Componentes de MHSA

- Servicios y Apoyos Comunitarios
- Prevención e Intervención Temprana
- **Innovación**
- Capacitación y Entrenamiento de la Fuerza Laboral
- Servicios de Capital y Necesidades Tecnológicas
- Planificación del Programa Comunitario

Metas del Componente de Innovación

Tratar uno de los siguientes propósitos de aprendizaje como su propósito primario:

(1) Aumentar acceso a los grupos marginados.
(2) Aumentar la calidad de servicios, incluyendo mejores resultados.
(3) Promover la colaboración interagencial.
(4) Aumentar acceso a los servicios.

Metas del Componente de Innovación, continuación

Apoyar métodos innovadores haciendo uno de los siguientes:

(A) Introduciendo nuevas prácticas o métodos de salud mental, incluyendo, mas no limitado a, prevención e intervención temprana.

(B) Haciendo un cambio a una práctica o método existente de salud mental, incluyendo, mas no limitado a, la adaptación de un nuevo entorno o comunidad.

(C) Introduciendo una nueva aplicación al sistema de salud mental de una práctica prometedora impulsada por la comunidad o un método que ha tenido éxito en contextos o entornos no relacionados con salud mental.

Requisitos Legislativos de Innovación WIC 5830, Parte 3.2

- Un proyecto de Innovación se define, para los propósitos de estas directrices, como uno que contribuye al aprendizaje en vez de un enfoque principal de brindar un servicio.

- Los programas de salud mental del condado deberán gastar los fondos para sus programas de innovación al ser aprobado por la Comite de Clientes y Lideres de Familia de la Comisión de Responsabilidad y Supervisión de Servicios de Salud Mental.

Requisitos Legales Pendientes de Inovación

Proyecto piloto de tiempo limitado

- Un máximo de 4 años a partir de la fecha de inicio del proyecto.
- Partes de éxito del proyecto podrán efectuarse en una fuente de financiación diferente o ser incorporada a los servicios existentes.
- Los proyectos pueden ser terminados antes de su fecha de finalización prevista.

*Toda esta información es propuesta y sujeto a cambiar a medida que la legislación propuesta pasa por la revisión legislativa.

Proyectos de Innovación en Transición

Dos Proyectos de Innovación están llegando a un final previsto en junio 2015:

- Campo Holístico
- Equipos Interagenciales de Resilencia Juvenil (IYRT, por sus siglas en inglés)

Equipos Interagenciales de Resilencia Juvenil (IYRT, por sus siglas en inglés)

La fecha de conclusión del proyecto es 30 junio 2015 :

- Información sobre los Datos y Resultados fueron discutidos en la reunión de CPAC en 8.21.14
- Debe hacerse la transición y conclusión de los servicios para el 31 mayo 2015.
- Los jóvenes recibirán un "traspaso cordial" para garantizar la continuación de los servicios que se reciben actualmente.
- Esfuerzos de evaluación en marcha.
- Contratistas deberán proveer los informes finales a inicios del año fiscal 15/16.

Nuestro objetivo de hoy es pasar esta reunión discutiendo:

Campo Holístico

Metas de Campo Holístico

Objetivo Legislado:

- Aumento de acceso a los grupos marginados

Propósito de Aprendizaje:

- Determinar si este alto porcentaje de diversas culturas compañeros, junto con la disponibilidad de recursos a los proveedores locales, fomenta un ambiente más diverso y al mismo tiempo un lugar con ambos métodos de curación culturalmente específicos y tradicionales.

- Determinar si nuestras poblaciones marginadas, sin servicio e con servicio inapropiado, son más cómodos buscando servicios en un Campo Holístico, donde la comunidad determina los servicios que se ofrecen, la mayoría de los empleados son los compañeros y los intermediarios culturales, y donde DBH ofrece la máxima flexibilidad.

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Metas de Campo Holístico, continuación

Calendarios del Proyecto

- Dos campos detuvieron los servicios directos en septiembre de 2014
- La fecha de finalización del tercer campo es 30 junio 2015

Nota: La diferencia de fechas de finalización son resultados de contratos separados y fechas de inicio.

Resultados Preliminares

A quienes servimos:

Fiscal Year	Central Valley	West Valley	High Desert	Total
2012/13	*0	3924	4614	8538
2013/14	1434	3592	4272	9298

*Central Valley no ofreció servicios para el Año Fiscal 2012/13

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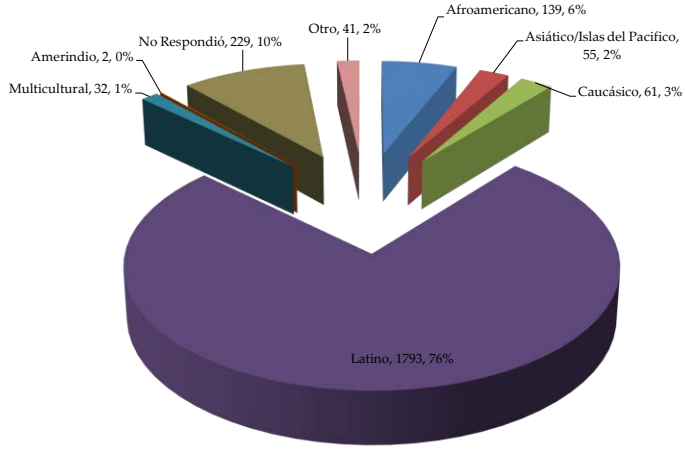
Resultados Preliminares, continuación

Región del Valle Central



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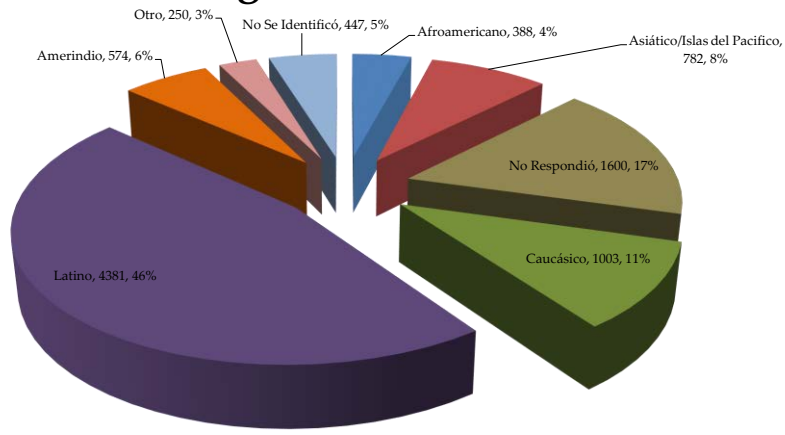
Resultados Preliminares, continuación

Region del Valle Oeste



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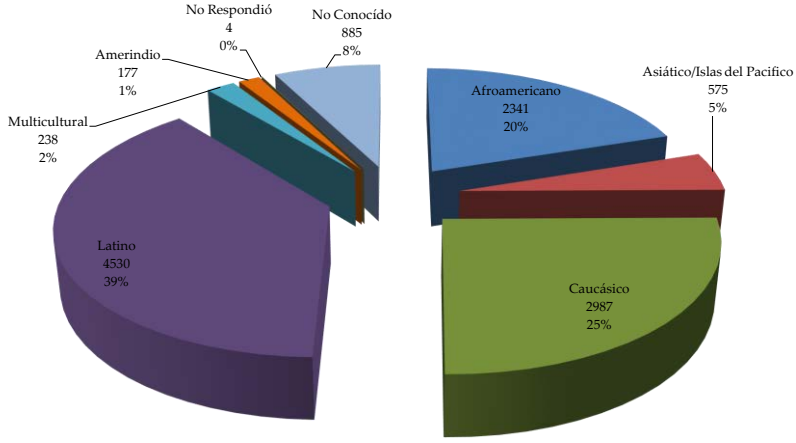
Resultados Preliminares, continuación

Region de Desierto/Montaña



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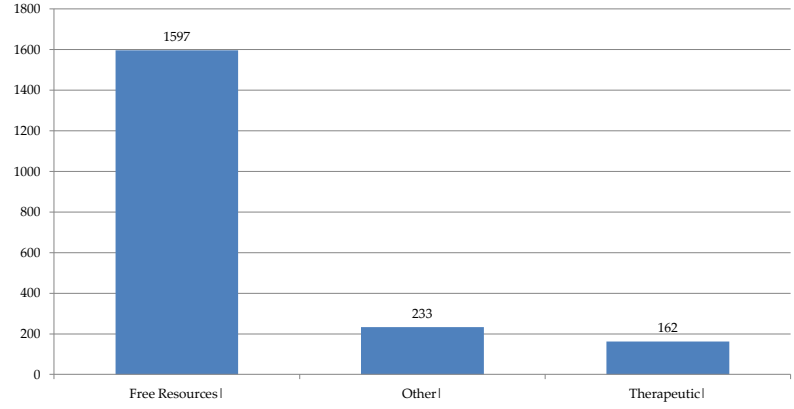
Resultados Preliminares, continuación

Servicios Más Utilizados – Valle Central



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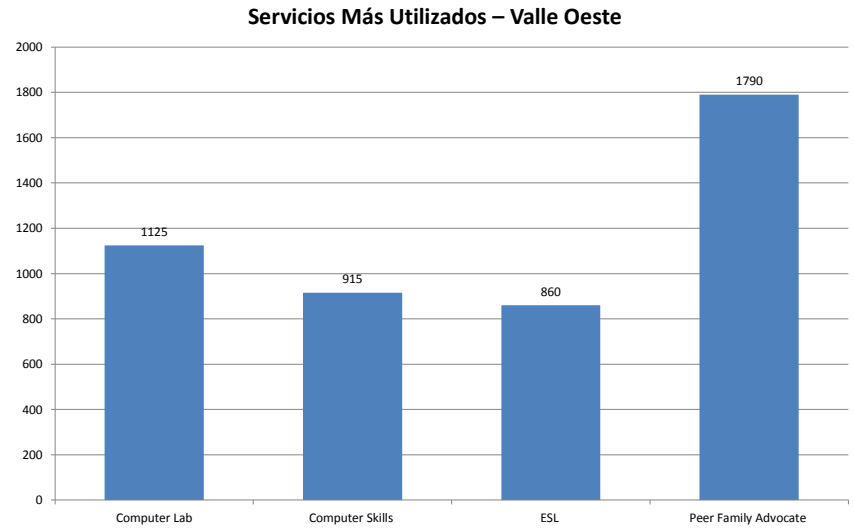
Resultados Preliminares, continuación



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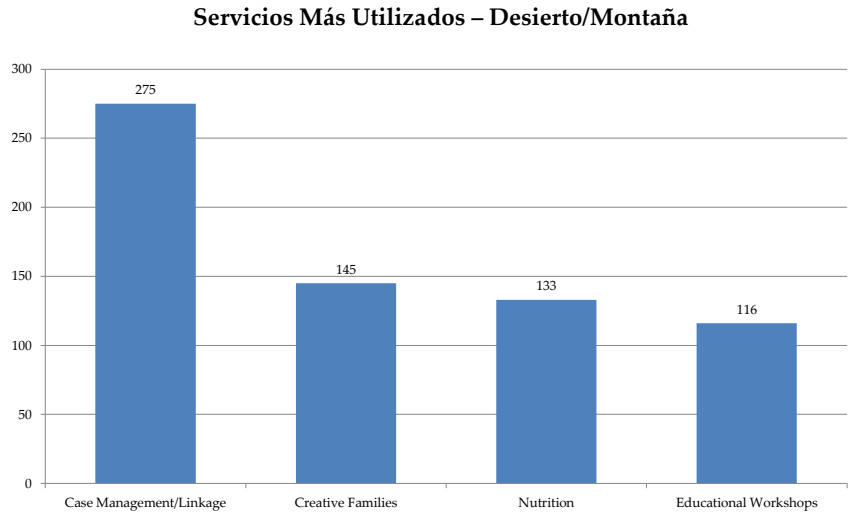
Resultados Preliminares, continuación



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Discusión

¿Cómo podemos aplicar lo que hemos aprendido?

- Evaluar lo que funcionó en este proyecto.
- Determinar si "lo que funcionó" está sucediendo en cualquier otro lugar.
- Hablar acerca de cómo podemos aplicar "lo que funcionó" en el resto del sistema de cuidado de DBH.

Definiciones

Actividades de Alcance - Actividades y eventos dirigidos a la difusión de información sobre los servicios que se ofrecen en el campo holístico. Ejemplos incluyen ferias de salud, ferias de empleo, Eventos "PowWow", eventos de "12 pasos", actividades culturalmente específicos.

Actividades de Bienestar- Las actividades que tienen por objeto mejorar el bienestar general de la persona. Las actividades se basan en la SAMHSA ocho dimensiones del bienestar (emocional, ambiental, financiero, intelectual, laboral, física, social, y espiritual). Consejería de Pares es una actividad de bienestar significativa. Esto incluye: asesoramiento individual de un defensor de pares y familias (PFA, pos sus siglas en inglés), Pareja de Pares, Socio Principal o Agente de salud comunitaria que abarca áreas básicas de vida, ofreciendo estímulo y apoyo a la persona. Otros ejemplos incluyen yoga, Zumba, terapia de arte, clases de computación, ESL, GED, habilidades para la vida, la nutrición, crianza, manejo de la ira, y otras actividades de auto-ayuda o de ejecución de pares.

Actividades Terapéuticos- Consejería individual, familiar o de grupos facilitado por un terapista.

*Ver la página de Datos/Definiciones

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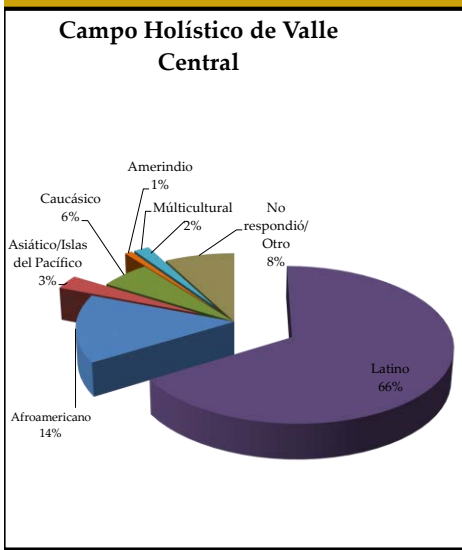
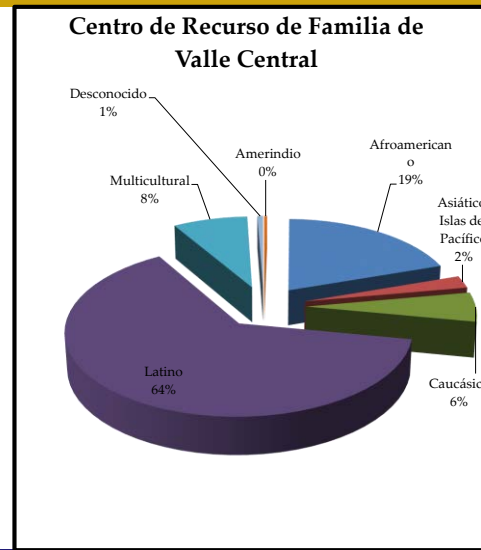
Discusión en Grupo

Sección I

Comparación de Difusión de Origen Étnico





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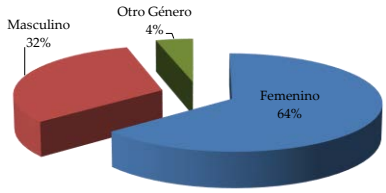
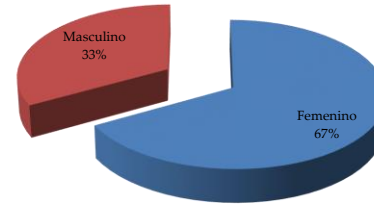
Comparación de Difusión de Género

Campo Holístico de Valle Central



Centro de Recurso de Familia de Valle Central



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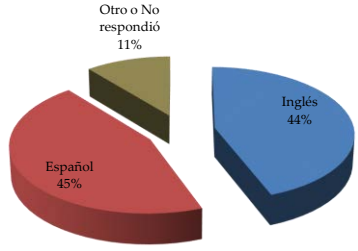
Comparación de Difusión de Lenguaje

Campo Holístico de Valle Central



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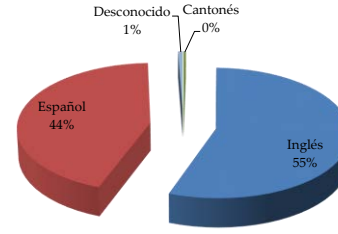

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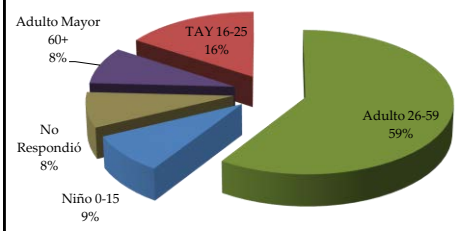
Comparación de Difusión de Edad

Campo Holístico de Valle Central



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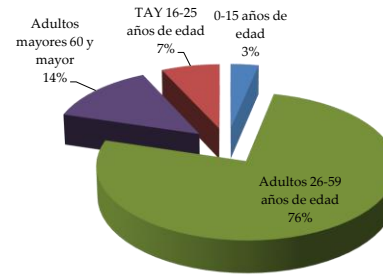

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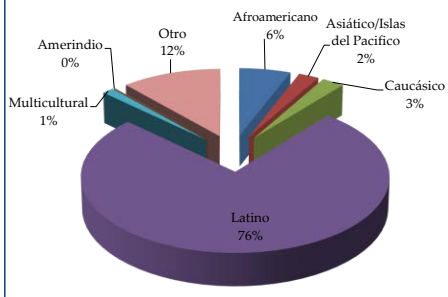
Comparación de Bienestar por Etnicidad

Campo Holístico de Valle Central



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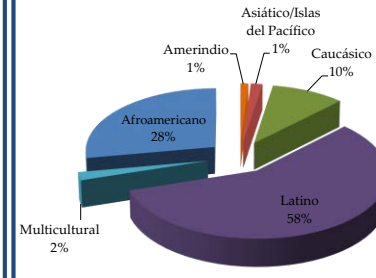

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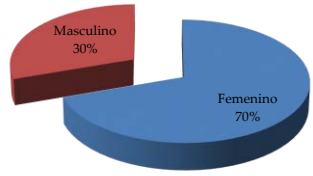
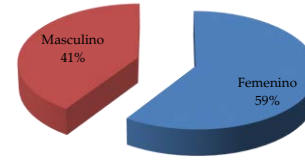
Comparación de Bienestar por Género

Campo Holístico de Valle Central



Centro de Recursos de Familia de Valle Central



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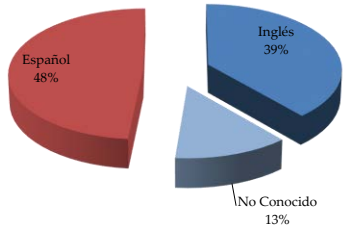
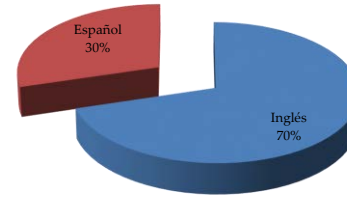
Comparación de Bienestar por Lenguaje

Campo Holístico de Valle Central



Centro de Recursos de Familia de Valle Central



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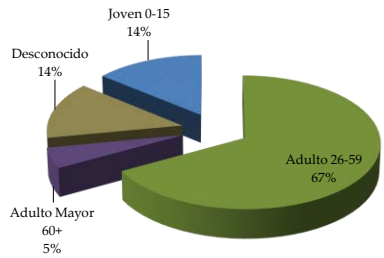
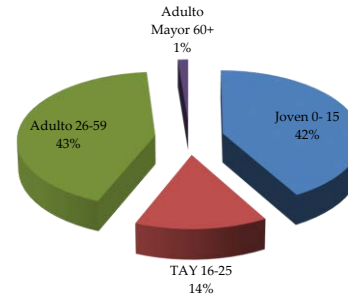
Comparación de Bienestar por Edad

Campo Holístico de Valle Central



Centro de Recursos de Familia de Valle Central



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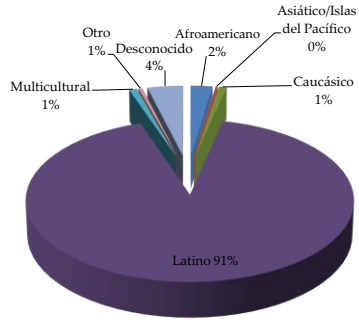
Comparación de Terapia por Etnicidad

Campo Holístico de Valle Central



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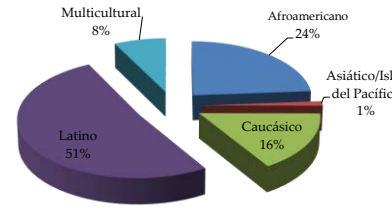

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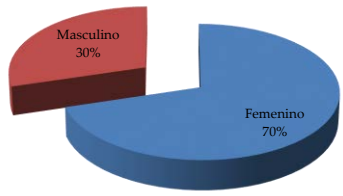
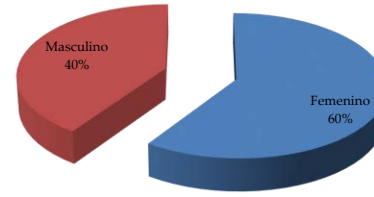
Comparación de Terapia por Género

Campo Holístico de Valle Central



Centro de Recursos de Familia de Valle Central



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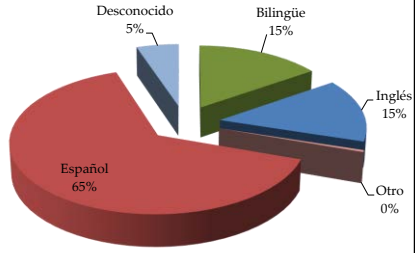
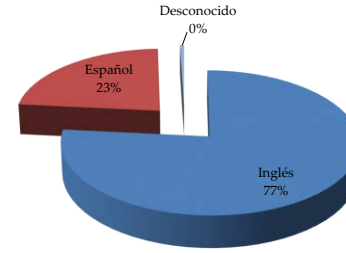
Comparación de Terapia por Lenguaje

Campo Holístico de Valle Central



Centro de Recursos de Familia de Valle Central



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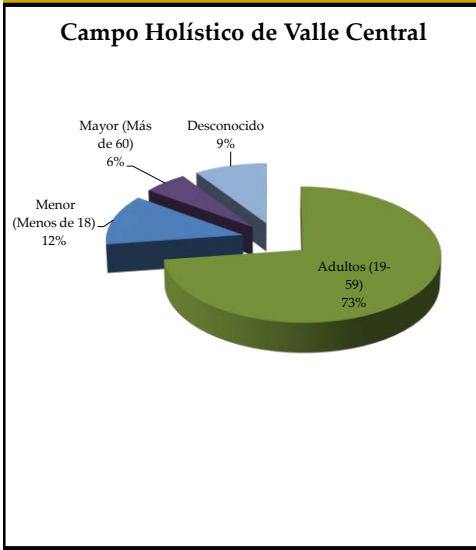
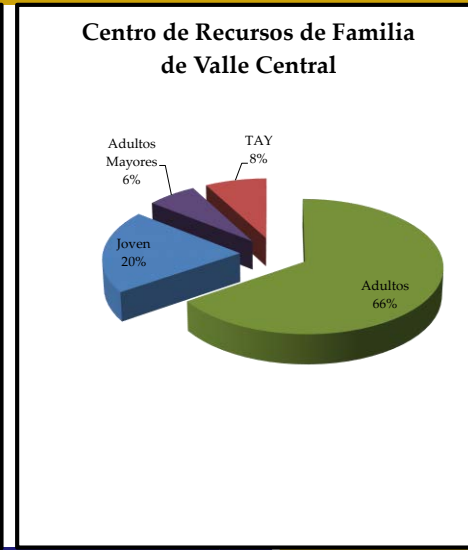
Comparación de Terapia por Edad





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Innovación
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Discusión en Grupo

Discusión
Sección I

Salud Mental
Innovación
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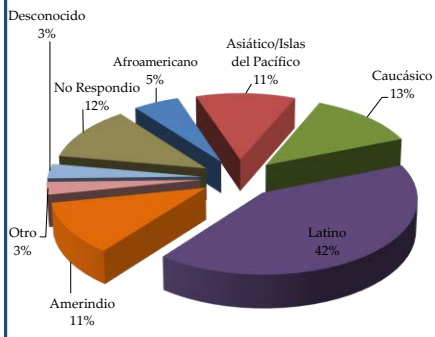
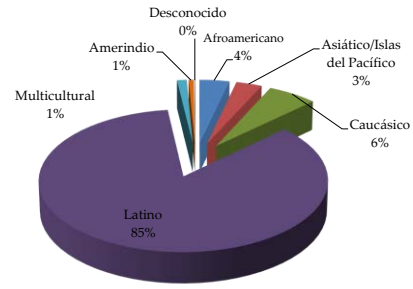
Sección II

Comparación de Difusión de Origen Étnico

Campo Holístico de Valle Oeste



Centro de Recurso de Familia de Valle Oeste



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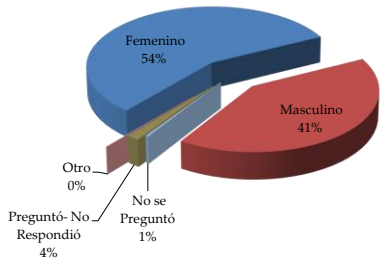
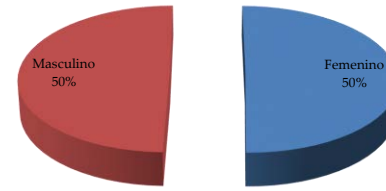
Comparación de Difusión por Género

Campo Holístico de Valle Oeste



Centro de Recurso de Familia de Valle Oeste



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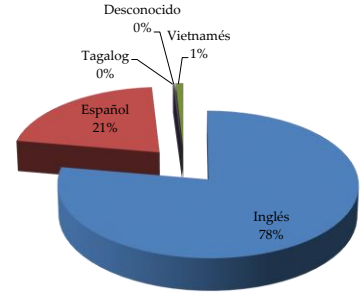
Comparación de Difusión de Lenguaje

Campo Holístico de Valle Oeste

Centro de Recurso de Familia de Valle Oeste



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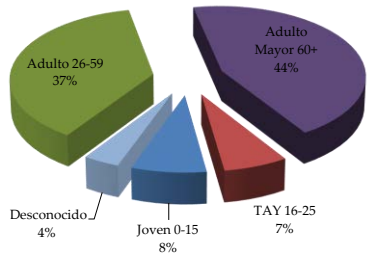
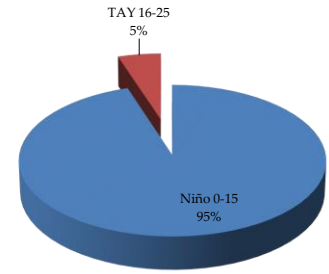
Comparación de Difusión por Edad

Campo Holístico de Valle Oeste



Centro de Recurso de Familia de Valle Oeste



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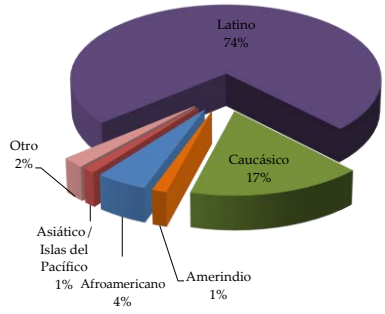
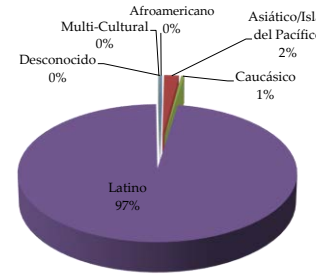
Comparación de Bienestar Etnicidad

Campo Holístico de Valle Oeste



Centro de Recurso de Familia de Valle Oeste



Salud Mental
Innovación

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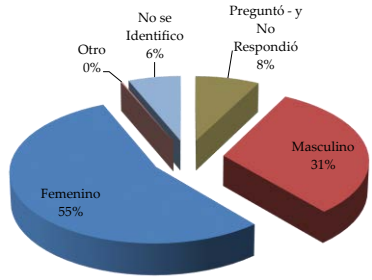
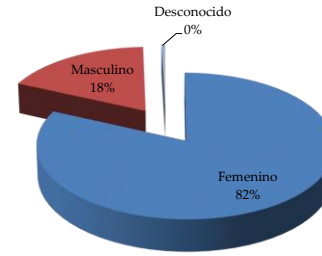
Comparación de Bienestar por Género

Campo Holístico de Valle Oeste



Centro de Recurso de Familia de Valle Oeste



Salud Mental
Innovación

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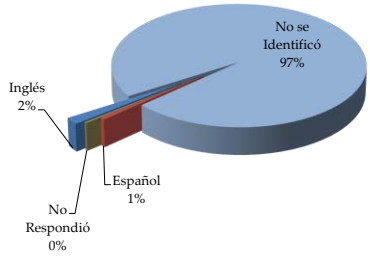
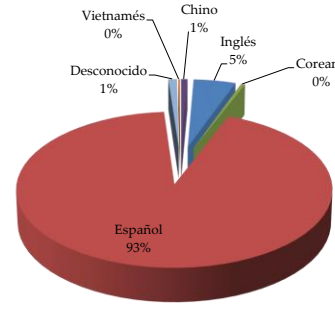
Comparación de Bienestar por Lenguaje

Campo Holístico de Valle Oeste



Centro de Recurso de Familia de Valle Oeste



Salud Mental
Innovación

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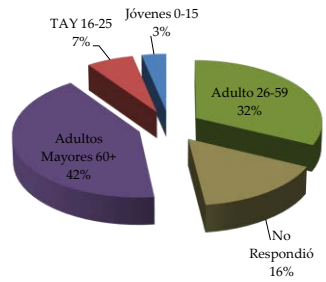
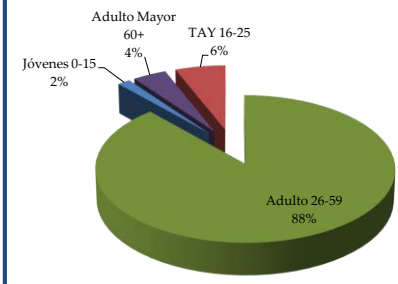
Comparación de Bienestar por Edad

Campo Holístico de Valle Oeste



Centro de Recurso de Familia de Valle Oeste



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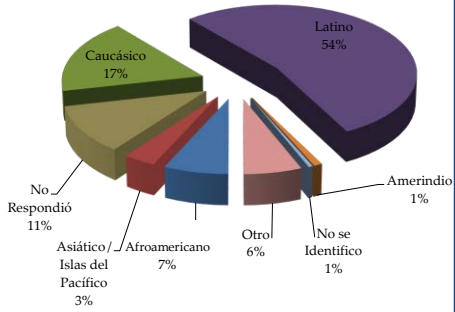
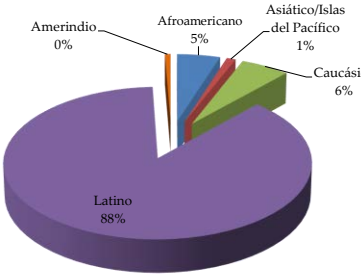
Comparación de Terapia por Etnicidad

Campo Holístico de Valle Oeste



Centro de Recurso de Familia de Valle Oeste



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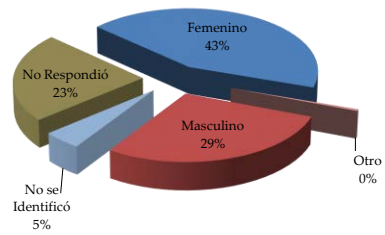
Comparación de Terapia por Género

Campo Holístico de Valle Oeste



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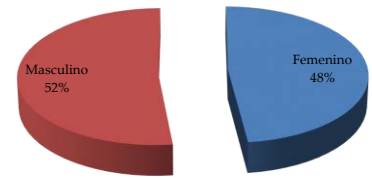

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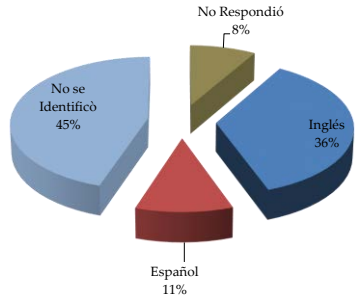
Comparación de Terapia por Lenguaje

Campo Holístico de Valle Oeste



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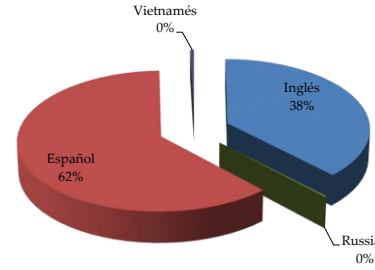

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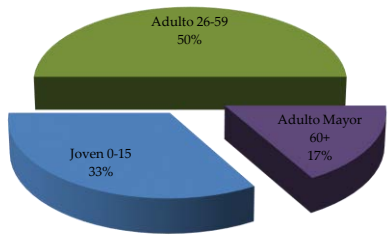
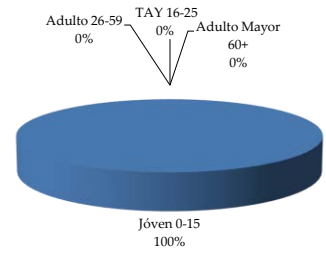
Comparación de Terapia por Edad

Campo Holístico de Valle Oeste



Centro de Recurso de Familia de Valle Oeste



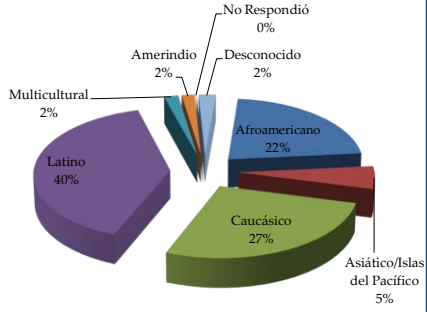
Discusión en Grupo

Discusión
Sección II

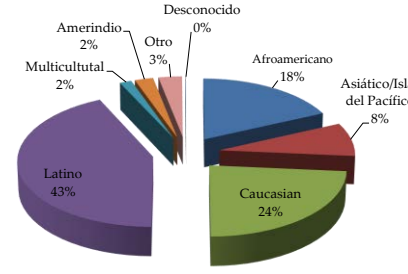
Sección III

Comparación de Difusión de Origen Étnico

Campo Holístico de Desierto/Montaña



Centro de Recurso de Familia de Desierto/Montaña



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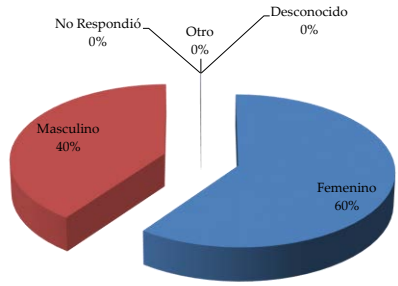
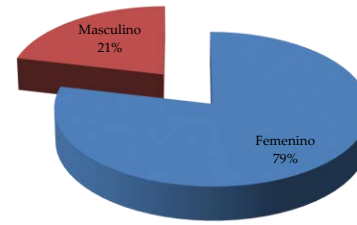
Comparación de Difusión por Género

Campo Holístico de Desierto/Montaña



Centro de Recurso de Familia de Desierto/Montaña



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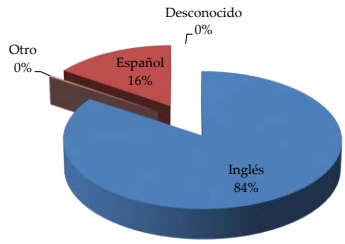
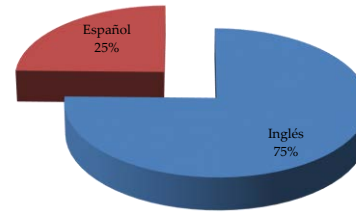
Comparación de Difusión de Lenguaje

Campo Holístico de Desierto/Montaña



Centro de Recurso de Familia del Desierto/Montaña



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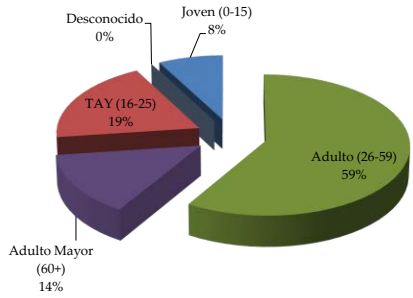
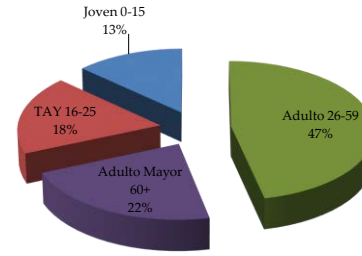
Comparación de Difusión por Edad

Campo Holístico de Desierto/Montaña



Centro de Recurso de Familia del Desierto/Montaña



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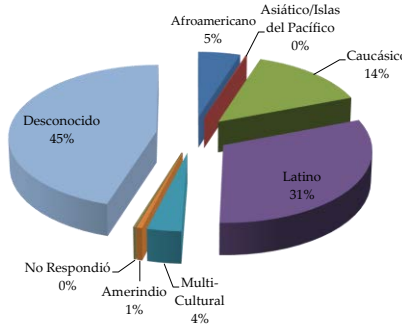
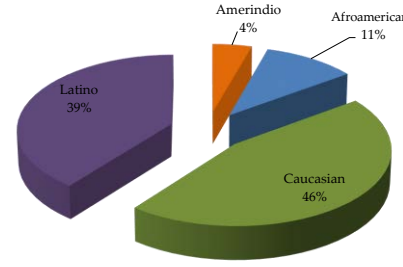
Comparación de Bienestar por Etnicidad

Campo Holístico de Desierto/Montaña



Centro de Recurso de Familia del Desierto/Montaña



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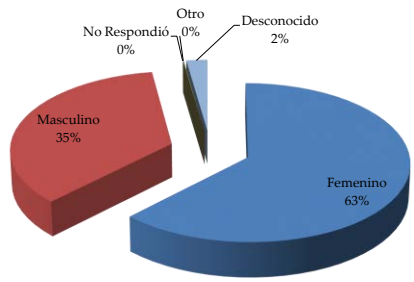
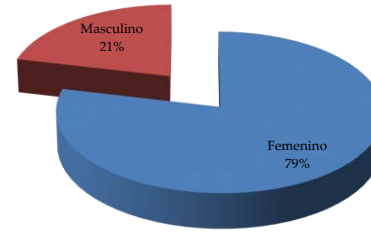
Comparación de Bienestar por Género

Campo Holístico de Desierto/Montaña



Centro de Recurso de Familia de Desierto/Montaña



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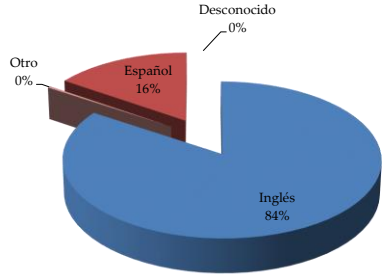
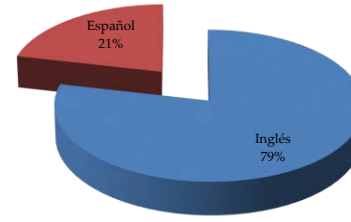
Comparación de Bienestar por Lenguaje

Campo Holístico de Desierto/Montaña



Centro de Recurso de Familia de Desierto/Montaña



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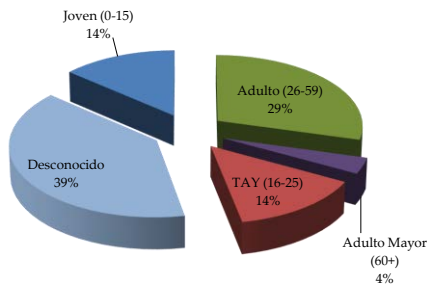
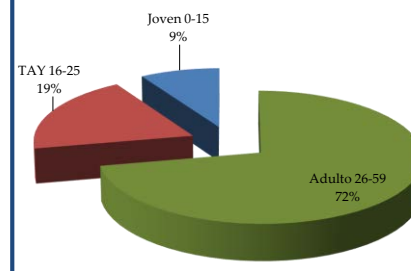
Comparación de Bienestar por Edad

Campo Holístico de Desierto/Montaña



Centro de Recurso de Familia de Desierto/Montaña



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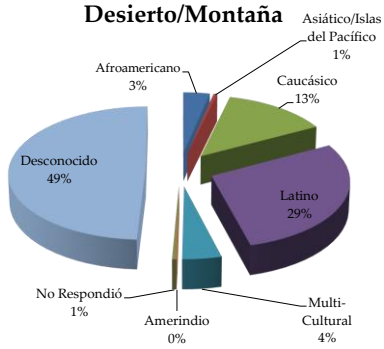
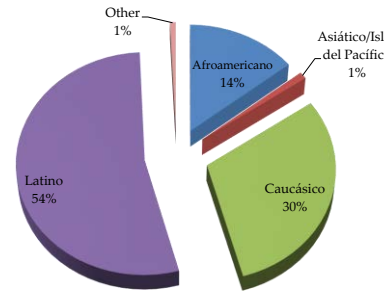
Comparación de Terapia por Etnicidad

Campo Holístico de Desierto/Montaña



Centro de Recurso de Familia de Desierto/Montaña



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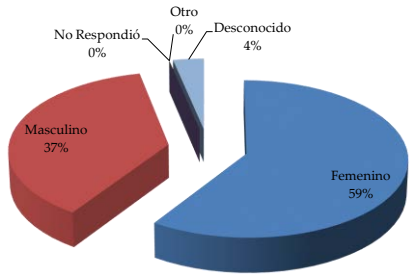
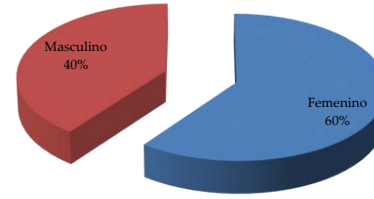
Comparación de Terapia por Género

Campo Holístico de Desierto/Montaña



Centro de Recurso de Familia de Desierto/Montaña



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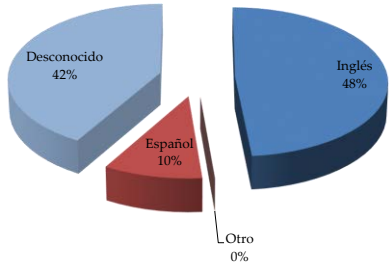
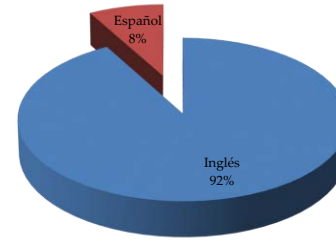
Comparación de Terapia por Lenguaje

Campo Holístico de Desierto/Montaña



Centro de Recurso de Familia de Desierto/Montaña



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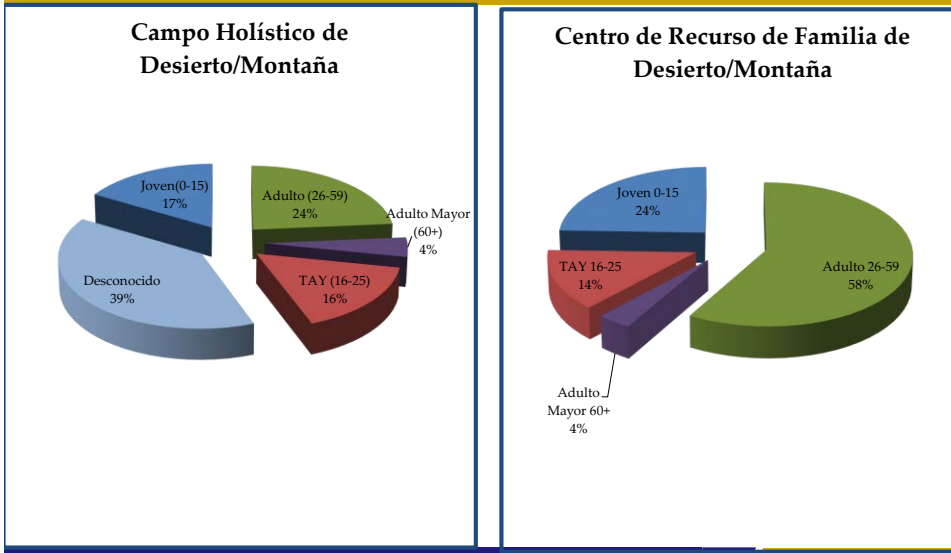
Comparación de Terapia por Edad



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Discusión en Grupo

Discusión
Sección III

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Sección IV

Puntos de Consideración

Funcionaron las estrategias culturales y de alcance que se utilizaron?

Etnicidad para Actividades de Alcance			
	Central Valley	West Valley	High Desert
African American	14.55%	5.31%	2.75%
Latino/Hispanic	66.34%	41.54%	49.51%
Asian/Pacific Islander	2.95%	11.44%	6.94%
Native American	1.79%	11.35%	2.06%
Caucasian	5.73%	12.57%	33.76%
Mixed/Other	0.85%	0.00%	2.26%
No Response	0.00%	2.76%	0.00%
Unknown/Not Asked	7.79%	15.02%	2.72%
Grand Total	100.00%	100.00%	100.00%

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Puntos de Consideración, continuación

¿Las estrategias de alcance aumentaron el acceso a servicios de salud mental (terapia) en el campus holístico?

Participantes del campo holístico que están recibiendo servicios de terapia en el campo holístico.			
	Central Valley	West Valley	High Desert
Total Holistic Campus Clients (Wellness & Therapy)	2381	9427	2022
Therapy Clients at Holistic Campus	185	437	209
% Receiving Therapy	7.77%	4.64%	10.34%

Puntos de Consideración, continuación

¿Las estrategias de alcance resultaron en un aumento en el acceso a el sistema de cuidado de DBH?

Participantes del campo holístico que están recibiendo servicios de salud mental en el sistema de cuidado de DBH.			
	Central Valley	West Valley	High Desert
Total Holistic Campus Clients (Wellness & Therapy)	2381	9427	2022
Total Clients in DBH	39	51	332
% Clients in DBH	1.64%	0.54%	16.42%

Discusión en Grupo

Discusión
Sección IV

Conclusiones de Proyectos

Pasos a Seguir

Conclusiones del Proyecto

Informes Finales

- Incluye análisis de las metas de aprendizaje del proyecto en comparación con la implementación del proyecto.
- Identificación de estrategias exitosas.
- Recomendaciones para mejorar el sistema de cuidado.
- Informe final sobre los proyectos será escrito e incluido en el Informe Anual de Actualización de MHSA del año fiscal 2016/2017 .

Conclusion

¡Gracias por su atenta participación!

La reunión de CPAC en marzo será enfocada en el Informe Anual de Actualización de MHSA del año fiscal 2015/16.

Su opinión es importante. Favor de asegurar que lleno su encuesta.

Información de Contacto

Para preguntas ó comentarios, favor de contactar:

Susanne Kulesa
Program Manager, Innovation
skulesa@dbh.sbcounty.gov
(909) 252-4068

IYRT Logic Model							
Domains	**Goals**	**Objectives**	**Strategies**	**Interim Outcomes (IO)**	**IO Measurement**	**Key Outcomes (KO)**	**KO Measurement**
DBH Domains	**Funding-Source-Specific Goal**	**Specific Objective that Theoretically Supports Goal INN Learning Goals**	**EBPs, Treatment Approaches, Interventions**	**As Relates to Objective(s)**	**Measurement Method or Tool and Frequency of Administration**	**As Relates to Goal(s)**	**Measurement Method or Tool and Frequency of Administration**
Access	Increase Access to Underserved Groups (Primary goal)	To increase understanding of the impact of grief and loss, exposure to violence and environmental trauma in diverse youth	• Seek referrals from agencies that serve system-involved youth • Service provided to non-Medi-Cal youth • Open to out-of-county youth • Trainings	Provider, participant, mentor and trainee reported understanding the impact of grief and loss, exposure to violence and environmental trauma in diverse youth	• EVALCORP Provider Survey (both quantitative endorsement of objective met and qualitative responses) • Mentor Training Survey • Participant Training Survey • Training Participant Survey	• Increased rates of Underserved participating in the program in comparison to standard services	• Participant tracking data • Matching to DBH services (Do IYRT youth get into DBH services?) • Comparisson of DBH, CFS, and Probation data
		To learn if the innovative application of a model that addresses the issues of grief, loss, trauma and exposure to violence in a culturally inclusive manner allows us to identify and address behaviors that manifest themselves in diverse youth at an earlier point in the youth's exposure to the "system"		• Provider observation that the innovative application of a model that addresses the issues of grief, loss, trauma and exposure to violence in a culturally inclusive manner allows us to identify and address behaviors that manifest themselves in diverse youth at an earlier point in the youth's exposure to the "system" • Participants have decreased behavioral and emotional problems, recovery from grief and loss	• EVALCORP Provider Survey (both quantitative endorsement of objective met and qualitative responses) • EVALCORP Participant Survey • CANS-SB (Behavioral and Emotional)		
		To develop methods and skill sets necessary for resource providers and for identified youth to address unresolved grief and loss as well as environmental trauma in a culturally inclusive manner		• Provider and resource provider participant reported development of methods and skills sets necessary for resource providers and for identified youth to address unresolved grief and loss as well as environmental trauma in a culturally inclusive manner • Participants have decreased behavioral and emotional problems; recovery from grief and loss	• EVALCORP Provider Survey (both quantitative endorsement of objective met and qualitative responses) • Resource Provider Participant Survey • CANS-SB (Relationship Permanence) • EVALCORP Participant Survey		
		To learn if the reality of being part of the dependency/ward "system" is a contributing factor and/or exacerbates youth's issues of grief and trauma		• Provider reported learning if being part of the dependency/ward "system" is a contributing factor and/or exacerbates youth's issues of grief and trauma • Participants report of feelings of grief and loss	• EVALCORP Provider Survey (both quantitative endorsement of objective met and qualitative responses) • CANS-SB (Relationsip Permanence Trauma) • EVALCORP Participant survey • Personal Narrative • CASE survey		

Service Effectiveness	*Increase Quality of Services, Including Better Outcomes*	*To learn if the provision of mentorship, and/or what types of mentorship help these youth address their unresolved issues*	*Crisis stabilization services with an emphasis on choice, wellness, recovery and resilience as defined by the client*	*• Provider reported undertanding that the provision of mentorship, and/or the types of mentorship help these youth address their unresolved issues* *• Participants have decreased behavioral and emotional problems, recovery from grief and loss*	*• Provider Survey (both quantitative endorsement of objective met and qualitative responses)* *• CANS-SB (Comparison of RU to Juvenile Justice Program)* *• Participant Survey*	*Regular collection, analysis, and reporting of data to improve the program* *Improved year-over-year outcomes* *Improved outcomes compared to standard services*	*• CANS-SB (intake, 3 months, 6 months, and/or post)* *• Participant survey (post only)* *• Reliable Change Index Scores for all* *• Impact Reports by items*
		To learn if the application of techniques addressing grief and loss, exposure to violence, and trauma help the youth build positive relationships with resource providers and peer counselors		*• Provider observation that the application of techniques addressing grief and loss, exposure to violence, and trauma help the youth build positive relationships with resource providers and peer counselors* *• Participants have positive relationships*	*• EVALCORP Provider Survey (both quantitative endorsement of objective met and qualitative responses)* *• CANS-SB (Comparison of RU to Juvenile Justice Program)* *• EVALCORP Participant Survey*		
		To learn if Peer Counselors and other professional staff who receive the training can engage youth as well as their resource providers to use the skills and information obtained from the training		*• Provider observation that Peer Counselors and other professional staff who receive the training can engage youth as well as their resource providers to use the skills and information obtained from the training* *• Trainees report skill development* *• Participants have decreased behavioral and emotional problems; academice and employment gains; positive relationships; recovery from grief and loss; improved or sustained housing* *Improved skill development of resource providers*	*• EVALCORP Provider Survey (both quantitative endorsement of objective met and qualitative responses)* *• Trainee Survey* *• EVALCORP Participant Survey* *• Resource Provider survey* *• CANS-SB (Relationship Permanence)*		
		To learn if a team that includes three major county departments (DBH, CFS, and Probation), and countless youth serving programs succeeds in addressing the issues of grief, loss, exposure to violence and environmental trauma experienced by these children		*Provider report that interagency collaboration occurs*	*• EVALCORP Provider Survey (both quantitative endorsement of objective met and qualitative responses)* *• Provider Collaboration Survey* *• CANS-SB (Violence Trauma Modules and Outcomes)*		

Linkages	*Promote Interagency Collaboration*	*To learn if the identification of a model for collaboration to address grief and loss issues, exposure to violence, and environmental trauma help build connections for diverse youth served by the project*	*Promote program to other agencies and community organizations*	*Provider observation that the identification of a model for collaboration to address grief and loss issues, exposure to violence, and environmental trauma help build connections for diverse youth served by the project*	*• EVALCORP Provider Survey (both quantitative endorsement of objective met and qualitative responses)* *• EVALCORP Participant survey*	*Collaboration by three or more agencies*	*Provider Collaboration Survey (end of fiscal year)*
		To learn if the above model for collaboration, methods and skills for intervention and strategies for interaction with youth effectively addresses the impacts of grief, loss, trauma on youth outcomes		*Provider observation that the above model for collaboration, methods and skills for intervention and strategies for interaction with youth effectively addresses the impacts of grief, loss, trauma on youth outcomes* *Participants report recovery from grief and loss*	*• EVALCORP Provider Survey (both quantitative endorsement of objective met and qualitative responses)* *• CANS-SB (Comparison of RU to Juvenile Justice Program)* *• EVALCORP Participant Survey*		

The County of San Bernardino, Department of Behavioral Health, MHSA Office of Innovation is proud to offer...

Interagency Youth Resiliency Team: Mentoring Program

The IYRT Mentoring Program is a new and innovative youth mentoring program for system involved youth. This program is designed to match youth with mentors of similar backgrounds.

Requirements:

- Current or Former Foster and Probation Youth ranging in ages 13 to 21 years old.

Program Includes:

- Positive/Lasting relationships with supportive adults
- Life Skill Building/Training
- Grief & Loss Support
- Fun Community Activities & Trainings
- Resources to Aid Youth in Transition to Adulthood
- One on One Attention
- Resources for Care Providers: Parent/Guardian Support Groups
- And much more!

EMQ: Central Region

- ✓ Serving: Fontana, Rialto, & San Bernardino
- ✓ Contact:
  Becky Heiple MS, LMFT
  Associate Director
  (909) 266-2729
  becky.heiple@emqff.org

ReachOut: West End Region

- ✓ Serving: Upland, Rancho Cucamonga, Ontario, Montclair, Chino, Chino Hills, Alta Loma, Guasti and Lytle Creek
- ✓ Contact:
  Dr. Andrew Williams
  Program Director
  (909) 982-8641
  andrew@we-reachout.org

Valley Star Children and Family Services: East End Region

- ✓ Serving: Colton, Grand Terrace, Highland, Loma Linda, Redlands, Yucaipa, Bloomington, Mentone, Patton, Forest Falls, Angelus Oaks, Bryn Mawr
- ✓ Contact:
  Wandalyn Lane
  Program Coordinator
  (909) 388-2222, Ext 132
  wlane@starsinc.com

Please contact one of our providers in your area for more information! Call 7-1-1 for TTY users, for all numbers above.

EMQ FamiliesFirst

Interagency Youth Resiliency Team (IYRT) Program
in partnership with
County of San Bernardino Department of Behavioral Health
presents

THE 3-5-7 MODEL:
A PRACTICE APPROACH TO PERMANENCY

An approach to support the work of children, youth, and their families to grieve losses resulting from their traumas and rebuild perceptions of safety in relationships.

Provided by Darla L. Henry, PhD, MSW

"No matter the environment, culture or dynamics of the families we serve, at the core of each individual, is the desire to belong, to feel secure in relationship with another."
~Darla L. Henry, PhD, MSW

Thursday, October 10, 2013	Take advantage of this FREE Training!!!	Friday, October 11, 2013
• **Philosophical Foundation** • **Components of Model:** **3 Tasks** **5 Conceptual Questions** **7 Skill Elements** • **Implementation & Actualization of Model** **8:30am- 4:00pm**		**Advanced professional training for those who attended Day 1 of Training.** **(In-Depth Consultation and Implementation of Model)** ***Professionals Only** **8:30am- 4:00pm**

Transition Age Youth (TAY)- One Stop Center
Hollywood Room
780 E. Gilbert St, San Bernardino CA 92415

Space is limited to 50 people

Continuing Education Units will not be offered for this event.

Please RSVP by October 4, 2013 with Edith Herrejon at
edith.herrejon@emqff.org or at (909) 266.2728 or 7-1-1 for TTY Users

Revised 08/13

Be A Part of TEAM Today!

Make a Difference. Be a Difference

TEAM is an exciting mentoring program that focuses on pairing current foster and probation youth with adult mentors of similar backgrounds. In addition, coaching is provided to current caregivers of foster or probation youth. TEAM aims to guide personal growth by teaching, empowering, advancing and mentoring. Our Program is available to foster and probation youth ages 13-21. The five main domains our curriculum focus on are: education, employment, enduring connections (healthy relationships), housing, and physical/mental health. Mentors meet one-on-one with youth mentees 4-8 hours a month. Interactive group activities take place monthly, along with field trips a few times throughout the year. Transportation is provided to facilitate match meetings/outings.

For more information and to schedule an orientation call (909) 982-8641 and ask for Alicia Taverner, LMFT, M.A.

Service Areas Include: Upland, Rancho Cucamonga, Ontario, Montclair, Chino, Chino Hills, Alta Loma, Guasti, Lytle Creek, and the Morongo Basin.

TEAM is part of the IYRT Project funded by the County of San Bernardino, Department of Behavioral Health, MHSA Innovation

Reach Out is located at 1126 W. Foothill Blvd. Upland CA 91786