

County of San Bernardino
Department of Behavioral Health
Mental Health Services Act
Fiscal Year 2013/14
Annual Update



June 20, 2013

Artwork Provided By:
SHEILA DERY



Message from the Director

**MENTAL HEALTH
SERVICES ACT**

M H S A A N N U A L U P D A T E

F I S C A L Y E A R 2 0 1 3 / 1 4

As you may know, leaders from across the County of San Bernardino recently developed a shared Countywide Vision, “Your County, Your Future.” As a major partner in this initiative, the Department of Behavioral Health is building a bridge through the general standards and principles of the Mental Health Service Act (MHSa), to the Wellness Component of our Countywide Vision. We seek to reduce health disparities through behavioral health education, promotion of healthy lifestyles, development of outcome-based services, and increased collaboration between and among providers and community-based organizations. We support a healthy county and value both prevention programs and superior healthcare services.

MHSa funded programs have provided enhancements to our system of care that promote wellness, recovery, resilience, cultural competency, community-based collaboration and meaningful inclusion of clients and family members in behavioral health services.

The comprehensive community-driven process that has always guided our County through the planning and implementation for all MHSa programs was utilized once again as DBH continues to focus on program modifications and enhancements based on the major priorities identified by stakeholders. It is with careful consideration and inclusion of diverse stakeholder input that we continually strive to conduct effective quality improvement and program evaluation.

In the stakeholder process section of this report, you will find a full description of the community planning process conducted by DBH across all geographical regions to ensure meaningful stakeholder conversation and participation were included in the annual update process for Fiscal Year 2013/14.

It is our pleasure to provide a report that highlights our MHSa efforts and services that embody the Department of Behavioral Health’s vision to improve access and achieve optimum wellness for the unserved, underserved and inappropriately served members of our community. Thank you for your review and feedback that continues to help DBH meet the needs of those residing in the County of San Bernardino.

Sincerely,


CaSonya Thomas, MPA, CHC
Director, Department of Behavioral Health



County of San Bernardino - Department of Behavioral Health





ACTUALIZACIÓN ANUAL DE
LA LEY DE SERVICIOS DE
SALUD MENTAL
(SIGLAS MHSA EN INGLÉS)

Mensaje de la Directora

ACTUALIZACIÓN ANUAL

AÑO FISCAL 2013/14

Como usted probablemente sepa, líderes de todo el Condado de San Bernardino recientemente desarrollaron de manera compartida, una Visión para el Condado: “Su condado, su futuro”. Como uno de los agentes principales de esta iniciativa, el Departamento de Salud Mental está tendiendo un puente basado en los valores y principios generales de la Ley de Servicios de Salud Mental (MHSA, por sus siglas en inglés) para que se conecten con el Componente de Bienestar de nuestra Visión del Condado. Buscamos reducir las disparidades en la salud a través de la educación sobre salud mental, promoción de estilos de vida saludables, desarrollo de servicios basados en resultados e incremento en la colaboración entre proveedores y organizaciones comunitarias. Apoyamos a un condado saludable y valoramos los programas de prevención y también los servicios superiores de salud.

MHSA financió programas que han enriquecido a nuestro sistema de cuidado, el cual promueve el bienestar, recuperación, resiliencia, competencia cultural, colaboración comunitaria y una inclusión con sentido de nuestros clientes y miembros de las familias a los servicios de salud mental.

El proceso integral impulsado desde la comunidad que siempre ha guiado a nuestro Condado por medio de la planeación e instrumentación de todos los programas MHSA, ha sido utilizado una vez más. Al mismo tiempo, DBH continúa enfocándose en las modificaciones y mejoras basadas en las prioridades principales identificadas por las partes interesadas. Debido a que tomamos con seriedad y con sentido de inclusión las aportaciones brindadas por las diversas partes interesadas, nosotros podemos continuar esforzándonos por brindar mejoras que sean efectivas; así como evaluación de programas.

En la sección de proceso de comentarios de este reporte, usted encontrará una descripción completa del proceso comunitario de planeación que fue conducido por DBH en todas las regiones geográficas para asegurarse que las conversaciones de importancia y la participación de las partes interesadas fueran incluidas en el proceso de la Actualización Anual para el año fiscal 2013/14.

Es un placer para nosotros brindar este informe, el cual resalta nuestros esfuerzos y servicios de MHSA, mismos que plasman la visión del Departamento de Salud Mental en el sentido de mejorar el acceso y alcanzar el logro por el bienestar óptimo para los miembros de nuestra comunidad que no reciben servicios, que los reciben de manera insuficiente o que reciben dichos servicios inadecuadamente. Gracias por su revisión y sus comentarios, los cuales ayudarán al Departamento de Salud Mental a atender las necesidades de las personas que residen en el Condado de San Bernardino.

Sinceramente,

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



County of San Bernardino - Department of Behavioral Health



Promoting Wellness, Recovery and Resilience



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County of San Bernardino - Department of Behavioral Health



BEHAVIORAL HEALTH
Promoting Wellness, Recovery, and Resilience

Promoting Wellness, Recovery and Resilience



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**MENTAL HEALTH
SERVICES ACT**

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County of San Bernardino - Department of Behavioral Health



Promoting Wellness, Recovery and Resilience



MENTAL HEALTH SERVICES ACT

Mental Health Services Act Annual Update Fiscal Year 2013/14

Background

Welfare and Institutions Code Section (WIC §) 5847 states that county mental health programs shall prepare and submit a Three-Year Program and Expenditure Plan (Plan) and Annual Updates for Mental Health Service Act (MHSA) programs and expenditures.

The County of San Bernardino is pleased to present our Mental Health Services Act (MHSA) Annual Update for Fiscal Year 2013/14.

Overview of Stakeholder Process

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 veterans 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.



County of San Bernardino - Department of Behavioral Health



Promoting Wellness, Recovery and Resilience

Overview of Stakeholder Process

The County of San Bernardino Department of Behavioral Health (DBH) is highly committed to including consumers and stakeholders from throughout the county within all levels of the organization, as well as in the annual update stakeholder process. To meet the requirements of WIC 5847, 5848 and California Code of Regulation (CCR), Title 9, Section 3300, 3320, extensive outreach to promote the annual update stakeholder process was done using a variety of methods at many levels to invite stakeholders to have their voice heard and their feedback included. Information regarding the stakeholder process was disseminated through the use of press releases to all local media outlets, email and flyer distribution to community partners, community and contracted organizations, other county agencies, cultural subcommittees and coalitions, and regularly scheduled stakeholder meetings, including the County of San Bernardino Behavioral Health Commission, to reach populations representative of the descriptions provided above. Social media sites such as Facebook were also used to promote the Annual Update process and 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.

During the month of April 2013, DBH scheduled eighteen (**18**) community forums across all geographic regions in the county (**please see page 11 and the attachments section of this Update**).

Additionally DBH engages stakeholders, provides information, and invites feedback about MHSA programs throughout the year using regularly scheduled monthly meetings. Schedules for these meetings are available to the public and distributed widely with interpreter services available to participating community members:

- Behavioral Health Commission (BHC).
- District Advisory Committee meetings five (**5**) separate monthly meetings, one held in each of the five (**5**) supervisorial districts within the county and led by the Behavioral Health Commissioners in that district).
- Community Advisory Policy Committee (CPAC).
- Cultural Competency Advisory Committee (CCAC), along with eight (**8**) 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.
- Workforce Development Committee.

Stakeholder engagement also takes place at specially scheduled events or forums. In September of 2012, the Department conducted a series of nine (**9**) focus groups throughout the county to evaluate contract and county operated adult clubhouse programs. Interactive exercises allowed the facilitators to collect verbal feedback, document on flipcharts, and discuss topics of interest within the group. Written comment forms were also collected from participants of the focus groups with program specifics included within the A-1 Clubhouse Expansion Program Summary section of this report.

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.

Another opportunity to receive stakeholder input regarding MHSA services was a forum conducted by the Mental Health Service Oversight and Accountability Commission (MHSOAC), hosted by the County of San Bernardino on March 14, 2013. Nearly **200** participants provided feedback in designated break out groups, as well as during a public comment period. While feedback is still being compiled for counties by the MHSOAC, once received, DBH will share the information at the regular meetings listed in this report.

Stakeholder attendance as documented on meeting sign-in sheets and consumer feedback forms indicate the representation of those community members as outlined in WIC 5848 and include underserved, unserved, and inappropriately served populations. Significant focus on outreach to diverse stakeholders that represent the demographics of the county included clients with severe mental illness as well as other community groups. Over the 2011/12 fiscal year DBH staff attended over **80** health fairs and community education events in an effort to provide community education, offer information and connect individuals with the Department of Behavioral Health. Outreach efforts also served to build internal list serves, email lists and contact lists that are used to distribute information about the Annual Update, community forums and regularly scheduled stakeholder meetings.

Stakeholder input is always considered when making system decisions within the Department. Outcomes from the Clubhouse Focus Groups led to programmatic and policy changes in this program. Policy, program planning and implementation issues are regularly discussed at all of the monthly meetings listed in this report. Monitoring, evaluation and quality improvement is the focus of the department Quality Management Action Committee (QMAC) meetings and often leads to quality of care improvements for MHSA programs. Budget allocations are discussed regularly at the CPAC and MHSA Executive meetings, as well as others as needed. When a need for training is identified, arrangements are made to deploy culturally and clinically competent trainings to providers of MHSA services that enhance the quality of care for consumers and their families. Consumers, family members, service providers and peer staff are among the membership of all committees allowing for consistent feedback and interaction to occur between department staff and community stakeholders regarding MHSA programs. Documentation of these activities are included in minutes recorded at each meeting and are frequently provided to Department of Health Care Services (DHCS) staff and External Quality Review Organization (EQRO), APS staff and are reviewed by meeting participants

Stakeholder Process Standards

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

As evidenced by the extensive schedule of community oriented meetings, the department embeds collaboration with the community into ongoing operations at multiple levels. DBH has a commitment to cultural competence with ten (10) cultural subcommittees and coalitions that meet monthly, in addition to the Cultural Competency Advisory Committee. Cultural competency is woven in to everything we do at DBH, including planning, implementing and evaluating programs. The Office of Cultural Competence and Ethnic Services (OCCES) reports to the DBH Director and is an essential part of all aspects 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 MHS program leads to ensure the delivery of culturally competent and appropriate services, including providing feedback and input into all programs. The CCO or members of OCCES regularly sit on boards or committees where they can provide input or effect change regarding program planning or implementation. OCCES provides support by translating documents for the department and arranging for translation services whenever requests for services, training, outreach, and/or stakeholder meetings are received. Additionally, language regarding cultural competence is included in all department contracts with organizational, and individual providers and is included as a category in every DBH employee's Work Performance Evaluation.

The County of San Bernardino, Department of Behavioral Health 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 active system stakeholders. Within DBH's organizational structure, the Office of Consumer and Family Affairs is elevated, reporting at the executive level, with access to the Department Director, CaSonya Thomas.

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 11 consumer clubhouses to encourage regular participation in MHS 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 actual decisions made. Consumer input, along with staff and community input is always considered when making MHS 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.

Stakeholder Process Standards

The Peer-Driven Room and Board Advisory Coalition, initiated and facilitated by the Patient's Rights Office, is an innovative, ground-breaking collaboration of behavioral health consumers, providers, Room & Board Operators and other community stakeholders. Conceptualized in response to the long-standing concerns regarding unlicensed Room & Boards in the community, the Coalition has established as its mission to "empower and educate" consumers, "promote self-advocacy" and identify "safe and supportive housing" that facilitates consumer wellness and recovery efforts for members in MHSA funded programs. This is one of the training grounds in which consumer and stakeholders are coached on how to strategically address issues that impact them personally.

Additionally, DBH has committed to the funding of **134** FTE Peer and Family Advocates through MHSA to assist in system transformation and valued contributions to the stakeholder process. These positions have increasing levels of responsibility and provide peer counseling, and linkages to services and supports. These positions are dispersed throughout the department providing consumer advocacy and assistance, as well as providing input on systems issues major program areas:

- Consumer Clubhouses
- Forensic Services
- Assertive Community Treatment
- Crisis Walk In Centers
- Hospital Triage Diversion
- Homeless Intensive Case Management
- Community Crisis Response Services
- Wraparound Services
- AgeWise
- Transitional Age Youth
- Department Administration

It is through the integration of consumers at all levels of our department structure that we are able to ensure wide-spread consumer representation in MHSA stakeholder meetings and activities. Also, this inclusion occurs regularly as their participation is embedded in department operations every day, not just during stakeholder meetings. Consumers participate in regularly occurring meetings as well as stakeholder meetings and meaningfully contribute to all levels of MHSA program planning activities.

This participation and integration in to all aspects of programming makes for a seamless culturally competent system. The OCCES highlights efforts made by staff, contract staff, consumers or members of the community who demonstrate a level of cultural competence that the committee feels deserves recognition. The Cultural Competency Excellence Award is awarded every month at our Behavioral Health Commission meeting. Over the past year, **25%** of the recipients were peer positions or consumer leaders.

Fiscal Year 2013/14 Annual Update Stakeholder Process



County of San Bernardino Department of Behavioral Health
Mental Health Services Act Annual Update
Community Planning Meetings
Fiscal Year 2013/2014



Central Valley Region

<p>Asian Pacific Islander (API) Coalition Meeting Asian American Resource Center 1115 South "E" Street San Bernardino, CA 92408</p> <p>April 9, 2013 10:00 a.m. – 12:00 p.m.</p>	<p>Spirituality Sub-Committee Training Institute 1950 S. Sunwest Lane, Suite 200 San Bernardino, CA 92415</p> <p>April 9, 2013 1:00 p.m. – 3:00 p.m.</p>	<p>Native American Awareness Committee Native American Resource Center Riverside-San Bernardino County Indian Health, Inc 2210 E. Highland Ave., Suite 101 & 102 San Bernardino, CA 92404</p> <p>April 16, 2013 2:00 p.m. – 4:00 p.m.</p>
<p>Transitional Age Youth (TAY) Committee One-Stop TAY Center 780 E. Gilbert Street San Bernardino, CA 92415</p> <p>April 17, 2013 10:00 a.m. – 12:00 p.m.</p>	<p>Community Policy Advisory Council County of San Bernardino (CPAC) County of San Bernardino Health Services, Auditorium 850 E. Foothill Blvd. Rialto, CA 92376</p> <p>April 18, 2013 9:00 a.m. – 11:00 a.m.</p>	<p>Cultural Competency Advisory Committee (CCAC) County of San Bernardino Health Services, Auditorium 850 E. Foothill Blvd. Rialto, CA 92376</p> <p>April 18, 2013 1:00 p.m. – 3:00 p.m.</p>
<p>Co-Occurring Substance Abuse Committee (COSAC) County of San Bernardino Health Services, F119-120 850 E. Foothill Blvd. Rialto, CA 92376</p> <p>April 18, 2013 2:30 p.m. – 4:30 p.m.</p>	<p>District Advisory Committee (DAC) 5th District New Hope Family Life Center 1505 W. Highland Ave. San Bernardino, CA 92411</p> <p>April 22, 2013 5:30 p.m. – 7:30 p.m.</p>	<p>Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ) Subcommittee One-Stop TAY Center 780 E. Gilbert Street San Bernardino, CA 92415</p> <p>April 23, 2013 12:30 p.m. - 2:30 p.m.</p>
<p>Department of Behavioral Health (DBH) Training Institute 1950 S. Sunwest Lane, Ste. 200 San Bernardino, CA 92415 Event will be live at the DBH Training Institute with a webcast in the desert & west-end regions. To participate from your own computer please call (800) 722-9866 to register.</p> <p>April 24, 2013 3:00 p.m. – 5:00 p.m.</p>		<p>Latino Health Coalition El Sol Neighborhood Educational Center 972 N. Mount Vernon Ave. San Bernardino, CA 92411 <i>Spanish Language Meeting</i></p> <p>April 25, 2013 10:00 a.m. - 12:00 p.m.</p>

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Full sized

Stakeholder Community Meeting Schedules in English and Spanish are available in the Attachments section of this Update.

Eighteen (18) community meetings were held for MHSa Annual Update FY 2013/14 process.

MHSa Annual Update Fiscal Year 2013/14 Community Planning Meeting Schedule

English

Desert / Mountain Region

<p>High Desert African American Mental Health Coalition Victor Valley Clubhouse 12625 Hesperia Rd. Victorville, CA 92395</p> <p>April 8, 2013 1:00 p.m. – 3:00 p.m.</p>	<p>City of Needles Recreation Center 1705 J Street Needles, CA 92363</p> <p>April 10, 2013 1:00 p.m. – 3:00 p.m.</p>	<p>District Advisory Committee (DAC) 1st District Victorville Behavioral Health Center, Room A-11 12625 Hesperia Rd. Victorville, CA 92395</p> <p>April 17, 2013 11:00 a.m. – 1:00 p.m.</p>
<p>Lake Arrowhead/Crestline Rim of the World High School, Library Room 27400 Highway 18 Lake Arrowhead, CA 92352</p> <p>April 18, 2013 3:30 p.m. - 5:30 p.m.</p>	<p>Big Bear Middle School room 4 41275 Big Bear Blvd Big Bear Lake, Ca, 92315</p> <p>April 22, 2013 1:00 p.m. - 3:00 p.m.</p>	<p>District Advisory Committee (DAC) 3rd District Santa Fe Social Club 56020 Santa Fe Trail, Suite M Yucca Valley, CA 92284</p> <p>April 23, 2013 1:00 p.m. – 3:00 p.m.</p>
<p>Morongo Basin Mental Health 55475 Santa Fe Trail Yucca Valley, CA 92284 Via Webcast</p> <p>April 24, 2013 3:00 p.m. – 5:00 p.m.</p>		

West Valley Region

<p>District Advisory Committees 2nd & 4th Districts Rancho Cucamonga Family Resource Center 9791 Arrow Route Rancho Cucamonga, CA 91730</p> <p>April 11, 2013 3:00 p.m. – 5:00 p.m.</p>	<p>South Coast Community Services 2930 Inland Empire Blvd., Suite 120 Ontario, CA 91764 Via Webcast</p> <p>April 24, 2013 3:00 p.m. – 5:00 p.m.</p>
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CONTACT: For additional information, please contact Susanne Kulesa at (909) 252-4068.

NOTE: If special accommodations or interpretation services are required or to learn more about the Spanish language forum please call 1-800-722-9866 or 711 for TTY users.

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Fiscal Year 2013/14 Annual Update Stakeholder Process



Condado de San Bernardino Departamento de Salud Mental
Ley de Servicios de Salud Mental (MHSa por sus siglas en inglés)
Reuniones Comunitarias para la Planificación de la
Actualización Anual de MHSa
Año Fiscal 2013/2014



Región del Valle Central

<p>Coalición Asiática-Islaños del Pacifico Asian American Resource Center 1115 South "E" Street San Bernardino, CA 92408</p> <p>9 de abril, 2013 10:00 a.m. – 12:00 p.m.</p>	<p>Subcomité de Espiritualidad Instituto de Entrenamiento 1950 S. Sunwest Lane, Suite 200 San Bernardino, CA 92415</p> <p>9 de abril, 2013 1:00 p.m. – 3:00 p.m.</p>	<p>Comité de Conciencia sobre Nativos Americanos Native American Resource Center Riverside-San Bernardino County Indian Health, Inc. 2210 E. Highland Ave., Suite 101 & 102 San Bernardino, CA 92404</p> <p>16 de abril, 2013 2:00 p.m. – 4:00 p.m.</p>
<p>Comité de Jóvenes en Edad de Transición (TAY por sus siglas en inglés) One-Stop TAY Center 780 E. Gilbert Street San Bernardino, CA 92415</p> <p>17 de abril, 2013 10:00 a.m. – 12:00 p.m.</p>	<p>Comité Asesor de Políticas Comunitarias (CPAC por sus siglas en inglés) County of San Bernardino Health Services, Auditorium 850 E. Foothill Blvd. Rialto, CA 92376</p> <p>18 de abril, 2013 9:00 a.m. – 11:00 a.m.</p>	<p>Comité Consultivo de Competencia Cultural (CCAC por sus siglas en inglés) County of San Bernardino Health Services, Auditorium 850 E. Foothill Blvd. Rialto, CA 92376</p> <p>18 de abril, 2013 1:00 p.m. – 3:00 p.m.</p>
<p>Comité de Abuso de Substancias y Trastornos Concomitantes (COSAC por sus siglas en inglés) County of San Bernardino Health Services, F119-120 850 E. Foothill Blvd. Rialto, CA 92376</p> <p>18 de abril, 2013 2:30 p.m. – 4:30 p.m.</p>	<p>Comité Consejero del Distrito 5 (DAC por sus siglas en inglés) New Hope Family Life Center 1505 W. Highland Ave. San Bernardino, CA 92411</p> <p>22 de abril, 2013 5:30 p.m. – 7:30 p.m.</p>	<p>Subcomité de la Comunidad de Lesbianas, Homosexual, Bisexuales, Transgénero y Personas Cuestionando su Sexualidad (LGBTQ por sus siglas en inglés) One-Stop TAY Center 780 E. Gilbert Street San Bernardino, CA 92415</p> <p>23 de abril, 2013 12:30 p.m. - 2:30 p.m.</p>
<p>Departamento de Salud Mental, Instituto de Entrenamiento 1950 S. Sunwest Lane, Suite 200 San Bernardino, CA 92415 <i>El evento será en vivo en el Instituto de Entrenamiento con un Reunión Vía La Red en las regiones del desierto y del este. Para participar desde su propia computadora, por favor llame al (800) 722-9866 para registrarse.</i></p> <p>24 de abril, 2013 3:00 p.m. – 5:00 p.m.</p>		<p>Coalición de Salud Latina El Sol Neighborhood Educational Center 972 N Mount Vernon Ave San Bernardino, CA 92411 <i>Reunión se llevará a cabo en el Idioma Español</i></p> <p>25 de abril, 2013 10:00 a.m. - 12:00 p.m.</p>

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Stakeholder Community Meeting Schedules in English and Spanish are available in the Attachments section of this Update.

Eighteen (18) community meetings were held for MHSa Annual Update FY 2013/14 process.

MHSa Annual Update Fiscal Year 2013/14 Community Planning Meeting Schedule

Spanish

Región del Desierto y Montañas

<p>Coalición de Salud Mental Afro- Americana del Desierto Alto Victor Valley Clubhouse 12625 Hesperia Rd. Victorville, CA 92395</p> <p>8 de abril, 2013 1:00 p.m. – 3:00 p.m.</p>	<p>City of Needles Recreation Center 1705 J Street Needles, CA 92363</p> <p>10 de abril, 2013 1:00 p.m. - 3:00 p.m.</p>	<p>Comité Consejero del Distrito 1 (DAC por sus siglas en inglés) Victorville Behavioral Health Center, Room A-11 12625 Hesperia Rd. Victorville, CA 92395</p> <p>17 de abril, 2013 11:00 a.m. – 1:00 p.m.</p>
<p>Lake Arrowhead/Crestline Rim of the World High School, Biblioteca 27400 Highway 18 Lake Arrowhead, CA 92352</p> <p>18 de abril, 2013 3:30 p.m. - 5:30 p.m.</p>	<p>Lutheran Social Services Bear Valley Unified School District 42271 Moonridge Road Big Bear Lake, CA 92315</p> <p>22 de abril, 2013 1:00 p.m. - 3:00 p.m.</p>	<p>Comité Consejero del Distrito 3 (DAC por sus siglas en inglés) Santa Fe Social Club 56020 Santa Fe Trail, Suite M Yucca Valley, CA 92284</p> <p>23 de abril, 2013 1:00 p.m. – 3:00 p.m.</p>
<p>Morongo Basin Mental Health 55475 Santa Fe Trail Yucca Valley, CA 92284 <i>Reunión Vía La Red (vía Webcast)</i></p> <p>24 de abril, 2013 3:00 p.m. – 5:00 p.m.</p>		

Región del Valle Occidental

<p>Comité Consejero de Distritos 2 & 4 (DAC por sus siglas en inglés) Rancho Cucamonga Family Resource Center 9791 Arrow Route Rancho Cucamonga, CA 91730</p> <p>11 de abril, 2013 3:00 p.m. – 5:00 p.m.</p>	<p>South Coast Community Services 2930 Inland Empire Blvd., Suite 120 Ontario, CA 91764 <i>Reunión Vía La Red (vía Webcast)</i></p> <p>24 de abril, 2013 3:00 p.m. – 5:00 p.m.</p>
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NOTA: Si se necesitan arreglos especiales (relacionados con alguna discapacidad) o servicios de interpretación, o si desea saber más sobre la reunión en español, o para registrarse para participar en el Webcast, por favor de llamar al (800) 722- 9866, ó al 7-1-1 si es usuario de TTY.

CONTACTO: Para más información, por favor comuníquese con Susanne Kulesa al (909) 252-4068.

Página 2 de 2

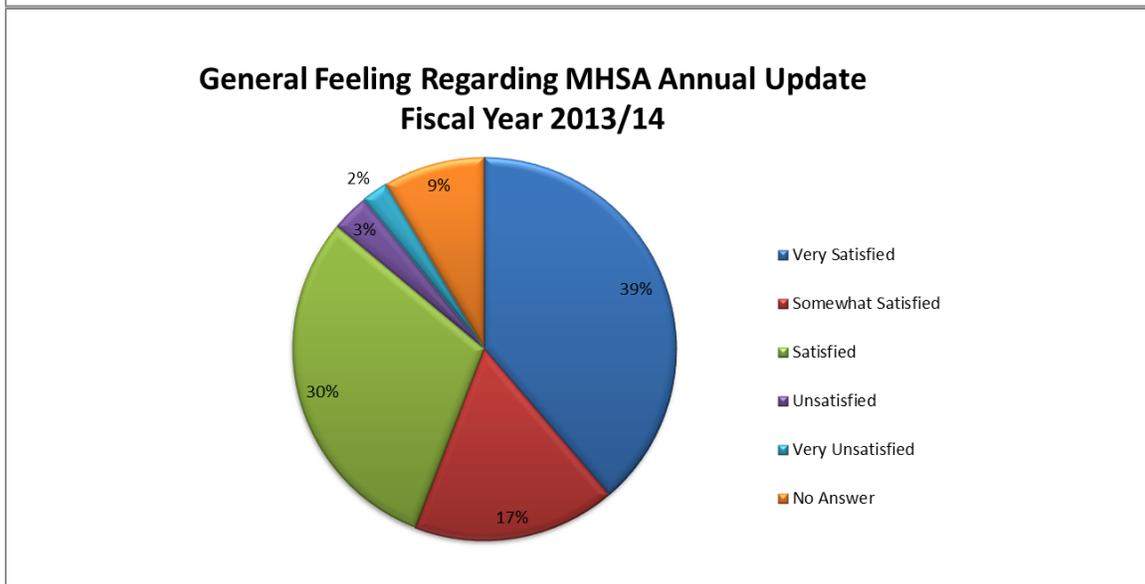
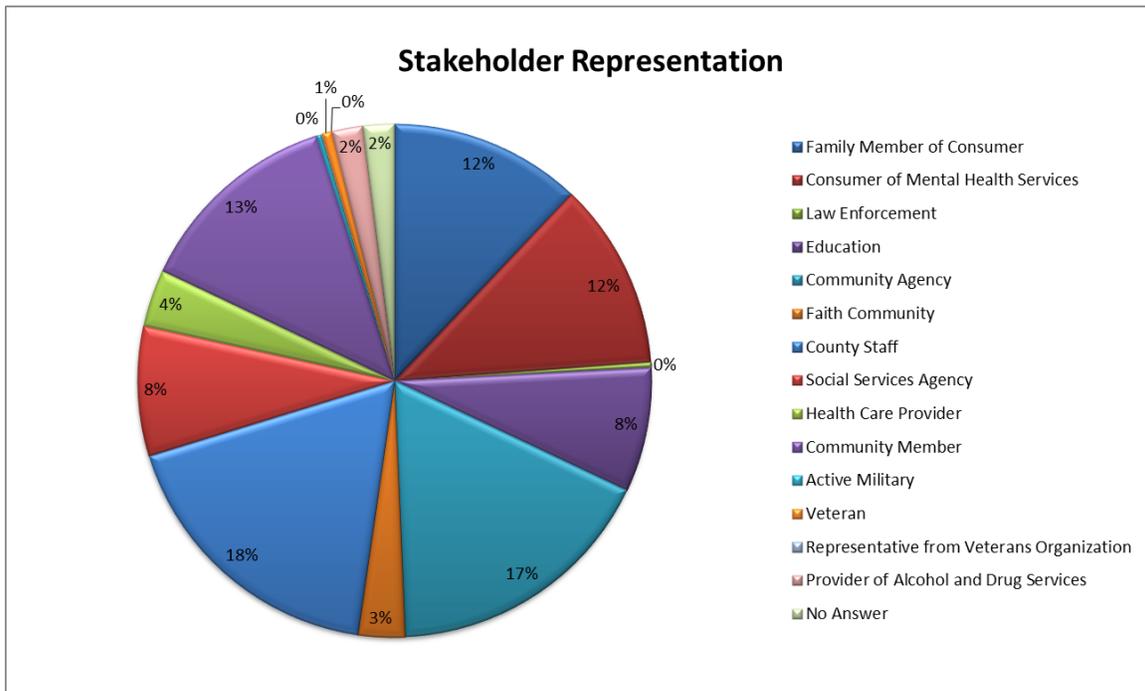
04/03/2013

Fiscal Year 2013/14 Annual Update Stakeholder Process

Approximately **224 stakeholders** completed a stakeholder comment form in the MHSA annual update fiscal year 2013/14 community planning Meeting process held throughout April 2013. 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 who 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.

The following demographic information was collected from the stakeholder meetings:

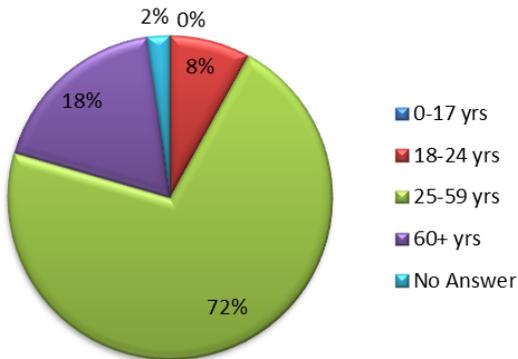
MHSA Annual Update Fiscal Year 2013/14 Community Planning Meeting Stakeholder Demographics



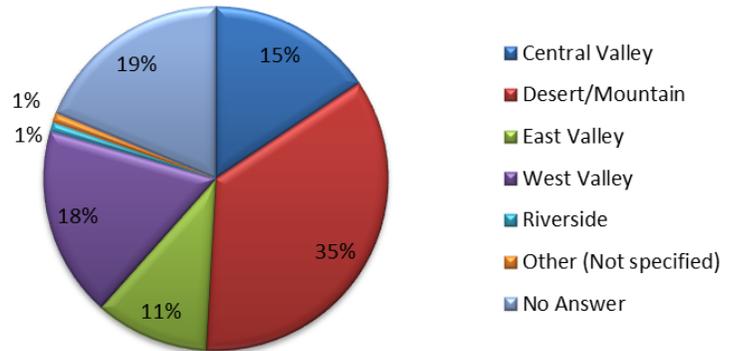
Fiscal Year 2013/14 Annual Update Stakeholder Process

MHSA Annual Update Fiscal Year 2013/14 Community Planning Meeting Stakeholder Demographics

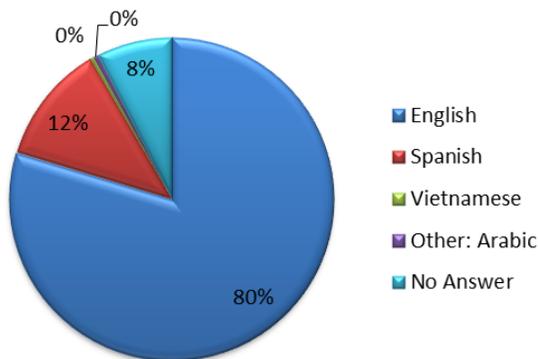
Age



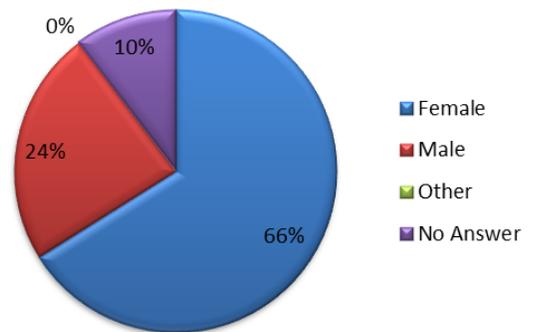
Region



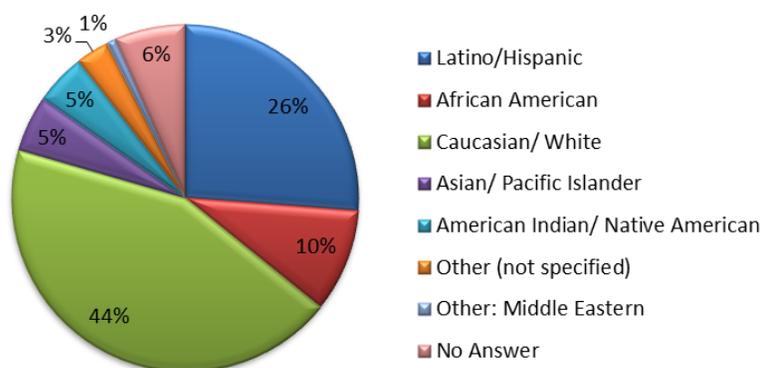
Primary Language



Gender



Ethnicity



Fiscal Year 2013/14 Annual Update Stakeholder Process

The Department continues to focus on five (5) priorities that emerged during stakeholder processes throughout the past five (5) years. These issues are used to help drive planning and evaluation efforts and are as follows:

- Family and Youth Support
- Basic Needs - Transportation
- Emergency Preparedness
- Administrative Support
- Improved Access/Availability of Treatment and Recovery Services

Stakeholders were asked to rank these topics in order of priority using a scale of 1-5, with 1 being the greatest prioritized need. Results were as follows:

Final Ranking	Priorities	*Rank of Stakeholder Preferred Priority					Total
		1	2	3	4	5	
1	Family and Youth Support	91	34	11	2	0	138
2	Increased Access/Availability of Treatment/ Recovery	61	38	17	7	2	125
3	Basic Needs- Transportation	56	15	16	1	1	89
**4	Administrative Support	8	3	5	12	24	52
**4	Emergency Preparedness	5	5	7	19	12	52

NOTE:

* Not all stakeholders ranked all five (5) priorities.

**Administrative support and emergency preparedness tied for fourth priority as identified by stakeholders.

During each stakeholder meeting, participants were provided with verbal **and** written information regarding the public posting of the draft Annual Update.

MHSA 30-Day Public Posting Promotional Business Cards

**MENTAL HEALTH SERVICES ACT
ANNUAL UPDATE**

The Annual Update will be posted online for public comment from May 1 through May 31, 2013 at www.sbcounty.gov/dbh.
(Printed copies will be available for viewing at all County libraries)

For additional information please call 1-800-722-9866 or 7-1-1 for TTY users or email mhsa@dbh.sbcounty.gov.




**ACTUALIZACION ANUAL DE LA
LEY DE SERVICIOS DE SALUD MENTAL**

La Actualización Anual será publicada en el Internet para comentarios públicos desde el 1 de mayo hasta el 31 de mayo del 2013 en: www.sbcounty.gov/dbh.
(Habrá copias del documento impresas disponibles en las bibliotecas del Condado para que lo puedan ver)

Para información adicional por favor comuníquese al 1-800-722-9866 ó al 7-1-1 para usuarios TTY o mande un correo electrónico a: mhsa@dbh.sbcounty.gov.




Fiscal Year 2013/14 Annual Update Stakeholder Process

The following are stakeholder comments as submitted directly from the MHSA annual plan update fiscal year 2013/14 community planning meeting comment forms.

In Their Own Words

#	WHAT DID YOU LEARN ABOUT THE MHSA ANNUAL UPDATE?
1	The increase in funding allows and how the funds will be allocated and used for the MHSA Community.
2	That MHSA is really helping the mental health
3	Nothing
4	Not sure
5	Because we can learn lot of stuff
6	The update on whets going on
7	No
8	No
9	Implemented in 2007 outcomes of SVCS but no info was given regarding specific age, cultural and ethnic groups reached/ served. No info was provided regarding where specifically services were provided.
10	What do we have to opinionate so that our necessities become reality?
11	It helps the community.
12	Information I have not heard, programs that exist to help the community, adolescents and adults.
13	I learned how much money there is on each different department and how important is to tell or said the things or programs the community need.
14	I learned there are many funds to help our community and we do not know they are there. We need you to let us know by way of magazines, flyers, t.v., radio and newspaper.
15	I learned there are many funds to help our community and we do not know how to ask for them or have access to those funds. We want to know how to acquire them.
16	Funding was interesting
17	Money allocated is helping the community receive more services.
18	The new programs, expansion and transportation.
19	Lots, that you exist.
20	Electronic medical systems importance. Would like to have a clubhouse for Needles, CA
21	What this program was
22	flyer
23	What TAY is and how it helps the youth, who funds the program, what services it provides to the consumers
24	Learned: how program is funded, amenities it provides, program outcomes & goals.
25	TAY center is continuously funded by tax money. The "STAY" is a 14 bed crisis intervention center. There is a crisis call center.
26	Funding for MHSA
27	A lot about the program outcomes and more information about the apartment attached to TAY.
28	Where the money comes from and where the money goes.
29	Its 58 counties in the state of California
30	Co-worker
31	About the housing continuum offered through TAY-STAY and apartment
32	The way funding is allocated.
33	Housing Complexes
34	That Innovation programs are evaluated for funding every three years.
35	100,000 consumers served. Diverted 981 by CWIC & CCRT from hospital, 3 TAY apartment buildings

Fiscal Year 2013/14 Annual Update Stakeholder Process

The following are stakeholder comments as submitted directly from the MHSA annual plan update fiscal year 2013/14 community planning meeting comment forms.

In Their Own Words

#	WHAT DID YOU LEARN ABOUT THE MHSA ANNUAL UPDATE?
36	Learned a lot. Interesting fact: the STAY and TAY connection is the only one in the state
37	58 counties
38	Good update
39	How much support is offered & available to our youth
40	Faith
41	That it's in a fiscal year
42	The progress over the last year across the dept. as a whole.
43	What is happening with other agencies and their concerns.
44	The allocated amounts for spending in specific programs.
45	Already knew.
46	Spent a lot of money to increase DBH influence & administration.
47	database uses; crisis walk-ins
48	At Bear communities resource network learned about electronic data gathering (future)
49	The goal to implement electronic reporting- throughout the county- Big difficult process.
50	Different areas that the DBH is working on, increasing services.
51	The different access to give and receive help. Where to go depending the case.
52	Good to know of June meeting.
53	Level of participation by the community. Programs in development: PEI, INN, WET
54	The different Components
55	All services being provided thanks to Mash funding and results on how many individuals are being reached.
56	Lots of numbers- not a lot of context. Some context would help (how compare w/ last years goal comparison, another county?) Were you pleased, challenged, satisfied?? Sounded amazing but without context, who knows.
57	Part of meeting
58	Good reminder/ update
59	The areas of proposed increase.
60	Potential decrease in 14-15 fiscal year
61	The projection of the budget and its division among the different departments.
62	I learned what the top 5 needs (as identified by stakeholders) are and I learned what the areas for improvement.
63	Last year availability of treatment was a priority on the update.
64	Very familiar with MHSA, process, etc.
65	That we have served lost of people.
66	All the good accomplishments over the next year. I was especially interested in the clubhouse evaluation that was done.
67	Decrease wait times for treatment. Increase access to services.
68	MHSA estimates for next year.
69	Everything basic about Prop 63
70	Financial information; Program information
71	I learned about Fiscal projections, that there are 10 clients currently residing in STAY
72	New programs/services are in the work.

Fiscal Year 2013/14 Annual Update Stakeholder Process

The following are stakeholder comments as submitted directly from the MHSA annual plan update fiscal year 2013/14 community planning meeting comment forms.

In Their Own Words

#	WHAT DID YOU LEARN ABOUT THE MHSA ANNUAL UPDATE?
73	Outcomes for existing programs.
74	We need to have more handout info. I have heard this comment twice from participants at meeting. Maybe give out talking points.
75	That not enough information was given in the report. Use PowerPoint presentation. Advance information about presentation.
76	I have a preference for written handout material.
77	Number of services provided in this fiscal year and the MHSA fund. An overview of MHSA program.
78	All the updates were informative.
79	Highlights of the MHSA components
80	How money is used and different programs
81	Updates were help in understanding what types of services are being offered around the county.
82	Emails from DBH
83	More attention on how MHSA works.
84	The funding comes from the 1% tax on 2nd million dollars persons make.
85	DAC meeting agenda
86	Progress of current programs and funding. Upcoming issues in DBH future.
87	More historical info from May Farr
88	That there is a lot of funding for SB County Mental Health. We are grateful to be receiving a portion of it and hope it continues to increase funding so we can continue to increase services.
89	Via an email from Tanya Perry
90	Through and email from Tanya Perry
91	That there is money out there for service to be brought to Big Bear.
92	Five areas of interest, Clubhouses- learn skills/independent, 14 bed youth hostel- 16- 25 (TAY), month by month funding, 3 funding areas, PEI- expand family resources centers
93	Funding
94	Question is not clear!
95	How funding is distributed
96	I belong to the Mental Health Alliance.
97	The overhaul of the data management system.
98	That there are still funds available but very limited money is still in the mountains.
99	Funds are available to mtn. regions but limited.
100	Not as much funding available in the mountains as other areas.
101	That Behavioral Health travels to various communities to gain input.
102	Behavioral travels to other communities to gain info and input.
103	Liked hearing what the budget is and how its planned on being spent.
104	Good overview of what is offered.
105	Funds allocation, expanding services, priority of services
106	How many community members have been served
107	Where the focus of spending is during the fiscal year.

Fiscal Year 2013/14 Annual Update Stakeholder Process

The following are stakeholder comments as submitted directly from the MHSA annual plan update fiscal year 2013/14 community planning meeting comment forms.

In Their Own Words

#	WHAT DID YOU LEARN ABOUT THE MHSA ANNUAL UPDATE?
108	Time and details that go into it (report/update). Interns- needed and why? Where the funds come from
109	Where and when to voice opinions
110	The needs of the County and its people. I also learned where the county plans to go next in programs.
111	I learned that the annual data update will be listed online. Thank you for the info.
112	I learned about the projected funding and upcoming projects.
113	Accomplishments, Priorities, Projections
114	The process overall and where to get report.
115	Much work is involve to gather information put together to be available for review.
116	San Bernardino Leadership Development Program
117	Know everything
118	Good ideas to help mental people or disabled to get ahead.
119	What we will be getting funds in a monthly basis instead of on a yearly basis.
120	Please send into CAB
121	First I heard of it. They really want to help.
122	That there are a lot more programs than I realized.
123	Remember to a millionaire!
124	That good things are in the works.
125	We done some good stuff.
126	That many resources are coming to make the job better.
127	What services in the community have been updated and the positive results that have been achieved during the 2013 fiscal year.
128	Everything was very interesting. There are clubs for young adults.
129	A lot of money was spent at CCRT and CWIC.
130	About TAY Behavioral Health Youth Hostel and Clubhouses
131	More.
132	About the process to make laws and implement services.
133	The new law, about MHSA
134	How to help family members, friends and other people

Fiscal Year 2013/14 Annual Update Stakeholder Process

The following are stakeholder comments as submitted directly from the MHSA annual plan update fiscal year 2013/14 community planning meeting comment forms.

In Their Own Words

#	WHAT ELSE WOULD YOU LIKE TO LEARN ABOUT THE MHSA PROCESS?
1	A notice released to the staff for member to view the MHSA website, when 1/2 of the fiscal year has passed to see how we are doing and how effective the programs are assisting.
2	To learn more resources so I could help others that need it.
3	For better addressed for your concern
4	Community Service
5	Yes
6	This is a very good get together once a month
7	No
8	Whatever
9	What ethnic groups were reached and served? Or targeted?
10	If you can offer free English classes in Ontario, CA.
11	If you can help people that could not go to school get their diploma, GED.
12	We want to know how to apply for these benefits through school, home, t.v. or radio. We want to know how to ask for these benefits. Thank you for coming and we want you to help us obtain these benefits.
13	Thank you.
14	What are problem areas and can they be fixed.
15	Excited to see new programs and community involvement.
16	RFP decisions
17	More thank you.
18	DBH meetings
19	I would be interested to hear feedback from community members receiving TAY/STAY services resources.
20	Would like more detail handout of some kind listing the programs and the percent of the money the use along with contact information.
21	More detail (in percentages) of where the money goes for each program.
22	It was sufficient
23	Interagency Collaborations
24	If the state will return the money they borrowed from MHSA.
25	Great presenter
26	How much progress per year
27	God
28	nothing
29	I support the focus discussed such that better public and more DBH provided transportation are needed.
30	What solutions happened for group concerns.
31	How new programs are considered/development in department.
32	It would be great to have this before RFP's come out so we could advocate.
33	Future RFP's planned.
34	How do we secure the funds from this Act? Seems there is funding for programs that we (Mt West End) is being left out.
35	How they decide on funding programs.

Fiscal Year 2013/14 Annual Update Stakeholder Process

The following are stakeholder comments as submitted directly from the MHSA Annual Plan Update Fiscal Year 2013/14 Community Planning Meeting Comment Forms.

In Their Own Words

#	WHAT ELSE WOULD YOU LIKE TO LEARN ABOUT THE MHSA PROCESS?
36	Where to start and follow up.
37	How to update more than yearly.
38	Funds cannot be transferred from one program to another program.
39	Great meeting well organized!
40	That the youth hostel is up and running with 10 youth currently at the location receiving services- grateful for this.
41	What determines how much each program/department receives funding?
42	Have MHSA programs resulted in increases in therapeutic services?
43	Actual cost per service, client, program compared to similar programs and previous years.
44	Comparison of Implementation MHSA programs/services vs. all cuts of other DBH programs.
45	I would like to know more about the effectiveness of programs and how people are responding to treatment.
46	None
47	More about the number of clients using the services.
48	Nothing
49	Can't think of anything right now.
50	Nice to see more outcomes, behavioral change. Not just numbers also testimony.
51	I am unable to say at this point.
52	Breakdown of spending in the different programs
53	AB109 information from DBH.
54	Continuing education
55	No
56	Did we serve more people this year than last year?
57	Excellent feedback
58	Not sure at this time.
59	What program gets what share of the MHSA money. Who decides what amount of the money goes to which program?
60	The information provided was sufficient.
61	unsure
62	Thank you very much for coming to Big Bear.
63	Are there services available that we could be receiving and aren't?
64	I want to learn more.
65	I already know work program.
66	Is there any funds not allocated yet?
67	Is there any funds that can be distributed to Big Bear Valley?
68	More community events.
69	More community events.
70	Would love to see a breakdown of money set to the valley as a proportion of the county.
71	Comparisons of services between past fiscal years.

Fiscal Year 2013/14 Annual Update Stakeholder Process

The following are stakeholder comments as submitted directly from the MHSA Annual Plan Update Fiscal Year 2013/14 Community Planning Meeting Comment Forms.

In Their Own Words

#	WHAT ELSE WOULD YOU LIKE TO LEARN ABOUT THE MHSA PROCESS?
72	How much help is needed to properly staff offices where services are provided
73	When the funds are released? Why are we given so little notice of the release of funds RFP's?
74	Is the funding from the County or is it statewide and redistributed based on population, etc.
75	Not sure
76	How else we can be involved and involve providers
77	How to sustain programs currently under INN such as CASE and IYRT passed the 3 year time frame.
78	I cannot think of any additional information.
79	Well done.
80	A summary sheet of the programs funded by DBH- MHSA.
81	To become acknowledge in the process to continue INN projects such as IYRT to sustain and continue funding.
82	Continual Updates
83	No
84	Everything
85	More of everything.
86	Get free bus passes funds for misc. things (passes, rent, bills, etc.) Transition. Shower in club for homeless.
87	How to use Mash to get back on track.
88	Volunteering opportunities.
89	Volunteering opportunities.
90	You're doing a good job.
91	Do you really listen to consumer input?
92	Have groups so that resources can be used on the internet.
93	I think the information was complete. Thank you.
94	What is the percent of MHSA money within the county that used on young adults? Did you provide the information for the Community forums to the parents of students in Spanish?
95	About child over 5 to 7 years behavior.
96	Better availability of treatment in Spanish about MH even for who doesn't have papers.
97	More capacities

Response to Substantive Comments/Recommendations

During the stakeholder meetings for this year's Annual Update several 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 the stakeholder meetings it was noted several times that community members would like information about how to access funds related with MHPA programs for their areas. The department releases several requests for proposals (RFPs) every year through a procurement process. MHPA 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/purchasing/RFP/Default.aspx>. 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. District Advisory meeting dates may be requested at the following link <http://www.sbcounty.gov/dbh/mhcommission/CommentForm.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.

Additionally, several questions were asked about program outcomes, MHPA funding percentages and how new MHPA programs get developed. Program outcomes can be found through the "Current Programs" section of this Annual Update report as well as MHPA funding information related to programs.

Response to Substantive Comments/Recommendations

New MHSa programs must be submitted through MHSa stakeholder processes such as the Annual Update. New programs and the need for programs are discussed at regularly occurring meetings including the following:

- Behavioral Health Commission (BHC)
- District Advisory Committee Meetings (DACS)
- Community Policy Advisory Committee (CPAC)
- Cultural Competency Advisory Committee Meetings (CCAC)
- Cultural Subcommittees and Coalitions
- 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
- Workforce Development Committee

In addition to the committees/meetings listed above, the department will also schedule other stakeholder meetings such as the series hosted in April 2013 to gather consumer and stakeholder feedback. Consumer and stakeholder feedback is a cornerstone of all new and current programming efforts. DBH depends on, greatly values and is open to feedback on an ongoing basis. 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 call **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. 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), program needs are considered.

Response to Substantive Comments/Recommendations

Based on the elements described, and if funding is available, new programs may be proposed. New programs are written up in detail and included in the “New Programs,” section of the Annual Update. If new programs are not included in the Annual Update, individual plans can be submitted for stakeholder review outside of the Annual Update pursuant to community stakeholder and public posting requirements. When plans are submitted outside of an Annual Update process, they are subject to the same public posting, and community stakeholder process the Annual Update is subject to. This means that in order to post a plan, stakeholder meetings and incorporation of stakeholder feedback must be included in the plan. Outreach to notify the community of stakeholder meetings and the opportunity to provide feedback must be sent out via press releases, shared in meetings, emailed to contact lists, and posted on the department Facebook page and website.

Once the plan is written and posted, feedback is regularly solicited on the content of proposed new 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 plan/Annual Update as to why it was not incorporated.

Once a new program is approved, then the program may be implemented. Depending on the new program proposal, services can be provided by DBH clinics or organizational contract providers. In many cases, new 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/purchasing/RFP/Default.aspx>.

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 new MHSA programs in general or the new MHSA program proposed in this Annual Update please email or call the department at MHSA@dbh.sbcounty.gov or **1-800-722-9866**.

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 the County of San Bernardino.

Public Review

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.

The DBH Annual Update is posted on the department's website from **May 1 through May 31, 2013**, at www.sbcounty.gov/dbh. The Public Hearing is scheduled to take place at the regularly scheduled Behavioral Health Commission Meeting on **June 6, 2012** which is held from **12 p.m. until 2 p.m.**

The Department of Behavioral Health conducted a comprehensive and robust local stakeholder process, which was open and inclusive of all mental health stakeholders who wished to participate. A total of eighteen (**18**) meetings were held, most of which utilized existing regularly scheduled stakeholder committee meetings, throughout the month of April. The meetings included remote areas of the county such as Needles, Morongo Basin, and the Mountain areas. One meeting was conducted in Spanish for monolingual stakeholders. Another meeting was broadcast to two (**2**) remote satellite sites via webinar technology so that stakeholders would not have to travel so far. The webinar was also available for anyone to attend the meeting from any computer internet location of their choosing. Press releases, in both English and Spanish, with the stakeholder meeting schedule (**please see attachments**) were sent to local newspapers and media contacts. Interpreter services are provided at all of the stakeholder events to ensure diverse community inclusion and these services were noted on all announcements prior to meetings.

Additionally, announcements were made available at all community and regularly occurring department meetings leading up to the eighteen (**18**) scheduled stakeholder meetings in the month of April 2013. Web blasts with stakeholder meeting information were sent to all DBH staff with instructions to disseminate to related interested parties. Meeting schedules were emailed to regular attendees of all meetings, specifically CPAC, Behavioral Health Commission, the DAC meetings, and cultural competence coalitions/subcommittees. Schedules were also emailed to all contacts within all of the department's contracted agencies. The stakeholder meetings were discussed at all outreach activities, events, and meetings in which department staff participate. Meeting schedules were distributed through multiple DBH distribution lists and email groups as well as posted on the DBH website and Facebook page. As is DBH policy, all announcements are in Spanish and English.

Feedback provided verbally and in writing in the eighteen (**18**) stakeholder meetings was analyzed and included in the preparation of the MHS Act Annual Update Fiscal Year 2013/14 as reflected in this report.

Any feedback received during the 30-day Public Posting Period from **May 1 through May 31, 2013**, is included in this report.

Response to Substantive Comments/Recommendations

DBH would like to thank those who participated in the public comment portion of the stakeholder process. During the thirty-day public posting of the Annual Update, ten (10) forms of feedback were received. Nine (9) of them were on the Stakeholder Comment Form that was provided to all stakeholders, and one (1) was in an email. Of the ten (10), two (2) contained positive appraisal for the report. The remaining eight (8) were analyzed and all related to the same basic topic of the ACE program implementation at a specific site. A summary and analysis of these comments, along with our response, is included as follows:

Summary and Analysis of Substantive Comments

The draft Annual Update contained information regarding a new program, Access, Coordination, and Enhancement (ACE) of quality behavioral services. The description of the new program included in the update made reference to an increase in staffing levels, but did not provide details regarding which of the four (4) pilot clinics the staff would be assigned, as the program is still in the planning stages. The comments received were all from staff at one of these clinics, regarding how they would be affected and how many additional staff they will receive, due to the volume of clients they currently see. There were also concerns regarding how the ACE program would affect services at the clinic, including medication management, the need for increased clerical support and increasing bilingual and bicultural licensed providers. Comments received addressed service gaps in the current outpatient system of care which supports the need for additional program services to increase capacity.

It is important to note that, MHSA funding is not the only funding that will be used in the system transformation aimed at outpatient clinics. Increased service capacity will also be addressed over the next several years utilizing Medi-Cal and EPSDT funding.

DBH Response

As the need for behavioral health services continues to grow, there are service gaps that need to be addressed in the outpatient care system on an ongoing basis. Increased treatment capacity is an issue that will continue to be addressed throughout the system of care. The ACE program is one of many steps in addressing the need to build continued capacity. The MHSA was enacted with the purpose of expanding service programs for children, adults and seniors in California, including culturally and linguistically competent approaches to mental health services, that have already demonstrated their effectiveness in providing outreach and integrated services, including medically necessary psychiatric services, and other services to the individuals most severely affected or most at risk of serious mental illness. Further, the Act intends to define serious mental illness as a condition deserving priority attention, including medical and supportive care. Therefore, MHSA funding can be used to enhance our outpatient care by focusing on unserved, underserved and inappropriately served populations. The ACE program is a system enhancement to address the above mentioned populations, and a beginning step to build capacity for unserved, underserved and inappropriately served.

Addressing capacity issues can be done not only by adding staff but by also enhancing and redesigning the outpatient care system. The ACE program will lead to enhancing and redesigning the outpatient clinic's services as well as the addition of treatment providers to the system of care.

Response to Substantive Comments/Recommendations

Screening and assessments will be uniform and standardized across clinics. Medical necessity and client functioning will be quantified into a level system so that appropriate referrals can be made to match the level of care needed. A treatment plan will then be developed based on the evaluation of the medical necessity, and the appropriateness and efficiency of the use of behavioral health services.

As the program is still in the planning phase, staffing allocation has not been finalized. The discussion regarding staffing allocation for the Mesa Community Counseling Clinic takes into consideration the assumption that current urgent medication and crisis services are being redirected to the Rialto Crisis Walk-In Clinic (CWIC). The need to add additional MD and clerical time will be considered as a result of concerns raised regarding Mesa not having medication support services (MSS) capacity for ongoing cases or capacity for specialty mental health services.

The ACE program is a critical step in enhancing DBH's managed care delivery system to allow increased tracking of capacity and service needs.

The following are direct questions or concerns regarding the implementation of ACE that were posed within the feedback that was received, along with appropriate responses.

Question: Will the program be centrally located, or in each clinic?

Response: The program will be located within each major regional clinic, Phoenix Community Counseling, Mesa Community Counseling, Victor Valley Behavioral Health, and Upland Community Counseling. There will also be smaller programs in two (2) desert rural clinics, Needles and Barstow.

Question: Will the ACE program refer to Fee-For-Service (FFS) providers?

Response: ACE will be able to refer to any part of DBH's system of care, including FFS, with referrals being the result of a screening and assessment.

Comment: ACE will only increase the need for Psychiatric evaluations, it will not shorten the gap between assessments and medication evaluations, and there will not be the capacity to handle increasing demand in Medication Support Services (MSS).

Response: The additional MD time allocated in ACE is to take over new client's medication evaluations/assessments and crisis visits. This should result in timely medication evaluations and decrease the current MD's time in these activities. By decreasing the demand on current MD's to perform medication evaluation and assessments, there should be an increased capacity of MSS for ongoing cases.

Comment: At MESA, this will only free up 65 hours-a-week of CT time for specialty mental health services and many recently discharge patients don't want Outpatient services or they only need ADS.

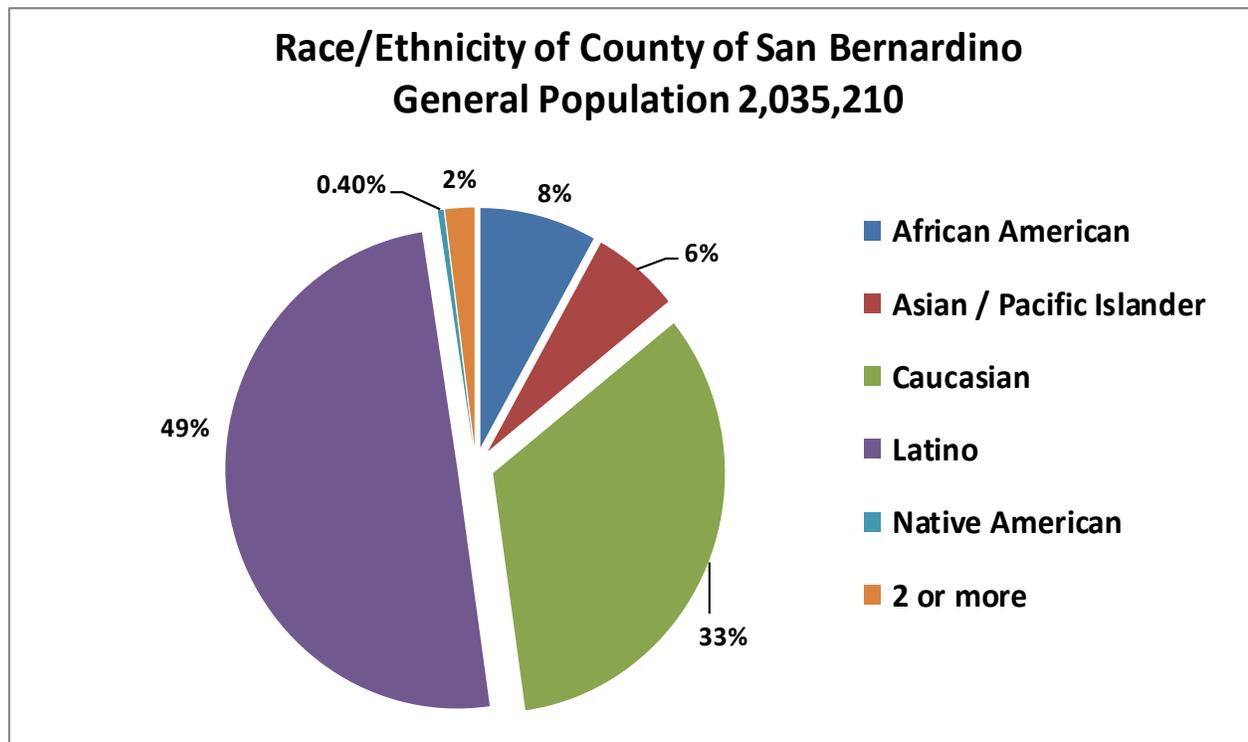
Response: DBH's Mental Health Plan (MHP) stipulates that patients discharged from a psychiatric hospital will have access to appointments within 14-days of discharge. The ACE program will aid in meeting this standard by providing a date and time for hospitals to refer patients. Not all clients qualify, need or respond to outpatient services. ACE will be able to refer to any part of DBH's system of care, including Alcohol and Drug Services (ADS), Fee-For-Service (FFS) providers, Transitional Age Youth (TAY) services, Club-house, Family Centers, and Holistic Campuses. Consumers will receive a screening and an assessment and in the consumer's participation, will be referred to the level of care that is medically necessary.

County Demographic Overview

The County of San Bernardino is located in Southeastern California, approximately **60** miles inland from the Pacific Ocean. The County is the largest county, 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). The total population as of the 2010 census is **2,035,210**. 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 Twenty-nine Palms, Marine Corps Logistics Base Barstow, and Twenty-nine Palms Strategic Expeditionary Landing Field.

The County of San Bernardino 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 **49%**, followed by Caucasian, then African American, Asian/Pacific Islander, then Native American.*

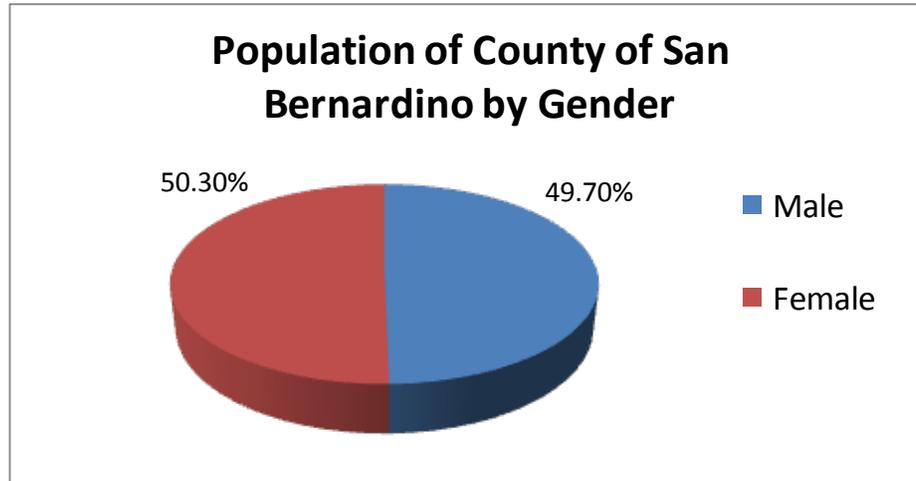


**2012 County of San Bernardino Community Indicators Report*

County Demographic Overview

The County's general population is young, with **28.7%** of residents under the age of 18*. The largest age group is those aged 15 to 19 years, followed by 25 to 29 years.

Gender breakdown is as follows: **50.3%** of the population are female, **49.7%** are male.*



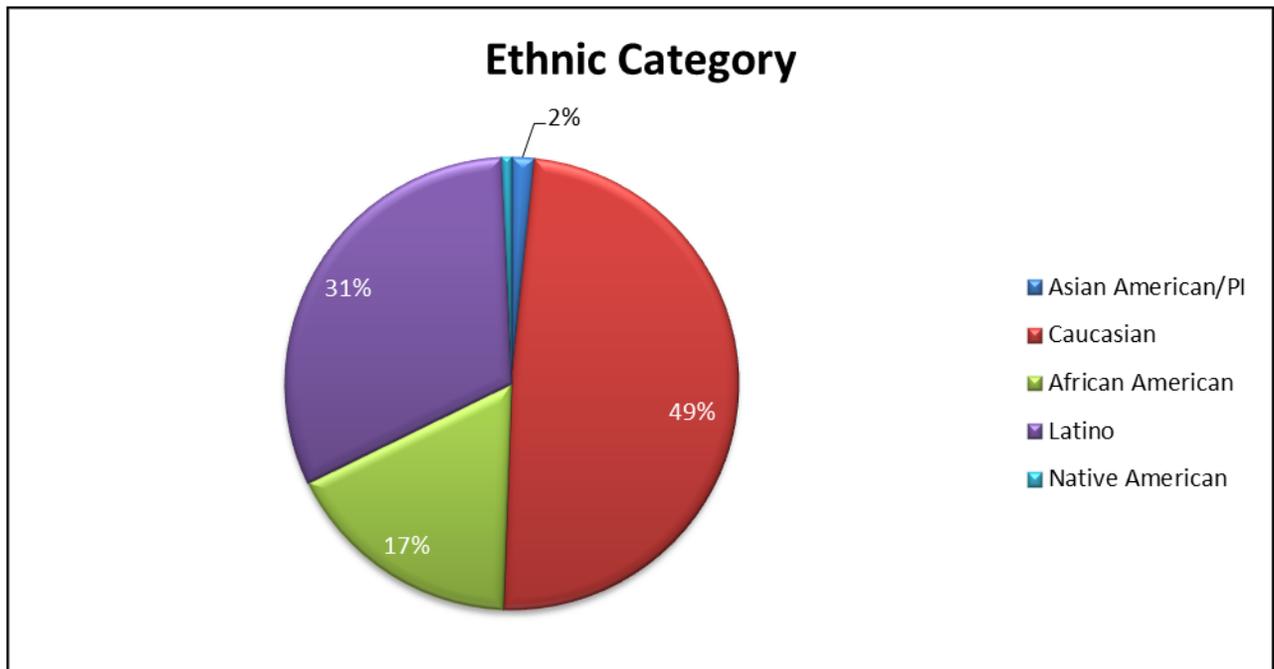
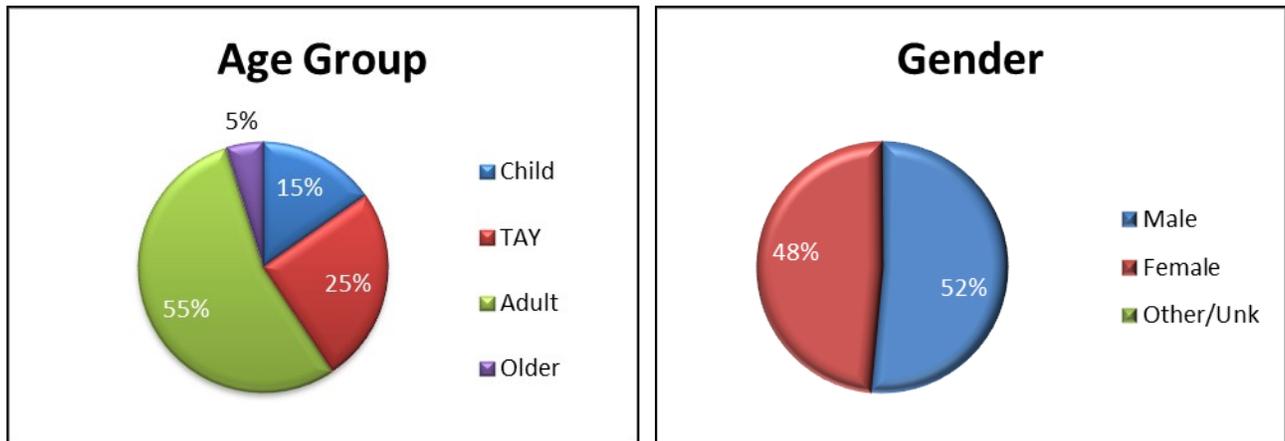
As of 2011, there are approximately **114,482** veterans residing in the County of San Bernardino, comprising approximately **5.5%** of the county's population. While the overall veteran population is declining, the number of veterans returning home from active duty is increasing.**

*Census data, 2011, <http://quickfacts.census.gov/qfd/states/06/06071.html>

**2012 County of San Bernardino Community Indicators Report

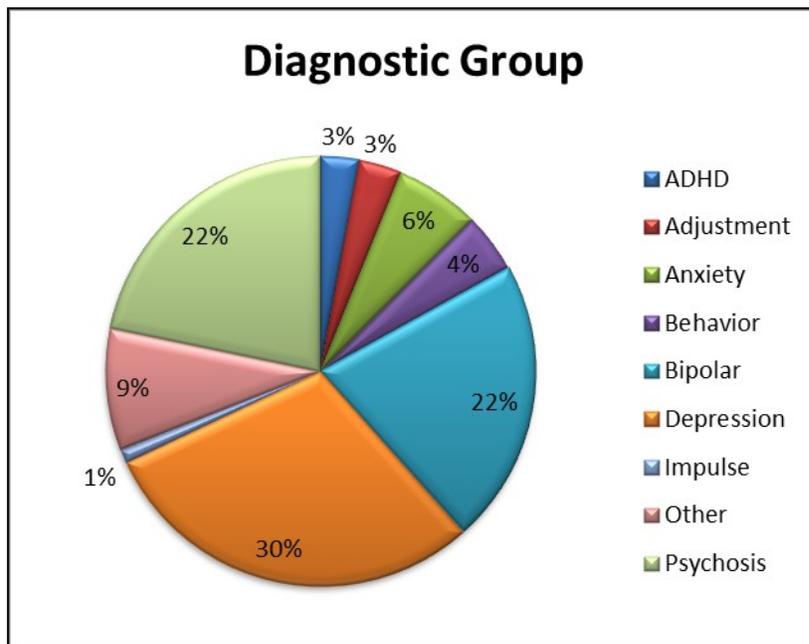
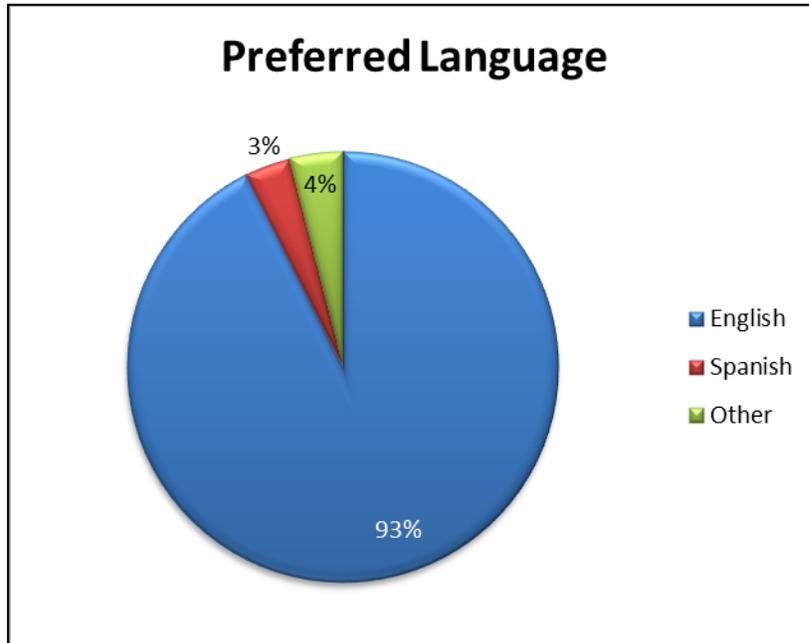
Demographic Overview of Community Members Served in MHSA Programs

Clients served in Community Services & Supports (CSS) and Prevention & Early Intervention (PEI) in Fiscal Year 2011/12 totaled **182,249**.



Demographic Overview of Community Members Served in MHSA Programs

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MHSA Work Plans

MHSA Component	Work Plan
Community Services & Supports (CSS)	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
	A-3: Members Assertive Positive Solutions (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 Services
	A-8: Alliance for Behavioral and Emotional Treatment (ABET) Big Bear Full Service Partnership (FSP)
	OA-2: AgeWise-Mobile Response
Prevention and Early Intervention (PEI)	Prevention and Early Intervention (PEI)
Workforce Education and Training (WET)	Workforce Education and Training (WET)
Innovation (INN)	Coalition Against Sexual Exploitation (CASE)
	Online Diverse Community Experience (ODCE)
	Community Resiliency Model (CRM)
	Behavioral Health Youth Hostel
	Interagency Youth Resiliency Team (IYRT)
	Holistic Campus
Capital Facilities & Technology (CFTN)	Capital Facilities
	Technology



MENTAL HEALTH SERVICES ACT

C-1: Comprehensive Children and Family Support Services (CCFSS)

M H S A A N N U A L U P D A T E

F I S C A L Y E A R 2 0 1 3 / 1 4

Service Goals/Outcome Measures

The objectives of Comprehensive Children and Family Support Services (CCFSS) are:

- **Provide** culturally sensitive/competent, family-centered, strength-based and needs-driven services to children and families who are underserved with complex mental health, behavioral or co-occurring needs in a family setting.
- **Decrease psychiatric hospitalizations** and prevent a higher level of mandated care.
- **Assist with community supportive services** both formal and informal support partnerships.
- **Utilize** flex funds fiscal assistance for immediate safety concerns such as to **prevent homelessness** or for immediate activities of daily living and assistance of clothing, food, housing and medications.
- **Coordinate services** consisting of respite options, 24/7 crisis phone and mobile crisis intervention services in cooperation with established community crisis centers as well as immediate issues over the phone.
- **Improve stability in the home.**
- **Provide outpatient services** as appropriate to the treatment needs and service goals of the child and family.
- **Improve** school advocacy, promotion and attendance by reducing expulsions, arrests, substance abuse and emergency interventions.



County of San Bernardino - Department of Behavioral Health



Promoting Wellness, Recovery and Resilience

Why Was Comprehensive Children and Family Support Services (CCFSS) Created?

Senate Bill (SB) 163 Wraparound had proven to be an effective means by which wards and dependents could be helped so that out of home placements, or loss of a current placements, were avoided. Additionally, wards and dependents were helped in accomplishing appropriate goals and developing constructive relationships within their family and community. However, there were still children and youth being identified by DBH, Probation, and Children and Family Services (CFS) as needing a wraparound style intervention; but, since these children and youth did not qualify for SB 163 Wraparound, these services were not available. Therefore, the need went unmet, and often situations worsened as a result of this unmet need.

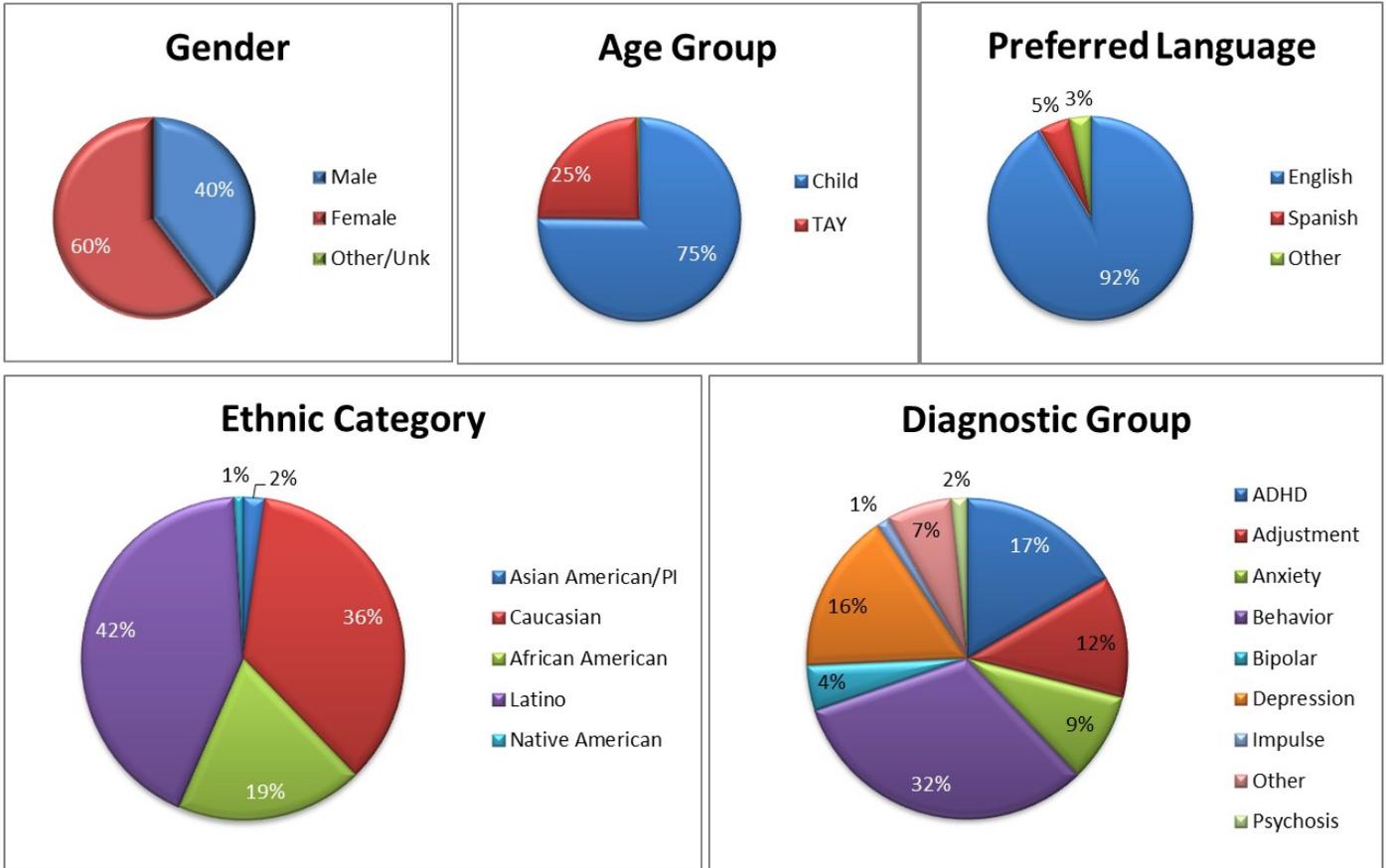
- Success First/Early Wrap was created to facilitate the success of these children and youth without requiring difficulties or issues to rise to the level that SB 163 Wraparound was warranted.
- Since inception CCFSS was expanded two (2) ways: 1) The Wrap informed Full Service Partnership culture was applied to youth in high levels of placement through the Residentially Based Services (RBS) pilot program; 2) SB 163 Wraparound was incorporated into CCFSS. Combined, the three (3) programs provide a continuum of wraparound, or wrap informed services for children and youth within placement, in a formal long term wraparound placement, and through a time limited wrap-informed program that allows for proactive efforts to help children and youth.

Positive Results

- **Increased** family connections.
- **Increased** community support and connections.
- **Decreased** hospitalizations.
- **Decreased** involvement with law enforcement and the Juvenile Justice system.
- **Increased** services to ethnic populations overly represented in Child Welfare and Juvenile Justice systems.
- **Increased** academic success and retention in school.
- **Decreased** homelessness.
- **Increased** lower level community supportive services.
- **Increased** family independence through increased informal community support.
- **Reduced** removal from family home to a higher level of care.
- **Provided** evidence-based treatment that specifically addresses trauma symptoms, substance abuse, parent-child relational difficulties and attachment disorders, oppositional defiance, mood disorders, disorders of infancy and early childhood and parenting skills deficits.
- **70%** of children/youth in Success First/Early Wrap reach their goals by the end of service.

Program Data

During Fiscal Year (FY) 2011/12, CCFSS demographics were as follows:



Challenges

- Child psychiatrists are a severely limited resource in the County of San Bernardino, and there has been difficulty linking children and youth to these resources for appropriate follow-up care.
- Single parent families without extended familial support and functioning at or below poverty pose exceptional challenges, as their natural resources are very limited.
- Balancing youth's and/or family's voice and choice with the "mandatory" terms and conditions of probation and/or dependency court.
- Orientation of many Children and Family (CFS) social workers and probation officers is not in sync with program rhythms of CCFSS (e.g., voice & choice, strength-based, family driven); this results in a significant portion of workers not referring to these programs.
- Some family participation appears to be more motivated by avoiding other consequences (e.g., placement), this results in less robust disclosure of family issues (e.g., alcoholism, domestic violence, etc.), and these unknown obstacles create multiple difficulties to service providers.
- Accessing appropriate community resources for youth in Residentially Based Services (RBS), during the time the youth are residing at the RBS residence is highly difficult due to complications of supervision requirements when parents or foster parents are not highly involved.

Solutions in Progress

- Use of Success First/Early Wraparound to transition more long-term care cases to other specialty programs within the same Community Based Organization (CBO) ensuring smoother transitions and continuity of care.
- Continue to expand the array of services provided by SB 163 Wraparound programs to include Therapeutic Behavioral Services (TBS) (i.e., one-to-one behavioral coaching). The implementation of this within the Wraparound programs has been difficult; however, significant gains appear to have been made in the past year.
- Consistent on-site training and campaigning regarding eligibility criteria, referral processes, and hands on support for making referrals to the CCFSS program (i.e., Success First / Early Wraparound, SB 163 Wraparound, and Residentially based Services).
- Participation with Children & Family Services (CFS) at Team Decision Making (TDM) meetings to ensure consistent information about eligibility criteria and referral processes. This is being accomplished by: 1) Participation of the CBO's that implement the CCFSS programs and 2) Incorporation of a DBH Prevention and Early Intervention (PEI) program designated to participate in Team Decision Making (TDM) meetings with CFS.

In Their Own Words

Success First / Early Wraparound

- ⇒ *"A few months ago, I may have told you that I was just trying to survive my child's childhood and make it out alive. Now, I can tell you that I have hope for my son's future and that although he may not ever be normal, there is definitely potential for better things than I thought possible a few months ago. It has never been easy, and it may never be easy, but I am able to enjoy my son so much more than I ever have. We still struggle as a family sometimes and it's not perfect or as good as it can be and will be, but we are a family and we have hope and we are better than we were, and that is the real miracle that the Success First team have been a part of. I wish there was more I could do to say thanks than this letter because the services we received have definitely improved our lives. Thank you very much."*
- ⇒ One Mom stated during her daughter's graduation that, she had seen a significant improvement.. She had been worried about her daughter's yelling and screaming and worried that her behavior would never change. She was glad a program like this existed because she was not aware of it prior.



SB 163 Wraparound

- ⇒ *"Without the encouragement of the Wrap team, my son would have gone back to smoking marijuana a long time ago. I would have probably had him arrested for beating up his brother without wraparound."*
- ⇒ *"The Wraparound team is really responsible for holding our family together through this tough time."*
- ⇒ *"Thank you for teaching us to not give up on our son by setting the example for us".*
- ⇒ *"Without the persistence and encouragement of the Wraparound team my son would have never had the motivation to complete his community services on his own."*
- ⇒ *"Without Wraparound my son would have been removed from our home. Now, he is able to self-sooth and behaves appropriately in social setting without having a tantrum."*
- ⇒ *"He's doing much better since we started working with him. I learned a lot. He used to hit me when I got him; now it's very rare. To me, that's a big step. He's working on personal stuff...taking a shower. Now he is working on taking a shower every day...or 4 days a week. He used to never shower."*

Collaborative Partners

Thank you to our partners!

County of San Bernardino Children & Family Services

County of San Bernardino Probation

Department of Behavioral Health Transitional Age Youth Centers

School Attendance Review Boards

School Districts

San Bernardino County First-Five

Local Communities

First/Early Wraparound & SB 163 Programs



C-1: COMPREHENSIVE CHILDREN AND FAMILY SUPPORT SERVICES (CCFSS)



MENTAL HEALTH SERVICES ACT

C-2: Integrated New Family Opportunities (INFO)

MHSA ANNUAL UPDATE

FISCAL YEAR 2013/14

Service Goals/Outcome Measures

The objectives of Integrated New Family Opportunities (INFO) are:

- **Reduce recidivism** and criminal behavior.
- **Improve family relations** through effective communication.
- **Increase school attendance.**
- **Reduce and/or eliminate substance abuse.**
- **Reduce cost** to the County of San Bernardino.



County of San Bernardino - Department of Behavioral Health



Promoting Wellness, Recovery and Resilience

Why Was Integrated New Family Opportunities (INFO) Created?

Juvenile arrests in the County of San Bernardino increased steadily from 2002 to 2005. In 2005, **7,482** juveniles were booked and detained in the County Juvenile Detention and Assessment Centers (JDACs). **The County had a significantly higher juvenile arrest rate than the rest of the state.**

The lack of early identification (screening, assessment and referral) of **mental health (MH) and alcohol and drug (AOD) problems in the County's juvenile justice population was evident in that only 8% of the County's detained juvenile justice population was identified with MH or AOD problems as opposed to 70% identified in the same population nationwide.**

Many youth are detained and placed in the system for relatively minor, non-violent offenses, but end up engaged in the system because of the lack of community-based mental health and AOD treatment services.

There was a need for a partnership between the Department of Behavioral Health, Probation and the Courts.

Positive Results

1) Reduce recidivism and criminal behavior results:

- Recidivism rate for minors served during Fiscal year (FY) 2011/12 was **15%**.
- Combined sustained allegations decreased during the program by **88%**.

2) Improve family relations through effective communication results:

- Based on family outcome reports administered throughout Functional Family Therapy (FFT) services, youth report a **23.5%** increase in family functioning, after receiving FFT services.

3) Increase school attendance results:

- Prior to entry to the program **28%** of youth enrolled were actively attending school, as a condition of program entry, all youth are required to attend school regularly while in the program.

4) Reduce and/or eliminate substance abuse results:

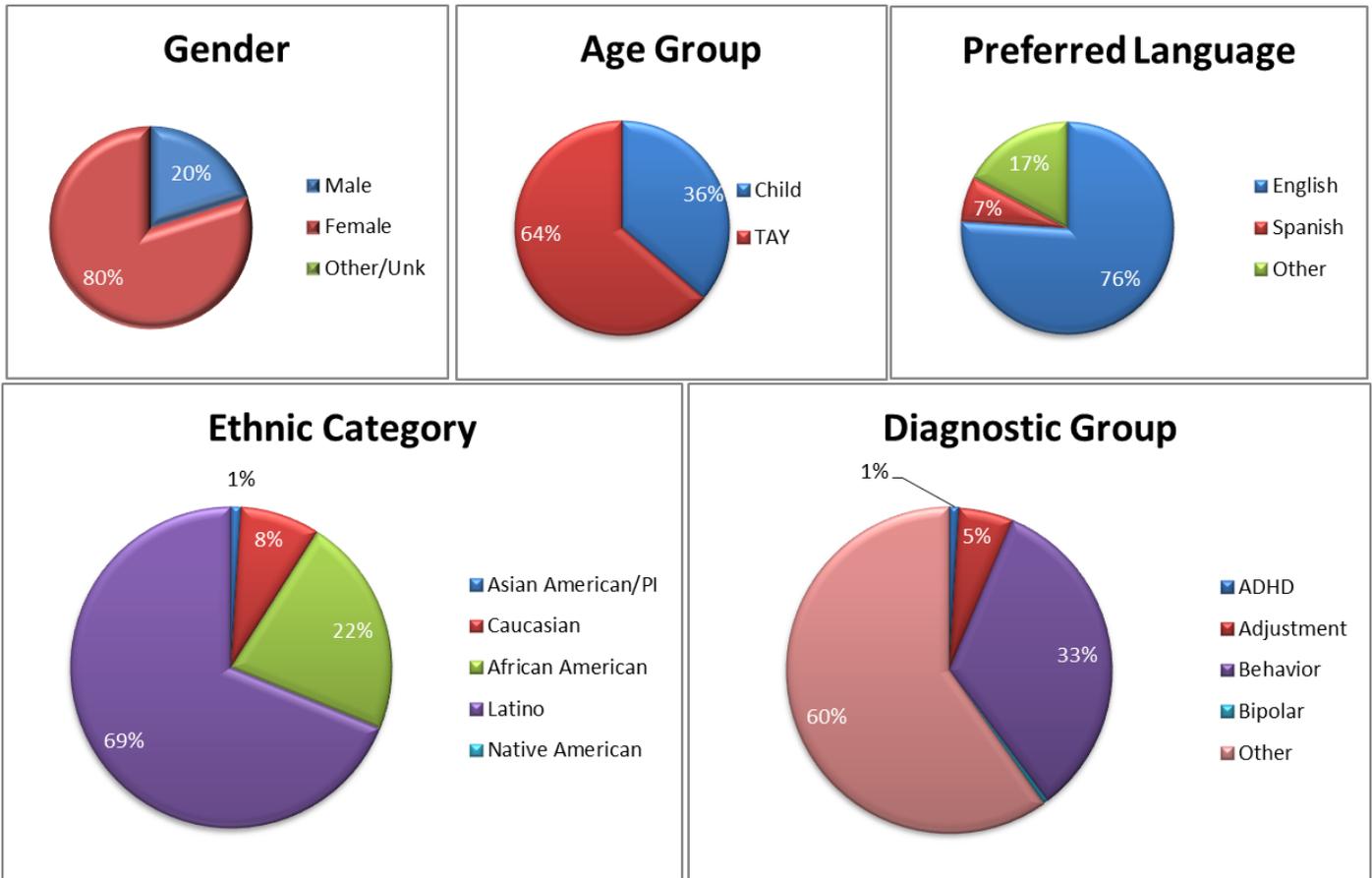
- Prior to entering the program, **76%** of the minors presented with a history of substance abuse. During the course of the program, with drug testing as a regular part of the intervention, only **16%** of the minors continued to use drugs.

5) Reduce cost to the County of San Bernardino results:

- Prior to entering the program, youth had a combined total of **774** days in custody that was reduced to **242** days during the program. A cost savings of **\$138,320**, which is a **69%** reduction in potential costs.

Program Data

During Fiscal Year (FY) 2011/12, INFO demographics were as follows:



Making a Difference

Sam was declared a ward of the court and placed on probation in March 2011, after the court found he had Possession of a Controlled Substance. In April 2011, Sam and his family were accepted into the INFO program. While in the program, Sam and his family received Functional Family Therapy (FFT) and intensive probation supervision. Staff assisted Sam with obtaining his driver's license and completing his resume, which helped him get his first job. In July 2011, Sam and his family graduated the INFO program and he was released from probation as well.

Since Sam's graduation in July 2011, he has completed the MHSA-funded Peer and Family Advocate training program offered through the Department of Behavioral Health (DBH), where he was the youngest person to have successfully completed the program. Currently, he is enrolled and attending community college, majoring in business, and working at a retail shoe store. On October 25, 2012, and February 14, 2013, Sam returned to his humble beginnings, as a SPECIAL GUEST SPEAKER to other INFO graduates who sat in the same place he was just a short time ago.



Challenges

Challenge 1: In the INFO program, **66%** of the minors and families are Latino. Due to the need for bilingual services for many of these families, the program developed a waitlist for Spanish speaking families. While the use of interpreters is helpful in providing intermittent services, families engage better with the program when the clinical therapist is speaking to them in their language of choice.

Challenge 2: Increase evidence-based substance abuse services to minors in program. In Fiscal Year (FY) 2010/11, **55%** of the minors enrolled in the INFO program had a substance abuse concern.



Solutions in Progress

Solution 1: The INFO program was able to hire additional bi-lingual clinical staff, which increased the pool of available clinical therapists to work with the family in their identified language for the duration of their involvement in the INFO program. There is no longer a waitlist for bilingual services for the INFO program.

Solution 2: INFO staff are in the process of implementing Moral Recognition Therapy (MRT), an evidence-based substance abuse treatment strategy that seeks to **decrease recidivism** among juvenile offenders by increasing moral reasoning. Originally developed as a criminal justice-based drug treatment, MRT has been adapted to fit other areas of interest like mental health treatment and co-occurring disorders. A MRT-trained alcohol and drug counselor holds a weekly group session where minors can enter or exit the program at any time, similar to a traditional 12-step program. Currently being piloted in the TAY Center, another MHSA-funded program, the plan is to begin MRT with INFO minors in the Summer of 2013.

In Their Own Words

- ⇒ *"When I first got in the INFO program to be honest I was kinda bored of the sessions we had but then weeks went by and I started getting used to sharing my feelings and emotions. I'd like to thank the INFO program, especially my therapist. When I first met her I thought she had a weird laugh but still she still helped me. I want to thank my probation officers... More importantly I want to thank my mom for never giving up on me. No one gave up on me." Parent of this youth said, "Thank you for giving him the courage to use his words and speak up."*
- ⇒ *"INFO really helped us... We lost communication and they helped us get it back." Parent of this youth said, "I would be going crazy if weren't for INFO helping us move forward".*
- ⇒ *"INFO helped me and my mom communicate more. I'm grateful me and my mom communicate more. We love each other. I'm better in school." Parent of this youth said, "I didn't know how to communicate with my son. INFO helped me."*
- ⇒ *"I never appreciated my mom and now I do. I'm in honors and my therapist helped me out!" Parent of this youth said, "She still acts up but it is NOTHING we can't deal with NOW!"*



Collaborative Partners

The INFO Program would like to acknowledge the support of the following agencies:

Department of Behavioral Health Administration

County of San Bernardino Probation Department

Juvenile Court San Bernardino

County of San Bernardino District Attorney's Office

County of San Bernardino Public Defender's Office

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 Unified School District

County Superintendent of Schools - Youth Services Program

San Bernardino County Museum

Community Action Partnership

Salvation Army San Bernardino

Boys & Girls Club San Bernardino

These agencies helped INFO meet the needs of our families, allowed our minors to perform community service, and assisted with resources for the basic life needs of our families.



MENTAL HEALTH
SERVICES ACT

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

M H S A A N N U A L U P D A T E

F I S C A L Y E A R 2 0 1 3 / 1 4

Service Goals/Outcome Measures

The objectives of Transitional Age Youth (TAY) One Stop Centers are:

- **Reduce** the subjective suffering of serious mental illness.
- **Reduce** homelessness; increase safe/permanent housing.
- **Increase** consumer self-help and family involvement .
- **Increase** access to treatment and services for co-occurring problems; substance abuse and health.
- **Reduce** service disparities for racial and ethnic populations.
- **Reduce** criminal and juvenile justice involvement.
- **Reduce** frequent emergency room visits and unnecessary hospitalizations.
- **Increase** a network of community support services.



County of San Bernardino - Department of Behavioral Health



Promoting Wellness, Recovery and Resilience

Why Were Transitional Age Youth (TAY)

One Stop Centers Created?

Transitional Age Youth (TAY) Centers were created to provide integrated services to transitional aged youth (16-25 years-old) who are unserved, uninsured and homeless or at risk of becoming homeless. Transitional age youth typically have been over-represented in the Justice System and out-of-home placements (foster care, group homes, institutions). The TAY Centers provide a high level of care with services that are gender specific, culturally and linguistically appropriate.

Positive Results

TAY Centers have contributed to savings in community costs by assisting transitional age youth in becoming independent, staying out of the juvenile justice system, and reducing hospitalizations and homelessness.

The new One-Stop TAY facility opened its doors in April 2012. The new building includes a 14-bed crisis residential facility, a multipurpose room, a training kitchen, recreation room, resource center and media education room.

Through an agreement with Workforce Development Department and using MSHA Innovation funding, the department created a summer program to offer system involved youth paid jobs to provide them with valuable job skills and experience. **Over 298 youth were employed.**

Performance Outcomes

The TAY Centers served **308** unduplicated Full Service Partnership (FSP) and **547** System Development youth during Fiscal Year 2011/12. The programs have also **increased** the amount of emergency shelter beds and board & care bed utilization and continue to outreach to **increase** the number of beds available in low-serving areas. Training records also show that consumers are increasingly participating in a number of diverse trainings across the County.

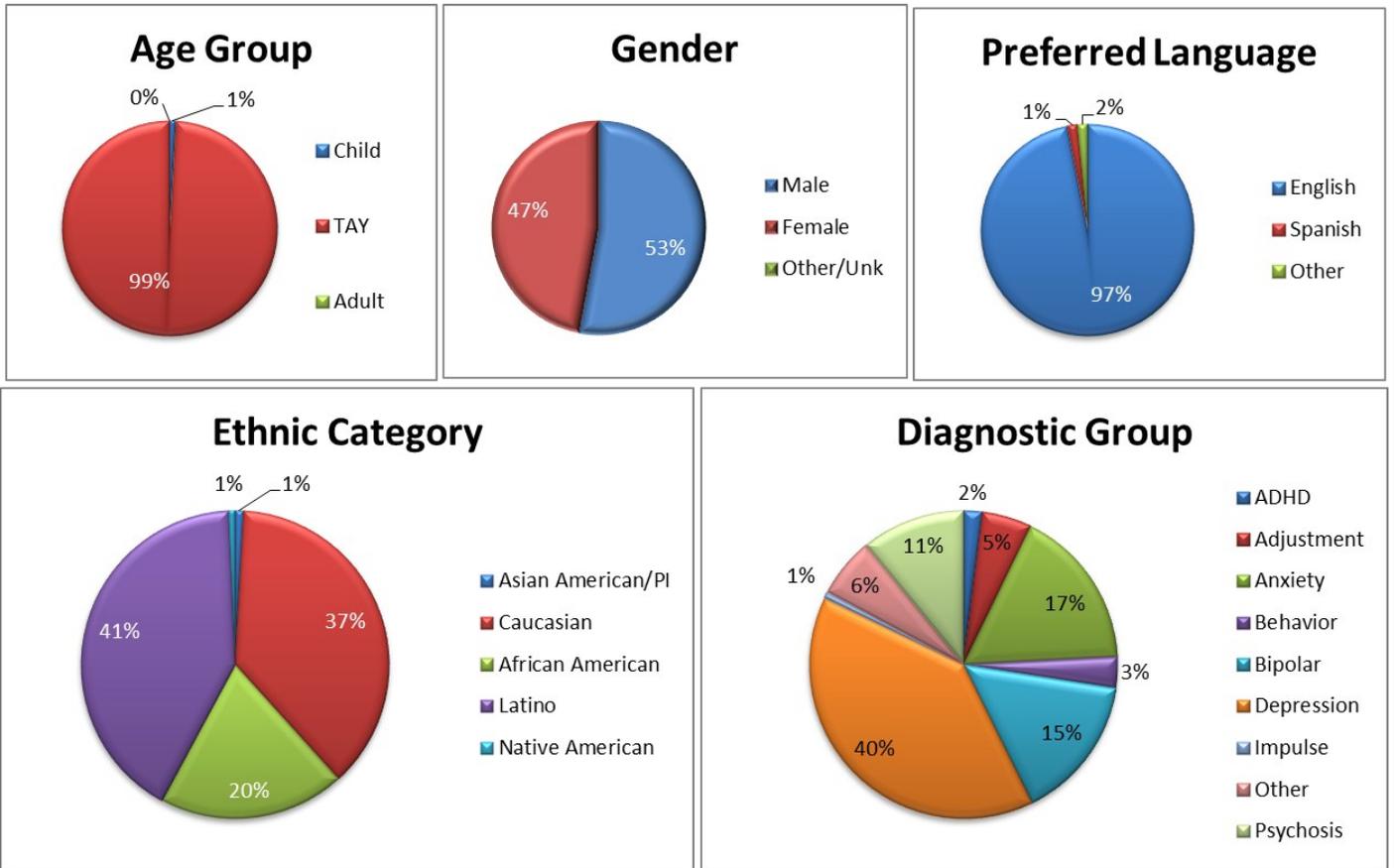
The continued collaboration between the TAY programs and the Probation Department continue to yield positive outcomes. During FY 2011/12 there was a reduction in criminal activity as shown by the Probation Department's records.

Making a Difference

When Derek first started attending the TAY program he barely spoke, did not interact with peers and lacked anger management skills. Through intensive case management and individual and group therapy, the team worked hard on engaging Derek, building his self-esteem and working on his coping and healthy communication skills. Derek began thriving in the program, was punctual to appointments and took a leadership role in the program. Derek is now renting his own place and continues to work with TAY staff on mastering activities of daily living and becoming more independent.

Program Data

During Fiscal Year (FY) 2011/12, TAY demographics were as follows:



Challenges

- There are limited services for system involved TAY to assist in areas of employment, educational opportunities, living situations, community life, medication, mental health, physical well-being, drug and alcohol use, trauma, domestic violence, physical, emotional and sexual abuse.
- Services are still needed to address the specific gender, culture and language of TAY.
- There is still a need for emergency shelter bed services to prepare for entry into the community, as well as a need for qualified housing providers and a lack of available housing throughout the county.
- Community collaboration for long-term employment for TAY remains a challenge.
- The number of individuals without insurance needing medical and dental treatment is still high.

Solutions in Progress

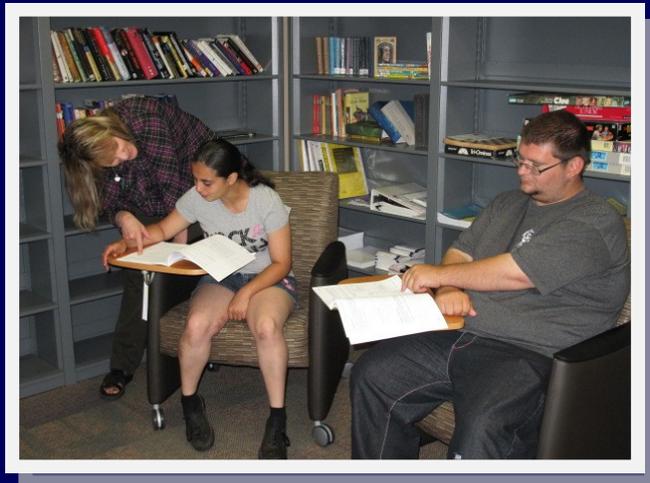
- All TAY Centers continue to work with the TAY Advisory Boards to address the needs and concerns of the TAY.
- Continued efforts are being made to reach the targeted populations of Latino and African Americans that do not have access to appropriate services and are inappropriately served or underserved.
- Continued outreach efforts are being made to establish new emergency shelter beds throughout the county. There is also increased collaboration with Board and Cares to provide housing for TAY clients.
- Continued efforts to assist clients in applying for Social Security and other medical insurance programs.
- In collaboration with the Housing Authority of County of San Bernardino and the County of San Bernardino Department of Behavioral Health Housing and Employment Program, a Request for Proposal was released in November 2011 to refurbish the Phoenix Apartments. This project offers eight (8) units to TAY in San Bernardino County with permanent, affordable housing and an array of services to help them maintain housing and reintegrate into the community.
- The TAY program worked closely with DBH's Innovation Program to develop the Youth Resiliency Team (YRT) Mentoring Program. This program provides intensive mentoring services to underserved and inappropriately served system-involved youth, providing them with tools and techniques to successfully engage enduring and positive relationships, resolve issues/reduce stress related to grief, loss, environmental trauma, exposure to violence, gangs, child abuse, exploitation and successfully transition into adulthood.

In Their Own Words

⇒ *"I was homeless and the TAY center sent me to rehab and gave me housing once I graduated from rehab."*

⇒ *"The TAY center has helped me stay clean and sober and has taught me coping skills."*

⇒ *"The TAY center had helped me overcome my anxiety and feel better about myself."*



Collaborative Partners

Thank you to the ongoing partnerships that enable success for our TAY!

Pacific Clinics

Victor Community Support Services

San Bernardino County Department of Behavioral Health Innovation Program

San Bernardino County Workforce Development Department

TAY-I: TRANSITIONAL AGE YOUTH (TAY) ONE STOP CENTERS



MENTAL HEALTH SERVICES ACT

A-1: Clubhouse Expansion Program

M H S A A N N U A L U P D A T E

F I S C A L Y E A R 2 0 1 3 / 1 4

Service Goals/Outcome Measures

The objectives of Clubhouse Expansion Program are:

- Clubhouses are **recovery oriented centers** for members, 18 years or older that **operate with minimal support from department staff.**
- Peer and Family Advocates and other **consumers assist peers** with issues resulting to overall wellness needs such as:
 - ◊ Employment.
 - ◊ Housing.
 - ◊ Life Skills.
 - ◊ Entitlement Benefits.
 - ◊ Recreation.
 - ◊ Social Support.
 - ◊ Physical Health including education and activities related to diet and exercise.
 - ◊ Promote members integration into the community and increase coping skills.
 - ◊ Provide and facilitate peer-run groups including basic education, money management and crisis management.
 - ◊ Increase members interactions and development of social skills by providing regularly scheduled social and recreational activities both onsite and in the community.
- **Employ a Peer and Family Advocate workforce** to assist consumers to link to housing, benefits, education and employment resources.
- **Assist consumers to make their own choices**, reintegrating into the community as a contributing member and achieving a satisfying and fulfilling life.
- **Provide Wellness, Recovery and Resilience model programs.**



County of San Bernardino - Department of Behavioral Health



Promoting Wellness, Recovery and Resilience

Why Was Clubhouse Expansion Program Created?

Priority issues identified by stakeholders through the community program planning process included:

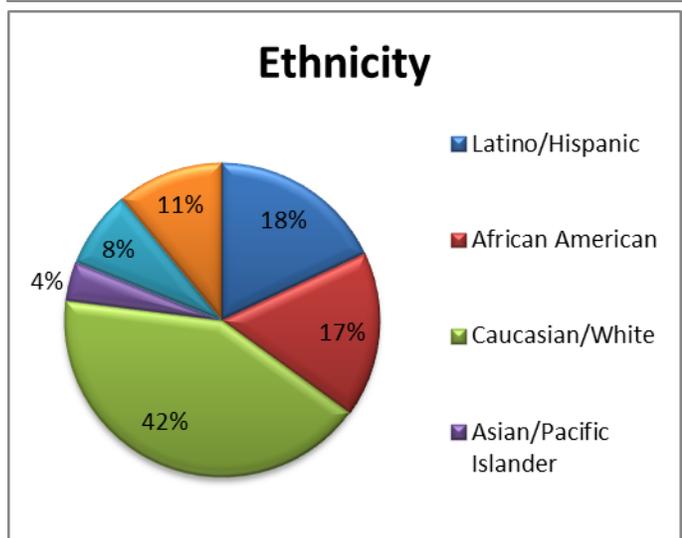
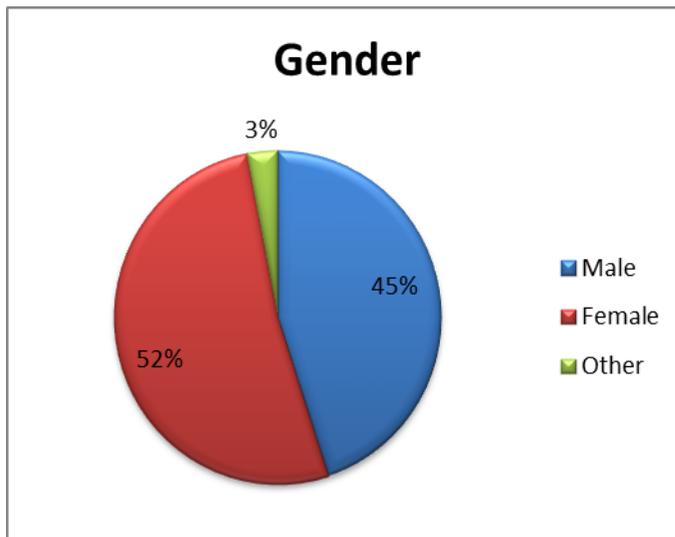
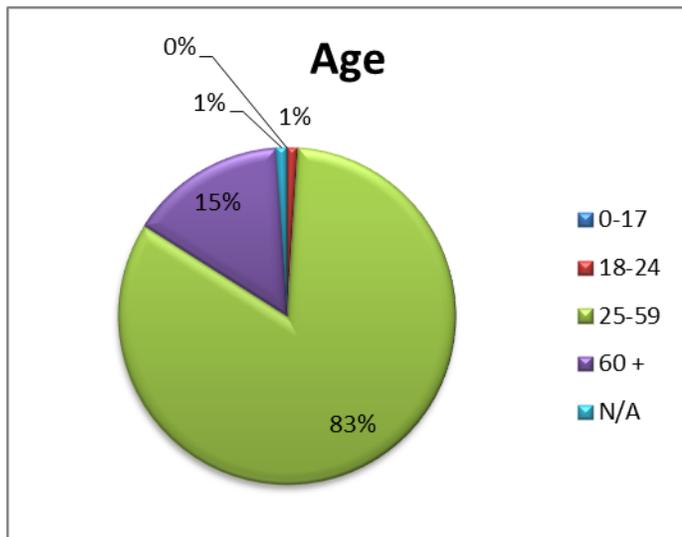
- Stigma and Discrimination.
- Physical well-being in response to reduced life span among individuals with mental health and substance abuse issues.
- Homelessness.
- Frequent hospitalizations and emergency room visits.
- Inability to manage independence.
- Institutionalization and incarceration.
- Isolation.
- Access to care; lack of transportation.

Positive Results

- Collectively up to **26** groups are run per clubhouse per week.
- Average daily attendance ranges from **20 to 44** members per day per clubhouse.
- Addition of five (**5**) Peer and Family Advocates in this reporting period with an additional Peer and Family Advocate being increased from part-time to full-time.
- A wellness component has been added which includes nutrition, exercise, and support for health related issues e.g. smoking cessation classes and partnership with 24 Hour Fitness to offer weekly fitness classes on site.
- Focused on community integration and awareness through the implementation of annual community service projects.
- Emphasis on partnership between county and contract operated clubhouses in order to broaden the peer support network.
- Identification and education on utilization of community resources to foster independent living.
- Through clubhouse participation, consumers are provided transportation assistance with the use of program vans and distribution of bus passes to ensure they can attend doctor, legal and program appointments and participation in community events.
- The Office of Consumer and Family Affairs is operated by a consumer and a family member with the long term goal of supporting, coordinating and advocating for system wide Recovery Model planning and implementation.
- Consumers are in charge of activities including running numerous groups, staffing the reception area, operating a clothes closet, cooking and engaging peers in recreational activities.

Program Data

Of the participants who attended the nine (9) Clubhouse Program Evaluation focus groups throughout the County of San Bernardino, **132** people completed a comment form. The participant demographics are broken down by age, gender and ethnicity.



Making a Difference

⇒ *"I was diagnosed with severe depression in 2006. I made three attempts to end my then miserable life. Thank God all three failed. I had reached the end of my rope in November of 2007, and I was thinking about trying for a fourth time. I walked into Upland Behavioral Health and asked for help. Everything was a blur at that time but I was seen right away. I was also diagnosed with severe anxiety and post-traumatic stress disorder (PTSD). The doctor got me into a men's therapy group and with the help of the group and the doctor my recovery began. I began just sitting there listening to other members talk and realized I wasn't alone in my journey toward recovery. Before long I was helping other members in the same manner that I was helped. I began volunteering my time to the clubhouse and members. I noticed that if I worked real hard for my recovery I could succeed. I look back at where I was when I was first diagnosed. I have never been happier with my life than now."*

Challenges

The Clubhouse Expansion program has faced some of the same challenges other peer run programs throughout the state have faced. Challenges include:

- Stigma and discrimination.
- Access to transportation.
- Ongoing evaluation of clubhouse programs to identify challenges and/or issues that need to be addressed and measure consumer satisfaction with clubhouse operations.
- Navigating restrictive policies when hiring consumer employees.
- Ongoing and specialized training for consumer employees.

Solutions in Progress

- Ongoing staff and community trainings are being conducted surrounding anti-stigma initiatives.
- The Clubhouse Expansion program utilizes bus passes, community transportation agencies and clubhouse vans to address transportation challenges.
- There were **144** individuals who participated in focus groups throughout the County of San Bernardino. The groups discussed important and challenging topics and individuals shared their opinions largely without reservation. **89%** of those filling out a comment form identified the program to be valued and a great place to be a member and belong. Improvements were also identified and a plan was put in place to work collaboratively with consumers and staff to address those needs.
- DBH Human Resources has worked extensively to ensure that consumers are able to gain employment through the county and navigate the hiring process.

In Their Own Words

- ⇒ *“Being at the clubhouse helps me identify, relate and socialize with others.”*
- ⇒ *“Attending the clubhouse is a therapeutic experience that helps me feel healed and cured.”*
- ⇒ *“Helps me to maintain my goals and provides the social support that I need.”*
- ⇒ *“Coming to the clubhouse has kept me off the streets and out of jail. It gave me a fresh start and now I am involved and a productive member of the clubhouse.”*
- ⇒ *“Helps to keep me out of the hospital, out of the house and off the streets.”*



A-1: CLUBHOUSE EXPANSION PROGRAM

County of San Bernardino Clubhouses

A Place to Be

805 E. Mt. View
Barstow, CA 92311
(760) 256-5026

TEAM House

201 W. Mill St.
San Bernardino, CA 92408
(909) 386-5000

Santa Fe Social Club

56020 Santa Fe Trail, Suite M
Yucca Valley, CA 92284
(760) 369-4057

Amazing Place

The Upland Social Club
934 N. Mountain Ave., Suite C
Upland, CA 91786
(909) 579-8157

Our Place

721 Nevada Street, Suite 205
Redlands, CA 92373
(909) 557.2145

Victor Valley Clubhouse

12625 Hesperia Rd., Suite B
Victorville, CA 92392
(760) 955-6224

Central Valley FUN Clubhouse

1501 S. Riverside Ave.
Rialto, CA 92376
(909) 877-4887

Harmony Clubhouse

82820 Trona Rd, Suite A
Trona, CA 93562
(760) 372-4843

Pathways to Recovery

850 E. Foothill Blvd.
Rialto, CA 92376
(909) 421-9248

Someplace to Go

32770 Old Woman Springs Rd, #B
Lucerne Valley, CA 92356
(760) 248-6612



MENTAL HEALTH SERVICES ACT

A-2: Forensic Integrated Mental Health Services

MHSA ANNUAL UPDATE

FISCAL YEAR 2013/14

Service Goals/Outcome Measures

The objectives of Forensic Integrated Mental Health Services are:

A. Mental Health Court (MHC)

- A specialized docket in which defendants with mental illness are diverted into judicially supervised, community-based treatment.
- These courts are designed to shift the seriously mentally ill away from the criminal justice system and into the mental health system.
- Maintain seriously mentally ill individuals in the least restrictive environment possible, consistent with their personal and community safety.

B. Forensic Assertive Community Treatment (FACT) Program

- **Reduce recidivism** (jail and psychiatric hospitalization).
- **Increase public safety** through focusing on information choice and decision making.
- **Increase community tenure** through development of independent living skills and providing appropriate array of services and support.
- **Support persons in recovering their lives** and roles by rekindling hopes and dreams and assisting with reunifying them with their families.

C. Crisis Intervention Team (CIT) Program

- **Help** law enforcement officers enhance their understanding, judgment, competence, physical safety, and the safety of others when responding to situations involving those with a mental illness.
- **Improve** positive police and mental health system collaboration and communication.
- **Decreased** repeat calls for service and reduced recidivism.



County of San Bernardino - Department of Behavioral Health



Promoting Wellness, Recovery and Resilience

Why Was Forensic Integrated Mental Health Services Created?

A. Mental Health Court (MHC)

Mental Health Courts began to be established throughout the United States pursuant to federal legislation and funding in the late 1990's. San Bernardino was one of the first counties to have such a program, beginning in 1999. With the growing community concern for more effective treatment of mentally ill offenders, the Mental Health Court system has greatly expanded in the last decade, both nationally and at the local level.

The County of San Bernardino currently has five (5) mental health courts located in the cities of San Bernardino, Rancho Cucamonga, Barstow, Victorville and Joshua Tree. Morongo Basin Mental Health Services is the treatment provider for Joshua Tree. **The Supervised Treatment After Release (STAR) program** is the treatment provider for the remaining four (4) courts.

B. Forensic Assertive Community Treatment (FACT) Program

In 2007, in order to provide a variety of mental health treatment options to meet the needs of probationers with mental illness, San Bernardino County funded a new treatment program based on the well-researched Assertive Community Treatment (ACT) Model to complement their existing innovative programs. Since ACT programs are community based, individuals who have trouble keeping appointments at outpatient clinics are seen at their homes weekly or whenever necessary, **including by a psychiatrist who makes home visits to those who can't make it into the office.**

C. Crisis Intervention Team (CIT) Program

The County of San Bernardino Mental Health and Criminal Justice Consensus Committee which includes, but is not limited to, members from the Department of Behavioral Health (DBH) and the Sheriff's Department identified the need to provide extensive training to law enforcement as first-line responders to crisis calls in which mental health issues are identified or suspected. CIT is a national program; the County of San Bernardino DBH adopted the core principles and tailored the program to the needs of its community.

The CIT program was brought about in an effort to combat increases in the following local factors, officer involved use of force, officer involved shootings, litigation, post-traumatic stress disorder in officers, and closure of state mental hospitals.

The core objective of training law enforcement and other County departments about mental illness is to identify those with mental illness early in the booking process and develop relationships and partnerships between County departments and mental health providers that foster improving services for those with mental illness.

Positive Results

A. Mental Health Court (MHC) - (Morongo Basin Mental Health and STAR Program)

The Mental Health Court program continues to see success with clients moving from custody to active participation and completion of the program. The program has shown successes during Fiscal Year (FY) 2011/2012 as evidenced below in the outcomes of clients. This is accomplished with direct supervision in cooperation with Probation, the Mental Health Treatment Team, the Drug and Alcohol Treatment Team, and the Mental Health Court. Active involvement includes group participation therapy (both individual and family), case management and participation in outside programs to provide assistance with teaching the activities of daily living and a safe environment to foster success.

In comparison to pre-enrollment levels, client participating in the STAR program have shown:

- **67%** decrease in per year in jail days.
- **74%** decrease in per year in hospital days.
- Throughout participation in the program, (typically 1.5 to 2 years) homelessness for all participants decreases to 0%, since the program facilitates or provides housing for all clients.
- In 2009 the STAR program received the Best Practices Award from California's Council on Mentally Ill Offenders. The Council was created by California legislation in 2001, in part to identify and encourage effective mental health programs.
- The STAR program has continued to grow, and in FY 2011/12 the program graduated or completed a **total of 51 clients**.

B. Forensic Assertive Community Treatment (FACT) Program

For the period of 7/01/09—6/30/12,

- Staff provided services to **136** unduplicated clients.
- Staff assisted **43** clients in completing probation

Compared to the year prior to their enrollment in the program:

- Clients decreased by **73%** their number of days spent in jail.
- Clients have decreased by **80%** their number of hospital admissions.
- Since 7/1/2009 clients have an **85%** drop in homeless days.

C. Crisis Intervention Team (CIT) Program

- Increased officer awareness of an ability to access appropriate community resources.
- Increased officer safety and safety of those in crisis.
- **90%** of those seen by CIT officers access mental health services.
- Time savings to patrol officers.
- Successful collaboration with Behavioral Health and police communities which has led to positive community relations as a whole.
- In FY 2011/12 **179 law enforcement officers were trained**.



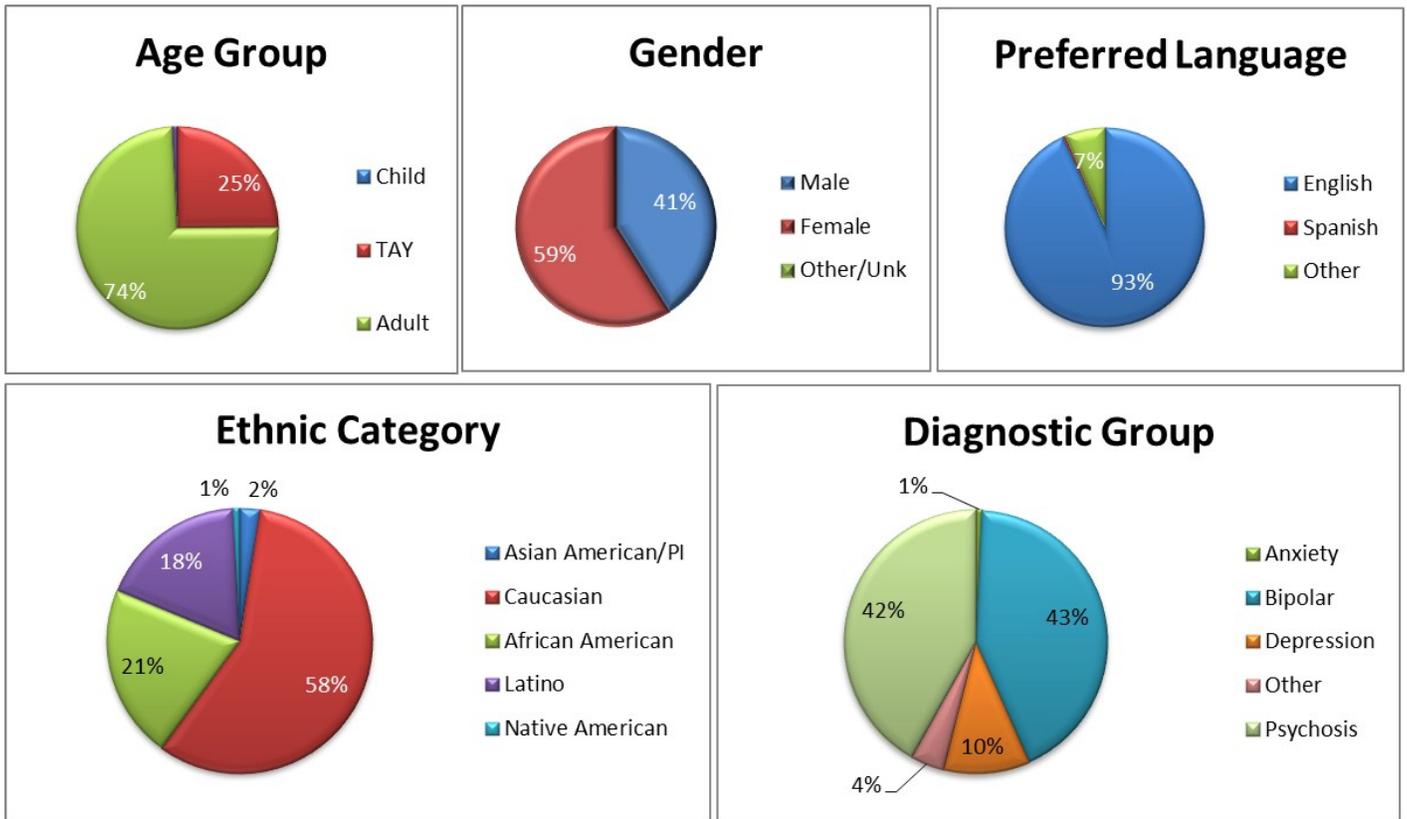
Making a Difference

A 29 year old, Indian-American woman received an opportunity to change her life when her Public Defender identified that she was in need of specialized treatment for her mental illness and substance abuse issues, and referred her to Mental Health Court. Upon acceptance into treatment for her co-occurring conditions, she was able to move from jail, to inpatient drug and alcohol services, to sober living facilities in the community, and finally to her own apartment. Today she is clean and sober and has not re-entered a psychiatric hospital or been remanded back to jail. She works full-time in the community and has re-established a positive relationship with her three children. She credits individual and group therapy, accountability and supervision from the court and probation, prescribed medications, multiple spiritual experiences, 12-step Recovery and her sponsors, for the accomplishments she has achieved.

A-2: FORENSIC INTEGRATED MENTAL HEALTH SERVICES

Program Data

During Fiscal Year (FY) 2011/12, Forensics demographics were as follows:



Challenges

Challenges continue to center largely on:

- **Homelessness and Appropriate Housing**
 - ◊ Maintaining a satisfactory broad resource base of accredited facilities.
 - ◊ Dealing with patients conflicts centering on residential issues and changes.
- **Financial Assistance**
 - ◊ Obtaining SSI for those clients who qualify for it.
 - ◊ Dealing with the resistance in awarding benefits for those clients who have co-occurring conditions.
- **Employment**
 - ◊ For those who are able to work, dealing with stigmas in the community regarding those with criminal records.
 - ◊ Complications with occupational training
- **Continuing Coordination with the Criminal Justice System**
 - ◊ Communication between law enforcement, probation, the courts and treatment facilities.
 - ◊ Training and attrition of law enforcement personnel.

Solutions in Progress

- Negotiating client housing has become a specialty for STAR case managers.
- The Mental Health Court (MHC) team has taken an active role in locating, and securing with the assistance of the mental health service, client appropriate, local area shelters that are stable and willing to be part of the treatment teams.
- Increase wellness activities for members and encourage the addition of wellness goals on treatment plans, such as developing a plan for exercise and addressing physical health issues by scheduling doctor appointments with primary care physicians.
- Also, begin a “Bicycle Scholarship: Incentive Program where members could receive financial assistance with purchasing bicycles.
- Increase promotion of employment as a recovery tool to members, either as a part or full time activity. Goal is to assist 3-5 members in developing and implementing an employment goal.
- Increase promotion of attending school, getting GED, or volunteer work as a recovery tool to members either as a part time or full time activity.
- Continue to assist clients with harm reduction behaviors that lead to recidivism, i.e. substance abuse, and criminal behaviors.
- Continue to find appropriate housing and provide financial assistance that will help the client in their recovery.
- Continue to locate employers that are willing to give clients a chance at employment.
- Both the CIT coordinator and the Program Manager II are now part of the internal Crisis Intervention Team Committee for the County of San Bernardino Sheriff’s Department. The Sheriff’s Department recognized the significance of CIT and integrated it into their basic academy. The basic academy is also

In Their Own Words

A. Mental Health Court (MHC)

STAR Program (Rancho Cucamonga, San Bernardino, Victorville, Barstow):

- ⇒ *"I get better when I follow program directions. When I do it my way it doesn't work and I get paranoid, start using, and go to jail again."*
- ⇒ *"I thought I was the only one. In the program I've found people who are like me, have some of the same experiences, and staff who care."*
- ⇒ *"I am learning better boundaries. I'm learning about my mental health symptoms and how to manage them. This makes me safer to myself and around other people."*

Morongo Basin Mental Health (Joshua Tree):

- ⇒ *"When I came into Joshua Tree Mental Health Court I was facing eight years in prison. Now I am off probation and on my way to becoming an AOD Counselor."*
- ⇒ *"I am so grateful for the Joshua Tree Mental Health Court. It saved my life!"*
- ⇒ *"Thanks to Joshua Tree Mental Health Court I have my life back. I take my meds as prescribed and stay clean and sober. I feel good about myself."*

B. Forensic Assertive Community Treatment (FACT) Program

- ⇒ *"Telecare is a good place for me because it keeps me in a good sense of mind. It helps me to live again."*
- ⇒ *"I thank Telecare for filling me with life once again. Telecare saves. I can smile once again."*
- ⇒ *"Telecare is awesome due to all the help they are giving us and giving us a new life. I can call them morning, noon or night and they are always there; they are my family."*

C. Crisis Intervention Team (CIT) Program

- ⇒ *"I like the fact that the class also focused on the mental health issues that we as officers must deal with and giving us the resources on how to take care of ourselves and partners."*
- ⇒ *"I am thankful for the opportunity to engage openly with individuals with mental illness when they are not in crisis—my first chance to share and appreciate their personal stories."*
- ⇒ *"I never knew these resources existed. This course should be required for all law enforcement."*
- ⇒ *"As law enforcement we are exposed to so much. It's important we take care of our own mental health and I am glad this class provided resources for us too."*

Collaborative Partners

Thank you to all of our partners!

Alzheimer Association
Behavioral Health Commissioners
Cedar House Life Change Center
Coalition Against Sexual Exploitation (CASE)
County of San Bernardino Department of Behavioral Health presenters and guest speakers
County of San Bernardino Sheriff Department
Department of Behavioral Health Clubhouse Members
Department of Behavioral Health Community Crisis Services
Department of Behavioral Health Peer & Family Advocates
Department of Probation
Inland Regional Center
Inland Valley Recovery Services
Institute for Public Strategies
Joshua Tree Department of Probation
Joshua Tree Panorama Residential Services
Joshua Tree Superior Court
Loma Linda Veteran's Affairs Healthcare System
Morongo Basin Clinical Treatment Teams
Morongo Basin Drug Court
Morongo Basin Rockin'
National Alliance on Mental Illness
Office of the District Attorney
Office of the Public Defender
Patton State Hospital
San Bernardino County Sheriff Department
San Bernardino County Superior Court
The Counseling Team International
Veteran's Center of Colton

Telecare San Bernardino FACT program would like to acknowledge the leadership in the Department of Behavioral Health for their support and guidance as well as for the collaboration with West Valley Detention Center, San Bernardino Superior Courts, and the treatment teams in the Mental Health Court.



MENTAL HEALTH SERVICES ACT

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

MHSA ANNUAL UPDATE

FISCAL YEAR 2013/14

Service Goals/Outcome Measures

The objectives of Members Assertive Positive Solutions (MAPS) / Assertive Community Treatment (ACT) are to:

- **Provide assertive case management and support**, 24/7 for those transitioning from locked facilities, including State Hospitals and Institutions for Medical Disease (IMD).
- **Provide intensive services** to **100** seriously and persistently mentally ill and those with co-occurring disorders.
- **Provide FSP services** to individuals from long term locked facilities.
- **Provide** a program that will place and work with those in placements (Board and Care, living with families, and in independent living) to maintain individual's recovery in the community.
- **Decrease** the number of mentally ill frequent users of acute psychiatric hospitalization.
- **Reduce** those caught in the cycle of arrest for minor crimes and the mentally ill/co-occurring diagnosed individuals who are repeatedly incarcerated.
- **Coordinate services** in partnership with families, probation, parole, providers of acute care and agencies that work with homeless mentally ill.
- **Include services** to support sober living, safe havens, transitional shelters, and permanent housing.
- **Preparation** for consumers to pursue further education, training, job search and employment.
- **Ensure** appropriate psychiatric services.



County of San Bernardino - Department of Behavioral Health



Promoting Wellness, Recovery and Resilience

Why Was Members Assertive Positive Solutions (MAPS) / Assertive Community Treatment (ACT) Created?

Historically, there have been a large number of consumers that were utilizing the emergency services and acute psychiatric hospitalization to meet their psychiatric needs. In addition, many mentally ill / co-occurring consumers were caught in the cycle of arrest and incarceration for minor crimes on a repeated basis. The Telecare ACT program was developed to provide intensive case management services 24/7 to maintain those with these issues in the community and provide a system of care to those ready to transition from a locked facility into a lower level of care. There are often minimal support systems for these individuals or continued family contacts. These consumers are often homeless or at risk of being homeless.

The need for the Assertive Community Treatment (ACT) program was developed because of the following:

- Increased number of homeless and severely and persistently mentally ill utilizing acute hospitalization as a main method of accessing treatment services.
- Increase in the number of homeless consumers not receiving treatment.
- Lack of transitional placements providing these intensive services for those being released from a locked facility (State hospital and Institutions for the Mentally Ill (IMD)).



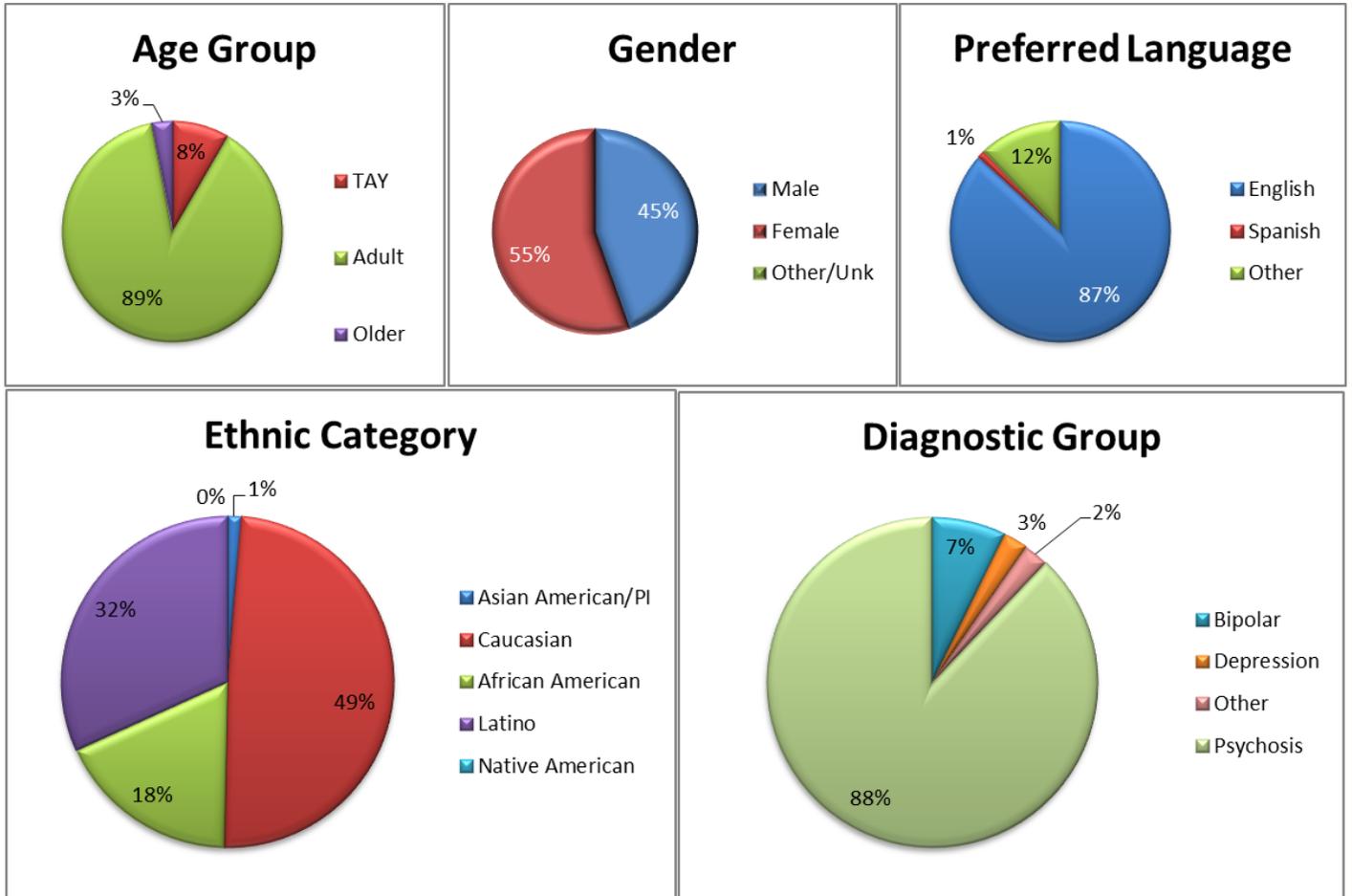
Positive Results

- Intensive services for **100** individuals transitioning from long term locked facilities, including State Hospitals and Institutions for Medical Disease (IMD).
- Intensive services provided 24/7 to maintain the mentally ill and those with co-occurring disorders in the community from long term locked facilities.
- Placement services for individuals transitioning from long term facilities.

A-3: MEMBERS ASSERTIVE POSITIVE SOLUTIONS (MAPS) / ASSERTIVE COMMUNITY TREATMENT (ACT)

Program Data

During Fiscal Year (FY) 2011/12, MAPS/ACT demographics were as follows:



A-3: MEMBERS ASSERTIVE POSITIVE SOLUTIONS (MAPS) / ASSERTIVE COMMUNITY TREATMENT (ACT)

Making a Difference

Tim came to the ACT program while residing in an Institution for Mental Disease (IMD). His goal was to become more independent and to eventually have his own apartment. Tim was discharged from the IMD to a board and care and showed difficulties following rules, anger management issues and substance abuse. The ACT team continued to work with him on his coping skills to decrease his anger and to increase his socialization skills with the support of the board and care and the ACT team, Tim started a daily routine and started working on achieving his goals. He attended classes at the local adult school and utilized the public transportation system to become more independent in the community. After the member terminated from conservatorship, he moved to an apartment and is now working with the ACT team on his budget skills. He is trying to go back to school to receive his GED and has improvement in managing his mental health related issues.

Challenges

- The effects of stigma on those who need to utilize mental health services .
- Consumers often show signs of reluctance and are uncomfortable going back out into the community.
- The presence of substance abuse along with mental illness.
- The absence of enough community placements (board and care facilities) to refer the consumers coming out of the locked facilities.

Solutions in Progress

- Coordination with state hospitals and IMD's to ensure the ACT program has sufficient information to place individuals from locked facilities in successful placements.
- Increased specialized training for staff of the Telecare ACT program to work with the severely mentally ill and those with co-occurring disorders.
- Increased hiring of master level staff to effectively provide the treatment intervention services.
- Education of consumers regarding their program and services to assist them as they transition back into the community.
- Coordination with the housing programs to help consumers be able to have a stable secure living situation.

In Their Own Words

- ⇒ *"I'm grateful for all that the ACT team has done for me."*
- ⇒ *"ACT is the reason why I'm stable in the community."*
- ⇒ *"ACT is there for me when I don't feel good."*



Collaborative Partners

Department of Behavioral Health

Telecare

State Hospital and Institution of Mental Disease Gatekeeping Team

Arrowhead Regional Medical Center

Public Guardians Office

Conservatorship Investigation Unit

State Hospital and Institution of Mental Disease Programs and Staff

A-3: MEMBERS ASSERTIVE POSITIVE SOLUTIONS (MAPS) / ASSERTIVE COMMUNITY TREATMENT (ACT)



MENTAL HEALTH SERVICES ACT

Community Crisis Services A-4: Crisis Walk-in Centers and A-6:Community Crisis Response Team

MHSA ANNUAL UPDATE

FISCAL YEAR 2013/14

Service Goals/Outcome Measures

The objectives of Community Crisis Services are:

- **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.
- **Increase** consumer access to services.
- **Provide** Crisis Intervention services in the community in response to traumatic events utilizing the Trauma Resiliency Model (TRM).



County of San Bernardino - Department of Behavioral Health



Promoting Wellness, Recovery and Resilience

Why Were Crisis Walk-in Centers and Community Crisis Response Teams Created?

- Outlying areas of the largest geographic county in the contiguous United States had no alternatives for mental health crisis other than hospital emergency departments or calls to law enforcement to place a person in crisis on a psychiatric hold.
- Law Enforcement personnel would spend 4 - 8 hours on psychiatric emergencies, delaying an officer's return to the community due to transporting mental health consumers to a hospital, up to 200 miles away.
- Hospitalization occurred in psychiatric hospitals miles from family and support systems.
- Community members from all walks of life were ending up in an emergency room, because they didn't know where else to go, resulting in hospital emergency department overload.
- A person experiencing a psychiatric emergency was often in an inappropriate service location, such as, emergency rooms, law enforcement agencies, correctional facilities and homeless shelters.

Positive Results

Community Crisis Services (CCS) has **increased availability of resources and access to services** for mentally ill community members in crisis. By providing these services individuals are helped in community settings with an appropriate level of care, thus avoiding unnecessary hospitalization. CCS has also increased collaboration among law enforcement, Department of Aging and Adult Services, Children and Family Services, and hospital emergency departments.

In **Fiscal Year 2011/12** the Community Crisis Response Team (CCRT) received a total of **7,898** calls. Of those 7,898 calls, **4,209 were crisis calls and 3,689 were referral & linkage calls**. Out of those 4,209 crisis calls, **CCRT diverted 2,015 clients from hospitalization**.

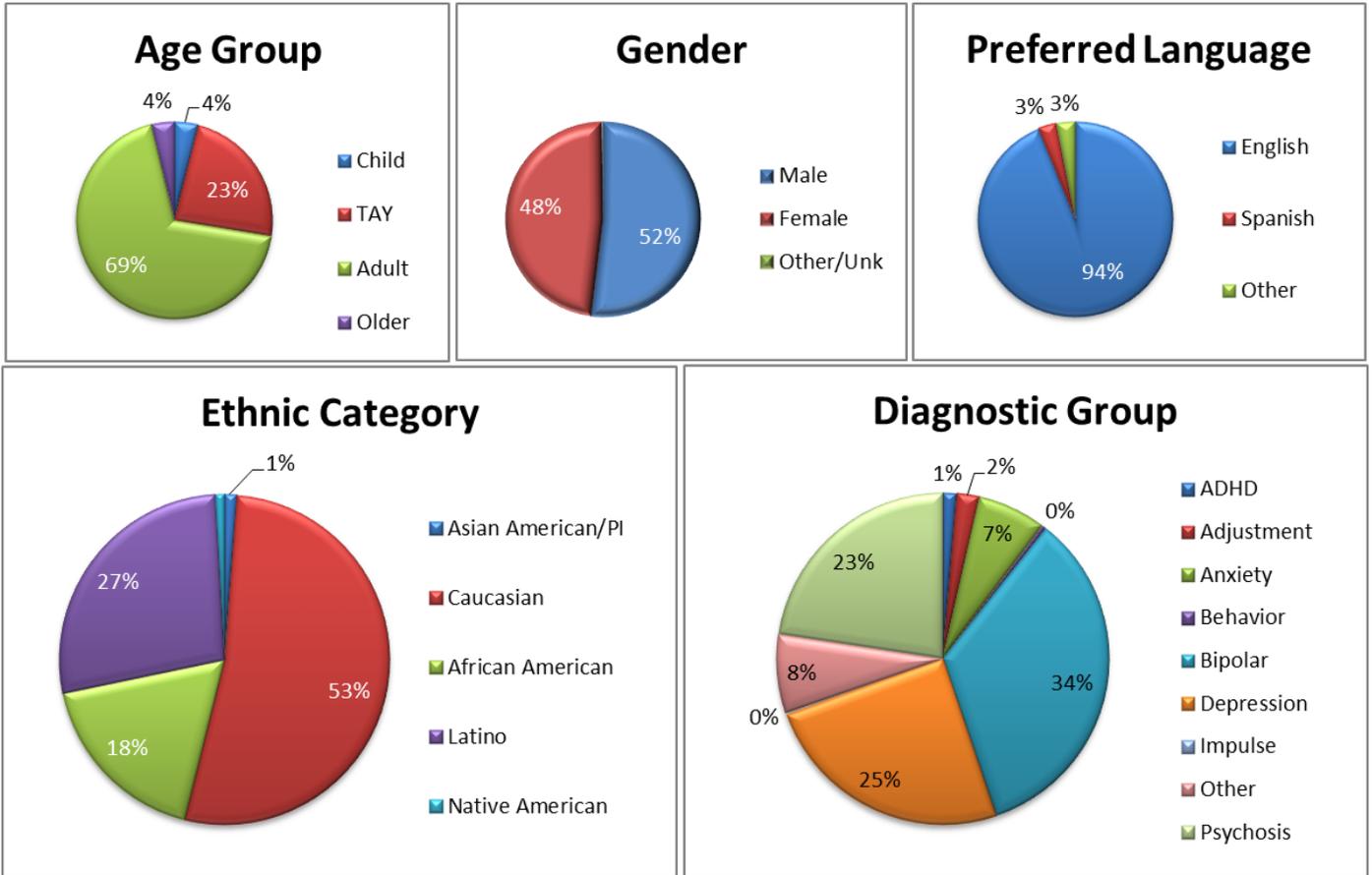
In **Fiscal Year 2011/12** the Crisis Walk-in Center (CWIC) provided services to a total of **8,854** clients. Out of those 8,854 clients, **CWIC diverted 8,489 of them from hospitalization**.

The positive outcomes CCRT and CWIC achieved by reducing inappropriate hospitalizations directly affect hospitalization costs in our communities. In **Fiscal Year 2011/12** CCRT and CWIC diverted a combined total of **10,504** individuals from hospitalization. The number of individuals diverted from hospitalization is 10,504, and the average daily bed rate is \$625.

Program Data

A-4: CWIC

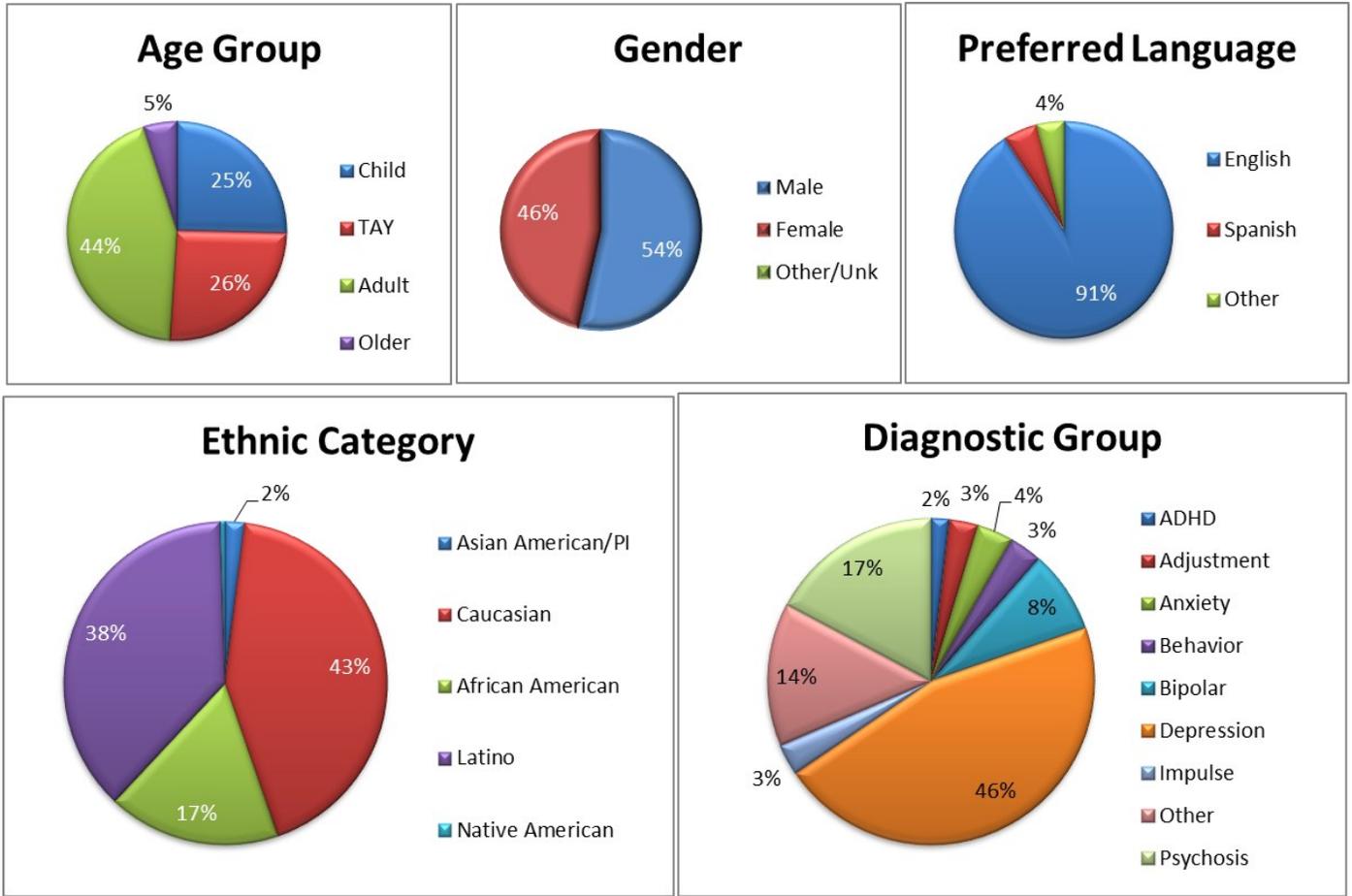
During Fiscal Year (FY) 2011/12, CWIC demographics were as follows:



Program Data

A-6: CCRT

During Fiscal Year (FY) 2011/12, CCRT demographics were as follows:



Making a Difference

Rick had been discharged from a forensic facility in Central California and was traveling by train to San Bernardino, was experiencing hallucinations and needed medication. He came to a hospital emergency room and CCRT was called out to assist him, as he did not meet criteria for hospitalization, but needed outpatient psychiatric services. CCRT staff transported Rick to the DBH Crisis Urgent Care, where he received a psychiatric evaluation and obtained needed medications. CCRT secured a shelter bed for him and transported him to the shelter. Rick was grateful for the assistance as he was able to obtain his medication and avoid an unnecessary hospitalization. The Emergency Room (ER) staff expressed their appreciation for the effective team work that provided services in a less restrictive setting and avoided hospitalization or an extended stay in the already impacted ER.



Challenges

CCRT has experienced significant staffing shortages, necessitating extra shifts to continue to provide 24/7 coverage. The teams face challenges with the County of San Bernardino's large geographical size, which can make for longer response times when responding to calls. The desert region lacks psychiatric inpatient services, which necessitates long distance travel and staff time to bring consumers to psychiatric hospitals. The increased need for mental health services combined with the decreased commercial health coverage and services has led to an increase in acute psychiatric emergencies.

Solutions in Progress

CCRT are in the process of hiring new staff with the goal of maintaining fully staffed teams and easing the work load for existing staff.

CCRT East Valley is currently assisting the Big Bear Sheriff's Department during daytime hours with transporting clients to emergency services.

CCRT staff in the High Desert region work closely with Law Enforcement to coordinate transportation of consumers to appropriate services in a timely manner. This collaboration works well for both agencies and most importantly for the consumers served.

CCRT provides outreach to schools, Police/Sheriff Briefings, Public Health and Department of Family Services, Job Corps and many other entities to collaborate and build community partnerships.



In Their Own Words

- ⇒ A minor female runaway said, *"I really appreciate what you guys did for me, you are kind and patient. I didn't think anyone would want to help me get home,"* regarding CCRT services that assisted at the San Bernardino Police Department.
- ⇒ The family of an adult woman living with her parents stated, *"We didn't know there were services like this, we were worried she would be arrested and go to jail. Thank you so much, she is taking her medication now and we are very happy,"* when assisted by CCRT in obtaining her necessary medications.

Collaborative Partners

Community Crisis Services wishes to thank our partners!!

CCRT and CWIC work closely with many community partners, including law enforcement, schools, other DBH programs and clinics, hospital emergency departments, Department of Aging and Adult Services, Department of Children and Family Services, Probation, Code Enforcement, community-based organizations, and individual community members and their families.





MENTAL HEALTH
SERVICES ACT

A-5: Psychiatric Triage Diversion Program

M H S A A N N U A L U P D A T E

F I S C A L Y E A R 2 0 1 3 / 1 4

Service Goals/Outcome Measures

The objectives of Psychiatric Triage Program Diversion are:

- **Screen and assess** individuals presenting to Arrowhead Regional Medical Center (ARMC) Psychiatric Triage to determine reason for Emergency Room visit.
- **Redirect clients** who need treatment to community-based services that appropriately meet their needs.
- **Help prevent** unnecessary and/or inappropriate inpatient hospitalizations.
- **Provide** crisis intervention services.
- **Provide** case management services, community-based placements, advocacy services, linkage to treatment options, education and assistance with transportation services for community members.



County of San Bernardino - Department of Behavioral Health



Promoting Wellness, Recovery and Resilience

Why Was Psychiatric Triage Diversion Program Created?

Approximately **40%** of individuals presenting to Arrowhead Regional Medical Center (ARMC) Psychiatric Triage Unit were in need of other services other than inpatient psychiatric treatment. These needs included, but are not limited to:

- Prescription refills.
- Housing assistance.
- Substance abuse assistance.
- Food assistance.
- Domestic violence issues.
- Social crisis.
- Health care services.
- Information regarding the availability of outpatient psychiatric care.

The Psychiatric Triage Diversion Program (Diversion Team) was created to address and minimize inappropriate and/or unnecessary admissions to the inpatient unit as well as provide a service option for the needs of individuals **who do not require inpatient treatment**.



Positive Results

The Diversion unit was begun with a target number of approximately **900** clients a year or **75** individuals per month. Currently, the program has seen as many as **450 clients a month**. During Fiscal Year 2011/12 a total of **3757** clients were served by the diversion Team. An average of **78% of these clients (2934) were successfully diverted to appropriate outpatient or community based services**.

Reducing the number of clients on the ARMC Triage unit assists in providing a safer environment for both the community and staff and better health care for our community members who may need psychiatric services.

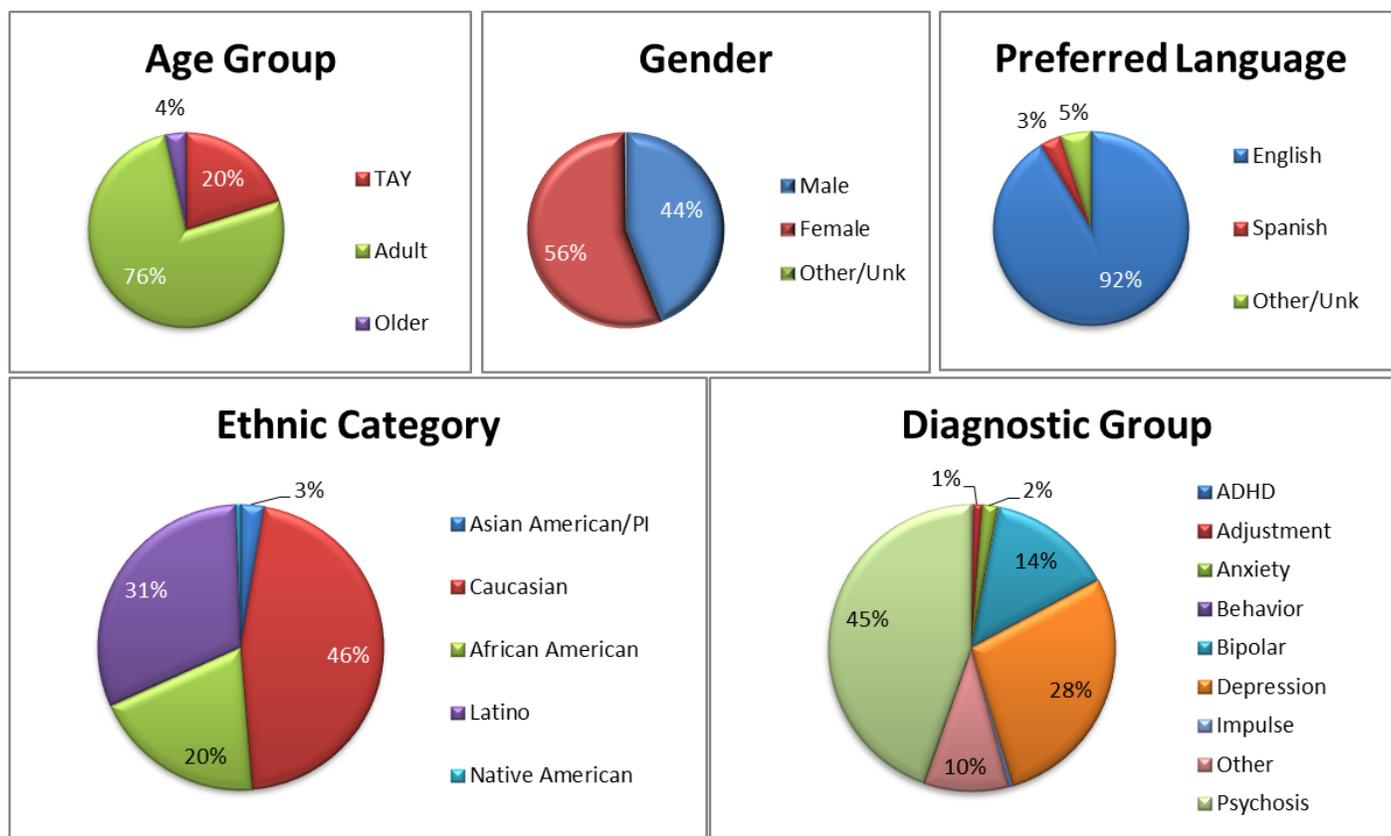
Program Data

During Fiscal Year 2011/2012 a total of **3,757** clients were served by the Psychiatric Triage Diversion Program.

Of those clients:

- 78% were successfully diverted to community-based services.
- 45% were uninsured.
- 8.9% were recently incarcerated.
- 47.4% had co-occurring disorders.
- 25.2% were homeless.

During Fiscal Year (FY) 2011/12, demographics were as follows:



Making a Difference

Larry was brought to the hospital multiple times over the course of a few weeks by law enforcement because he was felt to be gravely disabled and unable to provide for his own needs. He was found wandering along deserted roads in the desert region. Through careful assessments and investigations it was determined that Larry was both mentally ill and developmentally challenged. His family was attempting to provide care for him while still allowing him to live independently. He was socially isolated and often sought out mental health services as a means of social contact. His family had depleted all of their emotional and time resources in their attempts to care for him. The Diversion team was able to work with the client and his family to move him to a room and board facility in the San Bernardino Valley where regular supervision could be provided. Additionally, his psychiatric care was transferred to a nearby DBH outpatient clinic. The client was encouraged to attend a nearby Clubhouse for socialization activities. Since his move to the room and board the client has not returned to the hospital.

Challenges

The Diversion Unit initially experienced an unexpected demand for services due to a number of community circumstances.

More of a goal rather than a challenge was the need to form a strong collaborative team with the Arrowhead Regional medical Center (ARMC) Triage staff. This new concept of blending interagency staff required an open mindedness and flexibility on the part of staff members from both agencies.

Solutions in Progress

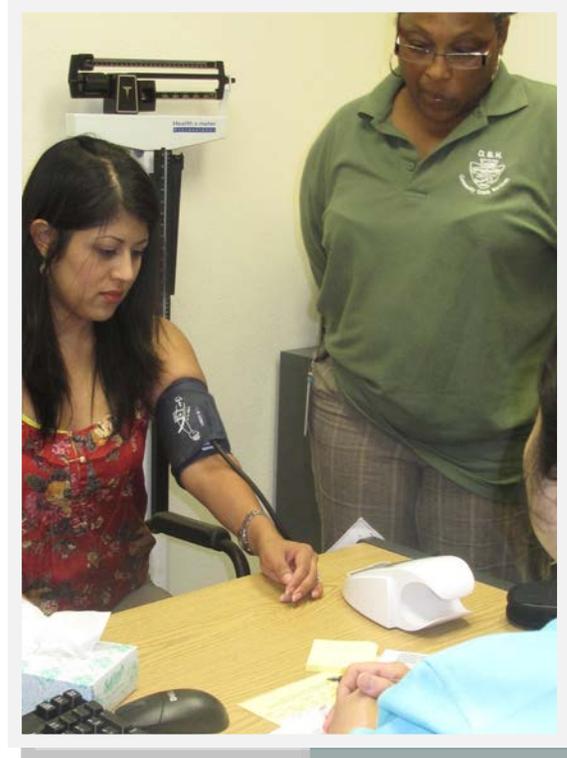
In order to provide for the volume of services, additional staff were added to the Diversion Team. Flexible scheduling was instituted to allow for service delivery 7 days a week, 16 hours a day. This type scheduling has allowed for the inclusion of staff, interns and graduate students who require flexibility in scheduling and added critical resources to the Diversion Team. Their increased education and knowledge has strengthened the Diversion Team.

The Diversion Unit continues to consistently provide high quality services to our clients and agency partners. Outreach efforts to our fee-for-service hospital system has resulted in collaboration between the hospital staff and the Diversion Unit many times during the past year. This collaboration has allowed for a more comprehensive outpatient treatment plan for our clients, avoiding unnecessary and/or inappropriate hospitalizations. The Diversion Unit will continue to strengthen these interagency relationships in order to assist in building a comprehensive continuum of care for our clients.

In Their Own Words

⇒ *"This was the third place I've been sent to. Thank you for not sending me away and giving me some options"*

⇒ *"I didn't know where else to go. They said you could help me here."*



Collaborative Partners

The primary partnering program is Arrowhead Regional Medical Center (ARMC). The Diversion Unit functions within the Behavioral Health Unit. ARMC's support and partnership has forged a collaborative team approach to caring for our clients. This partnership has been essential to the success of the Diversion Program.

ARMC's Behavioral Health Hospital Administrator, Jeff Hebb, has been instrumental in strengthening the team approach between the two agencies. His support and leadership has fostered many positive outcomes through interagency taskforces, work groups, and interdisciplinary team meetings.



MENTAL HEALTH SERVICES ACT

A-7: Homeless Intensive Case Management and Outreach Services

M H S A A N N U A L U P D A T E

F I S C A L Y E A R 2 0 1 3 / 1 4

Service Goals/Outcome Measures

The objectives of Homeless Intensive Case Management and Outreach Services are:

- **Provide** Full Service Partnership (FSP) services of intensive case management to the severely and persistently mentally ill and those with co-occurring disorders who may be homeless or at risk of being homeless.
- **Reduce** the risk of becoming homelessness, hospitalized or incarcerated.
- **Make** available temporary housing, including emergency homeless shelter beds for these individuals in a home like environment.
- **Provide** ongoing housing and placement services such as referral and placement in permanent housing in the community.
- **Engage** in outreach activities to identify homeless individuals throughout San Bernardino County including natural gathering places, and encampments.
- **Provide** outreach to the underserved areas of the county.
- **Develop** a system of care that increases the access of Behavioral Health services for the unserved and underserved homeless in the county.
- **Provide** case management and support services for employment preparation.
- **Assist** individuals who are homeless or at risk of being homeless to receive substance abuse services to help them deal with their co-occurring issues.



County of San Bernardino - Department of Behavioral Health



Promoting Wellness, Recovery and Resilience

Why Was Homeless Intensive Case Management and Outreach Services Created?

The 2011 County data on the number of homeless individuals indicate there are approximately **2,876** homeless persons in the County of San Bernardino. In addition, it indicates that the portion of mentally ill homeless adults was **30%**. This population of mentally ill homeless and those with co-occurring disorders are unserved or underserved often without linkages to medical, psychiatric, mental health and other community resources. They are at high risk of repeated psychiatric inpatient hospitalizations and incarcerations by law enforcement and the courts, and continued homelessness.

In an effort to address these issues the County of San Bernardino Department of Behavioral Health developed the Homeless Intensive Case Management and Outreach Program to provide outreach services, case management services, emergency shelter beds and supportive services for those who participate in employment preparation. By identifying mentally ill individuals who are homeless or on the verge of being homeless and working with them to access services, the Homeless Program aims to reduce the number of mentally ill homeless in the county by preventing vulnerable individuals from becoming homeless.

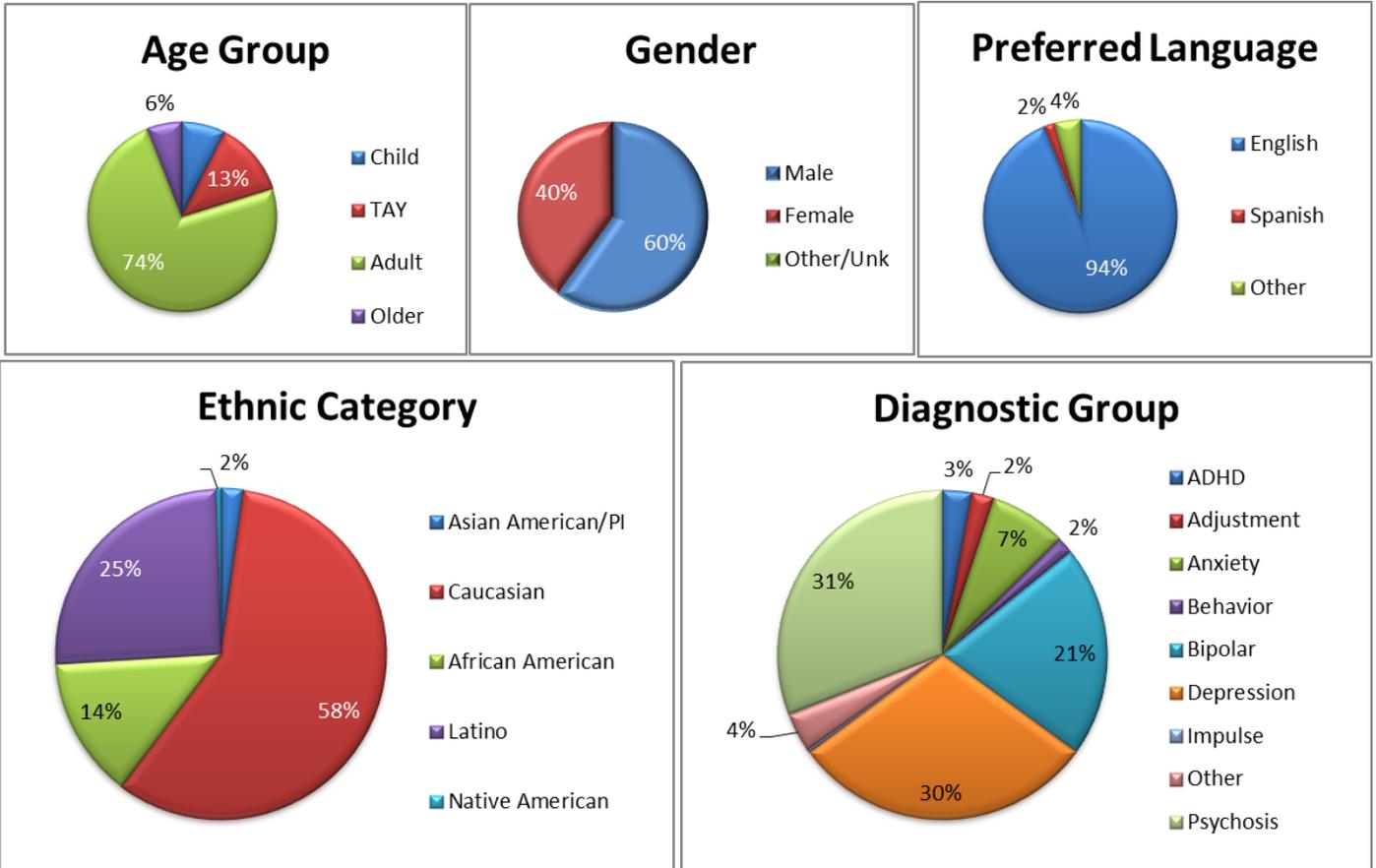


Positive Results

- **25%** of the homeless Full Service Partners obtained and sustained permanent housing.
- **90%** did not have repeated emergency hospital services.
- **80%** were assisted in obtaining entitlements (i.e. SSI, Medi-Cal, subsidized DBH specialized housing, etc.).
- **10%** obtained and maintain regular employment.

Program Data

During Fiscal Year (FY) 2011/12, HICMOS demographics were as follows:



Challenges

- Engaging the homeless mentally ill to trust the system and be open to getting services.
- Overcoming the stigma of having a mental illness.
- Providing on-going appropriate housing for homeless mentally ill following a stay in the homeless shelter.
- Endeavoring to meet the medical needs of the homeless.



Solutions in Progress

- Exploring new placement and housing opportunities including DBH subsidized housing.
- Expanding outreach services to all communities in the county to provide services or shelter.
- Collaborating and coordinating services with other county and community agencies serving the homeless such as veteran's organizations.

Making a Difference

Mr. F was a Vietnam veteran and older adult with a chronic history of mental health hospitalization. Mr. F lived in residential locked facilities and upon his discharge moved into a board and care. He was unable to manage his medications and was at high risk of being homeless. At the time he did not have income and the little money he earned from selling his art work was not sufficient to meet his daily needs. Upon enrolling in the Homeless (FSP) program, his quality of life steadily improved. Through the (FSP) intensive case management services, he secured a stable living arrangement of his choice. His mental health improved with the support of the FSP program. He learned to budget and save his money. He continued to do his art work which is displayed throughout the County of San Bernardino, and serves as his legacy.



** Mr. F was a well-known and talented artist.
This edition of the Program Summary is dedicated to his memory.*

**A special thanks to
Sarah Eberhardt-Rios for allowing us to
showcase this piece purchased from the artist.**

In Their Own Words

- ⇒ *“There is so much to say about being FSP. It’s everything. The people and case managers work with me to help me attain my goals.”*
- ⇒ *“Helped me with everything, to get off the streets and in my own housing. What you are doing is helping me improve my life and to move in a positive direction. Helped me with budgeting, hygiene, and to obtain dental care.”*

Collaborative Partners

Department of Behavioral Health Mental Health Services Act Housing Program

Department of Behavioral Health Regional Employment Program

Public Guardian / Department of Aging and Adult Services

Summit Payee Services, Inc.

San Bernardino Department of Public Health

National Alliance for the Mentally Ill

Arrowhead Regional Medical Center



MENTAL HEALTH SERVICES ACT

A-8: Alliance for Behavioral and Emotional Treatment (ABET) Big Bear Full Service Partnership (FSP)

MHSA ANNUAL UPDATE

FISCAL YEAR 2013/14

Service Goals/Outcome Measures

The objectives of ABET are to provide the following services in Big Bear Valley:

- Provide psychiatry services.
- Provide therapy services.
- Provide dual diagnosis services.
- Provide transportation access.
- Provide crisis management to prevent hospitalizations.
- Facilitate client qualification for other benefits programs.
- Compile and publish a local information brochure and resource guide to help area residents connect with local services.



County of San Bernardino - Department of Behavioral Health



Promoting Wellness, Recovery and Resilience

Why Was Alliance for Behavioral and Emotional Treatment (ABET) Big Bear Full Service Partnership FSP Created?

Big Bear Valley is a geographically isolated area in the San Bernardino Mountains with very few mental health services. Those who do not qualify for government assistance and who are unable to afford medical insurance, or pay out of pocket for services, typically go unserved. Access to services is even more severely limited in the winter due to snow and poor driving conditions. The nearest accessible mental health services are 40 miles away. In addition, with the poor economy, access to services is further limited due to lack of funds for transportation.

As a result, the Big Bear Mental Health Alliance (consumers, family and community members, and community and faith based organizations etc.) came together in 2007 to address mental health issues in the community. The Alliance completed a comprehensive community needs survey, and the ABET program was created based on prioritization of the identified needs.



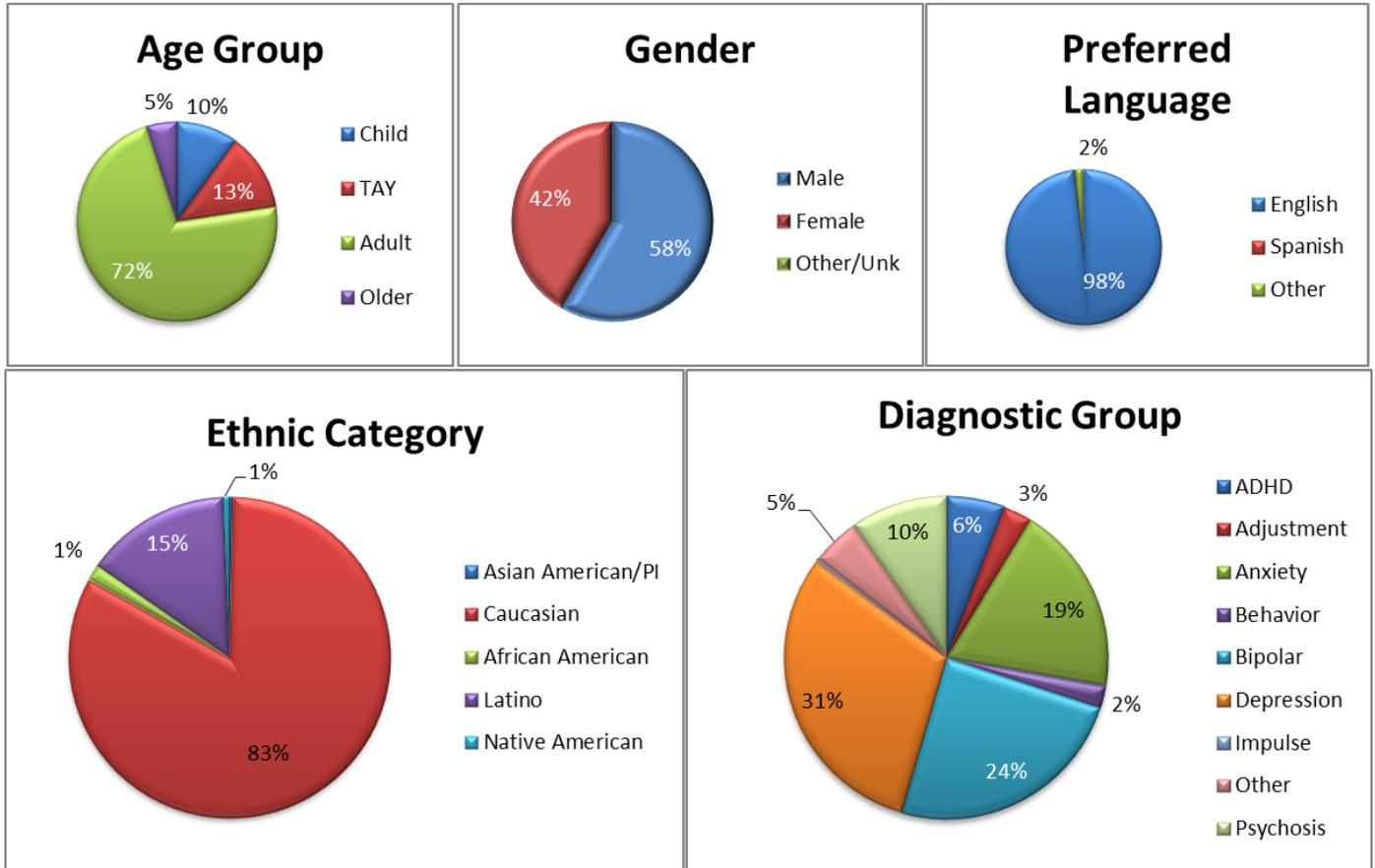
Positive Results

The Big Bear FSP: Over the past 4 years (Fiscal Year 2012/13 YTD)

- Services were offered to a total of 567 unduplicated individuals.
- **43** clients received crisis intervention which prevented them from being hospitalized, drastically reducing costs to the county/state.
- **65** clients were assisted in obtaining psychiatric medications, which prevented the need for a higher level of care.
- **6** clients were assisted in obtaining lab work needed to support their medication plan.
- **140** clients benefited from dual diagnosis treatment services.
- Transportation usage (van service) increased to over 80 trips per month allowing clients to receive services which they could not otherwise access (3173 trips to date).
- **817** therapy/stabilization visits were facilitated.
- **733** psychiatric visits were conducted.
- **416** case management visits were provided.

Program Data

In Fiscal Year 2011/12, Big Bear ABET demographics were as follows:



A-8: ALLIANCE FOR BEHAVIORAL AND EMOTIONAL TREATMENT (ABET) BIG BEAR FULL SERVICE PARTNERSHIP (FSP)

Making a Difference

The Big Bear FSP has served **567** clients over a 3 year, 8 month period. Since our FSP's origination, we have never had more than **1%** clients homeless at one time. Our case managers are quick to proactively respond to potential homeless situations and transition clients to alternative placements, prior to the client becoming homeless.

Challenges

- The geographic location of the community.
- Finding the appropriate level of staffing to work in the mountain area.
- Lack of transportation services.
- Access to benefit services i.e. Transitional Assistance.
- Clients not fully utilizing services and treatment options.

Western San Bernardino Mountain Communities access to services are severely limited due to the distance between these communities and the Big Bear Valley. Services are over 30 miles away and an hour drive on mountain roads.

Solutions in Progress

The Department of Behavioral Health (DBH) contracts out a variety of behavioral health services to meet the specific needs of the County's mountain communities.

Currently, Children Intensive Services, MHSA SAP, MHSA SATS, Cal Works and Substance Abuse Services have providers that are local to the Western San Bernardino Mountains.

The Department of Behavioral Health, In future Request For Proposal's, will include a complete list of the communities the RFP is seeking services, identify the Western San Bernardino Mountains as a separate service area from Big Bear Valley and review the benefit of changing management regions for better coordination of services.

The Department of Behavioral Health will emphasize MHSA FSP services for this region in upcoming contract negotiations. In addition, general mental health contracts will also emphasize the Western San Bernardino Mountains as a distinct service area.

In Their Own Words

- ⇒ *"I would not be alive if ABET was not here!"*
- ⇒ *"ABET has helped me with my drinking problem as well as my depression"*
- ⇒ *"I am so glad Lutheran Social Services is here !"*
- ⇒ *"I don't know what I would do without the ABET program . I could not get my meds without it."*



Collaborative Partners

Alliance Members Fiscal Year 2012-13:

Lutheran Social Services

Domestic Violence Education & Services (DOVES)

Operation Breakthrough Alcohol and Drug Services

M.O.M.: Provides prenatal information.

Morongo Basin Mental Health Services: Mental health and drug and alcohol services.

A-8: ALLIANCE FOR BEHAVIORAL AND EMOTIONAL TREATMENT (ABET) BIG BEAR FULL SERVICE PARTNERSHIP (FSP)



MENTAL HEALTH SERVICES ACT

OA-1: Age Wise I Program

M H S A A N N U A L U P D A T E

F I S C A L Y E A R 2 0 1 3 / 1 4

Service Goals/Outcome Measures

The objectives of Age Wise I Program are:

- **Increase** access to mental health, substance abuse, and case management services throughout the County of San Bernardino for older adults.
- **Provide** mobile mental health services to prevent premature institutionalization of older adults, inappropriate utilization of emergency rooms services, and psychiatric inpatient services.
- **Develop** a capacity building component with community partners and stakeholders serving the older adult population living with mental illness and their families.
- **Provide** culturally competent and client centered services to older adults in all regions of the county.
- **Enhance** the Senior Peer Counseling Program and expand it county-wide.
- Assist older adults with mental illness to maintain their independence in the community.
- **Provide** mental health services to older adults on Lanterman-Petris-Short Act (LPS) conservatorship.
- **Assist** older adults to transition from long term locked facilities safely into the community.
- **Facilitate** access to acquiring entitlements, attain housing and prevent homelessness.
- **Provide** outreach and engagement services in the community to educate clients, families, agencies and the public at large about the Age Wise Program (Health fairs, presentations, multidisciplinary meetings).



County of San Bernardino - Department of Behavioral Health



Promoting Wellness, Recovery and Resilience

Why Was Homeless Intensive Case Management and Outreach Services Created?

Older adults are especially vulnerable to the difficulties associated with accessing available services and frequently go unserved. The stigma associated with mental illness, under-identification or misidentification of mental health problems interfere in older adults accessing appropriate mental health services on a timely basis. Older adults often experience many physical problems and issues related to the aging process and losses in their lives. In addition, there are limited finances, lack of accessible and affordable transportation which creates a population that tends to be isolated and go unserved.

The Age Wise Program is a non-traditional mental health program for the high-risk and underserved older adult population. There are many different services available such as mobile case management services, counseling services, groups provided in the community, and the Senior Peer Counseling program. The Age Wise team accomplishes this through focusing on providing services, with integrity and respect for the aging process.

Some of the specific ways in which we partner with seniors include:

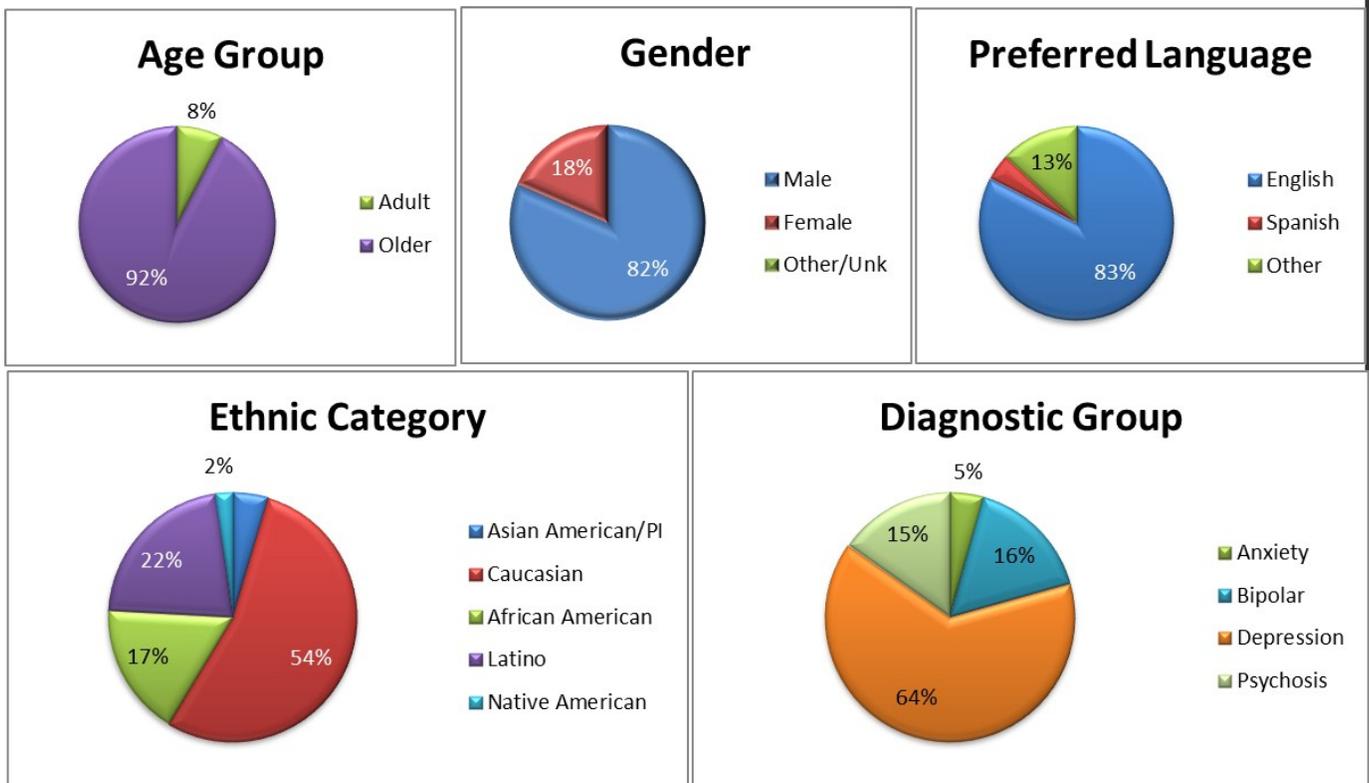
- Increased access to mental health and case management services due to in-home contacts.
- Improvement in maintaining the older adults in independent living environments such as low income housing, DBH subsidized housing, and other community living arrangements.
- Improvement in helping older adults access benefit programs such as Social Security, Medi-Cal, and Veterans services.
- Assist with transportation or access to transportation to get the Mental Health appointments, Medical appointments, or pharmacies to get their medications.
- Outreach in the community to the homeless mentally ill.
- Expansion of Senior Peer Counseling to the High Desert region of the county.

Positive Results

- Enabled older adults to remain out of psychiatric hospitals and jails.
- Decreased frequency of emergency room visits for mental health or substance abuse needs.
- Provided counseling for the grief and loss of a loved spouse or partner.
- Decreased the number of older adults who are homeless, or run the risk of becoming homeless.

Program Data

In Fiscal Year 2011/12, AgeWise I demographics were as follows:



Making a Difference

Maxine was chronically depressed and suicidal due to the loss of her husband. Upon his death her income and medical insurance was terminated. Through effective case management she was able to maintain until she received her benefits. The case manager was able to help her navigate through the social security system until she was approved. This enabled her to keep her home, her dog, and to help her stabilize. The Age Wise team also linked her to a mental health clinic in her area which provided her supportive services. She said, "Your program saved my life, all I could think about was dying." She continues to improve day by day and is successfully engaged in the program.



Challenges

- Engaging the older adult to utilize mental health/substance abuse services because of their distrust of government systems.
- Symptoms of the aging process and medical conditions are frequently inappropriately labeled as mental health issues.
- Reducing the stigma in the community associated with being mentally ill.
- Discovering homeless mentally ill older adults in the community.

Solutions in Progress

- Helping the older adult and their families navigate the behavioral health system by reducing anxiety by providing mobile services rather than in the clinic.
- Accessing services via the Senior Peer Counseling program.
- Working with medical doctors, Department of Aging and Adult Services, Adult Protective Services, etc., to ensure that care is coordinated, collaborative and beneficial to the older adult.
- Improving housing, preventing homelessness, and employment services.
- Continuing to expand the program from the West End of the County to the high desert, the mountains and as far as Morongo, Yucca Valley, and 29 Palms region of the county.
- Developing a Recovery and Outreach team to go out into the community at parks, homeless encampments to connect with homeless older adults.

In Their Own Words

- ⇒ *"This program has really helped better my life."*
- ⇒ *"I feel hopeful for a better tomorrow for me."*
- ⇒ *"It feels good to know you are there when I need you."*



Collaborative Partners

The Age Wise Program thanks all partners in serving older adults!

Department of Behavioral Health Clinics

Department of Behavioral Health Homeless Program

Department of Aging and Adult Services

Adult Protective Services

Lanterman-Petris-Short (LPS) Conservatorship Services

Department of Behavioral Health Housing and Employment Service



MENTAL HEALTH SERVICES ACT

OA-2: Age Wise II Circle of Care Mobile Outreach and Intensive Case Management

MHSA ANNUAL UPDATE

FISCAL YEAR 2013/14

Service Goals/Outcome Measures

The objectives of Age Wise II Program are:

- **Provide** mobile crisis response and crisis prevention services to the older adult population in the High Desert.
- **Partner with** hospitals and primary care providers in the High Desert to serve older adults living with mental illness.
- **Increase access** to mental health services by outreach and services in the homes of older adults
- **Provide** intensive case management services to assist the older adult to remain in independent living.
- **Provide** 17 Full Service Partnerships (FSP) 24/7 to the older adult population in the High Desert.
- **Provide** FSP services for those older adults living with mental illness at risk of emergency or inpatient services or those having the most difficulty accessing care due to system barriers.
- **Expand** Senior Peer Counseling program to the desert area.
- **Reduce** and prevent episodic institutionalization and incidents of relapse.
- **Utilize** mobile response to facilitate team mobility and reach geographically isolated older adults in large rural area of the High Desert.
- **Identify** appropriate housing for older adults who are homeless or at risk of being homeless.



County of San Bernardino - Department of Behavioral Health



Promoting Wellness, Recovery and Resilience

Why Was Age Wise II Circle of Care Mobile Outreach and Intensive Case Management Created?

The older adult population with mental illness in the rural areas of the high desert have had limited services and coordinated resources. Due to limitations of ability to access transportation, support systems to assist them and financial resources many older adults are isolated in their homes while some have been abandoned by their families. The Age Wise II program was created to address these and other important issues such as **crisis response and prevention**.

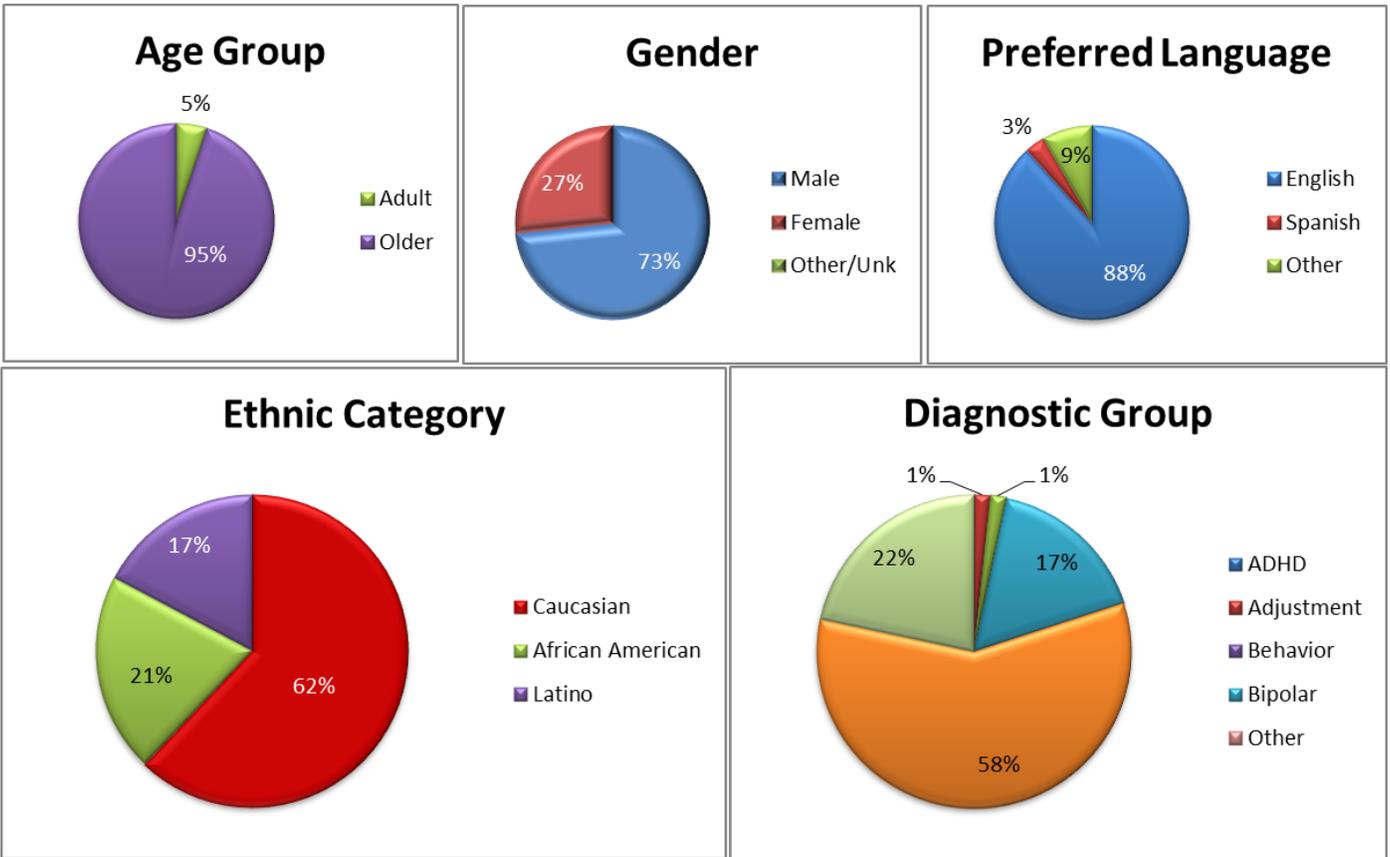
In the community of the high desert the Age Wise II program works with other County departments such as the Department of Aging and Adult Service, Adult Protective Services and hospitals in coordinating resources for the older adult. Both the mobile response unit and the Full Service Partnership (FSP) intensive case management services work to identify mentally ill older adults and help them be stable in their own homes and the community.

Positive Results

- **Established** mobile, field capable multidisciplinary outreach teams providing crisis response and prevention.
- **Served** a **10% increase** of older adults in Fiscal Year 2011/12.
- **Decreased use of emergency room visits** for mental health and substance abuse needs by **52%**.
- **Assisted 90% of older adults to access to access social security** and other federal and state benefits.
- **25% increase** in the number of older adults being able to receive appropriate medical and mental health services.
- **Increase** services by **10%** to prevent homeless older adults and those at risk of being homeless.
- **Educated** families about the aging process and mental illness issues of older adults.
- **Increased** number of older adults being able to receive appropriate medical and mental health services.
- **Developed** partnerships with law enforcement, other county and community agencies, and primary care providers serving the older adult to improve services either directly or through multidisciplinary teams.

Program Data

In Fiscal Year 2011/12, AgeWise II demographics were as follows:



Challenges

- Discovering available and affordable housing for older adults on fixed incomes.
- Engaging the older adult to accept mental health and co-occurring treatment due to their distrust of government entities.
- Addressing the stigma of mental health services in the community for the older adult.
- Ensuring the program continues to be recognized by the community and older adult.
- Outreach to seniors to recruit additional Senior Peer Counselors.
- Counseling to address substance abuse issues in the older adult population due to general denial of the problems in their life.
- Accessing and reaching homeless older adults through outreach at parks, river washes and various other locations that they gather.



Solutions in Progress

- Presentations to community organizations and participation in the community activities (health fairs, etc.) to educate the community about the need for older adult services with mental illness and substance abuse needs.
- Crisis response services to increase access of services for the older adult through quick mobile response teams.
- In-home services to the isolated older adult rather than clinic services.
- Full Service Partnerships to provide intensive case management 24/7 to ensure support for the older adult and prevent admissions to inpatient services, use of emergency rooms to meet mental health needs.
- Housing services established and developed to provide more suitable and affordable, safe housing for older adults.
- Emergency shelters for the mentally ill homeless and at-risk of being homeless older adults.
- Anti-stigma services to reduce the stigma associated with mental health services.

Making a Difference

Louise was suffering from severe depression and anxiety. She was isolated, lacked interest in life, and was not taking care of herself physically, mentally, or with her grooming and self-care. She resisted going to medical doctors, psychiatrists and counseling. She agreed to receive DBH services which were provided in her home. These services in the home assisted her in being more open to treatment. She was provided intensive case management services which involved assisting her to receive needed medical, psychiatric, social activities, access to benefits and housing. She received counseling to help her deal with her depression, isolation, and resistance to medication.

The DBH team provided intensive services accompanying her to medical appointments for support, helping her be compliant with medical and psychiatric medications, social activities and interactions with neighbors and family. She also received assistance in getting her social Security benefits and low income housing to live independently. Providing and helping her utilize these services resulted in her improvement and level of functioning.



In Their Own Words

- ⇒ *"I feel blessed and I attribute my new calm attitude to the peaceful nature of the placement Age Wise II placed me in."*
- ⇒ *You people always seem to come at the right time. I know that I can count on when I need you most."*
- ⇒ *I feel less stuck and more hopeful about the future."*

Collaborative Partners

The Age Wise Program thanks all partners in serving older adults!

Law Enforcement

Hospitals

Department of Behavioral Health Community Crisis Response Team

Department of Behavioral Health Crisis Walk-in Clinics

Department of Aging and Adult Services

Community Churches

Agencies Dealing with the Homeless

County Adult Protective Services





MENTAL HEALTH
SERVICES ACT

County of San Bernardino Department of Behavioral Health

ANNUAL UPDATE

FISCAL YEAR 2013/14

Prevention and Early Intervention



County of San Bernardino - Department of Behavioral Health



Promoting Wellness, Recovery and Resilience

Why Were Prevention and Early Intervention Programs Created?

INTRODUCTION TO PREVENTION & EARLY INTERVENTION



Prevention and Early Intervention (PEI) programs in the County of San Bernardino are provided as one of the six components of the Mental Health Services Act (MHSA).

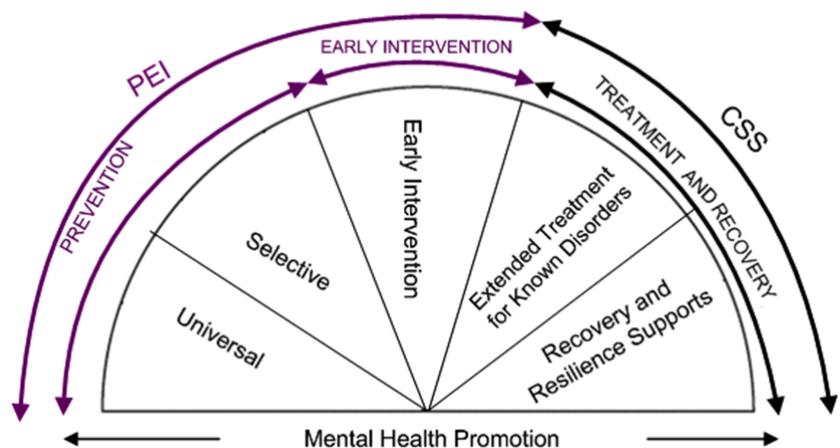
The MHSA, also known as Proposition 63, was passed by California voters in November of 2004. It imposes a 1% tax on adjusted annual income over \$1,000,000 to fund mental health programs. The proposition was enacted into law as the Mental Health Services Act (MHSA) effective January 1, 2005.

The California Department of Mental Health determined that Prevention programs should be designed at the **early end of the mental health intervention spectrum**. PEI programs are to be provided using the Institute of Medicine's definition of Universal, Selective and Early Intervention services.

Universal: Interventions or strategies used to target an entire population group, an entire community, or the general public that has not been identified as having a higher risk (Examples: implementation of projects that target an entire school or training gatekeepers on warning signs of suicide and how to intervene).

Selective: Interventions or strategies targeted to individuals or a subgroup with defined risk factors for the development of mental illness (Examples: targeting children of substance abusers for intervention or youth identified as truant).

Early Intervention: Therapeutic services that are directed toward individuals and families "for whom a short-duration (usually less than one year), relatively low-intensity intervention is appropriate to measurably improve a mental health problem or concern very early in its manifestation."



Adapted from Mrazek and Haggerty (1994) and Commonwealth of Australia

The County of San Bernardino's PEI Plan

In 2008, The County of San Bernardino, 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.

DBH's PEI plan was approved on September 25, 2008 and included twelve programs organized into three initiatives:

- School Based Initiatives
- Community Based Initiatives
- System Enhancement Initiatives

Overview of PEI Initiatives

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. Student-Based PEI programs include:

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

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:

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



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)
- ◇ LIFT Home Visitation Program
- ◇ Military Service and Family Support (MSFS)
- ◇ Community Wholeness and Enrichment (CWE)



Evaluation of PEI Programs

Why Evaluate?

In July 2009, DBH began providing PEI services throughout the County of San Bernardino. Over the past three years contract providers have grown in their capacity to deliver these programs and are beginning to show significant progress in their efforts.

In order to better understand the impact of PEI programs throughout the County of San Bernardino, the DBH Office of Prevention and Early Intervention has conducted a brief analysis of all twelve PEI programs for Fiscal Year 2011/12.

Data Collection and Analysis

This study was conducted using the standardized service collection tools and process evaluations supplied to DBH by contract providers.

The process evaluation methods for providers in Fiscal Year 2011/12 varied. While some providers used researched validated evaluation tools, others developed their own tools. Evaluation tools ranged from satisfaction surveys and participant and demographic counts, to assessments of client functioning and progress in key areas of social and emotional development.

One metric considered specifically for early intervention services was Global Assessment of Functioning (GAF) scores. Programs that provide Early Intervention services assign GAF scores for clients receiving counseling services.

GAF scores measure an individual's overall ability to carry out activities of daily living and psychological, social, and occupational functioning. Some of the providers were able to track these scores from client intake to case closing. A sampling of these scores were provided to DBH to measure the average increase in functioning of Early Intervention clients.

Data Notes

Providers of the Student Assistance Program (SAP) are required to provide DBH with the self reported level of family, school and community engagement and emotional wellness for students in their program. In assessing the available data for analysis, it was noted that some of the providers were not collecting, tracking or submitting this data to DBH. The lack of consistent data across providers makes evaluation of these measurements difficult; however, improvements in these areas are constantly being made.

The following pages detail the preliminary results of this brief analysis for each PEI Initiative.



SERVICE GOALS/PRELIMINARY OUTCOMES

Positive Results: School-Based Initiatives

Student Assistance Program



One goal of the Student Assistance program is to build protective factors and supports in the lives of students. These positive attitudes and skills are the building blocks for developing resiliency in children. SAP providers measured progress in this area through data collection, pre and post tests and other measurements. The data provided to DBH indicates that children involved in the SAP program **are increasing their social and emotional skills**. For example, in the table below the data indicates that students served by Provider A are increasing their ability to show respect to other students, take personal responsibility for their actions, and control their impulse behavior and resolve conflicts.

Progress in Social and Emotional Indicators—Provider A			
Domain	Pre-Test	Post Test	Gain
<i>Showing Respect Towards Others</i>	78%	90%	15%
<i>Taking Personal Responsibility</i>	81%	92%	14%
<i>Impulse Control</i>	80%	90%	13%
<i>Conflict Resolution</i>	73%	85%	16%

Despite using different indicators, the data submitted by Provider B also indicates progress towards building protective factors and supports in most areas.

Progress in Social and Emotional Indicators—Provider B	
Domain	Average Percentage of Improvement
<i>Feelings of Happiness</i>	21%
<i>Avoidance of Physical Aggression</i>	16%
<i>Avoiding referral to Principal's Office</i>	16%
<i>Feeling Proud</i>	11%
<i>Getting Good Grades</i>	11%
<i>Obeying Adult Directives</i>	19%
<i>Increased School Attendance</i>	3%
<i>Completion of School Assignments</i>	8%

SERVICE GOALS/PRELIMINARY OUTCOMES

Positive Results: School-Based Initiatives

It was noted that the curriculum and strategies used by Provider B were not effective at reducing drug and alcohol use or bullying behavior in their students. This data led Provider B to make modifications to their programming to ensure that the most effective curriculum is being utilized.

Provider B also tracked Global Assessment of Functioning (GAF) scores of early intervention clients. 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.

Average Student GAF Scores for Provider B		
At Case Intake	At Case Discharge	Improvement
57.5	67.75	17.83%

The GAF scores from Provider B indicate clients **had improvement in functioning after participating in SAP services.**

Preschool PEI Program

The Preschool PEI program serves students enrolled in the County of San Bernardino's Head Start program and is managed by the Preschool Services Department.

The Preschool PEI program was developed in part, to address the needs of preschool students with aggressive behaviors. A variety of research studies have found significant links between aggressive behavior in young children and negative "health and psychosocial outcomes" in adolescence and adulthood. ¹

Children demonstrating aggressive behavior in Head Start classrooms receive additional PEI support services. The data provided indicates that these services are having a positive impact on behavior.

Three times per year, every child enrolled in the Head Start program (about 4000 children total) **receives an assessment using the Desired Results Developmental Profile (DRDP) assessment tool.**



The DRDP measures a range of development in preschoolers. Each student receives a rating on their progress within the continuum of developmental levels. These ratings range from "Exploring" at the lowest point to "Integrating" at the highest point.

In Fiscal Year 2011-2012, the results of pre and post DRDP assessments were analyzed for all children enrolled in the Head Start program. According to the 3rd quarter report from the Preschool Services Department, the children receiving PEI services were enrolled in the "same classrooms, during the same time period, receiving the same basic educational services" as the larger group of children.

¹ (Van Lier, P.A. and Crijnen, A.A (2005) . Trajectories of Peer-Nominated Aggression: Risk Status, Predictors and Outcomes. Journal of Abnormal Child Psychology, Vol. 33, No. 1, 99-112. Retrieved December 5, 2012 from <http://link.springer.com/article/10.1007/s10802-005-0938-8>)

SERVICE GOALS/PRELIMINARY OUTCOMES

Positive Results: School-Based Initiatives

In the six developmental domains measured, **children receiving Preschool PEI services were more likely than their peers to be "integrating" positive behaviors.**

Practically speaking, children who were previously identified with aggressive behaviors in the classroom, were more likely than their peers to gain the social skills needed to succeed.

The table below illustrates the contrast between these two groups of children, and provides a definition of what "integrating" behavior looks like in the classroom.

DRDP Domain	Percentage of Children Integrating Behaviors		What "Integrating" Behavior Looks Like in the Classroom
Impulse Control	PEI Students	35.48%	Student consistently uses a variety of socially acceptable strategies to stop self from acting impulsively.
	<i>All Other Students</i>	<i>11.91%</i>	
Taking Turns	PEI Students	22.58%	Student routinely proposes taking turns as a solution to conflicts over materials and equipment
	<i>All Other Students</i>	<i>9.68%</i>	
Relationships with Adults	PEI Students	35.48%	Student works cooperatively with an adult to plan and organize activities and to solve problems.
	<i>All Other Students</i>	<i>12.08%</i>	
Cooperative Play with Peers	PEI Students	25.81%	Student leads or participates in planning cooperative play with other children
	<i>All Other Students</i>	<i>10.43%</i>	
Conflict Negotiation	PEI Students	9.68%	Student considers the needs and interests of another child when there is a conflict and accepts or suggests some mutually acceptable solutions
	<i>All Other Students</i>	<i>5.47%</i>	
Shared Use of Space and Materials	PEI Students	22.58%	Without adult prompting, the student invites others to share materials or space he or she is using
	<i>All Other Students</i>	<i>10.36%</i>	

SERVICE GOALS/PRELIMINARY OUTCOMES

Positive Results: Community-Based Initiatives

Family Resource Centers

Family Resource Centers (FRC) serve participants in settings located within their communities. Services provided include **research based parenting courses, adult skills-based education, activities for children that promote positive social skills, mental health education, youth educational programs, alcohol and drug counseling and community counseling for all ages.**



Provider A works with a high rate of children and utilized the Child and Adolescent Functional Assessment Scale (CAFAS) to assess the level of functioning in children ages 5-19 and to measure improvement.

The CAFAS scores provided indicate that children receiving PEI services from Provider A **have improved daily functioning and are learning important social-emotional skills.**

The table below illustrates the rate that identified problems were reduced in children served by Provider A.

CAFAS Scores for Children (Ages 5-19) - Provider A	
Area of Concern	Reduction in Problem after FRC Services
Thinking Problems	-64%
Substance Use	-55%
Possible Self-Harmful/ Severe Moods	-58%
Delinquency	-85%
Behavioral Problems with Moderate Mood	-44%
Behavioral Problems without Moderate Mood	-51%
Moderate Mood Problems	-76%
Mild Problems Only	-66%

It was also noted that at the most recent assessment, two children no longer had *any* noticeable problems.

SERVICE GOALS/PRELIMINARY OUTCOMES

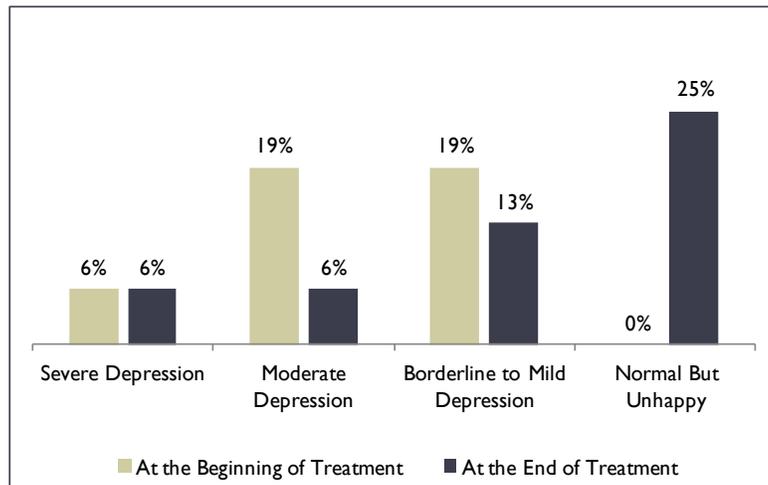
Positive Results: Community-Based Initiatives

Some of the most frequent presenting issues for which adults receive services at Family Resource Centers are **Depression and Anxiety**. These adults may receive group or individual counseling. The data provided indicates that adults are showing progress in overcoming these issues through the services provided by the Family Resource Centers.

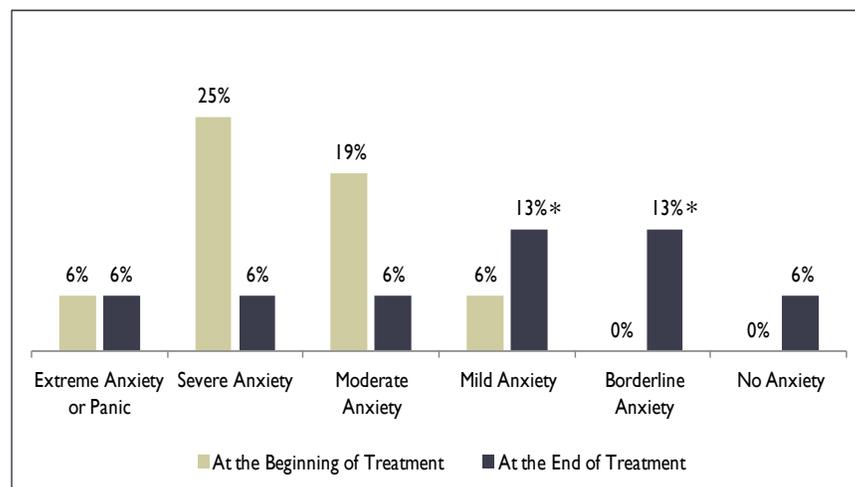
Provider B utilized the Burns Depression Checklist and Anxiety Inventory to measure progress in adults receiving services. The majority of adults receiving early intervention services from Provider B **indicated reduced depression and anxiety levels**. For example, an adult receiving services may be rated “Borderline to mild depression” at the beginning of treatment, and “normal but unhappy” at the end of treatment. The graphs below illustrate these results:



Provider B: Change in Rate of Depression for FRC Participants



Provider B: Change in Rate of Anxiety for FRC Participants



*As participants progressed in their treatment, they went from high levels of anxiety to lower levels of anxiety. The higher percentages of Mild Anxiety and Borderline Anxiety at the end of treatment reflect this progress.

SERVICE GOALS/PRELIMINARY OUTCOMES

Positive Results: Community-Based Initiatives

It was noted in this data, that participants with severe depression or extreme anxiety did not experience the level of improvement anticipated. It was determined by Provider B, that the participants that presented with Severe Depression or Extreme Anxiety either already had a mental health diagnosis or were suffering from very serious health issues and severe physical pain. These participants were transitioned to a higher level of care.

Native American Resource Center

The Native American Resource Center is unique in that it offers culturally specific services and traditional Native American activities. It also has similarities to the Family Resource Center as it provides mental illness and drug and alcohol prevention and early intervention services and family supportive services.



The results of traditional and cultural services are challenging to quantify or measure, but are key to expanding services to underserved or inappropriately served cultural groups.

The progress of participants receiving clinical services is able to be measured and the data shows promising results.

In order to measure the progress of participants receiving early interventions services, Global Assessment of Functioning (GAF) scores were tracked. 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.

The table below illustrates the progress in this area:

Average GAF Scores for Native American Resource Center		
At Case Intake	At Case Discharge	Improvement
61	67	9.84%

The GAF scores provided indicate clients of the Native American Resource Center had improvement in functioning after receiving Early Intervention services.

SERVICE GOALS/PRELIMINARY OUTCOMES

Positive Results: Community-Based Initiatives



Crossroads Education

The Crossroads Education programs employ a Cognitive Behavioral Change model to teach pro-social behaviors to children and youth through an interactive learning process.

Crossroads has built pre and post tests into the curriculum. These tests measure the level of knowledge obtained by participants and the fidelity of the program implementation, but cannot measure behavioral change.

The table below explains the learning objectives for each Crossroads course offered, and the increased rate of understanding students gained after completing each course.

Crossroads Skills Progression		
Class Title	Class Learning Objectives	Students Understanding of Course Content Increased:
Truancy	Understanding how success in school translates to success in work and in life	16.67%
Youth Anger Management Level 1	Understanding the influence that strong emotions have on behavior and gaining better control	21.16%
Youth Anger Management Level 2	Coping with stress Problem solving & Conflict Management Understanding Consequences	30.27%
Youth Drugs & Alcohol Level 1	Identity skills & resources that help develop a healthy, positive lifestyle	41.95%
Youth Drugs & Alcohol Level 2	Setting goals for the future Choosing new, positive activities to replace old, negative activities	43.75%
Youth Cognitive Skills	Discover how attitude affects behavior Practice and gain new life skills	66.27%

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

SERVICE GOALS/PRELIMINARY OUTCOMES

Positive Results: Community-Based Initiatives

Promotores de Salud

The Promotores de Salud (or Community Health Workers) program provides educational presentations to Latino community members about mental health and wellness topics. These community outreach efforts work to reduce the stigma associated with mental illness and treatment through a didactic educational process.

To ensure these objectives were met, the provider of this program developed three relevant outcome measurements. The first outcome measures the **level of knowledge gained** by participants through the educational presentations.



The second and third outcomes **measure participants positive attitudes and intentions to use available mental health prevention services**. Pre and post tests were used to facilitate this process.

Overall, participants surveyed showed gains in knowledge about mental health issues and appear likely to use mental health prevention and early intervention services if needed. This information is illustrated below.

Promotores de Salud Pre and Post Test Data	
Reported Participant Outcomes	Preliminary Conclusions
68%	Of participants scored a 90% on a mental health knowledge post-test
	➔
	Participating individuals are gaining knowledge about mental health issues
62.87%	Of participants scored at least a 4 (on a scale from 1 to 6) in the Positive Attitude Towards Mental Health Prevention Services Scale
	➔
	Participating individuals are gaining a positive view of mental health prevention services
62.43%	Of participants indicated an intention to use mental health prevention services on the Intention Scale
	➔
	Participants that receive educational services are likely to use mental health prevention services

SERVICE GOALS/PRELIMINARY OUTCOMES

Positive Results: System Enhancement Initiatives



Older Adults Community Services

The Older Adults Community Services (OACS) program provides activities that promote mental and physical health in older adults as well as home safety education; screenings for suicide; and interventions and case management for those experiencing mental, emotional or substance abuse problems.

To measure the progress of participants receiving early interventions services, Global Assessment of Functioning (GAF) scores were tracked. 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.

The scores provided for the OACS program indicate that participants have improved functioning after receiving early intervention services.

The GAF scores provided indicate clients had improvement in functioning after receiving early intervention services through the OACS program.

Average GAF Scores of Older Adult Community Services Participants		
At Case Intake	At Case Discharge	Improvement
62	70	14.20%

Additionally, one provider utilized a participant satisfaction survey. Of the 54 clients surveyed, 99% of clients were satisfied with the services provided through the OACS program.

SERVICE GOALS/PRELIMINARY OUTCOMES

Positive Results: System Enhancement Initiatives



LIFT Program

The LIFT program provides a unique strategy to **strengthen families and ensure the healthy delivery and development of newborns**. Some of the objectives of the program are to increase ongoing, direct access to medical services for pregnant mothers and to increase opportunities for pregnant mothers to access maternal and personal life course development.

Pregnant mothers enrolled in the LIFT program **were assessed to determine their progress in several areas at the beginning of services and again after six months**.

The data provided indicates that participants in the LIFT program showed marked improvement in all areas measured.

LIFT Program Outcomes			
Outcome Measurement	At Initial Assessment	At Six-Month Assessment	Preliminary Conclusions
Full Time or Occasional Employment	30%	38%	Participants are gaining employment
High School Diploma/GED	50%	58%	Participants are receiving support in obtaining their educational goals
Access to Health Care	74%	100%	All participants are obtaining access to healthcare
Keeping Healthcare Appointments	76%	88%	Participants are becoming familiar with the healthcare system
Use of Family Planning Methods	22%	83%	Participants are being educated on family planning methods
Signs of Depression	55%	41%	Depression is being reduced among participants

SERVICE GOALS/PRELIMINARY OUTCOMES

Positive Results: System Enhancement Initiatives



Military Services & Family Support

The Military Services & Family Support program **provides mental health, substance abuse, and family counseling to active and former military service members and their families.**

To measure the progress of participants receiving early interventions services, Global Assessment of Functioning (GAF) scores were tracked. 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.

The GAF scores indicate that participants showed improvement in functioning after receiving services.

Average GAF Scores for Military Services & Family Support—Provider A		
At Case Intake	At Case Discharge	Improvement
62	70	14.20%

Community Wholeness & Enrichment

The Community Wholeness & Enrichment (CWE) 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 abuse problems.



To measure the progress of participants receiving early interventions services, Global Assessment of Functioning (GAF) scores were tracked. 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. The scores provided indicate improvement in participants who received services.

Average GAF Scores of CWE Participants—Provider A		
At Case Intake	At Case Discharge	Improvement
60	72	20%

SERVICE GOALS/PRELIMINARY OUTCOMES

Positive Results: System Enhancement Initiatives

Provider A also gave participants a survey to record their feelings and behavior for 30 days prior to beginning CWE services. The participants were then surveyed again after completing CWE services and activities.

The data collected indicates that overall, participants reported improved feelings and behavior after receiving CWE services. Participants did not report improvement in the area of substance use.



Self Reported Improvement of Participants—Provider A

Domain	Percentage of Improvement
I feel hopeful	9%
I have the tools I need to accomplish my goals	20%
I know resources that I can access	5%
I have supportive relationships	2%
I have coping skills that I can use	9%

Provider B assessed Early Intervention clients using an in-house assessment tool . The clinicians periodically evaluated clients' emotions, functioning, behavior and parenting (if applicable).

The evaluation indicated improvement in both TAY and adults after receiving services.

Improvement in Early Intervention Participants—Provider B

Domain	% of Adults with Improvement in:	% of TAY with Improvement in:
Emotions	77.62%	50%
Functioning	78.73%	57.14%
Behavior	75.71%	28.57%
Parenting	81.99%	N/A

Program Data



It was projected that the twelve PEI programs would provide 61,575 services in Fiscal Year 2011-2012. PEI programs exceeded these projections, **by providing a total of 231,287 services.** This is an increase of 376% above projections.

61,575 *Projected Number of Services to be Provided*

231,287 *Actual Number of Services Provided*

Below is a breakdown of the number of services provided in each IOM category.

14,034 **Early Intervention Services**

70,213 **Selective Services**

147,040 **Universal Services**

Program Data

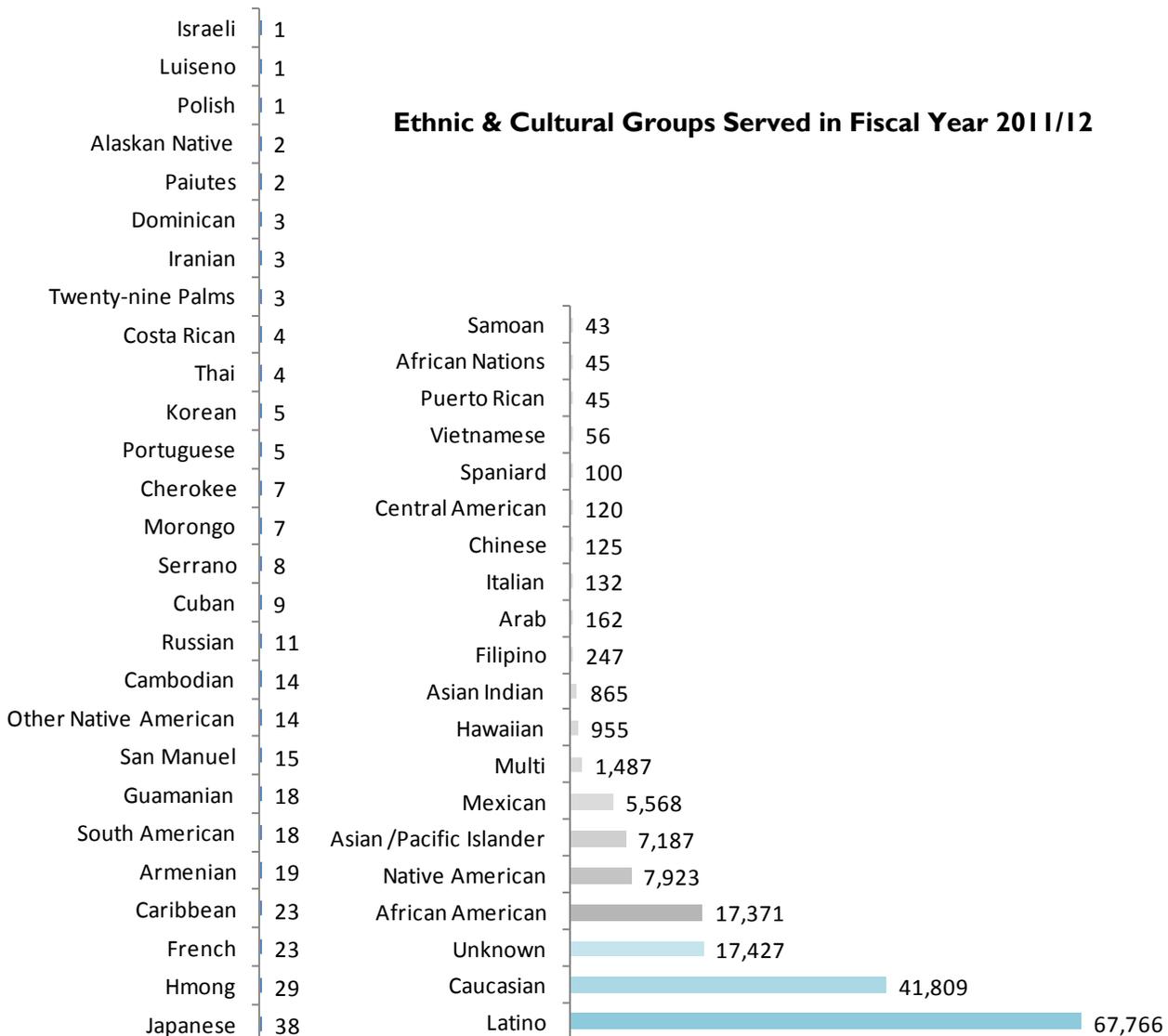


The County of San Bernardino, Department of Behavioral Health is dedicated to providing culturally competent services to its diverse ethnic and cultural population.

In Fiscal Year 2011/12 over 200,000 services were provided using Prevention and Early Intervention funds.

The graph below details the number of services provided to participants from ethnic and cultural groups.

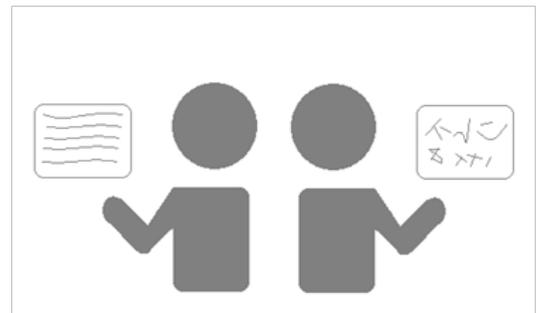
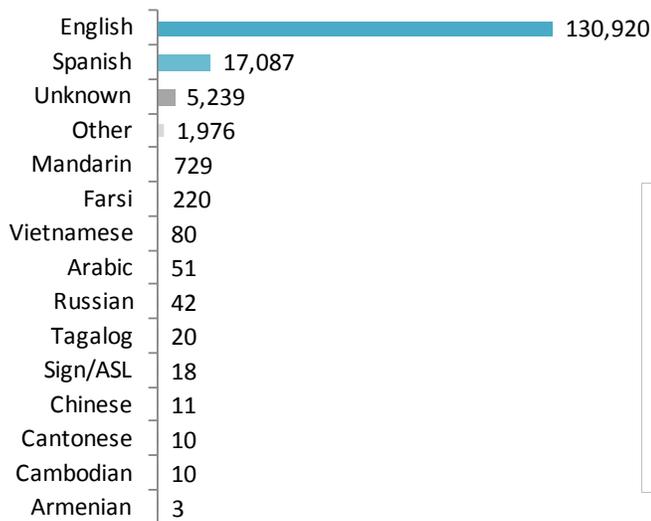
Ethnic & Cultural Groups Served in Fiscal Year 2011/12



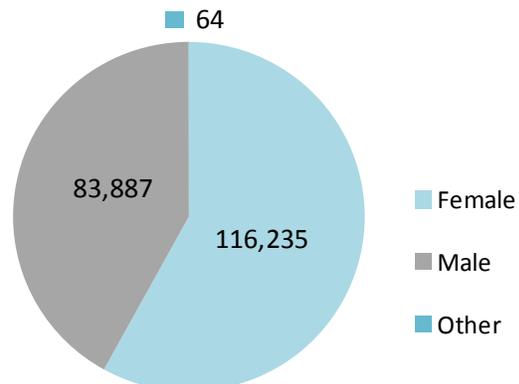
Program Data

A variety of languages are spoken in the County of San Bernardino. Spanish is one of the most widely spoken languages, and is considered a Threshold language. This means that at least 5% of the Medi-Cal population in the County of San Bernardino speaks Spanish. Twelve additional languages were also disclosed by program participants.

The graph below details the number of services provided by language.



In addition to ethnic, cultural and linguistic data, information is collected on participant gender, including those who identify their gender as “Other”. The majority of participants receiving PEI services in the County of San Bernardino were female. This data is illustrated below.



Challenges & Outcomes

In the effort to analyze the available data for the twelve Prevention and Early Intervention programs, the following gaps and challenges were identified:



- Some programs lack universal outcome measures and tools that can be utilized across providers.
- A small percentage of providers did not have sufficient data to adequately evaluate their progress.
- A small percentage of providers were found to be providing services that require more fidelity to the program model.

Despite these organizational challenges, the outcomes provided indicate that Prevention and Early Intervention (PEI) programs in the County of San Bernardino are valuable and are measurably improving the lives of residents.

- Underserved, Spanish speaking residents are gaining knowledge about mental health and are likely to use or refer others for services when needed, thus reducing the stigma of mental illness in the County of San Bernardino.
- Students are gaining important social and emotional skills and assets which are the building blocks of resiliency and wellness.
- Preschool students dealing with aggression and bereavement are outperforming their peers in social and emotional development after receiving PEI services.
- At risk, new mothers are gaining maternal skills and life development opportunities that help reduce stress, increase resiliency and their ability to raise healthy and appropriately developing children.
- Adults have measurably reduced levels of depression and anxiety after receiving early intervention services.
- Global Assessment of Functioning (GAF) scores from several programs show participants have improved daily functioning after receiving PEI services.
- Culturally competent services are being provided to a variety of ethnic, cultural and linguistic group of varied genders.

Solutions in Progress

Next Steps

In Fiscal Year 2012/13, the Office of Prevention will provide training, technical assistance and program monitoring to ensure program fidelity and appropriate modifications to program activities.

Additionally, an independent consultant, *Evalcorp*, has been contracted to assess the current progress of the Family Resource Center, the Student Assistance Program and the Military Services & Family Support program.

Evalcorp is developing universal evaluation tools and outcome measures for these three programs. These tools will inform future program design and modifications. A final report will be provided by *Evalcorp* in June 2013, detailing recommendations and findings.

These services provided by *Evalcorp* will help to eliminate the identified gaps in data collection and outcome measurements, and will contribute to the continued success of PEI programs in the County of San Bernardino.

The outcome data detailed in this report, along with continued evaluation efforts in Fiscal Year 2012/13 reveal a successful suite of prevention programs with continued success and improvement on the horizon.





MENTAL HEALTH
SERVICES ACT

WET: Workforce Education and Training (WET)

M H S A A N N U A L U P D A T E

F I S C A L Y E A R 2 0 1 3 / 1 4

Service Goals/Outcome Measures

The objectives of Workforce Education and Training are:

- **Expand** existing Department of Behavioral Health (DBH) training program.
- **Provide** training to support the fundamental concepts of the Mental Health Services Act.
- **Develop** standardized Work Performance Evaluation (WPE) competencies for clerical and administrative positions.
- **Continue** outreach to high school, community college, adult education and Regional Occupational Program (ROP) students.
- **Continue** the existing Leadership Development Program and create and implement an Executive LDP track.
- **Continue** to develop Peer and Family Advocate (PFA) workforce support initiatives.
- **Continue** the existing DBH Internship Program, including the Employee Internship Program.
- **Develop** and implement a new short term Psychiatric Residency Program with Loma Linda University.
- **Award** an Employee Scholarships and evaluate the program for possible expansion to contract agency employees.
- **Continue** to expand eligibility for federal workforce funding.



County of San Bernardino - Department of Behavioral Health



Promoting Wellness, Recovery and Resilience

Why Was Workforce Education and Training Created?

A workforce needs assessment was conducted as required by the Mental Health Services Act (MHSA) prior to submission of the Workforce Education and Training (WET) plan. The assessment revealed the following:

- Higher amounts of pre-licensed clinical staff than licensed clinical staff.
- Lack of bilingual staff in positions which provide clinical services.
- Loss of staff to state prison systems, due to competitive benefits packages.
- Large numbers of hard to fill positions, especially in rural areas of the county.
- Low number of staff close to retirement.

A stakeholder group, the Workforce Development Committee, was created to address these issues and oversee implementation of the WET plan. The Workforce Development Committee prioritized activities based on the findings in the workforce needs assessment. Priorities were to increase the number of licensed staff, transition bilingual staff from paraprofessional positions to direct service positions, develop a pipeline of future mental health workers, continue to develop the consumer workforce and invest in training for staff that are generally far from retirement age to increase competency and improve retention rates. As a result of these priorities the service goals listed in the prior section were included in the WET Plan.

Positive Results

Note: This report includes results only from Fiscal Year (FY) 2011/12 unless otherwise noted.

- The internship program coordinated **45** placements (of which 10 were employee interns) to help Marriage and Family Therapy (MFT), Master's Degree of Social Work (MSW), Bachelor's Degree in Social Work (BSW) or Psychology Intern program students obtain hours and experience necessary to pursue licenses as clinical therapists and at the same time provide programs with additional staff.
- Through three (**3**) cohorts, beginning in July 2009, the License Exam Prep Program (LEPP) has provided licensing exam materials to **130** DBH or DBH contract agency employees. **59** became licensed and another **14** have passed the first of their two (2) licensing exams.
- The WET Training Institute provided **147** live trainings (some via live webinars), created **24** online trainings and provided over **1,424** DBH and contract agency staff access to **671** courses (many that provide Continuing Education Credits) via our online learning system, Essential Learning.
- At the end of FY 2011/12, there were **115** volunteer placements throughout DBH. Volunteer placements are selected, trained and supervised by the WET Volunteer Services Program. This program helped provide needed coverage in many programs and helped community members learn the value of careers in public behavioral health.
- As part of the Mental Health Career Pathways component, WET staff provided a training opportunity for **13** ROP teachers to help them continue to promote behavioral health curriculum.
- In 2012, WET staff conducted another Leadership Development Program, which allowed **15** DBH and contract agency employees to participate in a program that provided training in competencies that will help them become future effective leaders in public behavioral health.



Making a Difference

- **Leadership Development Program (LDP)**

⇒ *“The LDP was a wonderful program not only for professional growth but personal growth as well. I have learned so much about the organization at all levels. I’ve learned the leadership structure and skills necessary to engage in the stakeholders to work towards common mission and vision for the organization. Having gone through LDP, I’ve noticed that it has enhanced my presentation, leadership, negotiation and assertiveness skills.”*

- **Regional Occupational Program (ROP) / The ROP Teacher Immersion Program**

⇒ *“One of the things that the team discussed with staff was the stigma that has long been associated with the mental health patient. We all agreed that this could only be corrected if educators in all sectors would begin to dispel the shroud that has veiled mental health by increasing awareness through education. The program provided a vehicle to support the efforts of DBH and opened a whole new vista of career exploration for our high school populations. What a satisfying experience!”*

Challenges

- The WET program has faced some of the same challenges other programs throughout the state have encountered, such as providing the best possible customer service during times of economic uncertainty.
- Difficulty in developing innovative Workforce Development programs within restrictive policies.
- Trying to bridge volunteer opportunities for ROP and other under age students interested in behavioral health careers.
- The License Exam Prep Program (LEPP) participants have experienced long delays in getting test dates or test results from the Board of Behavioral Sciences (BBS) due to BBS staffing shortages and communication remains a challenge.
- Utilizing interns uniformly across the department.



Solutions in Progress

- The pilot Employee Scholarship Program has been implemented for DBH employees. Awardees were selected through a competitive application process. It is anticipated that these awards will help employees advance careers in public behavioral health, including administrative careers. Outcomes will be evaluated and if the program is successful it will be offered to DBH contract agency employees as well”.
- Development and evaluation of the Leadership Development Program Executive Track with the continued assistance of Loma Linda University.
- Review of the minimum qualifications for clinical positions to make sure there is a path for direct service staff to advance to supervisory positions.

In Their Own Words

- **Training**

⇒ *"The Trauma Resiliency Model trainers and facilitators are great presenters, organizers and care about their duty to help implement ways of working with the community. I enjoyed it."*

- **Intern Program**

⇒ *"My internship at DBH was an amazing experience. The clinic staff was incredibly warm and gracious from my first day, making me feel I was a valued member of the team."*

- **License Exam Prep Program (LEPP)**

⇒ *"I just wanted to share with you that I'm now licensed! I couldn't have done it without the materials provided through the Workforce Education and Training LEPP program."*



Collaborative Partners

The WET program would like to acknowledge and thank our various collaborative partners that helped to connect with the community.

WET has accepted interns for the Social Work, Marriage and Family Therapist, and Psychology Internships from numerous schools. Among them are Alder School of Professional Psychology, Argosy University, Azusa Pacific University, Chapman (Brandman) University, California Baptist University, California State Polytechnic University Pomona, California State University San Bernardino, Fuller Theological Seminary, Loma Linda University, La Sierra University, and Rosemead School of Psychology (Biola University).

The following schools that have worked in partnership with WET: American Career College, California State University (CSU) Long Beach, Intercoast College, Mt. Saint Mary's College, ITT Technical Institute, University of Phoenix, Pacifica Graduate Institute, Summit Career College, Touro University, UEI college, and University of La Verne.

WET has also worked with the San Bernardino Regional Occupational Program (ROP) and Colton, Redlands, and Yucaipa ROP to immerse their teachers in various DBH programs to help develop curricula for their students.

Loma Linda University provided assistance with the current Leadership Development Program (LDP), including helping to develop curriculum and evaluating outcomes and will also provide assistance for the proposed LDP Executive Track.

WET has also collaborated with various national, state, and local organizations and agencies: American Association for Marriage and Family Therapy (AAMFT), California Institute for Mental Health (CiMH), California Social Work Education Center (CalSWEC), Children Family Services (CFS) Countywide Training Committee, Inland Empire Clinical Education Collaborative (IECEC), Inland Psychological Association, Marriage and Family Therapy Consortium of the Inland Empire, Office of Statewide Health Planning and Development (OSHPD), Performance, Education, & Resource Centers (PERC), Trauma Resource Institute (TRI), Workforce Development Department (WDD), and Working Well Together (WWT).



WET: WORKFORCE EDUCATION AND TRAINING (WET)



MENTAL HEALTH SERVICES ACT

INN: Innovation

MHSA ANNUAL UPDATE

FISCAL YEAR 2013/14

Service Goals/Outcome Measures

The objectives of Innovation are:

- **Increase access to services** by unserved, underserved, and inappropriately served groups.
- **Increase the quality of services**, including better outcomes.
- **Contribute to learning** and develop projects through a process that is community driven, inclusive and representative of the identified target unserved, underserved, and inappropriately served populations.



County of San Bernardino - Department of Behavioral Health



Promoting Wellness, Recovery and Resilience

Why Was Innovation Created?

Priority issues expressed by County residents for Innovations:

- Addressing disparities in access to services for the county's ethnic and cultural communities.
- Developing effective mental health education strategies throughout the county's diverse communities.
- Tapping into the strengths of the County's diverse communities.
- Collaboratively addressing hidden and vulnerable populations of children and youth.
- Testing strategies that are adaptable to our County's specialty populations.
- Learning from our programs' successes and challenges, in order to improve service planning and delivery in contribution to our County-wide Vision of, "creating a community where those who reside in it can prosper and achieve wellbeing".



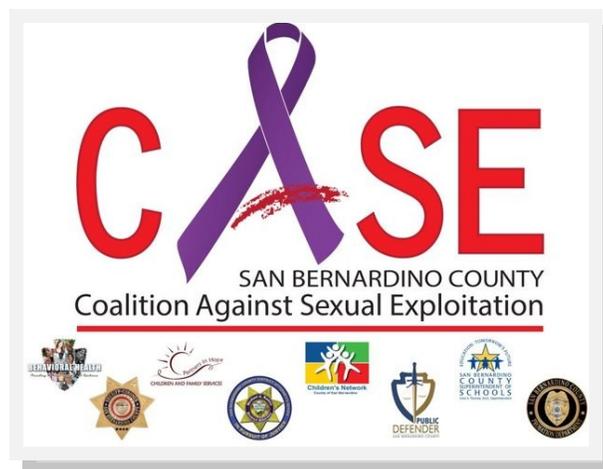
Positive Results

In efforts to meet the communities' needs, per the input received from our robust community stakeholder process, the following Innovation projects were developed and were in various stages of program development during Fiscal Year (FY) 2011/12:

- 1) **Coalition Against Sexual Exploitation (CASE)** - Collaboration between several County and community agencies, which will help develop and test a collaborative model of interventions and services to reduce the number of diverse children and youth that are sexually exploited. The CASE project has contributed to the County's learning through increasing our understanding of the impact of sexual exploitation through the development of a training and education module for social service practitioners, behavioral health professionals and those working in the criminal justice system.

Direct services include intensive case management, building of rapport, advocating in court proceedings and making treatment recommendations to the court, provision of therapy, placement and working with family members of the clients.

- **Increased community education:** CASE was mentioned in over ten (**10**) newspaper articles regarding the County of San Bernardino's CASE efforts in the last year.
- **Increased community events** regarding awareness of sexually exploited minors including film screenings that were followed by a panel discussion with panelists from a wide range of professional backgrounds, as well as a survivor of human trafficking.
- **Developed a training module** which includes on-going education with local agencies regarding sexual exploitation to assist with the identification and assessment of victims of trafficking.
- **A Speaker's Bureau was created** out of a request from several community members who wanted to be able to make short informational presentations in their communities.
- CASE Services provided in FY 2011/12: **33 minors received direct services, 116 public presentations and trainings were provided, and 4,927 professionals and community members were trained and educated** regarding commercial sexual exploitation of children and youth.



Positive Results

Learning to Date: Coalition Against Sexual Exploitation (CASE)

While these programs are currently being evaluated, learning to date includes:

- Working with Commercial Sexual Exploitation of Children (CSEC) victims has proven to be very challenging. On the surface these girls can be very aggressive, hostile and difficult to engage.
- It is sometimes difficult to even identify which girls have actually been exploited as they often will not disclose this information. While our initial source of referrals come from Probation, it became clear early on that many exploited children are not in Probation for prostitution charges, some are arrested on drug charges, shop lifting or curfew violations.
- Developing mechanisms for these girls to disclose took time and special training for Probation staff.
- Developing tools and profiles for identifying and serving these children successfully is an ongoing part of our program. At the same time, we are educating the community to recognize the wide spread nature of the problem and to serve as referral sources when exploitation is suspected.
- We are struggling to obtain a balance of recognizing these children as victims rather than criminals, when doing so may actually increase their risk for being reabsorbed in “the life”.

2) **Online Diverse Community Experience (ODCE)** - A project designed to use social media to increase access to services and overall awareness about behavioral health issues, education and resources. This social networking project serves to communicate and share local behavioral health news and other related topics of interest with County residents and consumers.

- In FY 2011/12, the ODCE data indicates **17,815** individuals have viewed our Facebook page and **39,120** have taken the time to browse our articles.
- Provided technical assistance to non-profit and government agencies regarding the use of social media in a behavioral health environments.



- The ODCE project conducted a short-term project with the Loma Linda School of Public Health to provide training and technical assistance to the individuals served in the County of San Bernardino’s Mexican Consulate. The project trained and educated the Latino community to the Department’s Spanish Facebook site, provided community outreach to increase promotional efforts and data regarding the needs and feedback of the Latino community in respect to content for the site.

Positive Results

Learning to Date: Online Diverse Community Experience (ODCE)

While these programs are currently being evaluated, learning to date includes:

- Providing behavioral health information in a forum like Facebook can lead to situations where personal information can be over-shared, or shared in a public forum viewable by other users.
- The Department must coordinate responses with the Public Information Office, as well as the Community Crisis Response Team as postings may require review from trained clinical professionals.
- This multi-layer review process adds another level of community response, that crisis teams must monitor.
- Community members can post messages at any time of the day and have 24-hour access to the page, however, the page is not staffed 24-hours a day.

3) **Holistic Campus** - A hub for holistic services to be offered, where services are culturally-informed and peer/community driven, with the goal of increasing access to underserved groups from all cultures, backgrounds and ethnicities. Services include culturally specific healing strategies and linkages to services that are cross-cultural and cross-generational. Healing strategies are determined by the particular community the campus serves, and as a result, vary by location. Some of the services and healing strategies include:

- Support Services for Veterans
- Equine Assisted Psychotherapy
- Community Resiliency Model (CRM) Skills Teaching and Interventions
- Health and Wellness Assessments
- Other Wellness-Promoting Activities, such as Yoga, Art Therapy, Music Therapy, Nutrition and Parenting Classes
- Case Management, referral and linkage to address various issues, including, but not limited to:
 - ◆ Housing
 - ◆ Employment
 - ◆ Education and Other Benefits
 - ◆ Mental and Physical Health Needs
- Residents of the County are currently being served by two (2) Holistic Campuses located in the West End and High Desert areas. The Mental Health Services Inc. STRIVE Holistic Campus served **1,850 clients**, and the Victor Community Support Services WISE Holistic Campus served **3,375** clients during FY 2011/12.

Positive Results

Learning to Date: Holistic Campus

While these programs are currently being evaluated, learning to date includes:

- Traditional mental health providers like county clinics and contract agencies were slow to integrate the campuses into their referral sources, due to lack of information about available services.
- Similarly, the above finding was true with regards to partner health plans and primary care providers.
- In a healthcare environment that is highly regulated and rapidly changing, outreach efforts to explain holistic campus service in targeted and effective ways to local providers was challenging. Next steps to address this include meeting regularly with direct service and professional medical/behavioral health staff to facilitate referrals in areas of our system of care that are currently receiving too many referrals.

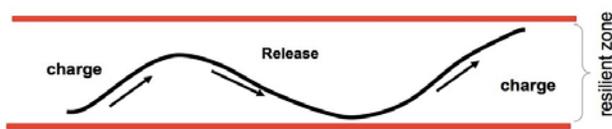
- 4) **Community Resiliency Model (CRM)** - A project intended to reach out to the County's diverse unserved, underserved, and inappropriately served communities, whose objective is to train community members to become certified CRM trainers, who then become capable of teaching the CRM in their respective communities. This model is specifically designed to address the needs of community members by providing mental health education, training and mentoring of CRM trainers, including coping skills, trauma response skills and resiliency techniques. The CRM Project trained **101** community members.

Results from Phase 1 of CRM training evaluations indicated:

- **92%** reported satisfaction with their understanding of the CRM skills.
- **97%** of the respondents believe that the CRM skill training will be very to moderately relevant or useful for their work with people in the community.
- **97%** said they thought they would use the skills very to moderately frequently during the month following the training.
- **100%** reported that they will be able to use the skills learned from the training for self-care.

The Resilient Zone

When we are in our "Resilient Zone," we have the best capacity for flexibility and adaptability in mind, body and spirit.



TRM skills help deepen the Resilient Zone

Additionally, trainees reported the following when asked how they will apply CRM skills in their community:

- **92%** to reduce someone's stress.
- **89%** when something challenging happens.
- **89%** to lessen anxiety.
- **84%** to ease depression.
- **84%** to build hope.
- **78%** to neutralize anger.
- **76%** to cope with physical pain.

Positive Results

Learning to Date: Community Resiliency Model (CRM)

While these programs are currently being evaluated, learning to date includes:

- While CRM was designed to prepare community members to be resources within the community when traumatic events occur, results indicate that those trained found the training to be most beneficial in reducing their own personal stress, which may, in turn assist them in reducing stress in the community.
- CRM as a curriculum is beneficial in educating participants about how to manage their own stress and anxiety and may be important to share with other stakeholders that could regularly use the curriculum such as Medi-Cal managed care plans, primary care practitioners, medical specialists, public health and first responders.



- 5) **Interagency Youth Resiliency Team (IYRT)** - An intensive mentoring program, designed for system-involved youth (e.g., youth in foster care or on probation, or youth at risk of entering either system, and youth receiving mental health services) and their caregivers. IYRT draws upon the experiences of former foster and probation youth to create a training/mentoring program that serves the specific needs of that youth population. During FY 2011/12, IYRT programs and their training curriculums were being developed. However, through an IYRT and Workforce Development Department (WDD) Collaborative (MOU), **298** IYRT eligible youths were provided with training and employment services, career guidance, skill assessment, case management, supportive services, and classroom and on-the-job training opportunities. The project resulted in a **78.8% success rate**, with **84** youths being hired by their worksite, **71** entering the Workforce Investment Act (WIA) youth program and **80** returning to high school or entering college.

Learning to Date: Interagency Youth Resiliency Team (IYRT)



While these programs are currently being evaluated, learning to date includes:

- The mere fact that a mentor has been a former foster youth or ward, does not give them instant credibility or acceptance with current foster youth.
- There are numerous cultural considerations that have asserted themselves that have required attention, everything from gang affiliations, to race, gender and sexual orientation, have become relevant to mentor/mentee matching.

Positive Results

- 6) **Transitional Age Youth (TAY) Behavioral Health Hostel** - A peer-driven, short term crisis residential treatment facility designed for youth ages 18 – 25, called the STAY, which opened for business in March 2013. The contracted provider is Valley Star Children and Family Services. No youths were served in FY 2011/12, as the procurement process was not finalized until July 2012.

Learning to Date: Transitional Age Youth (TAY) Behavioral Health Hostel

While these programs are currently being evaluated, learning to date includes:

- State licensing for the program was resource intensive and took longer than anticipated to be completed. This was partly due to staffing issues at the State, over which counties had no influence or control.
- While the need for such services is well known, the program staff will need to do targeted outreach to inpatient and other psychiatric diversion programs to be sure providers are aware of the uniqueness and availability of services at the STAY.





Making a Difference

IYRT Success Story

Before taking part in the IYRT program, Francisco lacked the motivation needed to set and accomplish goals, and had a difficult time taking responsibility for his own actions. He has lived most of his life in the foster care system, and at 18-years-old, he is living in a group home in extended foster care. The County's Children and Family Services (CFS) Department referred him to the Eastfield Ming Quong (EMQ) Families First IYRT Program, where he was matched with a mentor that would help him through the program. Francisco's mentor was paired with him after mentor/mentee-matching interviews revealed they had similar backgrounds, interests and career aspirations. Through IYRT, Francisco has attended education and employment workshops at the EMQ Families First IYRT Center and is working on other crucial life skills such as building lasting relationships, improving his physical and emotional health, and negotiating his way into adulthood. Before joining the program, Francisco was missing many of his high school classes, but with encouragement from his mentor, he completes more of his work and makes better decisions about school. Francisco has made great progress within the IYRT program, is looking to continue his education after high school and is looking for a job. He has become much more responsible in making and keeping appointments and meetings with his program team and other community members. The program is helping him establish his own support network that can help him as he works to reach his goals.

Making a Difference

CASE Success Story

Just an hour before Felicia* was arrested, her Mom said “goodbye” as she left the house to “go hang out with friends.” When her mom got the call from the police that her daughter had been arrested for prostitution, it was a complete shock. She had no idea that her daughter had been involved and even had hooked up with a pimp.

Once she was assigned to the Public Defender’s Office, their social workers and interns along with the rest of the CASE Team began working to assist her and her family. There were subsequent threats from the pimp and the family was fearful for their safety. It was determined that the family would need to be relocated for their safety.

While an application was being submitted to the District Attorney’s Office to receive victim of crime funds to pay for counseling, relocation and other services, the Children’s Fund stepped forward to provide some initial funding to help the family relocate. Felicia and her family are now attending counseling to work through the trauma they experienced as a result of her being trafficked. She is also learning parenting skills for her own 18-month old daughter.

The CASE Team will continue to work with Felicia and her family to assist with services and referrals when necessary. Working with Felicia and her family was gratifying for the CASE team and is a good example of why CASE was created.

*Name has been changed to protect anonymity.

IYRT WDD Collaborative Success Story

Andy, manager at Staples in Victorville, described his latest hire, a youth who came through the new program as follows: “He’s a good worker, he jumped right in, paid attention, and he is a good listener. He did everything we wanted. He’s very intelligent, he picks up things fast, and he was a find, let me tell you. He’ll be here awhile.” WDD staff explained that the work readiness portion of the program was a huge part of its success. The participants are taught how to behave on the job, including the importance of being punctual, being polite, knowing how to communicate, knowing how to take direction and use active listening skills.



Challenges

A challenge inherent in the Mental Health Services Act (MHSA) Innovation component is to implement ideas that challenge previous ways of providing traditional mental health services, such as:

- Identifying client information databases that fit the diverse program structure and needs of each Innovation project.
- Coordinating and allocating Innovation staff time between program planning, development, implementation, evaluation and monitoring responsibilities, with projects that are so diverse in nature and at different stages of the program development process.
- Maintaining high levels of community interest and education surrounding on-going Innovation projects.
- Implementing programs within multiple organizational partners and complex relationships.
- Quantifying and applying knowledge learned in realistic cost effective ways that actually improve quality of services

Solutions in Progress

The Innovation unit is working on the following identified actions to implement solutions and overcome challenges by:

- Consulting with DBH staff, familiar with the administration of other MHSA components, in order to trouble-shoot and utilize existing resources to develop data tracking systems, and for purposes of reporting outcomes and sharing information.
- Working on evaluation activities to obtain statistical information and assisting with data analysis needed to evaluate the effectiveness of programs and other learning objectives for the purposes of future program planning.
- Maintaining on-going contact with the Department of Healthcare Services (DHCS) for guidance and direction with regard to all aspects of the administration of Innovation projects.
- Initiating the Innovation stakeholder meetings to encourage and promote community involvement around all phases of the Innovation projects.
- Working to make connections with existing DBH programs so lessons learned can be applied in real time in the most appropriate areas of the service delivery system.

In Their Own Words

⇒ *"This is the first time in 40 years that I understand my symptoms, and you taught me that in two days." (Vietnam war vet/CRM Trainee)*

⇒ *"My relationship with my mentor is really good. My peers are a negative influence, but both my mentor and I love football, come from big families and we can talk about life issues. I think about my future now, and I'm more cautious about my behavior because I know that it will affect my future." (EMQ Families First IYRT program mentee, foster youth)*

Collaborative Partners

Thank you to the following partnering agencies:

Department of Behavioral Health

San Bernardino County District Attorney's Office

County of San Bernardino Probation Department

San Bernardino County Sherriff's Department

County of San Bernardino Children and Family Services

County of San Bernardino Children's Network

County of San Bernardino Public Defender

Workforce Development Department

County Schools

Performance, Education & Training Centers (PERC)

Transitional Assistance Department

Trauma Resiliency Institute

Mental Health Services, Inc.

Victor Community Services

Eastfield Ming Quong (EMQ) Families First, Inc.

Reach Out

Valley Star Children and Family Services

Mountain Counseling

Rim Family Services

Veterans Affairs



MENTAL HEALTH SERVICES ACT

Capital Facilities

MHSA ANNUAL UPDATE

FISCAL YEAR 2013/14

UPDATE

STATUS:

Building H – TAY One Stop Center

- DBH completed the renovation of a vacant County of San Bernardino owned building to become the new One Stop TAY Center in April 2012
- Ribbon cutting for the One Stop TAY Center occurred on April 2, 2012.
- DBH began One Stop TAY services in new building April 9, 2012.
- TAY Hostel (Crisis Residential) services began March 20, 2013.

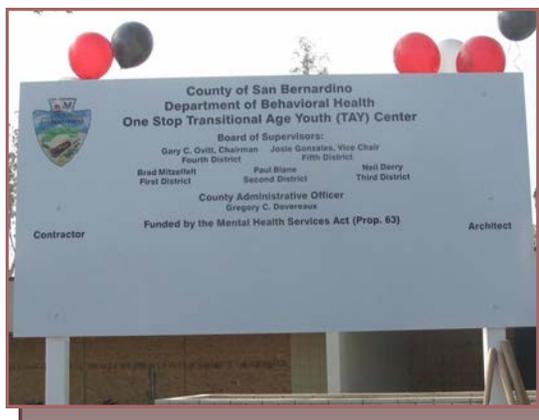
High Desert Facility

- DBH is in the preliminary stages of this project.
- DBH is searching to identify appropriate facility to meet project needs.

GOALS:

High Desert Facility

- Identify and acquire appropriate project facility.
- Begin renovation/construction planning for new facility.



County of San Bernardino - Department of Behavioral Health



BEHAVIORAL HEALTH
Promoting Wellness, Recovery, and Resilience

Promoting Wellness, Recovery and Resilience



MENTAL HEALTH SERVICES ACT

Technological Needs

M H S A A N N U A L U P D A T E

F I S C A L Y E A R 2 0 1 3 / 1 4

UPDATE

The objectives of the Technology portion of the Capital Facilities and Technological needs Component are:

- To modernize and transform information systems and increase consumer and family empowerment.
- Develop a long term integrated infrastructure for mental health to facilitate the highest quality, cost effective services and supports for consumer and family wellness, recovery and resiliency.
- Provide technology solutions to significantly improve quality of care.



County of San Bernardino - Department of Behavioral Health



BEHAVIORAL HEALTH
Promoting Wellness, Recovery, and Resilience

Promoting Wellness, Recovery and Resilience

Project Ripley

Achievements:

- Successfully issued RFP for Billing System and Electronic Health Record
- Successfully reviewed Vendor's Solutions.
- Selected Vendor to enter into Contract Negotiations.
- Face-to-Face negotiations have been scheduled with the first vendor for this month.
- Projected timeline to Board date for contract signing has been identified.
- IT Staffing requirements have been defined and proposed.

Future Goals:

- Successfully enter into Contract with Vendor Solution for Billing System and Electronic Health Record.
- Provide training to DBH staff to ensure proficiency with electronic solutions.
- Successfully Implement new Billing System and Electronic Health Record System.
- Successfully Bill to Medi-Cal and Medicare using new Billing System.



Empowered Communications

Achievements:

- Implemented Wireless Network at five DBH Locations.
- Purchase new Video Conferencing Equipment.
- Implemented SharePoint and Project Server in Internal Server Farm.

Future Goals:

- Implement Wireless Network at other DBH Locations.
- Deploy new Video Conferencing Equipment throughout the County of San Bernardino.

Virtual Server/Desktop Infrastructure

Achievements:

- Implemented Virtual Server Environment at County Data Center.
- Implemented Virtual Desktop Infrastructure at Training Institute.
- Successfully upgraded Virtual Desktop environment to take advantage of new technologies.

Future Goals:

- Further expand the use of Virtual Server Environment to include Project Ripley Implementation.
- Establish a Virtual Server Environment in the High Desert Government Center for Disaster Recovery of essential business systems.
- Expand on Virtual Desktop Infrastructure to include more users, operating systems, and applications.

Data Warehouse Project

With the major advance of implementing the SAS Data Warehouse, the Department of Behavioral Health is able to analyze information to discover patterns and connections that are helpful to administrators and managers to increase efficiencies and improve outcomes.

Achievements:

- The incorporation of multiple databases into a seamless and accessible location.
- Provides up to date as well as historical information regarding course of care.

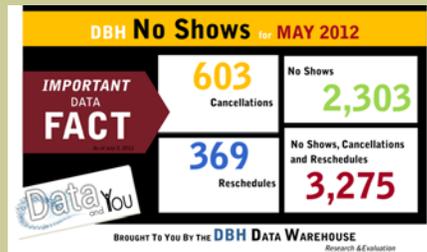
In Process:

- Creating program level reports and monitoring tools in collaboration with department Program Mangers.
- Analysis and reporting on client oriented outcomes.
- Creation of MHA Data Collection Reporting (DCR) management tools.
- Ongoing connection tool to support outcomes system for Children's programs.

Future:

- Integration with Project Ripley.
- Advanced data mining and analytics.
- Interactive departmental dashboard support.

The Data Warehouse's ability to combine data from multiple data sources can provide insightful information to assist staff in the development of more effective treatment plans and client care.



TECHNOLOGICAL NEEDS

Future Goals

1) Goal 1: DBH-SAS Infrastructure Development

Improve on the established DBH-SAS foundation to support and accommodate growth into the future for the County of San Bernardino.

Objectives:

- Strategic planning to accommodate growth.
- Research into upgrading the SAS environments; DEV, TEST and PROD, encompassing hardware and software requirements, cost, manpower and feasibility study.

2) Goal 2: Education and Training

Establish and maintain a training curriculum that will help educate and inform DBH-SAS Data warehouse users and administrators to meet the following objectives.

Objectives:

- Ensure the security of the SAS environment through training, educating users and establishing stringent security principles.
- To obtain training in non-SAS software such as JBOSS.
- Create and maintain a SharePoint SAS Documentation Library that will be administered by a SAS Platform administrator. This will ensure continued support for the SAS Administrator's role.
- Obtain more training on Information Delivery Portal administration in anticipation for future growth and content sharing.

Please note the following:

Project Ripley is a combination of the new Billing System Implementation and the Electronic Health Record Projects. No update was provided for the Charon Vax Upgrade due to this project being completed in previous years.



TECHNOLOGICAL NEEDS

Summary of Program Changes

While there have been no significantly changed programs since FY 2011/12, we have identified needs in several program areas that require expansion of services in FY 2013/14 due to increased demand. Because the expansion of programs would be for currently approved programs, the department would not characterize the expansion activities as substantive changes as the service philosophy and array of services will not be changed, but expanded and made available to more community members.

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.

The following programs will continue to operate as currently approved:

- **Community Services & Supports**
 - * C-2: Integrated New Family Opportunities (INFO)
 - * TAY-1: Transitional Age Youth (TAY) One Stop Centers
 - * A-2: Forensic Integrated Mental Health Services
 - * A-3: Members Assertive Positive Solutions (MAPS)
 - * A-4: Crisis Walk-In Centers (CWIC)
 - * A-6: Community Crisis Response Team (CCRT)
 - * A-7: Homeless Intensive Case Management and Outreach Service
 - * A-8: Alliance for Behavioral and Emotional Treatment (ABET) Big Bear Full Service Partnership
 - * OA-1: AgeWise - Circle of Care
 - * OA-2: AgeWise - Mobile Response
- **Prevention and Early Intervention**
- **Innovation**
- **Capital Facilities and Technological Needs**

Please note, while A-8 is not currently proposed for expansion at this time under CSS, the department is working to increase other resources that are available in the region while continuing to evaluate for potential CSS/MHSA expansion needs.

DBH is aware the Big Bear Valley is an isolated area in the San Bernardino Mountains with geographically restricted access to mental health services. As a result, the Big Bear Mental Health Alliance including consumers, family and community members, and community and faith-based organizations came together in 2007 to address mental health issues in the community. The Alliance completed a comprehensive community needs survey, and the Alliance for Behavioral and Emotional Treatment (ABET) program was created based on prioritization of identified needs. In FY 2010/11 the ABET program became the Big Bear Full Service Partnership (BBFSP) based on a stakeholder process conducted to review the program's effectiveness and the region's continued needs.

Summary of Program Changes

The objectives of BBFSP are to provide the following services in Big Bear Valley:

- Psychiatry services including medication support.
- Therapy services.
- Dual diagnosis services.
- Transportation access.
- Crisis intervention and management to prevent hospitalizations.
- Facilitate client qualification for other benefits programs.
- Compile and publish a local information brochure and resource guide to help area residents connect with local services.

Services under the BBFSP are currently available and reported on in the current programs section .

However, feedback from stakeholder meetings have identified that the Western San Bernardino Mountain community's access to services is severely limited due to the distance between these communities and the Big Bear Valley. Services are over 30-miles away and an hour drive on mountain roads. Currently, Children Intensive Services, MHSAP, MHSATS, CalWorks and Substance Abuse Services have providers that are local to the Western San Bernardino Mountains.

The Department of Behavioral Health, in future Request For Proposals (RFPs), will include a complete list of the communities the RFP is seeking services and identify the Western San Bernardino Mountains as a separate service area from Big Bear Valley. DBH will review the benefit of changing geographic regions for better coordination of services. Currently DBH is seeking MHSAP services for this region in upcoming contract negotiations not yet completed for FY 2013/14. In addition, general mental health contracts will also emphasize the Western San Bernardino Mountains as a distinct service area.

If after the addition of services per the efforts outlined above continued to be insufficient, DBH will evaluate, in partnership with the local community, if further service expansion under A-8 is needed. Continued tracking of penetration rates, availability of services and accessibility to services will be routinely monitored and shared with stakeholders in this region over the next year.

Innovation Programs will continue to operate as currently approved. There will be an extension of one of the Innovation projects, which will be implemented within the direction provided by the Mental Health Services Oversight and Accountability Commission (MHSOAC) criteria for programmatic changes not requiring further approval. The department will be adhering to the specific instructions outlined in the MHSOAC letter addressed to all County Mental Health Directors and MHSAP Coordinators dated August 3, 2012, written as a means to inform counties of changes related to Innovation Programs as a result of Assembly Bill (AB) 1467, enacted on June 27, 2012. Within the context of the letter is the designation of Innovation Programs as being a "Pre-AB 100 Innovation Program", if the Innovation Program received approval by the MHSOAC prior to the enactment of AB 100 on March 24, 2011. As clarified in the letter, the MHSOAC has determined that Pre-AB 100 Innovation Programs do not require further approval to expand or reduce the amount of funding if the proposed changes to the program continue the same primary purpose(s) and the same learning goal(s) as originally defined in the approved plan. DBH will be extending a contract for a Pre-AB 100 Innovation Program that will continue towards achieving the same primary purpose and the same learning goals as indicated and approved in the approved Innovation Plan. The Coalition Against Sexual Exploitation (CASE) was included as part of the DBH Innovation Plan, which received MHSOAC approval on Feb 25, 2010.

Summary of Program Changes

The CASE project is a collaboration between county and community agencies to help develop and test a collaborative model of interventions and services to reduce the number of diverse children/youth that are sexually exploited within the county. The county is committed to systemically addressing the issue of sexual exploitation and human trafficking, utilizing an interagency collaborative approach and a comprehensive model of interventions/services, addressing outreach, education, interventions, and outcome measurements. Through the development of an multi-disciplinary CASE team, in addition to outreach and education efforts, some direct services being provided include intensive case management, building of rapport, advocating in court proceedings and making treatment recommendations in court, provision of therapy, placement, and working with clients' family members. The purpose of the CASE project is to increase the quality of services, including better outcomes, with this target population. The learning goals for this project are to:

- Increase understanding of the impact of sexual exploitation, risk factors, and the means to develop rapport, initiate effective identification and collaborative intervention and treatment.
- Develop an effective means of identifying diverse children who are vulnerable to exploitation.
- Develop a means of identifying diverse children brought into the probation system who are exploited.
- Develop a system of comprehensive interventions and treatment models to determine which are the most effective for developing rapport, addressing the "brain washing" phenomenon related to childhood prostitution and improving the child's survival skills.
- Develop a training and education model, effective for community-based implementation, for those who interact with these children that most effectively works for San Bernardino County's cultural and ethnic populations.

The long term learning goal is to make use of an innovative collaboration to strengthen clinical practice for those serving sexually exploited children. The model created by this project has developed creative clinical strategies, combined existing best practices in trauma care and with local clinical expertise and intends to utilize ongoing outcome measures. Further details regarding recent progress within this project can be found on page 131 of this report. It is the intention of the county to continue to fund this project for one additional year, in the same capacity, providing the same services as originally defined, as more time is needed to fully achieve the learning goals and evaluate outcomes of this project, as well as for the purposes of collecting more data using a recently acquired data collection system, to be used toward evaluation efforts.

Innovation stakeholder meetings are slated for the Summer of 2013 for the purposes of reporting out progress and current learning results known to date on all implemented Innovation projects and to gather further stakeholder feedback to be used to drive future Innovation projects. Any new Innovation projects will be formulated and a plan will be submitted for MHSOAC review and approval at a later date. Updates on other current Innovation projects are provided in the program summaries appearing later in this report.

Summary of Program Changes

The following programs may be expanded per funding availability to meet consumer needs in FY 2013/14 and are consistent with stakeholder priority areas of family and youth support, basic needs/transportation, increased availability of treatment/recovery services, and administrative support.

C-1: COMPREHENSIVE CHILDREN AND FAMILY SUPPORT SERVICES (CCFSS)

DBH is continuing to work with county partners and community stakeholders to ensure the continuum of care for children and youth is accessible and effective. Currently the department is reviewing availability and access to children and youth services in all areas of our system.

If a need to provide expanded services for children and youth becomes evident, programs administered under C-1 and C-2, would be utilized to meet those needs, in addition to Medi-Cal programs for Specialty Mental Health Services that provide Early Periodic Screening Diagnosis and Treatment (EPSDT). Service needs include those of children/youth who are in foster care, or who are at imminent risk of foster placement.

Service approaches include family-centered values and principles that drive planning and service delivery processes as summarized below:

- Children/youth are first and foremost protected from abuse and neglect and maintained safely in their own homes.
- Services allow children/youth to achieve stability and permanence in their home and community based living situations.
- Services are needs-driven, strengths-based, and family-focused from the first conversation with or about the family. Services are individualized and tailored to the strengths and needs of each child/youth and their family.
- Services are delivered with multi-agency collaboration that is grounded in a strong, shared preference for community-based services and resources, and reflected in alignment of all service plans.
- Family voice, choice, and preference are assured throughout the process and can be seen in the development of formal plans and intervention strategies where the child/youth and family have participated in the design.
- Services incorporate a blend of formal and informal resources designed to assist families with successful transitions beyond system services that ensure long-term success.
- Services are respectful of and informed by the culture of the children/youth and their families.
- Services and supports are provided in the child or youth and family's local community and in the least restrictive and most normative settings.

Stakeholder processes facilitated in concert with community partners are currently underway, with process deliverables due after the posting of this annual update. Therefore, DBH is including this information in our annual update so that if expansion is necessary under C-1 and C-2 programs, the framework has been identified.

Summary of Program Changes

Before expansion of services, DBH stakeholders would be informed through standing stakeholder, and additional stakeholder meetings if necessary, about the specifics of the expansion, including number of children served, plans for service expansion and other critical program information.

A-1: CLUBHOUSE EXPANSION PROGRAM

The current program is being proposed to expand through the addition of more peer and family member staff positions under the approved plan. The peer and family member staff positions would be distributed across county and contracted clubhouses.

The additional peer positions would continue the implementation of important peer lead clubhouse services consistent with the approved plan and incorporate the suggestions and ideas of consumers gathered in a recent program evaluation aimed at getting stakeholder feedback for program improvements.

In September 2012, measurement of consumer satisfaction regarding DBH program efforts were documented in nine (9) focus groups conducted throughout the county for contract and county operated adult clubhouse programs. In addition to focus groups, individual evaluations were provided, collected and assessed for several variables, including overall satisfaction with clubhouse programming.

Over **144** individuals participated in DBH's county-wide focus groups. Participants were friendly, engaged and open in their observations. The groups discussed many important and challenging topics, and individuals shared their opinions largely without reservation.

Overall, of the participants who attended the Clubhouse Program Evaluation focus groups, **132** completed a comment form. Of those, **89%** identified the program to be valued and a great place to be a member and belong. While participants identified many positive themes, the focus groups were designed to address the following challenges and issues identified over the past year:

- Increased need for County-run clubhouse physical plant improvements.
- Increased PFA support and additional PFA positions.
- Increased efforts for all clubhouse coordination and learning collaboratives.
- Increased member and board member support for programming needs.
- Increased communications about "what clubhouses are for."
- Increased communication between clubhouse PFA's and clinic staff.
- Increased PFA career pathways and training opportunities.
- Increased need for clubhouse staff, PFA's and members to be integrated into the DBH culture at non-clubhouse related levels.

Feedback from the focus groups has also identified the following recommendations as a continued course of action for the Department of Behavioral Health/Contract Provider staff and clubhouse partners under the currently approved MHSA plan:

- Encourage and empower clubhouse members to implement suggestions/requests that do not require assistance from department /contract staff .
- Examine all fiscal options of acquiring additional space for the clubhouses most in need.

Summary of Program Changes

- Contact clinic managers to explore the possibility of sharing any available existing space with co-located clubhouse programs.
- Partner with the department's Leadership Development Program to explore outreach and marketing strategies.
- Explore avenues to develop and foster relationships with clinic staff.
- Add wellness and educational component .
- Identify advantages and means to arrange for additional field trips directed at supporting recovery and de-stigmatization of mental health issues.
- Increase family education in partnership with clinics, inpatient hospitals and community providers, including physical health providers.

The addition of more peer and family member positions will allow for current consumers who are ready for employment opportunities to continue to move into department funded positions and assist consumer led efforts in the areas detailed in this report. Positions would be implemented throughout the fiscal year and would be contingent on funding availability in both contract and county operations.

A-5: PSYCHIATRIC DIVERSION PROGRAM

The Department of Behavioral Health has had an outpatient program (Psychiatric Triage Diversion Program) co-located within the Arrowhead Regional Medical Center (ARMC) Behavioral Health Unit (BHU), known as, "Triage" since November of 2005. This program has been delivering services to adult clients from throughout the County, who walk-in voluntarily to ARMC BHU Triage, to provide culturally competent screening to determine whether or not the client meets medical necessity for inpatient care.

When their needs fall outside of the scope of inpatient treatment, the Diversion Staff provides additional services including linkage and referrals, housing assistance, transportation assistance, as well as collateral contacts and advocacy with other providers for the client. Additionally, this program has been providing services to clients held on Triage for which a final disposition has not been determined. These services include a repeat clinical assessment as well as an evaluation by a second psychiatrist. When medical necessity for inpatient care is not met, the same services as listed above are provided to the client.

Statistics indicate that the team is successful with **92%** clients, diverting them from inappropriate and or unnecessary hospitalization. The Diversion program was designed to work with clients who arrive at the hospital on a voluntary basis. The services provided by the Diversion staff are now being expanded to work with those clients in the ARMC Triage unit who came in with a 5150, involuntary hold, but who may not meet the medical criteria for inpatient treatment when sufficient and appropriate voluntary outpatient care can be arranged. This paradigm shift partners the assessment services provided by the ARMC staff with the clinical and case management services provided by the Diversion Staff in a team-based approach.

Additionally, services may be extended to other hospital campuses if the need for diversion services is further identified in the system of care. Services provided under the expansion are aimed at voluntary, outpatient services for those who do not need hospital or inpatient services but present at hospital campuses due to lack of knowledge and access to outpatient services, or are brought in via 5150 but are more appropriate for outpatient care.

Summary of Program Changes

The specific consumer population served includes underserved and inappropriately served adult clients between the ages of 18 and 65 who demonstrate signs and symptoms of an acute mental illness. There are benefits to all parties involved, including the client, their families and caretakers, the hospital system as well as the mental health provider. The trauma associated with psychiatric hospitalization is avoided. The disruption to lives is reduced by not having their loved-ones hospitalized. The strain on an already overburdened hospital system is reduced and the expensive inpatient treatment is avoided in favor of appropriate, less costly outpatient services.

Service expansion under the currently approved plan include:

- Available staff to provide outpatient mental health services to clients presenting unnecessarily on hospital campuses including mental health services, crisis intervention, medication support, case management, education and outreach, and access to housing options for homeless individuals.
- Available staff to make and coordinate follow-up appointments with outpatient services and housing resources within the system.
- Availability staff to provide additional transportation services.

CLINICAL TECHNOLOGY AND WORKFORCE EDUCATION AND TRAINING SUPPORT

As the new Electronic Health Record (EHR) and billing system is implemented in MHSA programs, administrative and technical support activities will need to be expanded.

Over the past several years, DBH has been developing a Request for Proposal (RFP) to solicit vendors to implement a new billing and Electronic Health Records (EHR) system. The project is internally referred to as, "Project Ripley." The RFP was released in December of 2011. As the implementation of a new system will naturally require the existing data within the current billing system to be validated and translated into the format expected in a new system, DBH chose to begin with the billing system implementation. However, a great amount of consideration has been placed on the clinical components and how they will be integrated into the systems database. As patient files are currently maintained in hardcopy, the billing system implementation phase will provide the clinical operations the opportunity to develop procedures based on using an EHR solution.

Major Milestones Completed

- Request for Proposal Released to the Public: **December 14th, 2011**
- Request for Proposal Bidder's Conference: **January 4th, 2012**
- Request for Proposal Closed: **April 9th, 2012**
- Proposals Evaluated: **June 7th, 2012**
- Demonstrations Evaluated: **September 26th, 2012**
- Vendor Selection: **April 2013-Ongoing**

The Department of Behavioral Health is continuing to move forward with the RFP process and has documented significant activity. Due to the nature of the procurement, no other information can be given at this time, however, project planning and implementation strategies for major elements of the project once a vendor is selected are currently occurring.

Summary of Program Changes

Once a vendor is selected and implementation of the technology component of the project begins, DBH will need to expand current staffing resources to include those with the expertise to implement the new vendor product. This will include additional staff with technical expertise such as programming, automated system expertise, and business support analysis.

Additionally, it is imperative for DBH to address the significant training needs of the staff associated with this project. All members of the DBH workforce must receive continuous, consistent and concise messages regarding the project to keep them apprised of developments, updates and changes as the project progresses. In order for the communication to be effective, accomplishments and challenges must also be shared. As a result, training efforts related to the project will be increased as related to the following:

- Learning about Project Ripley including projected timelines.
- Learning where to find additional information regarding the project.
- Understanding change(s),
 - * Possible changes,
 - * Needed changes.
- Identifying benefits of the system.
- Modifying work behavior, i.e., from a paper environment to an electronic environment.
- Learning the new billing system.
- Learning the EHR.

Learning the new billing system and EHR will begin with the development of the expert meetings, as the project will utilize the Workforce Education and Training Unit. The training aspect will also be dependent on the plan submitted by the selected vendor, which is currently unknown. However computer literacy assessments have already been completed with over 699 DBH staff completing literacy testing via various testing tools evaluating skills sets in basic computer knowledge, email etiquette, Microsoft Office Suite 2007 (Word, Outlook), PC hardware, data entry and regular typing. Results indicate specific training is necessary prior to implementation of the project and will be included in the general workforce training plan beginning January 2013 - January 2016 under an expanded focus in this area.

CSS PROGRAM EVALUATION SUPPORT

In response to the Mental Health Services Oversight & Accountability Commission's (MHSOAC) Evaluation Master Plan released in January 2013, and based on ongoing internal monitoring efforts, DBH identified the need to expand our program evaluation and data collection activities as mandated by the MHSOAC, DHCS and state regulations governing MHS.

In addition to the evaluation activities outlined in the MHSOAC master plan, DBH MHS programs are evaluated by several organizations including:

- California External Quality Review Organization (CAEQRO).
- California Mental Health Planning Council.
- Department of Health Care Services.
- California State Auditor.

Summary of Program Changes

The focus of expanded program review and evaluation of DBH CSS programs will be to answer the following questions:

- Has the mental health system improved in terms of service access, quality, efficiency, and satisfaction?
- Has the infrastructure (workforce, technology, housing alternatives) improved?
- Have the values and principles of the MHSA been incorporated into the system?
- Are more people being served?
- Have the disparities in amounts and types of services been reduced?

To answer these questions, DBH will expand data collection, analysis and evaluation activities for MHSA programs focused at two levels; 1) system evaluation of quality improvement, evaluation and performance measurement practices department-wide and 2) specific, measurable quality improvement efforts focused at program level operations.

DBH will also expand measurement and evaluation activities in the following areas:

- **County Level Behavioral Health Performance** Measurement and Improvement Efforts such as reduction in the county suicide rate.
- **Department Level Performance** and Improvement Efforts such implementation of important department level business metrics.
- **Program Level Performance** and Improvement Efforts such as fidelity to program model as described in program plan and program level business metrics.
- **Individual Level Performance** and Outcome and Improvement Efforts such as improvements quality of life, symptom reduction, resource brokering and individual functioning.

The goals of this expansion in evaluation, data collection, analysis and quality improvement are aimed at achieving the following outcomes:

- 1) Continue to meet federal and state regulations.
- 2) Evaluate best practices for measuring quality in mental health and substance abuse care.
- 3) Define/identify/standardize simple metrics for DBH programs.
- 4) Design and implement standardized measurement of identified metrics.
- 5) Implement changed metrics as appropriate when metrics exist.

Expansion of activities will include the addition of staff with expertise in data collection, healthcare analytics, program evaluation, measurement and outcome reporting/tracking. While expansion efforts will be added under this year's annual update, efforts will continue across future years as expectations from state and federal monitoring agencies increase. This includes the tracking of technology related capabilities for outcomes management such as Data Warehouse, clinical decision making tools, clinical studies, application based consumer management and provider tools, and definition of service efficacy measurement models.

Summary of Program Changes

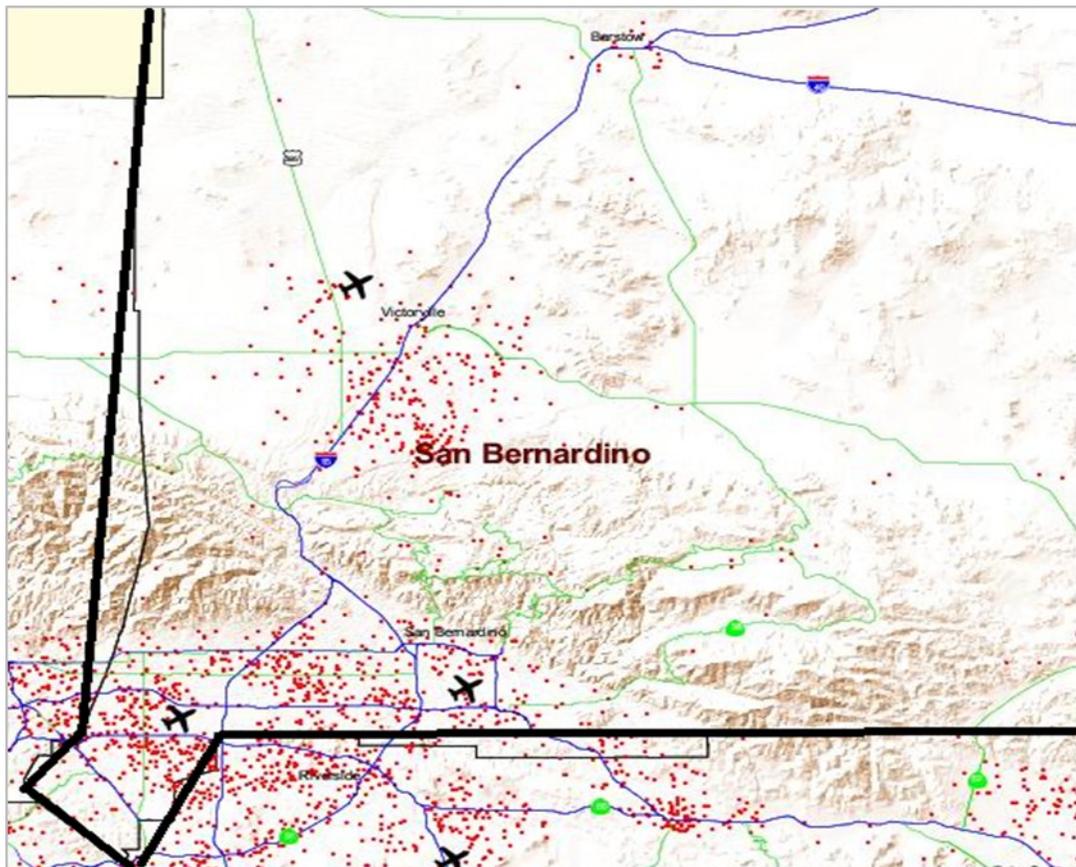
Additionally, expansion efforts will include strategies aimed at improving efficient production of non-burdensome evidence, improving diagnosis and assessment, strengthening the quality measurement and reporting infrastructure, applying quality improvement methods at the locus of care, linkages among quality improvement and program components including safety, effectiveness of treatment, patient-centeredness, timeliness, and equity of performance across programs. Significant expansion efforts will be aimed at increasing/documenting performance efforts related to improving patient care, beneficiary protections, access to services and coordination of care for those served in MHSA programs.

New Programs

New Program - Access, Coordination, and Enhancement (ACE) of Quality Behavioral Health Services A-9

As the population grows within the County of San Bernardino, requests for services from clients 15+ years of age (which cover TAY, adult and older adult populations) have significantly risen over the past decade.

The county population is expected to grow by **300,000** residents in the next eight (**8**) years and is projected to be at almost **2.6 million** by 2030. With the current demand for scarce treatment resources, current population growth has already out grown availability of behavioral health treatment staff. With the implementation of the Affordable Care Act in 2014, and the increasing behavioral health needs of our current population, DBH needs to adapt ways of working to ensure a more efficient and coordinated approach, while maintaining the same high level of service quality.



Projected Population Growth from 2010 to 2030

(each red dot = growth of 1,000 residents)

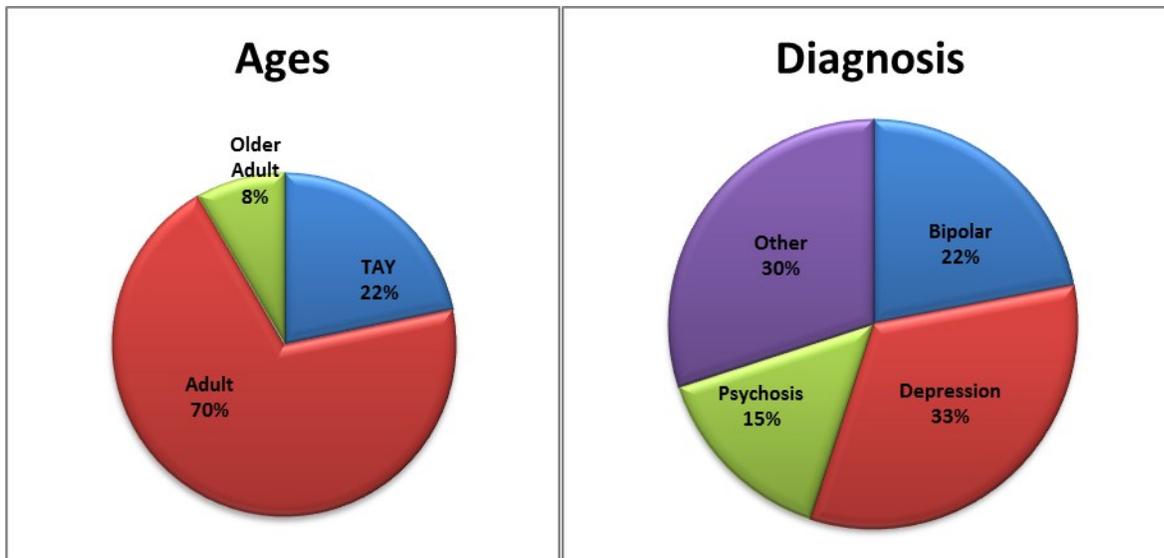
Source: Southern California Association of Governments, http://www.scaq.ca.gov/eMap/images/2.3_popchg_final.jpg

New Programs

DBH has been tracking current capacity in relationship to available treatment resources on a monthly, quarterly and yearly basis.

The Department's unserved, underserved, and inappropriately served populations have increased, the acuity and risk level of clients has climbed and referrals from hospitals, Diversion Teams, Crisis Response Teams and Crisis Walk-in Centers have grown. As size and scope of the crisis response teams and crisis walk in centers grow, so do the referrals to the clinics for aftercare services once crisis services have been provided. There is an increased focus from the State Department of Health Care Services (DHCS) on ensuring adequate availability within provider networks and adequacy of access to behavioral health services. Assuming a very conservative "in-need" rate of **10%** in a given year among this population, we would expect that, across the county, about **27,000** persons in the target population of 15-years of age and above would qualify for outpatient mental health services in a given year.

This number far exceeds the number of residents in this age range who actually *do* receive outpatient care from general-service Department or contract sites in a 12-month period, which is approximately **14,000** TAY/Adult clients. Of the **14,000** clients age 15 and above, the age categories, diagnostic groups, and ethnicity are included below (TAY ages are 15-25, adults are 25-59, and 59-above are older adults):



New Programs

Currently, service demand is exceeding DBH clinical resources. Referrals come from many sources, but the major referral sources are the Department's Access Unit, Arrowhead Regional Medical Center Behavioral Health, Fee-for-Service hospitals, emergency rooms, crisis services, law enforcement, Medi-Cal Managed Care plans such as Inland Empire Health Plan (IEHP), Molina and consumers and their families.

Data related to the number of clients served in the DBH system of care indicates over **60%** of those referred are seen in DBH outpatient or specialty clinics. This is likely due to the system of care approach needed for clients that have multiple needs and suffer from higher levels of mental health acuity. While DBH believes that all clients can experience recovery from mental illness, many consumers need a system of care approach that is accessible only through the many levels of DBH's system including residential treatment/placement, housing, assertive case management, full service partnership (FSP), intensive outpatient services, care coordination, substance use treatment services and consumer run clubhouse programs. As the mental health care plan administrator, DBH has responsibility as the provider and/or coordinator of all Specialty Mental Health Services (SMHS) including inpatient, residential placement, forensic and outpatient care for both children and adults.

Current service data indicates that DBH outpatient clinics are currently the most impacted service sites in the DBH system of care. Approximately **10,903** consumers will be screened by the outpatient clinics during Fiscal Year 2012/13. This is an average of **909** a month, or **208** each week. Of those consumers screened for services, **45%** (4,903) will have a clinical assessment and intake for services. This is an average of **409** a month, or **94** per week. Across the DBH outpatient clinics, there are **11** Full Time Employees (FTEs) dedicated to completing the screenings and intake assessments at the clinics below, which is not nearly enough to meet the current need of consumers requesting services. In looking at episode lengths and types of services provided at DBH clinics, the number of medication, therapy and case management visits vary from site to site. Additionally, of those services who were age 15 and older, DBH outpatient clinics tended to see more adults/TAY for medication visits than contracted providers, and clients tended to stay in care longer, not moving out and creating enough capacity for newly referred patients not yet in care.

New Programs

Victor Valley Behavioral Health (VVBH) current caseload per month: 1,385

Episode Length (months)- Bipolar: **26** months

Episode Length (months)- Depression: **18** months

Episode Length (months)- Psychosis: **25** months

Phoenix Community Counseling (Phx) current caseload per month: 2,358

Episode Length (months)- Bipolar: **19** months

Episode Length (months)- Depression: **20** months

Episode Length (months)- Psychosis: **22** months

Mesa Community Counseling (Mesa) current caseload per month: 1,924

Episode Length (months)- Bipolar: **19** months

Episode Length (months)- Depression: **16** months

Episode Length (months)- Psychosis: **23** months

Upland Community Counseling (Upland) current caseload per month: 1,771

Episode Length (months)- Bipolar: **26** months

Episode Length (months)- Depression: **21** months

Episode Length (months)- Psychosis: **32** months

Needles Community Counseling (Needles) current caseload per month: 213

Episode Length (months)- Bipolar: **26** months

Episode Length (months)- Depression: **18** months

Episode Length (months)- Psychosis: **25** months

Barstow Community Counseling (Barstow) current caseload per month: 736

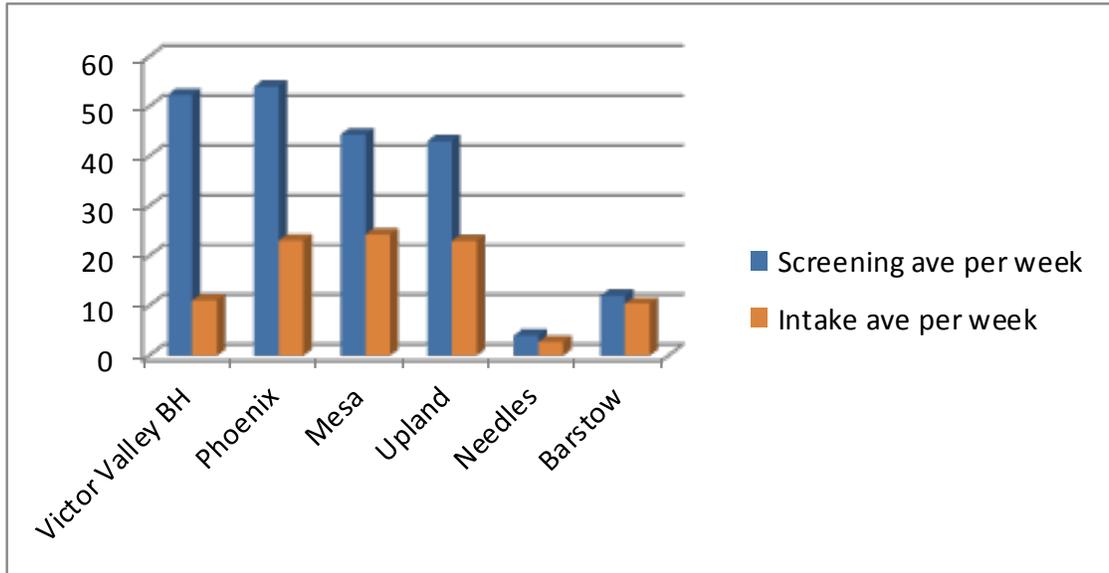
Episode Length (months)- Bipolar: **26** months

Episode Length (months)- Depression: **18** months

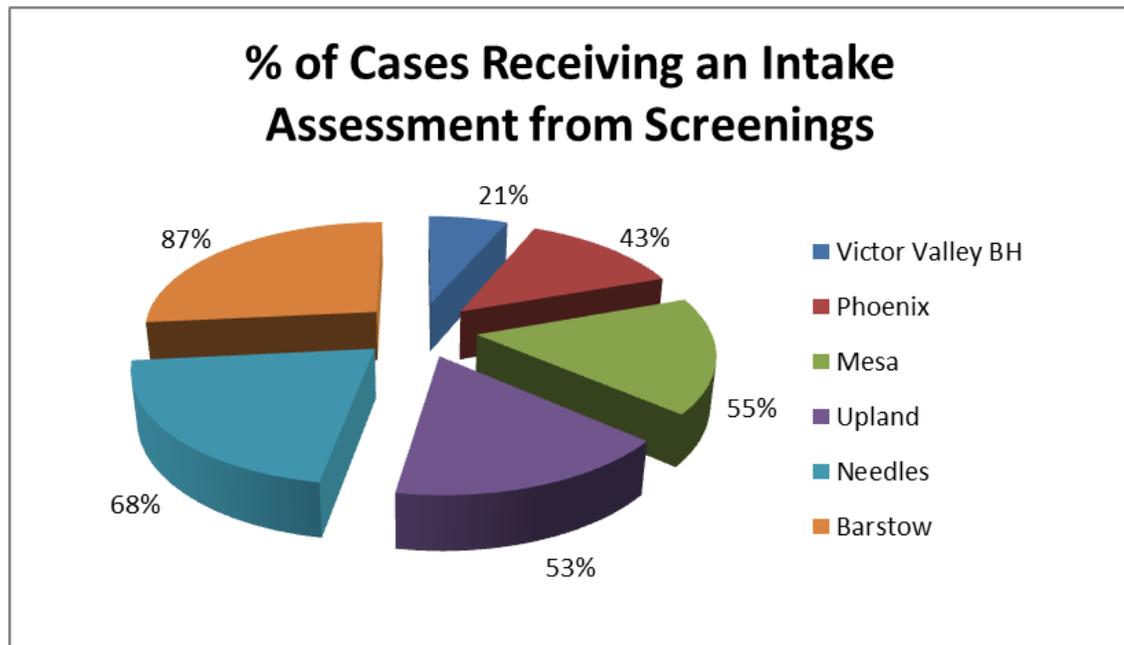
Episode Length (months)- Psychosis: **25** months

New Programs

As noted in the graph below, the number of intake assessments that can be completed per week is much lower than numbers of screenings, which is representative of overall demand. When intake assessment appointments are impacted, people with the most severe issues are prioritized while others may have to wait for additional services. While the screening does assess for clinical risk to ensure safety, a screening does not meet ongoing assessment and service needs.



Of all the cases screened, the percentage of cases receiving an assessment is detailed per site in the graph below.



New Programs

Once assessments are completed, clients need to have access based on medical necessity, to a variety of ongoing, outpatient mental health services including individual and group therapy, medication support, case management, family therapy and coordination of care services. According to data provided to DBH by the California External Quality Review Organization (CAEQRO), the average treatment costs per treatment episode per DBH beneficiary (**\$2,621/beneficiary**) over a 12-month period is **40%** less than the statewide average for the calendar year 2011 (**\$4,460/beneficiary**). Mental health services per beneficiary in this same time period, including individual therapy and case management services (**\$1,842**) were **43%** less than the state average (**\$3,269**). Additionally DBH percentages of beneficiaries that engage in outpatient services within 7-days upon discharge from an inpatient hospital is **41%** less than the state average. While these numbers do include Medi-Cal beneficiaries, they also include those receiving MHSA services and are indicative of the community feedback that we have repeatedly heard regarding impacted access to non-crisis outpatient mental health services. It is also consistent with data analysis both at the State (CAEQRO) and local level for the last calendar years of 2009, 2010, 2011.

Over the past several years DBH has built a crisis/emergency response and diversion system of care. Providing crisis and emergency services are of great importance; however, these services are to be provided in a system of care with availability of outpatient, non-emergency mental health after-care and follow-up services that include an array of medication support, individual and group therapy, case management and care coordination services.

Consistent with the stakeholder priorities of increasing Youth and Family Support as well as Improved Access to Treatment and Recovery Services, DBH is proposing to implement a new program, the Access, Coordination, and Enhancement (ACE) of Quality Behavioral Health services, A-9. The project seeks to improve the timeliness of access to DBH non-emergency outpatient services. ACE services would seek to change service delivery in the major DBH outpatient clinics and be the starting point for a transformational process in our outpatient programs and services. Strategies for reducing ethnic disparities and developing the capacity to provide values-driven, evidence-based and promising clinical practices would be addressed at the clinical system level.

Initially, ACE services will be added to the four (**4**) major regional clinics: Phoenix, Upland Community Counseling, Mesa Counseling, and Victor Valley Behavioral Health. Additional staff will be added to two (**2**) rural, desert clinics located in Barstow and Needles.

The ACE project would increase clinical staffing to perform screening and intake assessments and will increase walk-in hours from **33** per week to **120** hours per week by establishing five (**5**) days-a-week, 8:00 am - 5:00 pm walk-in assessment for clients.

New Programs

ACE would provide the following:

- Provide capacity in response to the demand for care.
- Shorter waiting times and shorter times between appointments.
- Same day psychiatrist evaluations when clinically appropriate.
- Reduced psychiatrist wait times by expediting opening of cases.
- Scheduled or non-scheduled appointments from Inpatient referrals.
- Increased individual and group therapy.
- Increased case management services.
- Facilitation of consumer access to additional benefits.
- Access to urgent psychiatric evaluation.
- Development of uniformed screenings and assessment tools.
- Improved coordination of care and referral within DBH's system of care.
- Improved access and better connectivity between referral and care organizations (such as homeless, primary health care and employment services).

Based on an increase in direct service Full Time Employees (FTEs) and the expanded hours, anticipated outcomes include:

- A **50%** increase in intake assessments scheduled.
- A **30%** increase in individual and case management cases in service.
- **100%** of clients discharged from Arrowhead Regional Medical Center Behavioral Health will have an assessment intake appointment with in 7-days of discharge.
- An appointment with a Psychiatrist within 14-days of discharge as medically necessary.
- Increased capacity to provide therapeutic services by redirecting existing FTE's.
- An increase in annual revenue of **\$1,069,000** from assessments and case management activities.
- An increase in annual service revenue from existing FTEs redirection into clinic services of **\$433,589**.

The expansion of our Community Support and Services (CSS) programs to include a ACE program include the following cost projections:

- FY 2013/14 \$2,326,527

The expansion expenses will cover staffing positions that potentially include:

- 3 - Psychiatrist
- 9 - Clinical Therapist I
- 1 - Mental Health Nurse II
- 3 - Licensed Psychiatric Technician (LPT) or Licensed Vocational Nurse (LVN)
- 3 - Mental Health Specialist
- 7 - Office Assistant III

New Programs

Once implemented, DBH would assess from the baselines measurements at current service levels in the sites above to see if objectives as listed in this program were met. Measurements would include:

- The time from hospital discharge to first outpatient service.
- The time from first service to Medication Support Service.
- The time from first screening to first therapy appointment.
- Time in the waiting room once arrived to service on the same day.
- The number and focus of case management services received.
- The number of care providers included in the care plan that are internal DBH providers (i.e., employment services, housing coordinators, Substance Use Providers).
- The number of care providers that are included in the care plan that are external providers (i.e., Primary Care Providers, Health Care Specialists, physical health care coordinators, preventive health workers).
- The inpatient psychiatric recidivism rate for those served.

Both outcomes and measurements as described would be utilized to evaluate program effectiveness through program evaluation. Outcomes will be compared to programs providing other adult, outpatient mental health services to assess if program redesigns aimed at creating additional capacity would be needed in other areas of the DBH system of care. This would include other DBH programs not included in the program expansion and contract providers of outpatient mental health services and would be addressed in future stakeholder and department planning meetings.

Cost Per Client FY 2013/14

County of San Bernardino
 Department of Behavioral Health
 Mental Health Services Act (MHSA)
 Annual Update FY 2013/14

COMMUNITY SERVICES & SUPPORTS

Program Name	Abbrev.	Total Estimated MHSA Funds	Estimated Clients Served by Age Group				Estimated Number of Clients	Cost Per Client
			Children/ Youth (0-15)	TAY (16-25)	Adult (26-59)	Older Adult (60+)		
Community Services and Supports (CSS)								
C-1: Comprehensive Children and Family Support Services	CCFSS	\$ 2,484,072	677	0	0	0	677	\$ 3,669
C-2 Integrated New Family Opportunities	INFO	\$ 1,174,792	0	68	0	0	68	\$ 17,276
TAY-1: Transitional Age Youth One Stop Centers	TAY	\$ 4,502,571	0	1,057	0	0	1,057	\$ 4,260
A-1: Clubhouse Expansion Program		\$ 2,774,875	0	0	2,367	0	2,367	\$ 1,172
A-2 Forensic Integrated Mental Health Services	STAR, FACT	\$ 3,718,799	0	0	0	180	180	\$ 20,660
A-3: Members Assertive Positive Solutions/Assertive Community Treatment Team	MAPS/ACT	\$ 2,227,355	0	0	195	0	195	\$ 11,422
A-4: Crisis Walk-In Centers	CWIC	\$ 4,133,072	220	1,850	6,300	310	8,680	\$ 476
A-5: Psychiatric Triage Diversion Program		\$ 2,300,803	5	0	4,600	152	4,757	\$ 484
A-6: Community Crisis Response Team	CCRT	\$ 5,751,411	1,500	1,500	3,300	450	6,750	\$ 852
A-7: Homeless Intensive Case Management and Outreach Services		\$ 5,463,481	0	0	1,310	0	1,310	\$ 4,171
A-8: Alliance for Behavioral and Emotional Treatment Big Bear Full Service Partnership	ABET	\$ 330,119	0	0	145	0	145	\$ 2,277
A-9: Rapid Access Service Enhancement		\$ 2,326,527	0	1,363	8,177	4,088	13,628	\$ 171
OA-1: Agewise - Circle of Care		\$ 1,518,506	0	0	0	240	240	\$ 6,327
OA-2 Agewise - Mobile Reponse		\$ 857,484	0	0	0	1,120	1,120	\$ 766
Total Program Costs		\$ 39,563,867						

Total Clients Served = **41,174** or **\$1,249** per person

Cost Per Client FY 2013/14

County of San Bernardino
 Department of Behavioral Health
 Mental Health Services Act (MHSA)
 Annual Update FY 2013/14

COMMUNITY SERVICES & SUPPORTS

Program Name	Abbrev.	Estimated MHSA Funds by Service Category		
		Full Service Partnership	General System Development	Outreach and Engagement
Community Services and Supports (CSS)				
C-1: Comprehensive Children and Family Support Services	CCFSS	\$ 2,484,072		
C-2 Integrated New Family Opportunities	INFO	\$ 1,174,792		
TAY-1: Transitional Age Youth One Stop Centers	TAY	\$ 4,502,571		
A-1: Clubhouse Expansion Program				\$ 2,774,875
A-2 Forensic Integrated Mental Health Services	STAR, FACT	\$ 3,718,799		
A-3: Members Assertive Positive Solutions/Assertive Community Treatment Team	MAPS/ACT	\$ 2,227,355		
A-4: Crisis Walk-In Centers	CWIC		\$ 4,133,072	
A-5: Psychiatric Triage Diversion Program			\$ 2,300,803	
A-6: Community Crisis Response Team	CCRT		\$ 5,751,411	
A-7: Homeless Intensive Case Management and Outreach Services		\$ 5,463,481		
A-8: Alliance for Behavioral and Emotional Treatment Big Bear Full Service Partnership	ABET	\$ 330,119		
A-9: Rapid Access Service Enhancement			\$ 2,326,527	
OA-1: Agewise - Circle of Care			\$ 1,518,506	
OA-2 Agewise - Mobile Reponse		\$ 857,484		
Total Program Costs		\$ 20,758,673	\$ 16,030,319	\$ 2,774,875
*Allocation of FSP, O/R & GSD based on MHSA Rev & Exp Report				

Cost Per Client FY 2013/14

County of San Bernardino
 Department of Behavioral Health
 Mental Health Services Act (MHSA)
 Annual Update FY 2013/14

INNOVATION

	Program Name	Abbrev.	Total Estimated MHSA Funds	Estimated Clients Served by Age Group					Cost Per Client
				Children/ Youth (0-15)	TAY (16-25)	Adult (26-59)	Older Adult (60+)	Estimated Number of Clients	
Innovation	Innovation								
	Coalition Against Sexual Exploitation	CASE	\$ 657,675	40	10	0	0	50	\$ 13,154
	Community Resiliency Model	CRM	\$ 20,000	0	0	0	0	0	
	Holistic Campus	HC	\$ 2,547,642	678	2,784	7,884	1,000	12,346	\$ 206
	Interagency Youth Resiliency Team	IYRT	\$ 1,471,744	90	110	50	50	300	\$ 4,906
	On-Line Diverse Community Experience	ODCE	\$ -	0	0	0	0	0	
	Transitional Age Youth Behavioral Health Hostel	TAYBHH	\$ 1,209,569	0	156	0	0	156	\$ 7,754
	Total Program Costs		\$ 5,906,630						
	INN Administration		\$ 576,782						
	Total INN		\$ 6,483,412						

Total Clients Served = **12,852** or **\$504** per person

Cost Per Client FY 2013/14

County of San Bernardino
 Department of Behavioral Health
 Mental Health Services Act (MHSA)
 Annual Update FY 2013/14

PREVENTION & EARLY INTERVENTION

	Program Name	Abbrev.	Total Estimated MHSA Funds	Estimated Clients Served by Age Group				Estimated Number of Clients	Cost Per Client
				Children/ Youth (0-15)	TAY (16-25)	Adult (26-59)	Older Adult (60+)		
Prevention and Early Intervention	Prevention and Early Intervention								
	Child and Youth Connection	CYC	\$ 1,838,593	6,247	84	373	8	6,712	\$ 274
	Community Wholeness and Enrichment	CWE	\$ 2,774,163	0	3,947	2,251	0	6,198	\$ 448
	Family Resource Centers	FRC	\$ 3,388,604	2,836	1,051	2,866	213	6,966	\$ 486
	Lift	Lift	\$ 396,000	0	55	65	0	120	\$ 3,300
	Military Services and Family Support	MSFS	\$ 600,000	92	232	1,336	8	1,668	\$ 360
	National Crossroads Education Institute Training	NCTI	\$ 500,000	15,619	0	0	0	15,619	\$ 32
	Native American Resource Center	NARC	\$ 500,000	277	785	475	213	1,750	\$ 286
	Older Adult Community Services	OACS	\$ 900,000	0	0	0	8,160	8,160	\$ 110
	PEI Preschool Program	PPP	\$ 312,192	734		101		835	\$ 374
	Promotores de Salud	PdS	\$ 1,050,000	420	1,469	17,833	1,259	20,981	\$ 50
	Resiliency in African American Children	RPiAAC	\$ 458,667	1,329	5	65	0	1,399	\$ 328
	Student Assistance Program	SAP	\$ 2,975,000	19,264	1,722	2,694	0	23,680	\$ 126
	Total Program Costs			\$ 15,693,219					
	PEI Administration			\$ 2,694,968					
Total PEI			\$ 18,388,187						

Total Clients Served = **94,088** or **\$195** per person

**FY 2013/14
MHSA FUNDING SUMMARY**

County: SAN BERNARDINO

Date: 4/25/2013

	MHSA Funding					
	CSS	WET	CFTN	PEI	INN	Local Prudent Reserve
A. Estimated FY 2013/14 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	\$22,521,133	\$4,682,224	\$12,096,413	\$21,034,234	\$9,087,727	
2. Estimated New FY 2013/14 Funding	\$46,636,684			\$11,657,852	\$3,066,189	
3. Transfer in FY 2013/14 ^{a/}	(\$1,105,015)		\$1,105,015			
4. Access Local Prudent Reserve in FY 2013/14						
5. Estimated Available Funding for FY 2013/14	\$68,052,802	\$4,682,224	\$13,201,428	\$32,692,086	\$12,153,916	
B. Estimated FY 2013/14 Expenditures	\$51,443,779	\$1,711,015	\$6,120,329	\$18,388,187	\$7,352,077	
C. Estimated FY 2013/14 Contingency Funding	\$16,609,023	\$2,971,209	\$7,081,099	\$14,303,899	\$4,801,839	

^{a/}Per 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 years.

D. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2013	\$22,152,363
2. Contributions to the Local Prudent Reserve in FY 2013/14	
3. Distributions from Local Prudent Reserve in FY 2013/14	\$0
4. Estimated Local Prudent Reserve Balance on June 30, 2014	\$22,152,363

Attachments

- A. County Certification
- B. County Fiscal Accountability Certification
- C. Press Releases (English & Spanish): Community Planning Meetings
- D. Stakeholder Meeting Schedule (English & Spanish)
- E. Stakeholder Community Planning Meeting Comment Forms
- F. Press Releases (English & Spanish): 30-Day Public Posting Notice
- G. Public Hearing Notice (English & Spanish)

MHSA COUNTY COMPLIANCE CERTIFICATION

County: San Bernardino

Local Mental Health Director	Program Lead
Name: CaSonya Thomas	Name: Susanne Kulesa
Telephone Number: (909) 382-3133	Telephone Number: (909) 252-4068
E-mail: cthomas@dbh.sbcounty.gov	E-mail: skulesa@dbh.sbcounty.gov
County Mental Health Mailing Address: 268 W. Hospitality Lane, Suite 400 San Bernardino, CA 92415	

I hereby certify that I am the official responsible for the administration of county mental health services in and for said county and that the County has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this annual update, including stakeholder participation and nonsupplantation requirements.

This 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 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.

CaSonya Thomas
Local Mental Health Director/Designee (PRINT)



 Signature Date 4/24/13

County: San Bernardino

Date: May 1, 2013

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION¹

County/City: San Bernardino County

- 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	Name: Larry Walker
Telephone Number: (909) 382-3133	Telephone Number: (909) 386-9000
E-mail: cthomas@dbh.sbcounty.gov	E-mail: Larry.Walker@atc.sbcounty.gov
Local Mental Health Mailing Address:	
268 West Hospitality Lane, Suite 400 San Bernardino, CA 92415	

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 other counties in future years.

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

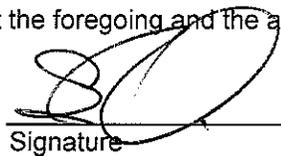
CaSonya Thomas
Local Mental Health Director (PRINT)

 4/30/13
Signature Date

I hereby certify that for the fiscal year ended June 30, 2012, 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 12/29/2012 for the fiscal year ended June 30, 2012. I further certify that for the fiscal year ended June 30, 2012, 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 the attached report is true and correct to the best of my knowledge

Sonia Hermosillo
County Auditor Controller / City Financial Officer (PRINT)

 5/2/13
Signature Date

¹ Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)
 Three-Year Program and Expenditure Plan Annual Update, and RER Certification (02/14/2013)
 County of San Bernardino Department of Behavioral Health
 Mental Health Services Act Annual Update Fiscal Year 2013/14

NEWS

From the County of San Bernardino
www.sbcounty.gov



FOR IMMEDIATE RELEASE

March 25, 2013

For more information, contact
Susanne Kulesa, Program Manager I
Department of Behavioral Health
909-252-4068
skulesa@dbh.sbcounty.gov

You are invited by the Department of Behavioral Health to attend a Mental Health Services Act (MHSA) Annual Update and Innovation Stakeholder Meeting.

WHO: All residents living in the County of San Bernardino who are interested in the public mental health service delivery system, learning about the Mental Health Services Act (MHSA) and participating in the Annual Update for Fiscal Year 2013/14 and Innovation Stakeholder Meeting.

WHAT: There is a series of public meetings planned that will take place throughout the county to promote community conversation and participation regarding the MHSA Annual Update for Fiscal Year 2013/14 and to discuss topics for future MHSA Innovation projects.

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% tax surcharge on personal income over \$1 million per year.

WHY: To provide information and promote community conversation regarding the MHSA Annual Update for Fiscal Year 2013/14 and how it will affect the residents of the County of San Bernardino. Also, we will be facilitating a discussion to obtain ideas, topics, and suggestions for future MHSA Innovation projects.

WHEN & WHERE:

Central Valley Region

<p>Asian Pacific Islander (API) Coalition Meeting Asian American Resource Center 1115 South "E" Street San Bernardino, CA 92408</p> <p>April 9, 2013 10:00 a.m. – 12:00 p.m.</p>	<p>Spirituality Sub-Committee Training Institute 1950 S. Sunwest Lane, Suite 200 San Bernardino, CA 92415</p> <p>April 9, 2013 1:00 p.m. – 2:30 p.m.</p>	<p>Native American Awareness Committee Native American Resource Center Riverside-San Bernardino County Indian Health, Inc 2210 E. Highland Ave., Suite 101 & 102 San Bernardino, CA 92404</p> <p>April 16, 2013 2:00 p.m. – 3:30 p.m.</p>	
<p>Transitional Age Youth (TAY) Committee One –Stop TAY Center 780 E. Gilbert Street San Bernardino, CA 92415</p> <p>April 17, 2013 10:00 a.m. – 11:30 a.m.</p>	<p>Community Policy Advisory Council County of San Bernardino (CPAC) County of San Bernardino Health Services, Auditorium 850 E. Foothill Blvd. Rialto, CA 92376</p> <p>April 18, 2013 9:00 a.m. – 11:00 a.m.</p>	<p>Cultural Competency Advisory Committee (CCAC) County of San Bernardino Health Services, Auditorium 850 E. Foothill Blvd. Rialto, CA 92376</p> <p>April 18, 2013 1:00 p.m. – 2:30 p.m.</p>	
<p>Co-Occurring Substance Abuse Committee (COSAC) County of San Bernardino Health Services, Auditorium 850 E. Foothill Blvd. Rialto, CA 92376</p> <p>April 18, 2013 2:30 p.m. – 4:30 p.m.</p>	<p>District Advisory Committee (DAC) 5th District New Hope Family Life Center 1505 W. Highland Ave. San Bernardino, CA 92411</p> <p>April 22, 2013 5:30 p.m. – 7:30 p.m.</p>	<p>Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ) Subcommittee One –Stop TAY Center 780 E. Gilbert Street San Bernardino, CA 92415</p> <p>April 23, 2013 12:30 p.m. - 2:00 p.m.</p>	
<p>Department of Behavioral Health (DBH) Training Institute 1950 S. Sunwest Lane, Ste. 200 San Bernardino, CA 92415 <i>Event will be live at the DBH Training Institute with a webcast in the desert & west-end regions.</i> <i>To participate from your own computer please call (800) 722-9866 to register.</i></p> <p>April 24, 2013 3:00 p.m. – 4:30 p.m.</p>		<p>Latino Health Coalition El Sol Neighborhood Educational Center 972 N. Mount Vernon Ave. San Bernardino, CA 92411 <i>Spanish Language Meeting</i></p> <p>April 25, 2013 10:00 a.m. - 11:30 a.m.</p>	

Desert / Mountain Region

<p>High Desert African American Mental Health Coalition Victor Valley Clubhouse 12625 Hesperia Rd. Victorville, CA 92395</p> <p align="center">April 8, 2013 1:00 p.m. – 2:30 p.m.</p>	<p>City of Needles Recreation Center 1705 J Street Needles, CA 92363</p> <p align="center">April 10, 2013 1:00 p.m. - 2:30 p.m.</p>	<p>District Advisory Committee (DAC) 1st District Victorville Behavioral Health Center, Room A-11 12625 Hesperia Rd. Victorville, CA 92395</p> <p align="center">April 17, 2013 11:00 a.m. – 12:30 p.m.</p>
<p>Lake Arrowhead/Crestline Rim of the World High School, Library Room 27400 Highway 18 Lake Arrowhead, CA 92352</p> <p align="center">April 18, 2013 3:30 p.m. - 5:30 p.m.</p>	<p>Big Bear Middle School Room 4 41275 Big Bear Blvd Big Bear Lake, CA 92315</p> <p align="center">April 22, 2013 1:00 p.m. - 3:00 p.m.</p>	<p>District Advisory Committee (DAC) 3rd District Santa Fe Social Club 56020 Santa Fe Trail, Suite M Yucca Valley, CA 92284</p> <p align="center">April 23, 2013 1:00 p.m. – 2:30 p.m.</p>
<p align="center">Morongo Basin Mental Health 55475 Santa Fe Trail Yucca Valley, CA 92284 <i>Via Webcast</i></p> <p align="center">April 24, 2013 3:00 p.m. – 4:30 p.m.</p>		

West Valley Region

<p>District Advisory Committees 2nd & 4th Districts Rancho Cucamonga Family Resource Center 9791 Arrow Route Rancho Cucamonga, CA 91730</p> <p align="center">April 11, 2013 3:00 p.m. – 4:30 p.m.</p>	<p>South Coast Community Services 2930 Inland Empire Blvd., Suite 120 Ontario, CA 91764 <i>Via Webcast</i></p> <p align="center">April 24, 2013 3:00 p.m. – 4:30 p.m.</p>
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NOTE: If special accommodations or interpretation services are required, or to learn more about the Spanish language forum please call 1-800-722-9866 or 711 for TTY users.

CONTACT: For additional information, please contact Susanne Kulesa at (909) 252-4068.

-END-

NOTICIAS

Del Condado de San Bernardino

www.sbcounty.gov



PARA PUBLICACION INMEDIATA

25 de marzo del 2013

Para más información, comuníquese con
Susanne Kulesa, Administradora de Programa
Departamento de Salud Mental
909-252-4068
skulesa@dbh.sbcounty.gov

El Departamento de Salud Mental le invita a asistir a una reunión sobre la Actualización Anual de la Planificación Pública de la Ley de Servicios de Salud Mental (MHSA, por sus siglas en inglés) y para personas o agencias interesadas en el componente de Innovación de MHSA.

¿Quién?: Todos los residentes del Condado de San Bernardino que estén interesados en el sistema de la prestación de servicios de salud mental, que quieran aprender sobre la Ley de Servicios de Salud Mental (MHSA, por sus siglas en inglés), que quieran participar en la Actualización de la Ley De Servicios de Salud Mental para el año fiscal 2013/2014 y que estén interesadas en el componente de Innovación de MHSA.

¿Qué: Hay una serie de reuniones públicas planificadas, que se llevarán a cabo en todo el condado para promover las conversaciones comunitarias y participación en cuanto a la Actualización Anual del MHSA, correspondiente al año fiscal 2013/2014, y para conversar sobre temas relacionados con futuros proyectos del componente de Innovación de MHSA.

La Ley De Servicios de Salud Mental (también conocida como Proposición 63, MHSA por sus siglas en inglés) fue aprobada por los electores de California en noviembre del 2004 para ampliar los servicios de salud mental para niños y adultos. MHSA es financiada por un impuesto adicional de 1% para aquellos cuyos ingresos personales son más de un millón de dólares al año.

¿Por qué?: Para proporcionar información y promover conversaciones comunitarias sobre la Actualización Anual del MHSA para el año fiscal 2013/2014 y explicar cómo esto afectará a los residentes del Condado de San Bernardino. También, vamos a llevar a cabo una conversación para obtener ideas, temas y sugerencias para futuros proyectos del componente de Innovación de MHSA.

Dónde y Cuándo:

Región del Valle Central

<p>Coalición Asiática-Isleños del Pacífico Asian American Resource Center 1115 South "E" Street San Bernardino, CA 92408</p> <p>9 de abril, 2013 10:00 a.m. – 12:00 p.m.</p>	<p>Subcomité de Espiritualidad Instituto de Entrenamiento 1950 S. Sunwest Lane, Suite 200 San Bernardino, CA 92415</p> <p>9 de abril, 2013 1:00 p.m. – 2:30 p.m.</p>	<p>Comité de Conciencia sobre Nativos Americanos Native American Resource Center Riverside-San Bernardino County Indian Health, Inc. 2210 E. Highland Ave., Suite 101 & 102 San Bernardino, CA 92404</p> <p>16 de abril, 2013 2:00 p.m. – 3:30 p.m.</p>
<p>Comité de Jóvenes en Edad de Transición (TAY por sus siglas en inglés) One –Stop TAY Center 780 E. Gilbert Street San Bernardino, CA 92415</p> <p>17 de abril, 2013 10:00 a.m. – 11:30 a.m.</p>	<p>Comité Asesor de Políticas Comunitarias (CPAC por sus siglas en inglés) County of San Bernardino Health Services, Auditorium 850 E. Foothill Blvd. Rialto, CA 92376</p> <p>18 de abril, 2013 9:00 a.m. – 11:00 a.m.</p>	<p>Comité Consultivo de Competencia Cultural (CCAC por sus siglas en inglés) County of San Bernardino Health Services, Auditorium 850 E. Foothill Blvd. Rialto, CA 92376</p> <p>18 de abril, 2013 1:00 p.m. – 2:30 p.m.</p>
<p>Comité de Abuso de Substancias y Trastornos Concurrentes (COSAC por sus siglas en inglés) County of San Bernardino Health Services, Auditorium 850 E. Foothill Blvd. Rialto, CA 92376</p> <p>18 de abril, 2013 2:30 p.m. – 4:30 p.m.</p>	<p>Comité Consejero del Distrito 5 (DAC por sus siglas en inglés) New Hope Family Life Center 1505 W. Highland Ave. San Bernardino, CA 92411</p> <p>22 de abril, 2013 5:30 p.m. – 7:30 p.m.</p>	<p>Subcomité de la Comunidad de Lesbianas, Homosexual, Bisexuales, Transgénero y Personas Cuestionando su Sexualidad (LGBTQ por sus siglas en inglés) One-Stop TAY Center 780 E. Gilbert Street San Bernardino, CA 92415</p> <p>23 de abril, 2013 12:30 p.m. -2:00 p.m.</p>
<p>Departamento de Salud Mental, Instituto de Entrenamiento 1950 S. Sunwest Lane, Suite 200 San Bernardino, CA 92415</p> <p><i>El evento será en vivo en el Instituto de Entrenamiento con un Reunión Vía La Red en las regiones del desierto y del este. Para participar desde su propia computadora, por favor llame al (800) 722-9866 para registrarse.</i></p> <p>24 de abril, 2013 3:00 p.m. – 4:30 p.m.</p>		<p>Coalición de Salud Latina El Sol Neighborhood Educational Center 972 N Mount Vernon Ave San Bernardino, CA 92411</p> <p><i>Reunión se llevará a cabo en el Idioma Español</i></p> <p>25 de abril, 2013 10:00 a.m. - 11:30 a.m.</p>

Región del Desierto y Montañas

<p>Coalición de Salud Mental Afro-Americana del Desierto Alto Victor Valley Clubhouse 12625 Hesperia Rd. Victorville, CA 92395</p> <p style="text-align: center;">8 de abril, 2013 1:00 p.m. – 2:30 p.m.</p>	<p>City of Needles Recreation Center 1705 J Street Needles, CA 92363</p> <p style="text-align: center;">10 de abril, 2013 1:00 p.m. - 2:30 p.m.</p>	<p>Comité Consejero del Distrito 1 (DAC por sus siglas en inglés) Victorville Behavioral Health Center, Room A-11 12625 Hesperia Rd. Victorville, CA 92395</p> <p style="text-align: center;">17 de abril, 2013 11:00 p.m. – 12:30 p.m.</p>
<p>Lake Arrowhead/Crestline Rim of the World High School, Biblioteca 27400 Highway 18 Lake Arrowhead, CA 92352</p> <p style="text-align: center;">18 de abril, 2013 3:30 p.m. - 5:30 p.m.</p>	<p>Big Bear Middle School Room 4 41275 Big Bear Blvd Big Bear Lake, CA 92315</p> <p style="text-align: center;">22 de abril, 2013 1:00 p.m. -3:00 p.m.</p>	<p>Comité Consejero del Distrito 3 (DAC por sus siglas en inglés) Santa Fe Social Club 56020 Santa Fe Trail, Suite M Yucca Valley, CA 92284</p> <p style="text-align: center;">23 de abril, 2013 1:00 p.m. – 2:30 p.m.</p>
<p>Morongo Basin Mental Health 55475 Santa Fe Trail Yucca Valley, CA 92284 <i>Reunión Vía La Red (vía Webcast)</i></p> <p style="text-align: center;">24 de abril, 2013 3:00 p.m. – 4:30 p.m.</p>		

Región del Valle Este

<p>Comité Consejero de Distritos 2 & 4 (DAC por sus siglas en inglés) Rancho Cucamonga Family Resource Center 9791 Arrow Route Rancho Cucamonga, CA 91730</p> <p style="text-align: center;">11 de abril, 2013 3:00 p.m. – 4:30 p.m.</p>	<p>South Coast Community Services 2930 Inland Empire Blvd., Suite 120 Ontario, CA 91764 <i>Reunión Vía La Red (vía Webcast)</i></p> <p style="text-align: center;">24 de abril, 2013 3:00 p.m. – 4:30 p.m.</p>
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NOTA: Si se necesitan arreglos especiales (relacionados con alguna discapacidad) o servicios de interpretación, o si desea saber más sobre la reunión en español, o para registrarse para participar en el Webcast, por favor de llamar al (800) 722- 9866, ó al 7-1-1 si es usuario de TTY.

CONTACTO: Para más información, por favor comuníquese con Susanne Kulesa al (909) 252-4068.

-FINAL-



**County of San Bernardino Department of Behavioral Health
Mental Health Services Act Annual Update
Community Planning Meetings
Fiscal Year 2013/2014**



Central Valley Region

<p>Asian Pacific Islander (API) Coalition Meeting Asian American Resource Center 1115 South "E" Street San Bernardino, CA 92408</p> <p align="center">April 9, 2013 10:00 a.m. – 12:00 p.m.</p>	<p>Spirituality Sub-Committee Training Institute 1950 S. Sunwest Lane, Suite 200 San Bernardino, CA 92415</p> <p align="center">April 9, 2013 1:00 p.m. – 3:00 p.m.</p>	<p>Native American Awareness Committee Native American Resource Center Riverside-San Bernardino County Indian Health, Inc 2210 E. Highland Ave., Suite 101 & 102 San Bernardino, CA 92404</p> <p align="center">April 16, 2013 2:00 p.m. – 4:00 p.m.</p>
<p>Transitional Age Youth (TAY) Committee One-Stop TAY Center 780 E. Gilbert Street San Bernardino, CA 92415</p> <p align="center">April 17, 2013 10:00 a.m. – 12:00 p.m.</p>	<p>Community Policy Advisory Council County of San Bernardino (CPAC) County of San Bernardino Health Services, Auditorium 850 E. Foothill Blvd. Rialto, CA 92376</p> <p align="center">April 18, 2013 9:00 a.m. – 11:00 a.m.</p>	<p>Cultural Competency Advisory Committee (CCAC) County of San Bernardino Health Services, Auditorium 850 E. Foothill Blvd. Rialto, CA 92376</p> <p align="center">April 18, 2013 1:00 p.m. – 3:00 p.m.</p>
<p>Co-Occurring Substance Abuse Committee (COSAC) County of San Bernardino Health Services, F119-120 850 E. Foothill Blvd. Rialto, CA 92376</p> <p align="center">April 18, 2013 2:30 p.m. – 4:30 p.m.</p>	<p>District Advisory Committee (DAC) 5th District New Hope Family Life Center 1505 W. Highland Ave. San Bernardino, CA 92411</p> <p align="center">April 22, 2013 5:30 p.m. – 7:30 p.m.</p>	<p>Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ) Subcommittee One-Stop TAY Center 780 E. Gilbert Street San Bernardino, CA 92415</p> <p align="center">April 23, 2013 12:30 p.m. - 2:30 p.m.</p>
<p>Department of Behavioral Health (DBH) Training Institute 1950 S. Sunwest Lane, Ste. 200 San Bernardino, CA 92415 <i>Event will be live at the DBH Training Institute with a webcast in the desert & west-end regions. To participate from your own computer please call (800) 722-9866 to register.</i></p> <p align="center">April 24, 2013 3:00 p.m. – 5:00 p.m.</p>		<p>Latino Health Coalition El Sol Neighborhood Educational Center 972 N. Mount Vernon Ave. San Bernardino, CA 92411 Spanish Language Meeting</p> <p align="center">April 25, 2013 10:00 a.m. - 12:00 p.m.</p>

Desert / Mountain Region

<p>High Desert African American Mental Health Coalition Victor Valley Clubhouse 12625 Hesperia Rd. Victorville, CA 92395</p> <p align="center">April 8, 2013 1:00 p.m. – 3:00 p.m.</p>	<p>City of Needles Recreation Center 1705 J Street Needles, CA 92363</p> <p align="center">April 10, 2013 1:00 p.m. - 3:00 p.m.</p>	<p>District Advisory Committee (DAC) 1st District Victorville Behavioral Health Center, Room A-11 12625 Hesperia Rd. Victorville, CA 92395</p> <p align="center">April 17, 2013 11:00 a.m. – 1:00 p.m.</p>
<p>Lake Arrowhead/Crestline Rim of the World High School, Library Room 27400 Highway 18 Lake Arrowhead, CA 92352</p> <p align="center">April 18, 2013 3:30 p.m. - 5:30 p.m.</p>	<p>Big Bear Middle School Room 4 41275 Big Bear Blvd Big Bear Lake, Ca, 92315</p> <p align="center">April 22, 2013 1:00 p.m. - 3:00 p.m.</p>	<p>District Advisory Committee (DAC) 3rd District Santa Fe Social Club 56020 Santa Fe Trail, Suite M Yucca Valley, CA 92284</p> <p align="center">April 23, 2013 1:00 p.m. – 3:00 p.m.</p>
<p align="center">Morongo Basin Mental Health 55475 Santa Fe Trail Yucca Valley, CA 92284 <i>Via Webcast</i></p> <p align="center">April 24, 2013 3:00 p.m. – 5:00 p.m.</p>		

West Valley Region

<p>District Advisory Committees 2nd & 4th Districts Rancho Cucamonga Family Resource Center 9791 Arrow Route Rancho Cucamonga, CA 91730</p> <p align="center">April 11, 2013 3:00 p.m. – 5:00 p.m.</p>	<p>South Coast Community Services 2930 Inland Empire Blvd., Suite 120 Ontario, CA 91764 <i>Via Webcast</i></p> <p align="center">April 24, 2013 3:00 p.m. – 5:00 p.m.</p>
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CONTACT: For additional information, please contact Susanne Kulesa at (909) 252-4068.

NOTE: If special accommodations or interpretation services are required or to learn more about the Spanish language forum please call 1-800-722-9866 or 711 for TTY users.



**Condado de San Bernardino Departamento de Salud Mental
Ley de Servicios de Salud Mental (MHSa por sus siglas en inglés)
Reuniones Comunitarias para la Planificación de la
Actualización Anual de MHSa
Año Fiscal 2013/2014**



Región del Valle Central

<p>Coalición Asiática-Isleños del Pacífico Asian American Resource Center 1115 South "E" Street San Bernardino, CA 92408</p> <p align="center">9 de abril, 2013 10:00 a.m. – 12:00 p.m.</p>	<p>Subcomité de Espiritualidad Instituto de Entrenamiento 1950 S. Sunwest Lane, Suite 200 San Bernardino, CA 92415</p> <p align="center">9 de abril, 2013 1:00 p.m. – 3:00 p.m.</p>	<p>Comité de Conciencia sobre Nativos Americanos Native American Resource Center Riverside-San Bernardino County Indian Health, Inc. 2210 E. Highland Ave., Suite 101 & 102 San Bernardino, CA 92404</p> <p align="center">16 de abril, 2013 2:00 p.m. – 4:00 p.m.</p>
<p>Comité de Jóvenes en Edad de Transición (TAY por sus siglas en inglés) One –Stop TAY Center 780 E. Gilbert Street San Bernardino, CA 92415</p> <p align="center">17 de abril, 2013 10:00 a.m. – 12:00 p.m.</p>	<p>Comité Asesor de Políticas Comunitarias (CPAC por sus siglas en inglés) County of San Bernardino Health Services, Auditorium 850 E. Foothill Blvd. Rialto, CA 92376</p> <p align="center">18 de abril, 2013 9:00 a.m. – 11:00 a.m.</p>	<p>Comité Consultivo de Competencia Cultural (CCAC por sus siglas en inglés) County of San Bernardino Health Services, Auditorium 850 E. Foothill Blvd. Rialto, CA 92376</p> <p align="center">18 de abril, 2013 1:00 p.m. – 3:00 p.m.</p>
<p>Comité de Abuso de Sustancias y Trastornos Concurrentes (COSAC por sus siglas en inglés) County of San Bernardino Health Services, F119-120 850 E. Foothill Blvd. Rialto, CA 92376</p> <p align="center">18 de abril, 2013 2:30 p.m. – 4:30 p.m.</p>	<p>Comité Consejero del Distrito 5 (DAC por sus siglas en inglés) New Hope Family Life Center 1505 W. Highland Ave. San Bernardino, CA 92411</p> <p align="center">22 de abril, 2013 5:30 p.m. – 7:30 p.m.</p>	<p>Subcomité de la Comunidad de Lesbianas, Homosexual, Bisexuales, Transgénero y Personas Cuestionando su Sexualidad (LGBTQ por sus siglas en inglés) One-Stop TAY Center 780 E. Gilbert Street San Bernardino, CA 92415</p> <p align="center">23 de abril, 2013 12:30 p.m. - 2:30 p.m.</p>
<p>Departamento de Salud Mental, Instituto de Entrenamiento 1950 S. Sunwest Lane, Suite 200 San Bernardino, CA 92415</p> <p><i>El evento será en vivo en el Instituto de Entrenamiento con un Reunión Vía La Red en las regiones del desierto y del este. Para participar desde su propia computadora, por favor llame al (800) 722-9866 para registrarse.</i></p> <p align="center">24 de abril, 2013 3:00 p.m. – 5:00 p.m.</p>		<p>Coalición de Salud Latina El Sol Neighborhood Educational Center 972 N Mount Vernon Ave San Bernardino, CA 92411</p> <p align="center"><i>Reunión se llevará a cabo en el Idioma Español</i></p> <p align="center">25 de abril, 2013 10:00 a.m. - 12:00 p.m.</p>

Región del Desierto y Montañas

<p>Coalición de Salud Mental Afro-Americana del Desierto Alto Victor Valley Clubhouse 12625 Hesperia Rd. Victorville, CA 92395</p> <p align="center">8 de abril, 2013 1:00 p.m. – 3:00 p.m.</p>	<p>City of Needles Recreation Center 1705 J Street Needles, CA 92363</p> <p align="center">10 de abril, 2013 1:00 p.m. - 3:00 p.m.</p>	<p>Comité Consejero del Distrito 1 (DAC por sus siglas en inglés) Victorville Behavioral Health Center, Room A-11 12625 Hesperia Rd. Victorville, CA 92395</p> <p align="center">17 de abril, 2013 11:00 a.m. – 1:00 p.m.</p>
<p>Lake Arrowhead/Crestline Rim of the World High School, Biblioteca 27400 Highway 18 Lake Arrowhead, CA 92352</p> <p align="center">18 de abril, 2013 3:30 p.m. - 5:30 p.m.</p>	<p>Big Bear Middle School Room 4 41275 Big Bear Blvd Big Bear Lake, CA 92315</p> <p align="center">22 de abril, 2013 1:00 p.m. - 3:00 p.m.</p>	<p>Comité Consejero del Distrito 3 (DAC por sus siglas en inglés) Santa Fe Social Club 56020 Santa Fe Trail, Suite M Yucca Valley, CA 92284</p> <p align="center">23 de abril, 2013 1:00 p.m. – 3:00 p.m.</p>
<p align="center">Morongo Basin Mental Health 55475 Santa Fe Trail Yucca Valley, CA 92284 <i>Reunión Vía La Red (vía Webcast)</i></p> <p align="center">24 de abril, 2013 3:00 p.m. – 5:00 p.m.</p>		

Región del Valle Occidental

<p>Comité Consejero de Distritos 2 & 4 (DAC por sus siglas en inglés) Rancho Cucamonga Family Resource Center 9791 Arrow Route Rancho Cucamonga, CA 91730</p> <p align="center">11 de abril, 2013 3:00 p.m. – 5:00 p.m.</p>	<p>South Coast Community Services 2930 Inland Empire Blvd., Suite 120 Ontario, CA 91764 <i>Reunión Vía La Red (vía Webcast)</i></p> <p align="center">24 de abril, 2013 3:00 p.m. – 5:00 p.m.</p>
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NOTA: Si se necesitan arreglos especiales (relacionados con alguna discapacidad) o servicios de interpretación, o si desea saber más sobre la reunión en español, o para registrarse para participar en el Webcast, por favor de llamar al (800) 722- 9866, ó al 7-1-1 si es usuario de TTY.

CONTACTO: Para más información, por favor comuníquese con Susanne Kulesa al (909) 252-4068.



County of San Bernardino Department of Behavioral Health

Mental Health Services Act (MHSA) Fiscal Year 2013/14 Annual Update

Stakeholder Comment Form

What is your age?

0-17 yrs 18-24 yrs 25-59 yrs 60 + yrs

What is your gender?

Male Female 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
- Consumer of Mental Health Services
- Law Enforcement
- Education
- Community Agency
- Faith Community
- County Staff
- Social Services Agency
- Health Care Provider
- Community Member
- Active Military or Veteran
- Representative from Veterans Organization
- Provider of Alcohol and Drug Services

What is your ethnicity?

- Latino/Hispanic
- African American
- Caucasian/White
- Asian/Pacific Islander
- American Indian/Native American
- Other (specify) _____

What is your primary language?

- English
- Spanish
- Vietnamese
- Other _____

What is your general feeling about the MHSA Annual Update in the County of San Bernardino?

Very Satisfied Somewhat Satisfied Satisfied Unsatisfied Very Unsatisfied

What is your highest priority regarding the MHSA Annual Update?

_____ Basic Needs-Transportation _____ Family and Youth Support _____ Emergency Preparedness
_____ Increased Access/Availability of Treatment/Recovery _____ Administrative Support

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 the County of San Bernardino.



Departamento de Salud Mental del Condado de San Bernardino

Actualización Anual del Año Fiscal 2013/14 de la Ley de Servicios de Salud Mental (MHSA por sus siglas en inglés) *Formulario de Comentarios para Personas Interesadas*

¿Cuál es su edad?

0-17 años 18-24 años 25-59 años 60 años o más

¿Cual es su género?

Masculino Femenino Otro _____

¿En qué región vive?

Región Valle Central Región Desierto/Montañas Región Valle Este Región Valle Oeste

¿Cuál grupo representa?

- Miembro de familia de consumidor
- Consumidor de Servicios de Salud Mental
- Departamento de Policía
- Personal de la Escuela
- Agencia Comunitaria
- Comunidad de Fe
- Personal Del Condado
- Servicios Humanos
- Proveedor de Atención Médica
- Proveedor de Salud
- Miembro de la comunidad
- Militar Activo o Veterano
- Representante de la Organización de Veteranos
- Proveedor de Servicios de Alcohol y Drogas

¿Cual es su origen étnico?

- Latino/Hispano
- Afroamericano
- Caucásico
- Asiático/Islas de Pacífico
- Indígenas Estadounidenses
- Otro (especifique) _____

¿Cual 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

¿Cuál es su mayor prioridad con respecto a la Actualización Anual de la MHSA?

_____ Necesidades básicas-transportación _____ Apoyo familiar y para juventud _____ Apoyo administrativo
_____ Preparación de emergencias _____ Aumento en el acceso/disponibilidad de tratamiento/recuperación

¿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.

NEWS

From the County of San Bernardino
www.sbcounty.gov



FOR IMMEDIATE RELEASE

May 1, 2013

For more information, contact
Susanne Kulesa, Program Manager
Department of Behavioral Health
909-252-4068
skulesa@dbh.sbcounty.gov

A draft of the Mental Health Services Act (MHSA, Prop. 63) annual report for fiscal year 2013/14 is now posted for public review.

WHO: All county residents who are interested in the public mental health service delivery system, learning about the Mental Health Services Act (MHSA, Prop. 63) and reviewing the draft MHSA annual report for fiscal year 2013/14.

WHAT: The County of San Bernardino has spent approximately \$296 million of MHSA funding to create new or expand existing behavioral health services. The services are geared to target the unserved, underserved and inappropriately served members of our community.

There are several components of the MHSA including Community Services and Supports, Prevention and Early Intervention, Workforce Education and Training, Capital Facilities, Technology and Innovation.

The annual report posted for public comment depicts the progress made by the Department of Behavioral Health, and our contracted partners, in providing behavioral health services over the last fiscal year. The public is invited to review the report and provide feedback on the comment forms, which are posted in English and Spanish.

The MHSA was passed by the California voters 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.

WHEN: A draft of the annual report will be available for review and public comment until May 31, 2013.

WHERE: The draft report and comment form is posted on the County of San Bernardino Department of Behavioral Health Inter and Intranet websites. To review please visit: <http://countyline/dbh/> or <http://www.sbcounty.gov/dbh/>.

CONTACT: For additional information, please contact Susanne Kulesa at (909) 252-4068.

-END-

NOTICIAS

Del Condado de San Bernardino
www.sbcounty.gov



PARA PUBLICACION INMEDIATA

1 de Mayo del 2013

Para más información, comuníquese con
Susanne Kulesa, Directora Administrativa
Departamento de Salud Mental
909-252-4068
skulesa@dbh.sbcounty.gov

Borrador del Informe Anual para el año fiscal 2013/14 de la Ley de Servicios de Salud Mental (MHSA, por sus siglas en inglés, también conocida como Proposición 63,) está presentado para revisión pública.

QUIEN: Todos los residentes del Condado de San Bernardino que estén interesados en el suministro de servicios del sistema de salud mental que quieran aprender sobre la Ley de Servicios de Salud Mental (MHSA por sus siglas en inglés) también conocida como Proposición 63, que quieran revisar el borrador del Informe Anual de la MHSA para el año fiscal 2013/14.

QUE: La MHSA ha proveído al Condado de San Bernardino aproximadamente \$296 millones para crear nuevos servicios de salud mental o expandir los servicios que ya existen. La meta es proveer servicios a aquellos miembros de la comunidad que carecen de servicios, que reciben servicios insuficientemente o que los reciben de manera inapropiada.

Hay varios componentes de la MHSA que incluyen servicios y apoyos comunitarios, prevención e intervención temprana, capacitación laboral y educativa, servicios y mantenimiento de instalaciones, tecnología e innovación.

El Informe Anual publicado para comentarios públicos representa el progreso que el Departamento de Salud Mental y nuestros contratistas han logrado en el suministro de servicios de salud mental durante el último año fiscal. Se le invita al público a revisar este informe para proveer sugerencias en los formularios para comentarios, los cuales han sido publicados en inglés y en español.

La Ley De Servicios de Salud Mental fue aprobada por los votantes de California en noviembre del 2004 y entró en vigor en enero del 2005. Esta ley es financiada por un impuesto adicional del 1% sobre aquellos contribuyentes cuyos ingresos personales son mayores a un millón de dólares al año.

CUANDO: El borrador del Informe Anual estará disponible para revisión y comentarios públicos hasta el 31 de Mayo del 2013.

DONDE: El borrador del informe y el formulario para comentarios están publicados en los sitios de Internet y Intranet del Departamento de Salud Mental del Condado de San Bernardino. Para revisarlos, por favor visite: <http://countyline/dbh/> o <http://www.sbcounty.gov/dbh/>.

CONTACTO: Para información adicional, por favor comuníquese con Susanne Kulesa, al: (909) 252-4068.

-FIN-



**County of San Bernardino
Department of Behavioral Health**



You Are Invited

The County of San Bernardino Department of Behavioral Health invites you to attend a Public Hearing regarding the Mental Health Services Act Annual Update for Fiscal Year 2013/14.

Public Hearing Information

June 6, 2013

County of San Bernardino Health Services, Auditorium (formerly known as Behavioral Health Resource Center)

850 East Foothill Blvd.
Rialto, CA 92376

Meeting begins at 12:00 p.m.

The Annual Update depicts the progress made by the Department of Behavioral Health and its contracted partners, in providing behavioral health services over the last fiscal year.

The public hearing will provide community members the opportunity to participate in an overview of the MHSA annual update stakeholder process. In addition to the overview, there will be time set aside for attendees to ask questions and share comments and/or concerns regarding the stakeholder process.

The Mental Health Services Act, Proposition 63, was passed by California voters in November 2004 and went into effect in January, 2005. The Act is funded by a 1% surcharge on personal income over \$1 million per year.

For questions, concerns, interpretation services or requests for disability-related accommodations please call (800) 722- 9866 or 7-1-1 for TTY users.

Please request accommodations at least 7 business days prior to the meeting.

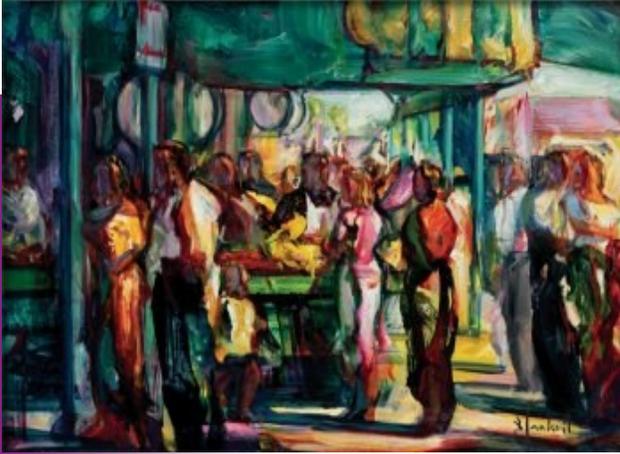
County of San Bernardino Department of Behavioral Health
Mental Health Services Act
1950 South Sunwest Lane, Suite 200
San Bernardino, CA 92415

For additional information please call 800-722-9866 or 711 for TTY users.





Condado de San Bernardino Departamento de Salud Mental



Usted esta invitado

El Departamento de Salud Mental del Condado de San Bernardino le invita a asistir a una Audiencia Pública sobre la Actualización Anual de la Ley de Servicios de Salud Mental del Año Fiscal 2013/14.

Información sobre la Audiencia Pública

6 de Junio del 2013

County of San Bernardino Health Services, Auditorio (anteriormente conocido como Behavioral Health Resource Center)

850 East Foothill Blvd.
Rialto, CA 92376

Junta empieza a las 12:00 p.m.

La Actualización Anual describe los progresos realizados por el Departamento de Salud Mental y sus socios contratados, en la prestación de servicios de salud mental durante el último año fiscal.

La audiencia pública proveerá a los miembros comunitarios la oportunidad de participar en el proceso de la visión general de las personas interesadas de la Ley de Servicios de Salud Mental. Además de la información sobre la visión general, habrá tiempo para que los participantes hagan preguntas, compartan comentarios y/o inquietudes sobre el proceso de las partes interesadas.

La Ley de Servicios de Salud Mental (MHSA, por sus siglas en inglés) fue aprobada por los votantes de California en noviembre de 2004 y entró en vigor en enero de 2005. Esta ley está financiada por un recargo del 1% sobre aquellos cuyos ingresos personales son más a un millón de dólares al año.

Para preguntas, inquietudes, servicios de interpretación o petición de acomodados relacionados con alguna incapacidad, por favor llame al: (800) 722- 9866 o marque el 7-1-1 si usted es usuario de TTY.

Por favor, solicitar acomodamiento por lo menos 7 días hábiles antes de la reunión.

Condado de San Bernardino Departamento de Salud Mental
Ley de Servicios de Salud Mental
1950 South Sunwest Lane, Suite 200
San Bernardino, CA 92415

Para información adicional, llame al: 1-800-722-9866; o al: 7-1-1 para usuarios de TTY.

