Artwork by Kyana Thompson

Mental Health Services Act Annual Update for Fiscal Year 2019/20

SAN BERNARDINO COUNTY

Behavioral Health

Message from the Director

Welcome to the San Bernardino County, Department of Behavioral Health's (DBH) Mental Health Services Act (MHSA) Fiscal Year (FY) 2019/20 Annual Update. Since the inception in 2005, MHSA funded programs have provided enhancements to the public behavioral health system of care that promote wellness, recovery, and resilience and include the values of cultural competency, community-based collaboration, and meaningful inclusion of clients and family members in all aspects of behavioral health planning and services.

The Annual Update is the opportunity for the Department to highlight the accomplishments of the previous fiscal year, engage the community in stakeholder-informed decisions, and update the Fiscal Year (FY) 2017/18 through FY 2019/20 MHSA Three-Year Integrated Plan.

The implementation of MHSA has allowed the department the opportunity to focus on developing a cohesive system of behavioral health services and care and include all stakeholders in the development, implementation, and evaluation of services.

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

Thank you for taking the time to review and provide feedback on this plan. The DBH Mental Health Services Act Administration looks forward to receiving your input at DBH-MHSA@dbh.sbcounty.gov.

Sincerely,

Veronica Kelley, DSW, LCSW
Director
San Bernardino County Department of Behavioral Health

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

Mensaje de parte de la Directora

Bienvenido a la Actualización Anual de la Ley de Servicios de Salud Mental (MHSA, por sus siglas en inglés) del Año Fiscal (FY, por sus siglas en inglés) 2019/20 del Departamento de Salud Mental (DBH, por sus siglas en inglés) del Condado de San Bernardino. Desde el inicio en 2005, los programas financiados por MHSA han proporcionado mejoras al sistema de atención de salud mental pública que promueven el bienestar, la recuperación y la resiliencia e incluyen los valores de la competencia cultural, la colaboración basada en la comunidad e inclusión significativa de los clientes y miembros de la familia en todos los aspectos de la planificación y los servicios de salud mental.

La Actualización Anual es la oportunidad para el Departamento de resaltar los logros del año fiscal anterior, involucrar a la comunidad en las decisiones informadas por las partes interesadas y actualizar el Plan Integrado Trienal del FY 2017/18 a través de FY 2019/20.

La implementación de MHSA ha permitido al Departamento la oportunidad de centrarse en el desarrollo de un sistema cohesivo de servicios y cuidados de salud mental e incluir a todas las partes interesadas en el desarrollo, implementación y evaluación de servicios.

Es mi esperanza que usted encuentre la Actualización Anual informativa y un reflejo de ambos el progreso del Departamento en el cumplimiento de la intención de la MHSA y el componente de bienestar contenido dentro de la Visión del Condado. Juntos nos movemos para apoyar un condado sano que valora los programas de prevención, los servicios de salud superiores, y la reducción de la enfermedad crónica y las disparidades socioeconómicas a través de la educación de salud, promoción de estilos de vida sanos, y el desarrollo de servicios de salud basados en resultados. Esperamos aumentar continuamente la colaboración de y entre los proveedores y las organizaciones basadas en la comunidad.

Gracias por tomarse el tiempo en revisar y ofrecer retroalimentación en este plan. La Oficina Administrativa de la Ley de Servicios de Salud Mental de DBH espera recibir sus opiniones al DBH-MHSA@dbh.sbcounty.gov.

Atentamente,

Veronica Kelley, DSW, LCSW
Directora
Departamento de Salud Mental del Condado de San Bernardino

Nuestra labor es fomentar un condado en donde quienes residen e invierten pueden prosperar y alcanzar el bienestar.

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MHSA COUNTY COMPLIANCE CERTIFICATION

County: San Bernardino

Local Mental Health Director	Program Lead
Name: Veronica Kelley, DSW, LCSW	Name: Michelle Dusick
Telephone Number: (909) 388-0820	Telephone Number: (909) 252-4046
E-mail: vkelley@dbh.sbcounty.gov	E-mail: mdusick@dbh.sbcounty.gov
County Mental Health Mailing Address: Department of Behavioral Health, 303 E. Vanderbilt Way, 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 May 21, 2019.

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.

Veronica Kelley, DSW, LCSW
Local Mental Health Director/Designee (PRINT)

Signature _____ Date 6/10/19

County: San Bernardino

San Bernardino County Department of Behavioral Health
Mental Health Services Act Annual Update, Fiscal Year 2019/20
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Enclosure 1

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION [1]

County/City: San Bernardino

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

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Veronica Kelley, DSW, LCSW	Name: Ensen Mason
Telephone Number: (909) 388-0820	Telephone Number: (909) 382-7000
Email: vkelley@dbh.sbcounty.gov	E-mail: Ensen.Mason@atc.sbcounty.gov

Local Mental Health Mailing Address:

Department of Behavioral Health
303 E. Vanderbilt Way
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 counties in future years.

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

Veronica Kelley, DSW, LCSW
Local Mental Health Director (PRINT)

Signature 6/10/19
Date

I hereby certify that for the fiscal year ended June 30, 2018, 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 December 28, 2018 for the fiscal year ended June 30, 2018. I further certify that for the fiscal year ended June 30, 2018, 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(1), in that local MHS funds may not be loaned to a county general fund or any other county fund.

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

Michael Alexander
for County Auditor Controller / City Financial Officer (PRINT)

Signature JUN 14 2019
Date

[1] Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)
Three-Year Program and Expenditure Plan, Annual Update, and RER Certification (07/22/2013)

State of California
Health and Human Services Agency

Department of Health Care Services

MENTAL HEALTH SERVICES ACT
PRUDENT RESERVE ASSESSMENT/REASSESSMENT

County/City: San Bernardino County

Fiscal Year: FY 2019/20

Local Mental Health Director

Name: Veronica Kelley, DSW, LCSW

Telephone: (909) 388-0820

Email: vkelley@dbh.sbcounty.gov

I hereby certify[1] under penalty of perjury, under the laws of the State of California, that the Prudent Reserve assessment/reassessment is accurate to the best of my knowledge and was completed in accordance with California Code of Regulations, Title 9, section 3420.20 (b).

Veronica Kelley, DSW, LCSW

Local Mental Health Director (PRINT NAME)

Signature DSW

Date 6/10/19

[1] Welfare and Institutions Code section 5892 (b)(2)

DHCS 1819 (02/19)

San Bernardino County Department of Behavioral Health
Mental Health Services Act Annual Update, Fiscal Year 2019/20
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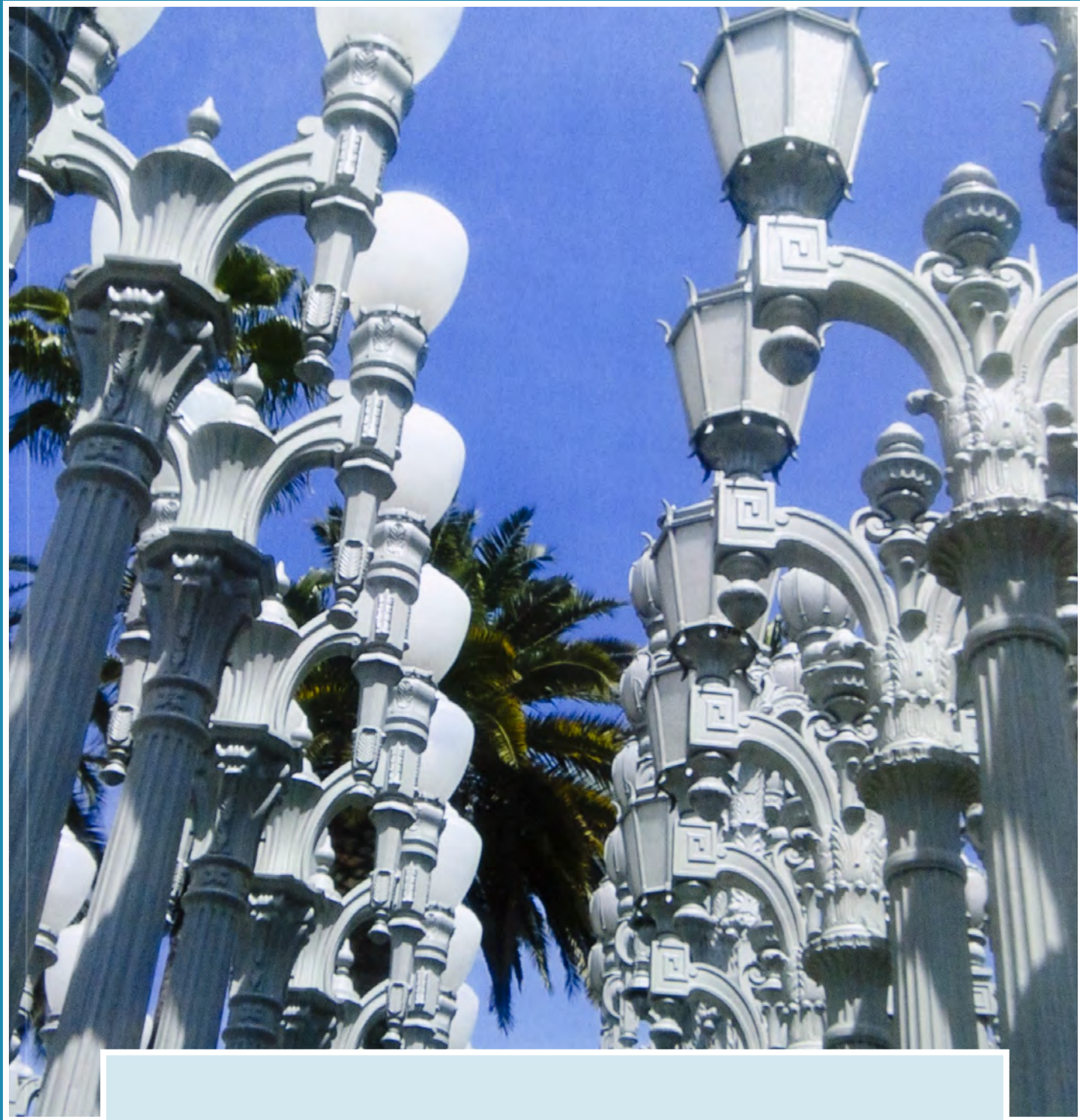


Artwork by Rose Stout

Community Program Planning (CPP)

Community Program Planning

The San Bernardino County Department of Behavioral Health (DBH) is dedicated to including diverse consumers, family members, stakeholders, and community members from throughout the county in the planning and implementation of Mental Health Services Act (MHSA) programs and services. DBH's Community Program Planning Process encourages community engagement with the goal of empowering the community for the purpose of generating ideas, contributions to decision making, and to engender a county/community partnership to improve behavioral health outcomes for San Bernardino County residents. These efforts include informing stakeholders of fiscal trends, evaluation, monitoring, and program improvement activities as well as obtaining feedback. DBH is committed to incorporating best practices in our planning processes that allow our consumer and stakeholder partners to participate in meaningful discussion around critical behavioral health issues. DBH considers community program planning a constant practice. As a result, this MHSA component has become a robust year-round practice that has been incorporated into standard operations throughout the department. Like the other MHSA components, the community program planning process undergoes review and analysis that allows us to enhance and improve engagement strategies.

DBH's Community Program Planning (CPP) protocol includes a participatory framework of regular, ongoing meetings with diverse stakeholders to discuss topics related to behavioral health policy, pending legislation, program planning, implementation and evaluation, and financial resources affiliated with behavioral health programs. This practice has allowed DBH to:

- Be responsive to changes and concerns in the public behavioral health environment
- Establish and maintain a two-way communication pathway for community identified areas of improvement, which are introduced into DBH's larger process improvement efforts and report results back to the larger community
- Encourage community involvement in DBH's planning beyond the typical "advisory" role
- Educate consumers and stakeholders about the MHSA, behavioral health resources and topics, to include the public behavioral health system as a whole

DBH ensures attendance by maintaining a published schedule of meetings and advertising these meetings using social media, press releases, other county departments, and an expansive network of known community partners and contracted vendors. To ensure participation from diverse stakeholders, meetings include interpreter services, or as the occasion dictates, meetings held in languages other than English. Meeting locations are coordinated in every region of San Bernardino County, and web-conference style meetings are available for remote communities or for individuals who are unable to attend an in-person session or prefer the web format.

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

9 CCR § 3300(c) 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.

Meetings are documented through agendas, sign-in sheets, and minutes and include the following regularly scheduled meetings:

- Behavioral Health Commission (BHC): 12 annual meetings- monthly meetings
- District Advisory Committee meetings: Five monthly meetings, one held in each of the five supervisorial districts within the county and led by the Behavioral Health Commissioners in each district
- Community Policy Advisory Committee (CPAC): 12 annual meetings- monthly meetings
- Cultural Competency Advisory Committee (CCAC), along with thirteen (13) separate cultural subcommittee/coalitions: fourteen (14) monthly meetings
- Transitional Age Youth (TAY) Center Advisory Boards

Community Program Planning Meeting

- MHSA Executive Committee meetings
- Association of Community Based Organizations (ACBO): twelve (12) monthly meetings
- Room and Board Advisory Coalition
- Screening, Assessment, Referral and Treatment (SART) Collaborative
- System-wide Program Outcomes Committee (SPOC)

Note: A regularly scheduled meeting may be rescheduled or cancelled by the collective agreement of the attendees.
Additional regular stakeholder engagement and education meetings include:

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

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

Cultural Competency

DBH has a commitment to cultural competency and ensuring that this value is incorporated into all aspects of DBH policy, programming and services, including planning, implementing, and evaluating programs. To ensure cultural competency in each of these areas, DBH has established the Office of Cultural Competence and Ethnic Services (OCCES), which reports to the DBH Director, a Cultural Competency Advisory Committee, and thirteen (13) monthly cultural subcommittees and coalitions. These elements are an essential part of the stakeholder process including the use of the regularly scheduled committee and subcommittee meetings to obtain feedback and input on services and programs. The Cultural Competency Officer (CCO) and the OCCES work in conjunction with MHSA program leads to ensure compliance with cultural competency standards and to ensure that the services provided address cultural and linguistic needs. The CCO or OCCES staff regularly sit on boards or committees to provide input or effect change regarding program planning or implementation. OCCES also provides support by translating documents for the department, as well as coordinating interpretation services for stakeholder outreach, meeting, and training events. Language regarding cultural competence is included in all department contracts with community-based organizations and individual providers to ensure contract services are provided in a cultural competent manner. Additionally, cultural competence is assessed in each DBH employee's annual Work Performance Evaluation.

DBH is highly committed to including consumers, family members, and other stakeholders within all levels of our organizational structure. It has been our mission to

include consumers and family members into an active system of stakeholders. Within DBH's organizational structure, the Office of Consumer and Family Affairs (OCFA) is elevated, reporting to the Cultural Competency Officer, with access to the Department Director. Outreach to consumers and family members is performed through the OCFA, as well as the Department's Public Information Office, Community Outreach and Education division, DBH's four TAY centers and DBH's nine consumer clubhouses, and by contracted provider agencies to encourage regular participation in MHSA activities.

Consumer engagement occurs through regularly scheduled Community Planning Process meetings, community events, department activities, and committee meetings. Consumer participation in department committees include meetings in which meaningful issues are discussed and decisions are made. Consumer input is always considered when making MHSA related system decisions in the Department of Behavioral Health. This includes decision makers such as the Director, Assistant Director, Medical Director, Deputy Directors, Program Managers, Clinic Supervisors, medical staff, clinicians, and administrative/clerical staff.

Improvements in Progress

Stakeholder feedback received during prior Community Program Planning (CPP) indicated that stakeholders would like:

- **Expanded cultural specific sub-committees** to include a subcommittee focused on older adult mental health.
- Comprehensive **materials and reports to communicate and share information** to our stakeholders.
- **Multi-media approaches to information sharing**, including the use of short videos and social media platforms.
- Changes in community meeting planning including, **later start times and meeting locations to** better accommodate our stakeholders.
- Focus on ensuring that **each region of the County can participate** in meaningful stakeholder opportunities.

The Following are examples of Department responses to stakeholder feedback.

Expanded Cultural Specific Sub-Committees

Cultural competency advisory subcommittees allow the department to get input from stakeholder driven cultural competency sub-committees which give the department direction and insight on how to address, intervene, and properly serve the various

cultures throughout the County. Through the expertise and feedback offered through these subcommittees, the department is able to alter and enhance programming to better meet the diverse cultural needs of the populations it serves. Based on stakeholder feedback and recognizing and need to address the mental health needs of older adults, the department created and added the Older Adults Awareness Subcommittee in Fiscal Year 2017/18. Like the other subcommittees, this subcommittee focuses on the unique mental health and service needs of the older adult population and through this feedback is better able to shape and enhance programming to better meet the needs of the adult population. DBH currently hosts a monthly Cultural Competency Advisory Committee meeting as well as **13** cultural competency subcommittees throughout the community to get programming input on the diverse needs of the populations it serves. A listing of the dates, times, and locations for these cultural competency subcommittee meetings can be found on the Office of Cultural Competence and Ethnic Services webpage.

Sharing Information With Our Stakeholders

Comprehensive Materials and Reports

In an effort to better educate and communicate information to our stakeholders, comprehensive materials and reports have been created to better communicate the information that is being presented on or discussed. Additionally, in response to stakeholder feedback and to highlight the stakeholder comments the department receives from the functions (conferences, trainings, meetings, etc.) it facilitates, comprehensive reports have been created for some of the meetings which analyze stakeholder demographics and feedback from these events, which has included stakeholder meeting topic preference(s) as well as stakeholder identification of additional resources/services needed to properly serve homeless individuals living with a mental illness. These reports include text as well as charts, graphs and infographics to communicate this information. This change has allowed the department to better communicate information and its services to the community and has allowed stakeholders to see how their involvement and suggestions shape and influence program planning and the services the department provides.

Multi-Media Approaches to Information Sharing

To better advertise, communicate, and educate our stakeholders to the departments, activities, events, goals, resources and programs, the department has incorporated multi-media approaches to information sharing which have included the use of short videos and social media platforms. Below are some of the activities and events that were highlighted via videos and social media in Fiscal Year 2017/18:

- 10th Annual Homeless Summit
- Annual MHSA Summit
- Crisis Residential Treatment and Crisis Stabilization Unit-Grand Openings

- Recovery Happens
- San Bernardino County, Point In Time Count
- Southern Region Student Wellness Happens
- Mental Health Awareness Month

County-Wide Regional Representation at Stakeholder Meetings

To increase stakeholder participation and to better accommodate the needs of our stakeholders, DBH has been flexible in altering meeting times for stakeholder meetings and has also changed or alternated some the meeting locations to allow for easier accessibility. An example of this is the change in the Community Policy Advisory Committee (CPAC) meeting time from 9:00am to 10:00am to accommodate stakeholders traveling from the high desert. To ensure that stakeholder input is received from each region of the county, the department has also made concentrated efforts to ensure that information regarding departmental events, conferences, and trainings, are shared with our stakeholders in the Central, Desert/Mountain, East Valley, and West Valley regions. This information has been shared via social media and e-mail with our, stakeholders, contract providers, and county partners and also through departmental events, presentations, and trainings that are facilitated by DBH throughout the county.

Technological Solutions for the County's Geographic Challenges

A continual theme during the Community Program Planning (CPP) process was the community's concern about the barriers our consumers, family members, and community members experience based on the geographical size of the San Bernardino County. The Department of Behavioral Health values and encourages community involvement in outreach, engagement, and education activities. In an effort to limit hardships that extensive travel could cause, the Department uses technology to remotely interact with our rural communities. DBH uses Adobe® Connect™ software in order to have webinar style meetings with these communities. This type of technology has the benefit of face to face interaction and presentation of materials, as well as having the ability to collect feedback from the participants in real time.

During the Community Program Planning meeting for the Annual Update, two sessions of Adobe® Connect™ were scheduled: one morning session to target stakeholders in remote communities of the County, and a second after-hours session to accommodate those that may not be available during normal business hours. Also, call-in options for other DBH facilitated meetings such as System-wide Program Outcomes Committee (SPOC), Association of Community Based Organizations (ACBO), etc. are also available.

24-Hour and Emergency Services

In an effort to create alternatives to inpatient hospitalization, institutionalization, and/or incarceration, the San Bernardino County behavioral healthcare system has expanded its

services to address the complex needs of adult individuals experiencing a behavioral health crisis. As a result, San Bernardino County Department of Behavioral Health (DBH) developed new Crisis Residential Treatment (CRT) and Crisis Stabilization Unit (CSU) facilities to strengthen the continuum of care. The CRTs and CSUs will support the community by increasing access and capacity to efficiently and effectively serve the individualized needs of those in crisis who may not need inpatient hospitalization.
The county has experienced significant population growth and a steady increase in the volume of individuals experiencing a psychiatric crisis has resulted in an increased demand for treatment resources and less restrictive crisis services. The increase in demand has had an adverse effect on law enforcement and hospital emergency departments and has substantially impacted the availability of inpatient psychiatric beds. The increasing behavioral health needs of the current population has made it necessary to proactively implement strategies that will expand access and capacity.

As part of DBHs commitment to stakeholder engagement, in Fiscal Year 2017/18, DBH hosted open houses at the two newly opened CSUs (Fontana and San Bernardino) and four CRTs (Fontana, San Bernardino, Joshua Tree, and Victorville) to educate stakeholders about the resources and services offered at these facilities and to get stakeholder feedback regarding the new facilities. Information flyers regarding CSU and CRT services were created and distributed to the community and DBH stakeholders.

MHSA Annual Update Fiscal Year 2017/18: Community Program Planning (CPP) Process

DBH is fully committed to a year-round stakeholder engagement process. Preparation and development of this Annual Update included meetings hosted in multiple venues in each region of the County, two (2) interactive countywide webinars, a monolingual Spanish session hosted in collaboration with the Consulate of Mexico in San Bernardino, and an MHSA Summit (scheduled for Spring 2019) .

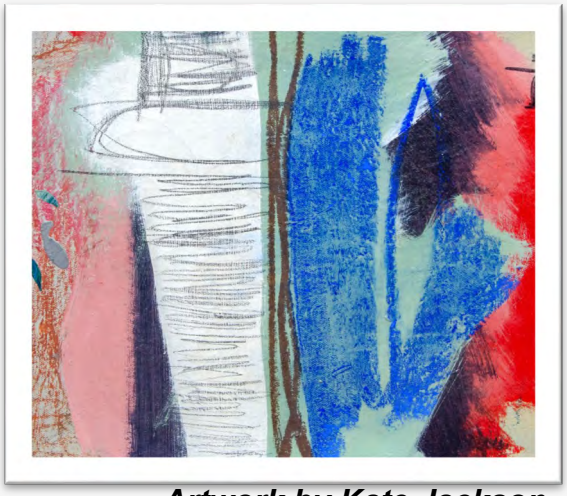
A DBH Program Manager discusses her program at a Stakeholder Meeting

A total of 36 scheduled meetings were held throughout San Bernardino County.

To meet the requirements of the MHSA, extensive outreach was conducted to promote the MHSA Annual Update Community Program Planning (CPP) process. A variety of methods were used at multiple levels to give all stakeholders, including consumers, family members, community members, and partner agencies the opportunity to have their feedback included and their voice heard. This included press releases to all local media outlets, including culturally specific media, and distribution of emails and flyers to community partners, community and contracted organizations, other county agencies, cultural subcommittees and coalitions, and regularly scheduled stakeholder meetings, such as the San Bernardino County Behavioral Health Commission. These materials were distributed in both English and Spanish to representatives of our diverse population. Social media sites, such as Facebook, Twitter, Pinterest, YouTube, and Instagram, were also used to extend the reach of the department in connecting interested community members with the stakeholder process. DBH's social media outlets can be assessed by clicking the icons below from the electronic version of this report.

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

- Individuals with serious behavioral health illness and/or serious emotional disturbance and/or their families
- Providers of behavioral health and/or related services such as physical health care and/or social services
- Representatives from the education system
- Representatives from local hospitals, hospital associations, and healthcare groups
- Representatives of law enforcement
- Veteran/military population of services organizations
- Other organizations that represent the interests of individuals with serious a behavioral health illness and/or serious emotional disturbance and/or their families



Artwork by Kate Jackson

As listed in the schedule, five special sessions of the Behavioral Health Commission's District Advisory Committee (DAC) meetings were conducted in each geographic region of the county. This schedule ensured representation and participation in each geographic region of San Bernardino County. To ensure participation of unserved, underserved, or inappropriately served cultural groups, the OCCES provided stakeholder engagement meetings for the Annual Update for each of their thirteen (13) Cultural Competency Advisory subcommittees. To further include community involvement, sessions were held in collaboration with Family Resource Centers and Senior Centers across the County. DBH staff were able to host a discussion with diverse attendees about the background and intent of the MHSA, the MHSA Plan and proposed updates, as well as obtain feedback and recommendations for system improvement. To ensure that stakeholders could fully benefit from the community meetings, OCCES staff arranged for Spanish, American Sign Language, and Vietnamese interpretation, upon request, at each meeting.

In order to increase opportunities for participation across the county, the department hosted two (2) sessions using Adobe® Connect™ software on the morning of January 9, 2019, from 10:00 a.m. to 12:00 p.m. and an evening session on January 16, 2019, from 5:00 p.m. to 7:30 p.m. These sessions allowed individuals living in remote areas of the county to participate via computed, smart phones, and other technological devices.

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

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

At the end of the presentation, the facilitator opened the presentation to encourage discussion, allow stakeholders to have questions answered, and provide input. Once the question and answer session concluded, participants were advised about additional opportunities to provide feedback. The link to the survey was provided in the presentation and participants were also provided information for alternative methods to provide input and feedback including the email address, phone number for the MHSA Coordinator, and a link to the MHSA Issue Resolution that can be accessed at: http://wp.sbcounty.gov/dbh/wp-content/uploads/2016/08/COM0947.pdf

To further support this Community Planning Process (CPP) effort, a special session of the Community Policy Advisory Committee (CPAC) was hosted by MHSA Administration on February 21, 2019. The session followed the format that had been established as a standard practice for all CPAC meetings. Attendees were seated in small groups, to allow for comfortable discussion opportunities. In preparation for future departmental program planning and to further inform the Three Year Annual Update, a comprehensive community needs assessment was distributed at the CPAC and at all of the Community Program Planning (CPP) meetings to allow our stakeholders to provide written and verbal input after the information was presented.

9 CCR § 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

A DBH staff member addresses the audience at a community planning meeting.

A special session of the Cultural Competency Advisory Committee was hosted by the MHSA Administrative Manager to ensure additional opportunities to stakeholders to interact with decision making staff. Attendees at all stakeholder engagement meetings were afforded the opportunity to provide feedback and input into the plan via verbal comment and a post meeting survey in which stakeholders could provide written comments as well. Surveys were available in both English and Spanish.

During the Community Program Planning (CPP) process meetings for the Annual Update, highlights of community recommendations included the need for improved housing for consumers. Attendees were educated about some of the new housing developments the department has planned through No Place Like Home (NPLH) and the Special Needs Housing Program (SNHP).

Additional feedback included a need to create better internship and job opportunities for persons with lived experience. Attendees were informed of the departments new restructuring around the employment program and that new internship and job opportunities, as well as events centered around employment, were anticipated.

Artwork by Sonia Stockton

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

SAN BERNARDINO COUNTY
Behavioral Health

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

District Advisory Committee Meetings

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

First District
Wednesday, January 16, 2019
11:00 a.m. - 12:00 p.m.
Victor Community Support Services
15400 Cholame Road
Victorville, CA 92392
Contact: La'Shawn Sifuentes (760) 955-8340

Second District
Thursday, January 10, 2019
2:30 - 3:30 p.m.
Mariposa Community Counseling
2940 Inland Empire Boulevard
Ontario, CA 91764
Contact: Karina Alvarez (909) 458-1381

Third District
Tuesday, January 15, 2019
11:00 a.m. - 12:00 p.m.
TEAM House
201 W. Mill Street
San Bernardino, CA 92415
Contact: Margaret Hernandez (909) 387-7607

Fourth District
Thursday, January 10, 2019
2:30 - 3:30 p.m.
Mariposa Community Counseling
2940 Inland Empire Boulevard
Ontario, CA 91764
Contact: Karina Alvarez (909) 458-1381

Fifth District
Monday, January 28, 2019
5:30 - 7:30 p.m.
New Hope Family Life Center - Auditorium
1505 W. Highland Avenue
San Bernardino, CA 92411
Contact: Crista Wentworth (909) 421-9335

For questions, concerns, interpretation services or requests for disability-related accommodations, please contact: Office of Cultural Competency (909) 386 - 8223 or 7-1-1 for TTY users or cultural_competency@dbh.sbcounty.gov. Please request accommodations at least 7 business days prior to the event.

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

Revised 1/2019

SAN BERNARDINO COUNTY
Behavioral Health

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

Reunión de Comité Consultiva de Distrito

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

Primer Distrito
miércoles, 16 de enero del 2019
11:00 a.m. - 12:00 p.m.
Victor Community Support Services
15400 Cholame Road
Victorville, CA 92392
Contacto: La'Shawn Sifuentes (760) 955-8340

Segundo Distrito
jueves, 10 de enero del 2019
2:30 - 3:30 p.m.
Mariposa Community Counseling
2940 Inland Empire Boulevard
Ontario, CA 91764
Contacto: Karina Alvarez 909-758-1381

Tercer Distrito
martes, 15 de enero del 2019
11:00 a.m. - 12:00 p.m.
TEAM House
201 W. Mill Street
San Bernardino, CA 92415
Contacto: Margaret Hernandez (909) 387-7607

Cuarto Distrito
jueves, 10 de enero del 2019
2:30 - 3:30 p.m.
Mariposa Community Counseling
2940 Inland Empire Boulevard
Ontario, CA 91764
Contacto: Karina Alvarez 909-758-1381

Quinto Distrito
lunes, 28 de enero del 2019
5:30 - 7:30 p.m.
New Hope Family Life Center - Auditorium
1505 W. Highland Avenue
San Bernardino, CA 92411
Contacto: Crista Wentworth (909) 421-9335

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

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

Revised 1/2019

SAN BERNARDINO COUNTY Behavioral Health

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

Cultural Competency Advisory Committee Sub-Committee Meetings

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

Asian Pacific Islander Awareness Subcommittee **Friday, January 11, 2019** Asian American Resource Center 1133 South E Street, San Bernardino, CA 92408 10:00 - 11:30 a.m.	**Spirituality Awareness Subcommittee** **Tuesday, January 8, 2019** Department of Behavioral Health Administration 303 E. Vanderbilt Way, San Bernardino, CA 92415 1:00 - 2:30 p.m.	**Native American Awareness Subcommittee** **Tuesday, January 15, 2019** Native American Resource Center 11980 Mt. Vernon Ave., Grand Terrace, CA 92313 2:00 - 3:30 p.m.
African American Awareness Subcommittee **Monday, January 14, 2019** Valley Star Community Services 1585 South D Street Suite 101, San Bernardino, CA 92408 2:00 - 3:30 p.m.	**Transitional Age Youth Awareness Subcommittee** **Wednesday, January 16, 2019** One Stop TAY Center 780 Gilbert St., San Bernardino, CA 92404 11:00 a.m. - 12:00 p.m.	**Co-Occurring and Substance Abuse Subcommittee** **Thursday, January 17, 2019** Uplift Family Services 572 North Arrowhead Ave, San Bernardino, CA 92401 3:00 - 4:30 p.m.
Consumer & Family Member Awareness Subcommittee **Monday, January 28, 2019** Pathways to Recovery Clubhouse 17053 E. Foothill Blvd. Fontana, CA 92335 10:00 - 11:30 a.m.	**LGBTQ Awareness Subcommittee** **Tuesday, January 22, 2019** Department of Behavioral Health Administration 303 E. Vanderbilt Way, San Bernardino, CA 92415 12:30 - 2:00 p.m.	**Women's Awareness Subcommittee** **Wednesday, January 23, 2019** Department of Behavioral Health Administration 303 E. Vanderbilt Way, San Bernardino, CA 92415 1:00 - 2:30 p.m.
Veteran's Awareness Subcommittee **Monday, January 7, 2019** Department of Behavioral Health Administration 303 E. Vanderbilt Way, San Bernardino, CA 92415 3:00 - 4:30 p.m.	**Latino Health Awareness Subcommittee** **Thursday, January 24, 2019** Consulate of Mexico in San Bernardino — Lobby 293 North D Street, San Bernardino, CA 92401 10:00 - 11:30 a.m.	**Older Adult Awareness Subcommittee** **Thursday, January 24, 2019** Victor Community Support Services 15400 Cholame Rd., Victorville, CA 92392 2:00-3:30pm

For questions, concerns, interpretation services or requests for disability-related accommodations, please contact: Office of Cultural Competency (909) 386-8223 or 7-1-1 for TTY users or cultural_competency@dbh.sbcounty.gov. Please request accommodations at least 7 business days prior to the event.

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

The Act is funded by a 1% tax surcharge on personal income over $1 million per year.

Revised 1/2019

SAN BERNARDINO COUNTY Behavioral Health

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

Coaliciones y Subcomités del Comité Consultivo de Competencia Cultural

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

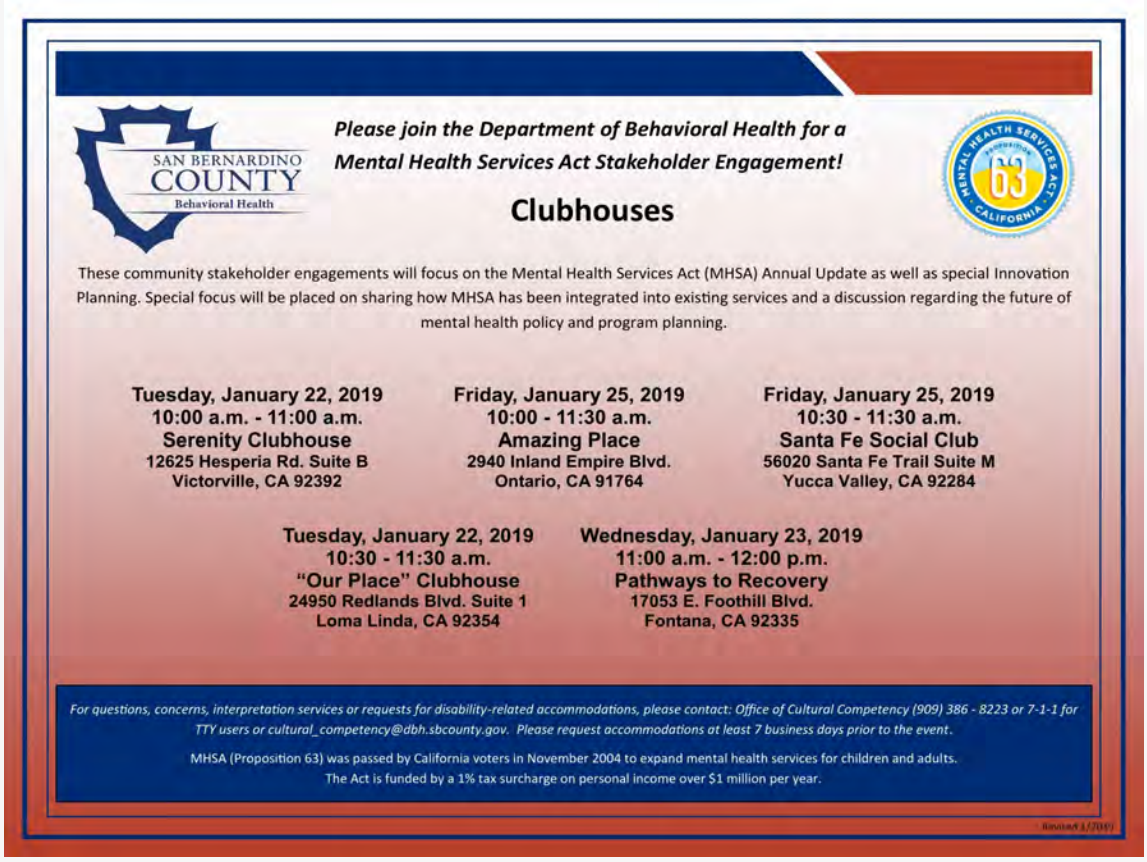
Subcomité de Concientización de Asiáticos/Isleños delPacifico **viernes, 11 de enero del 2019** Asian American Resource Center 1133 South E Street, San Bernardino, CA 92408 10:00 - 11:30 a.m.	**Subcomité de Concientización de Espiritualidad** **martes, 8 de enero del 2019** Administración de DBH 303 E. Vanderbilt Way, San Bernardino, CA 92415 1:00 - 2:30 p.m.	**Subcomité de Concientizacion de Nativos Americanos** **martes, 15 de enero del 2019** Native American Resource Center 11980 Mt. Vernon Ave., Grand Terrace, CA 92313 2:00 - 3:30 p.m.
Subcomité de Concientización de Afroamericanos **lunes, 14 de enero del 2019** Valley Star Community Services 1585 South D Street Suite 101, San Bernardino, CA 92408 2:00 - 3:30 p.m.	**Subcomité de Concientización de Jóvenes en Edad de Transición** **miércoles, 16 de enero del 2019** One Stop TAY Center 780 Gilbert St., San Bernardino, CA 92404 11:00 a.m. - 12:00 p.m.	**Subcomité de Concientización de Diagnostico Dual y Drogadicción** **jueves, 17 de enero del 2019** Uplift Family Services 572 North Arrowhead Ave, San Bernardino, CA 92401 3:00 - 4:30 p.m.
Subcomité de Concientización de Consumidores y Miembros de Familias **lunes, 22 de enero del 2019** Pathways to Recovery Clubhouse 17053 E. Foothill Blvd. Fontana, CA 92335 10:00 - 11:30 a.m.	**Subcomité de Concientización de LGBTQ** **martes, 22 de enero del 2019** Administración de DBH 303 E. Vanderbilt Way, San Bernardino, CA 92415 12:30 - 2:00 p.m.	**Subcomité de Concientización de Mujeres** **miércoles, 23 de enero del 2019** Administración de DBH 303 E. Vanderbilt Way, San Bernardino, CA 92415 1:00 - 2:30 p.m.
Subcomité de Concientización de Veteranos **lunes, 7 de enero del 2019** Administración de DBH 303 E. Vanderbilt Way, San Bernardino, CA 92415 3:00 - 4:30 p.m.	**Subcomité de Concientización de Latinos** **jueves, 24 de febrero del 2019** Consulado de México en San Bernardino—Sala de Espera 293 North D Street, San Bernardino, CA 92401 10:00 - 11:30 a.m.	**Subcomité de Concientización de Adultos Mayores** **jueves, 24 de enero del 2019** Victor Community Support Services 15400 Cholame Road, Victorville, CA 92392 2:00 - 3:30 p.m.

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

La Ley de Servicios de Salud Mental (Proposición 63) fue pasada por votantes de California en noviembre del 2004 para aumentar servicios de salud mental para niños y adultos.

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

Revised 1/2019



SAN BERNARDINO COUNTY
Behavioral Health

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

Clubhouses

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

Tuesday, January 22, 2019
10:00 a.m. - 11:00 a.m.
Serenity Clubhouse
12625 Hesperia Rd. Suite B
Victorville, CA 92392

Friday, January 25, 2019
10:00 - 11:30 a.m.
Amazing Place
2940 Inland Empire Blvd.
Ontario, CA 91764

Friday, January 25, 2019
10:30 - 11:30 a.m.
Santa Fe Social Club
56020 Santa Fe Trail Suite M
Yucca Valley, CA 92284

Tuesday, January 22, 2019
10:30 - 11:30 a.m.
"Our Place" Clubhouse
24950 Redlands Blvd. Suite 1
Loma Linda, CA 92354

Wednesday, January 23, 2019
11:00 a.m. - 12:00 p.m.
Pathways to Recovery
17053 E. Foothill Blvd.
Fontana, CA 92335

For questions, concerns, interpretation services or requests for disability-related accommodations, please contact: Office of Cultural Competency (909) 386 - 8223 or 7-1-1 for TTY users or cultural_competency@dbh.sbcounty.gov. Please request accommodations at least 7 business days prior to the event.

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

SAN BERNARDINO COUNTY
Behavioral Health

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

Clubhouses (por sus siglas en ingles)

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

martes, 22 de enero del 2019
10:00 a.m. - 11:00 a.m.
Serenity Clubhouse
12625 Hesperia Rd. Suite B
Victorville, CA 92392

viernes, 25 de enero del 2019
10:00 - 11:30 a.m.
Amazing Place
2940 Inland Empire Blvd.
Ontario, CA 91764

viernes, 25 de enero del 2019
10:30 - 11:30 a.m.
Santa Fe Social Club
56020 Santa Fe Trail Suite M
Yucca Valley, CA 92284

martes, 22 de enero del 2019
10:30 - 11:30 a.m.
"Our Place" Clubhouse
24950 Redlands Blvd. Suite 1
Loma Linda, CA 92354

miércoles, 23 de enero del 2019
11:00 a.m. - 12:00 p.m.
Pathways to Recovery
17053 E. Foothill Blvd.
Fontana, CA 92335

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

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

SAN BERNARDINO COUNTY
Behavioral Health

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

Family Resource Centers

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

Wednesday, January 23, 2019
10:30 - 11:30 a.m.
Victor Community Support Services
15400 Cholame Road
Victorville, CA 92395

Wednesday, January 9, 2019
10:00 - 11:00 a.m.
Rim Family Services
28545 Highway 18
Skyforest, CA 92385

Friday, January 18, 2019
11:00 a.m - 12:00 p.m.
Ontario Montclair School District
1556 S. Sultana Avenue
Ontario, CA 91761

Friday, January 11, 2019
10:00 a.m. - 12:00 p.m.
Pacific Clinics
58945 Business Center Dr. Suite D
Yucca Valley, CA 92284

Thursday, January 10, 2019
9:00 - 10:30 a.m.
Victor Community Support Services
1053 N. D Street
San Bernardino, CA 92410

For questions, concerns, interpretation services or requests for disability-related accommodations, please contact: Office of Cultural Competency (909) 386 - 8223 or 7-1-1 for TTY users or cultural_competency@dbh.sbcounty.gov. Please request accommodations at least 7 business days prior to the event.

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

Revised 1/2019

SAN BERNARDINO COUNTY
Behavioral Health

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

Centro de Recursos de Familia

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

miércoles, 23 de enero del 2019
10:30 - 11:30 a.m.
Victor Community Support Services
15400 Cholame Road
Victorville, CA 92395

miércoles, 9 de enero del 2019
10:00 - 11:00 a.m.
Rim Family Services
28545 Highway 18
Skyforest, CA 92385

viernes, 18 de enero del 2019
11:00 a.m - 12:00 p.m.
Ontario Montclair School District
1556 S. Sultana Avenue
Ontario, CA 91761

viernes, 11 de enero del 2019
10:00 a.m. - 12:00 p.m.
Pacific Clinics
58945 Business Center Dr. Suite D
Yucca Valley, CA 92284

jueves, 10 de enero del 2019
9:00 - 10:30 a.m.
Victor Community Support Services
1053 N. D Street
San Bernardino, CA 92410

Para preguntas, dudas, servicios de interpretación o solicitudes de acomodos especiales por razones de incapacidad, por favor comuníquese con Office of Cultural Competency al (909) 386-8223; marque el 7-1-1 si usted es usuarios TTY; también puede ir a: cultural_competency@dbh.sbcounty.gov. Por favor solicite estos acomodos por lo menos 7 días laborales previos al evento.
La Ley de Servicios de Salud Mental (Proposición 63) fue pasada por votantes de California en noviembre del 2004 para aumentar servicios de salud mental para niños e adultos. La Ley es financiada por un pago de impuesto de 1% en ingresos personal que sobrepasa un millón de dólares por año.

Revised 1/2019

SAN BERNARDINO COUNTY
Behavioral Health

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

Senior Centers

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

Wednesday, January 10, 2019 **10:00 - 11:00 a.m.** **San Bernardino Senior Center** **600 W. 5th Street** **San Bernardino, CA 92410**	**Monday, January 14, 2019** **10:00 - 11:00 a.m.** **Fontana Senior Center** **16710 Ceres Avenue** **Fontana, CA 92335**	**Wednesday, January 9, 2019** **10:00 - 11:00 a.m.** **Perris Hill Senior Center** **780 E. 21st Street** **San Bernardino, CA 92404**

For questions, concerns, interpretation services or requests for disability-related accommodations, please contact:
Office of Cultural Competency (909) 386 - 8223 or 7-1-1 for TTY users or cultural_competency@dbh.sbcounty.gov. Please request accommodations at least 7 business days prior to the event.
MHSA (Proposition 63) was passed by California voters in November 2004 to expand mental health services for children and adults.
The Act is funded by a 1% tax surcharge on personal income over $1 million per year.

SAN BERNARDINO COUNTY
Behavioral Health

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

Centro para personas mayores

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

miércoles, 10 de enero del 2019 **10:00 - 11:00 a.m.** **San Bernardino Senior Center** **600 W. 5th Street** **San Bernardino, CA 92410**	**lunes, 14 de enero del 2019** **10:00 - 11:00 a.m.** **Fontana Senior Center** **16710 Ceres Avenue** **Fontana, CA 92335**	**miércoles, 9 de enero del 2019** **10:00 - 11:00 a.m.** **Perris Hill Senior Center** **780 E. 21st Street** **San Bernardino, CA 92404**

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

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

SAN BERNARDINO COUNTY
Behavioral Health

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

Thursday, February 21, 2019

Cultural Competency Advisory Committee (CCAC) Meeting

1:00 - 2:30 p.m.

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

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

MHSA (Proposition 63) was passed by California voters in November 2004 and went into effect January 2005.
The Act is funded by a 1% tax surcharge on personal income over $1 million per year.

For questions, concerns, interpretation services or requests for disability-related accommodations, please contact:
Office of Cultural Competency (909) 386 - 8223 or 7-1-1 for TTY users or cultural_competency@dbh.sbcounty.gov.
Please request accommodations at least 7 business days prior to the event.

Revised 2/6/19

SAN BERNARDINO COUNTY
Behavioral Health

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

jueves, 21 de febrero del 2019

Comité Consultivo de Competencia Cultural (CCAC)

1:00 - 2:30 p.m.

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

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

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

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

Revised 2/6/19

Below is the press release notifying the public of the Community Program Planning (CPP) process for the annual update:

For Immediate Release

www.SBCounty.gov

SAN BERNARDINO COUNTY

NEWS RELEASE
Behavioral Health

January 9, 2019

CONTACT:
Monica Rosas
Mental Health Specialist
(909) 388-0942
mrosas@dbh.sbcounty.gov

Public invited to learn more about County mental health services

San Bernardino County Department of Behavioral Health (DBH) invites members of the community to attend an annual stakeholder engagement meeting to learn more about the public mental health service delivery system in San Bernardino County.

These public stakeholder meetings will promote community conversation and participation regarding the Mental Health Services Act (MHSA) Annual Update for Fiscal Year 2019/20, in addition to a facilitated discussion regarding the future of mental health policy and program planning in San Bernardino County.

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

"Participation in the stakeholder process is important because it gives residents both the opportunity to learn more about public services and their ability to influence those services," stated Michelle Dusick, MHSA Administrative Manager. "We encourage all community members to attend."

Stakeholder meetings will take place at locations throughout the county. For a complete list of dates, times and locations, please view the attached list. For more information, interpretation services or requests for disability-related accommodations, please call (800) 722-9866 or dial 7-1-1 for TTY users.

DBH, through the MHSA, is supporting the Countywide Vision by providing behavioral health and substance use disorder services that promote wellness, recovery, and resiliency in the community. Information on the Countywide Vision and on DBH can be found at www.sbcounty.gov.

-30-

San Bernardino County Department of Behavioral Health ···

Like This Page · January 15

San Bernardino County DBH invites members of the community to attend an annual stakeholder engagement meeting to learn more about public mental health service delivery system. Meetings will take place at locations throughout the county. See: http://wp.sbcounty.gov/dbh/wp-content/uploads/2019/01/CPP-News-Release-Com.-Final.pdf

Julia Perez, Brihana Dominguez, Merrill Johnson and 17 others like this.

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Represented below is an article published by a local newspaper notifying the public of stakeholder meetings in their area.

DAILY PRESS

County Department of Behavioral Health to host mental health meetings

By Rene Ray De La Cruz
Staff Writer

Posted Jan 13, 2019 at 6:08 AM

VICTORVILLE — The San Bernardino County Department of Behavioral Health will host a series of community meetings to share public mental health services in the county.

These public stakeholder meetings will promote community dialogue and participation regarding the Mental Health Services Act Annual Update for the current fiscal year and facilitate discussion regarding the future of mental health policy and program planning in the county.

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

"Participation in the stakeholder process is important because it gives residents both the opportunity to learn more about public services and their ability to influence those services," said MHSA Administrative Manager Michelle Dusick. "We encourage all community members to attend."

Stakeholder meetings will take place at several locations throughout the county, including the following locations in the Victorville.

Serenity Clubhouse / Desert Stars Clubhouse

11 a.m. on Jan. 22. The meeting will be held at 12625 Hesperia Rd., Ste. B in Victorville

Victor Community Support Service

10:30 a.m. on Jan. 23. The meeting will be held at 15400 Cholame Rd. in Victorville

Santa Fe Social Club Clubhouse

10:30 a.m. on Jan. 25. The meeting will be held at 15400 Cholame Rd. in Victorville

The Department of Behavioral Health, through the MHSA, is supporting the Countywide Vision by providing behavioral health and substance use disorder services that promote wellness, recovery, and resiliency in the community.

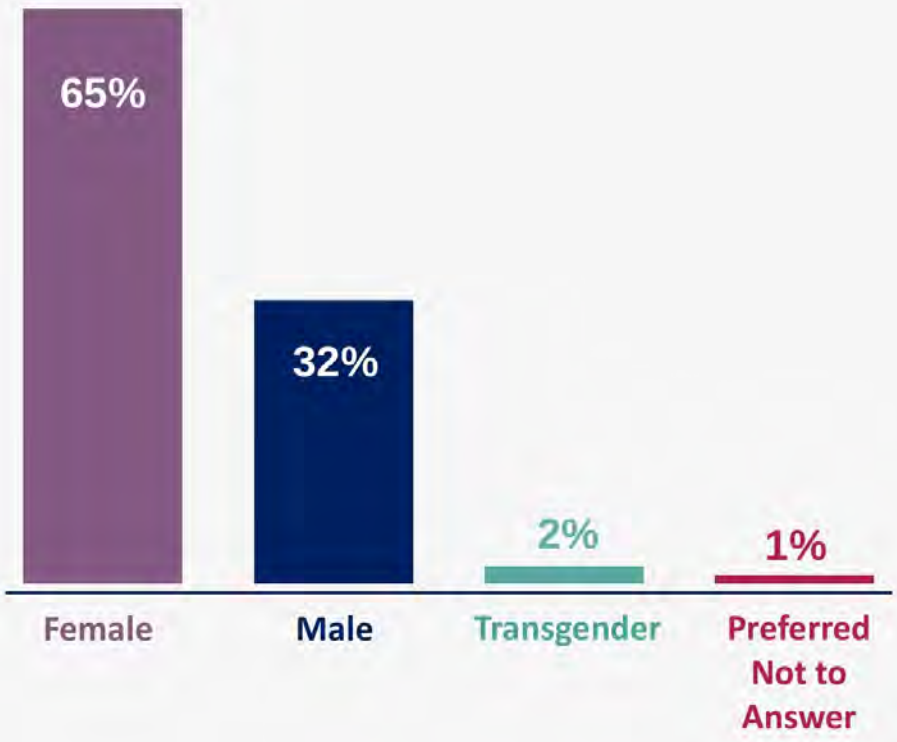
For more information including a complete list of dates, times and locations, call 800 - 722-9866 or visit www.sbcounty.gov.

Reporter Rene Ray De La Cruz may be reached at 760-951-6227, RDeLaCruz@VVDailyPress.com, Twitter @DP_ReneDeLaCruz

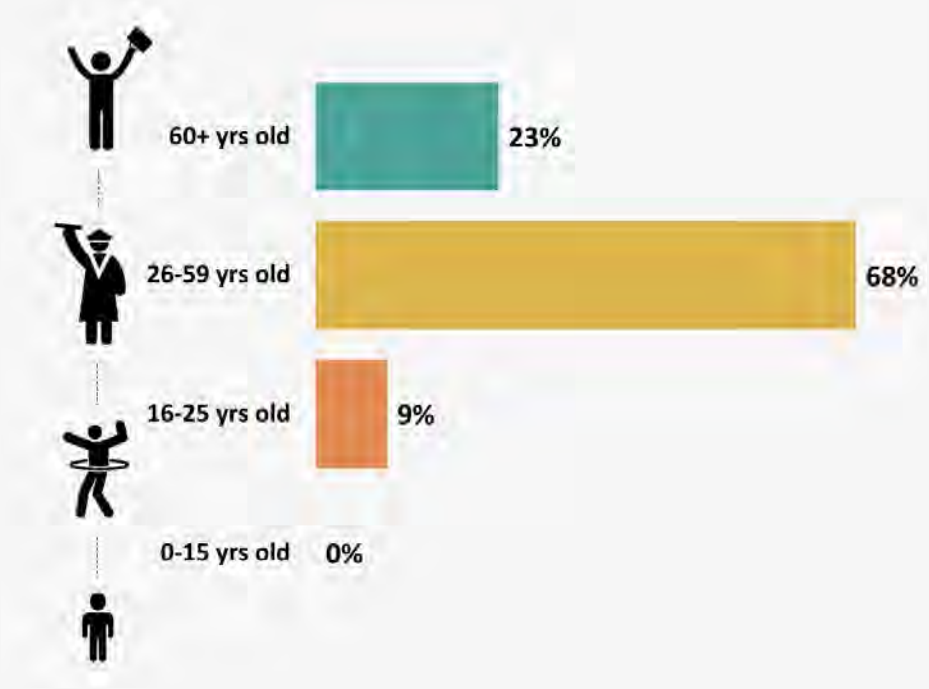
A total of **341** stakeholders attended this year's Community Program Planning (CPP) stakeholder sessions and DBH received **279** completed stakeholder comment forms as a result of those who attended the CPP stakeholder sessions. This year the department created a comprehensive needs assessment survey that was distributed at each of the CPP stakeholder sessions and also available online. Stakeholder comments and feedback will help the department to enhance, streamline, and restructure program programming, as the Department prepares to develop the forthcoming MHSA Three Year Integrated Plan.

The demographic breakdown of **279** participants who completed a stakeholder comment form is illustrated below and on the following page.

MHSA Annual Update CPP Demographics: Gender



MHSA Annual Update CPP Demographics: Age

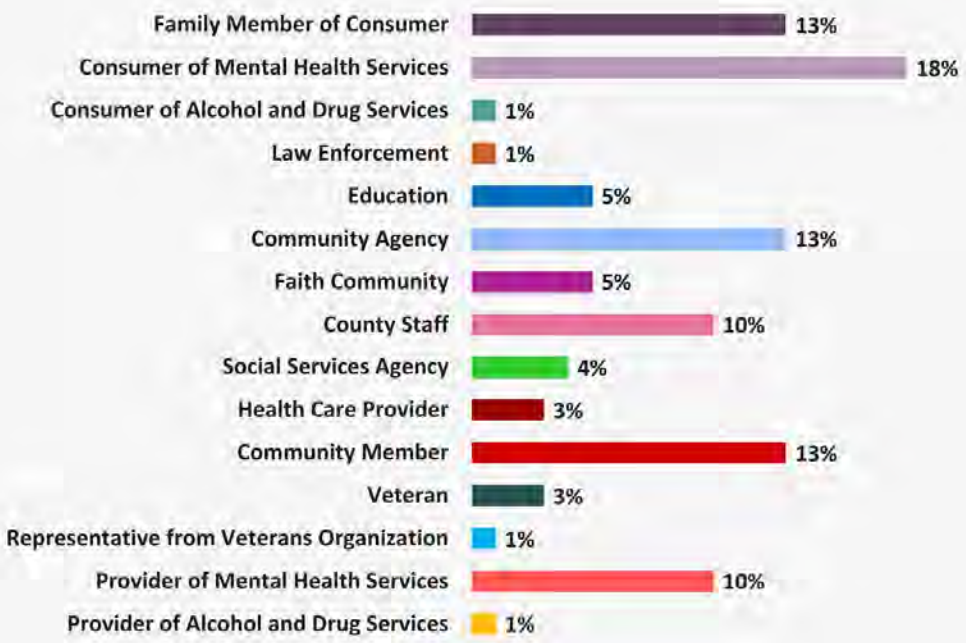


MHSA Annual Update CPP Demographics: Ethnicity

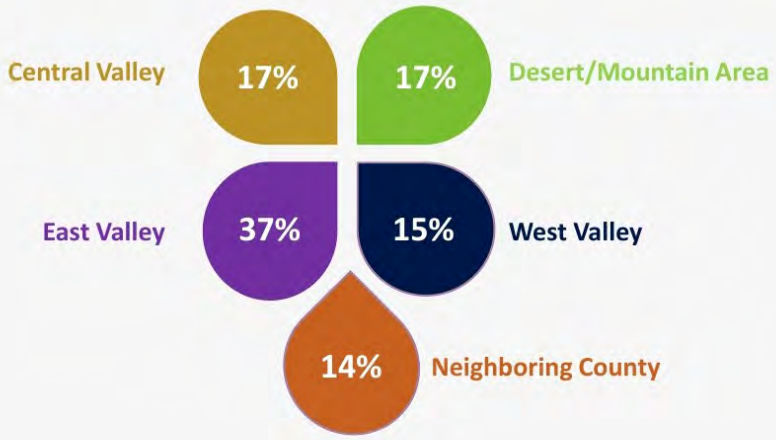
An overview of the groups, primary language, and San Bernardino County regions that stakeholders represented is illustrated below and on the top of the following page..

MHSA Annual Update CPP Demographics: Language

MHSA Annual Update CPP Demographics: Groups Represented

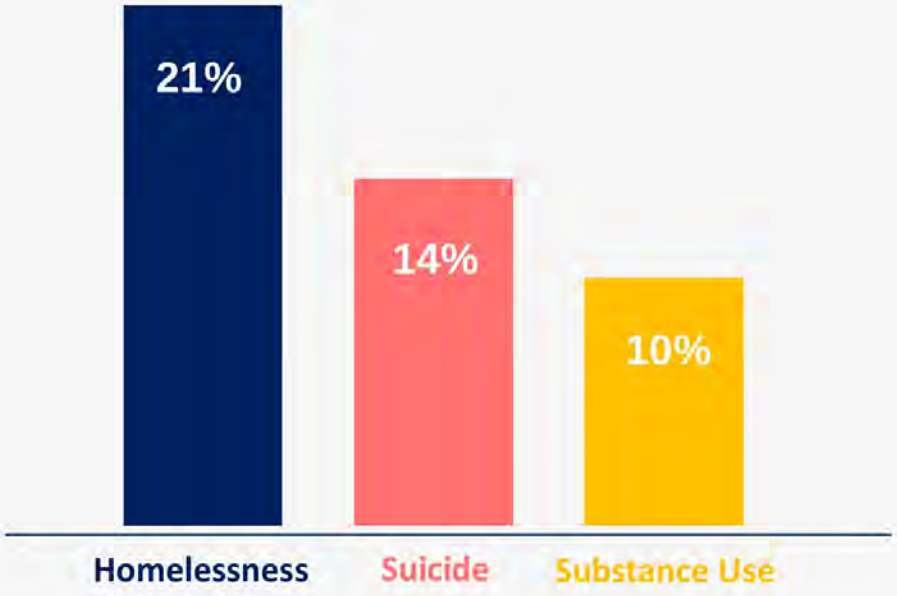


MHSA Annual Update CPP Demographics: Regions

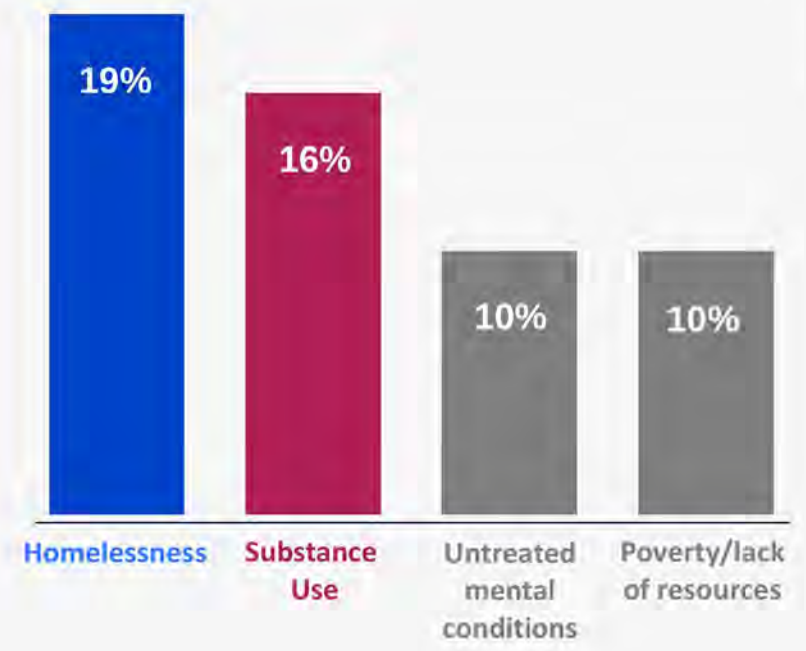


The following stakeholder responses below and on the following page are from some of the questions in this year's Community Program Planning Survey.

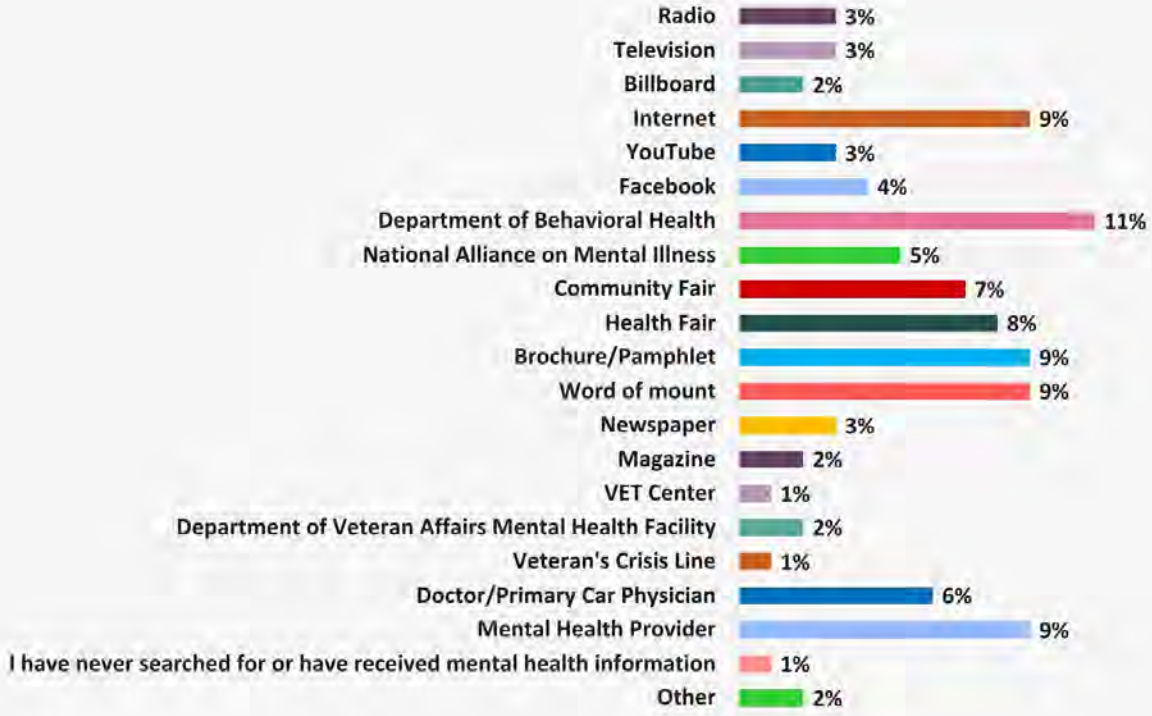
MHSA Annual Update CPP Demographics: In San Bernardino County, what are the perceived main issues resulting from untreated mental illness? (top three)



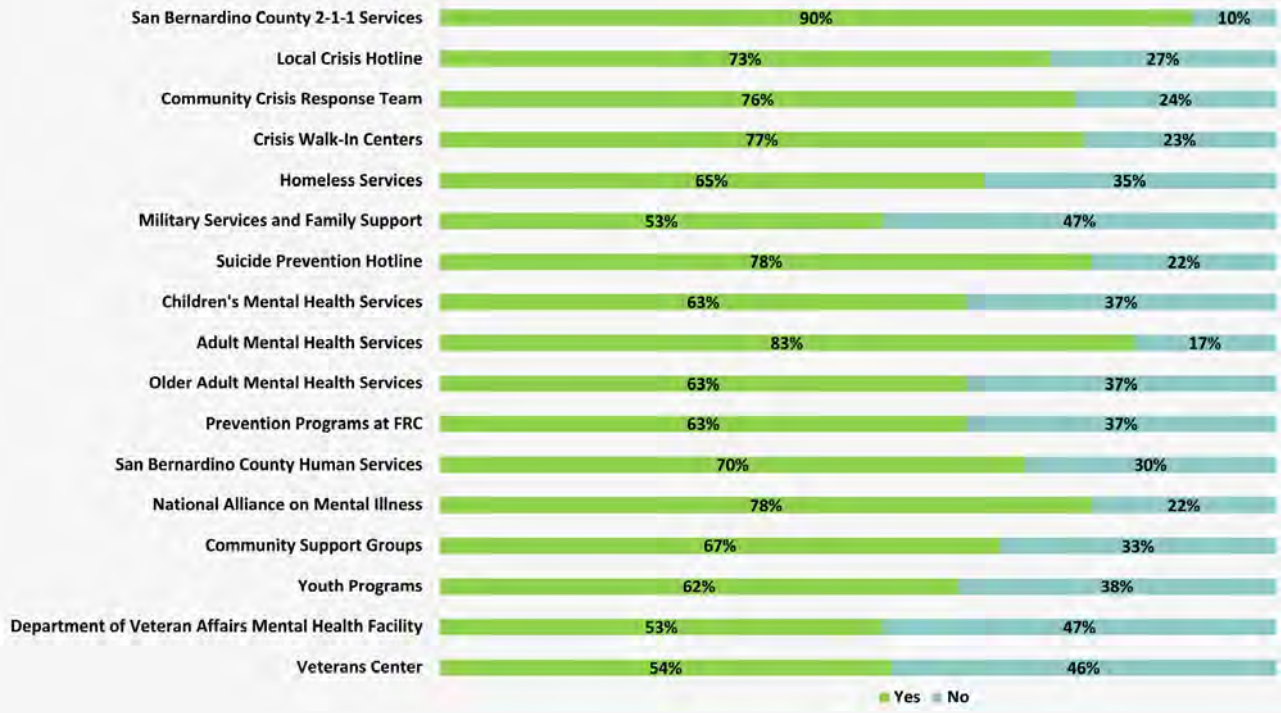
MHSA Annual Update CPP Demographics: In the community/ culture you identify with, what are the perceived main issues resulting from untreated mental illness? (top three)



MHSA Annual Update CPP Demographics: How have you heard of, or how have you received mental health information?



MHSA Annual Update CPP Demographics: What programs and services are you aware of or familiar with?



Artwork by Sonia Stockton

During the Community Program Planning (CPP) process meetings for the Annual Update, several community members voiced their support and approval of the plan, as well as the enhanced CPP that has occurred over the last year. Statements from the meetings are reflected below.

Stakeholder Comments

"I learned about the mental health services available to older adults."

"It's nice to know about the efforts that are being made in the areas of housing to assist those that are homeless and mentally ill."

"How I can get involved as a stakeholder in the planning process."

"I learned about crisis services and the new crisis centers that are being built throughout the county."

"DBH's identification of best practices and strategies through Innovation programs is key."

MHSA Summit

The final event of this year's Community Program Planning (CPP) process occurs in April 2019, when the Department of Behavioral Health will host its 4th Annual Mental Health Services Act (MHSA) Summit. The overarching goal of the Summit is to strategically advance MHSA communication and future planning with system partners, County residents, and key stakeholders.

The 2019 Summit will focus on Prevention and Early Intervention (PEI) programs and new state regulations and the potential impact on future programming as its primary topic. The agenda will include educational presentations by DBH staff and contract providers, a guided discussion, and thoughtful discussion concerning any potential updates of the PEI Component Plan.

More information regarding the date, time, and location of the MHSA Summit will be included in the final version of this plan.

Artwork by Terrance Martin

Summary of Program Changes

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

No program expansion is planned for Fiscal Year 2019/20, as the department is currently evaluating programs in all regions of the county. With input from a variety of stakeholders, DBH has identified program areas that require restructuring to better streamline services within programs and partner programs to better meet the needs of consumers . This includes a more collaborative and streamlined approach between the department's mental health and substance use disorder services, making service delivery more accessible and cost effective.

Expansion efforts, which are contingent on MHSA funding, will focus on the potential development of new MHSA housing under the "No Place Like Home" (NPLH) program and Special Needs Housing (SNHP) programs that will provide additional funding for the development of permanent supportive housing opportunities for our consumers and families throughout the county. Funding for housing under NPLH will be sought after through a competitive bidding processes where DBH in collaboration with Community Development and Housing Agency (CDHA) plans on bidding. If cash projections change such that housing expansion is not feasible, housing development efforts detailed within this report will not be implemented. To meet the requirements of NPLH, DBH in partnership with the Office of Homeless Services (OHS) and with stakeholder input, updated the MHSA Fiscal Year 2018/19 Plan to include additional housing services information. The full update can be accessed at Mental Health Services Act Fiscal Year 2019/19 update. Cost per consumer and consumers served estimates are included in the cost per consumer grids included with this report and are based on gross costs per Mental Health Services Oversight and Accountability Commission's (MHSOAC) direction provided in the plan instructions. This means cost per consumer information includes both MHSA and other funding utilized to serve the participants and consumers in MHSA Integrated programs.

The following programs will continue to operate as currently approved:

Prevention and Early Intervention

- PEI SI-2: Preschool Prevention and Early Intervention Program
- PEI SI-3: Resilience Promotion in African American Children

- PEI CI-1: Promotores de Salud/Community Health Worker (Pds/CHW)
- PEI CI-2: Family Resource Centers (FRC)
- PEI CI-3: Native American Resource Center
- PEI SE-1: Older Adult Community Services
- PEI SE-2: Child and Youth Connection (CYC)
- PEI SE-3: Community Wholeness and Enrichment (CWE)
- PEI SE-4: Military Services and Family Support
- PEI SE-5: LIFT Program
- PEI SE-6: Coalition Against Sexual Exploitation (CASE)

Community Services and Supports

- C-1: Comprehensive Children and Family Support Services Program (CCFSS)
- C-2: Integrated New Family Opportunities (INFO)
- TAY-1: Transitional Age Youth (TAY) One Stop Centers
- A-1: Clubhouse
- A-3: Members Assertive Positive Solutions/Assertive Community Treatment (MAPS/ACT)
- A-4: Crisis Walk-In Clinics (CWIC)
- A-6: Community Crisis Response Team (CCRT)
- A-7: Homeless Assistance Resource and Treatment Program (HART)
- A-8: Big Bear Full Service Partnership
- A-9: Access, Coordination, and Enhancement (ACE)
- A-10: Crisis Residential Treatment (CRT)
- A-11: Regional Adult FSP
- A-12: Whole Person Care
- OA-1: Age Wise;OA-1: Age Wise I– Circle of Care and OA-2: Age Wise II will be combined under one program as Age Wise

Innovation

- RBEST: Recovery Based Engagement Support Teams-Will sunset in October 201

The following are proposed changes in programs.

Prevention and Early Intervention (PEI)

New regulations and reporting requirements-Senate Bill 1004, passed in September 2018 by the California Legislature, establishes new priority populations to serve.

These priorities include:

- Childhood trauma prevention and early intervention to deal with early origins of mental health needs.
- Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention that occurs across the lifespan
- Youth outreach and engagement that targets secondary school and transition age youth, with a priority on partnership with college mental health programs.
- Strategies targeting the mental health needs of older adults.
- Other programs that the Mental Health Services Oversight and Accountability Commission (MHSOAC) identifies, with stakeholder participation, that are proven effective and are reflective of the goals outlined by the MHSOAC.

The MHSOAC will establish new PEI assessment tools and establish priorities by January 1, 2020. Due to these changes, DBH will launch a Community Program Planning (CPP) strategy to involve stakeholders in updating the current PEI plan.

Community Services and Supports (CSS)

In FY 2017/18, the Crisis System of Care Programs and the Crisis Stabilization Continuum of Care (CSCOC), were re-organized to better align to the services offered under each continuum and program and to include the expansion of crisis services that now include the Crisis Stabilization Units (CSUs) and Crisis Residential Treatment (CRTs) centers.

Crisis System of Care Programs (CSOC)

The crisis system of care (CSOC) programs now represent a continuum of services and it includes the Transitional Triage Services (TTS) program, Triage Engagement and Support Teams (TEST) program, Community Crisis Response Team (CCRT), and Crisis Intervention Training (CIT). These programs are designed to support individuals experiencing an immediate mental health crisis and provides training to first responders.

Crisis Stabilization Continuum of Care (CSCOC)

The Crisis Stabilization Continuum of Care (CSCOC) Is a continuum of services and includes the Crisis Walk-In Clinics (CWICs), Crisis Residential Treatment (CRT) centers, and Crisis Stabilization Units (CSUs). These programs provide services designed to support alleviating mental health symptoms and transitioning individuals to outpatient services.

Full Service Partnerships

Age Wise

Age Wise provides intensive case management services for older adults. The Age Wise I & II program's services will now be combined and the program will now just be referred to as Age Wise. Previously Age Wise I was the mobile services, outreach/engagement, and case management component of this program and Age Wise II was the Full Service Partnership (FSP) service component of the program .

Housing, Long-term Supports, and Transitional Care Programs

Permanent Supportive Housing

The No Place Like Home (NPLH) initiative allows MHSA funding to be taken at the state level and reallocates it for the development of supportive housing. A total of $2 billion dollars will be taken over the next two years from MHSA funds and will be made available for all 58 counties in the form of competitive and non-competitive funds. These funds will be used for the development of permanent supportive housing for individuals living with a serious mental illness, who are at-risk of homelessness, homeless, or chronically homeless. San Bernardino County plans to compete for available funds.

MHSA Special Needs Housing Program (SNHP)

The MHSA Special Needs Housing Program (SNHP) was initiated on June 24, 2016, after the MHSA Housing Program ended in May 2016. SNHP allows counties to assign MHSA funds to California Housing Finance Agency (CalHFA) for the development of new permanent supportive housing. Under this program, DBH has $4.7 million in capital development funding and Capitalized Operating Subsidy Reserves (COSR) for the development of new permanent supportive housing targeting individuals with a mental illness and their families, who are homeless or chronically homeless.

DBH anticipates local funding commitments for two potential housing developments.

- Desert Haven in the City of Barstow
- Bloomington Phase 3 in the City of Bloomington
- DBH committed funding to two additional housing developments accumulating into an additional 32 MHSA funded units under SNHP.
- Additional information regarding the MHSA Housing Program and the SNHP is available on the CalHFA website: http://www.calhfa.ca.gov/multifamily/mhsa/index.htm and http://www.calhfa.ca.gov/multifamily/snhp.index.htm

Innovation

The following programs are proposed projects that were developed with stakeholder input and are in various phases of development. These programs still require additional approval from the Mental Health Services Oversight and Accountability Commission (MHSOAC).

Innovative Remote Onsite Assistance Delivery (InnROADs)-The focus of this project will be the creation of an intensive, field-based engagement model that supports multidisciplinary/multiagency teams that meet, engage, and provide treatment to youth, adults, and families experiencing homelessness where they live. DBH is scheduled to present the Innovation project to the MHSOAC February 2019.

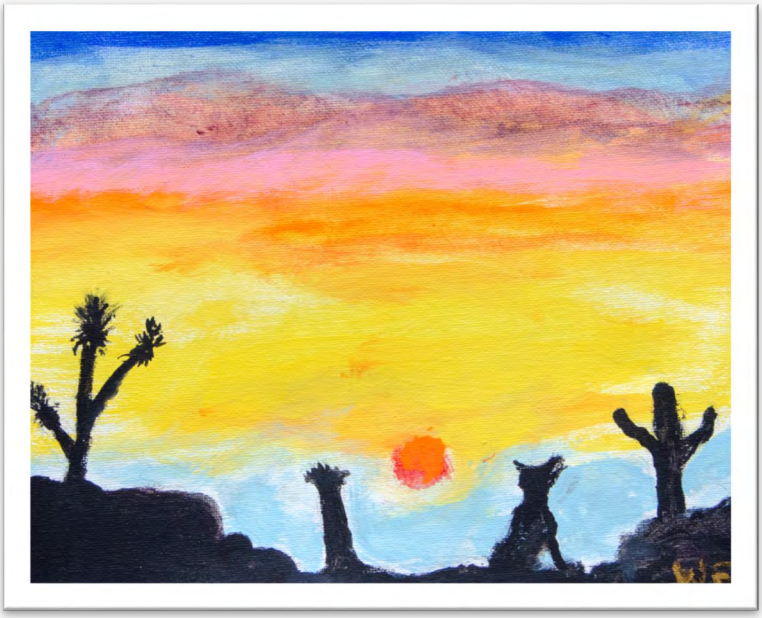
Eating Disorder Collaborative-The focus of this project is to develop a comprehensive and flexible interagency model of interventions and services for those that have been diagnosed with an eating disorder. This model will offer a new integrated care mode that offers care coordination that addresses both the medical and psychological needs of the patient. This project is still in development and will be presented in full via a Community Program Planning (CPP) process and a 30-day public posting process.

Cracked Eggs-This focus of this project is to allow participants to discover, learn, and explore their mental states. Workshops are structured and focus on performance, writing, and art using a series of techniques that include the use of the psychological model (now know as the biopsychosocial model of health and illness) as a method of acting. The Cracked Eggs workshop is a consumer designed multi-session process that results in the completion of a consumer designed art exhibition. This project is still in development and will be presented in full via a Community Program Planning (CPP) process and a 30-day public posting process.

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

Public Review

The DBH MHSA Annual Update will be posted on the department's website for stakeholder review and comment from **February 20, 2019 through March 22, 2019** at http://wp.sbcounty.gov/dbh/admin/mhsa/. The Public Hearing to affirm the stakeholder process will take place at the regularly scheduled Behavioral Health Commission Meeting (County of San Bernardino Health Services Auditorium-850 E. Foothill Blvd., Rialto, CA 92376) on **April 4, 2019**, which is held from **12:00 p.m. until 2:00 p.m.**



Artwork by Wanda Eggert

Substantive Comments/Recommendations

An analysis of substantive recommendations will be included in the Public Posting and Comment section of the final MHSA Annual Update. Comments/recommendations can be submitted via email to the DBH MHSA email box at MHSA@dbh.sbcounty.gov during the time the MHSA Annual Update Plan draft is posted for public comment. Stakeholders are informed that comments can be received anytime through the year, but will not be included in the final plan unless provided during the 30-day comment period. The plan is scheduled to be posted for 30-days, per Welfare and Institutions Code 5848, between February 15, 2019 and March 18, 2019 at www.sbcounty.gov/dbh/.

If you would like to provide comments/recommendations after the close of the 30-day posting period, you may request a comment form be sent to you by contacting DBH at MHSA@dbh.sbcounty.gov or calling **1-888-743-1478** for more information.

During the stakeholder meetings for this MHSA Annual Update Plan, 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://wp.sbcounty.gov/dbh/wp-content/uploads/2016/06/Directory_Service_Eng.pdf.

During stakeholder meetings, it was noted that community members would like information about how to access funds related with MHSA programs for their areas. The Department releases several Requests for Proposals (RFPs) every year through a procurement process. MHSA funds can be accessed by successful applicants who participate in the procurement process and are determined to meet criteria for RFPs. RFPs may be accessed at the County website per the following link: http://www.sbcounty.gov/main/Pages/rfp.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 found at the following link http://www.sbcounty.gov/dbh/mhcommission/mhcommission.asp. For meetings in which RFPs are on the agenda, outreach will be done to inform interested community members of the time and dates of the meetings.

DBH encourages and supports community collaboration, particularly the involvement of stakeholders, in all aspects of the MHSA programs provided. To address concerns related to DBH MHSA program issues in the areas of access to behavioral health services, violations of statutes or regulations relating the use of MHSA funds, non-compliance with MHSA general standards, inconsistency between the approved MHSA Plan and its

implementation, the local MHSA community program planning process, and supplantation,
please refer to the MHSA Issue Resolution process located at http://wp.sbcounty.gov/dbh/wp-content/uploads/2016/08/COM0947.pdf.

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

As feedback is collected from the community, it is analyzed with county demographic information, prevalence and incidence rates for behavioral health services, specific treatment information collected by programs, consumers 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 (e.g., inpatient, residential, long term care, day treatment, intensive outpatient, general outpatient care), and program needs are considered.

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

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

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

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

Assistance for Disabled Individuals:

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

Reduction of Discrimination and Stigma:

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

Support for Parents and Caregivers:

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

Innovation Projects:

There is currently one active Innovation Project and three newly proposed projects that still require final approval from the Mental Health Services Oversight Accountability Commission (MHSOAC) and the San Bernardino County Board of Supervisors. The current Innovation project is the Recovery Based Engagement Support Teams (RBEST). This project is scheduled to end in October 2019 with successful parts of the project being

transitioned into DBH operations. The currently proposed Innovation projects that have been developed with stakeholder input include the Innovative Remote Onsite Assistance Delivery (InnROADS), Eating Disorder Collaborative, and Cracked Eggs. Community Program Planning for these new Innovation projects is underway. Information regarding Innovation and the Community Program Planning process can be obtained at **1-800-722-9866**.

Shelter Beds and Homeless Assistance:

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

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

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

Engagement and Support Teams

The Triage Engagement and Support Teams (TEST) is a field-based, short-term intensive case management program to help individuals get connected to needed behavioral health, substance use treatment, and additional community resources to increase access to services. TEST staff is made up of social workers and substance use counselors located at key points of access in the community such as Sheriff Stations, Jail Discharge, Probation, hospitals, and the Public Defender's Office. Staff members provide needs assessments and case management plans. Cases can be kept open for up to two months to ensure appropriate linkage. More information can be obtained at **(909) 873-4409**.

The Recovery Based Engagement Support Teams (RBEST) project provides community (field-based) services throughout San Bernardino County for those mentally ill individuals who are unengaged in necessary psychiatric care in an effort to "activate" the individual into the behavioral health system to receive appropriate services. The multi-disciplinary nature of the engagement teams presents a holistic approach to the needs of the consumers. The program is "relational" in its orientation in that it will focus on the needs and goals of the consumer and helping that consumer meet the goals and eliminate obstacles through appropriate behavioral health treatment. As this is an Innovation project that is time limited, the program will end in October 2019. More information on services and the referral process can be obtained at **(909) 421-9452**.

Community Education and Resources:

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

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

Overview of Public Posting and Comment Period

The Department of Behavioral Health (DBH) would like to thank those who participated in the public review and comment portion of the stakeholder process. During the 30 day public posting of the MHSA Annual Update for Fiscal Year 2019/20, that occurred from February 20, 2019 through March 22, 2019, DBH continued to promote the 30 day posting and provided overviews and information related to the MHSA Annual Update. All 33 public libraries in San Bernardino County, as well as DBH's community, government, and law enforcement stakeholders received a copy of the plan's Executive Summary including instructions for submitting feedback. A total of 88 hard copies were distributed to these stakeholders. A press release, in English and Spanish, notifying the public of the posting was sent to 44 media outlets. A series of web blasts were released to all DBH clinics, contracted provider agencies, the Community Policy Advisory Committee, the Cultural Competency Advisory Committee and all associated cultural sub-committees, the Association of Community Based Organizations, and the Behavioral Health Commission. This information was also advertised on all DBH sponsored social media sites, including Facebook, Instagram, and Twitter and it was posted on the DBH website.

The MHSA Coordinator made printed copies of the plan available at every stakeholder meeting and distributed two hard copies to community and agency members, upon their request. As a result, 26 individual comments from 18 returned surveys, were received during the 30 day public posting and comment period. In addition, there were two e-mails sent to the DBH's MHSA mailbox at mhsa@dbh.sbcounty.gov , during the 30-day public posting period that provided general comments to the plan as well as comments specifically related to the creation and implementation of a career pathway, practicum or internship positions related to the Alcohol and Other Drug (AOD) counselor positions.

Summary and Analysis of Substantive Comments

DBH would like to thank everyone who reviewed the plan and/or submitted a comment. The following contains a summary and analysis of a sample of comments, along with responses, received during the 30 day public posting and comment period. DBH encourages and supports community collaboration, particularly the involvement of stakeholders, in all aspects of the MHSA program provided.

Question: Do you have any concerns not addressed in this document?

Comment:

Several comments addressing the desire to create additional capacity and workforce development opportunities related to substance use disorder services were received. The feedback included recommendations to enhance the Workforce Education and Training Component in future updates to include opportunities such as:

- Including an Alcohol and Other Drug (AOD) Counselor track in the Internship Program.
- Create a 20/20 program for clinical staff that wish to pursue an AOD certification
- Include clinical rotations in Substance Use Disorder and Recovery Services (SUDRS) as part of the existing internship and medical education programs.
- Create a dual diagnosis "certification" that allows AOD Counselors to obtain additional knowledge for addressing mental health concerns and mental health clinicians to address substance use disorders. This includes training mental health clinicians in the administration of the American Society of Addiction Medicine (ASAM) tool.

Response:

Thank you to the individuals who submitted a comment related to staff development to support further integration of Substance Use Disorder services in DBH's continuum of care. While the one time allocation of Workforce Education and Training (WET) has ended, DBH continues to maintain its commitment to the development of a competent workforce through the MHSA. The WET component plan is in the process of being evaluated and will be updated through a community planning process to be included in next year's MHSA Three Year Integrated Plan. Your comments and feedback are important to us and we encourage your participation in all future stakeholder opportunities. For more information, please contact MHSA Administration at (800) 722-9866 or email mhsa@dbh.sbcounty.gov.

Summary and Analysis of Substantive Comments

Question: What did you learn about the MHSA Annual Update?

Comment:

I learned that although items are discussed and goals presented as something to be achieved the actual implementation can take years.

Response:

Thank your for your patience with the program planning and implementation process. One of the unique features of the MHSA is that it is transparent, and involves stakeholders in the planning, implementation and review of programs and services. As the MHSA program planning process programs involve many stakeholders in the identification of new programs and in the planning process, which encompasses all regions of San Bernardino County, the collection of data, stakeholder feedback, and the analysis of this information is a time consuming process. Additionally, MHSA funded programs need local approval from the county's Behavioral Health Commission and Board of Supervisors. The Innovation component requires additional approval from the State of California's, Mental Health Services Oversight and Accountability Commission (MHSOAC), the approval protocol is a time consuming process.

Comment:

It is very refreshing to see how many Prevention and Early Intervention (PEI) services are in the community. The medical model is deficit based and waits for clients to not to be able to function. This results in higher cost to the client (quality of life) as well as a higher fiscal impact to the system of care. We should not have to wait to intervene, it is cost efficient for both the client and Mental Health Plan (MHP). These services are invaluable!

Response:

Thank you for your comment, insight and support of Prevention and Early Intervention (PEI) programs. As you mentioned, PEI services are vital in educating the community about mental health and the services that are available. Programs also seeks to identify and deter the early onset of a mental illnesses or to provide treatment before it becomes severe.

Summary and Analysis of Substantive Comments

Comment:

I learned about the outcomes related to MHSA programs.

Response:

Thank you for your response and comment. One of the unique characteristics of the MHSA is its transparency as it pertains to the identification and reporting of outcomes. Each program under MHSA has specific goals and outcomes that the program works to achieve based on the components and services related to each program.

Commentario (Comment):

Aprendí que DBH está haciendo un buen trabajo con los fondos de MHSA.

(I learned that DBH is doing a good job in utilizing MHSA funds).

Respuesta (Response):

¡Gracias por su comentario y respuesta! El uso de los fondos de MHSA es un proceso transparente y incluyen las ideas, solicitudes, y necesidades de la comunidad que están identificadas en varios medios que incluyen la educación de la comunidad en programas comunitarios como el programa de Promotores y en varias reuniones comunitarias facilitadas por el DBH.

(Thank you for your response and comment. The use of MHSA funds is a transparent process that includes the ideas, requests, and the identification of community needs through stakeholder outreach and education like the Promotores program and via input obtained through the community program planning process.)

Comment:

I just want to express my gratitude for increasing the availability of PEI services to our population in their community which increases access and helps remove stigma.

Response:

Thank you for your response and feedback. Prevention and Early Intervention (PEI) program goals are to implement strategies at the early end of the continuum of care to deter the onset of a mental illness, improve a mental health condition early in its development, and/or prevent relapse. Understanding issues related to accessibility, culture, and stigma, as it pertains to behavioral health services, the Department of Behavioral (DBH) has contracted services with community partners to make education system services easier to access as they are embedded in the communities in which clients reside and where services are needed.

Public Hearing

A public Hearing hosted by the San Bernardino County Behavioral Health Commission was conducted on April 4, 2019, as part of the regular Commission meeting. All attendees were provided with handouts which included an agenda, meeting regulations for MHSA public Hearings, access to Comment Forms in English and Spanish, and a copy of the MHSA public hearing PowerPoint Presentation. As with all public meetings, interpretive services and materials in Spanish were offered at the Public Hearing.

A flyer in English and Spanish advertising the Public Hearing was:

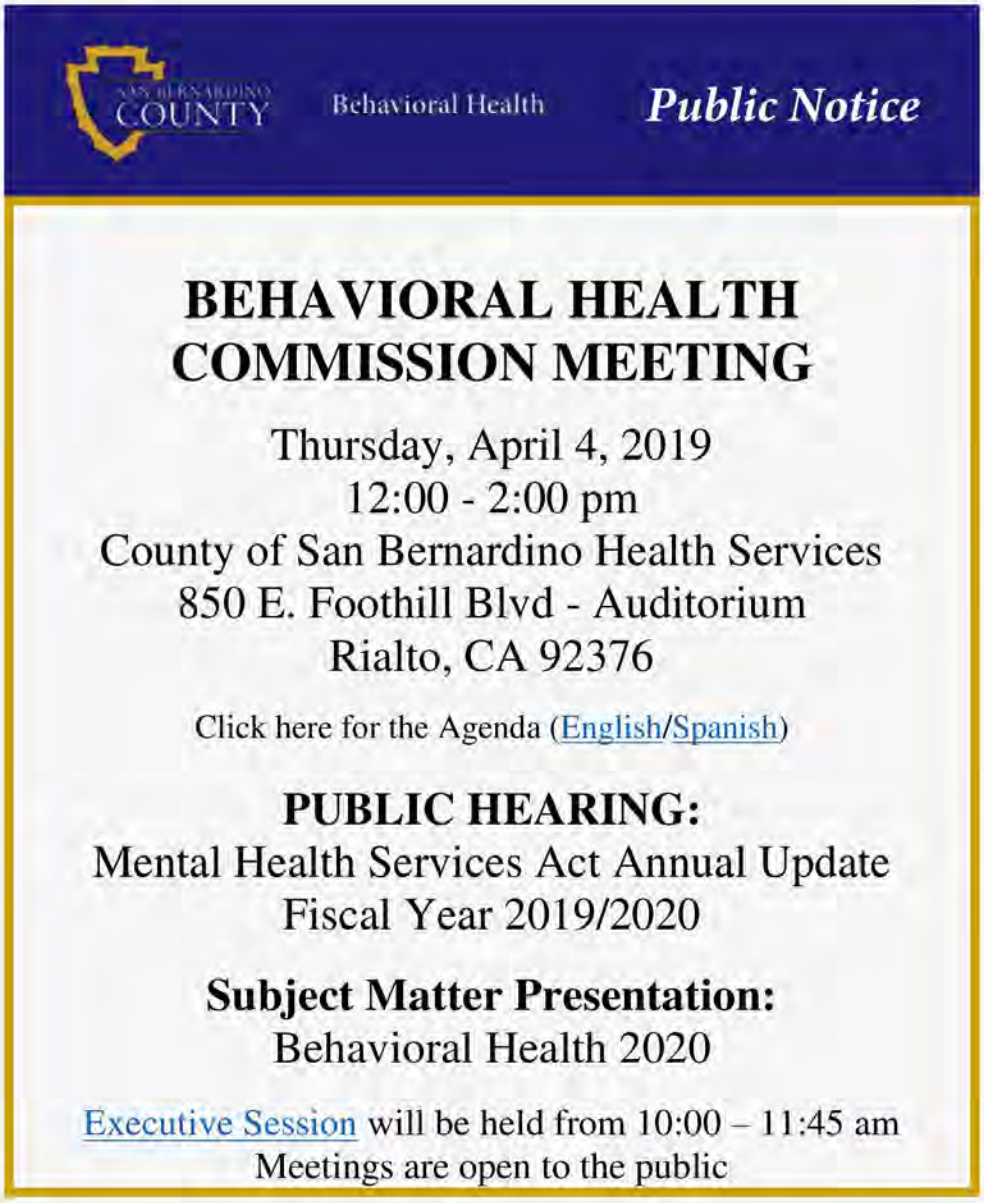
- Distributed at all DBH clinics and contracted provider agencies.
- Posted on the DBH Intranet and the Internet and the County internet site.
- Included as a post on all social media sites, including Facebook, Instagram, and Twitter.
- Distributed by Community Outreach and Education and MHSA Administration Staff at a variety of venues.
- Included with a press release that was created and distributed to 44 media outlets to inform all county residents of the Public Hearing.

People in attendance included consumers, family members, service agency representatives, advocates, students of local colleges and universities, DBH staff, and Behavioral Health Commissioners as evidenced by stakeholder introductions at the opening of the meeting and by sign-in sheets.

There were no public comments received. Comments and questions however were received from the Behavioral Health Commissioners. The first set of comments and questions focused on the Annual Update's Community Program Planning (CPP) process and the meetings and groups that were targeted . The facilitator highlighted the meetings, groups, and organizations where outreach had been conducted this year throughout the various regions of the county, including the online Adobe Connect sessions, identified the efforts the department has made to expand this outreach, and acknowledged areas of opportunity. The second set of comments and questions related to the promotion of the plan. The facilitator highlighted the different ways the Annual Update is promoted in the department and community and thanked the commissioners for their suggestions regarding other mediums of media that can be implemented in the future to promote the plan.

The Behavioral Health Commission affirmed that the Department had adhered to the MHSA CPP process and supported the submission of the MHSA Annual Update for Fiscal Year 2019/20 to the San Bernardino County Board of Supervisors for approval at the May 21, 2019 meeting and the subsequent submission to the Mental Health Services Oversight and Accountability Commission.

Below is a copy of the flyer that was distributed to the community to promote the MHSA Annual Update Public Hearing at the Behavioral Health Commission Meeting.


SAN BERNARDINO COUNTY Behavioral Health **Public Notice**

BEHAVIORAL HEALTH COMMISSION MEETING

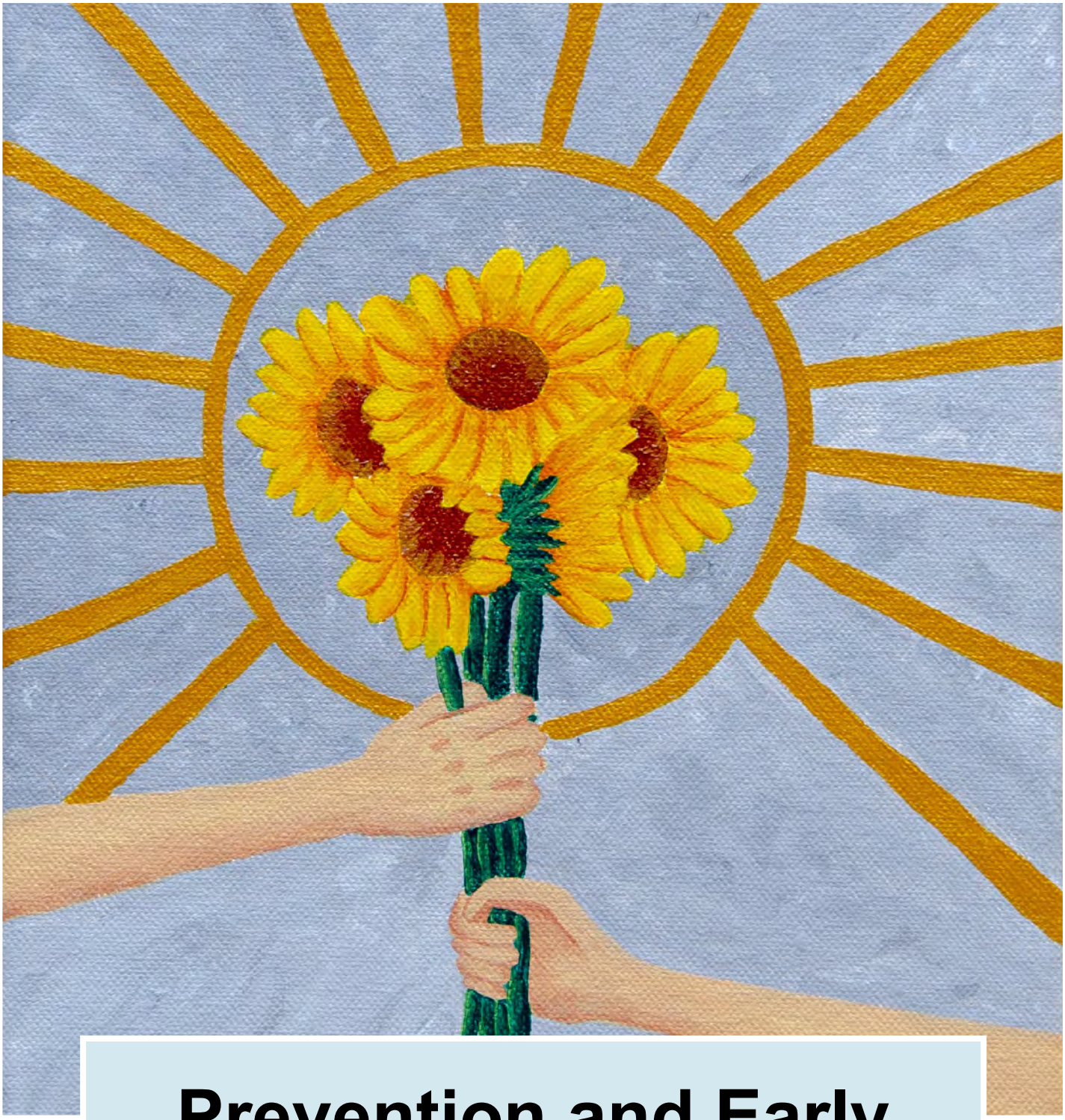
Thursday, April 4, 2019
12:00 - 2:00 pm
County of San Bernardino Health Services
850 E. Foothill Blvd - Auditorium
Rialto, CA 92376

Click here for the Agenda (English/Spanish)

PUBLIC HEARING:
Mental Health Services Act Annual Update
Fiscal Year 2019/2020

Subject Matter Presentation:
Behavioral Health 2020

Executive Session will be held from 10:00 – 11:45 am
Meetings are open to the public



Artwork by Alyssa Iniow

Prevention and Early Intervention (PEI)

Introduction

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

PEI programs incorporate the values of cultural competence, consumer and community empowerment, collaboration, and inclusion in providing services that emphasize recovery, wellness, and resilience. As such, PEI programs continue to strive to meet the priority needs identified by local diverse community stakeholders, meet the key community and priority population needs outlined in the Mental Health Services Act (MHSA) PEI Component, and transform the public mental health system.

Historically, the PEI program used a framework that provided guidance concerning key mental health needs and priority populations. The framework was grounded in the internationally recognized Institute of Medicine's (IOM) Framework and was provided by the California Department of Mental Health in 2007 through Information Notice 07-19 (DMH-IN 07-19). The IOM Framework, as related to PEI, describes a continuum of interventions that align with the severity of the population being served, ranging from activities targeting groups with no known risk for the development of a behavioral health condition to those experiencing the first onset of a serious mental illness, including psychosis.

On October 6, 2015, updated Prevention and Early Intervention (PEI) Component Regulations became effective. The updated regulations were designed by the Mental Health Services Oversight and Accountability Commission (MHSOAC) and changed the framework and structure of the PEI component as compared to the guidance received via DMH-IN 07-19.

The majority of the changes relate to restructuring IOM Framework principles and concepts. The principles are now parceled out as individual programs. A program is defined in the new regulations as "a stand-alone organized and planned work, action, or approach that evidence indicates is likely to bring about positive mental health outcomes either for individuals and families with or at-risk of serious mental illness or for the mental health system (WIC §3701 (b))."

Currently, there are six **(6)** State-Defined Prevention and Early Intervention Programs:

PEI State Programs

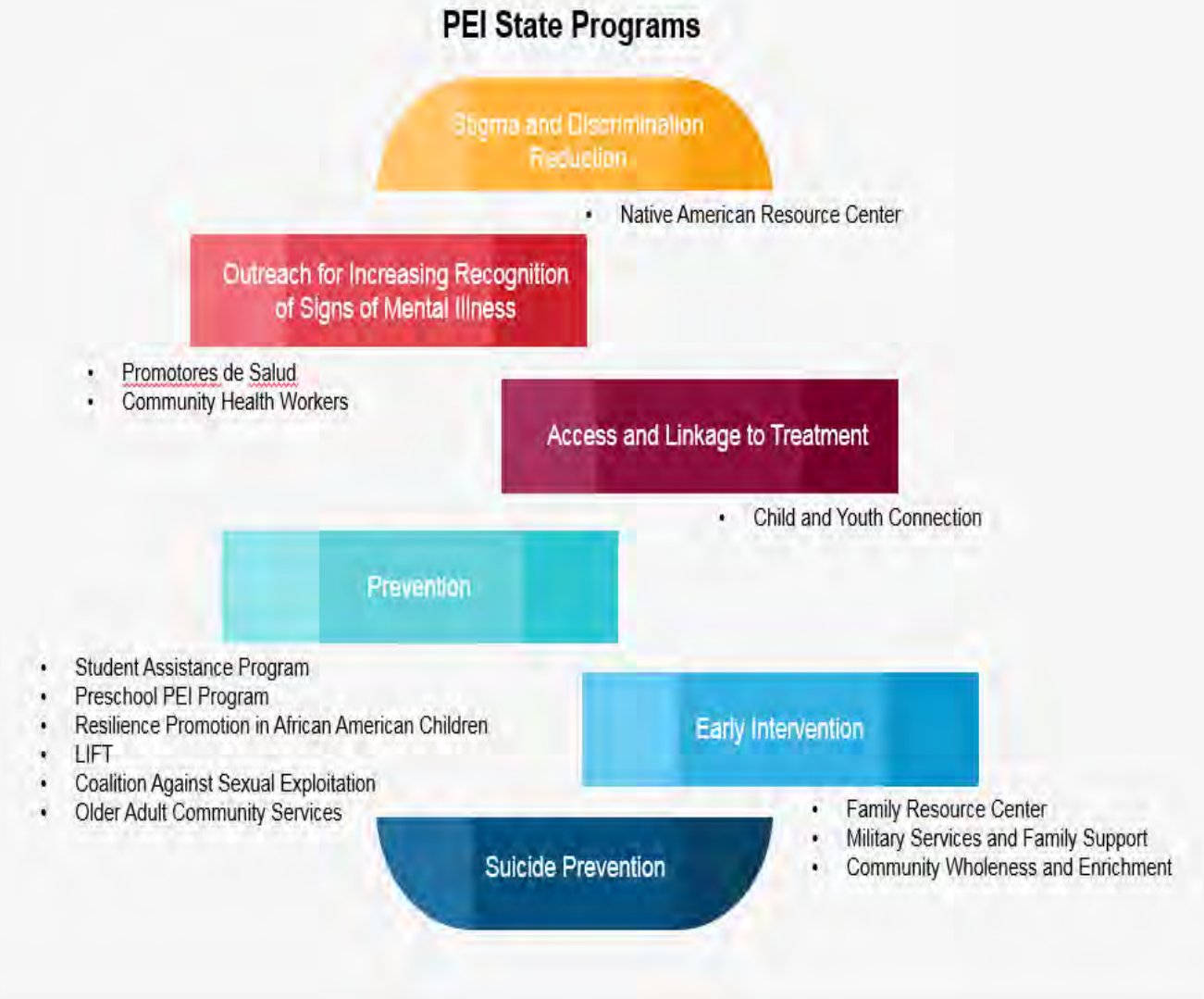
In addition, all Programs must include the following three **(3)** strategies, outlined in WIC §3735, as part of their programming.

- Access and Linkage
- Improve Timely Access
- Reduce and Circumvent Stigma

Local PEI Program Construct

Prior to the finalization of the PEI regulations, DBH conducted a robust community planning process to evaluate the current structure and framework of the PEI Component as compared to the new State Program categories. Stakeholders were given the new categories and definitions and asked to determine which new required program reporting category best aligned with the existing PEI program(s) by marking their selections on a form. They were also asked to determine if the required strategies were already contained within each program. Stakeholder groups reached consensus that the existing PEI Component programs met the Program and Strategy requirements of the new regulations.

As a result of our collaboration with stakeholders, implementation of the PEI Component now exists under the reporting construct as illustrated by the following:



In September 2018, California Senate Assembly Bill 1004 was approved by the Governor. This bill requires the Mental Health Services Oversight and Accountability Commission (MHSOAC) to establish priorities for the use of Mental Health Services Act Prevention and Early Intervention (PEI) funds, as specified, and to develop a statewide strategy for monitoring the implementation and effectiveness of PEI programs, as specified. The bill will standardize and improve PEI programs funded by the MHSA, ensuring access to effective, quality care in counties across the state.

The bill establishes specific priorities for the use of PEI funds. These priorities include:

- Childhood trauma prevention and early intervention to deal with the early origins of mental health needs.
- Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programming that occurs across the lifespan.
- Youth outreach and engagement strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs.

- Culturally competent and linguistically appropriate prevention and intervention.
- Strategies targeting the mental health needs of older adults.
- Other programs the commission identifies, with stakeholder participation, that are proven effective in achieving, and are reflective of, the goals stated in Section 5840.

The target date for these changes is January 1. 2020. Counties will receive more guidance for implementation from the MHSOAC in the next year.

MHSA Legislative Goals and Key Outcomes

PEI program goals and key outcomes were updated to align with the new legislation of October 2015. The following are the updated goals and key outcomes that became effective July 1, 2016.

- Increase early access and linkage to medically necessary care and treatment:
  - ◊ Connect children, adults, and seniors with severe mental illness, as early in the onset of these conditions as practicable, to medically necessary care and treatment including, but not limited to, care provided by County mental health programs.
- Improve timely access to services:
  - ◊ Increase extent to which an individual or family from an underserved population who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in onset as practicable.
- Promote, design, and implement programs in ways that reduce and circumvent stigma:
  - ◊ Reduce and circumvent stigma, including self-stigma.
  - ◊ Reduce discrimination related to being diagnosed with a mental illness, having a mental illness, or seeking mental health services.
  - ◊ Increase service accessibility.
- Prevent suicide as a consequence of mental illness:
  - ◊ Improve attitudes, knowledge, and/or behavior regarding suicide related to mental illness.
- Increase recognition of early signs of mental illness
  - ◊ Increase identification of early signs of potentially severe and disabling mental illness for potential responders.
  - ◊ Increase support to individuals with mental illness.
  - ◊ Increase referrals for individuals who need treatment or other mental health services.

- Reduce prolonged suffering associate with mental illness:
  - ◊ Reduce risk factors.
  - ◊ Reduce indicators.
  - ◊ Increase protective factors that may lead to improved mental emotional and relational functioning.
  - ◊ Reduce symptoms.
  - ◊ Improve recovery, including mental, emotional and relational functioning
- Reduce stigma and discrimination associated with mental illness:
  - ◊ Reduce negative feelings, attitudes, beliefs, perceptions, stereotypes, and/or discrimination related to having a mental illness, being diagnosed, or seeking services.
  - ◊ Reduce negative feelings, attitudes, beliefs, perceptions, stereotypes, and/or discrimination related to having a mental illness, being diagnosed, or seeking services.

PEI Data Collection

DBH-PEI providers use activity sheets to track daily activities and services and the number of participants served. Using these daily sheets, each provider prepares a summary report on a month to month basis and submits it to the San Bernardino County Department of Behavioral Health. These monthly reports provide a summary of the following:

- Access and linkage to treatment strategy
- Improve timely access to services for underserved populations strategy
- Effective methods used to deliver services
- Outreach for increasing recognition of early signs of mental illness strategy
- Number of unduplicated participants served, and services rendered by State program

Providers are required to submit the monthly reports to the Department no later than the tenth day following the last day of the month of services. In FY 2019/20, DBH anticipates launching a Prevention and Early Intervention Data Collection System (PEI-DCS) to streamline the electronic data collection process. This database will replace the current process of submitting monthly reports and will offer the County the ability to access real time data entered by the providers.

Providers who deliver early intervention services are required to enter all Early Intervention services into the San Bernardino Department of Behavioral Health's billing system, SIMON. They are required to input their service information and data in SIMON no later than seven days from the date of services. Starting in FY 2019/20, the SIMON system will be replaced by a Behavioral Health Information Management System (BHMIS). The BHMIS provides a more comprehensive method of capturing client information and service data.

Providers submit a qualitative report outlining the progress made toward the overall program goals, specific objectives, challenges encountered in achieving objectives, methods used to resolve challenges, and program modification that occurred as a result of program evaluation. These reports are submitted to DBH on a biannual basis.

PEI Statewide Projects

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

The three **(3)** statewide projects include:

1. **Stigma and Discrimination Reduction**
2. **Student Mental Health Initiative**
3. **Suicide Prevention**

These projects are administered by CalMHSA and collected under the banner of Each Mind Matters: California's Mental Health Movement.

As part of the community planning process, the Department and its stakeholders in the development of the Three Year Plan reaffirmed the commitment to statewide PEI projects and contributed resources to support these continued efforts through Fiscal Year 2019/20. The following provides an overview of the goals and activities related to each statewide project.

Stigma and Discrimination Reduction

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

ACTIVITIES:

- Development of policies/protocols/procedures
- Informational/online resources

- Training and education
- Media and social marketing campaigns

Student Mental Health Initiative

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

ACTIVITIES:

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

Suicide Prevention

GOAL: Supporting and coordinating with counties on the implementation of the California Strategic Plan for Suicide Prevention.

ACTIVITIES:

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

San Bernardino County Local Impact

Directing Change is a statewide contest that engages students in creating 60 second public services announcements about suicide prevention as well as stigma and discrimination reduction. San Bernardino County, in collaboration with Riverside County, hosted its fourth annual local screening and award ceremony on May 10, 2018, at the Fox Performing Arts Center where local student winners were announced and recognized for their films.

83 films were submitted from the following schools and youth organizations in San Bernardino County: American School of Correspondence High School Homeschool Program, Apple Valley High School, Cajon High School, California State University San Bernardino, CAMP, Chaffey Community College, Chaparral High School, Etiwanda High School, Grand Terrace High School, Healthy Rancho Cucamonga Youth Leaders, Ontario High School, Jaguar News Network, Rim of the World High School, Ruben S. Ayala High School, San Bernardino Valley College, and Upland High School. This represents a **17%** increase in participation from the prior year.
The films are used locally in outreach efforts and at various stakeholder meetings to bring awareness to the importance of suicide prevention. Community partners are also encouraged to use them as part of their suicide prevention engagement strategies. To view the winning films from San Bernardino County students, follow this link and select San Bernardino: http://www.directingchangeca.org/ .

In San Bernardino County, **5** organizations received **Each Mind Matters** community engagement mini-grants to combat stigma and discrimination related to mental illness: Alliance for Community Transformation and Wellness, Mil Mujeres, Turning Point Alcohol and Drug Education Program, Chino High School, and San Bernardino Valley Community College. Through these grants, selected agencies support the development, local integration, and dissemination of resource materials for local faith based organizations, health providers, and diverse communities that include but are not limited to Native American, African American, LGBTQ (Lesbian/Gay/Bisexual/Transgender/Questioning), Asian and Pacific Islander, and other populations. In FY 2017/18, **$12,250** in funding was distributed to these local organizations to distribute training and materials.

Trainings, presentations and other forms of in-person outreach provide additional skills and knowledge to communities about stigma reduction and suicide prevention. Over **1,600** individuals were reached through trainings, presentations and various outreach efforts with stigma reduction, suicide prevention and student mental health messages, resources, tools and materials through the collective efforts of all programs implemented under the Statewide PEI Project. These include:

- **Kognito Suicide Prevention and Mental Health trainings:** Online avatar-based suicide prevention and mental health trainings for college students, faculty and staff. All California Community Colleges staff and students were provided with the opportunity to utilize the Kognito training.
- **Directing Change Judges Training:** Online trainings that provided an overview of best practices in suicide prevention and mental health messaging, as a platform for judging submitted Directing Change videos.
- **Community College Outreach Events:** The Foundation for California Community Colleges and their local campuses conduct mental health outreach to campuses utilizing Each Mind Matters materials and messaging.
- **Each Mind Matters Tabling:** The Each Mind Matters Outreach & Engagement Team and Resource Navigators tabled at various conferences to engage conference

attendees with Each Mind Matters materials and messages.

- **Each Mind Matters Insiders Newsletter:** A monthly electronic newsletter created specifically for service providers that provides information about relevant resources, upcoming events and opportunities for providers to get involved in California's Mental Health Movement.

Technical assistance (TA) is provided to San Bernardino County and local community organizations by Statewide PEI Project contractors. Technical assistance includes providing crisis support, capacity building, guidance, and resource navigation on stigma reduction, suicide prevention and student mental health. It also includes building and maintaining a statewide network of providers and organizations who collaborate and learn from each other to implement more effective efforts and reach broader audiences. During FY 2017/18, **33** TA sessions were provided to San Bernardino County covering topics such as Suicide Prevention and Mental Health Awareness Month Toolkits, Self-Care and Coping with Crisis, Means Restrictions, Strategies to collaborate with Native Communities and others.

Between July 1, 2016 and June 30, 2017, a total of **27,120** physical, hardcopy materials across Each Mind Matters programs and initiatives were disseminated throughout San Bernardino County. In addition, county contacts received numerous emails to access and share resources electronically via the Each Mind Matters Resource Center (www.emmresourcecenter.org).

Applied Suicide intervention Skills Training (ASIST) is a training for individuals who want to feel more confident and competent in helping to prevent the immediate risk of suicide of those at risk. In San Bernardino County, **109** individuals were trained in ASIST as part of an early investment that allowed local individuals to become certified trainers. The County continues to capitalize on the investment by continuing to provide trainings for stakeholders throughout the county.

safeTALK is a suicide alertness training that prepares caregivers, students, teachers, community volunteers, first responders, military personnel, police, public and private employees, and athletes to become suicide-alert helpers. In FY 2017/18, **182** community members were trained in identifying early signs of someone who may be at risk of suicide, starting a discussion about suicide, and accessing resources available to connect someone in need of a suicide intervention to appropriate supports.

suicideTALK is an introductory program that teaches about suicide awareness and helps participants understand the issue of suicide. In Fiscal Year 2017/18, **628** community members participated in these sessions which include examining why people experience thoughts of suicide, encouraging open discussion about suicide and the surrounding attitudes, and exploring ways participants can help to prevent suicide.

Looking Forward

Changing the current culture around mental health and suicide prevention requires a long term commitment. The unprecedented statewide investment in strategies implemented by the Statewide PEI Project will result in larger social impact (e.g., changing attitudes, increasing knowledge, and modifying behaviors) by implementing programs that can benefit counties regionally and statewide, procuring resources at lower cost (e.g., cost efficiencies), and ultimately making a significant impact on preventing mental illnesses from becoming severe.

Projected 10 year outcomes:

- Increased intervention and provision of support by a community helper
- Increased proactive inclusion of individuals with mental health challenges
- Increased community encouragement and acceptance of seeking services early
- Increased knowledge and skills for recognizing and facilitating help seeking

Projected 20 year outcomes:

- Reduced discrimination against persons with mental illnesses
- Reduced social isolation and self-stigma
- Improved functioning at school, work, home and in the community
- Reduced suicidal behavior
- Reduced societal costs related to untreated mental illness

Artwork by Sonia Stockton

Native American Resource Center (PEI CI-3)

The Native American Resource Center functions as a one-stop center offering several prevention and early intervention services for Native American community members of all ages. The center provides services that incorporate traditional and strength-based Native American practices.

Artwork by Jesse Ramos

Services include mental health outreach and education, family support, parenting education, youth empowerment, talking circles, drumming circles, employment development, and education assistance. All services and supports are provided to the community in a culturally relevant context.

MHSA Legislative Goals and Related Key Outcomes

- Increase Early Access and Linkage to Medically Necessary Care and Treatment:
  - ◊ Connect children, adults, and older adults with severe mental illness to care as early in the onset as practicable to medically necessary care and treatment including, but not limited to, care provided by county mental health programs.
- Improve Timely Access to Services for Underserved Populations:
  - ◊ Increase the extent to which individuals or families from underserved populations who need mental health services because of risk or presence of a mental illness received appropriate services as early in onset as practicable.
- Reduce Stigma and Discrimination Associated with Mental Illness:
  - ◊ Reduce negative feelings, attitudes, beliefs, perceptions, stereotypes, and/or discrimination related to having a mental illness, being diagnosed, or seeking services.
  - ◊ Increase acceptance, dignity, inclusion, and equity for individuals with mental illness and members of their families.

Target Populations:

- Children: ages 0-15
- TAY: ages 16-26
- Adults: ages 26-59
- Older Adult: ages 60+

Projected Numbers to be Served FY 2018/19:

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

Positive Results

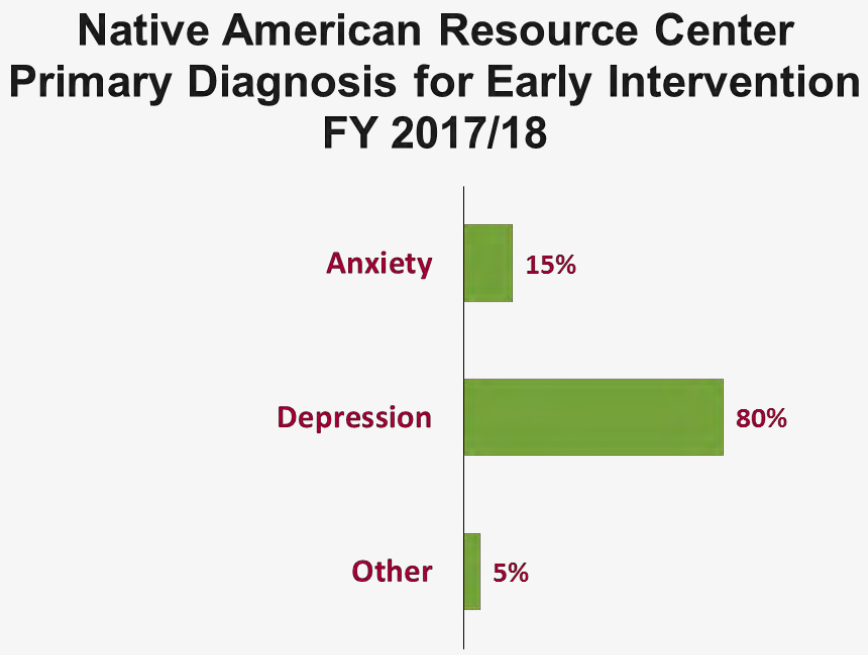
Early Intervention Outcomes

In FY 2017/18, the Native American Resource Center provided Early Intervention services to a total of **173** unduplicated participants resulting in **252** Early Intervention services. Historically, Native American populations have been hesitant to engage in therapeutic interventions for mental health issues. Due to increased efforts by Native American Resource Center staff to promote outreach and education that reduces the stigma surrounding receiving mental health services, the Native American Resource Center was able to meet their early intervention unduplicated participant target goals by **100%** and exceed their early intervention service goals by **10%**.

Unduplicated Early Intervention Participants	
Target Number	173
Reported Number	173
Percentage of Goal Reached	**100%**

Early Intervention Services	
Target Number	228
Reported Number	252
Percentage of Goal Reached	**110%**

The following graph illustrates the percentage of Native American Resource Center participants by diagnostic groups. Of those participants who received a diagnosis, **80%** were diagnosed with Depression, followed by **15%** with Anxiety, and **5%** with a diagnosis of Other.



Prevention Outcomes

The Native American Resource Center participated in several events during Native American Heritage Month. Through these events, participants learned about Native American beliefs towards mental health and strategies for engagement with this population. These events also served as a conduit for providing cultural sensitivity and awareness trainings and exposing the community to local services available for the Native American community. The Native American Resource Center also provided prevention activities in other collaborative events, such as:

- The Family Conference
- National Innovative Communities Conference
- Relationships Sustaining Unity in the Community Conference
- Family Wellness Conference
- National Day of Prayer
- Wellness Fair at Marine Corp
- San Manuel Pow-Wow
- World Breastfeeding Event
- IEHP Diversity Resource Fair
- Clothes Line Project
- Rancho Cucamonga Resource Fair
- TANF Resource Fair
- Men's Wellness Day
- Maternal Mental Health Conference

During these collaborative events, workshops focusing on Native American beliefs and culturally appropriate healing traditions used in Native American settings were offered to all participants. Activities such as cultural storytelling, song, and dance were highlighted as some of the ways that that the Native American community copes with trauma. These traditions display the strength and resiliency of the Native American community and represent effective strategies for engaging the Native American population.

The Native American Resource Center utilizes several methods to address mental health concerns in the community. Pathways to Wellness and Sons & Daughters of Tradition are community-defined practices that provide cultural sensitivity and support groups to promote wellness and reduce the stigma and discrimination associated with mental health issues. Cognitive Behavioral Therapy (CBT) and Community Resiliency Model (CRM) educate participants about the connection between thoughts, feelings, and behaviors. Participants learn to change the ways that they think, feel, and act about a situation even when the situation does not change. The goals of these practices are to learn simple skills to balance the mind, body, and spirit; educate participants about common reactions to trauma and stress; reduce side effects related to trauma; shift perceptions that reactions are mental weaknesses in order to reduce shame and increase hope; and encourage participants to integrate wellness skills into daily life.

Access & Linkage to Treatment

The program reported **13** participants as needing additional access and linkage to treatment services. Clients who need a higher level of care beyond prevention received written referrals to ensure that clients are linked to appropriate services.

Improve Timely Access to Services for Underserved Populations

The Native American Resource Center provides services to groups who have historically been reluctant to seek behavioral health treatment or recovery services. The Native American Resource Center increases timely access to services to Native Americans who have been diagnosed with a serious mental illness or whose family members are not receiving appropriate services to support the client's recovery.

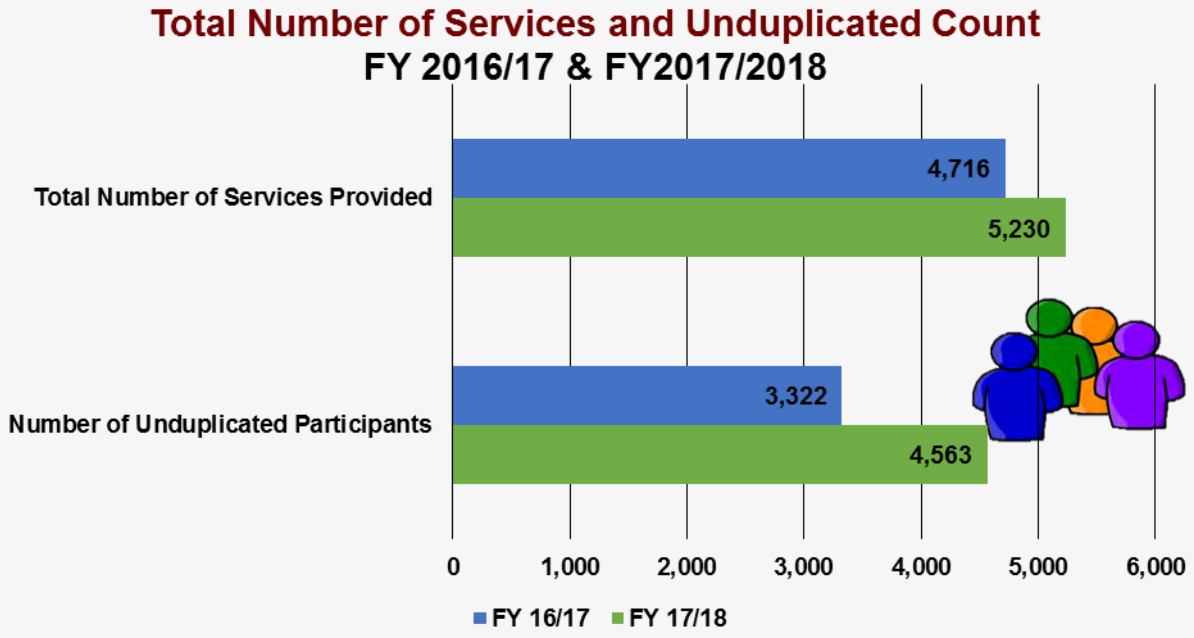
The **13** participants linked to treatment services, are also members of historically underserved populations, including Native Americans and clients who are experiencing co-occurring disorders. The participants were referred to early intervention services and followed through, participating in the referral program on the same day.

Outreach for Early Signs of Mental Illness

In FY 2017/18, the Native American Resource Center provided outreach and education opportunities about recognizing the early signs of mental illness to **4,388** potential responders. These events included culturally specific information on reducing stigma and discrimination associated with receiving mental health services. Potential responders were provided with information on general mental health, historical trauma, domestic violence, substance use disorder, suicide prevention, bullying, cultural sensitivity, and community resiliency.

Total Number of Participants Served

The following table represents the total number of services provided and the number of unduplicated participants the Native American Resource Center Program served for FY 2016/17 and FY 2017/18.

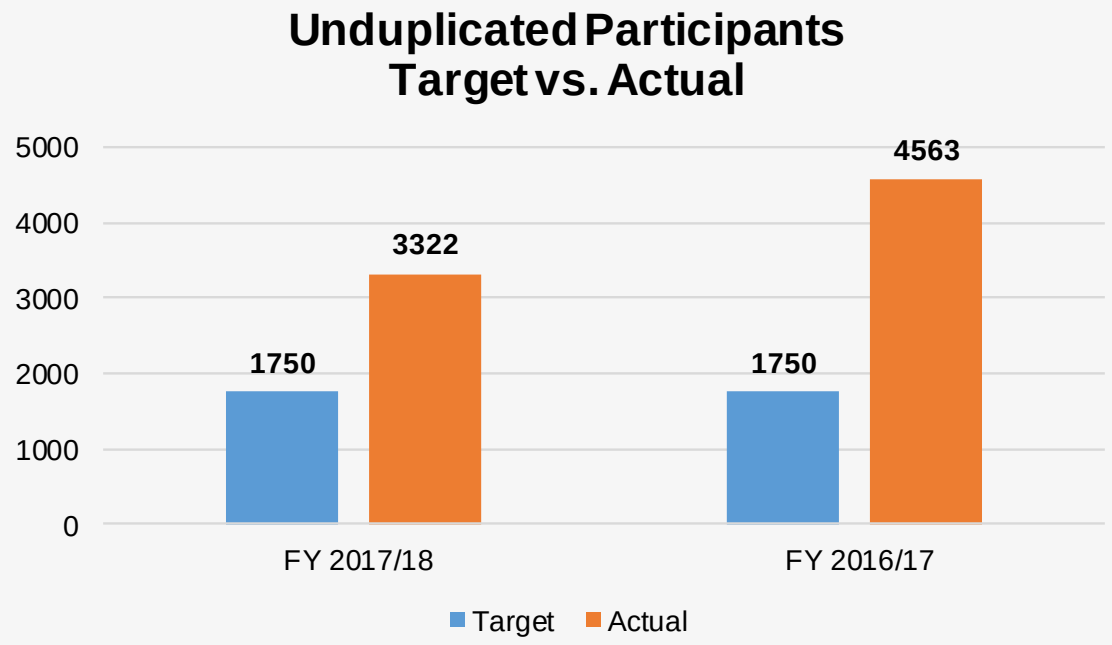


The Native American Resource Centers program provided services to **5,230** unduplicated participants in FY 2017/18 through a variety of activities both in the Native American Resource Center facility as well as at various locations in the community through collaborations with schools, libraries, law enforcement, shelters, and community events.

Through these efforts, the Native American Resource Center Program increased the number of unduplicated participants served by **37%** and increased total number of services by **12%**, from the prior fiscal year.

Of the total number of participants served, **4,217** individuals participated in activities focused on stigma and discrimination reduction. These activities included educational information to increase knowledge about mental health and increase participants' intent to seek mental health services, if necessary.

The target number of unduplicated participants to be served by the Native American Resource Center per fiscal year is **1,750**. The program exceeded its contractual agreement by **62%** in FY 2016/17 and by over **52%** in FY 2017/18.



Fiscal Year 2016/17 & 2017/18

Program Demographics

		FY 16/17	FY 17/18
Assigned Sex at Birth	Male	22%	15%
	Female	49%	31%
	Declined to Answer	29%	54%
Age	Child 0-15	10%	8%
	TAY 16-25	32%	8%
	Adult 26-59	37%	13%
	Older Adult 60+	6%	3%
	Declined to Answer	15%	68%
Primary Language Used	English	92%	100%
	Spanish	0%	0%
	Other	1%	0%
	Declined to Answer	7%	0%

		FY 16/17	FY 17/18
Veteran	U.S. Military Veteran - Yes	1%	1%
	U.S. Military Veteran - No	67%	29%
	Declined to Answer	32%	70%

Fiscal Year 2016/17 & 2017/18 Program Demographics

		FY 16/17	FY 17/18
Disability	Difficulty seeing	3%	1%
	Difficulty hearing or having speech understood	1%	0%
	Other	0%	0%
	Cognitive Disability	1%	0%
	Physical/mobility domain	2%	0%
	Chronic health condition (including but not limited to chronic pain)	1%	0%
	No	30%	15%
	Declined to Answer	62%	84%

		FY 16/17	FY 17/18
Sexual Orientation	Gay or Lesbian	1%	0%
	Queer	0%	0%
	Bisexual	1%	0%
	Another Sexual Orientation	1%	0%
	Heterosexual or Straight	25%	4%
	Questioning or Unsure of Sexual Orientation	0%	0%
	Declined to Answer	72%	96%

Fiscal Year 2016/17 & 2017/18 Program Demographics

		FY 16/17	FY 17/18
Race	American Indian or Alaskan Native	56%	40%
	Asian	0%	1%
	Black or African American	5%	2%
	Native Hawaiian or Pacific Islander	0%	0%
	White (Caucasian)	8%	4%
	More than one race	8%	0%
	Other race	8%	5%
	Declined to Answer	15%	48%
Hispanic or Latino Ethnicity	Caribbean	1%	0%
	Central American	4%	0%
	Mexican/Mexican-American/Chicano	83%	17%
	Puerto Rican	2%	0%
	South American	0%	0%
	Other Hispanic or Latino Ethnicity	9%	76%
	Declined to Answer	1%	7%
Ethnicity	African	3%	0%
	Asian Indian/South Asian	1%	0%
	Cambodian	0%	0%
	Chinese	0%	0%
	Eastern European	0%	0%
	European	0%	0%
	Filipino	0%	0%
	Japanese	0%	0%
	Korean	0%	0%
	Middle Eastern	0%	0%
	Vietnamese	0%	0%
	Other	7%	25%
	More than one ethnicity	7%	0%
	Declined to Answer	82%	75%

Success Stories

The Native American Resource Center provides a variety of activities that reduce stigma and discrimination. Programs such as “Daughters of Tradition,” brings teens together to share their stories and learn about historical trauma and coping skills. Teens have also participated in San Bernardino County’s Mental Health Awareness Month Art Show. The Native American Resource Center offers additional activities which educate participants on wellness and addresses one’s physical, spiritual, emotional and mental needs to improve their life and their community. The Native American Resource Center program has been utilized by various agencies as well as universities to provide cultural competency training for their staff and student programs.

-***Native American Resource Center Staff***

Historical Trauma Conference, 2018

Program Challenges

The Native American Resource Center continues to face challenges with persistent stigma surrounding mental health and wellness. Historic differences between traditional Native American cultural values and Western culture make it a challenge to engage participants in Prevention and Early Intervention activities.

In addition, stigma attached to participating in mental health services makes it a challenge to collect relevant demographic data. While participants are willing to attend and participate in events, they are not comfortable with divulging their demographic data.

Program Solutions

The Native American Resource Center uses culturally appropriate terminology for its program activities. For example, instead of labeling groups as a “Teen/Youth Group,” the Native American Resource Center identifies the group as “Sons & Daughters of Tradition”. This change utilized the cultural component to help address trauma and decision making as well as empowering the youth participants to experience healthy behaviors.

The Native American Resource Center increased their outreach efforts to include providing information on the culturally appropriate strategies that are implemented in their service delivery. In addition, they are working with Department of Behavioral Health staff to modify the required data collection forms to request demographics in a more culturally appropriate manner and provide participants with a deeper explanation of the importance of data collection and how it is used to inform future programming.

Program Updates

The program has no planned program updates to report for FY 2019/20.

Collaborative Partners

- Arrowhead Regional Medical Center
- Boys & Girls Club of San Bernardino
- Building A Generation
- Cahuilla Consortium
- California Indian Legal Services
- California State University San Bernardino - Special Events & Guest Services
- Casa Paseo Residential Treatment Center
- First 5 of San Bernardino
- Healthy San Bernardino County Coalition
- Housing Opportunities Collaborative - Inland Empire Hub
- Inland Caregivers
- Jerry L. Pettis Veterans Administration
- Juvenile Justice Program
- Latino Health Collaborative
- Lewis Library & Technology Center
- Molina Healthcare
- Morongo Band of Mission Indians TANF program
- National Orange Show
- One Stop TAY Center
- Option House
- Reach Out West End
- Riverside County Sheriff's Department
- San Bernardino County Department of Public Social Services
- San Bernardino County Nutrition Action Partnership
- San Bernardino County Unified School District Title VII Program
- San Bernardino Unified School District
- San Manuel Band of Mission Indians Education Department
- San Manuel Band of Serrano Mission Indians
- Sherman Indian School
- Steps 4 Life Community Services
- Tribal Alliance
- University of Redlands Native Student Program
- Valley College
- Victor Valley Union High School District

Collaborative Community Outreach Event, 2018

Promotores de Salud/Community Health Workers (CI-1)

The Promotores de Salud/Community Health Workers (PdS/CHW) program is categorized as a State Outreach for Increasing Recognition of Early Signs of Mental Illness program. It is designed to increase awareness of and access to community based prevention and mental health services in culturally diverse communities. The program promotes mental health awareness, education, and available resources for members of various culturally-specific populations throughout the county. Services are specifically targeted for unserved and underserved populations including Latino; African-American; Native American; Asian/Pacific Islander; and Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) communities.

Outreach services and activities are culturally and linguistically appropriate for each community served. The services provided by this program include:

- Recruitment and training of individuals interested in becoming Promotores or Community Health Workers for the community
- Regularly scheduled outreach presentations to faith-based, community, and school groups
- Presentations to smaller groups, families, or individuals for the purpose of facilitating a discussion on specific behavioral health topics covered in the outreach presentations
- Participation in culturally and linguistically relevant community events that provide an opportunity to present information on mental health and resources
- A peer counseling component where peer providers provide support to participants on a one-on one basis or through peer groups
- Case management coordination that includes referrals and linkage to additional services and follow-up

MHSA Legislative Goals and Related Key Outcomes

- Increase early access and linkage to medically necessary care and treatment:
  - ◊ Connect children, adults, and seniors with severe mental illness and care as early in the onset of these conditions as practicable, to medically necessary care and treatment, including, but not limited to, care provided by county mental health programs.
- Improve timely access to services for underserved populations:
  - ◊ Increase extent to which individual or family from underserved population who need mental health services because of risk or presence of a mental illness receives appropriate services as early in onset as practicable.
- Reduce Prolonged Suffering:
  - ◊ Improve life satisfaction
  - ◊ Decrease hopelessness/increase hope
  - ◊ Increased resiliency
  - ◊ Decreased impairment in general areas of life functioning
- Reduce Stigma and Discrimination Associated with Mental Illness:
  - ◊ Increase accurate knowledge about mental illness
  - ◊ Increase intent to seek services, if needed

Target Populations:

- Children: Ages 0-15
- TAY: ages 16-25
- Adults: ages 26-59
- Older Adult: ages 60+

Projected Number to be Served:

- FY 2019/20
  - ◊ 650 Children
  - ◊ 2,300 TAY
  - ◊ 25,680 Adults
  - ◊ 1,900 Older Adults

Positive Results

In San Bernardino County, the PdS/CHW program provides culturally specific services to **5** underserved target populations, as identified in previous years by a community planning process. These underserved populations include:

- Latino
- African American
- Asian and Pacific Islander
- Lesbian, Gay, Bisexual Transgender, Questioning/Queer (LGBTQ)
- Native American

In FY 2018/19, the PdS/CHW program began a new contract cycle allowing the Department of Behavioral Health to partner with new service providers to deliver culturally specific Pds/CHW services to all areas of the county. As illustrated in the following table, each target population was assigned one or more providers, based on funding availability, to ensure services were equitably deployed out to the community.

Provider	Target Population	Region Served
Hearts & Lives	Latino	Mountain Region
Valley Star	Latino	East Valley
Victor Community Support Services	Latino	Central Valley/ West End/High Desert/ Morongo Basin
Riverside-San Bernardino County Indian Health	African American	Countywide
Asian American Resource Center	Asian and Pacific Islander	Countywide
Riverside-San Bernardino County Indian Health	LGBTQ	Countywide
Riverside-San Bernardino County Indian Health	Native American	Countywide

Collectively, all PdS/CHW providers reached **54,423** participants in FY 2017/18 through various community outreach events and services. The total exceeded the established goal by **54%** from their target number of unduplicated numbers to be served.

Latino

The Promotores de Salud program provides outreach and education specifically to the Latino population. Providers deploy services out to the community using various culturally specific outreach methods. Spanish speaking members of the community are recruited to become Promotores de Salud in order to serve the Latino population in the most comfortable manner possible. Promotores are members of the target population and share many social, cultural and socio economic characteristics held by the Latino community. As trusted members of their community, Promotores are more easily able to provide culturally appropriate services.

Promotores attend various cultural events, targeted at engaging the Latino community, to provide education and outreach to members of the community about the stigma surrounding receiving mental health services. They provide materials in both English and Spanish to address the diverse needs of bilingual households.

PdS providers work collaboratively with entities where the Latino population will traditionally visit when seeking help in a crisis situation. Among those entities are:

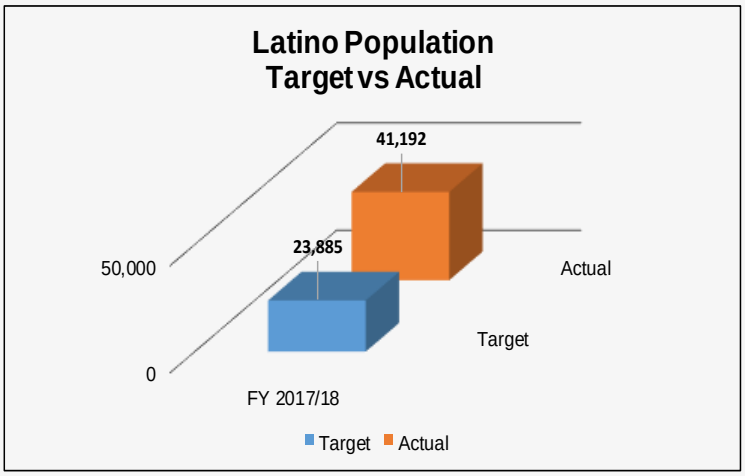
- Faith based organizations
- Community Centers
- Schools
- Health Care Providers

These partnerships have been instrumental in building rapport with the communities they serve in order to facilitate the dissemination of information and services throughout the community and increase community awareness about the importance of mental health and wellness.

In remote areas of the county, providers employ a more personal approach to disseminate information to the community. For example, providers in the mountain communities, where residents may live in isolated areas, will visit residents at their homes to provide general information about signs and symptoms of someone who may be experiencing a behavioral health concern and the services available in the community. They will also use local gathering areas (Post Office, Grocery Stores, etc.) in the community to engage residents in education and outreach.

Artwork by Gary Bustin

In FY 2017/18, the target number of participants to be reached by the Promotores de Salud Program was **23,885**. PdS providers exceeded their goal by **72%** serving a reported **41,192** community members.

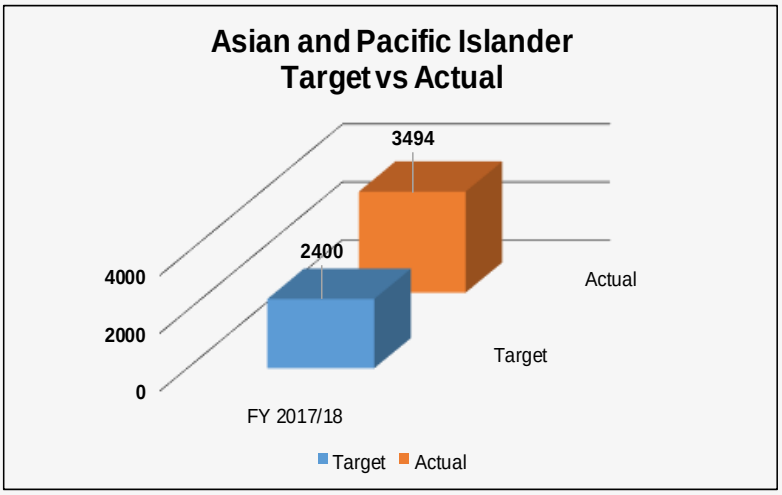


Asian and Pacific Islander

The Community Health Workers serving the Asian and Pacific Islander populations, have made great progress in penetrating this target population. Historical data, shows that a large quantity of this population immigrated to the United States because of economic or political oppression from their country of origin. This had led to an innate need to be self-sufficient and not very trusting of organizations that offer services that are not familiar.

The provider for this target population has implemented strategies that have been successful in increasing engagement amongst a community that traditionally will not seek information or services, especially for behavioral health concerns. The agency coordinates larger community events and gatherings to attract their target population. They also use the door to door approach to engage community members on an individual level. Similar to the Latino population, faith based organizations play a large role in identifying the needs of this target population. The agency partners with local churches and temples to establish a presence in the community and build trust within the community.

These culturally specific strategies have helped the provider exceed their targeted goal, of **2,400** participants, by **46%**.



African American, LGBTQ, and Native American

The Community Health Worker program for African American, LGBTQ, and Native American target populations are administered by a single agency. They utilize culturally specific strategies in order to reach each target population.

Community Health Workers for the African American population use traditional engagement strategies that have proven to be effective. Establishing strong community bonds and creating long lasting relationships with local community resources has helped to increase participation in the CHW program. The provider has partnered with various faith-based organizations as well as African American groups and organizations to establish a consistent presence in the community. They work collaboratively with partners to identify and address the needs of the African American community. They attend large cultural events to promote the outreach and education available through the program. They attend smaller meetings to deliver educational materials on reducing the stigma surrounding seeking mental health services. They have been successful as establishing themselves as an access point for individuals seeking information on services for behavioral health concerns.

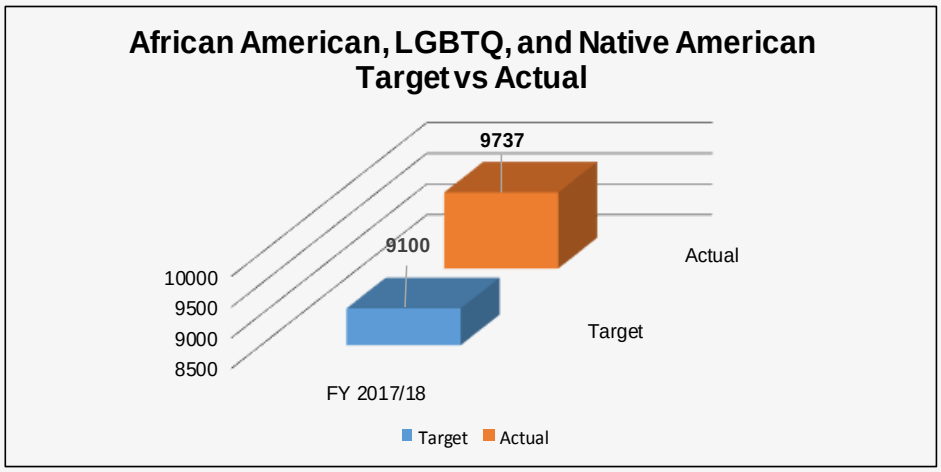
There are specific challenges when engaging the LGBTQ community. Overall, there is still a great deal of stigma and discrimination surrounding sexuality and gender identity. In addition, there is also stigma surrounding seeking mental health services as a member of the LGBTQ community. The provider has made significant progress in reaching out to this target population. They are quickly establishing a reputation in the community for understanding the needs of a vastly underserved population. The outreach and education modules used in presentations have been tailored to address the behavioral health needs of

Community Health Worker Event, 2018

the LGBTQ community in a manner that is relevant and easily understood.

The Outreach and Education service delivery model for the Native American population also uses strong community engagement and cultural understanding as underlying theme. A primary strategy that is of paramount importance in a successful CHW program is recruiting Community Health Workers who are part of the community and understand the cultural norms. This strategy creates greater confidence in the program and the services they provide. The historical trauma associated with this target population, challenges the provider to develop strategies that are highly appropriate culturally. Large cultural events draw the greatest amount of attention to the program. Incorporating Native American traditions to events and gatherings has increased the probability that participants will engage in the outreach and education opportunities that exists as part of this program. The provider has established spaces in the community where the Native American population can gather and learn about their culture and the impact that historical trauma as on mental health and wellness.

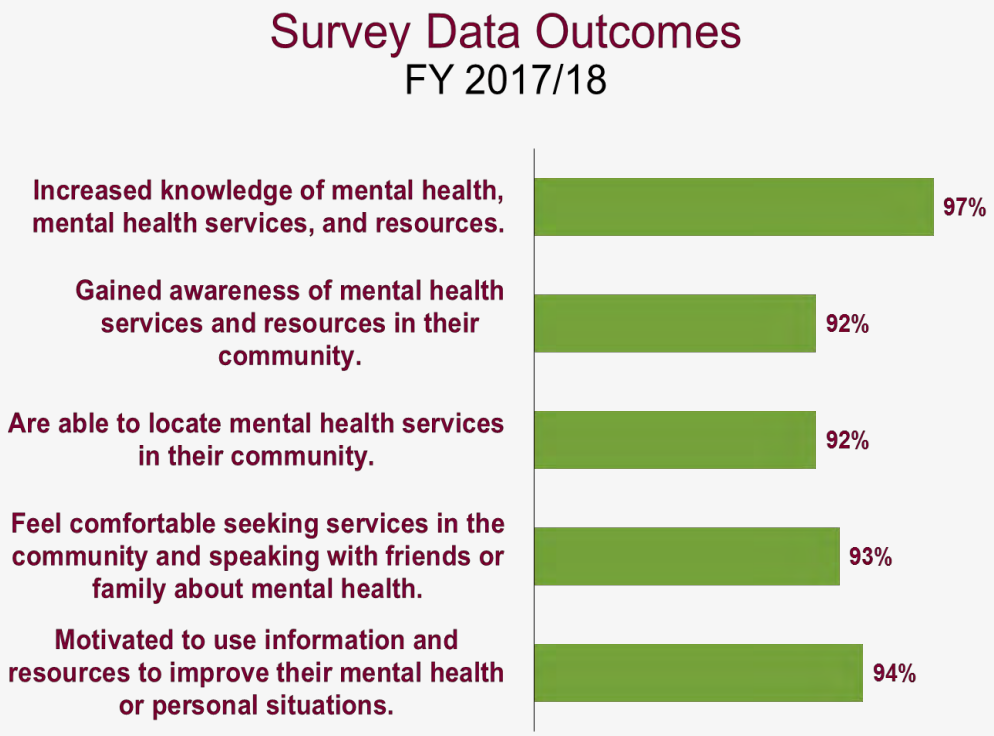
The provider selected to provide CHW services for the African American, LGBTQ and Native American populations was targeted to serve **9,100** participants countywide. In FY 2017/18 the provider served **9,737** participants, thus exceeding their goal by **7%**.



Program Participant Survey Data

In FY 2017/18, the PdS/CHW program collected a total of **12,085** outcome surveys. The questions on the survey vary slightly, depending on the target population. However, there are some common questions that are included in all surveys. The following is a summary of the common findings:

- The majority of participants surveyed across providers agreed the presentations increased their knowledge of mental health.
- The majority of participants surveyed across providers agreed or reported that they gained awareness of mental health services and resources in their community.
- The majority of participants surveyed across providers reported that they are now able to locate mental health services in their community.
- The majority of participants surveyed across providers feel comfortable seeking services.
- The majority of participants surveyed across providers reported that they are motivated to use information and resources to improve their mental health or personal situations.



Outcomes for Access and Linkage to Treatment

The program reported **168** participants as needing additional access and linkage to treatment services. Clients who need a higher level of care beyond prevention received written referrals to ensure that clients are linked to appropriate services.

Outcomes for Improving Timely Access to Services

The PdS/CHW program increased timely access to services for **162** members of underserved populations. These individuals were referred to appropriate Prevention and Early Intervention services. The underserved populations identified in increasing timely access to services include

Underserved Populations	
African American	Asian/Pacific Islanders
Latino	Military/veterans
Native American	Co-occurring
Individuals experiencing onset of serious psychiatric illness	Trauma Exposed Individuals

Outreach for Increasing Recognition of Early Signs of Mental Illness Strategy

The Pds/CHW program served **54,228** potential responders.

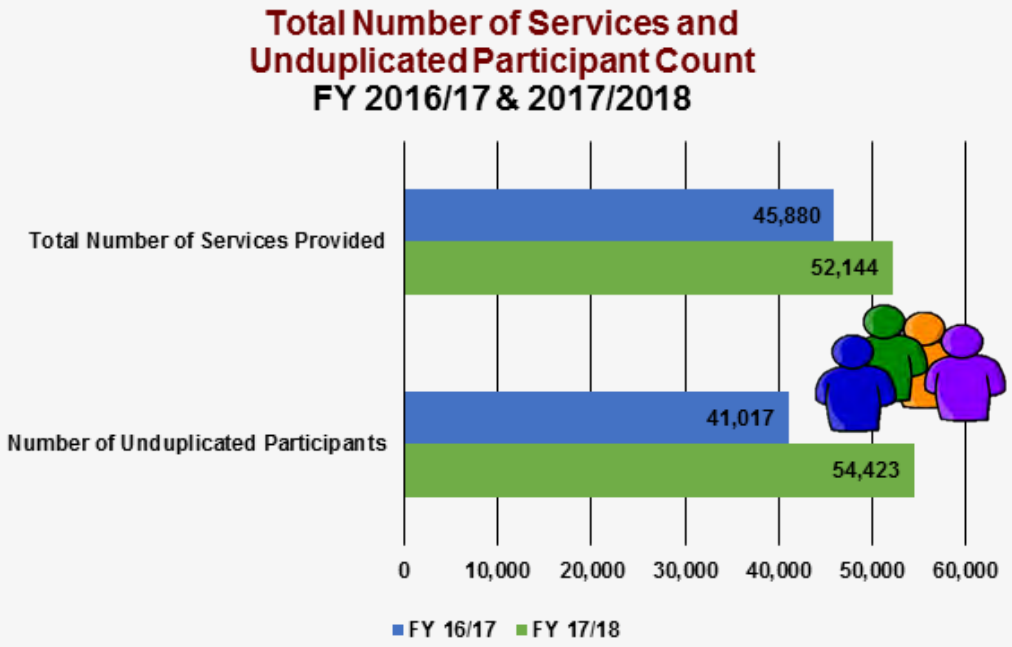
The program engaged potential responders at community events, cultural organizations and, “Other” settings including:

Types of Responders
School Personnel
Community Service Providers
Peer Providers
Consumer Family Members
Leaders of faith based organizations
Families
Employers
Cultural Brokers
Primary Health Care Providers

Settings
Schools
Community-Based Organizations
Community Events
Health Centers
County Offices
Churches
Residences
Cultural Organizations
Primary Health Care

Total Number of Participants Served

The following table represents the total number of services provided in the program and the number of unduplicated participants served for FY 2016/17 and FY 2017/18. The "Total Number of Unduplicated Participants" represents the number of individuals who were new to the program during the respective fiscal year.



Fiscal Year 2016/17 & 2017/18

Program Demographics

		FY 16/17	FY 17/18
Assigned Sex at Birth	Male	34%	35%
	Female	62%	53%
	Declined to Answer	4%	12%
Age	Child 0-15	9%	12%
	TAY 16-25	16%	17%
	Adult 26-59	65%	53%
	Older Adult 60+	7%	7%
	Declined to Answer	3%	11%
Primary Language Used	English	14%	22%
	Spanish	77%	71%
	Other	1%	1%
	Declined to Answer	8%	6%

		FY 16/17	FY 17/18
Veteran	U.S. Military Veteran - Yes	0%	1%
	U.S. Military Veteran - No	52%	59%
	Declined to Answer	48%	40%

Fiscal Year 2016/17 & 2017/18

Program Demographics

		FY 16/17	FY 17/18
Disability	Difficulty seeing	1%	1%
	Difficulty hearing or having speech understood	0%	0%
	Other	0%	0%
	Cognitive Disability	0%	0%
	Physical/mobility domain	0%	0%
	Chronic health condition (including but not limited to chronic pain)	1%	0%
	No	45%	49%
	Declined to Answer	53%	50%

		FY 16/17	FY 17/18
Sexual Orientation	Gay or Lesbian	1%	0%
	Queer	0%	0%
	Bisexual	0%	0%
	Another Sexual Orientation	0%	0%
	Heterosexual or Straight	40%	41%
	Questioning or Unsure of Sexual Orientation	0%	0%
	Declined to Answer	59%	59%

Fiscal Year 2016/17 & 2017/18

Program Demographics

		FY 16/17	FY 17/18
Race	American Indian or Alaskan Native	0%	3%
	Asian	1%	1%
	Black or African American	1%	4%
	Native Hawaiian or Pacific Islander	0%	0%
	White (Caucasian)	31%	28%
	More than one race	0%	0%
	Other race	13%	9%
	Declined to Answer	54%	55%
Hispanic or Latino	Caribbean	0%	0%
	Central American	2%	5%
	Mexican/Mexican-American/Chicano	64%	61%
	Puerto Rican	1%	0%
	South American	0%	0%
	Other Hispanic or Latino Ethnicity	30%	26%
	Declined to Answer	3%	8%
Ethnicity	African	3%	10%
	Asian Indian/South Asian	1%	0%
	Cambodian	0%	0%
	Chinese	3%	2%
	Eastern European	0%	0%
	European	1%	0%
	Filipino	1%	0%
	Japanese	0%	0%
	Korean	0%	0%
	Middle Eastern	1%	0%
	Vietnamese	2%	0%
	Other	12%	34%
	More than one ethnicity	2%	0%
	Declined to Answer	74%	54%

Success Stories

"Mr. and Mrs. Rodriquez" attended a Promotores de Salud Outreach & Education event with their family. The family was experiencing some marital issues but was hesitant to ask for help. They inquired about family counseling services available to the Spanish speaking community. The Promotor provided an overview of the services that were locally available and how they could help the family. The Promotor referred them to the appropriate agency that could provide them with the help they needed. Upon following up with the family, the Promotor discovered that the family has successfully started to attend weekly therapy sessions. After several weeks of services, the family is doing much better and continuing with family therapy.

- Promotor de Salud Staff

◆ ◆ ◆ ◆ ◆ ◆ ◆ ◆ ◆ ◆

During a Community Health Workers Outreach & Education event at a local park, "Shelley" approached the Community Health Workers outreach table. She shared that she was experiencing some challenges after she and her daughter were involved in a traumatic event. She asked the Community Health Worker if there were resources available to her. The Community Health Worker provided some information on signs and symptoms of post traumatic stress disorder and anxiety. The community health worker provided Shelley with guidance in locating a mental health provider in the local area so that she could receive further assistance.

- Community Health Worker

Challenges

A primary challenge with the Promotres de Salud/Community Health Worker lies within the data collection efforts. Providers are asked to collect demographic data from all the participants engaged in services. The form currently used to collect the data is drafted based on the current PEI regulation requirements. The data set is extensive and can be overwhelming for light touch services such as outreach and education events. A large part of the service delivery in the PdS/CHW involves first time contact or brief contacts that make it difficult to collect comprehensive data. This can be exacerbated when services are targeted at traditionally underserved populations that have experienced historical trauma and discrimination. As a result, there is a large percentage of the participants that will not complete the survey or prefer not to answer all the questions. This makes it increasingly difficult for the DBH and providers to accurately capture data that can be used to evaluate the impact the programs are having in the underserved populations addressed by this program.

Additionally, some target populations encounter diverse groups with many differences in language, dialects, socio-economic backgrounds, religions, educational levels, and generational perspectives. Values and norms are embedded in their language, religion and forms of social organization. These significant differences present challenges for Promotores de Salud and Community Health Workers, as they can create barriers and challenges when promoting services and resources to a diverse community. For example, services for the broad category of Asian/Pacific Islander can require having on hand materials in ten different languages.

Solutions in Progress

Providers are collaborating closely with DBH Staff and local cultural groups to modify the data collection forms to be more consumer friendly and inclusive. Also, providers are restructuring their presentation format to include more information on the importance of data collection and how it helps inform future programming and policy changes.

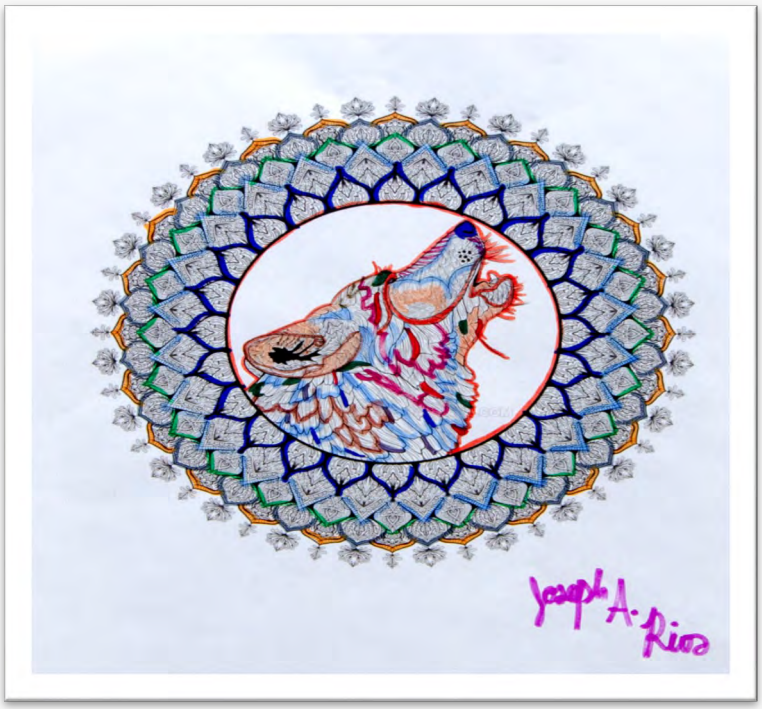
Providers experiencing challenges with highly diverse groups are increasing their recruitment efforts to include specific languages, dialects and cultures. They are providing more personal development opportunities to PdS/CHW and staff to help increase their cultural awareness. All PdS/CHW providers are collaborating closely to address these challenges.

Program Updates

There are no planned program changes for FY 2019/20.

Collaborative Partners

- Abundant Living Family Church
- Asian American Resource Center (AARC)
- Barstow Community College
- Burning Bush Community Church
- Delta Sigma Theta
- Desert Mountain Children's Center
- Family Assistance Program
- Healthy Victorville - City of Victorville
- IEHP Community Resource Center
- Inland Empire Presbyterian Fellowship
- Khanh Anh Temple
- Loma Linda Chinese SDA Church
- Loma Linda University
- Moses House
- NAACP - High Desert Chapter
- No Drugs America
- Rainbow Pride Youth Alliance (RPYA)
- Riverside-San Bernardino County Indian Health Inc. (RSBCIHI)
- San Bernardino County, Department of Public Health
- San Bernardino County, Children and Family Services
- San Joaquin Valley College
- Shawn Wang's Home
- St. Mary Medical Center
- Victor Valley College



Artwork by Joseph Rios

Child and Youth Connection (PEI SE-2)

The Child and Youth Connection (CYC) program is categorized as a State Access and Linkage to Treatment program that connects children with severe emotional disturbances to medically necessary care and treatment. CYC is comprised of several components:

- Screening, Assessment, Referral, and Treatment (SART) – SART provides comprehensive treatment services for children ages 0-6 who are experiencing social, physical, behavioral, developmental, and/or physiological issues. It is an intensive program that serves at-risk children, many of whom have experienced abuse, neglect, and/or prenatal exposure to harmful substances. Services include assessments, individual family therapy, rehabilitative services, and intensive care coordination.
- Early Identification and Intervention Services (EIIS) – EIIS offers services to children ages 0-6 who are experiencing social, physical, behavioral, developmental, and/or psychological issues but do not require the intensive interventions from SART. Services include assessments, individual and family therapy, rehabilitative services, and care coordination. Children participating in EIIS might not have a history of trauma and are typically referred from SART after a child has been screened.
- Children's Assessment Center – The Department of Behavioral Health partners with Loma Linda University Children's Hospital to support the development of a therapeutic alliance prior to forensic interviews and medical examinations for evaluation of child abuse allegations. Crisis intervention support, referrals, and trauma-focused therapy services are provided in a child-friendly environment as a part of this partnership.
- Juvenile Public Defender's Office – The Department of Behavioral Health collaborates with the Public Defender's Office Juvenile Division to offer in-home screenings to youth involved in the juvenile justice system. Social workers provide supportive services to juveniles that have been identified as having chronic truancy issues and work with the participants and their families to assist them in achieving a higher level of functioning. Additional services include psychosocial assessment, drug assessments, referrals and consultations regarding mental health, education, and placement needs.
- Mentoring Network – The Department of Behavioral Health collaborates with Children's Network to conduct mentoring needs assessments of at-risk children and youth through a collaborative effort involving several County departments that includes Behavioral Health, the Public Defender's Office,

Children's Network, and Children and Family Services. The Mentoring Network connects juvenile justice and child welfare involved youth with mentoring agencies. This component also works to bring together existing mentoring organizations and resources, identifying new mentoring organizations, and linking system-involved children and youth with the appropriate agencies.

MHSA Legislative Goals and Related Key Outcomes

- Increase early access and linkage to medically necessary care and treatment:
  - ◊ Connect children, adults, and older adults with severe mental illness to care as early in the onset as practicable to medically necessary care and treatment including, but not limited to, care provided by county mental health programs.
- Reduce Stigma and Discrimination Associated with Mental Illness:
  - ◊ Reduce negative feelings, attitudes, beliefs, perceptions, stereotypes, and/or discrimination related to having a mental illness, being diagnosed, or seeking services.
  - ◊ Increase acceptance, dignity, inclusion, and equity for individuals with mental illness and members of families.
- Improve timely access to services for underserved populations:
  - ◊ Increase the extent to which individuals or families from underserved populations who need mental health services because of risk or presence of a mental illness receives appropriate services as early in onset as practicable.

Target Populations:

- Children: ages 0-15
- TAY: ages 16-26
- Adults: ages 26-59

Projected Numbers to be Served FY 2019/20:

- 6,992 Children
- 552 TAY
- 1,656 Adults

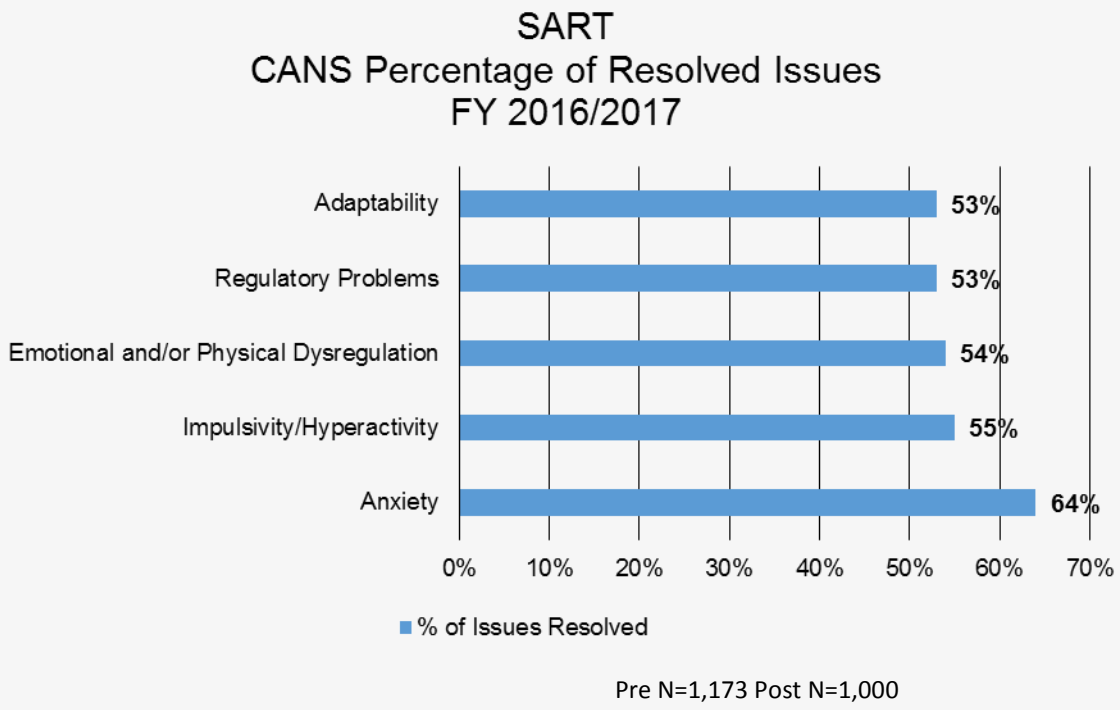
Positive Results

Early Intervention

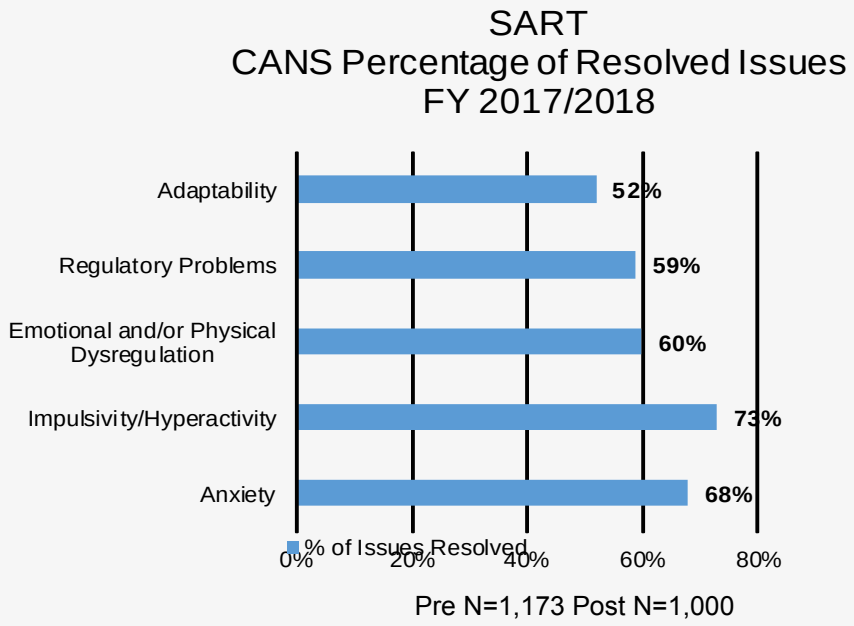
The CYC program uses the Child and Adolescent Needs and Strengths – San Bernardino (CANS-SB) tool to evaluate participants' achievements. The assessment is a broad range tool covering typical needs and strengths experienced by Children, Youth, and Transitional Aged Youth (TAY).

Children and TAY receive their first CANS-SB assessment within the first 30 days of services. Follow-up assessments are completed every three to six months and a final assessment is completed at the end of services.

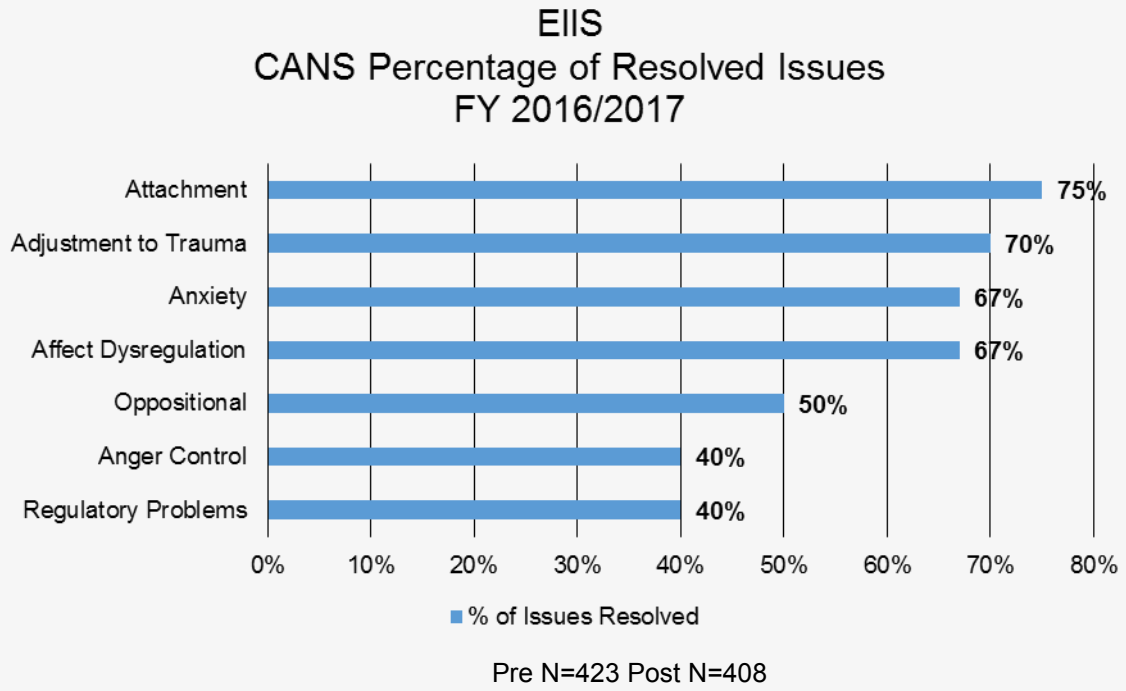
The graphs below display the percentage of children who required or needed immediate action on the following CANS-SB domains and resolved their challenges by the end of treatment in the SART or EIIS programs.



The CANS-SB measured items such as adaptability, regulatory problems, emotional and/or physical dysregulation, impulsivity/hyperactivity, and anxiety. Results show that in FY 2016/17, 53% of the children who presented on the adaptability domain and/or the regulatory problems domain resolved their challenges by the end of the program. 54% of the children who presented on the emotional and/or physical dysregulation domain resolved their challenges by the end of the SART program. 55% of the children who presented on the impulsivity/hyperactivity domain, and 64% of the children who presented on the anxiety domain resolved their challenges by the end of the SART program.

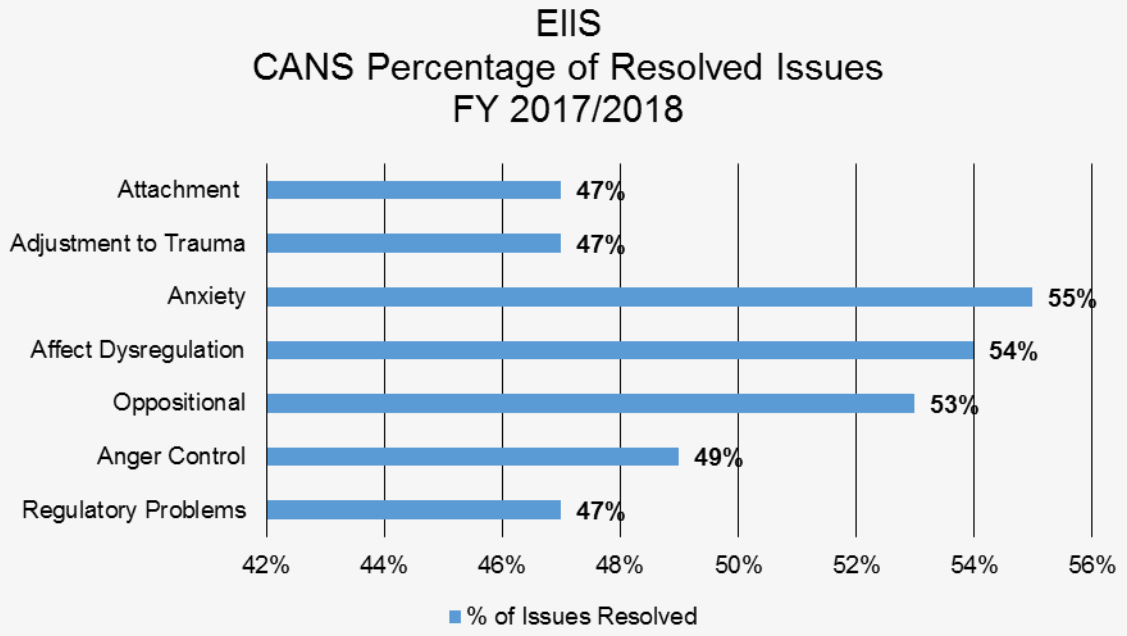


Results show, in FY 2017/18, 52% of the children who presented on the adaptability domain and 59% of the children who presented on the regulatory problems domain, resolved their challenges by the end of the program. Of the children who presented on the emotional and/or physical dysregulation domain, 60% resolved their challenges by the end of the SART program. Of the children who presented on the impulsivity/ hyperactivity domain, 73% resolved their challenges and 68% of the children who presented on the anxiety domain resolved their challenges by the end of the SART program.



The graph above illustrates, in FY 2016/17 the CANS-SB assessment used by the EIIS program measured items such as Attachment, Adjustment to Trauma, Anxiety, Affect

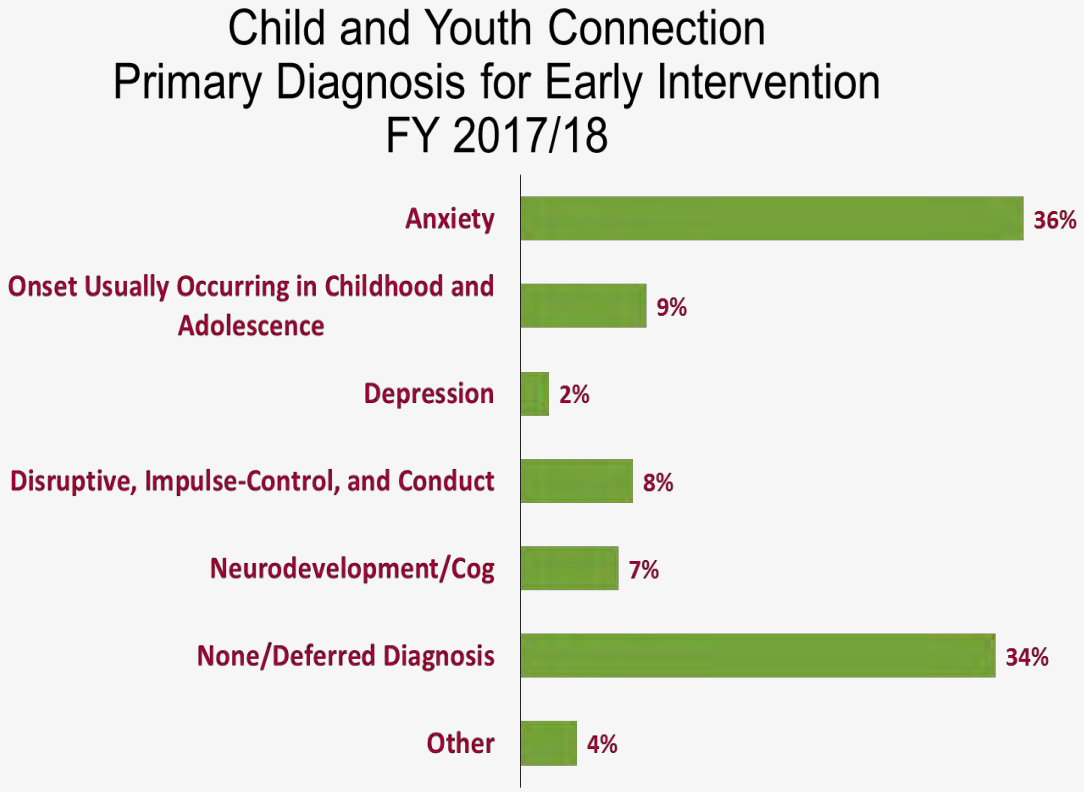
Dysregulation, Oppositional, Anger Control, and Regulatory Problems. Results show that 75% of the children who presented on the Attachment domain and 70% of the children who presented on the Adjustment to Trauma domain, resolved their challenges by the end of the program. Of the children who presented on the Anxiety domain and/or the Affect Dysregulation domain, 67% resolved their challenges by the end of the EIIS program. Of the children who presented on the Oppositional domain, 50% resolved their challenges and 40% of the children who presented on the Anger Control and/or Regulatory Problems domain resolved their challenges by the end of the EIIS program.



Pre N=1,123 Post N=528

Results show, in FY 2017/18, 47% of the children who presented on the Attachment domain and/or on the Adjustment to Trauma domain resolved their challenges by the end of the program. Of the children who presented on the Anxiety domain, 55% resolved their challenges and 54% of the children who presented on the Affect Dysregulation domain resolved their challenges by the end of the EIIS program. Of the children who presented on the Oppositional domain, 53% resolved their challenges as well as 49% of the children who presented on the Anger Control domain, and 47% of the children who presented on the Regulatory Problems domain resolved their challenges by the end of the EIIS program.

The following table illustrates the primary diagnoses of CYC-SART participants in categories such as anxiety and depression. The majority of CYC participants were diagnosed with anxiety at 36%, followed by none/deferred diagnosis at 34%. A deferred diagnosis is a temporary hold pending further assessment of the participant's symptoms. Less than 10% of participants were placed in the remaining diagnostic groups.



In FY 2016/17, 65% of participant treatment was successful or partially successful. In FY 2017/18, 57% of participant treatment was successful or partially successful. A participant's treatment was successful if they met the goals of their treatment plan. The treatment was partially successful if the participant made progress toward their treatment goals but did not meet the full criteria of their treatment plan e.g., participant's treatment plan goal was to reduce aggressive behaviors such as biting or hitting from six times per week to one time per week, and at the end of the treatment plan, the participant had reduced aggressive behaviors to two times per week. A participant's treatment would not be successful if there was no progress made toward reaching the goal or the participant did not complete the treatment plan.

The following table provides the average duration of treatment for participants in the CYC Program. In FY 2016/17, participants had an open case for an average of 103 days with an average of 13 days of direct services and an average of 1,285 cumulative minutes. In FY 2017/18, on average participants had an open case for 84 days with an average of 15 days of direct services and 1,446 cumulative minutes.

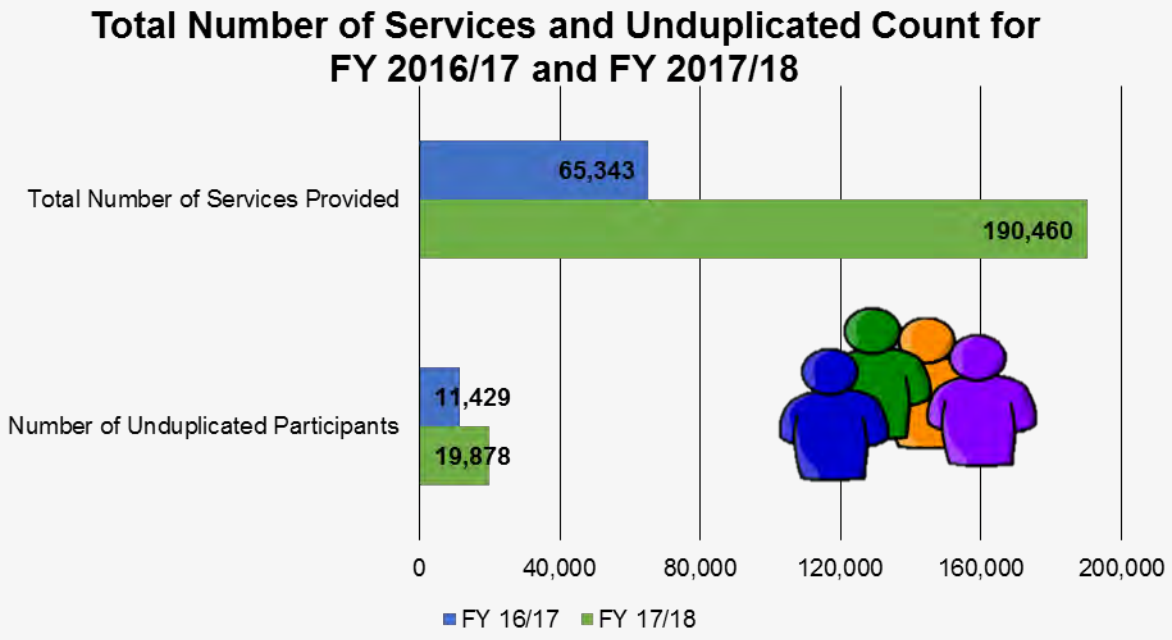
Duration of Treatment	FY 2016/17	FY 2017/18
Average Number of Cumulative Minutes	1,285	1,446
Average Number of Days	13	15
Average Length of Time in Days from Episode Opening to Episode Closing	103	84

Outcomes for Improve Timely Access to Services Strategy or Program

In FY 2017/18, the CYC Program provided Access to Services to 6,046 unduplicated participants. The program identified and served the following underserved populations:

Underserved Populations	
African American	Foster Youth/Former Foster Youth
Asian	Latino
Children and Youth At Risk for School Failure	Native American
Children and Youth at risk of or Experiencing Juvenile Justice Involvement	Pacific Islander
Children and Youth in Stressed Families	Trauma Exposed Individuals

The following table represents the total number of services provided in the CYC Program and the number of unduplicated participants served for FY 2016/17 and FY 2017/18. The number of unduplicated participants represents the number of individuals who were new to the program during the fiscal year.



Fiscal Year 2016/17 & 2017/18

Program Demographics

		FY 16/17	FY 17/18
Assigned Sex at Birth	Male	55%	52%
	Female	45%	48%
	Declined to Answer	0%	0%
Age	Child 0-15	94%	96%
	TAY 16-25	6%	4%
	Adult 26-59	0%	0%
	Older Adult 60+	0%	0%
	Declined to Answer	0%	0%
Primary Language Used	English	92%	93%
	Spanish	7%	7%
	Other	1%	0%
	Declined to Answer	0%	0%

		FY 16/17	FY 17/18
Veteran	U.S. Military Veteran - Yes	0%	0%
	U.S. Military Veteran - No	100%	100%
	Declined to Answer	0%	0%

Fiscal Year 2016/17 & 2017/18

Program Demographics

		FY 16/17	FY 17/18
Disability	Difficulty seeing	0%	0%
	Difficulty hearing or having speech understood	1%	1%
	Other	1%	1%
	Cognitive Disability	0%	0%
	Physical/mobility domain	0%	1%
	Chronic health condition (including but not limited to chronic pain)	0%	0%
	No	98%	97%
	Declined to Answer	0%	0%

		FY 16/17	FY 17/18
Sexual Orientation	Gay or Lesbian	0%	0%
	Queer	0%	0%
	Bisexual	0%	0%
	Another Sexual Orientation	0%	0%
	Heterosexual or Straight	1%	1%
	Questioning or Unsure of Sexual Orientation	0%	0%
	Declined to Answer	99%	99%

Fiscal Year 2016/17 & 2017/18

Program Demographics

		FY 16/17	FY 17/18
Race	American Indian or Alaskan Native	1%	1%
	Asian	0%	1%
	Black or African American	15%	14%
	Native Hawaiian or Pacific Islander	3%	4%
	White (Caucasian)	25%	25%
	More than one race	14%	15%
	Other race	42%	40%
	Declined to Answer	0%	0%
Hispanic or Latino Ethnicity	Caribbean	0%	0%
	Central American	0%	0%
	Mexican/Mexican-American/Chicano	3%	4%
	Puerto Rican	0%	0%
	South American	0%	0%
	Other Hispanic or Latino Ethnicity	0%	0%
	Declined to Answer	97%	96%
Ethnicity	African	8%	0%
	Asian Indian/South Asian	18%	2%
	Cambodian	3%	0%
	Chinese	3%	0%
	Eastern European	0%	0%
	European	0%	1%
	Filipino	22%	1%
	Japanese	5%	0%
	Korean	1%	0%
	Middle Eastern	0%	0%
	Vietnamese	11%	1%
	Other	5%	0%
	More than one ethnicity	1%	1%
	Declined to Answer	24%	94%

Success Stories

"Sandra" is a five year old child who came to the attention of Children and Family Services (CFS) due to an unsafe home environment which included drugs and domestic violence. Sandra was temporarily placed with family members and CYC completed an initial assessment. Due to her trauma, Sandra displayed very limited language skills; at five years old she spoke in single words which were often unintelligible. Sandra was withdrawn and displayed a lack of interest in socializing and preferred engaging with objects rather than people. Sandra participated in intensive therapy sessions offered through CYC which included: individual rehabilitation, Parent-Child Interaction Therapy, Activities of Daily Living, Occupational Therapy, and speech-language services. At the conclusion of her intensive program, Sandra was communicating with others using multiple words, engaging in play with her peers, and animated in her expressions. In addition to improving Sandra's outcomes, her family was able to improve their attachment bond with Sandra as well.

Artwork by Stella Grosso

Challenges

A continuous challenge has been retaining trained therapists, medical, and bilingual staff. Other barriers surround the transitory nature of the system-involved youth. It is difficult to provide continuous services while client's physical address and contact information change, as well as their program eligibility, caretakers and social service workers.

Solutions in Progress

The Children's Assessment Center (CAC) plans to address staffing challenges by creating a Fellowship program where the CAC can train doctors to increase medical care capacity. A new process was developed to address the special circumstances of system-involved youth to assist the referral, communication, and follow-up needs specific to this population. Appointments are able to be scheduled in the office and at clients' home, if needed. Also, multiple therapists are available to provide in home assessments to assist with providing services to multiple children in one family. When possible, appointments will be scheduled at or near the same time as the completion of the assessment to reduce the number of and length of time between appointments.

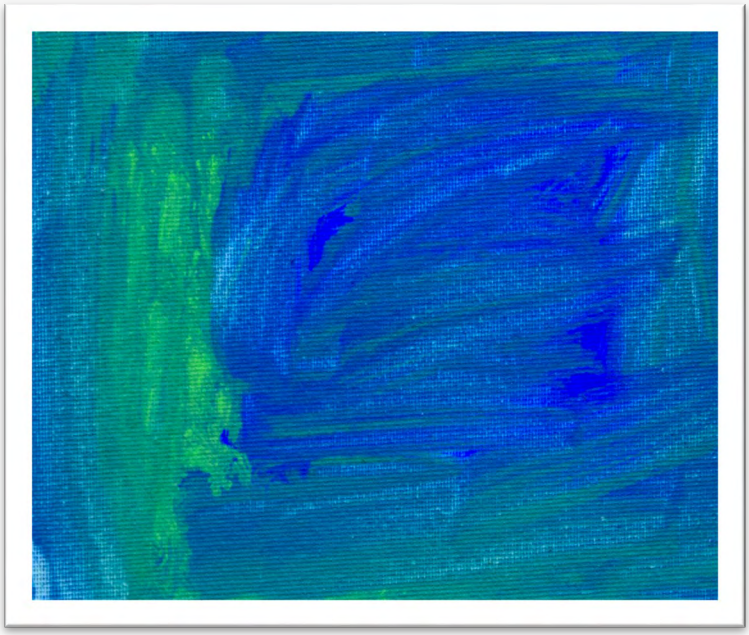
Artwork by Unknown

Program Updates

There are currently no planned program or budget changes for Fiscal Years 2019/20.

Collaborative Partners

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



Artwork by Robert Edwards

Student Assistance Program (PEI SI-1)

The Student Assistance Program (SAP) is a State Prevention program that focuses on services for diverse students (grades K-12) and their families who are in need of prevention education and early interventions for substance abuse, mental health, emotional and social issues. This program supports students and their families by connecting them with behavioral health professionals and educators. This allows for a network of supports to be created between schools and community-based organizations.

Artwork by Kyana Thompson

The SAP program minimizes barriers to learning, supports students in developing academic and personal successes, and helps shorten the duration of untreated behavioral health concerns. The core component of the program consists of professionally trained teams that include school personnel and staff from community behavioral health agencies. SAP team members are trained to identify potential barriers to learning and make recommendations that will assist both the student and their families. The SAP team coordinates services that will improve student wellbeing, and provides follow-up services to ensure success. When the student requires services that fall outside the scope of the program, the SAP team refers the student and their families to additional resources and services within the community.

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

SAP services utilize science or research based curriculum, programs and practices such as, Second Step, Project Alert, and Social Skills Group Intervention (S.S.GRIN). The evidence-based clinical interventions utilized in SAP include Trauma Focused Cognitive Behavioral Therapy, Dialectical Behavior Therapy, and Motivational Interviewing.

As a support to SAP providers and education partners, San Bernardino County Superintendent of Schools in collaboration with the Department of Behavioral Health hosts a weeklong Student Wellness Conference to support, train, and educate providers, school staff, and other individuals responsible for working with students. Each year, there are approximately **450** attendees who are trained on Positive Behavioral Interventions and Supports (PBIS) for the classroom, identification of behavioral issues, and referral to services.

MHSA Legislative Goals and Related Key Outcomes

- Reduce prolonged suffering associated with untreated mental illness:
  - ◊ Reduce risk factors
  - ◊ Reduce indicators
  - ◊ Increase protective factors that may lead to improved mental, emotional, and relational functioning
- Increase early access and linkage to medically necessary care and treatment:
  - ◊ Connect children, adults, and seniors with sever mental illness to care as early in the onset of these conditions as practicable, to medically necessary care and treatment, including, but not limited to, care provided by county mental health programs.
- Improve Timely Access to Services:
  - ◊ Increase extent to which individual or family from underserved population who need mental health services because of risk or presences of a mental illness receives appropriate services as early in onset as practicable.

Target Populations:

- Children: ages 0-15
- TAY: ages 16-25
- Adults: ages 26-59

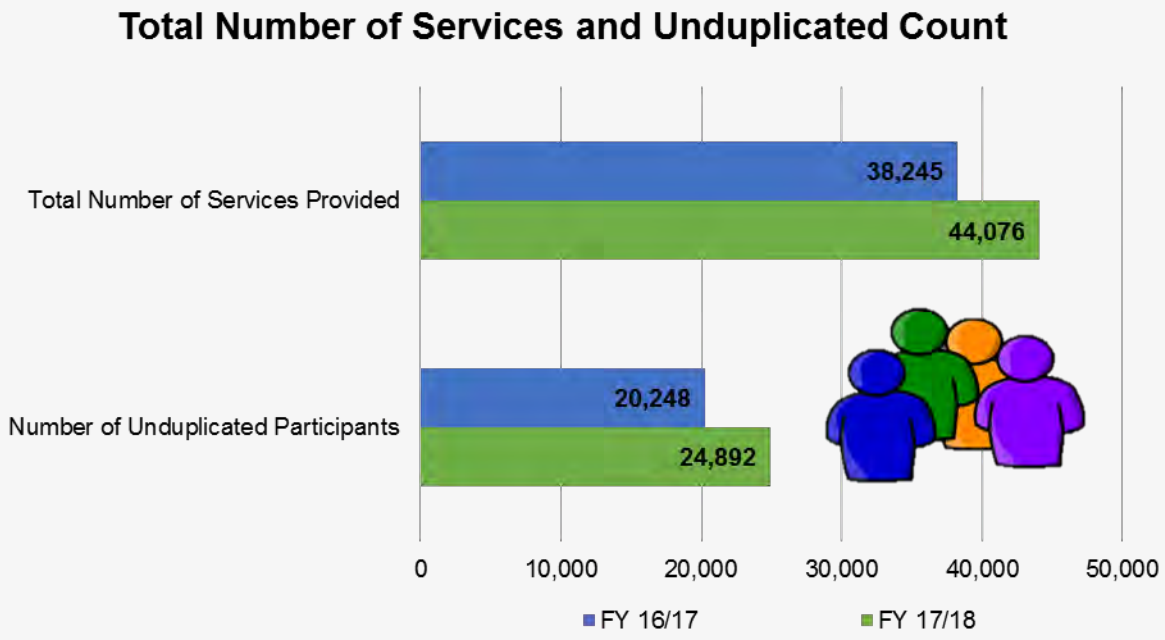
Projected Numbers to be Served:

- FY 2018/19:
  - ◊ 21,250 Children
  - ◊ 2,750 TAY
  - ◊ 3,500 Adults

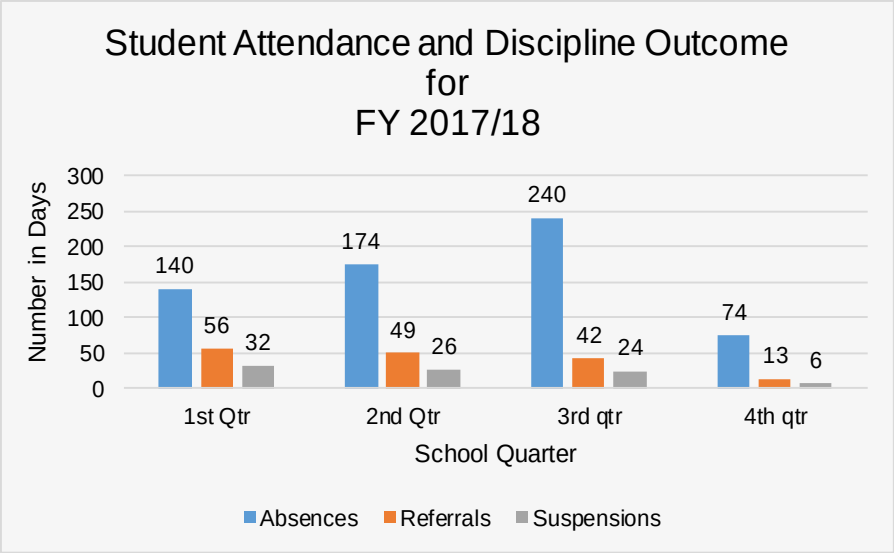
- Reduce stigma and discrimination associated with mental illness:
  - ◊ Reduce negative feelings, attitudes, beliefs, perceptions, stereotypes, and/or discrimination related to having a mental illness, being diagnosed, or seeking services.
  - ◊ Increase acceptance, dignity, inclusion and equity for individuals with mental illness and members of their families.

Positive Results

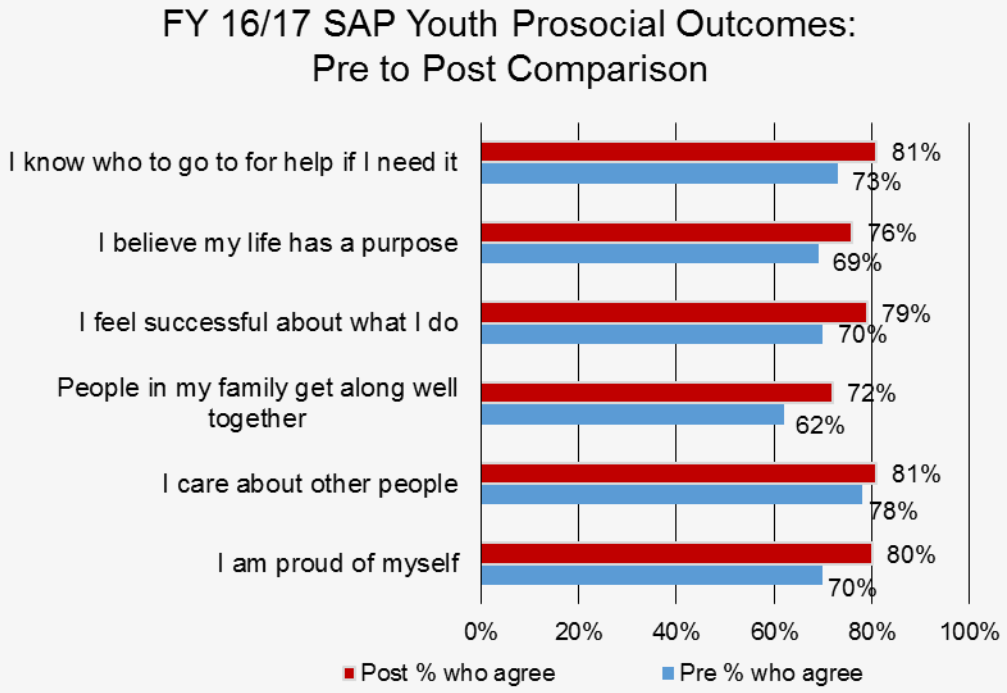
The following table represents the total number of services provided in the program and the number of unduplicated participants served for FY 2016/17 and FY 2017/18. The number of unduplicated participants represents the number of individuals who were new to the program during the fiscal year.

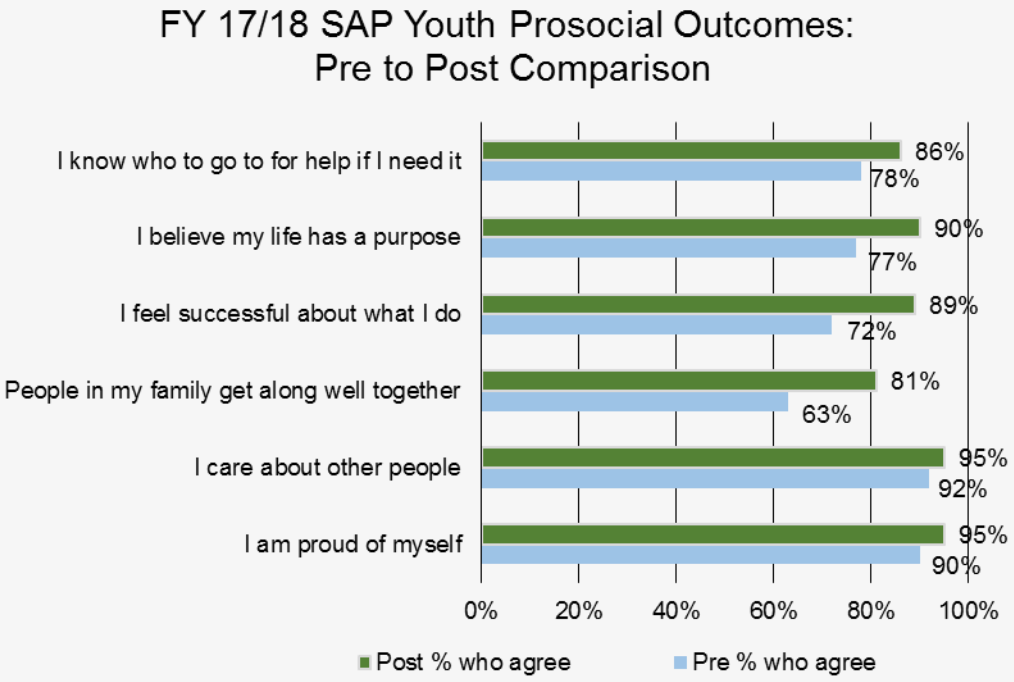


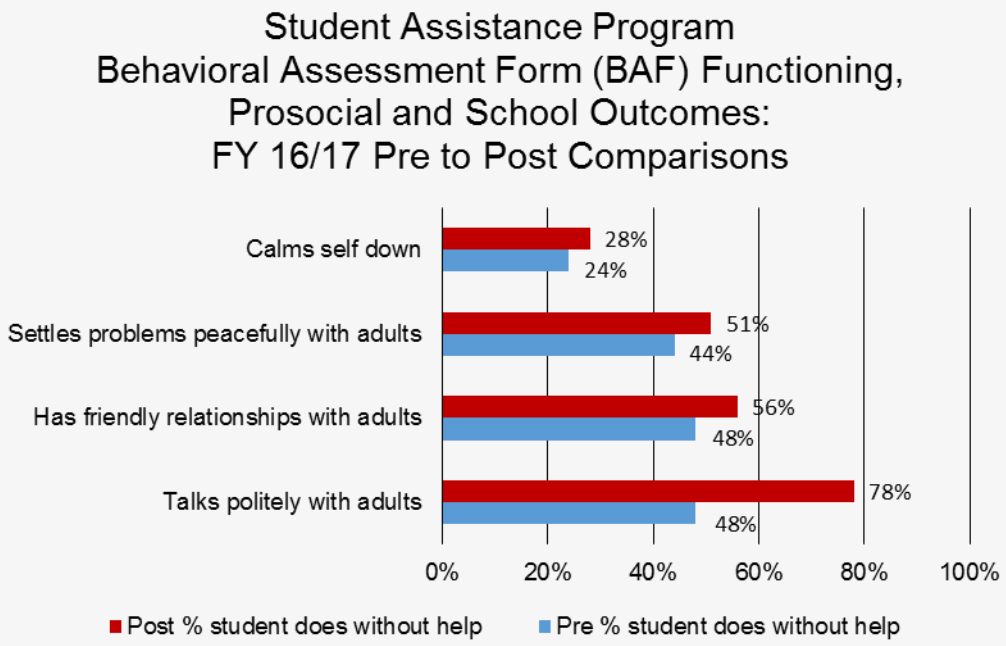
The graph below represents a sample of **119** students and their attendance, referrals and suspension outcomes during the 2017/18 school year. The data shows an overall decrease from the 1st quarter to the 4th quarter in the students' number of referrals received and the number of suspensions received.

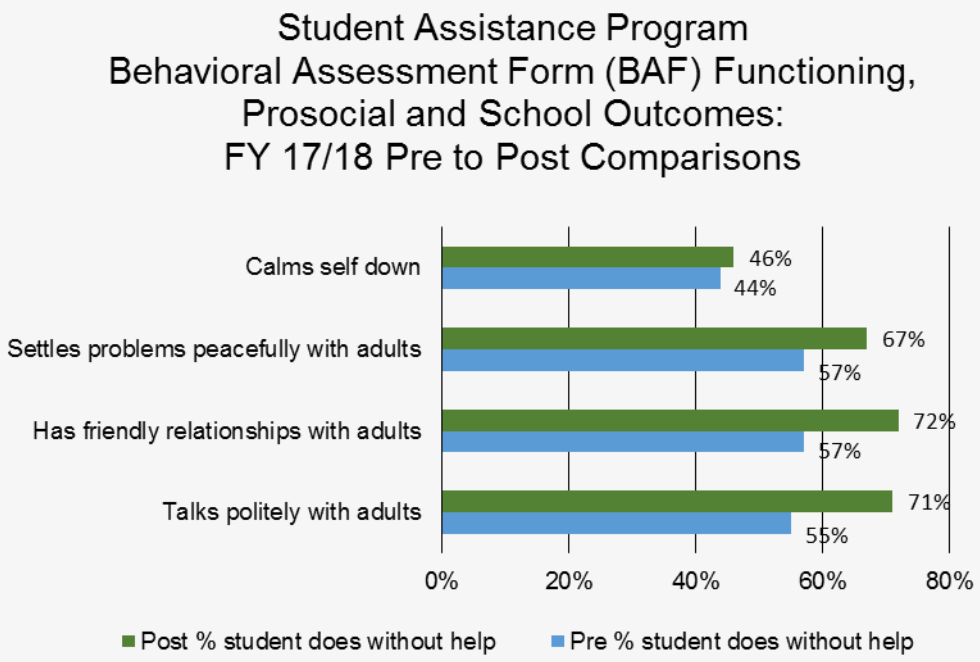


The graphs below highlight the improvement of children and youth outcomes related to self-esteem and prosocial behaviors after their participation in the SAP program. The post-test results show that a higher proportion of students agreed that they are proud of themselves, care about other people, and people in their family get along well together. They also showed great improvement with feeling successful in what they do and believing their life has a purpose. Lastly, students were more likely to agree at post-test that they know who to approach for help if they need it. Improvement on these items are an indication of increased protective factors that increase students' global, mental health, and social functioning.









The Behavioral Assessment Form (BAF) is completed by the student's teacher or counselor. The BAF pre to post comparison results indicate that, after participation in the SAP program, teachers/counselors report that their students (without any help from others) have a greater ability to manage one's emotions and maintain positive relationships with adults. The results also show that after participation in the SAP program, a higher proportion of students had a greater ability to talk politely and settle problems peacefully with adults.

Early Intervention Outcomes

The SAP program identifies students who are exhibiting early signs of a behavioral health condition and other problems associated with mental illness and provides them with early intervention services. Early intervention services include short-term individual and/or family counseling and other services and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including applicable negative outcomes that may result from untreated mental illness.

In FY 2016/17, SAP provided early intervention services to a total of **500** unduplicated participants and a total of **444** unduplicated participants in FY 2017/18. These numbers include all episodes that were active in the fiscal year.

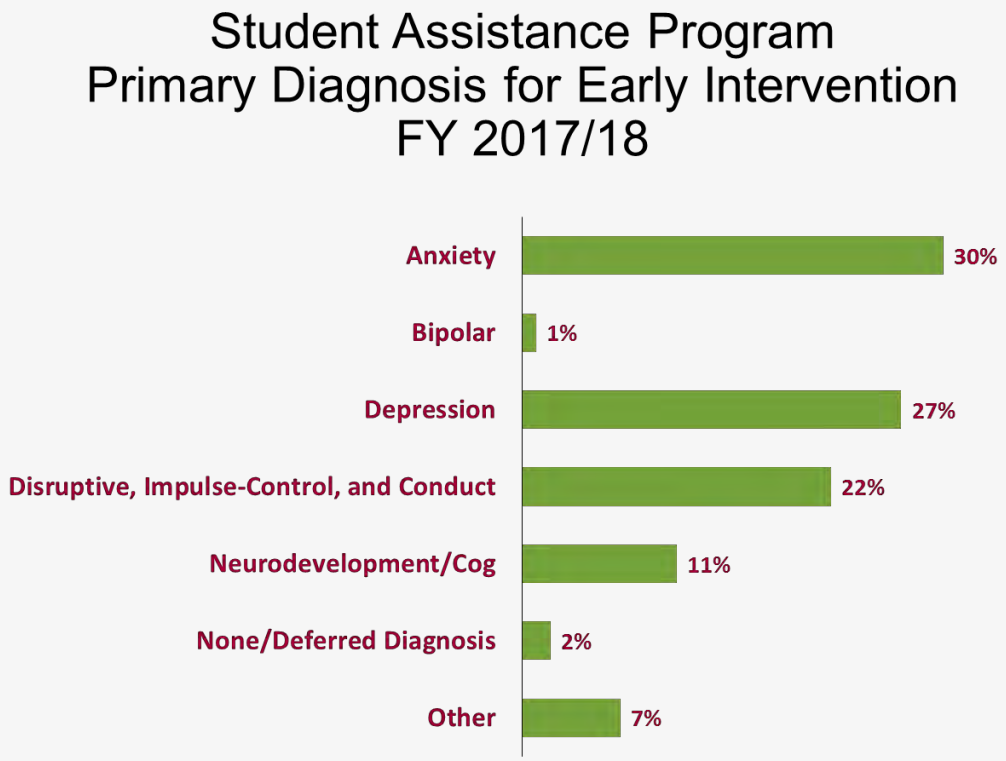
"My son struggled socially at school and got into a lot of fights with siblings at home. After starting School Based Counseling sessions, we have noticed that he has made friends at school and in our neighborhood. He is doing a lot better with siblings and we have noticed his grades getting better. Thank You."

– SAP Parent

"Thank you for coming to present in my class on social skills. My 6th grade class struggles with social interactions and it was causing a disruption in our class. I've noticed that the students are calmer and are raising their hands appropriately in class when they need help. Before, they would blurt out answers, comments, or questions without raising their hands. They enjoyed having the SAP Program in class."

- Middle School Teacher

The following table provides an overview of the primary diagnosis for SAP participants participating in early intervention services. The majority of SAP participants, 30%, were diagnosed with anxiety, followed closely by depression at 27%. Of the participants diagnosed, 22% were placed in the disruptive, impulse-control, and conduct group while 11% were placed in the neurodevelopment/cognition group. The remaining categories comprise less than 10% of the SAP participants.



The following table provides the average duration of treatment for participants in the SAP Program. In FY 2016/17, participants had an open case for an average of **120** days with an average of nine days of direct services and an average of **907** cumulative minutes. In FY 2017/18, on average participants had an open case for **146** days with an average number of **10** day of direct services and **930** cumulative minutes.

Duration of Treatment	FY 2016/17	FY 2017/18
Average Number of Cumulative Minutes	907	930
Average Length of Time in Days from Episode Opening to Episode Closing	120	146
Average Number of Days	9	10

Prevention Outcomes

The SAP program provides several types of prevention activities to the following priority populations:

Priority Population
• Trauma exposed individuals
• Individuals experiencing the onset of a serious psychiatric illness
• Children and Youth in stressed families
• Children and youth at risk for school failure
• Children and youth at risk of or are experiencing juvenile justice involvement.

Prevention activities and services are designed to target risk factors known to contribute to the development of a behavioral health condition. Prevention services assist students with reducing the risk factors for developing a potentially serious mental illness and stressors, build protective factors and skills, and increase support. They promote positive cognitive, social, and emotional development and encourage a state of well-being that allows the individual to function well in the face of changing and sometimes challenging circumstances.

The table below provides a list of prevention activities administered by the SAP program, a description of each activity and the completion rate for FY 2017/18.

Average Completion Rate for Prevention Activities (FY 17/18)		
Prevention Activity	**Description**	**Participant Completion Rate**
Positive Action	Life Skills group Grades 6th-12th	53%
SS Grin	Social Skills Group Grades K-5th	79%
Classroom Social Skills	Social Skills Lessons Provided to Classes in Grade K-8th	84%
Motivational Interviewing	Individual Sessions provided to Students Grade 6th-12th	67%
Jellybean Jamboree	Social Skills lessons provided to Kindergarten Classes	99%
One on One	Evidence Based Curriculum	95%
Group Intervention	NCTI Curriculum	95%
Central Group	Small Psychoeducational Group	90%
East Group	Small Psychoeducational Group	83%

Outcomes for Access and Linkage to Treatment

In FY 2017/18, the SAP referred **141** unduplicated participants to a higher level of care. Of those **141** participants, **111** followed through on their referrals. Most of the referrals from SAP providers were for Mental Health assessments for serious mental illness and individual outpatient services for treatment beyond early onset.

Outcomes for Improve Timely Access to Service

The SAP program seeks to improve timely access to treatment for underserved populations who need preventative, early intervention, or treatment beyond early onset by providing school based services. Some providers have staff that are stationed in school campuses identified as having a high need by the respective school districts. Other agencies have staff that rotate through school districts based on need. The underserved populations identified for FY 2017/18 are as follows:

Underserved Populations	
Children and youth at risk for school failure	Children and youth in stressed families
Individuals experiencing an onset of serious psychiatric illness	Latino
African-American	Foster Children/Former Foster Children
LGBTQ	Native American
Pacific Islander	Trauma Exposed Individuals

For all underserved populations served, SAP referred **112** participants to Prevention programs, **109** participants to Early Intervention programs, and **3** participants to treatment beyond early onset.

The number of individuals who followed through on the referral were **106** for the prevention program, **81** for the Early Intervention program, and **2** participants for treatment beyond early onset.

Outreach for Increasing Recognition of Early Signs of Mental Illness

In fiscal year 2017/2018, SAP reached **7,634** potential responders which included:

Potential Responders Reached	
Child Protective Services	Community service providers
Consumer Family Member	Cultural Brokers
Employers	Families
Family Law Practitioners	Law Enforcement Personnel
Leaders of Faith-Based Organizations	Military Personnel or Veteran
Peer Providers	Visiting Nurses
Primary Health Care Providers	School Personnel
People who provide services to Individuals who are homeless	Other

The types of settings in which potential responders were engaged for FY 17/18 were the following:

Outreach Settings	
Behavioral Health Clinics	Churches
County Facilities	Cultural Organizations
Law Enforcement	Recreation Centers
Schools	

Fiscal Year 2016/17 & 2017/18

Program Demographics

		FY 16/17	FY 17/18
Assigned Sex at Birth	Male	36%	44%
	Female	56%	55%
	Declined to Answer	8%	1%
Age	Child 0-15	70%	75%
	TAY 16-25	7%	5%
	Adult 26-59	20%	18%
	Older Adult 60+	0%	1%
	Declined to Answer	3%	1%
Primary Language Used	English	81%	91%
	Spanish	8%	8%
	Other	2%	1%
	Declined to Answer	9%	0%

		FY 16/17	FY 17/18
Veteran	U.S. Military Veteran - Yes	0%	0%
	U.S. Military Veteran - No	63%	66%
	Declined to Answer	37%	34%

Fiscal Year 2016/17 & 2017/18

Program Demographics

		FY 16/17	FY 17/18
Disability	Difficulty seeing	1%	1%
	Difficulty hearing or having speech understood	0%	0%
	Other	0%	0%
	Cognitive Disability	0%	0%
	Physical/mobility domain	0%	0%
	Chronic health condition (including but not limited to chronic pain)	3%	0%
	No	2%	13%
	Declined to Answer	94%	86%

		FY 16/17	FY 17/18
Sexual Orientation	Gay or Lesbian	0%	0%
	Queer	0%	0%
	Bisexual	0%	0%
	Another Sexual Orientation	0%	0%
	Heterosexual or Straight	20%	9%
	Questioning or Unsure of Sexual Orientation	0%	0%
	Declined to Answer	80%	91%

Fiscal Year 2016/17 & 2017/18

Program Demographics

		FY 16/17	FY 17/18
Race	American Indian or Alaskan Native	1%	4%
	Asian	1%	1%
	Black or African American	8%	13%
	Native Hawaiian or Pacific Islander	0%	1%
	White (Caucasian)	32%	45%
	More than one race	5%	11%
	Other race	12%	5%
	Declined to Answer	41%	20%
Hispanic or Latino Ethnicity	Caribbean	0%	0%
	Central American	1%	0%
	Mexican/Mexican-American/Chicano	64%	42%
	Puerto Rican	0%	0%
	South American	0%	0%
	Other Hispanic or Latino Ethnicity	31%	43%
	Declined to Answer	4%	15%
Ethnicity	African	4%	1%
	Asian Indian/South Asian	0%	1%
	Cambodian	0%	0%
	Chinese	0%	0%
	Eastern European	0%	0%
	European	2%	2%
	Filipino	1%	1%
	Japanese	0%	0%
	Korean	0%	0%
	Middle Eastern	0%	0%
	Vietnamese	0%	0%
	Other	3%	5%
	More than one ethnicity	4%	5%
	Declined to Answer	86%	85%

Success Story

During a group prevention activity that addresses depression and suicidality, a student approached the facilitator for help. She shared with the facilitator that she had thoughts of suicide and a plan. The facilitator quickly assessed the student for risk of suicide and connected her with a counselor. The counselor and facilitator worked collaboratively with the student to create a safety plan and a plan for follow-up. The student indicated that this group presentation activity helped her to understand the importance of seeking help for mental health issues.

Challenges

The SAP program experienced difficulty with identifying and communicating with the appropriate school personnel at the beginning of the school year due to changes in staffing. This made identifying appropriate space at school sites, receiving appropriate referrals, and obtaining the data needed from school personnel to report on student outcomes at the end of each round of group sessions a challenge.

Solutions

The SAP providers have increased their utilization of the SAP partnership with San Bernardino County Superintendent of schools to identify school sites and contact personnel to coordinate services. They are also having preliminary meetings with the schools before the school year begins to plan for space and time needed to conduct services. Providers attend back to school nights and other school activities to provide information on SAP services to the parents and teachers. To address the challenge of receiving student outcome data, SAP providers are revising the surveys to include more information regarding the purpose collecting the data, instructions on completing the information, and contact information for questions and follow-up.

Program Updates

In FY 2018/19, the SAP program was refined to include Medi-Cal Specialty Mental Health Services as an element of SAP. As a result, the SAP program will now be classified as a Prevention and Early Intervention program under the State reporting structure. Reclassifying the State program designation will more accurately reflect the increased focus to early intervention services in the program. SAP also integrated the National Curriculum and Training Institute® Crossroads® (NCTI) Education program into its service delivery model. NCTI was previously a separate PEI program and has now been integrated into other PEI programs serving the same target population. NCTI outcome data will be included in future reports and updates.

Collaborative Partners

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

Preschool PEI Program (PEI SI-2)

The Preschool PEI Program (PPP) is categorized as a State Prevention Program that is administered by the Preschool Services Department and implemented at Head Start Preschool sites throughout San Bernardino County. This program provides prevention services to children ages two through five, their parents or caregivers, and teachers.

The goal of the Preschool PEI Program is to promote social, emotional, and academic competencies of young children while addressing and preventing behavioral challenges faced by young children.

The Preschool PEI Program also includes a bereavement and loss component to offer support groups for children grieving loss related to death, separation, and/or divorce. This component provides a safe and healthy outlet for processing grief related to such loss.

Modeled after a program used by the National Center for Grieving Children and Families, the Preschool PEI program uses evidence-based practices, promising practices, and community/practice-based activities in the delivery of services. Services include:

- Child, parent, and teacher training using the Incredible Years® model to help strengthen children's social and emotional skills while reducing inappropriate and aggressive behaviors.
- Screenings and assessments.
- Linkage and referrals.
- Development of behavioral support plans.

Artwork by Linda James

The Preschool PEI Program also employs strategies within their current service delivery model that assist in reducing the stigma related to seeking and receiving help for mental health concerns. The program helps teachers and caregivers understand mental health and wellness and connects them to additional supportive services and treatment for their children as needed.

MHSA Legislative Goals and Related Key Outcomes

- Increase early access and linkage to medically necessary care and treatment:
  - ◊ Connect children, adults, and seniors with severe mental illness to care as early in the onset of these conditions as practicable, to medically necessary care and treatment, including, but not limited to, care provided by county mental health programs.
- Improve Timely Access to Services:
  - ◊ Increase extent to which an individual or family from an underserved population who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in onset as practicable.
- Reduce prolonged suffering associated with untreated mental illness:
  - ◊ Reduce risk factors.
  - ◊ Reduce indicators.
  - ◊ Increase protective factors that may lead to improved mental, emotional, and relational functioning.

Target Populations:

- Children: ages 0-15
- TAY: ages 16-25
- Adults: ages 26-59

Projected Numbers to be Served:

- FY 2019/20:
  - ◊ 924 Children
  - ◊ 42 TAY
  - ◊ 542 Adults

- Reduce stigma and discrimination associated with mental illness:
  - ◊ Reduce negative feelings, attitudes, beliefs, perceptions, stereotypes, and/or discrimination related to having a mental illness, being diagnosed, or seeking services.
  - ◊ Increase acceptance, dignity, inclusion, and equity for individuals with mental illness and members of families.

Positive Results

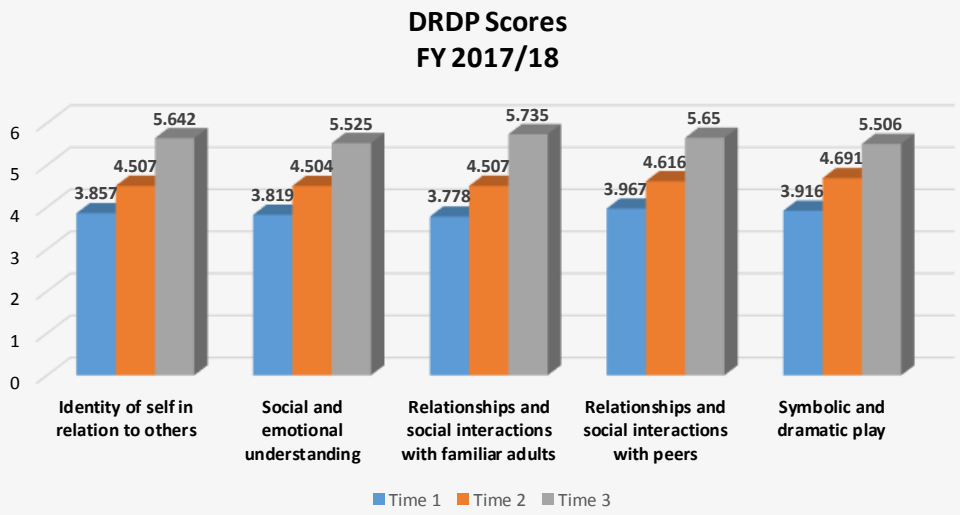
Early Intervention Outcomes

The PPP functions primarily as a prevention program. It does not provide Early Intervention services. Rather, it serves as a conduit for connecting individuals in need of early intervention services to the appropriate level of care.

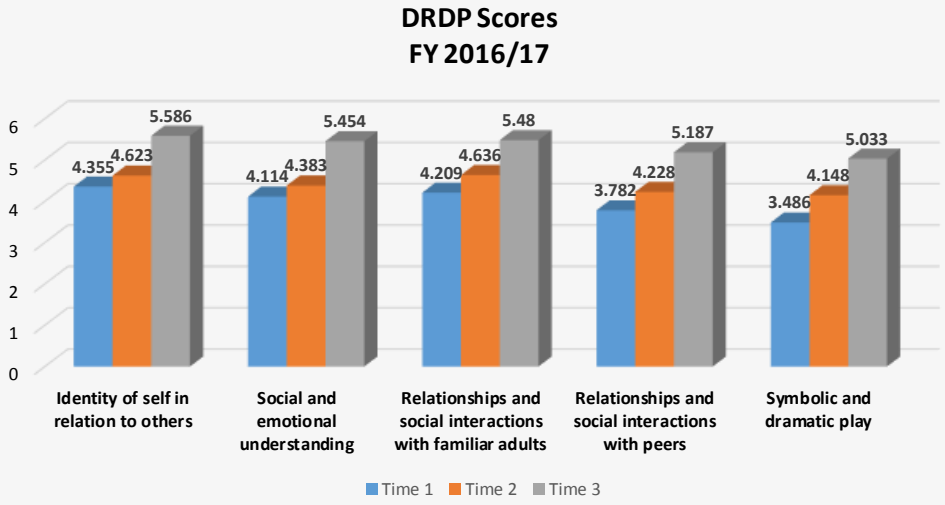
Prevention Outcomes

The PPP uses the Desired Results Developmental Profile (DRDP) to gauge the effectiveness of the services being provided to the children in the program. The DRDP is an assessment instrument designed to observe, document, and reflect on the learning, development, and progress of the child. The assessment results are used by the program staff to create individual care and treatment plans for the children that will guide continuous improvement.

The assessment is administered at **3** times during the course of the interaction with the child. It is completed at initial contact, at midterm and at the conclusion of services. In FY 2017/18 the DRDP showed a continuous improvement in **5** domains that specifically measure the social emotional development in preschool age children: **1)** Awareness of self as related to others **2)** An understanding of peoples behaviors, feelings thoughts and individual characteristics **3)** How the child develops close relationships with one or more familiar adults **4)** The ability to become increasing competent and cooperative in interactions with peers and develop relationships with peers **5)** Developing the capacity to use objects to represent other objects or ideas and to engage in symbolic play with others. The following illustrates degree of the improvement in the these domains:



The DRDP Scores for FY 2016/17, shown on the following chart, share similar results to FY 2017/18 indicating that the program consistently improves the social emotional development of the children they serve from year to year.



Outcomes for Access and Linkage to Treatment Strategy or Program

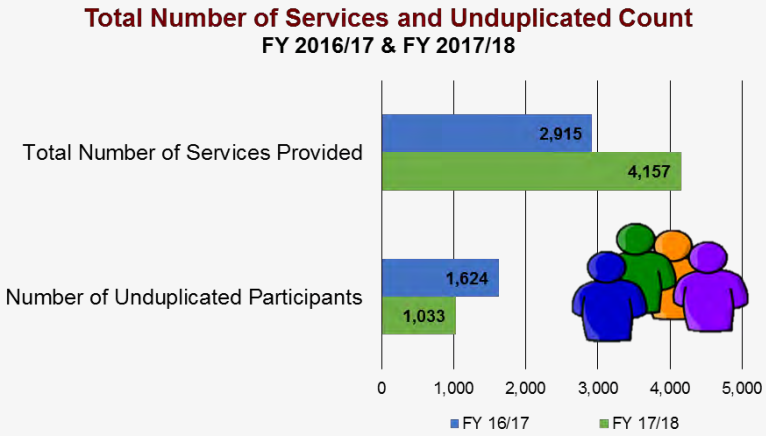
Twenty **(20)** participants were referred to a higher level of care or treatment outside of the scope of work of this prevention program. This included referrals for clinical assessments, crisis intervention and other therapeutic behavioral services.

Outcomes for Improve Timely Access to Services

The PPP did not report referring any participants with a serious mental illness (SMI) or serious emotional disturbance (SED) of a specified underserved population to a prevention program, early intervention program or treatment beyond early onset. Nor did they report having a family member living with SMI or SED who is a member of a specified underserved population to a prevention program, early intervention program or treatment beyond early onset.

Total Number of Services and Unduplicated Count

The following illustrates the number of services and unduplicated individuals served in the PPP. Each time a participant engages in a program activity it is counted as a services. When the participant enters the program for the first time, they are counted as an unduplicated participant.



Fiscal Year 2016/17 & 2017/18

Program Demographics

		FY 16/17	FY 17/18
Assigned Sex at Birth	Male	64%	34%
	Female	36%	51%
	Declined to Answer	0%	15%
Age	Child 0-15	92%	61%
	TAY 16-25	2%	2%
	Adult 26-59	6%	35%
	Older Adult 60+	0%	1%
	Declined to Answer	0%	1%
Primary Language Used	English	89%	79%
	Spanish	6%	8%
	Other	4%	13%
	Declined to Answer	1%	0%

		FY 16/17	FY 17/18
Veteran	U.S. Military Veteran - Yes	0%	0%
	U.S. Military Veteran - No	94%	75%
	Declined to Answer	6%	25%

Fiscal Year 2016/17 & 2017/18

Program Demographics

		FY 16/17	FY 17/18
Disability	Difficulty seeing	2%	0%
	Difficulty hearing or having speech understood	7%	2%
	Other	3%	1%
	Cognitive Disability	0%	1%
	Physical/mobility domain	0%	1%
	Chronic health condition (including but not limited to chronic pain)	6%	0%
	No	30%	16%
	Declined to Answer	52%	79%

		FY 16/17	FY 17/18
Sexual Orientation	Gay or Lesbian	1%	0%
	Queer	0%	0%
	Bisexual	1%	0%
	Another Sexual Orientation	0%	0%
	Heterosexual or Straight	41%	25%
	Questioning or Unsure of Sexual Orientation	1%	0%
	Declined to Answer	56%	75%

Fiscal Year 2016/17 & 2017/18

Program Demographics

		FY 16/17	FY 17/18
Race	American Indian or Alaskan Native	0%	1%
	Asian	2%	1%
	Black or African American	20%	21%
	Native Hawaiian or Pacific Islander	0%	0%
	White (Caucasian)	39%	28%
	More than one race	10%	2%
	Other race	17%	4%
	Declined to Answer	12%	43%
Hispanic or Latino Ethnicity	Caribbean	1%	0%
	Central American	2%	1%
	Mexican/Mexican-American/Chicano	57%	32%
	Puerto Rican	0%	0%
	South American	4%	0%
	Other Hispanic or Latino Ethnicity	30%	25%
	Declined to Answer	6%	42%
Ethnicity	African	14%	2%
	Asian Indian/South Asian	0%	0%
	Cambodian	0%	0%
	Chinese	0%	0%
	Eastern European	1%	0%
	European	1%	3%
	Filipino	1%	1%
	Japanese	0%	0%
	Korean	0%	1%
	Middle Eastern	3%	0%
	Vietnamese	0%	0%
	Other	3%	0%
	More than one ethnicity	1%	1%
	Declined to Answer	76%	92%

Success Story

When “Devin” was referred to the Preschool PEI program he was having trouble adjusting to the new environment. He was having tantrums, refusing to nap, throwing objects, and hitting other children. These difficulties created a concern for the overall safety in the classroom.

PPP staff worked closely with Devin. As a result, many of the negative behaviors were reduced or eliminated. Devin’s teachers agreed that he had improved growth. However, he needed help with redirection and staying on task. The PPP staff worked with Devin to help him with his focus and direction.

The PPP staff built a rapport with Devin. This lead to a discovery of his challenges with feelings of loneliness and separation due to his mother’s work schedule. The PPP staff taught Devin and his mother helpful coping mechanisms for the separation anxiety they were experiencing.

Devin’s mother, his teacher, and the site supervisor all believe that he has improved and they are confident he will be successful in kindergarten.

Artwork by Ami Jacobsen

Challenges

An increasing number of preschool age children are entering the classroom who are struggling with self-regulation. The challenge has been to provide the Incredible Years® training program to teach parents and caregivers as well as to teaching staff quickly enough to keep pace with the increasing number of children entering the classroom.

Solutions in Progress

The Preschool PEI Program has engaged various mental health professionals, developed strong collaborative partnerships with the parents, and utilized appropriate community resources to address these challenges.

PPP is increasing the number of Incredible Years® training sessions to keep pace with the Preschool PEI Program's needs. This will ensure that teaching staff, parents, and caregivers receive training to provide effective behavioral interventions, and implement classroom strategies to support positive classroom behaviors in a timely manner.

Preschool Services Behavioral Health Specialists partner with an Associate Marriage and Family Therapist (AMFT) and work under the supervision of a licensed clinician to administer the Desired Results Developmental Profile (DRDP) for each child. The team meets with parents and teachers to develop behavioral goals based upon the DRDP data. In addition, parent and teacher education is provided and strategies to meet these goals are developed to implement at home and in the classroom.

Program Updates

There are no planned program changes for FY 2019/20.

Collaborative Partners

- Cal Baptist University MFT Intern Program
- Cal Baptist University MSW Intern Program
- California University of San Bernardino ECE/Psychology Interns
- Comprehensive Assessment Research Evaluation (CARE)
- Early Identification and Intervention Services (EIIS Hearts and Lives)
- Fontana Unified School District
- Making A Difference Associate (MaDA)
- Norco College ECE Special Education Students
- Sam Bernardino County First 5 AmeriCorps
- San Bernardino County Schools
- Screening, Assessment, Referral, Treatment (SART)
- Victor Community Support Services
- Volunteers of America

Resilience Promotion in African-American Children PEI (SI-3)

The Resilience Promotion in African American Children (RPiAAC) program provides prevention and early intervention services to African American children/youth (ages 5-18) and their families. The program incorporates African American values, beliefs, and traditions into educational behavioral health programs. The goal of the program is to promote resilience in African American children in order to reduce the risks associated with the development of mental health and/or substance use disorders. Outreach and education is delivered to diverse student populations, including African American populations, to generate awareness regarding the importance of mental health and wellness for all students at specific school sites. The program incorporates culturally specific strategies and approaches and includes curriculum-based education, cultural awareness activities, conflict resolution training, educational workshops, weekly interventions, career-related presentations, parent support/education, individual and family therapy, and linkage to additional resources. These services were recently expanded to include the High Desert region.

MHSA Legislative Goals and Related Key Outcomes

- Reduce prolonged suffering associated with untreated mental illness:
  - ◊ Reduce risk factors.
  - ◊ Reduce indicators.
  - ◊ Increase protective factors that may lead to improved mental, emotional, and relational functioning.
- Increase early access and linkage to medically necessary care and treatment:
  - ◊ Connect children, adults, and seniors with severe mental illness to care as early in the onset of these conditions as practicable, to medically necessary care and treatment, including, but not limited to, care provided by county mental health programs.

Target Populations:

- Children: ages 0-15
- TAY: ages 16-25
- Adults: ages 26-59

Projected Numbers to be Served:

- FY 2019/20:
  - ◊ 2,400 Children
  - ◊ 500 TAY
  - ◊ 1,000 Adults

- Improve timely access to services:
  - ◊ Increase extent to which individuals or families from underserved populations who need mental health services because of risk or presence of a mental illness receive appropriate services as early in onset as practicable.
- Reduce stigma and discrimination associated with mental illness:
  - ◊ Reduce negative feelings, attitudes, beliefs, perceptions, stereotypes, and/or discrimination related to having a mental illness, being diagnosed or seeking services.
  - ◊ Increase acceptance, dignity, inclusion, and equity for individuals with mental illness and family members.

Positive Results

Prevention Outcomes

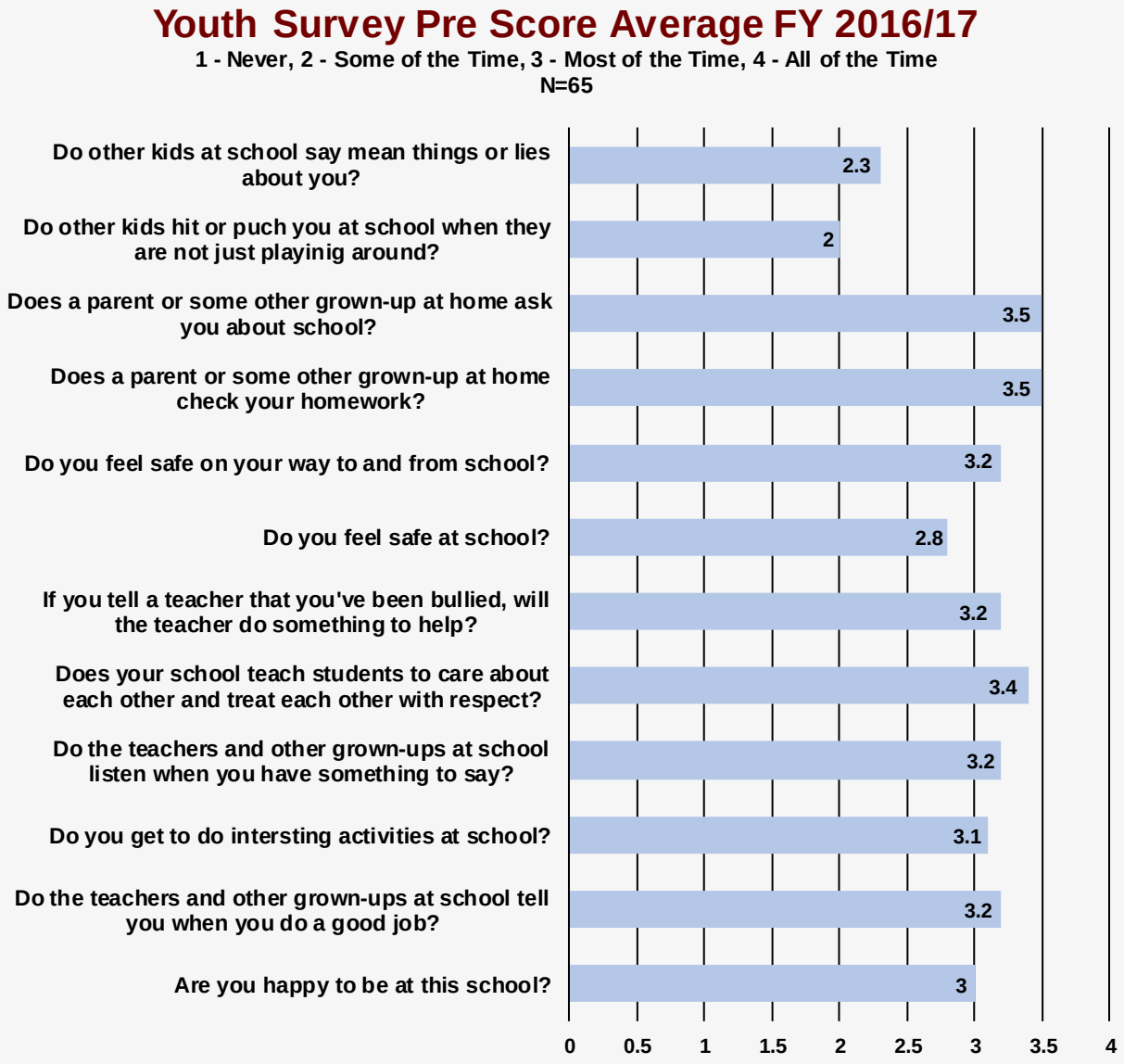
The Resilience Promotion in African-American Children program implements a variety of social skill groups through evidence based curriculums. “Teaching Students to be Peacemakers” is a curriculum that is used on elementary school campuses and delivered during school hours. Students that are part of this group learn about violence prevention, conflict resolution, and positive peer interaction. The students participate in monthly trainings on different topics throughout the school year. Additionally, instructional leaders in this program provide support to teachers during class. This enables instructional leaders to support students who exhibit behavioral challenges and need assistance redirecting and refocusing their energy to avoid disciplinary actions by the school. These students are connected with Peacemakers to learn more about:

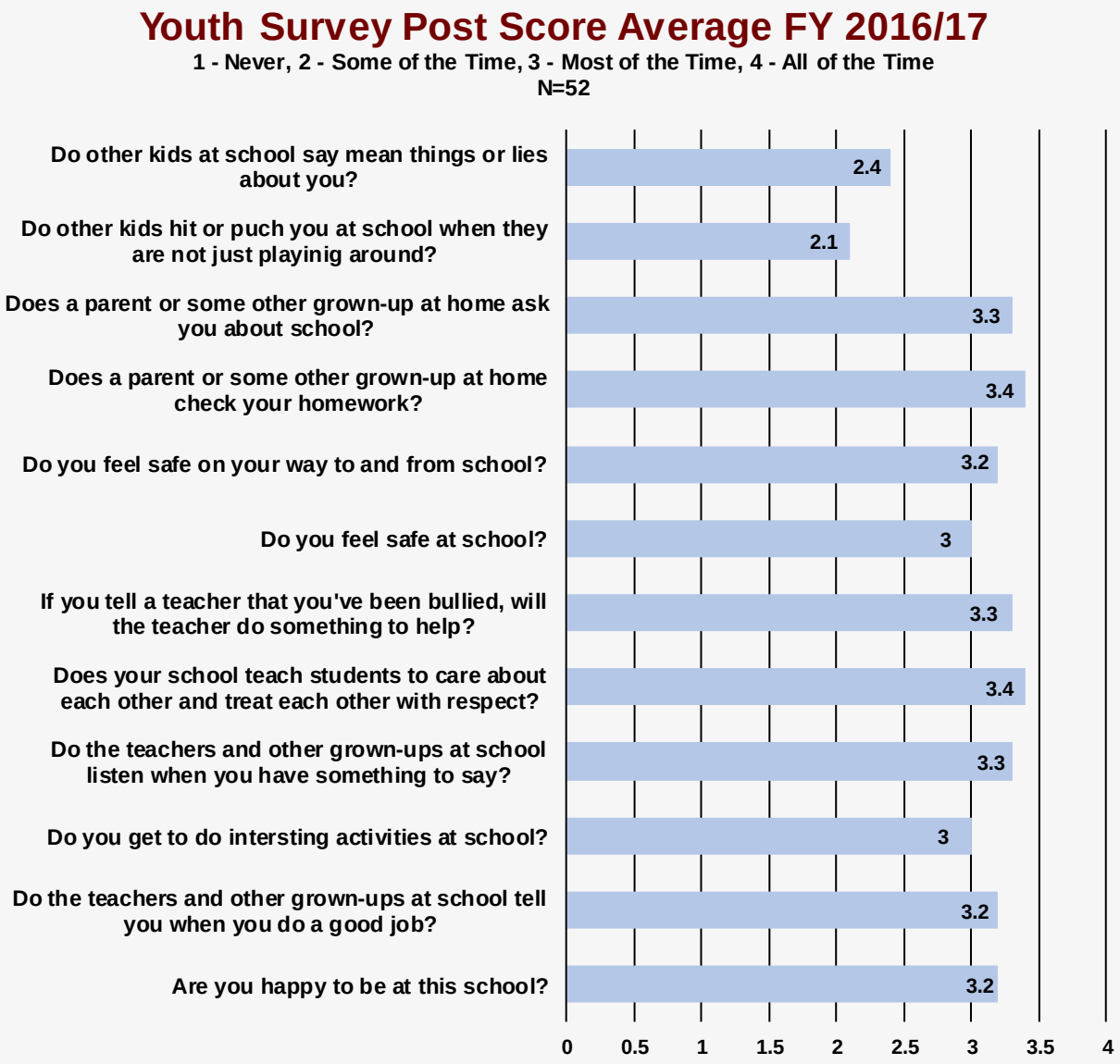
- Self-regulation,
- Social skills, and
- Becoming a more positive members of the student body.

A supportive piece to the “Teaching Students to be Peacemakers” is the bi-weekly after school program. During these meetings, students receive academic tutoring, health and wellness education, and opportunities to participate in various activities that focus on the arts, science, and physical fitness.

The program works on increasing participants’ protective factors, such as school connectedness, which help mitigate risks that can contribute to the development of mental health and/or substance use disorders. Research has shown that youth who feel connected to their school are less likely to engage in many risky behaviors.

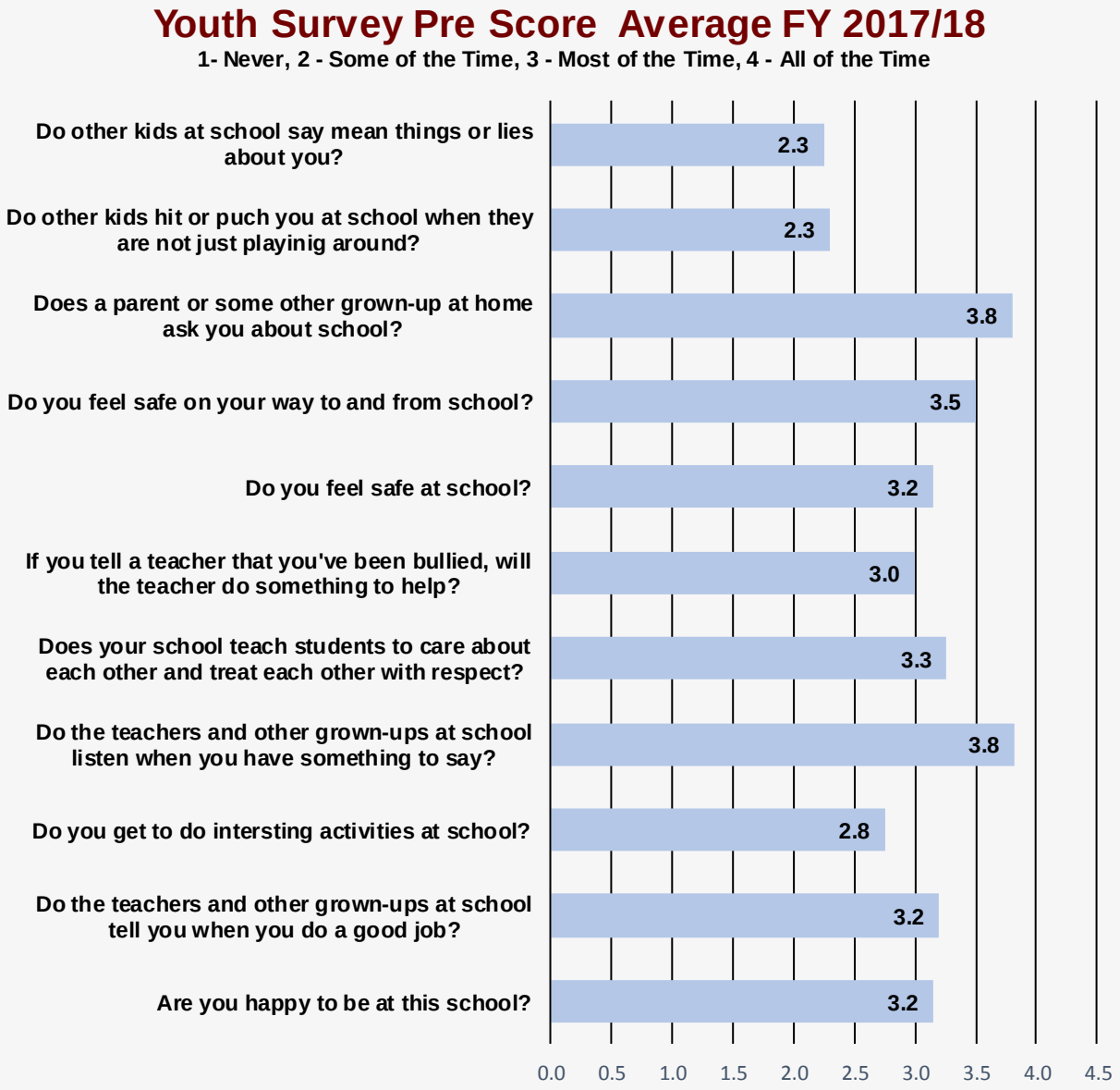
To measure students' school connectedness, **65** student participants were given a pre assessment in FY 2016/17. **52** of these participants returned at the end of the school year to take the post assessment. On a scale ranging from one **(1)** to four **(4)**, with one **(1)** indicating "never," and four **(4)** indicating "all of the time," student assessments averaged **3.2**, in FY 2016/17. This suggest that youth in the program feel that "most of the time" they are happy to be in school, feel safe at school and believe adults care about them and their learning. Two key assessment questions address student perceptions of well-being and safety: "Are you happy to be at this school?" and "Do you feel safe at school?" There was a modest improvement in participants' scores between pre and post assessment for FY 2016/17.

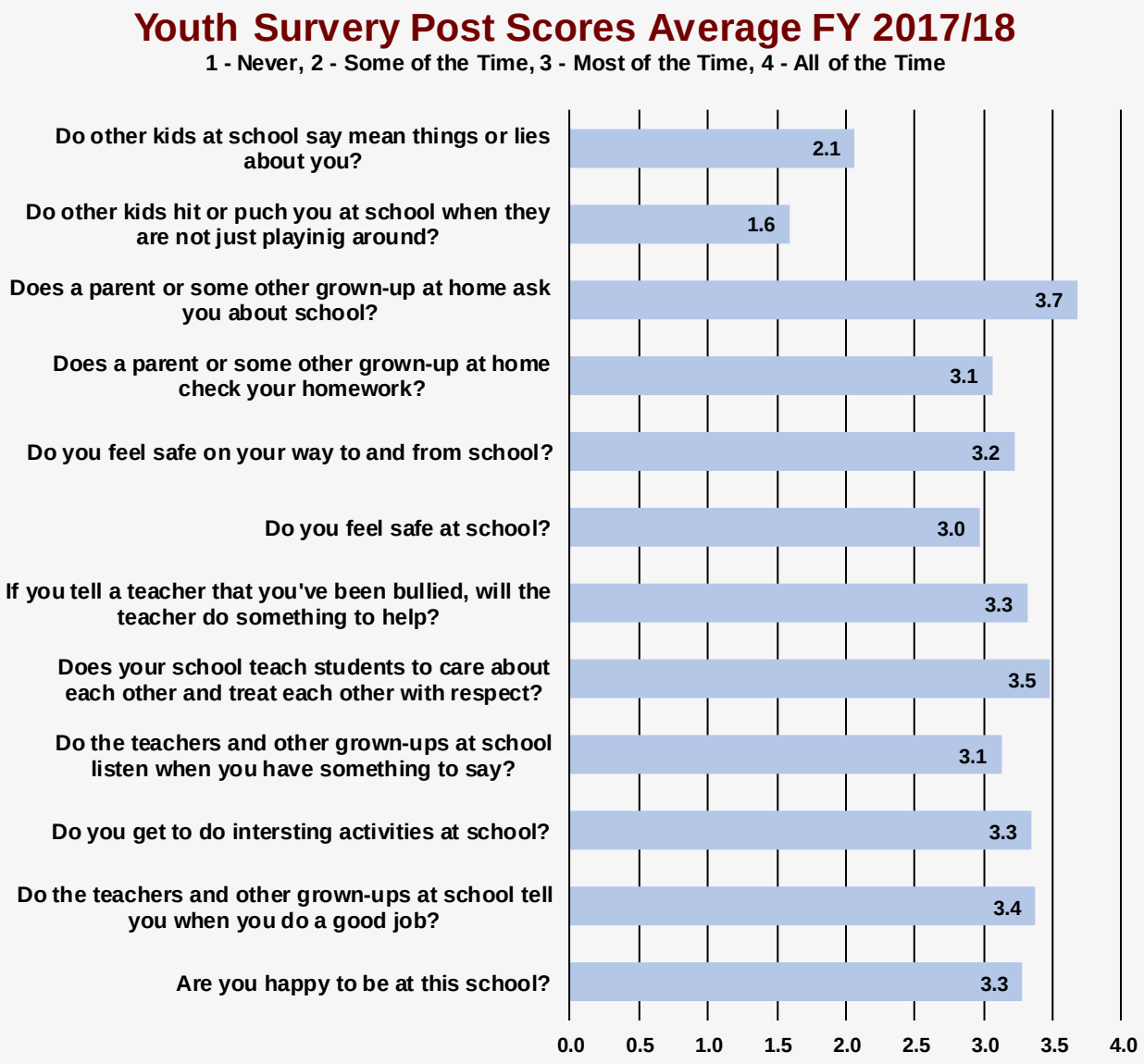




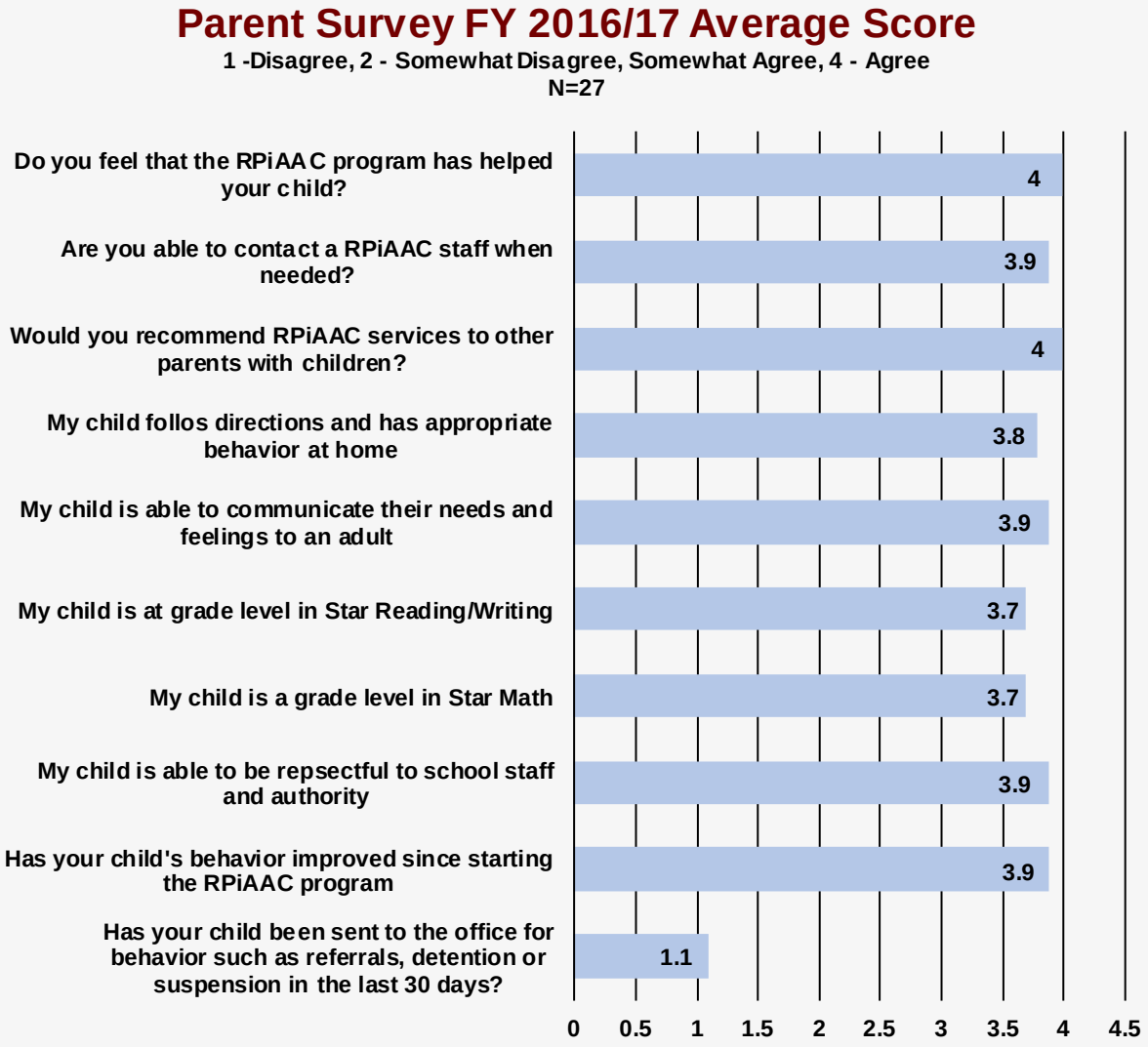
In FY 2017/18, **28** student participants were given a pre assessment and all **28** participants returned to complete the post assessment. Using the same measuring scale used for the pre and post assessments in FY 2016/17, the student assessments for FY 2017/18 averaged a post score of **3.1.** This is a **3%** decrease from FY 2016/17**.** Similar to FY 2016/17, this score indicates that, on average, youth participating in the

program feel happy to be at school and feel safe, “most of the time.” The average score for the assessment question, “Are you happy to be at this school?” increased by **3%.** Conversely**,** the average score for the assessment question, “Do you feel safe at school?” decreased by **6%,** suggesting student participants felt less safe at school at the end of participating in the program. This decrease is possibly due to variables outside of the programs control, such as the influence of resent tragedies in schools on the student participants’ perception regarding school safety.





The program administered a parent survey to twenty-seven **(27)** parents of program participants in FY 2016/17. The assessment uses a 4-point scale with one **(1)** indicating “Disagree,” two **(2)** = “Somewhat Disagree,” three **(3)** = “Somewhat Agree,” and four **(4)** indicating “Agree.” Results suggest parents felt their children’s behavior improved during Resilience Promotion in African-American Children participation (average score of **3.9**), and that they would recommend the program to others (average score of **4.0**).



Grade Reports

Academic performance was measured over time at three elementary schools for students enrolled in Resilience Promotion in African-American Children. In FY 2016/17, Teachers of **60** students participating in the RPiAAC program were asked to evaluate these students in reading, writing, speech and listening, and math, on a scale of one (1) to four (4) (4 = Exceeds standard/expectation; 3 = Meets standard/ expectation; 2 = working toward standard/expectation; 1 = Does not meet standards/ expectations). Students' scores improved modestly between the first quarter of FY 16/17 and the third quarter. The average score was 2.6 in the first quarter versus 2.9 in the third and final quarter.

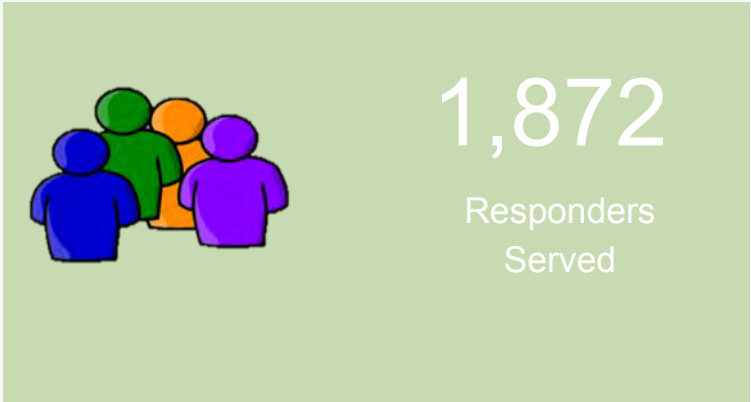
In FY 2017/18, reports cards of **42** students enrolled in the RPiAAC program at three different elementary schools were reviewed to determine academic improvement. In the first quarter of FY 2017/18, 24% of the 42 student participants showed proficiency at grade standard in reading, 10% showed proficiency in writing, and 26% showed

proficiency in math. In the third quarter, **43%** of the 42 student participants showed proficiency in reading, indicating a **79%** improvement since the first quarter; 45% showed proficiency in writing, indicating a **350%** improvement since the first quarter; and **55%** percent showed proficiency in math indicating a **111%** improvement since the first quarter.

Outreach for Increasing Recognition of Early Signs of Mental Illness

The RPiAAC program completed several outreach and educational events during FY 2017/18. Outreach and educational events were held at different types of settings within the community. During these outreach events, the program focuses on engaging and educating potential responders on mental health, wellness and behavioral health services available to the community.

Number of Potential Responders Served

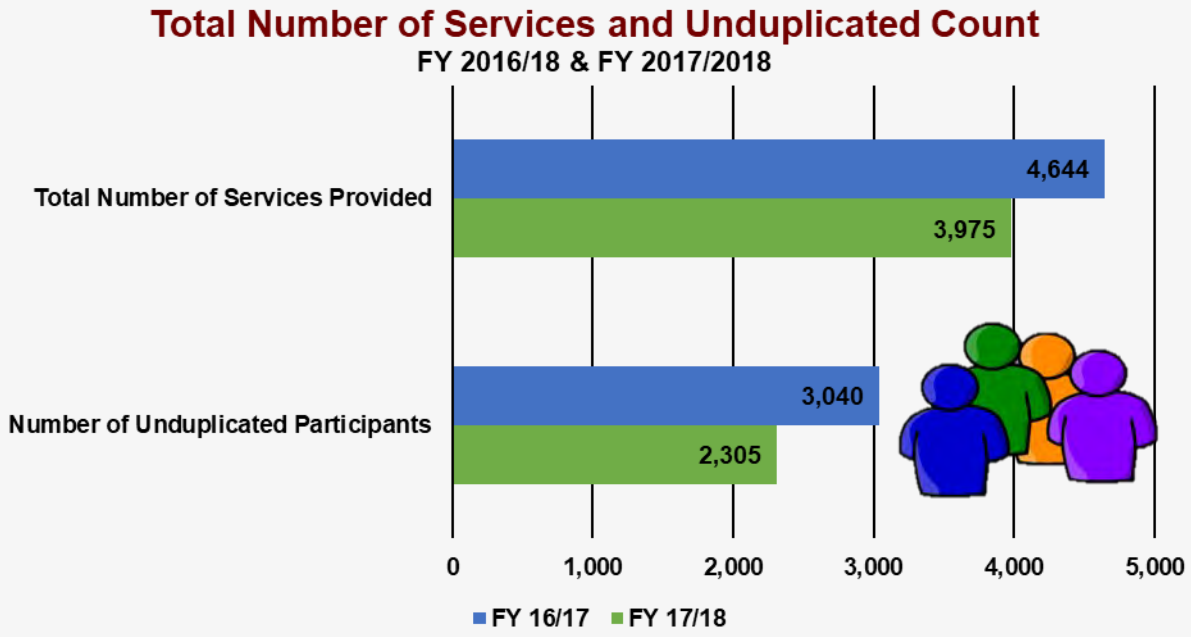


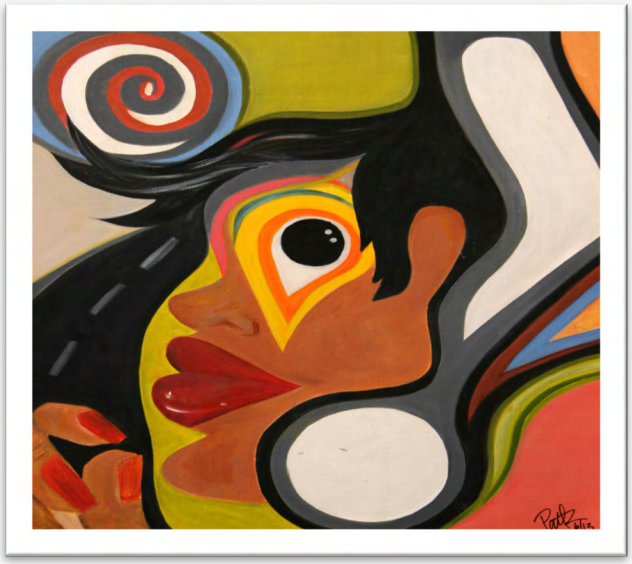
Responders include, but are not limited to:

Potential Responders Reached	
Children and Family Services Staff	Peer Providers
Community Service Providers	People who provide services to individuals who are homeless
Families	School Personnel
Family Law Practitioners	Individuals in a position to identify early signs of severe & disabling mental illness

Total number of participants served

The following table represents the total number of services provided in the program and the number of unduplicated participants served for FY 2016/17 and FY 2017/18. The number of unduplicated participants represents the number of individuals who were new to the program during the fiscal year.

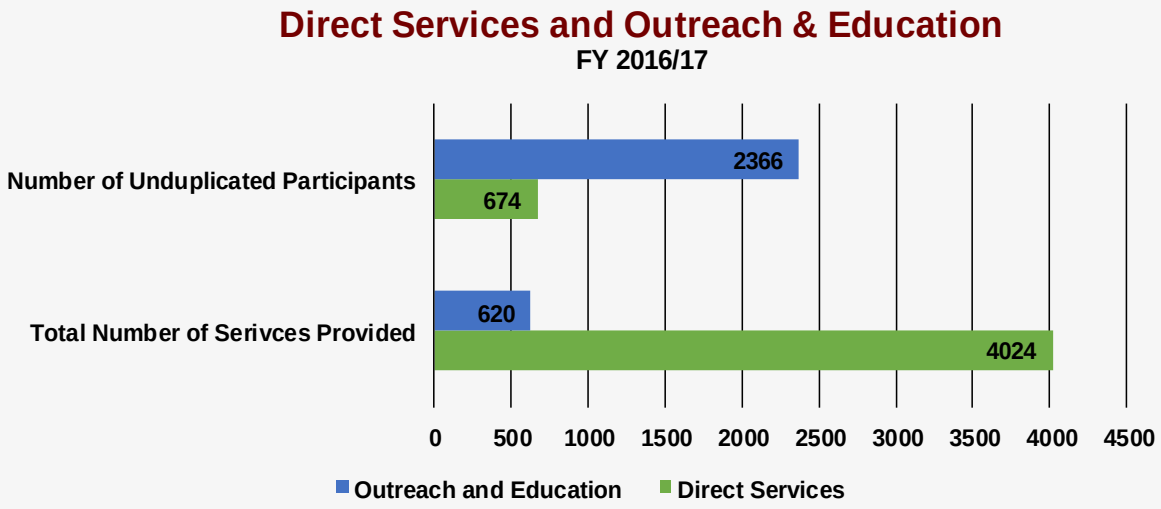




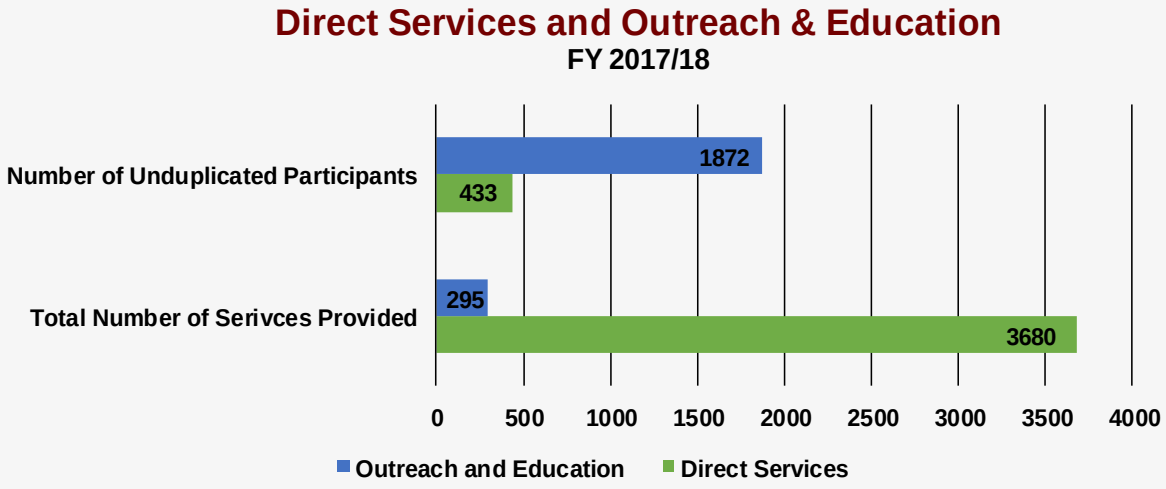
Artwork by Hazel Lambert

Positive Results

The unduplicated participant count and total services reported for each fiscal year, in the previous table, represents the combined totals for the program's direct services and outreach and education services.



In FY 2016/17, the RPiAAC program provided **4,024** direct services to **674** unduplicated participants, and provided **620** outreach and education services to **2,366** unduplicated participants.



In FY 2017/18, the RPiAAC program provided **3,680** direct services to **433** unduplicated participants, and **295** outreach and education services to **1,872** unduplicated participants.

Fiscal Year 2016/17 & 2017/18

Program Demographics

		FY 16/17	FY 17/18
Assigned Sex at Birth	Male	37%	46%
	Female	61%	54%
	Declined to Answer	2%	0%
Age	Child 0-15	79%	50%
	TAY 16-25	14%	35%
	Adult 26-59	6%	14%
	Older Adult 60+	1%	1%
	Declined to Answer	0%	0%
Primary Language Used	English	93%	96%
	Spanish	6%	4%
	Other	0%	0%
	Declined to Answer	1%	0%

		FY 16/17	FY 17/18
Veteran	U.S. Military Veteran - Yes	0%	0%
	U.S. Military Veteran - No	88%	97%
	Declined to Answer	12%	3%

Fiscal Year 2016/17 & 2017/18

Program Demographics

		FY 16/17	FY 17/18
Disability	Difficulty seeing	3%	0%
	Difficulty hearing or having speech understood	0%	0%
	Other	0%	4%
	Cognitive Disability	0%	0%
	Physical/mobility domain	0%	%
	Chronic health condition (including but not limited to chronic pain)	1%	0%
	No	78%	92%
	Declined to Answer	18%	4%

		FY 16/17	FY 17/18
Sexual Orientation	Gay or Lesbian	1%	2%
	Queer	0%	0%
	Bisexual	2%	2%
	Another Sexual Orientation	0%	1%
	Heterosexual or Straight	51%	54%
	Questioning or Unsure of Sexual Orientation	0%	0%
	Declined to Answer	46%	41%

Fiscal Year 2016/17 & 2017/18

Program Demographics

		FY 16/17	FY 17/18
Race	American Indian or Alaskan Native	0%	0%
	Asian	0%	1%
	Black or African American	57%	62%
	Native Hawaiian or Pacific Islander	0%	0%
	White (Caucasian)	18%	21%
	More than one race	10%	9%
	Other race	6%	3%
	Declined to Answer	9%	4%
Hispanic or Latino Ethnicity	Caribbean	0%	0%
	Central American	0%	0%
	Mexican/Mexican-American/Chicano	80%	80%
	Puerto Rican	1%	1%
	South American	0%	0%
	Other Hispanic or Latino Ethnicity	11%	10%
	Declined to Answer	8%	9%
Ethnicity	African	64%	64%
	Asian Indian/South Asian	0%	0%
	Cambodian	0%	0%
	Chinese	0%	0%
	Eastern European	0%	0%
	European	1%	0%
	Filipino	0%	0%
	Japanese	0%	0%
	Korean	0%	0%
	Middle Eastern	0%	0%
	Vietnamese	0%	3%
	Other	10%	0%
	More than one ethnicity	12%	9%
	Declined to Answer	13%	24%

Success Stories

"Nelda," an older adult is now raising her granddaughter. She felt as though her granddaughter may be suffering with behavioral health concerns. When a coordinator from the RPiAAC contacted Nelda to ask her if she would like to attend the Effective Black Parenting workshops, she jumped at the chance. Nelda completed the parenting workshops. She now feels like she has the skills to raise her granddaughter and create a healthier relationship with her. Nelda's granddaughter, who participated in the RPiAAC program, has now gone from being a child with low self-esteem to being a child who is able to stand in front of a group and speak with confidence.

Artwork by Unknown Artist

Challenges

The RPiAAC program has struggled with maintaining parent engagement in the Effective Parenting classes. This has been a challenge for the program during FY 2016/17 and FY 2017/18. The lack of engagement in the parenting classes is partially due to practical concerns related to frequent re-location of families being served, along with the length of the program. Additionally, parents of student participants tend to have minimal or no transportation to attend parenting classes. Participant parents are often reluctant to leave their family alone to attend classes.

Also, the program continues to experience challenges with obtaining data on student outcomes from some schools due to the concern of breaching student confidentiality.

Solutions in Progress

The program has used several strategies to encourage engagement and attendance for the Effective Black Parenting class by offering one-day classes, seven-week class series, classes on school sites, attendance incentives, and childcare options. The program has adopted a grassroots approach that is proving to be effective in engaging parents, students and community partners. When a student is referred to the program, program administrators reach out to the students participants' parents. During this contact staff members are offering increased assistance for families to locate resources for transportation, housing, food, utilities, and other basic needs.

The program plans to create forms to be completed by the students to self report their grades, attendance, and suspension rates without breaching student confidentiality.

Program Updates

In effort to engage providers to explore culturally acceptable practices for evaluation and increase program efficiencies, the National Curriculum and Training Institute® (NCTI®) Crossroads Education program has been integrated into the RPiAAC scope of work as an alternative for the parent curriculum Effective Black Parenting. Outcomes will be reported in next years report.

Collaborative Partners

- Act of Kindness Program
- African American Mental Health Coalition
- African Soul International
- Black Voice News
- Roman Catholic Diocese of San Bernardino
- Gaining Early Awareness and Readiness for Undergraduate Programs
- (GEAR UP) - California State University San Bernardino
- Rialto Unified School District
- San Bernardino City Unified School District
- San Bernardino County, Probation Department
- San Bernardino County, Superintendent of Schools
- San Bernardino Valley College
- True Vine Ministries
- TAY Center
- Valley Star Children and Family Services
- Young Visionaries Youth Leader Academy
- Young Women Empowerment

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

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

Providers utilize the NCTI Crossroads® curricula and The Real Colors® Personality instrument to focus on the relationship between values, attitudes, and behaviors, as they relate to the decision making process.
Class topics include:

- Anger management
- Life skills
- Parent education
- Substance abuse prevention
- Gang involvement
- Truancy intervention
- Graffiti prevention
- Parenting classes (offered to families of those participating in the program)

Artwork by Gabriel Horne

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

MHSA Legislative Goals and Related Key Outcomes

- Improve timely access to services:
  - ◊ Increase extent to which individuals or families from underserved populations who need mental health services because of risk of presence of mental illness receives appropriate services as early in onset as practicable.
- Increase early access and linkage to medically necessary care and treatment:
  - ◊ Increase extent to which individuals or families from underserved populations who need mental health services because of risk or presence of a mental illness receives appropriate services as early in onset as practicable.
- Reduce prolonged suffering associated with untreated mental illness:
  - ◊ Reduce risk factors.
  - ◊ Reduce indicators.
  - ◊ Increase protective factors that may lead to improved mental, emotional, and relational functioning.
- Reduce stigma and discrimination associated with mental illness:
  - ◊ Reduce negative feelings, attitudes, beliefs, perceptions, stereotypes, and/or discrimination related to having a mental illness, being diagnosed or seeking services.
  - ◊ Increase acceptance, dignity, inclusion, and equity for individuals with mental illness and members of families.

Artwork by Erica Porteous

Positive Results

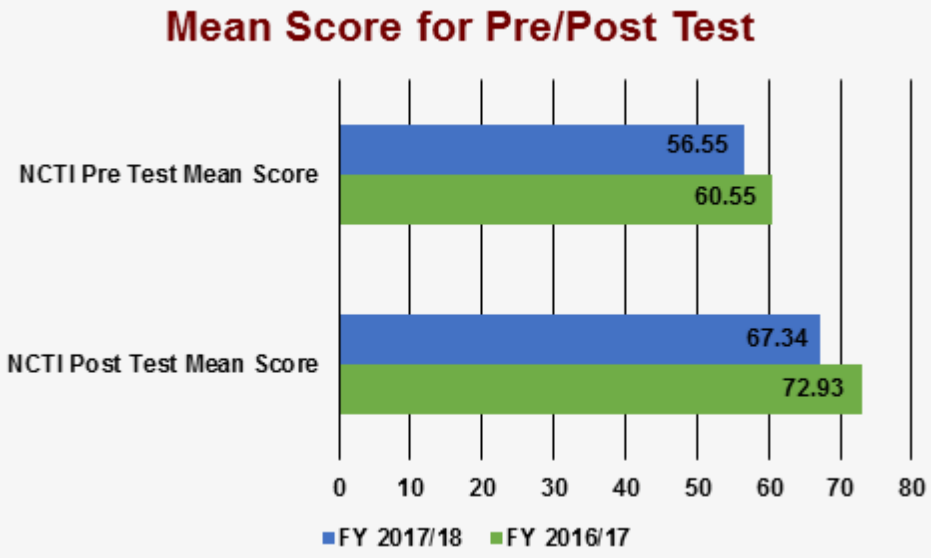
Prevention Outcomes

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

Of the **1,969** individuals that participated in the NCTI® program in FY 2016/17, **1,165** completed the pre test (administered at the beginning of each course) and **1,007** completed the post test (administered at completion of each course). Of the **4,422** individuals who participated in the NCTI® program in FY 2017/18, **731** completed the pre test and **649** completed the post test.

The pre test measures the participants' knowledge and understanding of the subject before participating in the classes and the post test measures the participants' knowledge and understanding of the subject at the end of the course as a method to measure gains.

The table below illustrates the mean pre test and post test scores for FY 2016/17 and FY 2017/18. The higher post test scores indicate that the participants' knowledge has increased as a result of the NCTI classes. The average percentage of increase between pre and post tests in FY 2016/17 was **20.45%** and **19.08%** for FY 2017/18. The percentage of increase indicates the rate of understanding that students gained after completing each course.



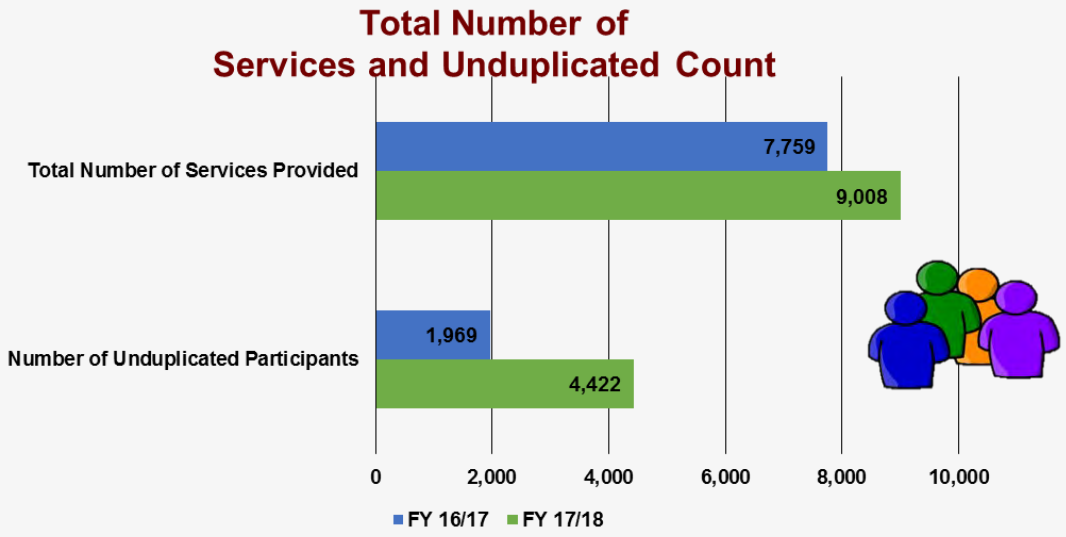
Outcomes for Improve Timely Access to Services

In FY 2017/18, the NCTI Program reported referring **25** participants or family members of a specified underserved population to a prevention program. The program identified and served the following underserved populations:

Underserved Populations	
Asian	Latino
Children and Youth At Risk for School Failure	LQBTQ
Children and Youth at risk of or Experiencing Juvenile Justice Involvement	Native American
Children and Youth in Stressed Families	Trauma Exposed Individuals

Total Number Served/Unduplicated Count

The following table represents the total number of services provided in the program and the number of unduplicated participants served. The number of unduplicated participants represents the number of individuals who were new to the program during the fiscal year.



Fiscal Year 2016/17 & 2017/18

Program Demographics

		FY 16/17	FY 17/18
Assigned Sex at Birth	Male	55%	52%
	Female	39%	40%
	Declined to Answer	6%	8%
Age	Child 0-15	46%	44%
	TAY 16-25	32%	41%
	Adult 26-59	15%	11%
	Older Adult 60+	1%	1%
	Declined to Answer	6%	3%
Primary Language Used	English	80%	91%
	Spanish	5%	2%
	Other	15%	7%
	Declined to Answer	0%	0%

		FY 16/17	FY 17/18
Veteran	U.S. Military Veteran - Yes	0%	1%
	U.S. Military Veteran - No	36%	82%
	Declined to Answer	64%	17%

Fiscal Year 2016/17 & 2017/18

Program Demographics

		FY 16/17	FY 17/18
Disability	Difficulty seeing	3%	4%
	Difficulty hearing or having speech understood	0%	1%
	Other	0%	0%
	Cognitive Disability	1%	1%
	Physical/mobility domain	1%	0%
	Chronic health condition (including but not limited to chronic pain)	1%	0%
	No	27%	69%
	Declined to Answer	67%	25%

		FY 16/17	FY 17/18
Sexual Orientation	Gay or Lesbian	1%	0%
	Queer	0%	1%
	Bisexual	1%	1%
	Another Sexual Orientation	0%	0%
	Heterosexual or Straight	45%	59%
	Questioning or Unsure of Sexual Orientation	0%	0%
	Declined to Answer	53%	39%

Fiscal Year 2016/17 & 2017/18

Program Demographics

		FY 16/17	FY 17/18
Race	American Indian or Alaskan Native	2%	2%
	Asian	0%	1%
	Black or African American	18%	18%
	Native Hawaiian or Pacific Islander	0%	1%
	White (Caucasian)	25%	27%
	More than one race	10%	33%
	Other race	30%	6%
	Declined to Answer	15%	12%
Hispanic or Latino Ethnicity	Caribbean	1%	1%
	Central American	2%	1%
	Mexican/Mexican-American/Chicano	63%	38%
	Puerto Rican	0%	0%
	South American	1%	1%
	Other Hispanic or Latino Ethnicity	17%	54%
	Declined to Answer	16%	5%
Ethnicity	African	19%	21%
	Asian Indian/South Asian	1%	1%
	Cambodian	0%	0%
	Chinese	0%	1%
	Eastern European	1%	1%
	European	17%	22%
	Filipino	0%	2%
	Japanese	0%	1%
	Korean	0%	1%
	Middle Eastern	0%	1%
	Vietnamese	0%	1%
	Other	4%	5%
	More than one ethnicity	11%	6%
	Declined to Answer	47%	37%

Success Story

"Cindy," was experiencing truancy issues and was referred to the NCTI program. Through an assessment process, it was determined that the family was experiencing a crisis situation. Cindy and a close family member had recently been through a traumatic event and were having difficulty coping. The stressors associated with the trauma were affecting Cindy's school performance. The program connected Cindy and her family to supportive services to address the issues associated with the trauma. Cindy also participated in a life skills group to help learn healthy coping mechanisms. Cindy's mother attended a parenting class, which helped her learn new skills and information on how to provide a safe family environment for her daughter.

Cindy is now attending school regularly and receiving high marks in her classes.

Challenges

The NCTI® program has faced challenges with recruitment of new school sites, as well as scheduling of the sites in which partnerships are established. The program has also faced barriers with permission slip protocol at the high schools due to the participants not returning the permission slips. Furthermore, the retention of trained staff and continuity of school administration policies and personnel have been a concern.

Solutions in Progress

In order to connect students and families with services, the NCTI program was integrated into other PEI programs that serve the same target population.

NCTI is now included as part of the service delivery model for Student Assistance Program (SAP), Resilience Promotion in African American Children (RPiAAC), and Family Resource Center (FRC). These programs have previously established partnerships with school sites which will serve to reach school sites not previously reached by the NCTI program.

Program Updates

Effective in FY 2018/19, the NCTI® Crossroads Education® program is no longer a stand-alone program. This program has been integrated into the PEI Student Assistance Program (SAP) and has been included as part of the scope of work in the Family Resource Center (FRC) and Resilience Promotion in African American Children (RPiAAC) programs. Partnerships with local community organizations have allowed services to continue to be offered in existing areas.

Due to this reported change, next year's Three Year Integrated Plan will not report NCTI activities as a stand-alone program. The outcomes will be reported as part of the respective programs (SAP, FRC & RPiAAC).

Collaborative Partners

- Barstow Unified School District
- Chino Valley Unified School District
- Family Service Agency
- Inland Valley Drug and Alcohol Services
- Kiwanis Club
- Morongo Unified School District
- Reach Out
- Rim Family Services
- Rim of the World School District
- Yucca Valley Chamber of Commerce

Artwork by Celina Castrejon

Older Adult Community Services (PEI SE-1)

The OACS program is categorized as a State Prevention program. This program is designed to promote a healthy aging process for older adults (ages 60+). Prevention and early intervention services focus on providing assistance to older adults before mental health issues develop and/or require a more intensive level of treatment. The OACS program has four main components:

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

Early intervention services are available to those exhibiting the onset of a mental illness and/or relapse episodes due to a pre-existing psychiatric condition. The program addresses specific causes and risk factors that can contribute to suicide and/or suicidal ideations and targets those who are exposed to trauma or are experiencing grief and loss. The program also utilizes Older Adult Peer Counselors who are trained in suicide prevention and have access to licensed staff.

MHSA Legislative Goals and Related Key Outcomes

- Reduce stigma and discrimination associated with mental illness:
  - ◊ Reduce negative feelings, attitudes, beliefs, perceptions, stereotypes, and/or discrimination related to having a mental illness, being diagnosed, or seeking services.
  - ◊ Increase acceptance, dignity, inclusion, and equity for individuals with mental illness and members of families.
- Improve timely access to services, for underserved populations:
  - ◊ Increase extent to which individual or family from underserved population who need mental health services because of risk or presence of a mental illness receives appropriate services as early in onset as practicable.
- Reduce prolonged suffering associated with untreated mental illness:
  - ◊ Reduce risk factors
  - ◊ Reduce indicators
  - ◊ Increase protective factors that may lead to improved mental, emotional, and relational functioning.
- Increase early access and linkage to medically necessary care and treatment:
  - ◊ Connect children, adults and seniors with severe mental illness and care as early in the onset of these conditions as practicable, to medically necessary care and treatment, including but not limited to, care provided by county mental health programs.

Target Population:

- Older Adults: ages 60+

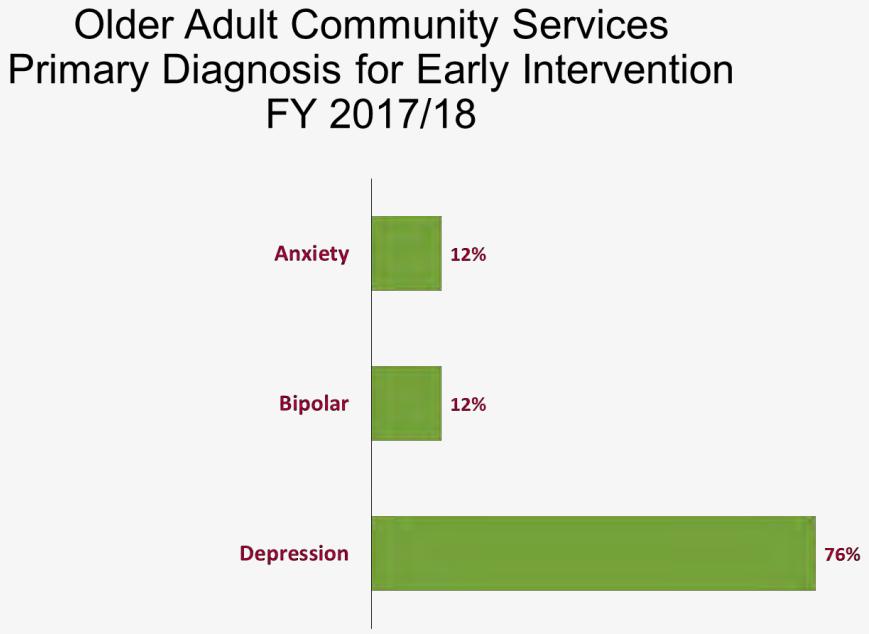
Projected Number to be served:

- FY 2019/20:
  - ◊ 6,339 Older Adults

Positive Results

Early Intervention Outcomes

The following table illustrates the primary diagnosis of OACS participants engaged in Early Intervention services. The majority of OACS participants, 76%, were diagnosed with depression. The Division of Population Health, National Center for Chronic Disease Prevention and Health Promotion states, “about 80% of older adults have at least one chronic health condition, and 50% have two or more. Depression is more common in people who also have other illnesses (such as heart disease or cancer) or whose function becomes limited.” The OACS program assesses older adults for depression and other possible illnesses upon entry into the program and provides interventions as early as possible. The Geriatric Depression Assessment, Patient Health Questionnaire (PHQ-9) and Becks Depression Inventory are assessment tools used within the program.



Positive Results

One of the tools that the OACS program uses to measure the success of the Early Intervention treatment is the discharge status of the recovery goals at the end of treatment. A participant reached their goals and had successful treatment if their treatment plan goals were met. The participant partially reached their treatment goals or treatment was partially successful if progress was made but the participant did not meet the full criteria of their treatment plan. The participant would not have met their goals or treatment was not successful if progress was not made or they did not complete the treatment.

In FY16/17, **72%** of participants met or partially met treatment goals. In FY 17/18, **68%** of participants met or partially met treatment goals. The most common reason participants did not meet their treatment goals was due to not completing the program. Common reasons individuals did not complete treatment included transportation issues and unsafe weather conditions.

On average, participants of the OACS program had an open Early Intervention case for 70 days in FY 2017/18. Of those 70 days (approximately 2 1/2 months) participants had 12 days of direct services with an average of 962 cumulative minutes of services (approximately 16 hours).

In FY 16/17, participants had Early Intervention cases open for an average of 99 days (approximately 3 months) and had 11 days of direct services with an average of 829 cumulative minutes of services (approximately 14 hours).

Duration of Treatment	FY 2016/17	FY 2017/18
Average Number of Cumulative Minutes	829	962
Average Length of Time in Days from Episode Opening to Episode Closing	99	70
Average Number of Days	11	12

Prevention Outcomes

The Prevention activities for the OACS program are designed to decrease isolation and increase socialization among older adults. The 2018 Senior Report produced by the America's Health Rankings United Health Foundation states: "Meaningful social relationships are essential to good health and well-being, especially during one's senior years. Social isolation, or lack of these relationships, can have negative consequences for a person's physical health and mental well-being. Life events such as retirement, loss of a spouse and friends, and age-related health conditions may make it difficult for seniors to maintain the same level of social interactions or the breadth of a support network they once had."

The following provides a list of Prevention activities administered by the program, a description of each activity and the completion rate for FY 2017/18.

Average Completion Rate for Prevention Activities (FY 17/18)		
Prevention Activity	**Description**	**Participant Completion Rate**
Monthly Craft Classes	Craft activities are created by staff and volunteers to provide challenging tasks for the older adults which stimulate them both mentally and physically	100%
Quarterly Luncheons	Educational presentations Mental Health and Wellness	92%
Life Skills Class	Educating and empowering Older Adults with the knowledge needed to improve their sense of self-sufficiency and ability to ask for help	100%
Fall Prevention/ Home Safety	Workshops offered throughout the County in order to assist Older Adults with home and personal safety to support independence.	100%
Step Down Group	Relapse Prevention for participants who have received or are receiving mental health services	100%
Safetalk	Suicide prevention curriculum integrated in to the weekly group sessions	100%
PEARLS	8–9 session program using University of Washington's Developed P.E.A.R.L.S program	80%

The OACS program utilizes a variety of assessments and surveys to evaluate program effectiveness. Below are descriptions and results from a sample of the assessments used during FY 2017/18:

- **The Wellness Survey** is used to capture the following information:
  - How likely a person is to participate in a social or physical activity,
  - How likely they are to implement home safety practices,
  - The usefulness of the information received, and
  - Any suggestions on topics they could benefit from in the future.

This survey was given to **69** participants at the beginning and end of each Wellness Support Group session. The Wellness pre-post surveys indicated that **74%** of the participants were more likely to participate in a social or physical activity as a result of the information they received from the presentation.

- **The Home Safety survey** is used to determine how likely a participant would be to implement home safety practices, what information they received was most useful, and any suggestions on topics they could benefit from in the future. This survey was given to participants at the beginning and end of each Home Safety supportive group session. The Home Safety pre-post surveys indicate that **57%** of the participants were more likely to implement home safety practices as a result of the information they received from the presentation.

- The OACS providers utilize the Program to Encourage Active, Rewarding Lives for Seniors (PEARLS) program. PEARLS is an evidenced-based program providing treatment for depression in older adults. A PEARLS coordinator makes eight to nine home visits to participants to help them learn the signs of depression and provides them with problem solving skills. Participants of the PEARLS program complete a **Patient Health Questionnaire-9 (PHQ-9)**. The PHQ-9 consists of nine questions that measures the participant's perception of the frequency and severity of identified depression symptoms.
  - A total score of 0-4 suggests a minimal risk for depression and that a patient may not need to be referred to treatment.
  - A score of 5-9 suggests mild depression risk and 10-14 suggests moderate depression risk. Clinicians or Screeners use clinical judgement about treatment, based on the patient's duration of symptoms and functional impairment for scores from 5-14.
  - Total scores of 15-19 suggest moderately severe depression and 20-27 suggest severe depression. Scores higher than **15** warrant treatment for depression.

Positive Results

This survey was administered to **17** participants during each of the home visits. PEARLS participants had an average pre-test score of **22** and the post-test score was **7** which translates to a **68%** reduction in symptoms of depression at program completion.

The OACS programs also use a variety of Client/Perception Surveys to measure the usefulness of presentations, speakers, customer service, and counseling effectiveness. These surveys are administered after each completed service/ presentation.

The following summary of results highlight the effectiveness of the program:

- **95%** of the respondents felt that they learned something new or useful from the presentations.
- **96%** of the respondents know who to contact if they need assistance or additional resources.
- **100%** of the respondents stated that they had a better understanding of the functions and services that the Adult Protective Services Agency provides.
- **100%** of the respondents stated that they felt more comfortable identifying and referring someone to services that the Adult Protective Service Agency provides.
- **90%** of the respondents stated that they had a better understanding of the roles and responsibilities of a caregiver.
- **100%** of the respondents stated that they had a better understand of the important questions that need to be asked of potential caregivers.

"Coming here is the highlight of my week."

-Support Group Member

Outcomes for Access and Linkage to Treatment

The following results describe the number of individuals with severe mental illness referred to treatment that is provided, funded, administered, or overseen by county mental health programs:

- The OACS program made **59** participant referrals to treatment.
- Of the **59** participants **12** individuals followed through on the referral and engaged in treatment.
- On average, OACS program participants reported experiencing **7** days of mental health challenges before they received treatment for the for the symptoms they were experiencing.
- On average, OACS program participants reported a **4** day interval between receiving a referral for mental health treatment to actually participating in the treatment referred.

Outcomes for Improve Timely Access to Service Strategy or Program

In FY 2017/18, the OACS program identified and served the following underserved populations:

Underserved Populations		
Monolingual Spanish	Older Adults of Latino descent	Middle Eastern
Asian	African-American	Asian Indian
Native American	Military/Veterans	Older Adults

Twenty-four participants received referrals for additional services: **21** participants were referred to Prevention programs, **2** participants were referred to Early Intervention, and **1** participant was referred to Treatment Beyond Early Onset.

The OACS program successfully had **22** participants follow through on their referrals.

The FY 2017/18 average interval between referral and participation in services and the corresponding standard deviation are displayed in the following table.

	Prevention	Early Intervention	Treatment Beyond Early Onset
Number of days	6	19	17
Standard Deviation	14	5	3

Positive Results

Outcomes for Outreach for Increasing Recognition of Early Signs of Mental Illness

The OACS program conducts outreach and engagement in a variety of ways. The outreach and engagement goal for the program is to reduce the stigma associated with receiving or seeking mental health services amongst older adults. The majority of services are delivered at locations frequently attended by this target population such as senior and community centers, senior housing complexes, faith based organizations and service clubs. In addition, information and educational materials have been placed at medical offices, post offices, and offered at local community events for easy access.

Number of potential responders served

OACS served a total of **4,330** potential responders in FY 17/18.

Settings in which the potential responder were reached include:

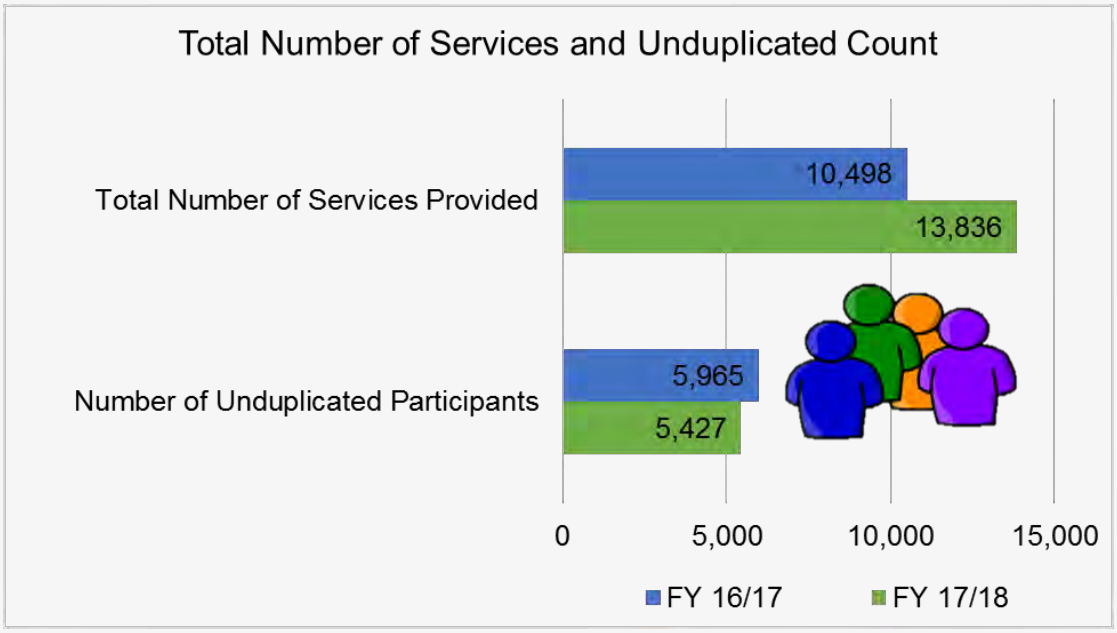
Outreach Settings	
Behavioral Health Clinics	Local Symposiums
Senior Housing Facilities	Health Fairs / Flu Clinics
National Day of Prayer	Senior Centers
Polar Plunge community event in Big Bear	Community Based Organization Facility
Adult Protective Services/ Multidisciplinary Team Meetings	Adult Protective Services/ Multidisciplinary Team Conference

The OACS program reached a variety of potential responders at the Outreach events and trainings. The following table lists how the attendees identified themselves:

"I feel so much more comfortable with myself since I started this program."
-OACS Client

Potential Responders Reached	
Medical / Dental Professionals	County Staff
Food & Housing Service Staff	Volunteers
Senior Housing Staff	Seniors
Senior Assistance Program staff	Ministerial staff and Church
Friends and family members of seniors with possible mental health issues	

The following chart represents the total number of services provided in the program and the number of unduplicated participants served for FY 16/17 and FY 17/18. The number of unduplicated participants represents the number of individuals who were new to the program during the fiscal year.



Fiscal Year 2016/17 and 2017/18

Program Demographics

		FY 16/17	FY 17/18
Assigned Sex at Birth	Male	22%	23%
	Female	69%	58%
	Declined to Answer	9%	19%
Age	Child 0-15	0%	0%
	TAY 16-25	0%	0%
	Adult 26-59	1%	9%
	Older Adult 60+	94%	83%
	Declined to Answer	5%	8%
Primary Language Used	English	77%	60%
	Spanish	13%	19%
	Other	2%	2%
	Declined to Answer	8%	19%

		FY 16/17	FY 17/18
Veteran	U.S. Military Veteran - Yes	5%	5%
	U.S. Military Veteran - No	50%	49%
	Declined to Answer	45%	46%

Fiscal Year 2016/17 and 2017/18

Program Demographics

		FY 16/17	FY 17/18
Disability	Difficulty seeing	9%	10%
	Difficulty hearing or having speech understood	4%	7%
	Other	5%	1%
	Cognitive Disability	14%	3%
	Physical/mobility domain	22%	14%
	Chronic health condition (including but not limited to chronic pain)	1%	18%
	No	10%	13%
	Declined to Answer	35%	34%

		FY 16/17	FY 17/18
Sexual Orientation	Gay or Lesbian	1%	0%
	Queer	0%	0%
	Bisexual	0%	0%
	Another Sexual Orientation	0%	1%
	Heterosexual or Straight	38%	43%
	Questioning or Unsure of Sexual Orientation	0%	1%
	Declined to Answer	61%	55%

Fiscal Year 2016/17 and 2017/18

Program Demographics

		FY 16/17	FY 17/18
Race	American Indian or Alaskan Native	1%	1%
	Asian	1%	2%
	Black or African American	8%	8%
	Native Hawaiian or Pacific Islander	1%	1%
	White (Caucasian)	59%	57%
	More than one race	0%	2%
	Other race	14%	7%
	Declined to Answer	16%	22%
Hispanic or Latino Ethnicity	Caribbean	0%	1%
	Central American	2%	5%
	Mexican/Mexican-American/Chicano	14%	39%
	Puerto Rican	1%	2%
	South American	1%	5%
	Other Hispanic or Latino Ethnicity	15%	14%
	Declined to Answer	67%	34%
Ethnicity	African	9%	3%
	Asian Indian/South Asian	1%	1%
	Cambodian	0%	0%
	Chinese	2%	1%
	Eastern European	1%	1%
	European	5%	7%
	Filipino	1%	1%
	Japanese	0%	0%
	Korean	0%	0%
	Middle Eastern	1%	0%
	Vietnamese	0%	11%
	Other	2%	5%
	More than one ethnicity	0%	26%
	Declined to Answer	78%	44%

Artwork by Robin Cline

Success Story

"Crystal", an older adult, enrolled in the OACS program because she was experiencing suicidal ideation and was overwhelmed with housing repairs and grief from the loss of her spouse. OACS staff completed a depression screening survey with Crystal, which confirmed her need for Early Intervention services. Crystal received therapeutic services from the OACS program and significantly improved within several months. At the completion of her services, Crystal was able to complete activities of daily living which consisted of applying for a grant to assist with funding the repairs for her home. Crystal was awarded the grant and has had her home repairs completed. This was a milestone for Crystal. Her self-esteem improved and she feels safer in her home.

Challenges

The OACS providers continue to experience challenges with connecting participants with timely Early Intervention and Psychiatric services when they have private health insurance. The mountain communities are especially impacted due to some insurance providers not having mental health service providers in the mountain region. The shortage of mental health service providers in the geographically isolated mountain region has caused significant transportation challenges for the older adult population that must travel into the city for services.

Identifying and providing services to homebound and/or isolated seniors, especially during winter months, in remote regions of the County continues to be a challenge for the OACS program.

Solutions in Progress

The OACS program addresses the isolation issues by conducting safety calls. They increase the frequency of calls during extreme weather conditions. They have increased their presentations and workshops that address the benefits of socialization, reducing stress, and how to access local resources. The OACS program also plans to increase focus on activities that appeal to older adult males to reduce stigma in this high-risk population.

The OACS program is constantly searching for new options to address transportation challenges. They have built relationships with local health insurance providers that will provide transportation to clients for medical appointments. They provide information and workshops to older adults on how to use the public transportation system. There are several ride sharing and driver reimbursement services that are made available to OACS participants that meet the program qualifications. The OACS program is also able to utilize the Department of Aging and Adult Services transportation voucher program as supplies permit.

Program Updates

There are currently no planned program or budget changes for Fiscal Years 2019/20.

Artwork by Lilian Iskandar

Collaborative Partners

- Mercy Air
- Ministerial Association
- Healthy Start
- Marcain Communications
- Alzheimer's Association
- DOVES
- CERT
- Bear Valley
- Methodist Church
- MPHelm Insurance
- Supplement Professors
- Sunset Lions Club
- Home Instead
- Department of Aging and Adult Services
- San Bernardino County Public Authority In Home Supportive Services
- Housing Mediation Services
- Bear Valley Community Hospital
- Bear Valley Hospice
- Kiwanis
- Adult Protective Services
- Mom & Dad Project
- Mountain Meadows
- Salvation Army
- Elder & Disability Law Firm
- Christian Faith Center
- Knights of Columbus
- Community Hospice of Victor Valley
- Heritage Senior Care
- San Bernardino County Fire Department
- Mountain Transit/Transportation Reimbursement Program

Lift Program

Administered by San Bernardino County Preschool Services Department, the Lift Program is designed to promote healthy outcomes for at risk mothers and their infants. Nurses provide education and services in participants' homes to promote the physical and emotional care of children by their mothers, family members, and caretakers. Families are linked with needed physical and mental health services.

Services include:

- Prenatal screenings
- Postpartum depression screenings
- Maternal attachment support
- Substance use/abuse screenings and support
- Parenting education/support
- Life and employment skills development
- Case Management
- Assistance with developmental milestones for the child

These services last for the duration of the mother's pregnancy up until the child is two years of age.

First-time mothers, no later than the end of the 28th week of pregnancy, are given priority enrollment. However, mothers who are at risk and are not first time moms may also be enrolled in the program. Although mothers and their infant are the primary population, home visits may also involve fathers and other family members, as appropriate.

The Lift Program uses an evidence-based model which pairs new mothers with registered nurses who provide support during home visits throughout pregnancy and up until the child reaches two years of age. Goals of the program include ensuring healthy development of the infant/toddler and encouraging mothers to engage in preventative care including reduction of cigarette and alcohol use.

MHSA Legislative Goals and Related Key Outcomes

- Increase early access and linkage to medically necessary care and treatment:
  - ◊ Connect children, adults, and seniors with severe mental illness to care as early in the onset of these conditions as practicable, to medically necessary care and treatment, including, but not limited to, care provided by county mental health programs.
- Improve Timely Access to Services:
  - ◊ Increase extent to which an individual or family from an underserved population who needs mental health services because of risk or presences of a mental illness receives appropriate services as early in onset as practicable.
- Reduce prolonged suffering associated with untreated mental illness:
  - ◊ Reduce risk factors.
  - ◊ Reduce indicators
  - ◊ Increase protective factors that may lead to improved mental, emotional, and relational functioning.
- Reduce stigma and discrimination associated with mental illness:
  - ◊ Reduce negative feelings, attitudes, beliefs, perceptions, stereotypes, and/or discrimination related to having a mental illness, being diagnosed, or seeking services.
  - ◊ Increase acceptance, dignity, inclusion, and equity for individuals with mental illness and members of families.

Target Populations:

- Children: ages 0-15
- TAY: ages 16-25
- Adults: ages 26-59

Projected Numbers to be Served:

- FY 2019/20:
  - ◊ 60 Children
  - ◊ 30 TAY
  - ◊ 30 Adults

Positive Results

Prevention Outcomes

Lift participants are assessed at intake and then again in six (**6**) months. In addition, the Lift program nurses complete activity sheets to track daily activities/services and the number of participants served. Preschool Services Department prepares a monthly summary report providing monthly information on the following data:

- Access & Linkage to treatment,
- Improving timely access to services for underserved population,
- Effective methods used to deliver services,
- Outreach for increasing recognition of early signs of mental illness, and
- Number of unduplicated participants served, and the number services provided by State program.

The LIFT program served **120** unduplicated participants, including mothers and their children. The Lift program provided **340** contacts totaling **964** service related hours for FY 2017/18.

Program participants took part in the following prevention screenings:

- Edinburgh Post Natal Depression scale,
- Fagerstrom Test for Nicotine Dependence,
- Life Skills Progression,
- Maternal Fetal Attachment scale,
- Teeth for Two, and
- WIC pregnancy nutrition assessment.

29 of the mothers enrolled in the Lift Program completed both pre and post assessments.

Edinburgh Post Natal Depression Scale

The Edinburgh Depression Scale (EDS) is a ten-item questionnaire that was developed to identify women who have postpartum depression. The items on the EDS scale identify symptoms such as sleep disturbance, low energy, suicidal thought, etc. High scores indicate depressive symptoms. The EDS is

used within eight weeks postpartum and is applied for screening during pregnancy. The Lift Registered Nurse (RN) administers the EDS at initial enrollment and about eight weeks after delivery of her newborn. Based on scoring, the mother will be referred to Associate Marriage and Family Therapists (AMFTs) in the Preschool Services Department (PSD) PEI program for further evaluation, or to outside agencies for more serious signs of depression.

The Edinburgh postnatal depression scale identified five of the **29** mothers that exhibited signs of possible or highly probable likelihood of dealing with Postpartum Depression. The Lift nurse made joint home visits with an AMFT and a social worker. All five mothers showed signs of improvement by the conclusion of their program.

Edinburgh Postnatal Depression Scale	
FY 2016/17	**FY 2017/18**
30 of **82** mothers showed signs of possible or highly probable likelihood of dealing with Postpartum Depression.	**5** of **29** mothers showed signs of possible or highly probable likelihood of dealing with Postpartum Depression.

Fagerstrom Test

The Fagerstrom Test for nicotine addiction determines the degree of nicotine dependence based on smoking habits and frequency. Upon enrollment, the Lift Registered Nurse (RN) asks mothers about their history of smoking. If the mother has a recent history of smoking, the Lift nurse administers the Fagerstrom test. Based on the outcome measure of risk, the Lift nurse will provide education of potential risk to newborn and/or suggest follow-up support such as advice from mothers' medical provider. Three of the **29** mothers were smokers and had smoked less than **10** cigarettes a day. One of the three mothers stopped smoking shortly after services began.

Fagerstrom Test for Nicotine Dependence	
FY 2016/17	**FY 2017/18**
1 of **82** mothers smoked cigarettes. The smoking mother stopped smoking shortly after services began.	**3** of **29** mothers smoked cigarettes. **1** of the **3** smoking mothers stopped smoking shortly after services began.

Maternal-Fetal Attachment Scale

The Maternal-Fetal Attachment Scale is a series of questions that range from “definitely yes” to “definitely no”. The questions relate to: pregnancy planning, strength of the relationship with mother’s mate, gestational age, and maternal self-concept. The Lift RN administers this scale at initial enrollment of the mother into the Lift program. This screening provides the Lift RN a planning tool for establishing and individualizing topics for ongoing bi-weekly home visits.

Maternal Fetal Attachment Scale		
Indicator	**FY 2016/17**	**FY 2017/18**
Reading to unborn child	**42** of **82** mothers were reading to their unborn child.	**11** of **29** mothers were reading to their unborn child.
Negative body image	**18** of **82** mothers held a negative body image.	**2** of **29** mothers had a negative body image.
	Lift nurses provided additional self-esteem training.	
Pregnancy is supported by family	**76** of **82** mothers felt that their family supported their pregnancy.	**25** of **29** mothers felt that their family supported their pregnancy.
	Mothers who did not feel that their family supported their pregnancy were offered family counseling to support positive, nurturing relationships.	
Pregnancy interferes with relationship with mate	**6** of **82** mothers said that their pregnancy interfered with their relationships with their mates.	**0** of **29** mothers said that their pregnancy Interfered with their relationships with their mates.
	10 of the **29** accepted family counseling which resulted in more positive nurturing relationships.	

Maternal Fetal Attachment Scale (cont.)		
Indicator	**FY 2016/17**	**FY 2017/18**
Pregnancy is planned	**50** of **82** mothers reported that their pregnancy was unplanned.	**11** of **29** mothers reported that their pregnancy was unplanned.
	Family Planning information was provided by the Lift nurse.	
Uncertainty about the future	**33** of **82** mothers reported that they were uncertain as to what the future holds for them and their babies.	**15** of **29** mothers reported that they were uncertain as to what the future holds for them and their babies.
	The mothers were offered enrollment in PSD Apprentice Program, Temporary Aid to Needy Families (TANF) job training and/or high school diploma programs. • **16** of the **33** mothers enrolled in at least one of the programs in FY 16/17. • **6** of the **15** mothers enrolled in at least one of the three programs in FY 17/18.	

Woman, Infants, and Children (WIC) Questionnaire

The Woman, Infants, and Children (WIC) Questionnaire is a fifteen question assessment that is used by the San Bernardino County WIC program. The questionnaire assesses services that can be provided to the mother by WIC during and after her pregnancy. This questionnaire is administered by the LIFT RN upon initial enrollment of the pregnant mother. Based on the mother's responses, the mother is connected to WIC services.

Women, Infants and Children (WIC) Questionnaire	
FY 2016/17	**FY 2017/18**
24 of **82** mothers were referred and received WIC services as a result of the questionnaire.	**11** of **29** mothers were already receiving services from WIC when they enrolled in the Lift program. **18** of **29** began receiving WIC services, including breast feeding information, food packages, and/or formula and CalFresh information. **6** of **29** mothers were not receiving WIC services and were referred to the WIC program.

Teeth for Two

Teeth for Two is a questionnaire about basic oral health provided to Preschool Services Department(PSD) by a local dentist. The Lift nurse conducts this questionnaire with participants upon enrollment of a new pregnant mother in the Lift program.

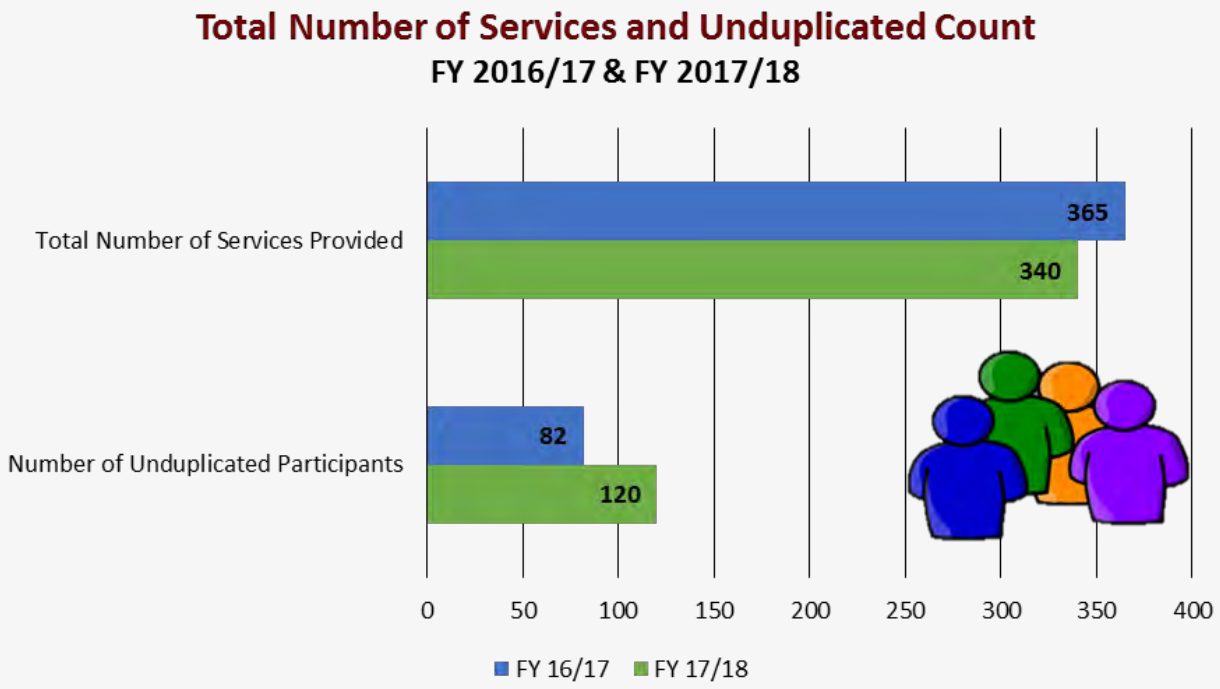
The tool considers ten basic health symptoms that would suggest a need for follow-up dental care. If one or more questions are answered “yes,” then an oral health concern is present and the mother is referred for dental follow-up. The LIFT RN provides education on poor dental hygiene and the effects it may have on the mother’s newborn.

Teeth for Two	
FY 2016/17	**FY 2017/18**
49 of **82** mothers needed oral health care. All **49** were referred to Medi-Cal dentists and received care.	**16** of **29** mothers needed oral health care. All **16** were referred to Medi-Cal dentists and received care.

Outcomes for Outreach for Increasing Recognition of Early Signs of Mental Illness

The LIFT program utilizes community outreach as well as internal recruitment within the PSD Preschool programs. They meet with and provide recruitment materials to Community Hospitals, Community Clinics, WIC, Department of Public Health, Transitional Assistance Department, Department of Behavioral Health and Children Family Services, local High Schools, homeless shelters and the High Desert Well Babies Coalition.

The following table represents the total number of services provided in the program and the number of unduplicated participants served. The number of unduplicated participants represents the number of individuals who were new to the program during the fiscal year.



Fiscal Year 2016/17 & 2017/18

Program Demographics

The demographic data collected for the Lift program during FY 2016/17 and FY 2017/18 is presented below. The demographic information represents the demographics of the participants who chose to complete the survey.

		FY 16/17	FY 17/18
Assigned Sex at Birth	Male	15%	26%
	Female	85%	63%
	Declined to Answer	0%	11%
Age	Child 0-15	42%	44%
	TAY 16-25	33%	18%
	Adult 26-59	24%	27%
	Older Adult 60+	0%	0%
	Declined to Answer	1%	11%
Primary Language Used	English	0%	77%
	Spanish	9%	7%
	Other	91%	1%
	Declined to Answer	0%	15%

		FY 16/17	FY 17/18
Veteran	U.S. Military Veteran - Yes	0%	2%
	U.S. Military Veteran - No	100%	83%
	Declined to Answer	0%	15%

Fiscal Year 2016/17 & 2017/18

Program Demographics

		FY 16/17	FY 17/18
Disability	Difficulty seeing	0%	6%
	Difficulty hearing or having speech understood	5%	1%
	Other	0%	2%
	Cognitive Disability	0%	2%
	Physical/mobility domain	0%	2%
	Chronic health condition (including but not limited to chronic pain)	0%	1%
	No	5%	18%
	Declined to Answer	90%	68%

		FY 16/17	FY 17/18
Sexual Orientation	Gay or Lesbian	0%	0%
	Queer	0%	1%
	Bisexual	0%	2%
	Another Sexual Orientation	3%	2%
	Heterosexual or Straight	82%	66%
	Questioning or Unsure of Sexual Orientation	0%	0%
	Declined to Answer	15%	29%

Fiscal Year 2016/17 & 2017/18

Program Demographics

		FY 16/17	FY 17/18
Race	American Indian or Alaskan Native	0%	3%
	Asian	0%	0%
	Black or African American	18%	19%
	Native Hawaiian or Pacific Islander	0%	0%
	White (Caucasian)	64%	15%
	More than one race	0%	22%
	Other race	0%	14%
	Declined to Answer	18%	27%
Hispanic or Latino Ethnicity	Caribbean	0%	2%
	Central American	0%	0%
	Mexican/Mexican-American/Chicano	54%	64%
	Puerto Rican	0%	0%
	South American	0%	3%
	Other Hispanic or Latino Ethnicity	46%	25%
	Declined to Answer	0%	6%
Ethnicity	African	22%	9%
	Asian Indian/South Asian	1%	0%
	Cambodian	0%	0%
	Chinese	0%	0%
	Eastern European	0%	0%
	European	0%	0%
	Filipino	0%	0%
	Japanese	0%	0%
	Korean	0%	0%
	Middle Eastern	0%	0%
	Vietnamese	0%	0%
	Other	11%	4%
	More than one ethnicity	44%	13%
	Declined to Answer	22%	74%

Success Story

"Brianna" was a teenager with a history of drug and alcohol use before her pregnancy. She was recruited to the Lift Program through Central Valley Juvenile Justice Center.

She was five months pregnant and a first time mom when she entered the Lift Program. Brianna was provided information on different topics including substance use disorders, trust building, and child development.

Brianna said one of her greatest concerns was her baby may suffer the same challenges she had as a child. She was open to receiving help and education. She was engaged in the Lift program and followed all instructions and teachings. She read and studied all the books and pamphlets given to her and learned how to make goals and to keep them.

Brianna explained that the Lift program benefited her by helping her to become empowered with resources. She learned to rebuild self-confidence. She learned recover from her substance use disorder and completed parenting classes. The Lift program made it possible and she enjoys being with her baby.

Artwork by Ami Jacobsen

Challenges

Some of the challenges and barriers experienced by the Lift Program includes families who are dealing with domestic violence and relocating. This presents a challenge because families relocate without leaving contact information.

Additionally, maintaining a full staff of Lift RNs was a challenge. During this year, the Lift Program operated with two or less RNs, which diminished the capacity to provide services to pregnant mothers. This affected the number of families served. Understaffing also created a challenge in administering and pre and post participants screenings, resulting in only a sampling of assessments being collected and evaluated.

Solutions in Progress

Preschool Services Department has established resources to educate families about domestic violence to improve their situation. For instance, the Salvation Army provides shelter and domestic violence education for the family. Another program, Moses House Ministries, provides families with case management, mentoring, counseling, self-esteem courses, and parenting classes.

Preschool Services has improved recruitment and retention efforts to attract qualified nurses to the program. These efforts have resulted in increased nursing staff which will positively affect the number of families that the program will be able to serve. In addition, the increased staff will result in improved administration of pre and post screening assessments.

Program Updates

For Fiscal Year 2019/20, the Lift Program intends to increase collaborative efforts with San Bernardino County Transition Assistance Department, Probation Department and other local agencies to increase referrals of mothers to the Lift Program.

Collaborative Partners

- Los Angeles County Child and Family Services (CFS)
- San Bernardino County Child and Family Services (CFS)
- San Bernardino County Homeless Coalition
- San Bernardino County Juvenile Probation

Artwork by Manuel Cordoba

Coalition Against Sexual Exploitation (CASE) (PEI SE-6)

The San Bernardino County Coalition Against Sexual Exploitation (CASE) is a partnership of public and private entities who have joined together to develop resources in the County to educate, prevent, intervene, and treat victims of commercial sexual exploitation. CASE consists of two main components: training/ education/outreach and direct services. The CASE Team is comprised of staff from multiple departments which combine efforts to reduce the number of commercially sexually exploited children (CSEC). CASE provides services that include:

- Mental health assessments
- Crisis intervention
- Case management, including linkage and referrals
- School enrollment assistance
- Therapeutic interventions
- Transportation assistance
- Placement
- Outreach and community awareness training on commercial sexual exploitation of children

Target Population:

- Children: ages 0-15
- TAY: ages 16-25

Projected Number to be Served:

- FY 2019/20:
  - ◊ 10 Children
  - ◊ 75 TAY
  - ◊ 3,000 Adults

MHSA Legislative Goals and Related Key Outcomes

- Reduce stigma and discrimination associated with mental illness:
  - ◊ Reduce negative feelings, attitudes, beliefs, perceptions, stereotypes, and/or discrimination related to having a mental illness, being diagnosed, or seeking services.
  - ◊ Increase acceptance, dignity, inclusion and equity for individuals with mental illness and members of families.

- Improve timely access to services for underserved populations:
  - ◊ Increase extent to which an individual or family from an underserved population who needs Mental Health services because of risk or presence of a mental illness receives appropriate services as early in onset as practicable.
- Reduced prolonged suffering associated with untreated mental illness:
  - ◊ Reduce risk factors.
  - ◊ Reduce indicators.
  - ◊ Increase protective factors that may lead to improved mental, emotional, and relational functioning.
- Increase early access and linkage to medically necessary care and treatment:
  - ◊ Connect children, adults and seniors with severe mental illness, as early in the onset of these conditions as practicable, to medically necessary care and treatment, including but not limited to, care provided by county mental health programs.

Positive Results

The CASE Program utilizes community based and evidenced-based approaches, which have been found to yield positive results over time, to address the unique characteristics and needs of the target population. Such approaches include case management, referrals and linkage, multidisciplinary team meetings and collaboration, Commercial Sexual Exploitation of Children (CSEC) trainings, and community outreach presentations.

CASE served a total of **59** unduplicated participants and provided **590** total direct services. The CASE team participated in several resource fairs, and hosted and facilitated trainings with partnering agencies. CASE was able to reach **1,568** potential responders (i.e., family members, primary health care providers, nurses, school personnel, etc.) and prepare them with the necessary tools needed to identify and appropriately respond to the needs of this population.

Outcomes for Outreach for Increasing Recognition of Early Signs of Mental Illness

The program provided outreach services to 1,586 potential responders in FY 2017/18. Outreach services were held at the following locations:

Outreach Settings
Community Resource Fairs
CASE Hosted Trainings
Social Media Platforms Facebook www.facebook.com/sanbernardinocase Instagram @sanbernardinocase

The CASE team has focused on educating the community and partner agencies that provide services to children on the signs and appropriate responses to victims of sexual exploitation. CASE provided several community trainings throughout San Bernardino County as well as technical assistance trainings specifically targeted for potential responders, including educational sessions at several conferences and community events targeting children, youth, and sexual exploitation awareness. They also had resource tables at many local events and resource fairs.

In addition, CASE was available for informational in-service staff meetings for education and child welfare professionals. During FY 2017/18, CASE continued to utilize social media platforms (Facebook and Instagram) as a way to connect with potential responders, at risk youth, and the public.

Through the program's outreach efforts, CASE reached the following type of responders:

Potential Responders		
Attorneys	Advocates	College Students
Community members	Probation officers	Educators
Medical students	High school students	Law enforcement
Foster parents and group home staff	Faith-based community members	Mental health service providers
Community service providers	Service clubs and organizations	Social workers and other child welfare staff

Total number of participants served by program

The following table represents the total number of services provided in the program and the number of unduplicated participants served in FY 16/17 and FY 17/18. The number of unduplicated participants represents the number of individuals who were new to the program during the fiscal year.

Number of Participants Served		
	FY 2016/17	**FY 2017/18**
Number of Unduplicated Participants (Direct Services)	67	59
Number of Services Provided (Direct Services)	374	590
Number of Unduplicated Participants (Outreach and Education)	1,571	499
Number of Services Provided (Outreach and Education)	2,459	1,568

Artwork by Shelby Nash

Fiscal Year 2016/17 and 2017/18

Program Demographics

		FY 16/17	FY 17/18
Assigned Sex at Birth	Male	1%	25%
	Female	99%	52%
	Declined to Answer	0%	23%
Age	Child 0-15	40%	11%
	TAY 16-25	60%	18%
	Adult 26-59	0%	46%
	Older Adult 60+	0%	2%
	Declined to Answer	0%	23%
Primary Language Used	English	73%	81%
	Spanish	0%	1%
	Other	27%	18%
	Declined to Answer	0%	0%

		FY 16/17	FY 17/18
Veteran	U.S. Military Veteran - Yes	0%	0%
	U.S. Military Veteran - No	100%	6%
	Declined to Answer	0%	94%

Fiscal Year 2016/17 and 2017/18

Program Demographics

		FY 16/17	FY 17/18
Disability	Difficulty seeing	33%	20%
	Difficulty hearing or having speech understood	8%	4%
	Other	16%	9%
	Cognitive Disability	0%	2%
	Physical/mobility domain	3%	2%
	Chronic health condition (including but not limited to chronic pain)	3%	3%
	No	0%	60%
	Declined to Answer	37%	0%

		FY 16/17	FY 17/18
Sexual Orientation	Gay or Lesbian	1%	0%
	Queer	0%	0%
	Bisexual	0%	0%
	Another Sexual Orientation	0%	0%
	Heterosexual or Straight	0%	63%
	Questioning or Unsure of Sexual Orientation	0%	2%
	Declined to Answer	99%	35%

Fiscal Year 2016/17 and 2017/18

Program Demographics

		FY 16/17	FY 17/18
Race	American Indian or Alaskan Native	0%	0%
	Asian	0%	2%
	Black or African American	79%	32%
	Native Hawaiian or Pacific Islander	0%	1%
	White (Caucasian)	5%	50%
	More than one race	0%	1%
	Other race	0%	11%
	Declined to Answer	16%	3%
Hispanic or Latino Ethnicity	Caribbean	0%	0%
	Central American	0%	0%
	Mexican/Mexican-American/Chicano	16%	43%
	Puerto Rican	0%	0%
	South American	0%	0%
	Other Hispanic or Latino Ethnicity	0%	0%
	Declined to Answer	84%	57%
Ethnicity	African	0%	0%
	Asian Indian/South Asian	0%	0%
	Cambodian	0%	0%
	Chinese	0%	8%
	Eastern European	0%	2%
	European	0%	6%
	Filipino	0%	6%
	Japanese	0%	2%
	Korean	0%	0%
	Middle Eastern	0%	2%
	Vietnamese	0%	6%
	Other	0%	6%
	More than one ethnicity	0%	62%
	Declined to Answer	100%	0%

Success Stories

"Nicole" is a teen who was known to both the Probation and Child and Family Services (CFS) agencies. She came to the attention of the CASE team due to her extensive needs of placement, therapy and legal assistance. The CASE team provided several supports to Nicole including referrals to advocacy services. A survivor advocate from Open Door reached out to Nicole and developed a mentoring bond. The advocate was able to help secure approval from CFS and Probation for a specialized placement. Additional supports and interventions were provided to Nicole at her new placement. Stabilizing Nicole's living arrangements helped the treatment team focus on other areas of concern. In a 30 day period Nicole has attended school daily and started participating in school and placement social activities. Nicole is now much happier and can see a positive future for her life.

"Amy", was referred to the Public Defenders office after experiencing some legal issues related to human trafficking. Initially, Amy was hesitant to speak with the Public Defender Social Worker (PDSW) and did not understand why she had to meet with her. Amy had a history of drug abuse and reconnecting with the people that hurt her. Over time, the social worker built a rapport with Amy, establishing a healthy bond with Amy which allowed her to further treatment services.

Amy became comfortable with seeking help and reached her goals. The CASE multi-disciplinary team was able to help Amy obtain a driver's license, complete her GED, and enroll in college. Amy attends college, she is working on her relationship with her family, and has stable housing. She stated that she never felt so supported by so many people. She appreciates the team.

Challenges

A continuous challenge for the CASE program is finding safe and appropriate placements for sexually exploited children and youth. This population often has mental health and/or substance abuse issues, frequently flees from placement, may display aggressive behaviors, and may have an exacerbated mistrust of authority figures. There are few placement options in San Bernardino County that have staff with the necessary skills and resources to house and treat this population.

Solutions in Progress

CASE continues to collaborate with other county agencies, such as Probation and Children and Family Services, to work actively with foster and/or adoptive resource families and group homes to house CASE participants and provide in-placement therapeutic services in attempts to stabilize the youth.

The CASE steering committee, comprised of the various county department heads, is working collaboratively to address the logistics and mitigate barriers created by department regulations and funding policies to assist the CASE MDT members in securing additional placements options.

Program Updates

There are currently no planned program or budget changes for Fiscal Years 2019/20.

Collaborative Partners

- San Bernardino County, Department of Public Health
- San Bernardino County, Department of Children and Family Services
- San Bernardino County, Children's Network
- San Bernardino County, District Attorney's Office
- San Bernardino County, Department of Probation
- San Bernardino County, Public Defender's Office
- San Bernardino County, Sheriff's Department
- San Bernardino County, Superintendent of Schools
- Superior Court of California – Juvenile Court Division
- The Open Door – Human Trafficking Department

Family Resource Centers (PEI CI-2)

Family Resource Centers (FRCs) offer prevention and early intervention services at **14** different sites located within local community areas. Because services are offered in their respective communities, services are tailored to meet the identified needs of the community. In addition, this connection to the community allows the Family Resource Centers to offer services in culturally and linguistically competent ways. This increases the likelihood that community members will use the services, while reducing stigmatizing attitudes associated with behavioral health services.

The Family Resource Center is categorized as a State Prevention and State Early Intervention program and implements the State strategies of Improving Timely Access for Underserved Populations, Access and Linkage to Treatment, and Non-Discriminatory and Non-Stigmatizing practices.

This program serves all ages utilizing various effective methods which include evidence-based, promising practices, and community-based services which include:

- Adult skill-based education
- After-school programs for children, youth, and transitional age youth (TAY)
- Behavioral health educations workshops
- Cognitive Behavioral Therapy
- Communities That Care Model
- Counseling and therapy activities for all ages and cultural backgrounds
- Maternal mental health
- NCTI® Crossroads® and Real Colors ® Education
- Parent/caregiver support and education
- Personal development activities
- Social Work Model
- Strategic Family Therapy
- Strengthening Families Program
- Trauma Focused Cognitive Behavioral Therapy

Target Population:

- Children: ages 0-15
- TAY: ages 16-25
- Adults: ages 26-59
- Older Adults: ages 60+

Projected Number to be Served:

- FY 2018/19:
  - ◊ 7,000 Children
  - ◊ 4,000 TAY
  - ◊ 13,245 Adults
  - ◊ 2,700 Older Adults

MHSA Legislative Goals and Related Key Outcomes

- Increase early access and linkage to medically necessary care and treatment:
  - ◊ Connect children, adults, and seniors with severe mental illness to care as early in the onset of these conditions as practicable, to medically necessary care and treatment, including, but not limited to, care provided by county mental health programs.
- Increase recognition of early signs of mental illness:
  - ◊ Identify early signs of potentially severe and disabling mental illness.
  - ◊ Provide support to individuals with mental illness.
  - ◊ Recognize own symptoms.
  - ◊ Refer individuals who need treatment or other mental health services.
  - ◊ Respond to symptoms.
- Improve Timely Access to Services:
  - ◊ Increase extent to which individuals or families from underserved populations who need mental health services because of risk or presence of mental illness receives appropriate services as early in onset as practicable.
- Reduce prolonged suffering associated with untreated mental illness:
  - ◊ Reduce risk factors.
  - ◊ Reduce indicators.
  - ◊ Increase protective factors that may lead to improved mental, emotional, and relational functioning.
- Reduce symptoms:
  - ◊ Improve recovery, including mental, emotional, and relational functioning.
- Reduce stigma and discrimination associated with mental illness:
  - ◊ Reduce negative feelings, attitudes, beliefs, perceptions, stereotypes, and /or discrimination related to having a mental illness, being diagnosed or seeking services.
  - ◊ Increase acceptance, dignity, inclusion and equity for individuals with mental illness and members of their families.

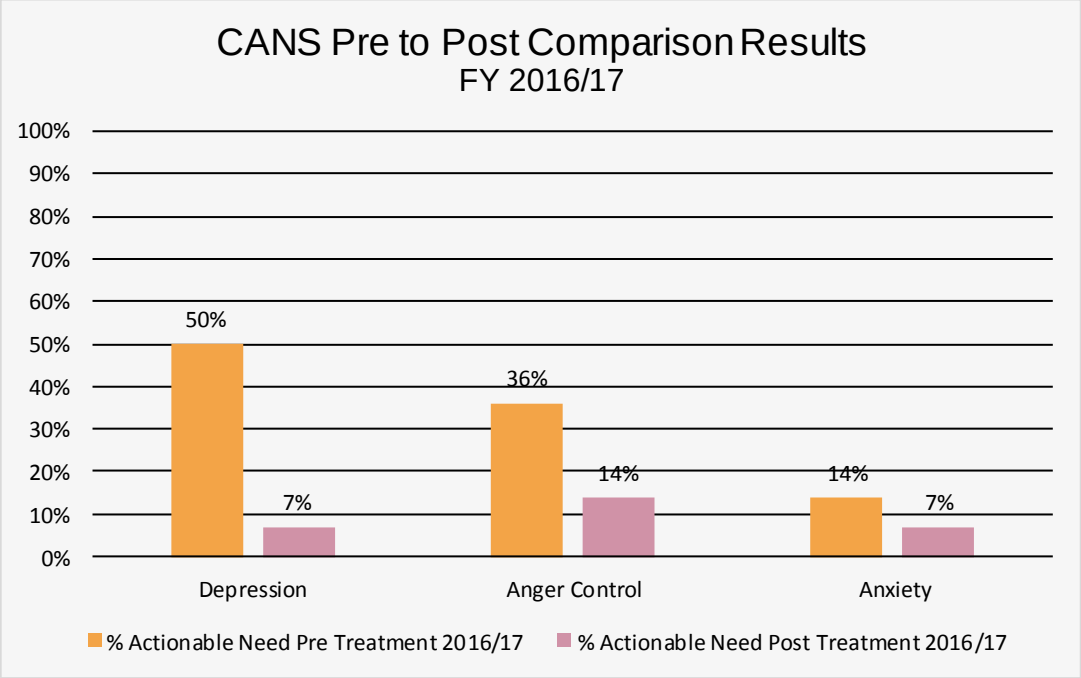
Positive Results

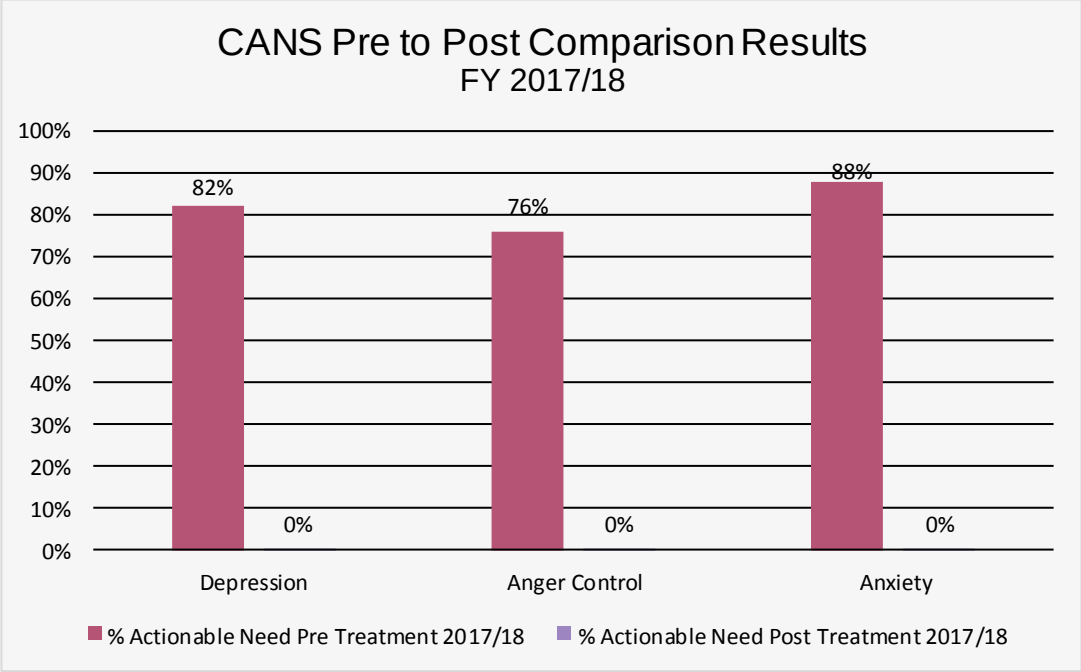
Early Intervention

The Family Resource Centers use the Child Adolescent Needs and Strengths (CANS) and the Adult Needs and Strengths Assessments (ANSA) as the primary method of identifying clients' needs and strengths at the onset of services and through the duration of treatment. These assessments are used to inform client treatment planning and allow the agency to track client progress.

The graphs below illustrate a sampling of the Child Adolescent Needs and Strengths (CANS) administered to Family Resource Center participants. The graphs compare the proportion of clients who had an actionable need in a particular CANS item at intake with the proportion of those who still had that same need at discharge. A lower post score indicates a decreased need for intervention in that category.

These results suggest that clients who participated in the Family Resource Center Early Intervention program significantly reduced or resolved needs in depression, anger control, and anxiety domains by discharge.

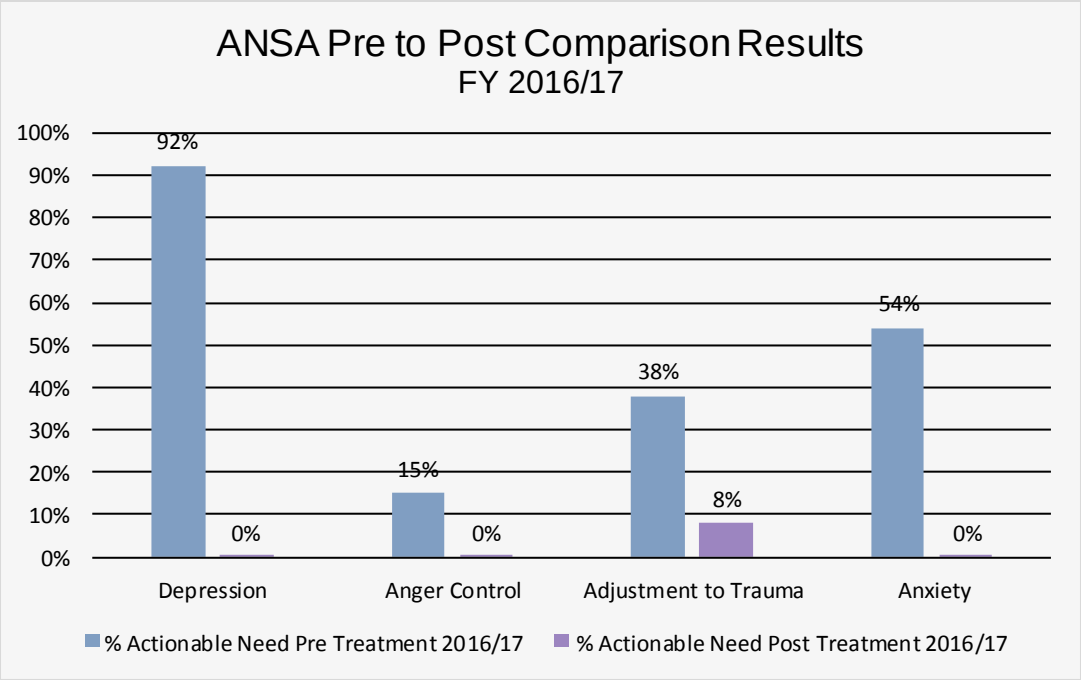


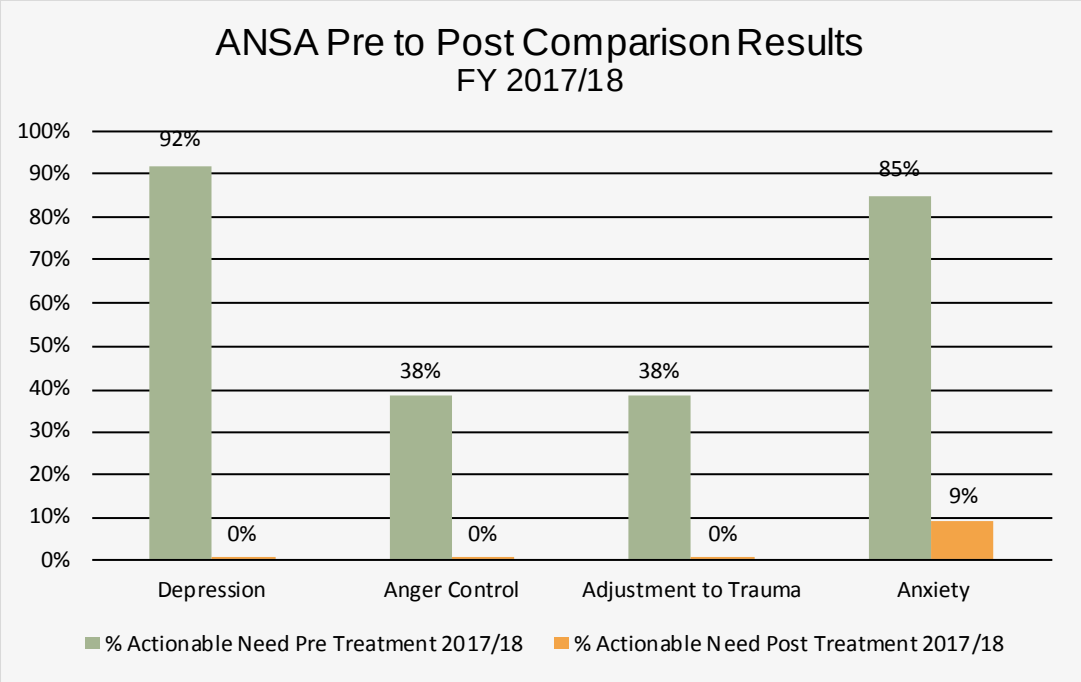


Artwork by Karina Rodriguez Torres

The following graphs are a sampling of the Adult Needs and Strengths Assessments (ANSA) that were administered to adult Family Resource Center participants. The pre and post assessments compare the proportion of clients who had an actionable need for intervention in areas of depression, anger control, adjustment to trauma, or anxiety at intake with the proportion of clients who still had an actionable need at discharge.

As shown in the graphs on the following page, Family Resource Center participants significantly reduced their need for continuing intervention in all four of these key areas.


ANSA Pre to Post Comparison Results
FY 2016/17
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
92%
0%
15%
0%
38%
8%
54%
0%
Depression
Anger Control
Adjustment to Trauma
Anxiety
% Actionable Need Pre Treatment 2016/17
% Actionable Need Post Treatment 2016/17


ANSA Pre to Post Comparison Results
FY 2017/18
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
92%
0%
38%
0%
38%
0%
85%
9%
Depression
Anger Control
Adjustment to Trauma
Anxiety
% Actionable Need Pre Treatment 2017/18
% Actionable Need Post Treatment 2017/18

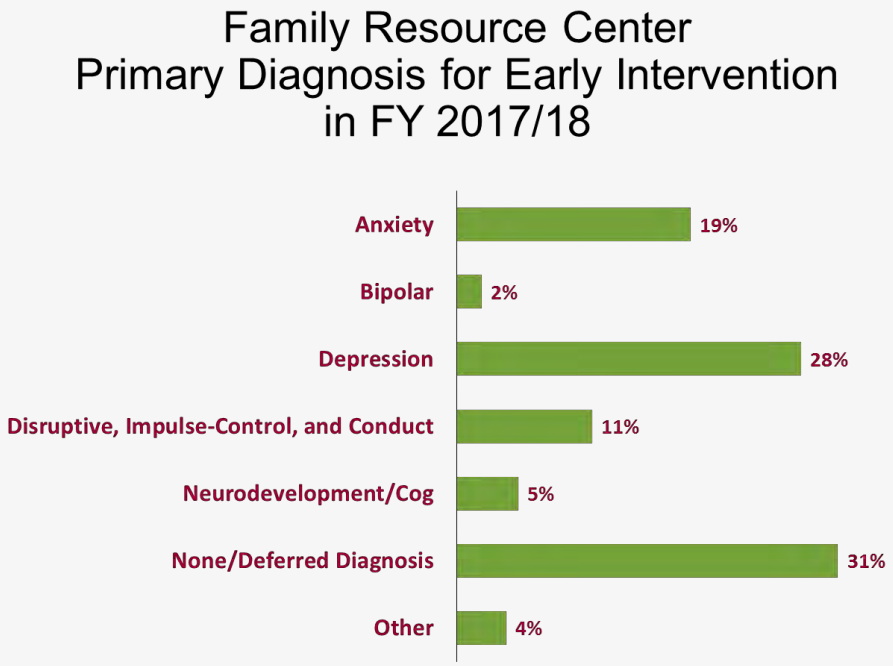
The Life Skill Progression is an outcome measurement and intervention planning tool designed specifically for use with parents during pregnancy and early parenting. It shows strengths, needs and progress in the areas of relationships, education & employment, parent & child health, mental health & substance abuse, and basic essentials.

As shown below, participants made progress by showing positive improvements in all areas. The most significant improvements were made in the Mental Health areas of suicide and depression where positive improvement increased by 60.2% and improvement in mental health had increased by 68.4%. Participants indicated that signs and symptoms of depression had decreased and mental wellness had increased.

Life Skills Progression Pre and Post Results
FY 2017/18

	Scales		Pre	Post	Improvement	Change
Relationships	1	Family	3.01	3.44	+.43	14.1%
	2	Boyfriend, FOB, or Spouse	2.8	2.96	+.16	5.5%
	3	Friends/Peers	2.48	3.02	+.53	21.4%
	5	Nurturing	3.3	3.74	+.45	13.6%
	6	Discipline	3.34	3.68	+.34	10.2%
	7	Development	3.07	3.47	+.39	12.7%
	8	Safety	4.14	4.47	+.32	7.8%
	9	Home Visitor	3.02	3.76	+.74	24.6%
Resources	10	Use of Information	3.05	3.79	+.74	24.2%
	11	Use of Resources	2.89	3.67	+.79	27.3%
	15	Employment	1.74	2.02	+.28	15.9%
Medical	18	Parent Sick Care	2.96	3.18	+.22	7.6%
	20	Child Well Care	3.77	4.11	+.35	9.2%
	21	Child Sick Care	3.75	4.11	+.36	9.7%
	22	Child Dental Care	3.76	4.08	+.32	8.5%
	23	Child Immunizations	4.71	4.74	+.02	0.5%
Mental Health	26	Depression/Suicide	2.73	4.37	+1.64	60.2%
	27	Mental Illness	2.74	4.61	+1.87	68.4%
Basic Essentials	30	Housing	3.12	3.63	+.51	16.2%
	31	Food/Nutrition	2.91	3.14	+.23	8.0%
	32	Transportation	3.7	3.78	+.07	2.0%
	33	Medical/Health Insurance	2.54	2.61	+.07	2.7%
	34	Income	2.2	2.36	+.16	7.2%
	35	Child Care	1.34	1.51	+.16	12.3%

The following table illustrates the percentage of FRC participants by diagnostic groups. The majority of FRC participants, 31%, were placed in the category of none/ deferred diagnosis. A deferred diagnosis is a temporary diagnosis given to a participant who is pending further assessment. The participant's diagnosis will then be updated to reflect their actual diagnosis, or remain at none. Closely following this group, 28% of participants were diagnosed with depression, and 19% with anxiety.



In FY16/17, **91%** of participants met or partially met treatment goals. In FY 17/18, **85%** of participants met or partially met treatment goals. The most common reason for participants to not meet treatment goals was due to not completing the program. The most common reasons individuals did not complete treatment included relocation or transportation issues.

On average participants of the FRC program had an open Early Intervention case for **111** days in FY 2017/18. Of those **111** days (approximately 3 1/2 months) participants had **11** days of direct services with an average of **846** cumulative minutes of services (approximately 14 hours).

In FY 16/17, participants had Early Intervention cases open for an average of **84** days (approximately 3 months) and had **7** days of direct services with an average of **629** cumulative minutes of services (approximately 11 hours).

Duration of Treatment	FY 2016/17	FY 2017/18
Average Number of Cumulative Minutes	629	846
Average Length of Time in Days from Episode Opening to Episode Closing	84	111
Average Number of Days	7	11

Prevention Program Outcomes for FY 2016/17 and FY 2017/18

In fiscal year 2017-2018, Family Resource Centers conducted many prevention activities within the community. Several of the activities are shown in the table below:

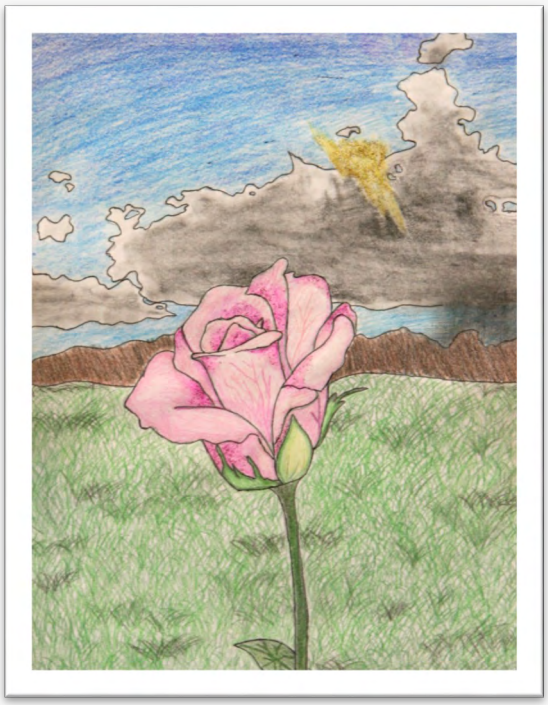
Prevention Activity	Description	Completion Rate
Health and Wellness for Mommies	Support group for mothers	80%
Empowerment for African American Mommies	Support group for African American mothers	10%
Yo Soy Importante	Support group for Hispanic women	100%
Padres Carinos	Spanish nurturing parenting group	85%
Nurturing Parenting	Parenting group	100%
One Heart Two Homes	Co-parenting group	100%
Personal Power for Girls	Support group for girls 6-9 years old	60%
Personal Power for Boys	Support group for boys 6-9 years old	50%
Seven Habits for Teens	Support group for teens 12-15 years old	90%

Outcomes for Access and Linkage to Treatment Strategy

During the fiscal year 2017/2018, **149** participants were referred to a higher level of care. The average duration of untreated mental illness was calculated as **1.17days.**

The following table illustrates Access and Linkage to Treatment outcomes:

Access and Linkage to Treatment Outcomes	
Individuals with a serious mental illness referred to treatment	149
Individuals who followed through on referral	61
Average duration of untreated mental illness	1.17 days
Average interval between referral and participation in treatment	23 days



Artwork by Mikaylla Davis

Outcomes for Improve Timely Access to Service

The Family Resource Center program provided services to the following underserved populations in the fiscal year 2017/18.

Underserved Populations	
African American	Asian
Children & Youth at Risk for School Failure	Children & Youth at Risk of or Experiencing Juvenile Justice Involvement
Children & Youth in Stressed Families	Children at Risk of Removal from Home Due to Severity of Illness
Co-occurring	Foster Children / Former Foster Children
Individuals Experiencing Onset of Serious Psychiatric Illness	Latino
LGBTQ	Military / Veteran
Native American	Pacific Islander
Trauma Exposed Individuals	Victims of Human Trafficking

FRCs referred **435** participants to Prevention activities and **286** participants followed through on the referral. FRCs also referred **664** participants to Early Intervention activities with **517** participants following through on the referral .

Outcomes for Outreach for Increasing Recognition of Early Signs of Mental Illness

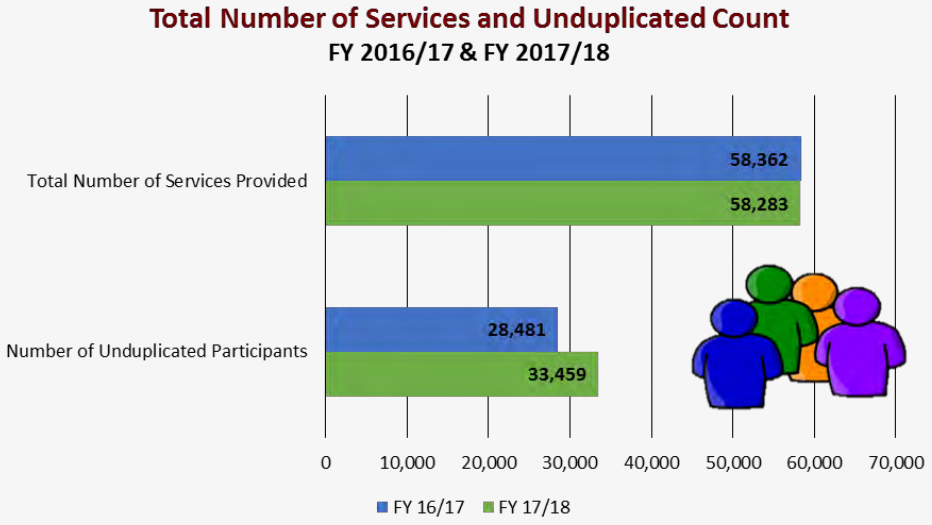
Family Resource Centers use a variety of ways to engage new participants and educate potential responders on the signs and symptoms of mental illness and how to receive appropriate services.

During FY 2017/18, FRC providers hosted community resource fairs, participated in several community outreach events, hosted mental health workshops, clothing closets, and food drives.

In fiscal year 2017/2018, Family Resource Centers reached **7,412** potential responders in the following settings:

Outreach Settings	
Behavioral Health Clinics	Community Based Organization Facilities
Community Events	County Facilities
Family Resource Centers	Primary Health Care Centers
Recreation Centers	Residences
Schools	Senior Centers

Family Resource Centers provided **58,283** services to **33,459** unduplicated participants who were new to the Family Resource program during the fiscal year. The graph below shows a comparison of the total number of unduplicated participants and number of services provided during the fiscal years 2016/17 and FY 2017/18.



Fiscal Year 2016/17 & 2017/18

Program Demographics

The demographic data collected for the Family Resource Center program during FY 2016/17 and FY 2017/18 is presented below representing the demographics of the participants who chose to complete the survey.

		FY 16/17	FY 17/18
Assigned Sex at Birth	Male	29%	35%
	Female	47%	53%
	Declined to Answer	24%	12%
Age	Child 0-15	19%	22%
	TAY 16-25	7%	12%
	Adult 26-59	52%	51%
	Older Adult 60+	10%	10%
	Declined to Answer	12%	5%
Primary Language Used	English	53%	70%
	Spanish	36%	29%
	Other	0%	1%
	Declined to Answer	11%	0%

		FY 16/17	FY 17/18
Veterans	U.S. Military Veteran - Yes	0%	1%
	U.S. Military Veteran - No	29%	29%
	Declined to Answer	71%	70%

Fiscal Year 2016/17 & 2017/18

Program Demographics

		FY 16/17	FY 17/18
Disability	Difficulty seeing	1%	1%
	Difficulty hearing or having speech understood	1%	0%
	Other	0%	0%
	Cognitive Disability	1%	1%
	Physical/mobility domain	1%	1%
	Chronic health condition (including but not limited to chronic pain)	1%	1%
	No	19%	17%
	Declined to Answer	76%	79%

		FY 16/17	FY 17/18
Sexual Orientation	Gay or Lesbian	0%	1%
	Queer	11%	1%
	Bisexual	0%	2%
	Another Sexual Orientation	0%	1%
	Heterosexual or Straight	11%	68%
	Questioning or Unsure of Sexual Orientation	0%	1%
	Declined to Answer	78%	26%

Fiscal Year 2016/17 & 2017/18

Program Demographics

		FY 16/17	FY 17/18
Race	American Indian or Alaskan Native	0%	2%
	Asian	0%	1%
	Black or African American	14%	18%
	Native Hawaiian or Pacific Islander	1%	0%
	White (Caucasian)	21%	27%
	More than one race	2%	4%
	Other race	27%	28%
	Declined to Answer	35%	20%
Hispanic or Latino Ethnicity	Caribbean	0%	0%
	Central American	0%	1%
	Mexican/Mexican-American/Chicano	33%	19%
	Puerto Rican	0%	0%
	South American	2%	2%
	Other Hispanic or Latino Ethnicity	44%	60%
	Declined to Answer	21%	18%
Ethnicity	African	4%	5%
	Asian Indian/South Asian	0%	1%
	Cambodian	0%	0%
	Chinese	0%	0%
	Eastern European	0%	0%
	European	2%	3%
	Filipino	0%	0%
	Japanese	0%	0%
	Korean	0%	0%
	Middle Eastern	0%	0%
	Vietnamese	0%	0%
	Other	8%	19%
	More than one ethnicity	2%	2%
	Declined to Answer	84%	70%

Success Story

"Julieta" came to the Family Resource Center for help for herself and for her seven-year-old daughter, "Anna". Anna had witnessed a traumatic event and was having difficulties with fear.

Julieta was referred to PEI counseling services for early intervention sessions. These early intervention sessions were successful and Anna exited counseling having met all of the identified goals.

Julieta indicated that she had been suffering from depression, but self-care had taken a backseat to everyday life pressures. Julieta was referred to counseling sessions of her own to help her access mental health services and to get the support and counseling she needed for her depression.

Challenges

Family Resource Center providers noted three main areas of challenges during the previous fiscal year. One area is in maintaining adequate staff due to changes and staff turnover. Another challenge was incorporating changes to PEI regulations into existing service reporting models. The third challenging area was in obtaining appropriate referrals and authorizations for children to participate in treatment services.

Solutions in Progress

Solutions to the staffing challenge included new recruiting to maintain a full staff and cross-training staff to provide coverage during any shortage periods.

Service providers updated internal reporting methods to incorporate regulation changes and capture service data more effectively.

Representatives from partner organizations were trained to provide a conduit for mental health and case management services, and to work with parents to reduce stigma and help the parents feel more comfortable authorizing treatment.

Program Updates

Beginning FY 2018/19, the NCTI® Crossroads® Education program will no longer be funded as a stand-alone PEI program and will be integrated into other PEI programs. The FRC program is one of the programs to that has integrated the NCTI curriculum into its program services delivery model. Outcomes for NCTI curriculum provided in the Family Resource Center program will be reported in this section in the future.

Artwork by Margaret Garcia

Collaborative Partners

- Anti-Bullying Task Force
- Barstow Senior Center
- Borrego Health
- Boys and Girls Club
- Centro de Consejeria Familiar
- Children are Our Future Resource Fair
- Council on Aging-Southern California
- Desert Manna Homeless Shelter
- Eagle's Nest Community Service
- El Sol Neighborhood Educational Services
- Greater Hope Foundation
- La Poderosa
- Lighthouse Social Services
- Mercy House
- Morongo Basin Community Health Care District
- New Hope Family Life Center
- Option House Inc.
- Options for Youth
- Our Lady of Hope Parish
- San Bernardino Sexual Assault Services
- Silver Valley Unified School District
- St. John of God Health Care Services
- St. Mary's Hospital
- Supremo Llamamiento Ministerio
- Telacu
- TruEvolution
- Unidos por la Musica
- Unity Home
- Valenta, Inc.
- Vida Life Ministries

Community Wholeness and Enrichment (SE-3)

The Community Wholeness and Enrichment (CWE) Program is a State Prevention Program and Early Intervention Program. It provides mental health services to Transitional Age Youth (TAY) ages **16-25**, adults ages **26-59**, and family members of those living with a behavioral health condition. The CWE Program provides services that include, but are not limited to:

- Screenings and assessments
- Case management, linkage, and referrals
- Support groups (including suicide bereavement)
- Psychoeducation to support individuals living with a mental health condition and their families
- Therapeutic mental health and counseling for individuals, couples, and families using evidence-based practices
- Educational presentations and trainings to potential responders about ways to recognize and respond effectively to the early signs of mental health conditions.

CWE providers utilize a variety of evidence-based practices (EBPs) that are supported by research and have demonstrated effectiveness.
Some EBPs used by CWE providers include:

- Cognitive Behavioral Therapy
- Dialectical Behavioral Therapy
- Community Resilience Model
- Internal Family Systems Therapy
- Psychodynamic Therapy
- Seeking Safety
- Solution-Focused Brief Therapy
- Narrative Therapy

Target Population:

- TAY: ages 16-25
- Adults: ages 26-59

Projected numbers to be served:

- FY 2019/20:
  - ◊ 1,013 Adults
  - ◊ 2,990 TAY

Curricula, such as Applied Suicide Intervention Skills (ASIST), safeTALK, suicideTALK, Mental Health First Aid, and National Curriculum Training Institute's Adult Cognitive Life Skills®, are also used in CWE's educational and training services.

Various assessment tools and outcome measures are utilized to track participants' progress in the program. One such tool, the Adults Needs and Strengths Assessment (ANSA), is designed to provide a profile of the needs and strengths of adults and is completed by clinical staff when a case is opened and at the end of treatment. The ANSA is used in support of treatment planning, as well as in measuring outcomes.

MHSA Legislative Goals and Related Key Outcomes

- Improve timely access to services for underserved populations:
  - ◊ Increase the extent to which individuals or families from underserved populations who need mental health services because of risk or presence of a mental illness receives appropriate services as early in onset as practicable.
- Increase early access and linkage to medically necessary care and treatment:
  - ◊ Connect children, adults, and older adults with severe mental illness to care as early in the onset as practicable to medically necessary care and treatment including, but not limited to, care provided by county mental health.
- Reduce prolonged suffering associated with untreated mental illness:
  - ◊ Reduce risk factors
  - ◊ Reduce indicators
  - ◊ Increase protective factors that may lead to improved mental emotional, and relational functioning
  - ◊ Reduce symptoms, and
  - ◊ Improve recovery including emotional and relations functioning.
- Reduce stigma and discrimination associated with mental illness:
  - ◊ Reduce negative feelings, attitudes, beliefs, perceptions, stereotypes, and/or discrimination related to having a mental illness, being diagnosed, or seeking services.
- Increase acceptance, dignity, inclusion, and equity for individuals with mental illness and members of families.

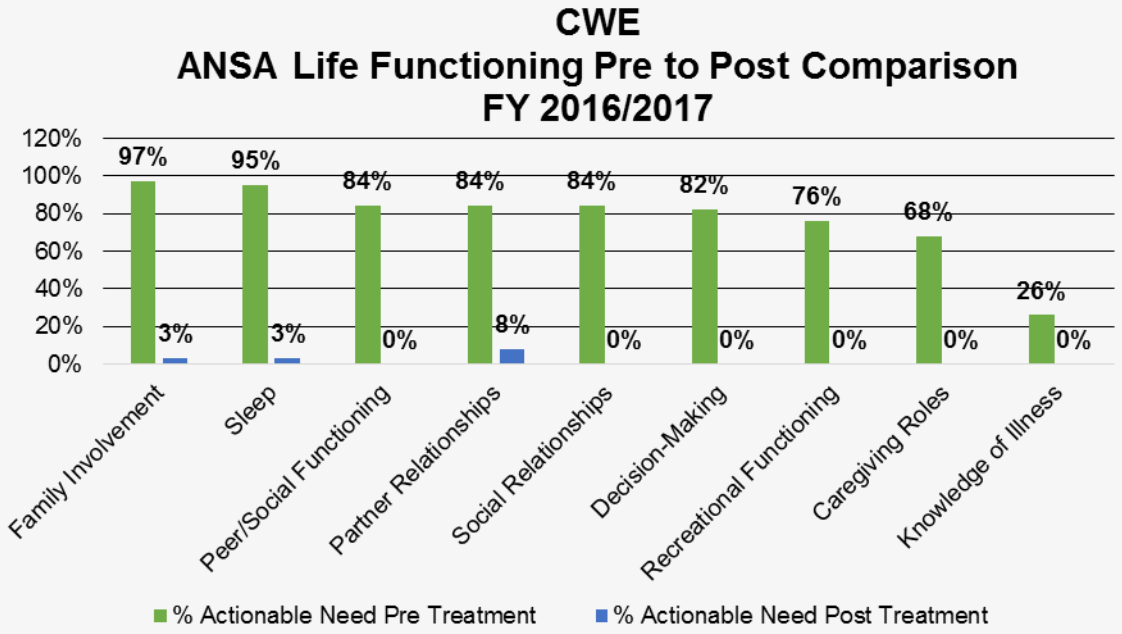
Positive Results

Early Intervention

The CWE Program uses the Adult Needs and Strengths Assessment-San Bernardino (ANSA-SB) which is a comprehensive assessment of psychological and social factors for use in treatment planning. ANSA-SB is a multi-purpose tool developed for adult behavioral health services. It is used in adult individual treatment plans to measure functioning in several important life domains. ANSA-SB also helps to support clinical decision making, determining the appropriate level of care, and service planning, as well as facilitating quality improvement initiatives and allowing for the monitoring of outcomes and services. ANSA-SB is also used to ensure projected goals are being met.

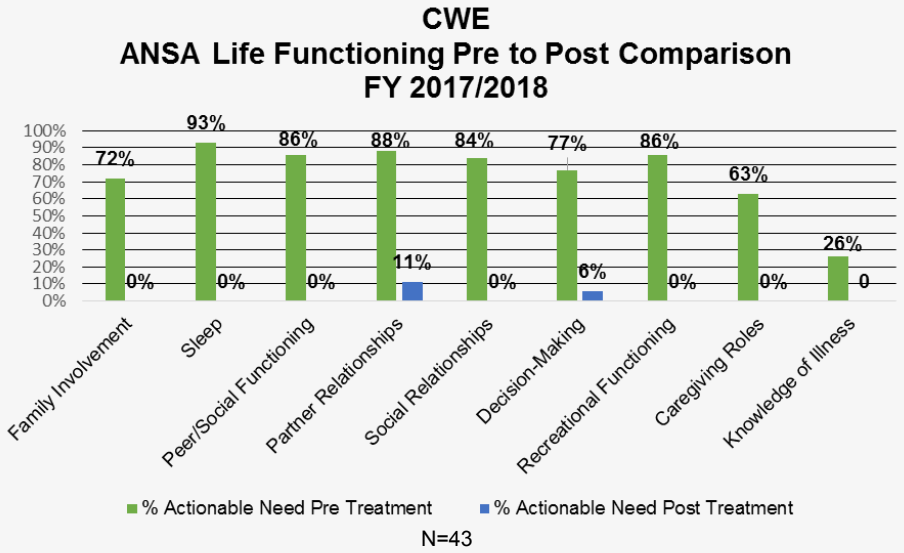
Adult Early Intervention clients served during the fiscal year were assessed using ANSA-SB upon intake and discharge. Comparison data from initial to planned discharge were analyzed using the Impact Outcomes report. Below are results that demonstrate clients' improvement in areas of life functioning, mental health needs, and strengths. The graphs compare the proportion of clients who had an actionable need in a given ANSA-SB item at intake with the proportion of those who still had an actionable need at discharge. These results suggest that clients who participated in the CWE program significantly reduced their needs in various items of life functioning, including: family, peer/social, and recreational functioning, sleep, partner and social relationships, caregiving roles, decision-making, and knowledge of illness.

The following graphs demonstrate data for FY 2016/2017 and FY 2017/2018 in areas of life functioning, mental health, and strengths.



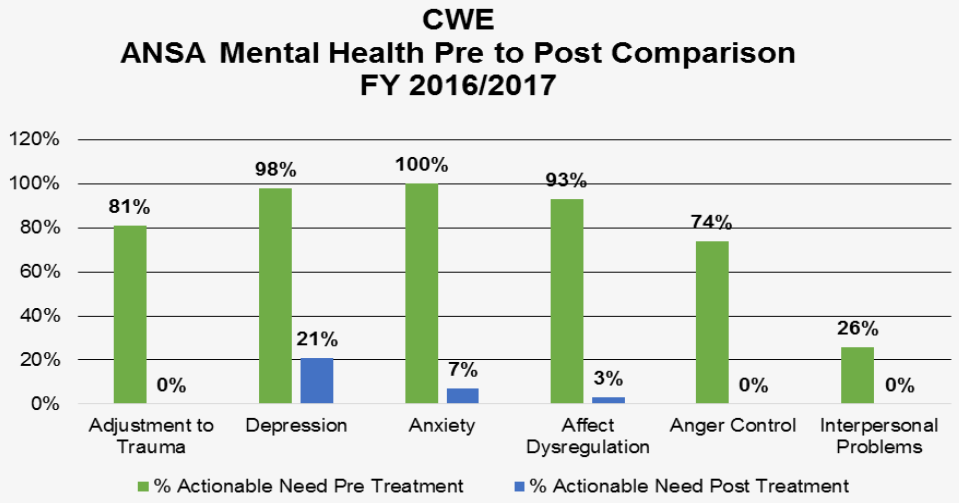
N=38

ANSA-SB results in the area of life functioning in FY 2016/17 show 3% of participants maintained family involvement and sleep as an actionable need, reduced from 97% and 95% respectively. In the category of partner relationships, 8% still had an actionable need reduced from 84%. In the remaining categories of peer/social functioning, social relationships, decision-making, recreational, caregiving roles, and knowledge of illness, 0% of participants had an actionable need post treatment.



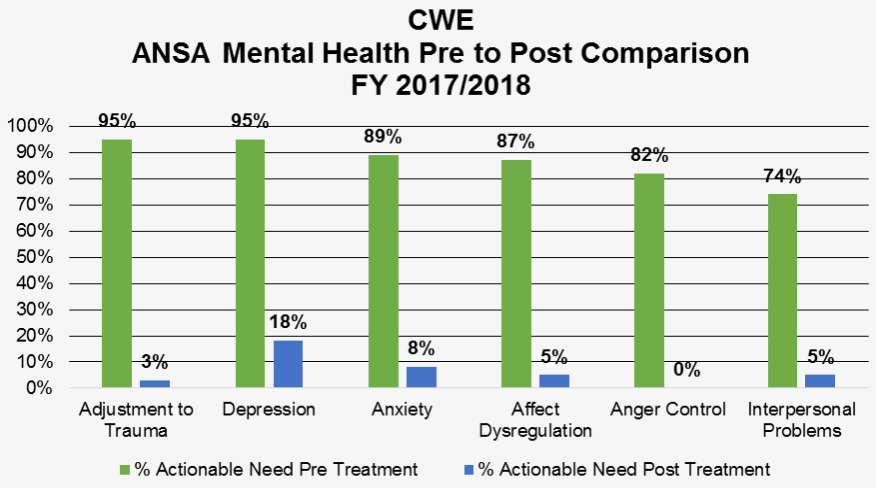
N=43

For FY 2017/18, in the category of partner relationships, 88% of participants had an actionable need pre treatment while only 11% maintained an actionable need post treatment. In the category of decision-making, 77% had an actionable need pre treatment, but only 6% still had this need post treatment. In the categories of family involvement, sleep, peer/social functioning, social relationships, recreational, caregiving roles, and knowledge of illness, 0% of participants maintained an actionable need post treatment.



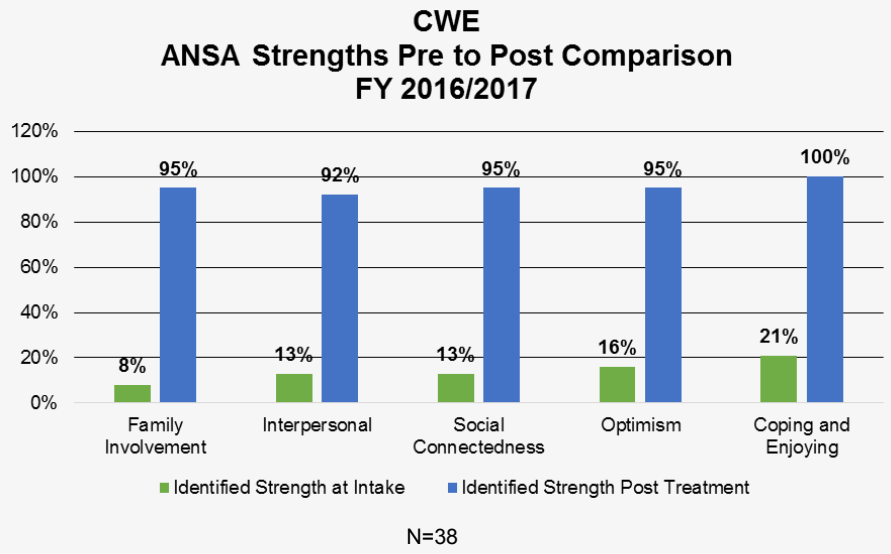
N=38

For the ANSA-SB results in the area of mental health, results show for FY 2016/17, 98% of participants in the category of depression had an actionable need reduced to 21% post treatment. In the category of anxiety, 100% of participants had an actionable need reduced to 7%. For the category of affect dysregulation, 93% had a need reduced to 3%. In the categories of adjustment to trauma, anger control, and interpersonal problems, actionable needs were reduced to 0% post treatment.

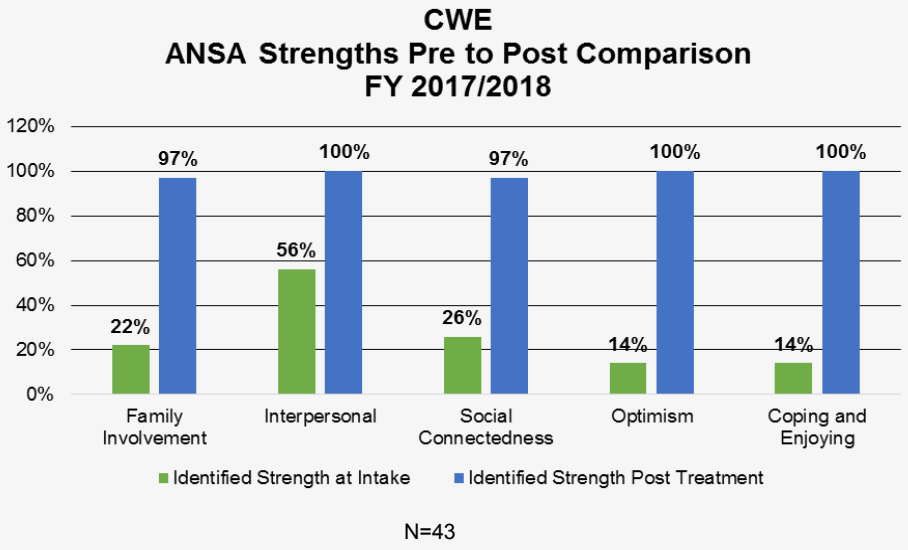


N=43

In FY 2017/18, 95% of participants in the category of adjustment to trauma had an actionable need reduced to 3%. In the category of depression, 95% had a need reduced to 18%. For the category of anxiety, 89% had an actionable need reduced to 8%. In the category of affect dysregulation, 87% had an actionable need reduced to 5% post treatment. Those in the category of interpersonal problems was also reduced to 5% from 74%. In the category of anger control, 82% had an actionable which was reduced to 0% post treatment.

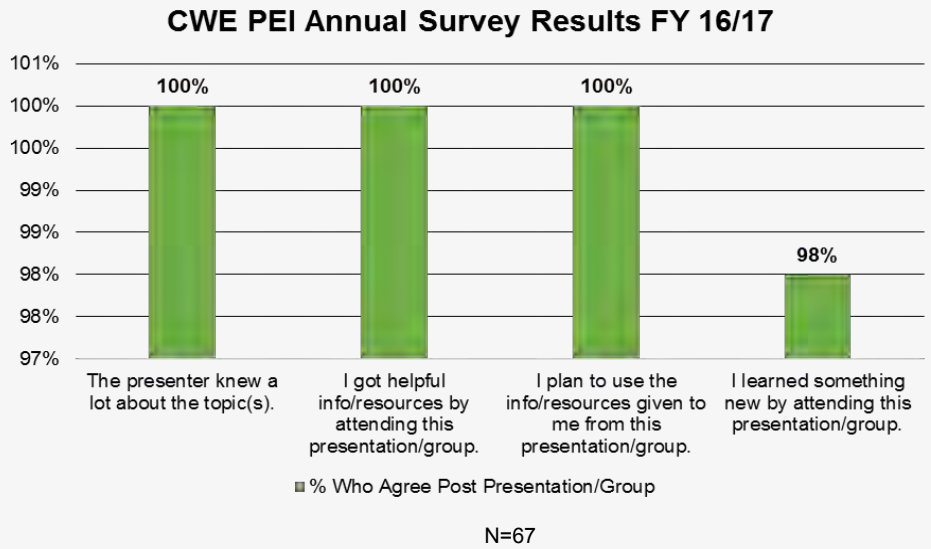


In FY 2016/17, in the area of strengths, results show that 8% of participants in the category of family involvement identified this as a strength, but 95% of participants identified this as a strength post treatment. In the category of interpersonal, only 13% of participants identified this strength and increased to 92% post treatment. For social connectedness, 13% of participants identified this strength pre treatment but 95% identified this strength post treatment. In the category of optimism, 16% identified this as a strength compared with 95% post treatment. In the category of coping and enjoying, 21% identified this as a strength, but 100% of participants identified this as a strength post treatment.



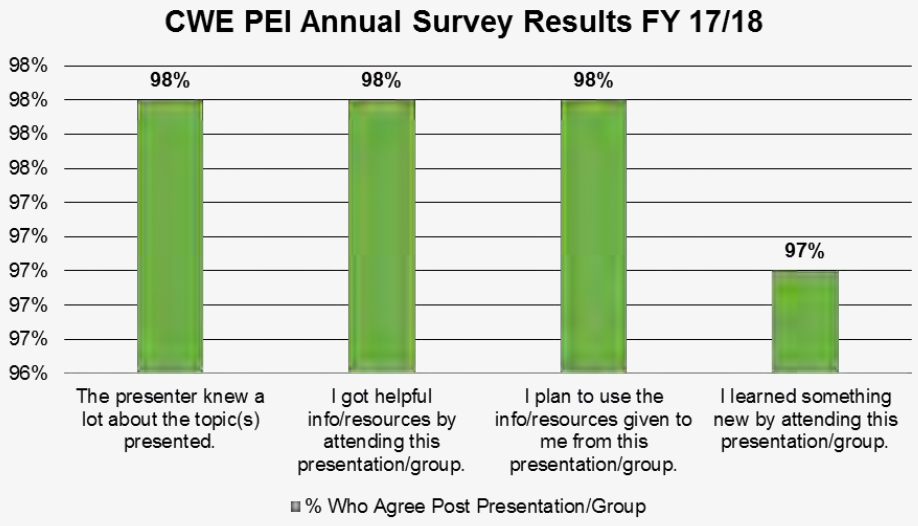
In FY 2017/18, 22% of participants identified family involvement as a strength as compared to 97% post treatment. In the category of social connectedness, 26% identified this as a strength, however 97% identified this strength post treatment. In the categories of interpersonal, optimism, and coping and enjoying, 100% of participants identified this as a strength post treatment.

The PEI Survey assesses the participant's perception and satisfaction with the CWE Program. The survey is administered after every presentation and group. Using the PEI Survey enables the providers to determine whether participants found the presentations and groups beneficial. In FY 2016/17, in the categories of presenter's topic knowledge, helpful information and resources received, and planning to use the information and resources,100% of participants surveyed agreed. In the category of whether a participant learned something new, 98% agreed.



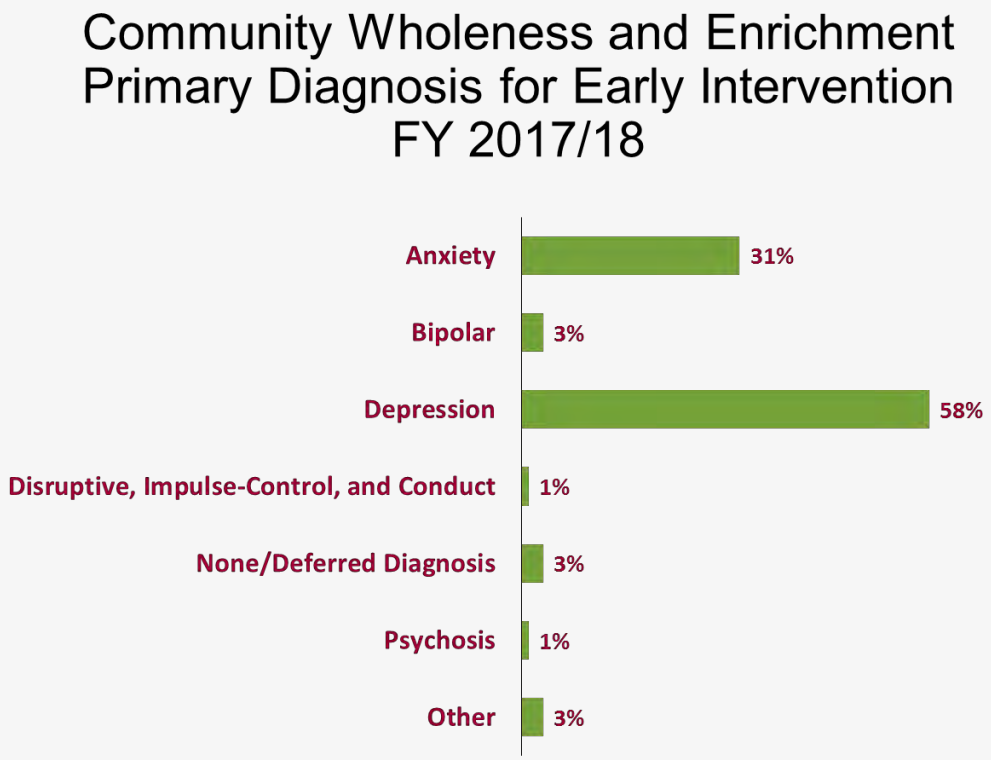
N=67

In FY 2017/18, in the categories of presenter's topic knowledge, helpful information and resources received, and planning to use the information and resources, 98% of participants surveyed agreed. In the category of whether a participant learned something new, 97% agreed.



N=633

The following table illustrates the primary diagnoses of CWE participants receiving Early Intervention services. The majority, 58%, of CWE participants receiving a diagnosis of depression, followed by anxiety at 31%. The remaining diagnostic categories comprise 3% or less of the CWE participants.



The following table provides the average duration of treatment for participants in the CWE Program. In FY 2016/17, participants had an open case for an average of 102 days with an average of ten days of direct services and an average of 887 cumulative minutes. In FY 2017/18, on average participants had an open case for 95 days with an average of nine days of direct services and 850 cumulative minutes.

Duration of Treatment	FY 2016/17	FY 2017/18
Average Number of Cumulative Minutes	887	850
Average Number of Days	10	9
Average Length of Time in Days from Episode Opening to Episode Closing	102	95

Prevention Outcomes

In fiscal year 2017/2018, CWE conducted the following Prevention activities within the community. These activities included:

Prevention Activity	Description	Rate of Completion
Mental Health First Aid	To teach lay people methods of assisting someone who may be in the early stages of developing a mental health problem or in a mental health crisis	100%
ASIST Training	A two day interactive workshop that prepares caregivers to provide life-assisting suicide first-aid intervention.	100%
suicideTALK	A 1-2 hour suicide awareness presentation. Provides information for suicide prevention, it explores the issue of suicide, attitudes towards it and how the individual can find ways to prevent it in their communities.	100%
Presentations	Psychoeducational	100%

Outcomes for Access and Linkage to Treatment Strategy or Program

During the fiscal year 2017/18, one participant identified as living with a Serious Mental Illness (SMI) was referred to a higher level of care. There were zero days between the number of days from the date of referral to engagement in treatment.

Outcomes for Improve Timely Access to Service Strategy or Program

In fiscal year 2017/2018, CWE identified and provided services to the following underserved populations:

Underserved Populations	
African American	Latino
LGBTQ	Trauma Exposed Individuals

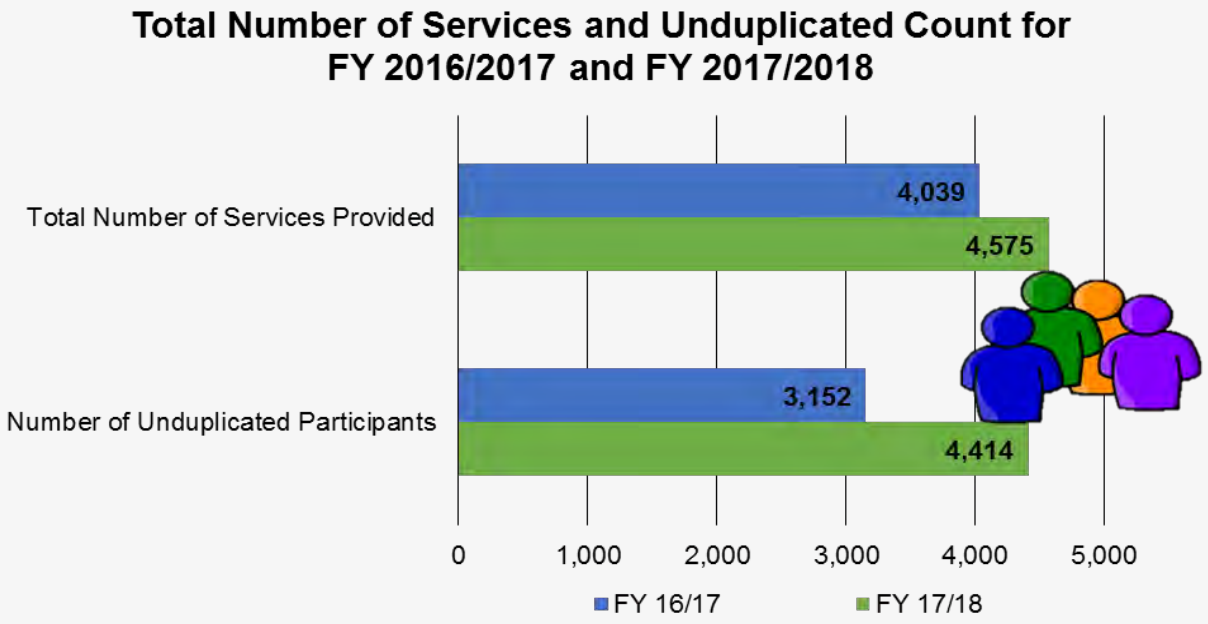
Of these underserved populations, CWE had seven referrals to Prevention activities and all of the seven followed through on the referrals.

Outcomes for Outreach for Increasing Recognition of Early Signs of Mental Illness

CWE reached 1,655 potential responders in fiscal year 2017/2018. The table below illustrates the types of responders reached and the settings in which they were engaged:

Types of Responders	Settings
Homeless Coalition	Family Resource Center
Clergy Members	Faith Based Organizations
Behavioral Health Clinics	Community Based Organizations
Consumer Family Members	Behavioral Health Clinics
High School Staff	Schools
Homeless Coalition	Homeless Outreach

The following table represents the total number of services provided in the CWE Program and the number of unduplicated participants served for FY 2016/17 and FY 2017/18. the number of unduplicated participants represents the number of individuals who were new to the program during the fiscal year.



Fiscal Year 2016/17 & 2017/18

Program Demographics

		FY 16/17	FY 17/18
Assigned Sex at Birth	Male	37%	33%
	Female	62%	57%
	Declined to Answer	12%	10%
Age	Child 0-15	0%	1%
	TAY 16-25	39%	21%
	Adult 26-59	56%	58%
	Older Adult 60+	2%	8%
	Declined to Answer	3%	12%
Primary Language Used	English	84%	76%
	Spanish	9%	19%
	Other	2%	3%
	Declined to Answer	5%	2%

		FY16/17	FY 17/18
Veteran	U.S. Military Veteran - Yes	5%	2%
	U.S. Military Veteran - No	90%	85%
	Declined to Answer	5%	13%

Fiscal Year 2016/17 & 2017/18

Program Demographics

		FY 16/17	FY 17/18
Disability	Difficulty seeing	8%	6%
	Difficulty hearing or having speech understood	3%	2%
	Other	1%	3%
	Cognitive Disability	3%	3%
	Physical/mobility domain	4%	12%
	Chronic health condition (including but not limited to chronic pain)	4%	9%
	No	61%	38%
	Declined to Answer	16%	27%

		FY 16/17	FY 17/18
Sexual Orientation	Gay or Lesbian	2%	1%
	Queer	0%	0%
	Bisexual	1%	2%
	Another Sexual Orientation	2%	0%
	Heterosexual or Straight	76%	69%
	Questioning or Unsure of Sexual Orientation	1%	1%
	Declined to Answer	18%	27%

Fiscal Year 2016/17 & 2017/18

Program Demographics

		FY 16/17	FY 17/18
Race	American Indian or Alaskan Native	3%	2%
	Asian	1%	2%
	Black or African American	8%	8%
	Native Hawaiian or Pacific Islander	1%	0%
	White (Caucasian)	44%	30%
	More than one race	8%	13%
	Other race	22%	25%
	Declined to Answer	13%	20%
Hispanic or Latino Ethnicity	Caribbean	1%	0%
	Central American	8%	3%
	Mexican/Mexican-American/Chicano	53%	77%
	Puerto Rican	3%	1%
	South American	3%	1%
	Other Hispanic or Latino Ethnicity	15%	9%
	Declined to Answer	17%	9%
Ethnicity	African	3%	8%
	Asian Indian/South Asian	1%	0%
	Cambodian	0%	0%
	Chinese	0%	0%
	Eastern European	1%	1%
	European	17%	13%
	Filipino	3%	2%
	Japanese	0%	1%
	Korean	0%	0%
	Middle Eastern	0%	1%
	Vietnamese	0%	0%
	Other	12%	9%
	More than one ethnicity	14%	8%
	Declined to Answer	49%	57%

Success Stories

Transitional Age Youth (TAY) "Maria" was referred by her school to CWE due to a noticeable drop in her grades, depressed mood, and a recent transition to a new school. At the time of her assessment, Maria reported family struggles, feelings of hopelessness, and suicidal ideation. She missed her friends from her previous school and was experiencing difficulties adjusting to her new social environment. Through therapeutic interventions, Maria was able to alter her negative feelings and gradually began to show progress. Maria's school functioning improved tremendously and she was able to transition back to her previous high school and began to raise her grades. However, Maria was informed she may not be able to graduate on time due to her tardiness. She worked in collaboration with school to ensure she could graduate with her classmates. Through CWE, she learned how to look for alternative solutions before allowing herself to feel defeated. She now knows how to manage stressful situations in a healthy manner. She also has not reported suicidal thoughts for over four months. Most importantly, Maria learned that life has more to do with her perspective than her circumstances.

Artwork by Unknown

Challenges

The Community Wholeness and Enrichment program provides various services to family members whose loved ones are living with a behavioral health condition. Among those services are support groups where family members have a safe environment in which to share amongst themselves and learn from each other. An ongoing challenge is that although extensive promotion of these services was routinely conducted throughout the county, attendance at the support groups has been lower than projected.

Solutions in Progress

Providers continue to focus on increasing the number of promotional and educational activities to keep the community informed of their services. They are collaborating with various service agencies and organizations, faith-based groups, and schools to increase awareness of the available support groups. In the upcoming fiscal year, DBH plans to work with Providers to increase collaboration with DBH outpatient clinics to offer additional support to family members of those engaged in a system of care services.

Program Updates

There are currently no planned program or budget changes for Fiscal Years 2019/20.

Collaborative Partners

- Rim Family Services
- South Coast Community Services
- Victor Community Support Services

Artwork by Sarah Favorite

Military Services and Family Support (SE-4)

The Military Services and Family Support (MSFS) program is categorized as a State Prevention and Early Intervention Program. It provides mental health services to military veterans, active duty and retired military personnel, reservists, and members of the National Guard who served on or after September 11, 2001, and their families, throughout San Bernardino County. The program, in collaboration with the County Department of Veterans Affairs and other community agencies, works specifically with military service members and their families.

The MSFS program services include, but are not limited to:

- In-home screenings and assessments
- Case management and referrals to connect participants with long term mental health services and other resources, including those offered through the San Bernardino County Department of Veterans Affairs
- Peer support groups led by trained individuals who have similar experiences that are designed to meet the unique needs of military families
- Psychoeducation to educate individuals with a mental health condition and their families, to help empower them and manage their condition
- Therapeutic mental health services and counseling for individuals, couples, and families using evidence-based practices such as Brief Strategic Family Therapy, Trauma-Focused Cognitive Behavioral Therapy, and Parent Child Interaction Therapy

Target Population:

- Children: ages 0-15
- Transitional Age Youth: ages 16-25
- Adults
- Older Adults

Projected number to be served :

- FY 2019/20:
  - 84 Children
  - 113 TAY
  - 812 Adults
  - 73 Older Adults

To increase access to and decrease stigma associated with mental health services, the MSFS program services are delivered in the homes of participants as well as at various sites that are conveniently located throughout San Bernardino County.

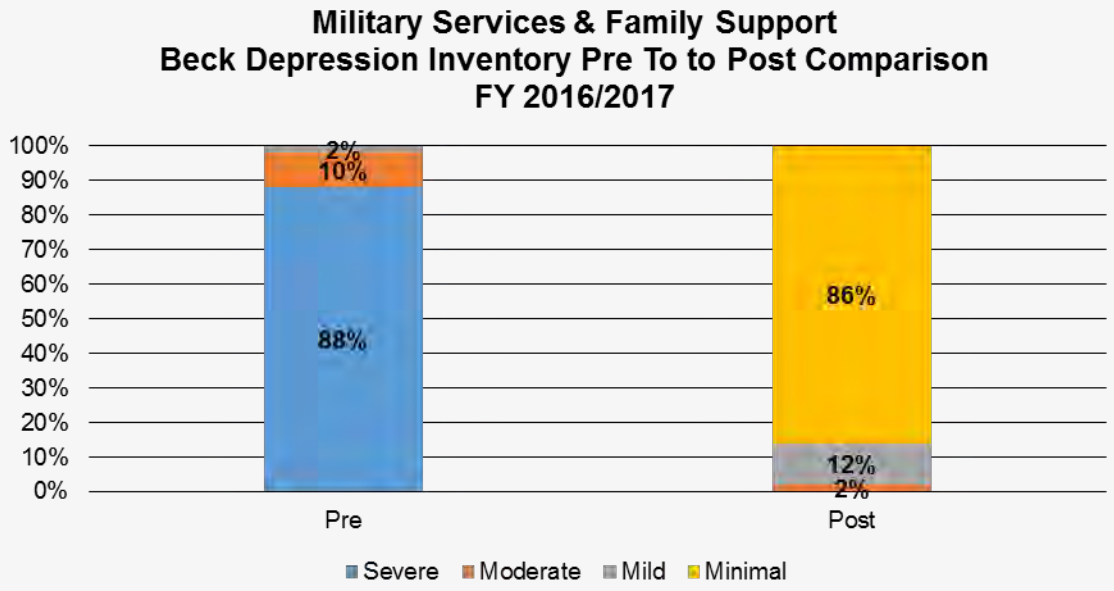
MHSA Legislative Goals and Related Key Outcomes

- Increase early access and linkage to medically necessary care and treatment:
  - ◊ Connect children, adults, and older adults with severe mental illness to care as early in the onset as practicable to medically necessary care and treatment including, but not limited to, care provided by county mental health programs.
- Improve timely access to services for underserved populations:
  - ◊ Increase the extent to which individuals or families from underserved populations who need mental health services because of risk or presence of a mental illness receives appropriate services as early in onset as practicable.
- Reduce prolonged suffering:
  - ◊ Reduce risk factors
  - ◊ Reduce indicators
  - ◊ Increase protective factors that may lead to improved mental, emotional, and relational functioning
  - ◊ Reduce symptoms, and
  - ◊ Improve recovery including emotional and relational functioning.
- Reduce stigma and discrimination associated with mental illness:
  - ◊ Reduce negative feelings, attitudes, beliefs, perceptions, stereotypes, and/or discrimination related to having a mental illness, being diagnosed, or seeking services.
- Increase acceptance, dignity, inclusion, and equity for individuals with mental illness and members of families.

Positive Results

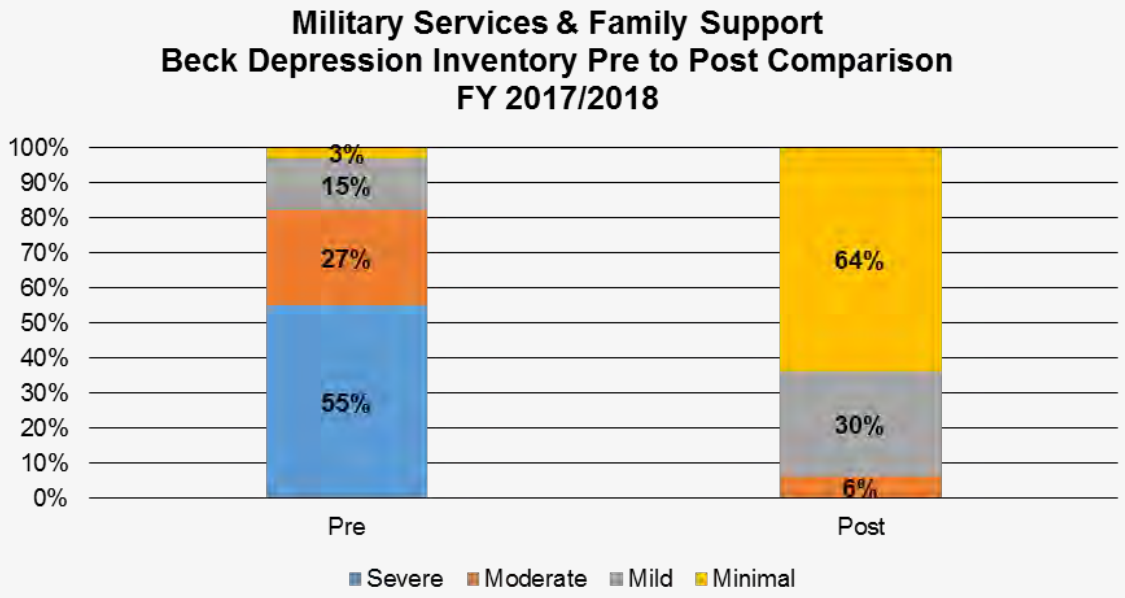
Early Intervention:

The MSFS Program utilizes the Beck Depression Inventory (BDI) and Beck Anxiety Inventory (BAI) to measure the attitudes and symptoms of depression and anxiety for its participants. The Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) includes **21** items. Each item is ranked in terms of severity and scored from zero to three. The statements express feelings common in depression (e.g. guilt, low self-worth, and suicidal ideation) that participants answer. The results are scored. The scoring cutoffs are **0-9** for normal range, **10-18** for mild to moderate depression, **19-29** for moderate to severe depression, and **30-63** for severe depression (Beck, Steer, & Garbin, 1988). Higher scores indicate greater depressive symptoms. Using the threshold criteria established by this scale, client scores were categorized according to varying levels of mild to severe depressive symptoms. In fiscal year 2016-2017, before receiving treatment, **98%** of clients reported scores that met either severe or moderate depression criteria. Following early intervention treatment, **97%** of clients reported scores that met mild or minimal depression criteria. Below is a sample of BDI results for fiscal year 2016/17:



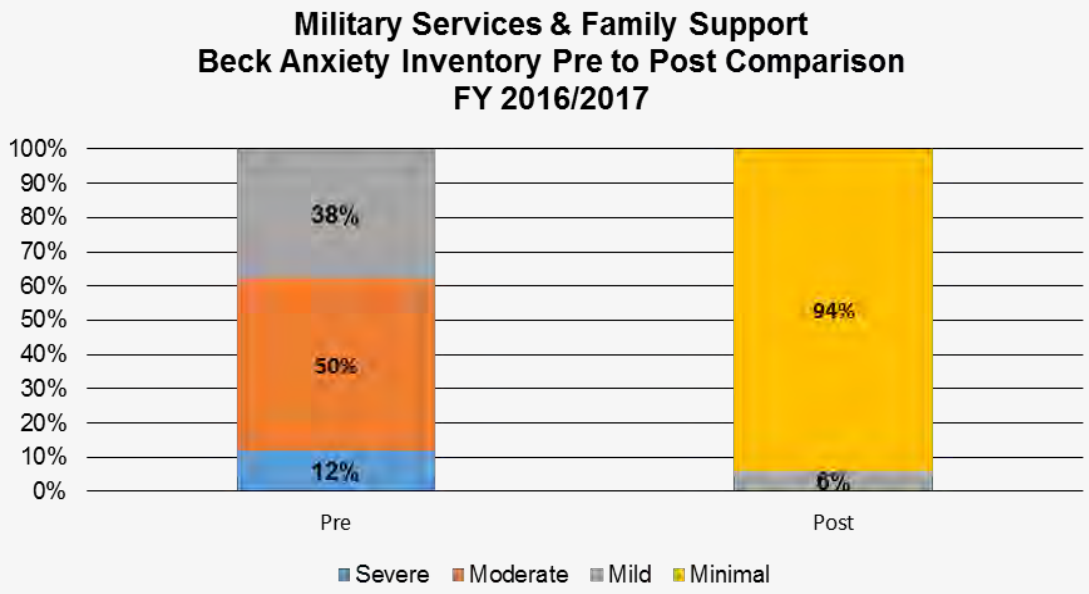
N=Pre 52 N=Post 49

In FY 2017/2018, before receiving treatment, **82%** of clients reported scores that met either severe or moderate depression criteria. Following early intervention treatment, there was a significant reduction in depressive symptoms reported for all clients, with **94%** of clients meeting minimal or mild depression criteria. In turn, the results indicate that clients significantly reduced their depressive symptoms during their participation in MSFS early intervention services. Below is a sample of BDI results for FY 2017/2018:



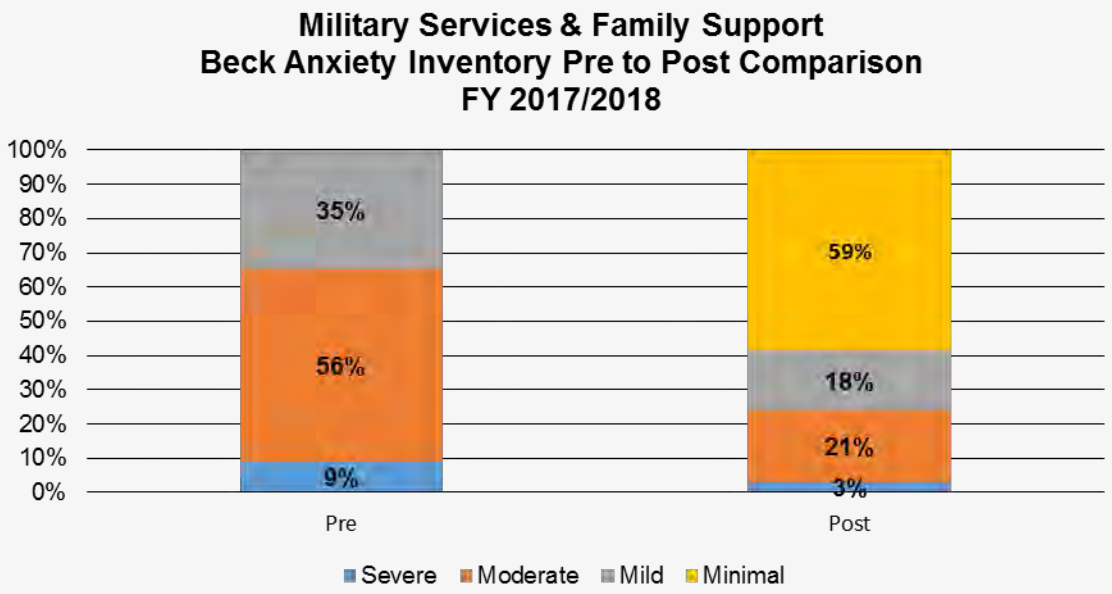
N=Pre 33 N=Post 33

The Beck Anxiety Inventory (BAI) also includes **21** items. Each item is ranked in terms of severity and scored from zero to three. The statements express symptoms commonly related to anxiety (e.g., anxious feelings, anxious thoughts, and physical symptoms). The scoring cutoffs are **0-4** minimal or no anxiety, **5-10** borderline anxiety, **11-20** mild anxiety, **21-30** moderate anxiety, **31-50** severe anxiety, and **51-99** extreme anxiety or panic. A score of **11 or more** would indicate a need for intervention. A score of **21 or more** would be referred to Early Intervention services. The graphs below depict the comparison of client pre to post scores for BAI. Higher scores indicate greater symptoms of anxiety. Using the threshold criteria established for this scale, client scores were categorized according to varying levels of mild to severe symptoms of anxiety. In 2016/2017, **72%** of clients reported scores that met either severe or moderate anxiety criteria. Following early intervention treatment, **94%** of clients reported scores meeting minimal levels of anxiety. Below is a sample of the BAI outcomes:



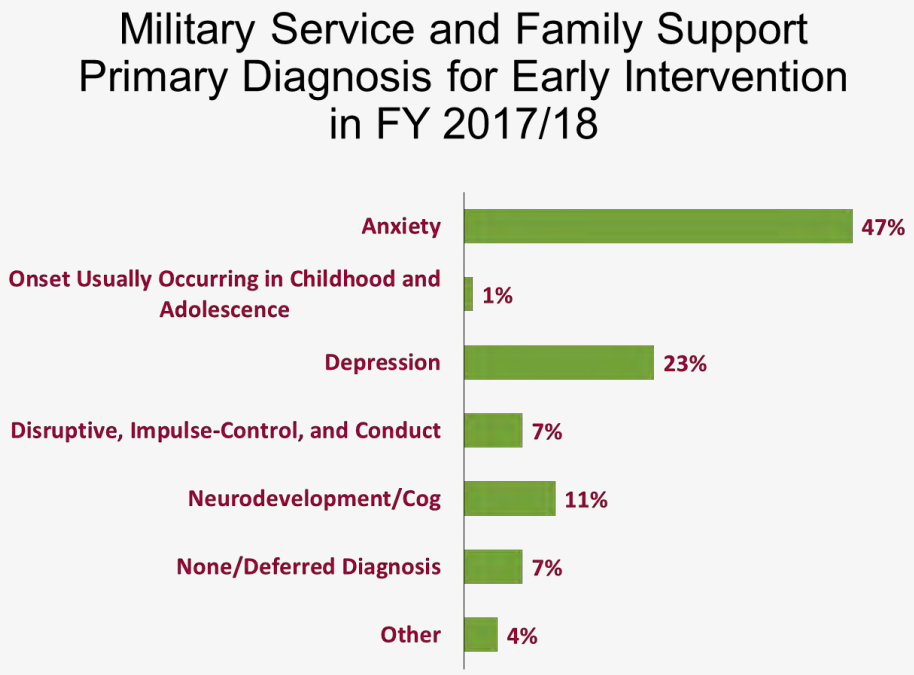
N=Pre 52 N=Post 49

In FY 2017/2018, before receiving treatment, **65%** of clients reported scores that met severe or moderate anxiety criteria. Following Early Intervention treatment, there was a significant reduction in anxiety symptoms reported for all clients, with **77%** falling under criteria for minimal or mild levels of anxiety. In turn, the results indicate that there was a substantial reduction of anxiety symptoms at the conclusion of clients' participation in the Military Services and Family Support Program. Below is a sample of BAI outcomes:



N=Pre 52 N=Post 49

The following table represents the percentage of MSFS participants by diagnostic groups. The majority of MSFS participants, 47%, were diagnosed with anxiety. This diagnosis was followed by depression at 23%. Only 7% were placed in the category of none/deferred diagnosis. A deferred diagnosis is a temporary diagnosis given to a participant who is pending further assessment of their symptoms.



One of the tools that the MSFS program uses to measure the success of the early intervention treatment is the discharge status of the recovery goals at the end of treatment. A participant reached their goals and had successful treatment if their treatment plan goals were met. The participant partially reached their treatment goals or treatment was partially successful if progress was made but the participant did not meet the full criteria of their treatment plan. The participant would not have met their goals or treatment was not successful if progress wasn't made or they did not complete the treatment.

In FY 2016/17, **90%** of participants met or partially met treatment goals and in FY 2017/18, **90%** of participants met or partially met treatment goals. The most common reasons for participants to not complete treatment included transportation difficulties, relocation, and loss of contact.

In FY 2016/17, participants had early intervention cases open for an average of 120 days (approximately 4 months) and had 9 days of direct services with an average of 907 cumulative minutes of services (approximately 15 hours).

On average, participants of the MSFS program had an open early intervention case for 146 days in FY 2017/18. Of those 146 days (approximately 5 months), participants had 10 days of direct services with an average of 930 cumulative minutes of services (approximately 16 hours).

Duration of Treatment	FY 2016/17	FY 2017/18
Average Number of Cumulative Minutes	907	934
Average Length of Time in Days from Episode Opening to Episode Closing	120	146
Average Number of Days	9	10

Prevention Outcomes

In fiscal year 2017/2018, MSFS conducted many prevention activities within the community. These activities included:

Prevention Activity	Description	Completion Rate
Adult Crossroads Education	Parenting/Socialization Skills	78%
Youth Crossroads Education	Child/Adolescent Functioning Support	100%
National Curriculum Training Institute (NCTI) Groups	Criminal justice based groups, EBP, anger management, domestic violence perpetrators	80%
Women's Seeking Safety	Experience with trauma and/or substance use history	75%
Men's Seeking Safety	Experience with trauma and/or substance use history	75%
STEP Parenting	Parenting Skills	80%
Assertive Communication	Assertions skills/communication styles	80%
Second Step	Socioemotional skills, antibullying, empathy development	90%

Outcomes for Access and Linkage to Treatment Strategy or Program

The table below indicates how many participants with a serious mental illness were referred to a higher level of care, and how many of those referred followed through on their referral. The table also includes the average duration of untreated mental illness and the interval between referral and participation in days.

Access and Linkage to Treatment Outcomes	
Individuals with SMI referred to treatment	10
Individuals who followed through on referral	0
Average duration of untreated mental illness	10
Average interval between referral and participation in treatment	2

Outcomes for Improve Timely Access to Service Strategy or Program

The MSFS Program identified and provided services to the following underserved populations in fiscal year 2017-2018:

Underserved Populations	
African American	Asian
Latino	Military/veterans
Native American	Co-occurring
Individuals experiencing onset of serious psychiatric illness	Children and Youth at risk of school failure
Children and youth at risk of or experiencing juvenile justice involvement	Children in stressed families
Trauma Exposed Individuals	Victims of Human Trafficking

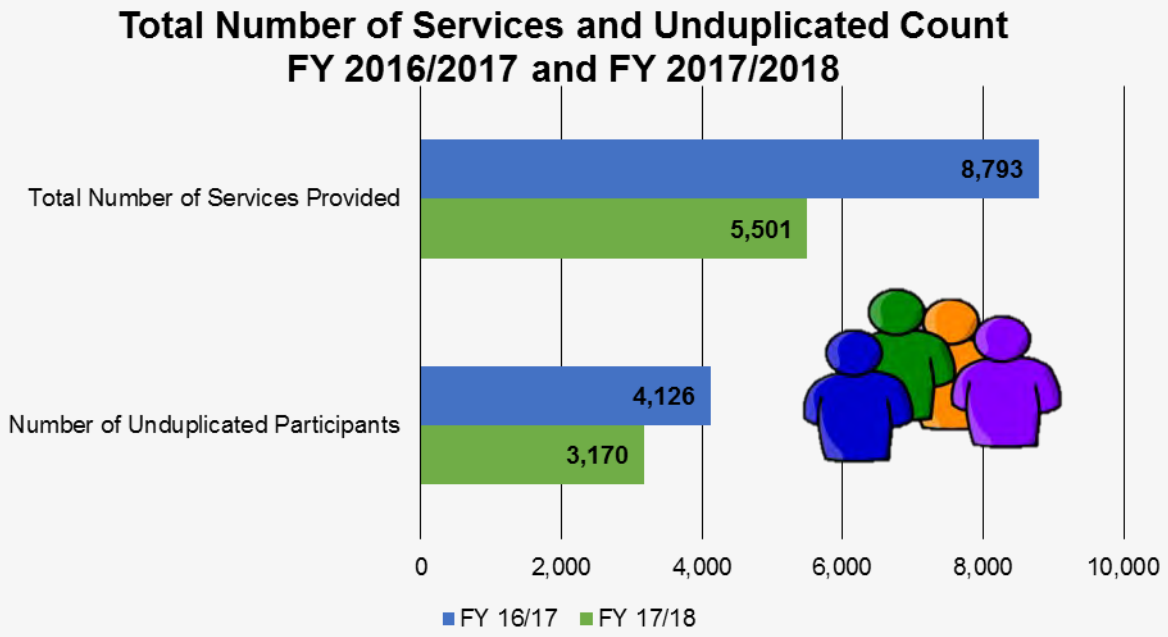
Of these underserved populations, MSFS had 35 referrals to Prevention activities and 29 participants followed through on the referrals. MSFS also had 23 referrals to Early Intervention activities with 13 participants following through on their referrals.

Outcomes for Outreach for Increasing Recognition of Early Signs of Mental Illness

In fiscal year 2017/2018, MSFS reached 232 potential responders. The table below illustrates the types of responders reached and the settings in which responders were engaged:

Types of Responders	Settings
School Personnel	Schools
Community Service Providers	Community-Based Organizations
Peer Providers	Community Events
Consumer Family Members	Health Centers
Military Personnel	County Offices

The following table represents the total number of services provided in the MSFS Program and the number of unduplicated participants served for FY 2016/17 and FY 2017/18. The number of unduplicated participants represents the number of individuals who were new to the program during the fiscal year.



Artwork by Karina Rodriguez Torres

Fiscal Year 2016/17 & 2017/18
Program Demographics

		FY 16/17	FY 17/18
Assigned Sex at Brith	Male	33%	42%
	Female	46%	58%
	Declined to Answer	21%	0%
Age	Child 0-15	15%	19%
	TAY 16-25	11%	13%
	Adult 26-59	50%	56%
	Older Adult 60+	8%	11%
	Declined to Answer	16%	1%
Primary Language Used	English	85%	98%
	Spanish	0%	2%
	Other	0%	0%
	Declined to Answer	15%	0%

		FY 16/17	FY 17/18
Veteran	U.S. Military Veteran - Yes	21%	13%
	U.S. Military Veteran - No	21%	19%
	Declined to Answer	58%	68%

Fiscal Year 2016/17 & 2017/18
Program Demographics

		FY 16/17	FY 17/18
Disability	Difficulty seeing	0%	1%
	Difficulty hearing or having speech understood	0%	1%
	Other	1%	1%
	Cognitive Disability	0%	1%
	Physical/mobility domain	1%	2%
	Chronic health condition (including but not limited to chronic pain)	1%	2%
	No	23%	21%
	Declined to Answer	74%	71%

		FY 16/17	FY 17/18
Sexual Orientation	Gay or Lesbian	0%	1%
	Queer	0%	0%
	Bisexual	0%	2%
	Another Sexual Orientation	0%	0%
	Heterosexual or Straight	25%	31%
	Questioning or Unsure of Sexual Orientation	0%	1%
	Declined to Answer	75%	65%

Fiscal Year 2016/17 & 2017/18
Program Demographics

		FY 16/17	FY 17/18
Race	American Indian or Alaskan Native	1%	1%
	Asian	0%	2%
	Black or African American	1%	13%
	Native Hawaiian or Pacific Islander	1%	0%
	White (Caucasian)	51%	57%
	More than one race	7%	8%
	Other race	13%	13%
	Declined to Answer	26%	6%
Hispanic or Latino Ethnicity	Caribbean	0%	0%
	Central American	0%	0%
	Mexican/Mexican-American/Chicano	7%	12%
	Puerto Rican	0%	0%
	South American	8%	7%
	Other Hispanic or Latino Ethnicity	3%	1%
	Declined to Answer	82%	80%
Ethnicity	African	9%	1%
	Asian Indian/South Asian	0%	1%
	Cambodian	0%	0%
	Chinese	0%	0%
	Eastern European	1%	2%
	European	2%	0%
	Filipino	0%	0%
	Japanese	0%	0%
	Korean	0%	0%
	Middle Eastern	0%	0%
	Vietnamese	0%	5%
	Other	4%	0%
	More than one ethnicity	6%	2%
	Declined to Answer	78%	89%

Success Stories

After five years of service, “Shane” seemed to adjust well to civilian life. Shane and his wife had the appearance of a well-adjusted lifestyle, but Shane felt he was suffocating. The routines that could have been comforting began to feel monotonous and Shane’s marriage suffered. Shane began to experience suicidal ideations and sought help. He was referred to therapeutic services through MSFS to address his concerns. His visits to the MSFS Program helped Shane to process and effectively express his emotions. Shane’s relationship with his wife improved, he feels hopeful, and no longer experiences suicidal ideations. Shane continues to work on his mental health and wellness with the support of his family, friends, and the MSFS Program.

Artwork by Linda James

Challenges

An ongoing challenge for MSFS is the requirement that those eligible for the program must be post-9/11 service members and veterans. The MSFS program also faces challenges with engaging community members for group based interventions. The stigma surrounding publicly acknowledging a mental health need continues to be a challenge for active duty service members and spouses. Additionally, MSFS has experienced a high demand for intensive trauma-informed trainings. Securing these types of trainings has been a challenge as they are costly and not offered locally.

Solutions in Progress

Although the program requires that those eligible for MSFS services be post-9/11 service members and veterans, providers do serve as an access point for any military members needing assistance. If they are unable to provide the services under MSFS, they are able to provide services under a different funding source, or give referrals to additional agencies or resources. Due to stakeholder feedback, the MSFS program will be expanding its eligibility requirements to include all service members, veterans, and their families. Providers of the MSFS program have managed to engage active duty service members and their families by ensuring participants are aware that the MSFS services are completely confidential. These services are different than military-based services and are not reflected on a service member's military record. They have also looked for lower cost training opportunities that will provide staff with additional information on providing trauma-informed care.

Program Updates

For Fiscal Year 2019/20, the MSFS program will be expanding its eligibility requirements to include service members, veterans, and their families regardless of service era.

Collaborative Partners

- 2-1-1 Vetlink
- Christian Counseling Service
- Pacific Clinics
- San Bernardino County, Veterans Affairs
- Veterans Health Administration, Loma Linda
- Victor Community Support Services
- Marine Corps Base Camp Pendleton

Artwork by Unknown

Artwork by Gabriel Horne

Community Services and Supports (CSS)

Introduction

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

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

The majority of MHSA funding **(80%)** is mandated to be directed toward the Community Services and Supports (CSS) component. In contrast to the Prevention and Early Intervention (PEI) component that focuses on population health and early intervention, the CSS component provides access to an expanded continuum of care for persons living with Serious Mental Illness or Serious Emotional Disturbance made possible through MHSA Investments. Seriously Emotionally Disturbed refers to children and youth with difficulty functioning in multiple life domains such school, home, and/or community. Serious Mental Illness (SMI) is a term defined by Federal regulations that describes mental disorders that significantly interfere with some area of functioning.

WIC § 5892(a)(5) states:

- The majority of MHSA funding **(80%)** is mandated to be directed toward the Community Services and Supports (CSS) component.
- CSS provides enhanced mental health services for Seriously Emotionally Disturbed (SED) children and youth and Seriously Mentally Ill (SMI) adult populations.

Community Services and Supports (CSS) Goals

The overarching goals of the CSS programs are outlined below:

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

The CSS section is organized according to programs that operate with similar intent or purpose, but may serve different target populations. Programs intended to provide interventions or supports during a mental health crisis are described in the Crisis System of Care section of the CSS component, eight Full Service Partnership (FSP) Programs are contained in the FSP section; and programs that provide Housing, Long Term Supports, and Transitional Care are contained within that section. All CSS programs provide the necessary services and support to help consumers achieve their mental health and treatment plan goals.

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

- Augmenting existing services
- Establishing a system of care for crisis services
- Creating collaborations and partnerships with various County agencies to maximize and leverage resources to serve consumer needs
- Developing programming to address the needs of Transitional Age Youth (TAY)
- Developing programming to address the needs of Older Adults
- Developing supportive housing and maximizing MHSA, SNHP, and NPLH funds for housing opportunities
- Enhancing and expanding wraparound services to children
- Expansion of adult Full Service Partnerships to serve underserved population

There are currently 17 CSS programs designed to serve all age groups within the behavioral health system of care. The programs are as follows:

Crisis System of Care Programs (CSOC):

- A-5: Triage Transitional Services (TTS and TEST)
- A-6: Community Crisis Response Team (CCRT and CIT)

Crisis Stabilization Continuum of Care (CSCOC):

- A-4: Crisis Walk-In Centers (CWIC and CSU)
- A-10: Crisis Residential Treatment Program (CRT)

Full Service Partnership Programs:

- 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 (TAY and The STAY)

- A-2: Adult Criminal Justice Continuum of Care (FACT, STAR)
- A-3: Members Assertive Positive Solutions/Assertive Community Treatment (MAPS/ACT)
- A-8: Big Bear Full Service Partnership
- A-11: Regional Adult Full Service Partnership (RAFSP)
- OA-2: Age Wise - Mobile Response

Housing, Long Term Supports, and Transitional Care Programs:

- A-1: Clubhouse Expansion Program
- A-7: Homeless Assistance Resource and Treatment Program (HART)
- A-9: Access, Coordination, and Enhancement (ACE) of Quality Behavioral Health Services
- A-12: Whole Person Care (WPC)
- OA-1: Age Wise - Circle of Care

Artwork by Skyla Tarwater

Crisis System of Care

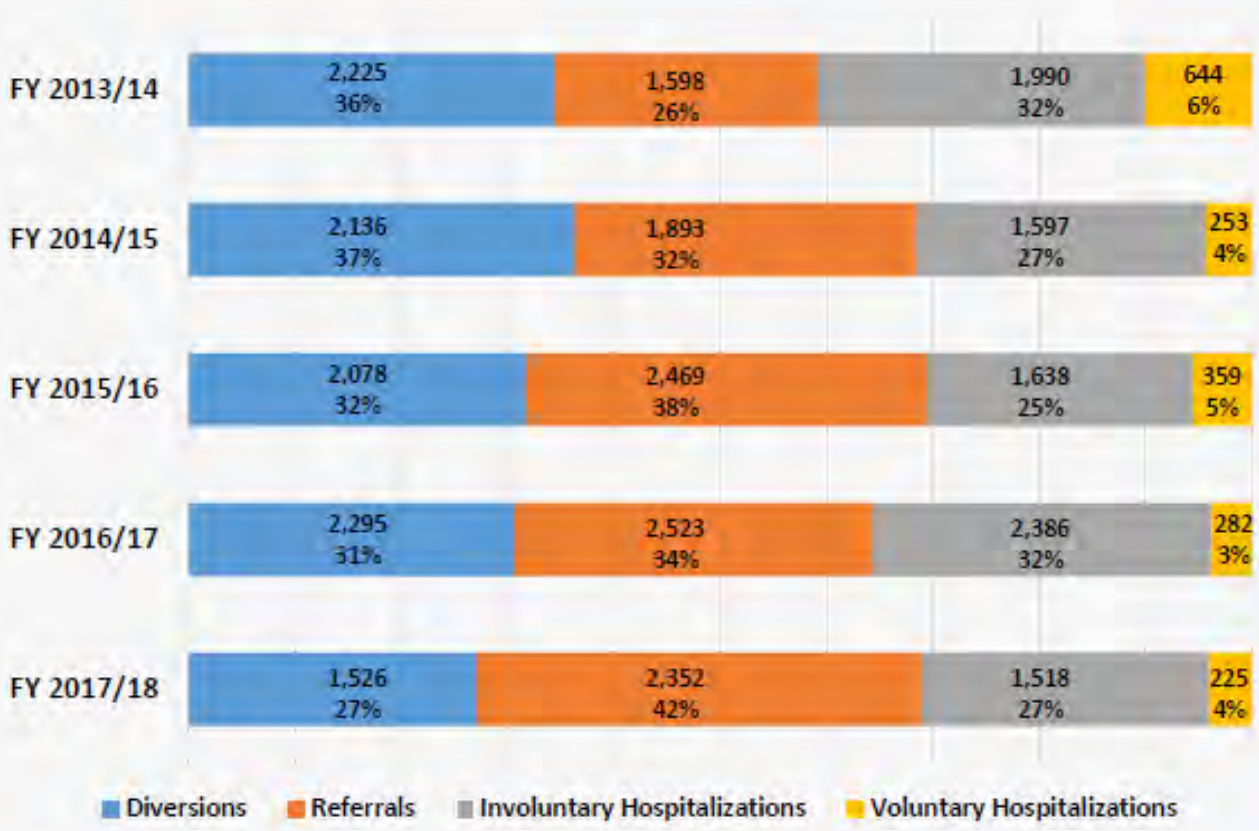
Crisis System of Care (CSOC) programs are considered system development strategies that help develop the capacity to provide values-driven, evidence-based services for the MHSA populations. Through system development, counties improve program services and supports for all consumers and families to change their service delivery systems and build transformational programs and services. The CSOC is comprised of a continuum of programming that provides education and support for community partners and allows field-based responses prompted by calls from the community, agency partners, or consumers experiencing a behavioral health crisis access to walk-in centers, stabilization and diversion from acute psychiatric hospitalization, and residential crisis stabilization.

The primary intent of the CSOC is to reduce hospital emergency room and unnecessary acute psychiatric hospitalization, improve consumer participation in outpatient services after a crisis, and reduce the percentage of consumers who return for additional crisis services within a short time frame.

Artwork by Eneida Reboucas

A review of the last five fiscal years of data for the Community Crisis Response Team in the chart below demonstrates the disposition of the contacts made for each year. The majority of consumers experiencing a behavioral health crisis were able to be stabilized to avoid acute psychiatric hospitalization and/or referred and linked to resources.

Community Crisis Response Team (CCRT) Disposition



Triage Transitional Services (TTS) (A-5)

Triage Transitional Services (TTS) and the Triage, Engagement, and Support Teams (TEST) programs are designed to increase the use of alternatives to inpatient psychiatric hospitalization, screen, assess and intervene in crises with those consumers who are voluntarily seeking help, and provide linkages and referrals to community resources. TTS provides services in a hospital setting co-location, while TEST provides services in the field through key co-location sites throughout the community.

Triage Transitional Services (TTS)

Triage Transitional Services (TTS) was designed to assess consumers who voluntarily present to the Arrowhead Regional Medical Center Behavioral Health Unit to determine if they meet criteria for inpatient psychiatric treatment or if their needs can be met in other, less restrictive settings outside of an emergency department or inpatient treatment unit. The TTS program is located within the Psychiatric Emergency Department (ED) of the county hospital, Arrowhead Regional Medical Center Behavioral Health (ARMC-BH). Many individuals enter emergency departments requesting behavioral health services that can be more effectively and efficiently met in an outpatient setting. The staff complete assessments of these individuals to determine how to best meet their needs outside of the hospital environment, if appropriate. Services provided include:

- Crisis assessment and intervention
- Case management
- Collateral contacts
- Transportation assistance
- Housing assistance
- Linkage with outpatient resources and providers
- Referrals to medical and social service agencies
- Family and caretaker education
- Consumer advocacy

Target Population:

- Children
- TAY
- Adults
- Older Adults

Projected Number to be Served:

- FY 2019/20
  - ◊ 285 Children
  - ◊ 946 TAY
  - ◊ 2,950 Adults
  - ◊ 709 Older Adults

Triage, Engagement, and Support Teams (TEST)

The Triage, Engagement, and Support Teams (TEST) program was developed to provide intensive crisis case management services to unserved/underserved residents of San Bernardino County. The TEST program provides crisis intervention and support services to individuals experiencing behavioral health crises. In November 2014, San Bernardino County was awarded a crisis triage grant through the Mental Health Services Oversight and Accountability Commission (MHSOAC) based on the Mental Health Wellness Act of 2013 and Senate Bill (SB) 82. The grant allowed for the expansion of the crisis system of care and the hiring of additional county staff to provide these services. SB82 grant funding expired on June 30, 2018; however, the need still exists for the crisis intervention and support services provided by the TEST program. Therefore, in Fiscal Year 2018/19, TEST transitioned to be included as part of the MHSA Plan.

Today, TEST staff are co-located within twenty-five agencies, including internal County partners, such as the Sheriff's Department and Public Defender's Office, and external community partners, such as local police departments throughout the County, hospital emergency departments, and California State University San Bernardino. The TEST program provides support to the partnering departments and agencies in which staff are co-located. TEST staff respond in the field with law enforcement personnel and/or assist other partnering agency staff in managing behavioral health crises. TEST then provides follow-up case management services to link consumers with needed resources for ongoing stability. TEST continues to provide services for up to 59 days in order to help ensure continued engagement in needed behavioral health services.
Services provided include:

- Crisis assessment and intervention in the field
- Case management
- Collateral contacts
- Referrals and linkage to community resources and providers
- Family and caretaker education
- Consumer advocacy
- Education and support to law enforcement and community partners regarding behavioral health issues and resources

MHSA Legislative Goals and Related Key Outcomes

Triage Transitional Services

Reduce the frequency of emergency room visits and unnecessary hospitalizations:

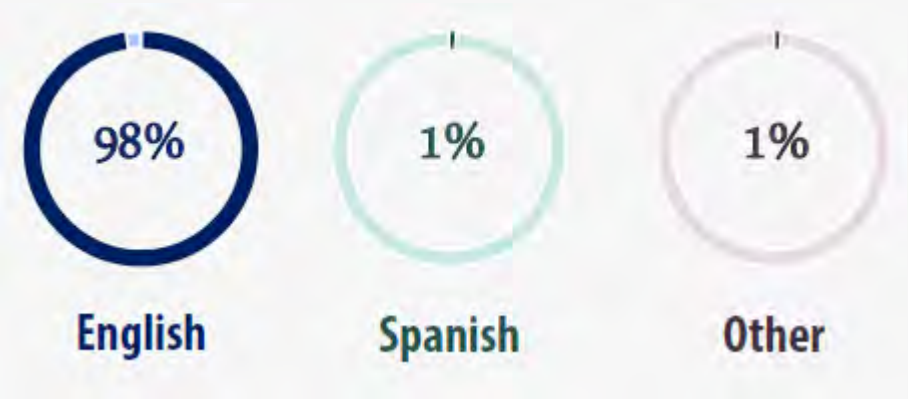
- ◊ Reduced rate of emergency room visits for mental health concerns
- ◊ Reduced administrative hospital days
- ◊ Increased use of alternative crisis interventions (e.g., CWIC, CCRT, CSU)
- ◊ Increase in number of individuals diverted from hospitalization

Triage, Engagement, and Support Teams

Reduce unnecessary psychiatric hospitalizations:

- ◊ Increased use of alternative crisis interventions (e.g., CWIC, CCRT, CSU)
- ◊ Increase in number of individuals diverted from hospitalization
- ◊ Increase access to and use of existing community resources (e.g., housing, mental health services, alcohol and drug services, medical treatment, education services, etc.)

Program Demographics: Primary Language - Triage Transitional Services



Positive Results

Triage Transitional Services

In Fiscal Year 2017/18, **1,546** individuals received services. Of which, **44%** were diverted from hospitalization, while an additional **6%** were provided with referrals and linkage to assist upon their discharge in reducing the rate of recidivism.

Outreach and Engagement

In Fiscal Year 2017/18, Triage Transitional Services organized and/or participated in the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Triage Transitional Services (TTS)		
Presentations to Community Partners and DBH programs: FFS Hospitals, Probation, Case Manager monthly meeting, CIT (quarterly), IRC, and CRT	9	290

"Thank you for taking the time to tell us about all the outpatient services. Thank you for helping us."

- TTS consumer

Challenges

Triage Transitional Services

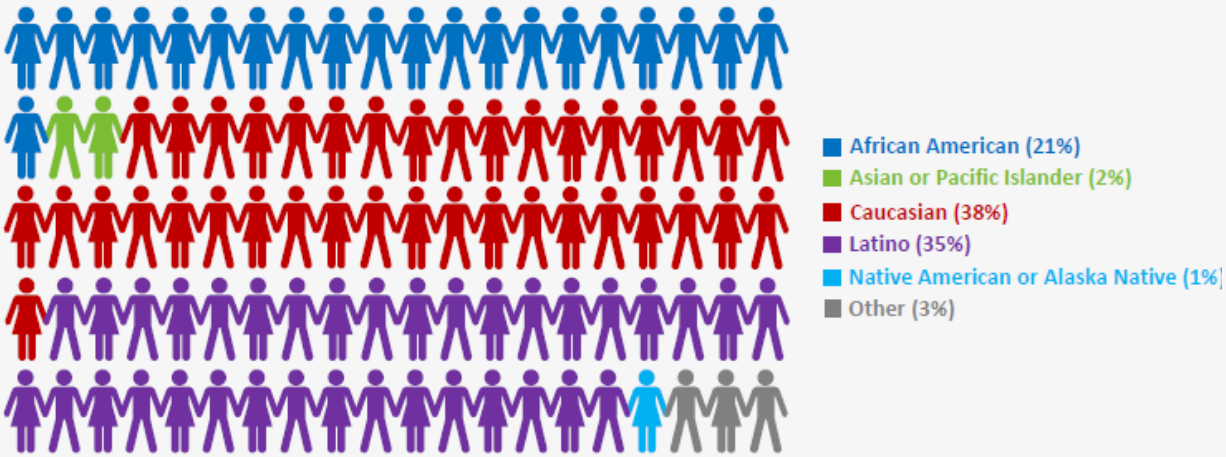
New program requirements were implemented to meet the needs of consumers presenting voluntarily at ARMC BHU.

Solutions in Progress

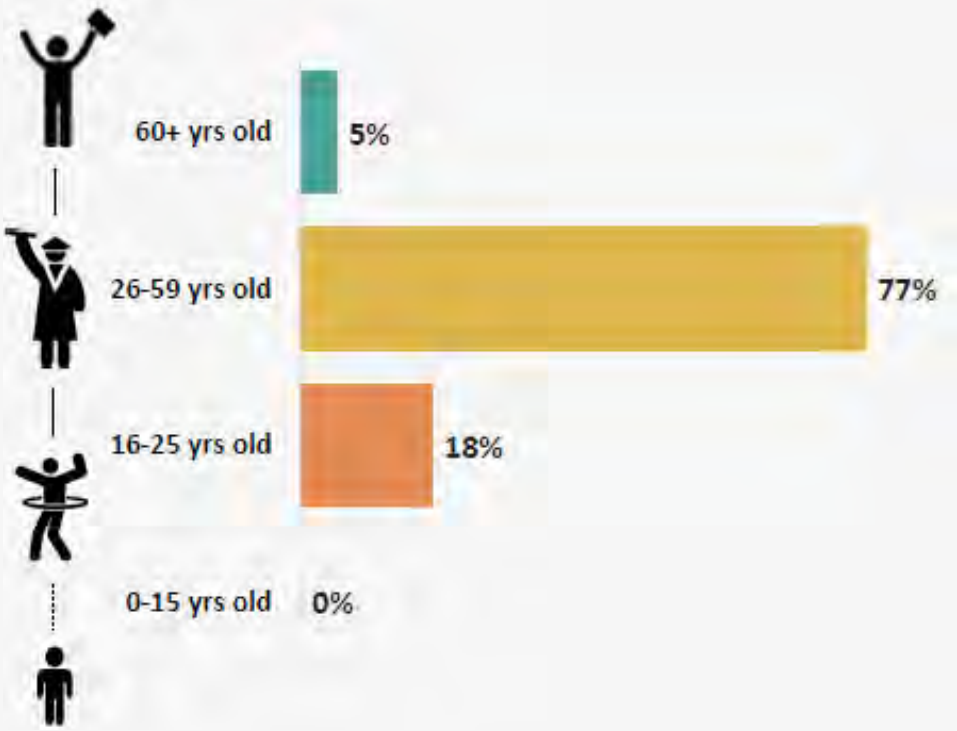
Triage Transitional Services

Communication was increased and processes were streamlined. Trainings and meetings have been facilitated with staff and community partners to continue to meet the resource needs of the consumers.

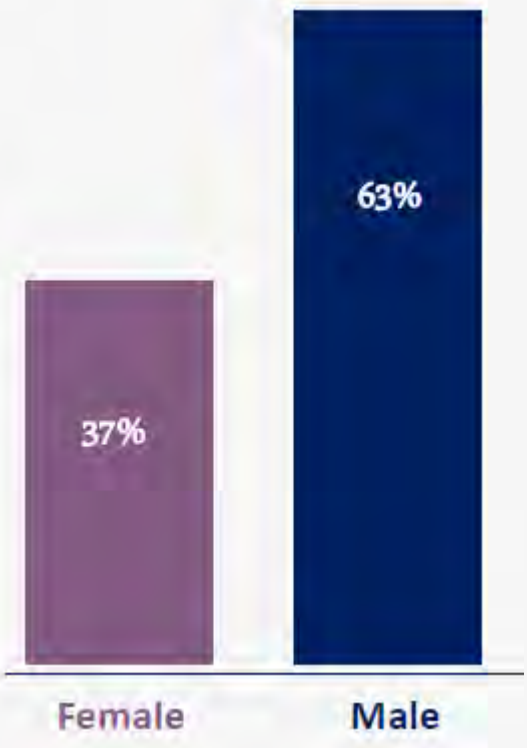
Program Demographics: Ethnicity - Triage Transitional Services



Program Demographics: Age - Triage Transitional Services



Program Demographics: Gender - Triage Transitional Services



Success Story

Triage Transitional Services

"Ryan" experienced multiple hospitalizations in a short time frame. The TTS staff worked with a local hospital's staff to determine the cause of his recidivism. At first, he was uncooperative, demanded independent housing, and refused to work on his discharge planning. However, with time, the TTS staff were able to secure housing for Ryan, and link him to outpatient services to help him function better independently. Ryan has reduced hospitalizations.

"Alek" had struggled with substance use since he was an adolescent, and reported trauma exposure. Although Alek was previously hospitalized, he continued to engage in dangerous behaviors and did not know how to ask for help. TTS staff explained substance use recovery services, offered linkage, and recommended inpatient services. Alek chose to voluntarily admit himself for hospitalization at a local hospital and was thankful for the help.

Artwork by Robin Cline

Collaborative Partners

- Arrowhead Regional Medical Center (ARMC)
- Barstow Police Department
- California Department of Parole
- California State University, San Bernardino
- Chino Police Department
- Contracted behavioral health providers
- Desert Valley Hospital
- Fee for Service Acute Psychiatric Hospitals
- Fontana Police Department
- Kaiser Foundation Hospital, Fontana
- Law enforcement agencies throughout San Bernardino County
- Los Angeles County Department of Mental Health
- Ontario Police Department
- Orange County Department of Mental Health
- Redlands Police Department
- Rialto Police Department
- Riverside County Department of Mental Health
- San Bernardino County, Children and Family Services
- San Bernardino County, DBH Community Crisis Response Team
- San Bernardino County, Department of Aging and Adult Services
- San Bernardino County, Probation Department
- San Bernardino County, Office of the Public Guardian
- San Bernardino County, Public Defender's Office - Rancho Cucamonga
- San Bernardino County, Sheriff Department
- San Bernardino Police Department
- St. Mary's Medical Center
- Telecare Corporation
- Upland Police Department
- Victor Valley College

"I didn't know where to go for help. I'm glad I came here."

- TTS consumer

Community Crisis Response Teams (CCRT) (A-6)

The Crisis System of Care's Community Crisis Response Team (CCRT) provides urgent behavioral health services to residents of San Bernardino County and the Crisis Intervention Training program (CIT) provides training to law enforcement and community partners who may respond to calls that involve a consumer experiencing a behavioral health crisis.

Community Crisis Response Team (CCRT)

The Community Crisis Response Team (CCRT) utilizes specially trained mobile crisis response multidisciplinary staff to provide crisis interventions, assessments, case management, relapse prevention, and medication referrals. CCRT has regional teams located in Hesperia, Rialto, Ontario, and the Morongo Basin area of San Bernardino County. CCRT responds to community locations through collaboration with law enforcement, schools, Department of Behavioral Health (DBH) clinics and contractors, specialty programs, group homes, Board and Care (B&C) facilities, family members, and self-referrals. Anyone in San Bernardino County can call CCRT in the event of a behavioral health crisis. CCRT Teams are committed to assisting San Bernardino County consumers in the least restrictive manner by providing behavioral health services where the consumer is experiencing their crisis which includes public locations such as parks, parking lots and restaurants. CCRT staff may also provide the consumer and family members with referrals and linkage to necessary and appropriate behavioral health and non-behavioral health resources and services.

Target Population:

- Children
- TAY
- Adults
- Older Adults

Projected Number to be Served:

- FY 2019/20

CCRT

- ◊ 3,391 Children
- ◊ 1,456 TAY
- ◊ 4,456 Adults
- ◊ 696 Older Adults

CIT

- ◊ 900 Adults
- ◊ 300 Older Adults

MHSA Legislative Goals and Related Key Outcomes

Reduce the frequency of emergency room visits and unnecessary hospitalizations:

- ◊ Reduced rate of emergency room visits for mental health concerns
- ◊ Increased use of alternative crisis interventions (e.g., CWIC, CCRT, CSU)
- ◊ Increase in number of individuals diverted from hospitalization

Increase a network of community support services:

- ◊ Increase in number of collaborative partners

Positive Results

- In Fiscal Year 2017/18, **5,621** calls were received and **3,269** of those calls were crisis calls. Out of the 3,269 crisis calls, **1,526** calls **(65%)** were diverted from hospitalization.
- A total of **216** outreach activities were conducted with **146** different community collaborative partners, including law enforcement, schools, hospitals, Board and Cares, and medical partners. A total of **27,479** attendees were present during the outreach activities.

Artwork by B. Lopez

Outreach and Engagement

In Fiscal Year 2017/18, the CCRT program organized and/or participated in the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
CCRT		
Community Presentation/Meetings	152	31,692
Referral and Linkage Calls	2,352	2,352
Law Enforcement Briefings/Collaborative Meetings	51	871
School Outreach	13	4,916
TOTAL	**2,568**	**39,831**

Program Demographics: Ethnicity - CCRT

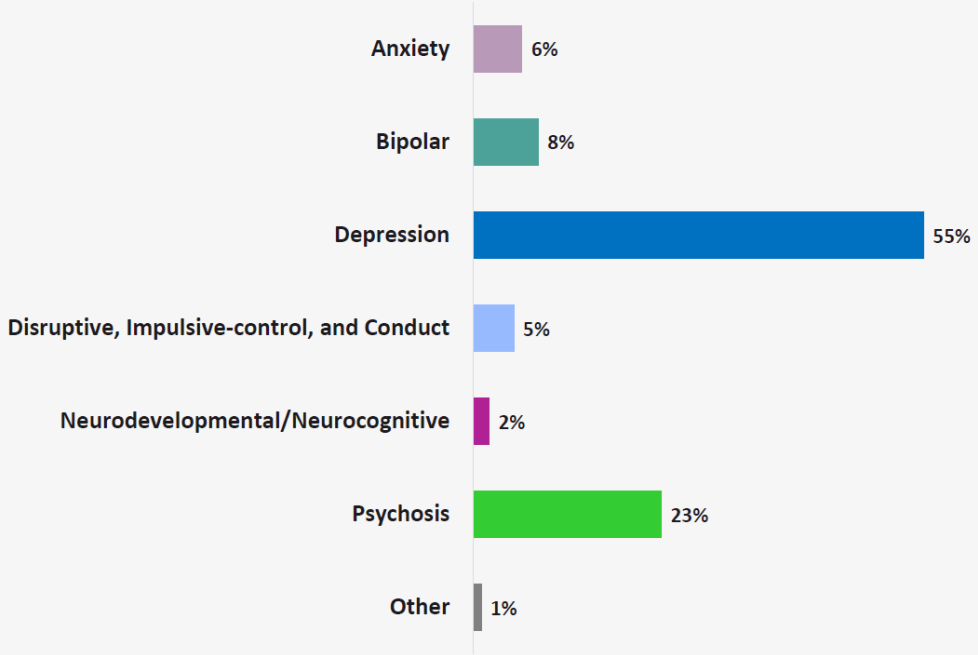
Success Story

CCRT was contacted by a local police department to collaborate with a consumer experiencing a behavioral health crisis. While "Abby" was experiencing psychosis, it was determined that she was not in need of an inpatient hospitalization. Law enforcement and CCRT staff collaborated with Abby and her family to find a safe resolution and appropriate level of care. CCRT also worked with her psychiatrist for medication support. A couple of days later, CCRT provided her with transportation to an appointment. CCRT followed up with Abby several weeks later and learned she was doing well without any further incidents.

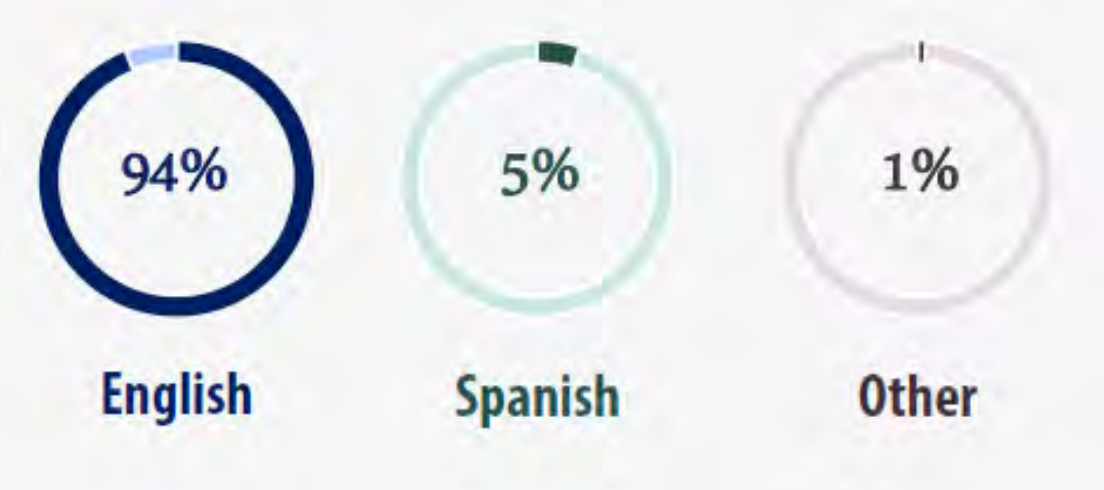
"Thank you CCRT because you guys helped to get my daughter and me the help we needed."

- CCRT consumer

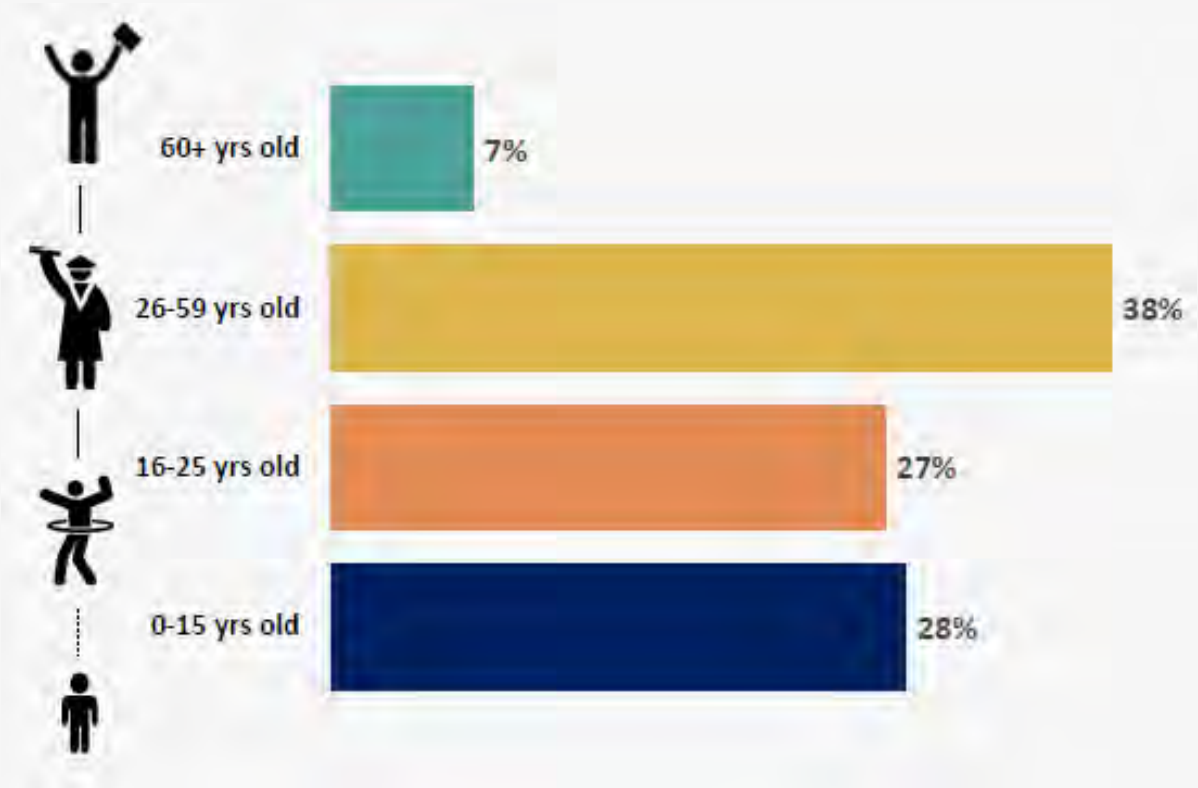
Program Demographics: Primary Diagnosis - CCRT



Program Demographics: Preferred Language - CCRT



Program Demographics: Age - CCRT



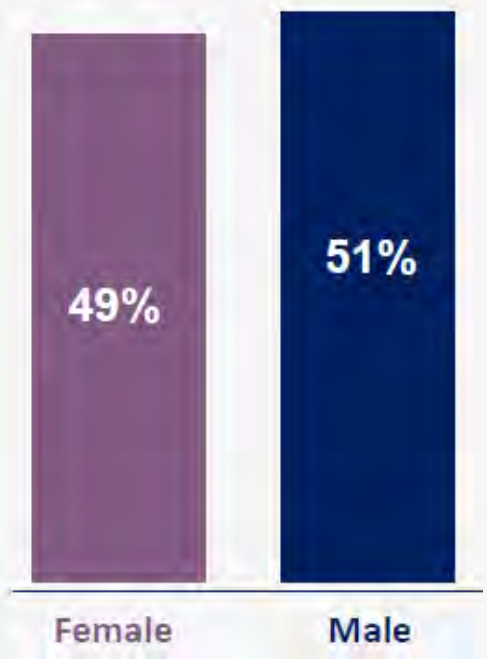
Challenges

CCRT transitioned from an on-call shift between the hours of 10:00 p.m. and 7:00 a.m. to a fully staffed night shift in three regions (e.g. East Valley, West Valley, and High Desert). The program faced hiring challenges with the new scheduling format and over the course of two years, the program was only able to hire one licensed staff to oversee the overnight shift. When that position became vacant, DBH collaborated with law enforcement partners to identify new operating hours of 7:00 a.m.-10:00 p.m., 7 days a week, 365 days a year.

Solutions in Progress

DBH managers are working in collaboration with the Human Resources Office (HRO) to make the CCRT program more attractive to aid in recruitment. Additionally, current CCRT staff are encouraged to apply for promotional opportunities.

Program Demographics: Gender - CCRT



Collaborative Partners

- Arrowhead Regional Medical Center (ARMC)
- Barstow Community Hospital
- Barstow Police Department
- Bear Valley Community Hospital
- Canyon Ridge Hospital
- Chino Valley Medical Center
- Children's Intensive Case Management Services
- Coalition Against Sexual Exploitation (CASE)
- Community Hospital of San Bernardino
- Desert Valley Medical Center
- Family Resource Centers
- Hi-Desert Medical Center
- Inland Regional Center (IRC)
- Juvenile Group Homes
- Kaiser Emergency Department and Outpatient Services
- Local police departments throughout San Bernardino County
- Loma Linda Behavioral Medical Center
- Loma Linda University Medical Center (LLUMC)
- Mountains Community Hospital
- National Alliance of Mental Illness (NAMI)
- Needles Desert Community Hospital
- Office of Veterans Affairs
- Private Providers (Medical and Psychiatric)
- Public and private schools
- Red Carnation House
- Redlands Community Hospital
- San Antonio Regional Hospital
- San Bernardino County Children's Network
- San Bernardino County, Department of Aging and Adult Services (DAAS)
- San Bernardino County, Children and Family Services (CFS)
- San Bernardino County, DBH One Stop TAY Centers, Clinics, Contract Agencies, and Crisis Walk-In Centers (CWIC) in three regions
- San Bernardino County, Probation Department
- San Bernardino County, Sheriff's Department
- St. Bernadine Medical Center
- St. Mary Medical Center
- The Counseling Team International
- Upland Police Department
- Victor Valley Global Medical Center

Crisis Intervention Training (CIT)

The Crisis Intervention Training (CIT) program provides training to law enforcement and community partners who respond to crisis calls where behavioral health issues are identified or suspected. The goal of each training is to enhance communication skills, identification of behavioral health resources for persons in crisis and ensure that first responders have the necessary education and tools to safely resolve the crisis situation.

In collaboration with the San Bernardino County Sheriff's Department, the CIT program carries out an average of four 32 hour CIT courses and four 8 hour Senate Bill 29 Field Training Officer (FTO) CIT courses per year. These trainings have resulted in increased law enforcement officer awareness of stigma associated with mental illness, the ability to access appropriate community resources, and an increase in law enforcement officer safety and the safety of consumers who are in crisis through de-escalation tactics.

Prior to Fiscal Year 2017/18, the CIT program's staffing consisted of one Mental Health Education Consultant. However, due to increased training requests from various collaborative agencies, the CIT program initiated a program expansion plan during Fiscal Year 2017/18. The expansion included adding a Program Manager I, an Office Assistant III, and three Staff Training Instructors to the team. With the staff increase, the CIT program was able to offer and facilitate additional specialized training and presentation opportunities to additional law enforcement agencies, fire, emergency management systems, emergency departments, and other community partners.

Artwork by Jeanelle Pearson

MHSA Legislative Goals and Related Key Outcomes

Increase a network of community support services:

- ◊ Increase in number of collaborative partners

Reduce the frequency of emergency room visits and unnecessary hospitalizations:

- ◊ Reduced rate of emergency room visits for mental health concerns
- ◊ Increased use of alternative crisis interventions (e.g., CWIC, CCRT, CSU)
- ◊ Increase in number of individuals diverted from hospitalization

Positive Results

- Throughout Fiscal Year 2017/18, **828** law enforcement and community partners received training from the CIT program.
- **277** law enforcement personnel completed the 32 hour CIT Course.
- **145** Field Training Officers (FTO) completed the 8 hour FTO CIT Course.
- **406** community partners, including fire, public employees, and emergency departments received specialized training from the CIT program.

Outreach and Engagement

In Fiscal Year 2017/18, the CIT program organized and/or participated in the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
CIT		
Cultural Competency Advisory Committee	1	65
Colton Redlands Yucaipa (CRY) ROP	1	8
DBH Law Enforcement Collaborative Meeting	2	45
Conference-Exhibit Hall	1	150
Azusa Pacific University Nursing Student	1	15
Coffee with the Chief/Cop-Community Meeting	9	205
Heart Advisory Committee SBUCSD	1	2
Probation Training Unit Meeting	3	18
Riverside County CIT Program	1	5
Osaka Japanese Social Work Student Presentations	1	26
2nd Annual County, School, and Campus Safety and Security Symposium	1	65
TAY Advisory Board	1	30
Station Briefings	2	26
Child Abuse Collaborative/ACE Meeting	5	82
Chino Police Department Meeting with CIT Team	4	34
Inland Counties Emergency Management Agency Meeting	1	7

CIT (cont.)		
Mountain Area Collaboration Meeting	1	13
Joint Terrorism Task Force (JTTF)/FBI Meeting	3	120
Sheriff Academy LD37 Class	2	75
Chino Valley Behavioral Health Coordination Meeting	1	18
Ontario PD/TEST Program Meeting	3	18
Redlands PD/TEST Program Meeting	1	5
Gangs and Drugs Taskforce Meeting	2	80
Health Fair	1	100
TOTAL	**49**	**1,212**

Challenges

One of the program challenges was establishing collaborative relationships with Emergency Management Systems (EMS) and Fire personnel who would benefit from behavioral health training.

Solutions in Progress

To tackle the challenge, the CIT program will focus efforts in attending more outreach events that are geared toward EMS and Fire personnel. CIT will also continue to work with Inland Counties Emergency Medical Agency (ICEMA) in an effort to create and deliver behavioral health training to EMS and Fire personnel.

In addition, a Sheriff Deputy and Social Worker II (SWII) will be added to the CIT team. The Sheriff Deputy will provide first hand knowledge and expertise on first responder culture and training needs. The SWII will assist all first responders in San Bernardino County by providing resources and case management/consultation via a phone hotline.

Collaborative Partners

- City of Chino Police Department
- The Counseling Team International
- Inland Counties Emergency Medical Agency (ICEMA)
- Inland Regional Center (IRC)
- National Alliance on Mental Illness (NAMI)
- Office of Veteran Affairs
- San Bernardino County Children's Network
- San Bernardino County, Department of Aging and Adult Services (DAAS)
- San Bernardino County, Probation Department
- San Bernardino County, Sheriff's Department

Artwork by Jess Ramos

Crisis Stabilization Continuum of Care

The Crisis Stabilization Continuum of Care (CSCOC) is a unit under the DBH's 24-Hour and Emergency Services division that has the responsibility of managing contracts along with Memorandum of Understandings (MOUs) with treatment providers who are delivering behavioral health services to consumers residing in San Bernardino County. The services offered through these contracts are centered on providing immediate intervention along with ongoing stabilization services to consumers who are experiencing a psychiatric crisis. These services of care are accessible through various settings operated by contracted treatment providers with DBH including Fee-For-Service Lanterman Petris Short (LPS) hospitals, Crisis Stabilizations Units (CSUs), Crisis Walk-In Centers (CWICs), and Crisis Residential Treatment Centers (CRTs).

CSCOC prioritizes the importance of having a collaborative partnership with the behavioral health treatment providers within this division to ensure that service delivery continually meets the requirements of the contractual agreements per setting. CSCOC achieves this responsibility by monitoring clinical services delivered to individuals on a regular basis along with collecting and analyzing performance outcome data that is specifically aligned to the contracts. The following are the contracted services monitored by CSCOC:

- Fee-For-Service LPS Hospitals provide inpatient treatment to individuals requiring voluntary or involuntary inpatient services. These consumers meet criteria for medical necessity by presenting as a danger to themselves or to others. The goals are to stabilize and link consumers to a lower level of care in the community for optimum recovery and stability.

- Arrowhead Regional Medical Center (ARMC) offers acute inpatient psychiatric services in a behavioral health unit and a CSU for consumers who meet the same criteria as outlined for Fee-For-Service LPS Hospitals, with the goal to stabilize and link consumers to a lower level of care. ARMC works closely with the DBH Long Term Care (LTC) program that is under the DBH Centralized Hospital Aftercare Services (CHAS) unit to provide long term placement options along with securing other viable treatment settings to meet the complex needs of consumers as recommended by a designated treatment team.

- Crisis Walk-In Centers (CWICs) are unlocked, voluntary, 23 hour psychiatric urgent care center that offers a positive, safe, and quiet environment to consumers of all ages experiencing a mental health crisis in this county. Consumers can be evaluated for a higher level of care, if necessary.

- Crisis Stabilization Units (CSUs) will provide crisis stabilization services offering clinical and psychiatric assessment, crisis intervention, and crisis stabilization for up to 23 hours. The goal is to stabilize individuals experiencing psychiatric crisis and to provide linkage to community outpatient services.

- Crisis Residential Treatment (CRT) facilities are voluntary 16 bed facilities for adults, ages 18 to 59, needing a structured treatment milieu for up to 90 days.

Artwork by Robin Cline

Crisis Walk-In Centers (CWIC) (A-4)

The Crisis Walk-In Center (CWIC) is an unlocked, voluntary, 23-hour psychiatric urgent care center that offers a positive and safe environment to consumers of all ages experiencing a behavioral health crisis in this county. Consumers can be evaluated for a higher level of care, if necessary. The CWICs are located in Joshua Tree (Morongo Basin Region), Victorville and Rialto. Centers are staffed by a multi-disciplinary team who focus on stabilizing consumers and providing linkage to resources within the community for follow-up behavioral health care and continued stabilization. At the CWICs located in Joshua Tree and Victorville, services are offered 24-hours per day, 7 days a week. The Central Valley CWIC (Rialto) operates Monday through Friday from 8:00 a.m. – 10:00 p.m. and Saturday 8:00 a.m. – 5:00 p.m. In collaboration with the Community Crisis Response Teams (CCRT) and the Triage, Engagement, and Support Teams (TEST), the CWICs work to reduce inappropriate hospitalizations and improve the quality of life for their consumers.

Two Crisis Stabilization Units (CSU) are coming to this county, specifically in the cities of Fontana and San Bernardino in the Fall of 2018. While the CSUs will operate similarly to the CWIC, CSUs will provide services to individuals ages 13 and older.

Artwork by Alyssa Iniow

Target Population:

- Children
- TAY
- Adults
- Older Adults

Projected Number to be Served:

- FY 2019/20

CWIC

- ◊ 386 Children
- ◊ 1,583 TAY
- ◊ 4,184 Adults
- ◊ 315 Older Adults

CSU

- ◊ 122 Children
- ◊ 480 TAY
- ◊ 1,096 Adults
- ◊ 94 Older Adults

MHSA Legislative Goals and Related Key Outcomes

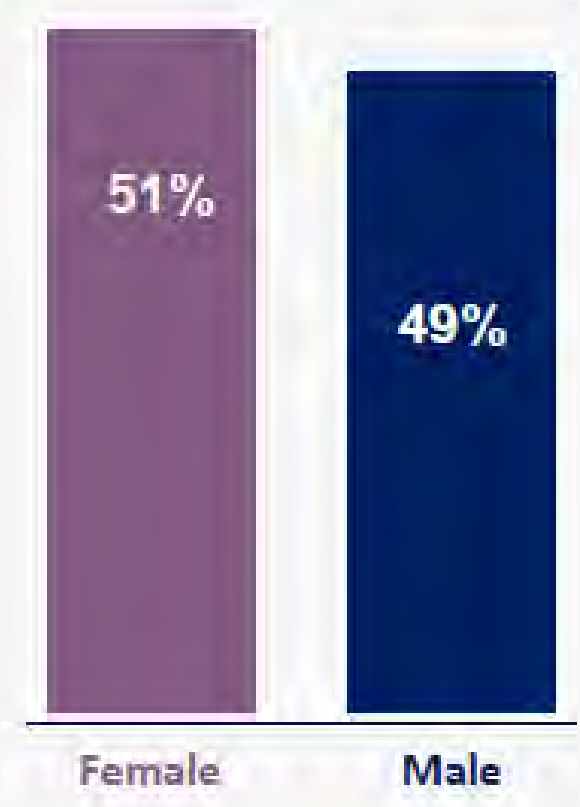
Reduce the subjective suffering from serious mental illness:

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

Reduce the frequency of emergency room visits and unnecessary hospitalizations:

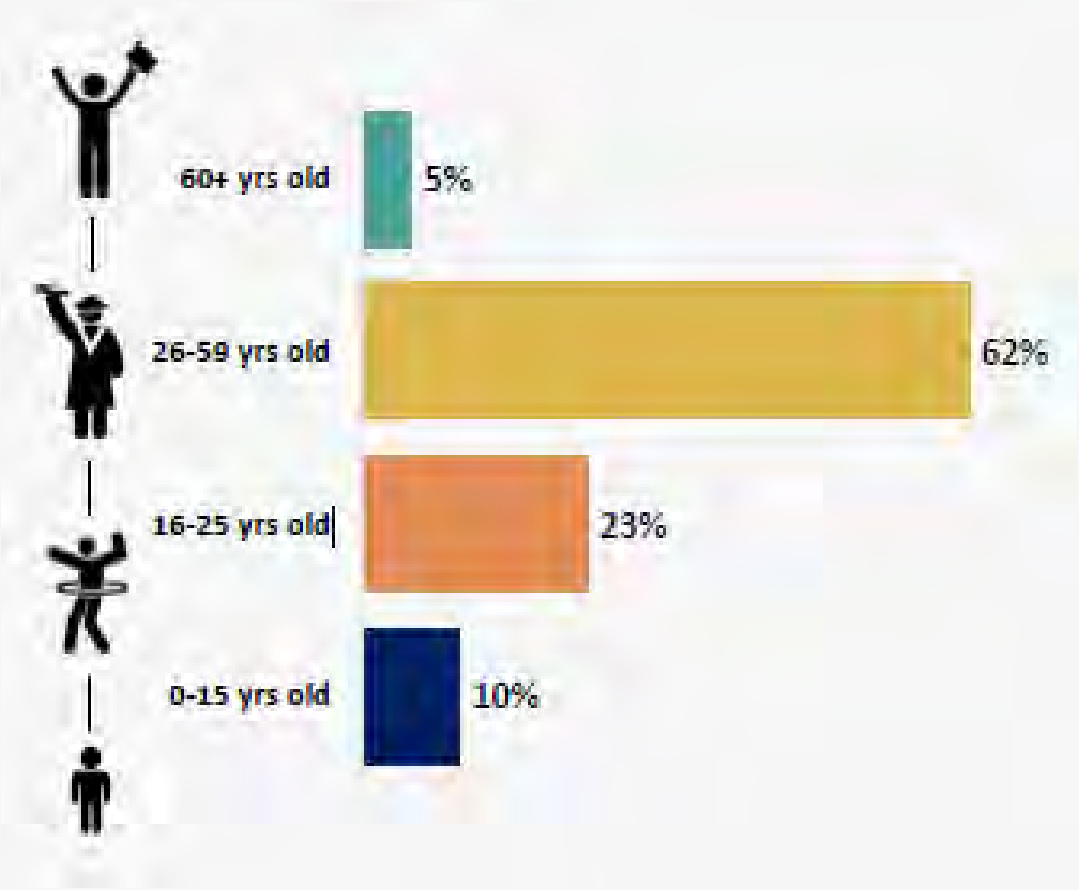
- ◊ Reduced rate of emergency room visits for mental health concerns
- ◊ Increased use of alternatives crisis interventions (e.g., CWIC, CCRT, CSU)
- ◊ Increase in number of individuals diverted from hospitalization

Program Demographics: Gender - CWIC



Program Demographics: Ethnicity - CWIC

Program Demographics: Age - CWIC



Positive Results

CWIC/CSU

- In Fiscal Year 2017/18, Rialto CWIC served **7,615** consumers and diverted **95.29% (7,257)** of consumers from hospitalization.
- In Fiscal Year 2017/18, contracted CWICs, Morongo Basin and Victorville, served **4,770** consumers and provided **7,188** referrals and linkages. Referrals and linkages included linkages to medication support (2,957), referrals to outpatient clinics (1,675), and referrals to community resources including, but not limited to, housing, legal services, and food banks (2,556). Of the 4,770 served, **4,528 (94.93%)** were diverted from hospitalization.
- The two CSU centers are in process of being built and anticipating to deliver services to consumers in the Fall of 2018.

Outreach and Engagement

In Fiscal Year 2017/18, the CWIC program organized and/or participated in the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
CWIC		
Health and Resource Fair	14	925
Probation Orientation	24	280
Collaborative Meetings with Various Community Partners	69	2,230
School Presentations	3	275
Workshop Presentation	1	125
Other Community Outreach	1	100
TOTAL	**112**	**3,935**

Program Demographics: Primary Language - CWIC

Challenges

CWIC/CSU

One of the challenges, particularly in the Joshua Tree (Morongo Basin) Region, is the lack of additional behavioral health resources, such a psychiatric services for medication support. Another challenge was adapting to a variety of populations, as the CWICs continued to support outpatient clinics and specialty programs.

Solutions in Progress

CWIC/CSU

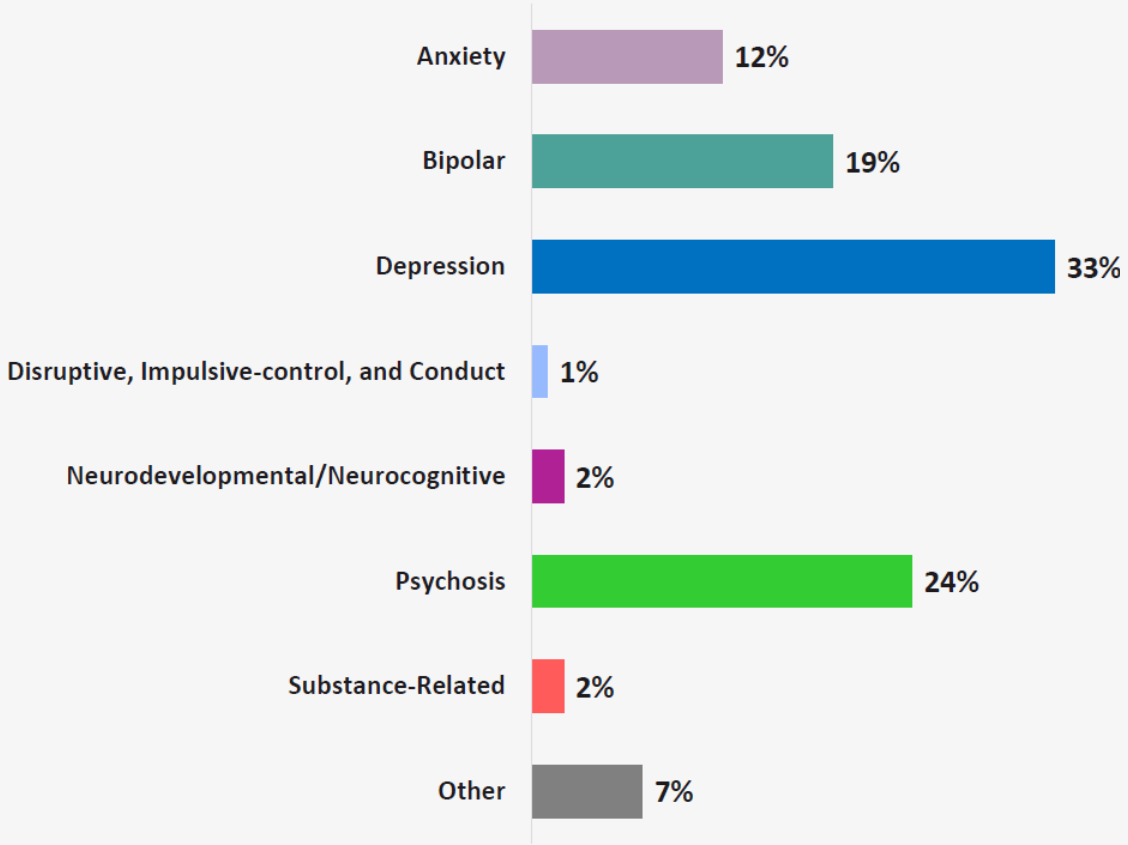
With the opening of one of four Crisis Residential Treatment (CRT) facilities (remaining three CRTs are scheduled to open for services in Fall 2018), remote regions of the County will have additional options for mental health services. CWIC/CSU staff will continue to do outreach to community partners regarding the various services being offered at the CWIC/CSUs (when open) as well as collaborate with community partners to help bridge gaps in services. CWIC/CSUs will continue to enhance resource development to support various populations including the recently released forensic population experiencing behavioral health conditions.

Success Story

"Jim" was feeling helpless and had nowhere to go before visiting his local CWIC. The CWIC staff provided transportation to Jim and helped him secure long-term housing. After a few weeks, Jim returned to the CWIC to share his appreciation for their help and how the services received at CWIC saved his life.

"Pam", who had a history of homelessness, visited her local CWIC on several occasions. However, after being seen by the CWIC staff, Pam declined services. On her most recent visit, she consented to have an assessment completed followed by discussing available treatment options. Since accepting services, Pam has not returned to the CWIC for crisis services.

Program Demographics: Primary Diagnosis - CWIC



Collaborative Partners

- Arrowhead Regional Medical Center (ARMC)
- Barstow Community Hospital
- Barstow Police Department
- Bear Valley Community Hospital
- Canyon Ridge Hospital
- Chino Valley Medical Center
- Children's Intensive Case Management Services
- Coalition Against Sexual Exploitation (CASE)
- Community Hospital of San Bernardino
- Desert Valley Medical Center
- Family Resource Centers
- Hi-Desert Medical Center
- Loma Linda Behavioral Medical Center
- Loma Linda University Medical Center (LLUMC)
- Mountains Community Hospital
- National Alliance of Mental Illness (NAMI)
- Needles Desert Community Hospital
- Office of Veterans Affairs
- Office of Veterans Affairs
- Private Providers (Medical and Psychiatric)
- Public and private schools
- Red Carnation House
- Redlands Community Hospital
- San Antonio Regional Hospital
- San Bernardino County Children's Network
- San Bernardino County, Department of Aging and Adult Services (DAAS)
- San Bernardino County, Children and Family Services (CFS)
- San Bernardino County, DBH One Stop TAY Centers, Clinics, Contract Agencies, and Crisis Walk-In Centers (CWIC) in three regions
- San Bernardino County, Probation Department
- San Bernardino County, Sheriff's Department
- St. Bernadine Medical Center
- St. Mary Medical Center
- Triage, Engagement, and Support Teams (TEST)
- The Counseling Team International
- Upland Police Department
- Victor Valley Global Medical Center

Crisis Residential Treatment (CRT) (A-10)

The Crisis Residential Treatment (CRT) program consists of short-term (less than **90** days) voluntary crisis residential treatment for San Bernardino County adult residents, age **18 to 59**, who are experiencing an acute psychiatric episode or crisis and are in need of short-term crisis residential treatment services to deter acute psychiatric hospitalization. CRTs serve as an alternative to hospitalization for consumers experiencing psychiatric episodes or crises and consist of a homelike environment that supports and promotes the consumer's recovery, wellness, and resiliency within the community. Services are offered 24-hours a day, 365 days a year (24/7).

Casa Paseo CRT in San Bernardino opened on September 15, 2017. Upcoming CRTs will be located in Victorville, Fontana, and Morongo Basin in Fall of 2018. Each facility is designated to have a living/common space area, family room, group rooms, separate interview rooms, bedrooms designed with separate living and visiting spaces, laundry room, cooking facilities, an outdoor patio, and gardening areas.

Consumers in need of this level of care will be provided case management and mental health services. The program is designed to empower and support diverse consumers in the process of stabilization and transition to outpatient services. It provides the following structured recovery-based, enriched treatment services, and activities:

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

Target Population:

- TAY
- Adults

Projected Number to be Served:

- FY 2019/20
  - ◊ 158 TAY
  - ◊ 1,359 Adults

The program provides crisis interventions for consumers diagnosed with a mental health or co-occurring mental health and substance use disorders. Services are culturally and linguistically appropriate, allow for freedom of choice and embrace recovery principles.

MHSA Legislative Goals and Related Key Outcomes

Reduce the subjective suffering from serious mental illness for adults and serious emotional disorders for children and youth:

- Decrease hopelessness/increased hope
- Increased resiliency
- Decreased impairment in general areas of life functioning (e.g., health/ self-care/housing, occupation/education, legal, managing money, interpersonal/social)

Reduce the frequency of emergency room visits and unnecessary hospitalizations

- Reduced rate of emergency room visits for mental health concerns
- Reduced number of emergency room visits for routine medical concerns
- Reduced administrative hospital days
- Increased use of alternative crisis interventions (e.g., CWIC, CCRT, CSU)
- Increase in number of individuals diverted from hospitalization

Success Story

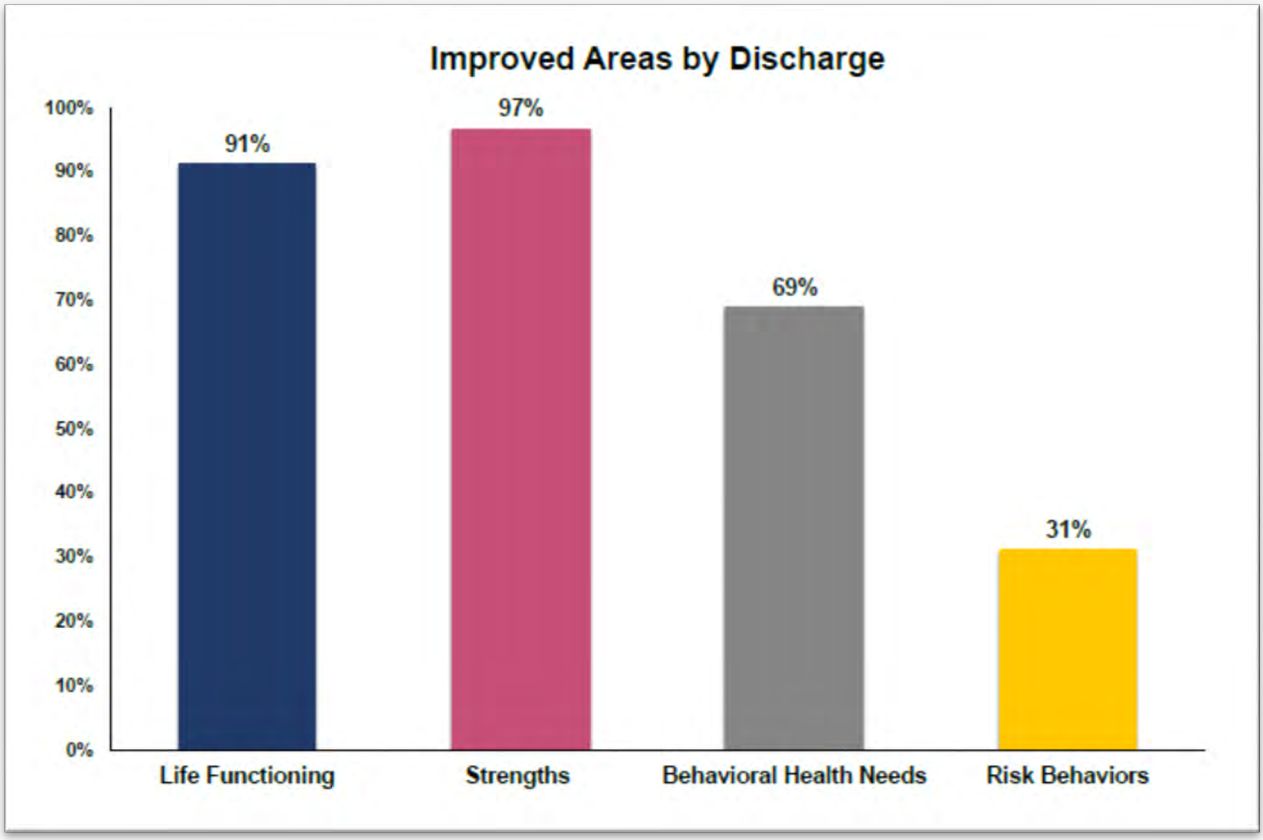
"Barney" was referred to CRT because he had a history of high utilization of psychiatric hospitals, homelessness, substance use, and frequent contact with the legal system. The CRT staff was able to help Barney stabilize his mental health crisis through medication support services, daily wellness group activities, weekly individual psychotherapy, and substance use treatment classes. With CRT's assistance, he has maintained his sobriety. Upon discharge, he was able to secure housing, outpatient mental health services, and substance use services.

Positive Results

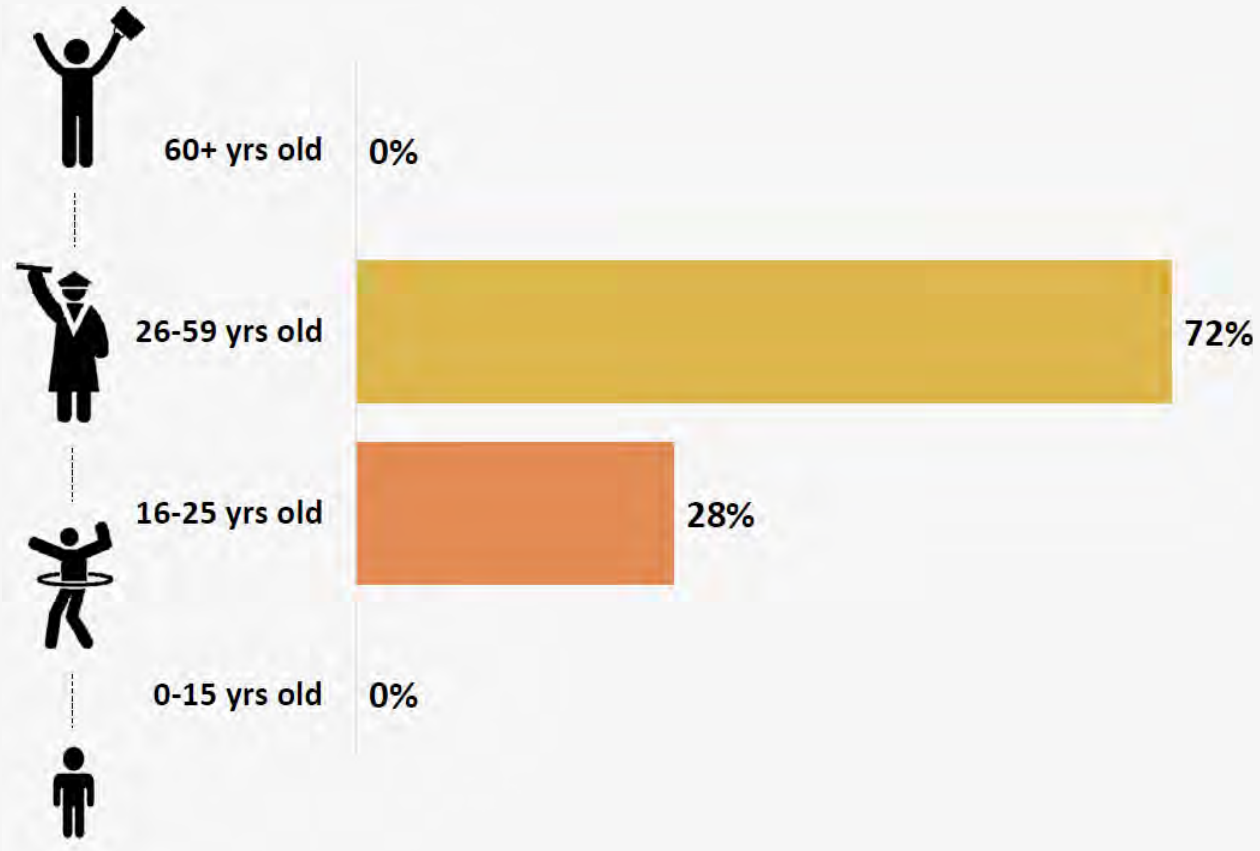
Casa Paseo

- Since the opening of the program on September 15, 2017 to September of 2018, Casa Paseo served **102** consumers with an average of 4.13 administrative days. Prior to admission, 66 consumers had previous hospitalizations. Post discharge, **47** (**71%**) of the 66 consumers, who had previous hospitalizations, had not been hospitalized after discharge.

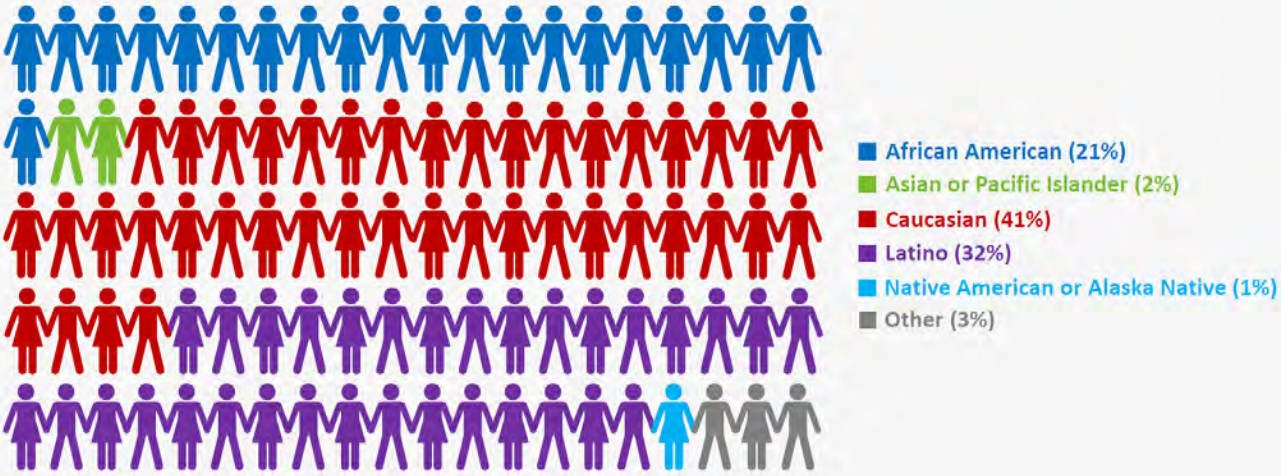
In Fiscal Year 2017/18, results from the Adult Needs and Strengths Assessment (ANSA) show the percentage of clients (N=45) who presented with a significant issue, and had that issue improve by end of participation in the program.



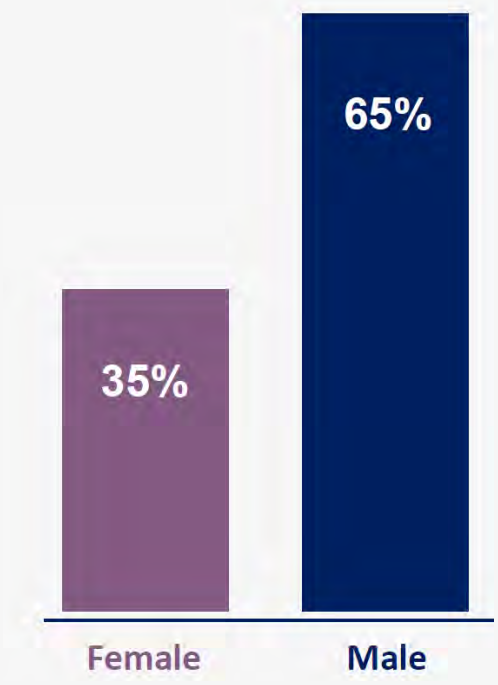
Program Demographics: Age



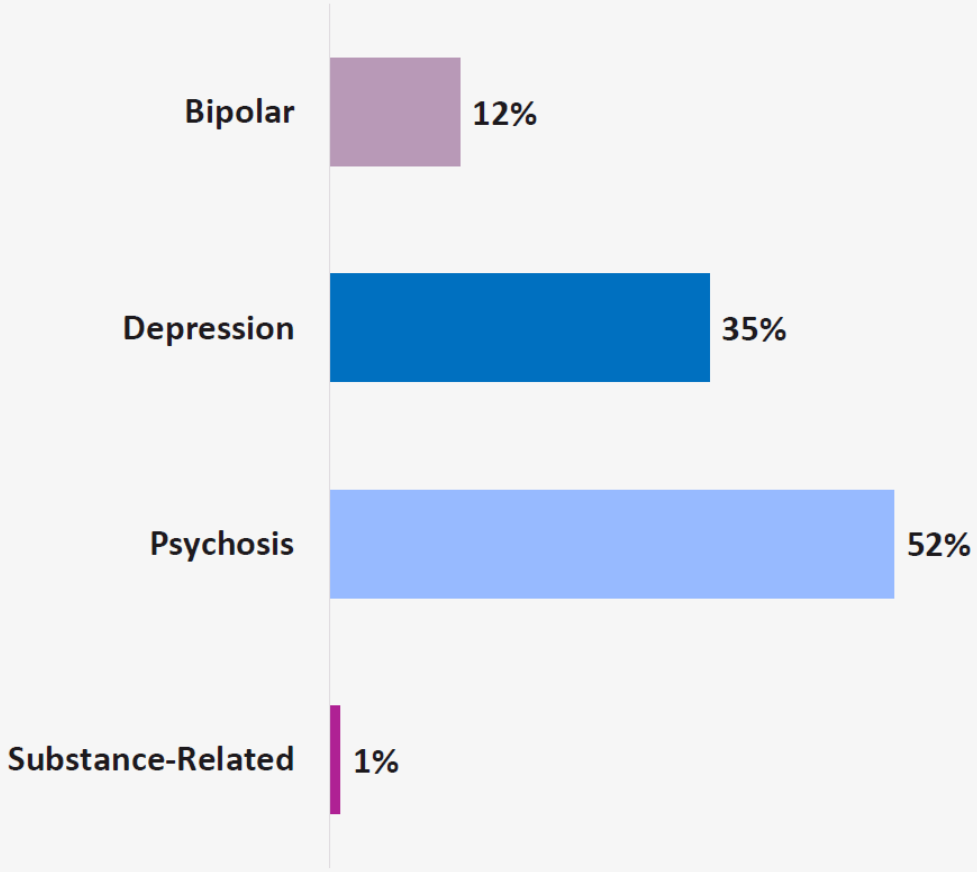
Program Demographics: Ethnicity



Program Demographics: Gender



Program Demographics: Primary Diagnosis



Challenges

Casa Paseo

Casa Paseo experienced a number of consumers discharging from the program against clinical advice prior to program completion or having appropriate housing and outpatient services established. During the fiscal year, 30 (27%) of 110 consumers who discharged from the program left against clinical advice.

Solutions in Progress

Casa Paseo

A majority of those consumers who left against clinical advice were consumers who entered into the program in its infancy. The number of consumers leaving against clinical advice has dropped in recent months, and it is believed that peers' positive influences are attributed to the decline in consumers' decisions to leave early. The program will continue to empower consumers to support each other positively. Casa Paseo will also address this challenge by encouraging to continue with regular attendance at Alcoholic Anonymous and Narcotics Anonymous meetings in the community for our residents who struggle with substance use. The program added the "Recovery Road to our Wellness" curriculum to the schedule which offers in-house drug treatment programming, one time per week, by a Resource Specialist/ Alcohol, Tobacco, and Other Drug (ATOD) counselor.

In Fiscal Year 2018/19, three additional CRT facilities will open in the Fall of 2018:

- Desert Hill Center in Victorville
- Morongo Oasis Center in Joshua Tree
- Wellspring Center in Fontana

Outreach and Engagement

In Fiscal Year 2017/18, the CRT program organized and/or participated in the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Crisis Residential Treatment (CRT)		
Engagement meeting with Citadel Community Development Corporation (San Bernardino)	1	3
Engagement meeting with Helen Lawrence Immigration Public Defender	1	1
Presentation to Law Enforcement CIT Training	2	75
Engagement meeting with Rosa Huertas, Federal Probation Officer	1	1
Presentation to San Bernardino County Probation Department	2	25
Chino Police Department Health Fair	1	100
NAMI Triathlon	3	150
Engagement meetings with San Bernardino County Hospitals	5	50
Engagement meetings with San Bernardino County DBH clinics and programs	5	75
Presentation to California Mental Health Advocates for children and youth	1	35
Total	**22**	**515**

Program Demographics: Primary Language

Collaborative Partners

- Arrowhead Regional Medical Center (ARMC)
- California Conservation Corps
- Canyon Ridge Hospital
- Citadel Economic Development Corp.
- Community Hospital of San Bernardino
- Helping Hearts
- Inland Empire Job Corps Center
- Premier Program
- Red Carnation
- Redlands Community Hospital
- San Antonio Hospital
- San Bernardino County, DBH Clinics, Choosing Healthy Options to Instill Change and Empowerment (CHOICE), Crisis Walk-In Centers (CWICs), Member Assertive Positive Solution (MAPS), One Stop TAY Centers, Recovery Based Engagement Support Team (RBEST)
- San Bernardino County, Probation Department
- San Bernardino County, Public Guardian
- San Bernardino County, Regional Occupational Program (ROP)

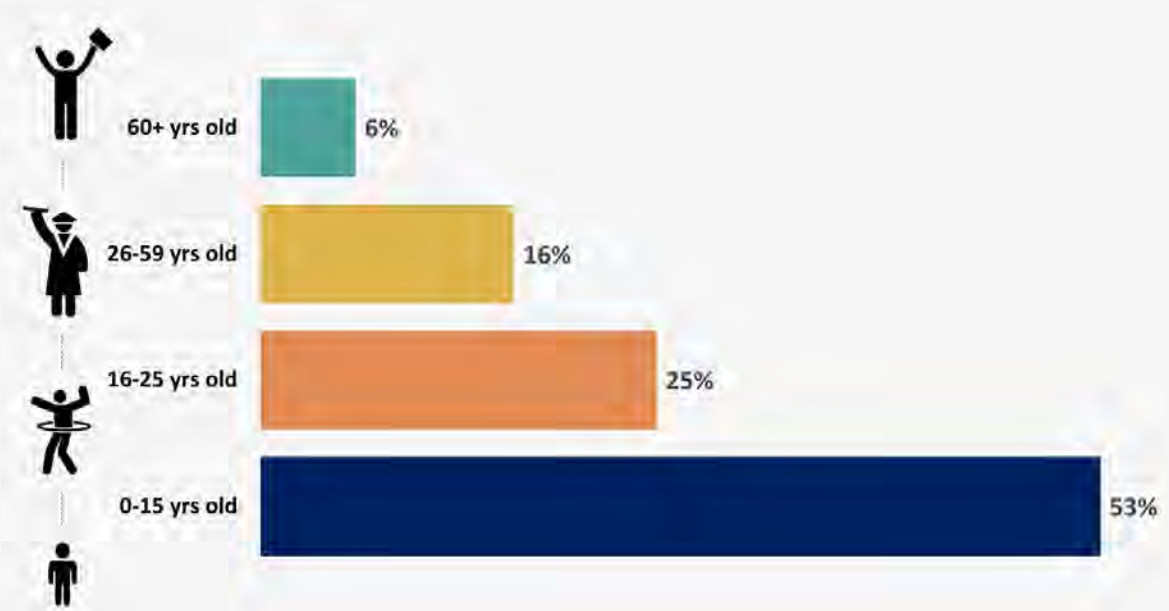
Full Service Partnerships

Full Service Partnership (FSP) programs are designed for consumers who have been diagnosed with a severe mental illness or serious emotional disturbance and would benefit from an intensive service program. FSP services comprehensively address client and family needs and do “whatever it takes” to meet those needs, including supports and strong connections to community resources with a focus on resilience and recovery. FSP programs implement key practices that consistently promote good outcomes for mental health consumers and their families and differ from traditional, clinic-based outpatient care due to the 24 hour per day, 7 days per week available support. Frequently, FSP services are field-based and are population and age specific.

The primary goals for the FSP programs are to reduce the subjective suffering of consumers living with a behavioral health condition, reduce homelessness and increase safe and permanent housing, reduce unnecessary psychiatric hospitalizations, reduce justice involvement, reduce crisis services, and reduce out of home placement for children and youth.

FSP Consumer Ages, Fiscal Year 2017/18

Unduplicated, with at least one service



Comprehensive Children and Family Support Services (C-1)

Comprehensive Children and Family Support Services (CCFSS) programs serve children and youth with intensive mental health needs. The most significant change from last year is that the planned expansion of the Children's Residential Intensive Services (ChRIS) program has been implemented with 24 new providers joining this program as of July 1, 2017. The program is still comprised of three unique Full Service Partnership (FSP) programs which utilize the Core Practice Model (CPM) to serve children and youth.

The three Full Service Partnership (FSP) programs are:

- Children's Residential Intensive Services (ChRIS) integrates the FSP approach within the residential care of children and youth placed into a group home by either Children and Family Services (CFS) or Probation.
- Wraparound is a collaborative program between the Department of Behavioral Health (DBH) and Child and Family Services (CFS) designed to serve wards and dependents who are at risk of needing group home services. All referrals for Wraparound are made by CFS or Probation.
- Success First/Early Wrap is a short-term wrap-informed FSP which serves children and youth who are not eligible for Wraparound services outlined in SB 163 but are having sufficient difficulties that without intervention a higher level of service is likely to be required.

Target Population:

- Children
- TAY
- Adults

Projected Number to be Served:

- FY 2019/20
  - ◊ 2,050 Children
  - ◊ 525 TAY
  - ◊ 30 Adults

All three FSP programs can refer to Therapeutic Behavioral Services (TBS) program as a short-term service that provides one on one coaching in conjunction with other specialty mental health services to help children and youth in need of intensive services.

CCFSS programs help develop service plans that focus on the individual strengths and needs of children/youth or consumers and families. The process provides individualized, comprehensive, community-based services and supports to children and families. Wrap informed full service partnerships that utilize the Core Practice Model structure have proven to be an effective means by which children and youth receive assistance

and avoid out-of-home placements or loss of current placements due to the severity of their emotional disturbance. Additionally, participants are helped in accomplishing appropriate goals and developing constructive relationships within their family and community.

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

MHSA Legislative Goals and Related Key Outcomes

Reduce the subjective suffering from serious emotional disorders for children and youth:

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

Reduce homelessness and increase safe and permanent housing:

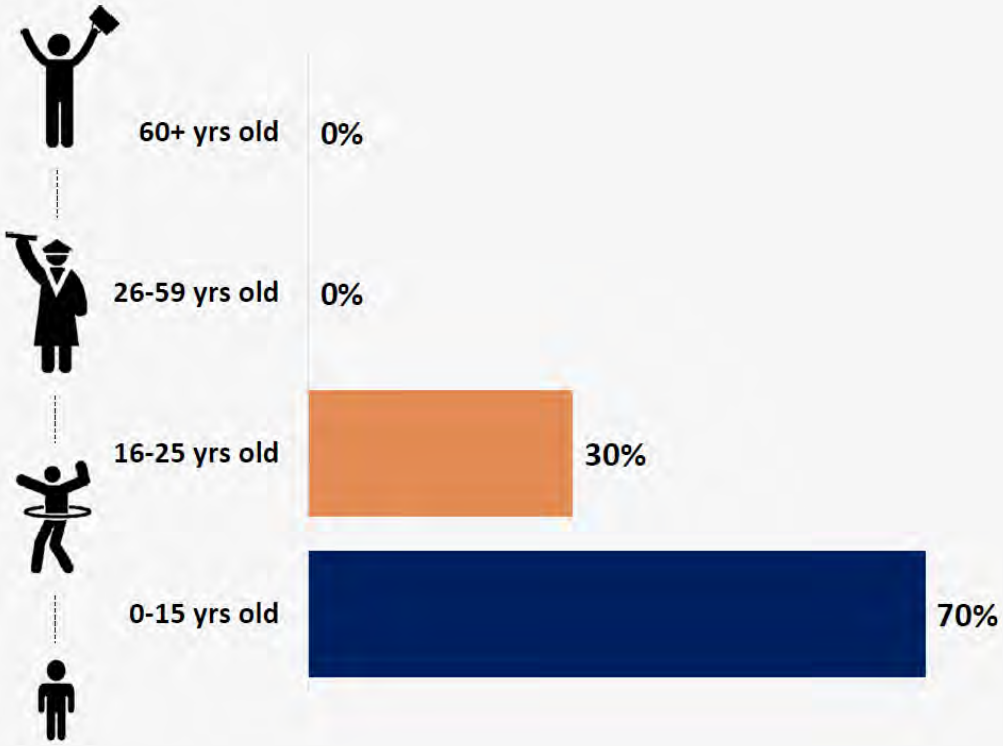
- ◊ Increased residence stability and safe and permanent housing

Reduction in criminal and juvenile justice involvement:

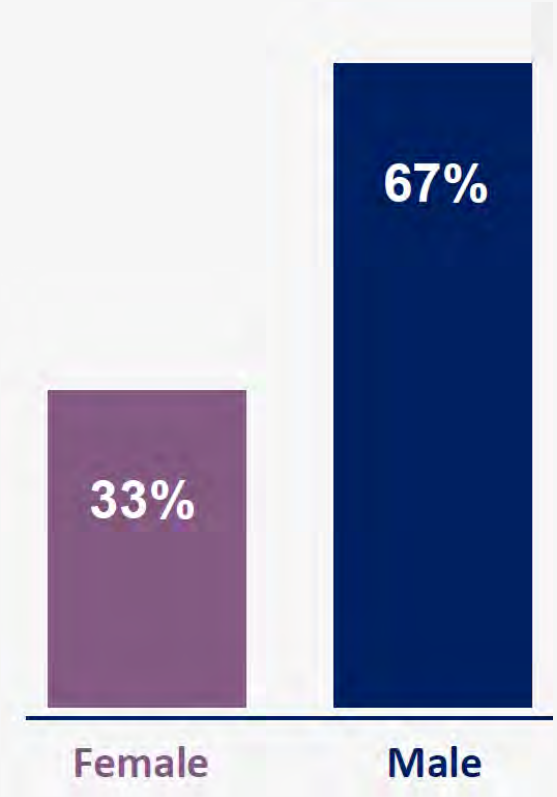
- ◊ Reduce delinquent behaviors which increase likelihood of juvenile justice involvement
- ◊ Reduce difficulties related to conduct disorders

Program Demographics: Primary Language

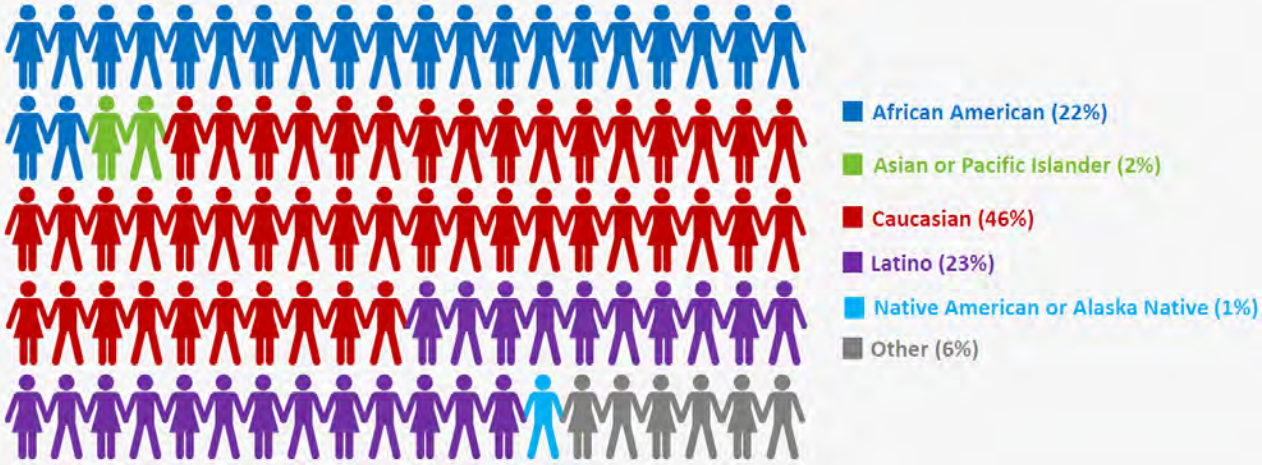
Program Demographics: Age



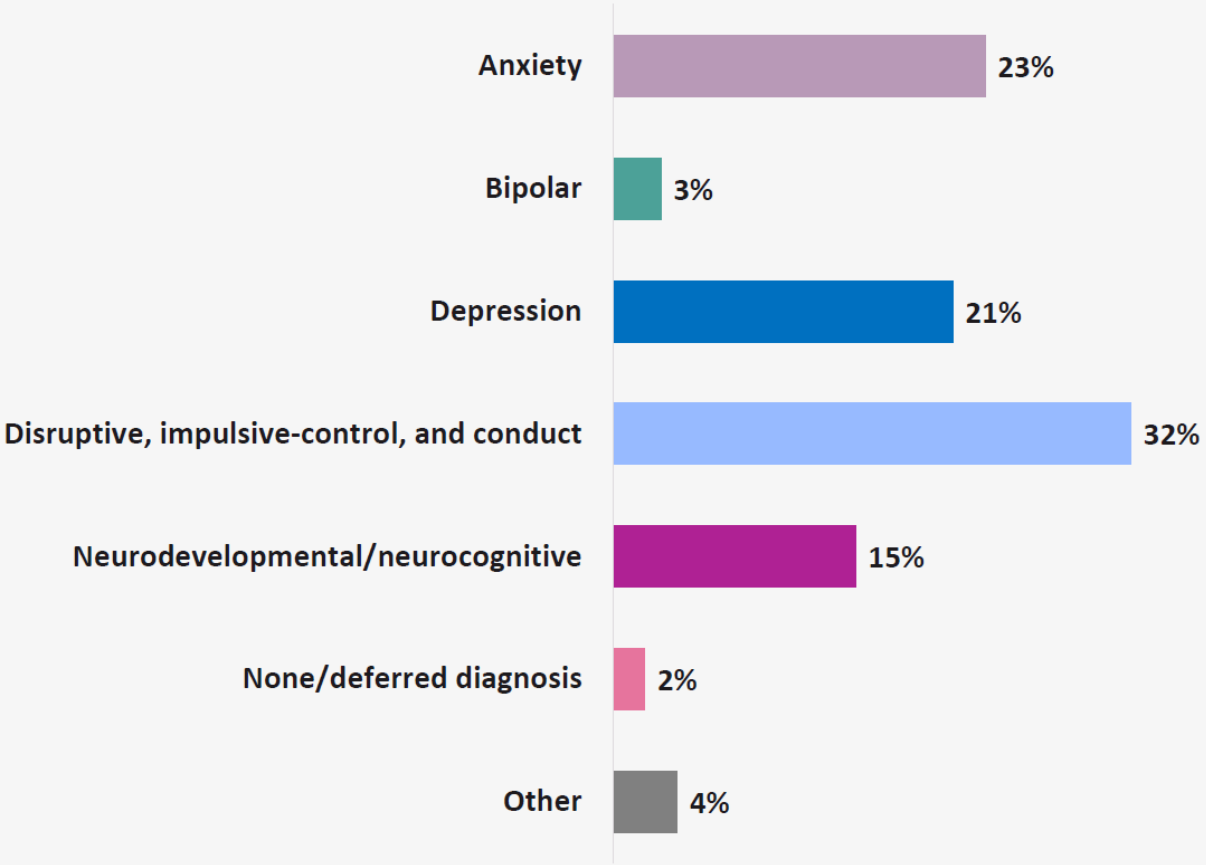
Program Demographics: Gender



Program Demographics: Ethnicity



Program Demographics: Primary Diagnosis



Positive Results

The Child Adolescent Needs and Strengths (CANS) assessment tool is utilized within all CCFSS programs. The CANS data in Fiscal Year 2017/18 was used by all CCFSS Full Service Partnership (FSP) programs and is analyzed in two ways: Global Measurement and Specific Area/Construct. The Global Measurement analysis incorporates specific items in a domain (e.g., Life Functioning) and compares scores from the onset of services to the planned discharge. The Specific Area analysis considers only those children and youth who presented with a significant need for help on an item/construct and reports what percentage of those children and youth no longer needed help on that issue at the conclusion of services.

Of all of the children and youth who started a CCFSS program, **73%** successfully completed the program and had a 'planned discharge'. Of those children and youth, the following issues and outcomes in improvement are described below:

Global Measurement of Life Functioning:

- **98.9%** of children and youth entering CCFSS Programs were scored as having at least one area of impaired life functioning (Progression Report).
- **74.1%** of these children showed significant improvement in this area that no additional help was needed at the time of exiting the program (Reliable Change Index Report).

Specific Areas of Life Functioning (Impact Report):

Family Difficulties:

- **81%** of the children needed help with family difficulties.
- Of those, **72%** showed sufficient improvement in this area that no additional help was needed at the time of exiting the program.

Social Functioning:

- **73%** of the children needed help improving their social functioning.
- Of those, **72%** showed sufficient improvement in this area that no additional help was needed at the time of exiting the program.

Recreational:

- **43%** of children needed help with positive recreational leisure time activities.
- Of those, **59%** showed sufficient improvement in these area that no additional help was needed at the time of exiting the program.

Sleep:

- **37%** of the children needed help with sleep disruption.
- Of those, **74%** showed sufficient improvement in this area that no additional help was needed at the time of exiting the program.

School Behavior:

- **58%** of the children needed help with behavior in school.
- Of those, **75%** showed sufficient improvement in this area that no additional help was needed at the time of exiting the program.

School Achievement:

- **56%** of the children needed help with academic achievement.
- Of those, **65%** showed sufficient improvement in this area that no additional help was needed at the time of exiting the program.

School Attendance:

- **28%** of the children needed help with school attendance deterrents.
- Of those, **74%** showed sufficient improvement in this area that no additional help was needed at the time of exiting the program.

Global Measurement of Behavioral and Emotional Needs:

- **99.3%** of children and youth entering CCFSS programs were scored as having at least one significant behavioral or emotional need.
- **72.5%** of these children showed statistically significant improvements upon exiting the program.

Specific Areas of Behavioral and Emotional Needs:

Impulsivity/Hyperactivity:

- **54%** of the children required treatment for difficulties related to impulsivity and/or hyperactivity.
- Of those, **59%** showed sufficient improvement in this area that no additional help was needed at the time of exiting the program.

Depression:

- **51%** of the children required treatment for difficulties related to depression.
- Of those **70%** of them showed sufficient improvement in this area that no additional help was needed at the time of exiting the program.

Anxiety:

- **44%** of the children required treatment for difficulties related to anxiety.
- Of those, **63%** of them showed sufficient improvement in this area, that no additional help was needed at the time of exiting the program.

Anger Control:

- **76%** of the children require treatment of anger control.
- Of those, **76%** showed sufficient improvements in this area that no additional help was needed at the time of exiting the program.

Adjustment to Trauma:

- **50%** of the children required treatment for difficulties adjusting to a traumatic experience.
- Of those, **61%** showed sufficient improvement in this area that no additional help was needed at the time of exiting the program.

The concept of residential stability is different for children than it is for adults. Children coming to the CCFSS programs are in a variety of situations regarding their residence. Some children reside with biological families and do not have any child welfare involvement, while other children reside with biological families and do have child welfare involvement. Some children are placed into a family and others are placed into a group home or Short Term Residential Therapeutic Program (STRTP) by Children and Family Services (CFS) or Probation.

In addition to the question of residential stability for the caregiver, the key outcomes likely to increase residential stability for a child are: being with a caregiver likely to be involved once the child has grown, how well the child is functioning within the family home, and how involved and knowledgeable the caregiver is in regards to the needs of the child. These last items are indicative of a level of engagement from the caregiver and more engaged caregivers are less likely to work toward having the child removed from their home.

Specific indicators likely to increase residential stability:

Caregiver's Residential Stability:

- **8%** of the caregivers involved in the CCFSS programs indicated needing help in obtaining a more stable residence. **68%** of those needing this residential stability were able to obtain this by the end of services.
- **66%** of the children started a CCFSS Program needing help improving their functioning within their living situation. **76%** of these children were able to significantly improve on this item, indicating a decrease in conflict within the home.
- **15%** of the caregivers were significantly uninvolved with the mental health needs of their children at the time of admission. **70%** of these caregivers were appropriately involved by the end of services.

- **50%** of the caregivers showed a low level of knowledge regarding the child's mental health needs at the start of services. **70%** of these caregivers gained enough knowledge related to the child's needs that this was of no concern by the end of the program.

More than half **(74.5%)** of the children seen in CCFSS programs needed help with issues that could easily lead to criminal or juvenile justice involvement. However, only **17%** had specific difficulties related to formal legal charges. Evaluating the effectiveness of CCFSS on reducing the likelihood of juvenile justice involvement focuses on the impact made on these specific issues which could lead to juvenile justice involvement.

Specific indicators likely to increase juvenile justice involvement:

Delinquency:

- **9%** of the children were engaging in delinquent type of behaviors that could result in an arrest at the start of services.
- **80**% of these children were no longer seen as needing help on this upon exiting the program.

Danger to Others:

- **26%** of the children needed help to address the possibility that they would harm someone else.
- **81%** of these children were no longer considered to be at risk for harming others at the end of the program.

Runaway:

- **7%** of the children seen were engaging in runaway behaviors at the start of services.
- **76%** of them successfully managed to stop these behaviors by the end of services.

Conduct Disorder Behaviors:

- **20%** of the children displayed conduct disorder behaviors requiring intervention at the start of services.
- **78%** of these children improved to the point of not needing help with this issue upon discharge.

Oppositional Behaviors:

- **64%** of the children needed help with oppositional behaviors at the start of services.
- **69%** of these children improved to the point of not needing help with this issue upon discharge.

Outreach and Engagement

In Fiscal Year 2017/18, the CCFSS program organized and/or participated in the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Referral Coordination and Outreach	281	281
Consultations	1,696	201
Total	**1,977**	**482**

"My child has been able to manage her anger more effectively ever since we started with the program, and I feel like I have a lot of support."

Caregiver of CCFSS consumer

Challenges

Challenges faced in the various CCFSS programs were slightly different for each program; they were often related to the large scale shift of services for children and youth in California with the implementation of the Continuum of Care Reform (CCR). CCR impacted multiple aspects of Human Services for Dependents, Wards, and others.

CCR establishes the new residential license of Short Term Residential Therapeutic Programs (STRTPs) and sundowns the established group home system. Every ChRIS provider was navigating this transition during Fiscal Year 2017/18 and continues to navigate ongoing changes. Additionally, those agencies starting with Children's Residential Intensive Services (ChRIS) as of July 1, 2017 needed to learn the requirements of being an FSP and a Medi-Cal provider while simultaneously applying to become an STRTP.

Wraparound and Success First/Early Wrap are needed to increase the incorporation of Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) within the array of services provided to children and youth served by these programs. It is critical to include these services to ensure the Full Service Partnerships (FSP) are meeting the need for intensive coordination and coaching, but it requires established programs to make significant shifts in service delivery patterns and expectations. Some agencies have embraced these services, some agencies are still working to include them consistently, and few agencies appear to be providing ICC and IHBS at the exclusion of other services.

The presumptive transfer of Medi-Cal to the county of residence unless there is waiver submitted by the placing social worker for probation officer took effect in Fiscal Year 2017/18. Since all CCFSS programs incorporate Medi-Cal, this had a significant impact. Some ChRIS providers located outside of San Bernardino decided to discontinue the program since children and youth placed with them could be served through a Host County program. Other providers, located within San Bernardino, needed to learn to navigate the incorporation of another county's placement processes and system, since integration of services with the placing agency is a critical element of the FSPs. Lastly, while Fiscal Year 2017/18 did not show the full impact, there is concern that the resources allocated to CCFSS will be utilized by children and youth placed into the county of San Bernardino.

"I think I have better communication because I talk to a lot people now. I have better eye contact. I got new friends, and I tried out new things like soccer."

Consumer of CCFSS

Solutions in Progress

In an attempt to help the ChRIS agencies navigate the transition to Short Term Residential Therapeutic Programs (STRTP), DBH has been (1) conducting regular program meetings (once or twice a month, depending upon agency); (2) providing consultations with specific clinical staff liaisons; (3) conducting on site visits to help establish required practices; and (4) providing one on one coaching on specific requirements.

In an attempt to help all the Full Service Partnerships (FSPs) incorporate Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) in an appropriate manner, DBH has been incorporating discussion of these services, and their use within a specific program or agency, in program meetings, agency meetings, and on site visits.

In an attempt to help navigate the impact of presumptive transfer of Medi-Cal, the outreach and engagement team within CCFSS was increased during Fiscal Year 2017/18. Staffing of this increase was delayed due to a variety of reasons, but approximately half of the expected staff started by the end of the first quarter of Fiscal Year 2018/19. The intention is to have these clinical staff function as a hub through which CCFSS providers will be better able to navigate issues related to presumptive transfer.

"I've accomplished being less angry, like I can control my anger better. I feel a lot more confident in like, talking to people. I am able to have more regular conversations."

Consumer of CCFSS

Success Story

"Kevin," a young child, struggled with poor school attendance, symptoms of a mental health issue, cried frequently, felt isolated, and had poor hygiene. Kevin's parent reached out for services to help her child. Kevin was provided a psychiatric evaluation, individual therapy, rehabilitation services, and child and family team meetings. The Success First/Early Wrap program staff helped the child build their self esteem and feelings of self-worth. They also helped identify his feelings regarding grief and loss. They worked with Kevin and his parent to develop a regular and consistent hygiene routine. He began attending school on a consistent basis and his grades improved significantly. He interacted more with others, developed friendships and, as a result, he felt less isolated and his self-esteem improved. Kevin decided to enroll in a school that would allow him to pursue a career in law enforcement with his parent's support. Upon graduation from the services, he wanted to share his uniform with the team and was excited about his new opportunity which will result in Kevin creating a positive life path for himself.

Success Story

"Katie," an adolescent, struggled with an eating disorder and interpersonal relationships in school and with family. Katie suffered with depressive symptoms including thoughts of death, intrusive/shaming thoughts, lack of focus, lack of interest in daily activities, and irritability. Although Katie's grades were above average and she was taking honors classes, her grades began falling.

Katie's self-worth was associated to her body size, and she had lost 30 pounds in less than a year before coming to the program. Through therapy, Katie began utilizing coping strategies to challenge her negative thought patterns, and decreased internalizing other's actions as her fault. Katie increased her ability to see her worth, speaking up for herself when warranted.

Katie now reports reaching out for support when feeling sad instead of isolating herself. She has challenged herself to increase her social circle to include new and supportive friends. Katie's grades improved to previous above grade point average levels. She reports stronger and more meaningful relationships with family members, and contacts school counselors when struggling during school.

Katie recently reported, "I'm sad to end things with my therapist and team but I know I'm ready. It feels so good to know that things are not just my fault. Before I would have blamed myself. I know now that if I want my mom to reach out to me, I have to reach out to her. I tell people what I need now. I give myself credit when I deserve it now. I wore this crop top because even if I feel uncomfortable I am trying to show myself that I am pretty."

"He talks more and asks us how work was and how it went. He runs now and is participating more in school. I see him more confident."

Caregiver of CCFSS consumer

Collaborative Partners

- All God's Children
- Alpha Connections Youth and Family Services
- Aspiranet
- Berhe Group Home
- Boys Republic
- Childhelp, Inc.
- Children's Hope Group Home
- Crittenton Services for Children and Families
- CYS South Coast Children's Society
- David and Margaret Youth and Family Services
- East Valley CHARLEE
- Eggleston Youth Centers, Inc.
- Ettie Lee Homes, Inc.
- Family Services Agency of San Bernardino
- Father's Heart – A Ranch for Children
- Field's Comprehensive Youth Services
- First Step Group Homes
- Girls Republic
- Guiding Light Home for Boys, Inc.
- Inland Empire Residential Center
- Inspire A Youth, Inc.
- Lutheran Social Services
- McKinley's Children's Center
- Mental Health Systems, Inc.
- Mountain Valley Child & Family
- New Dawn
- Oak Grove Center
- PHILOS Adolescent Treatment
- Plan It Life, Inc.
- River Stones Residential Treatment Services
- Rosemary Children's Services
- San Bernardino County, Children and Family Services (CFS)
- San Bernardino County, First Five
- San Bernardino County, Probation
- San Gabriel Children's Center, Inc.
- School Attendance Review Boards
- South Coast Community Services
- Silence Aloud, Inc.
- Starshine Treatment Center
- Tender Loving Care Home for Boys (Corinthians)
- Trinity Youth Services
- Uplift Family Services
- Victor Community Support Services

Integrated New Family Opportunities (INFO) (C-2)

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

MHSA Legislative Goals and Related Key Outcomes

Increase in self-help and consumer/family involvement:

- ◊ Increase in number of encounters with collateral contact, such as family members and informal supports

Reduction in criminal and juvenile justice involvement:

- ◊ Decreased sustained allegations
- ◊ Reduced jail/prison recidivism
- ◊ Decrease in jail days

Target Population:

- Children
- TAY
- Adults

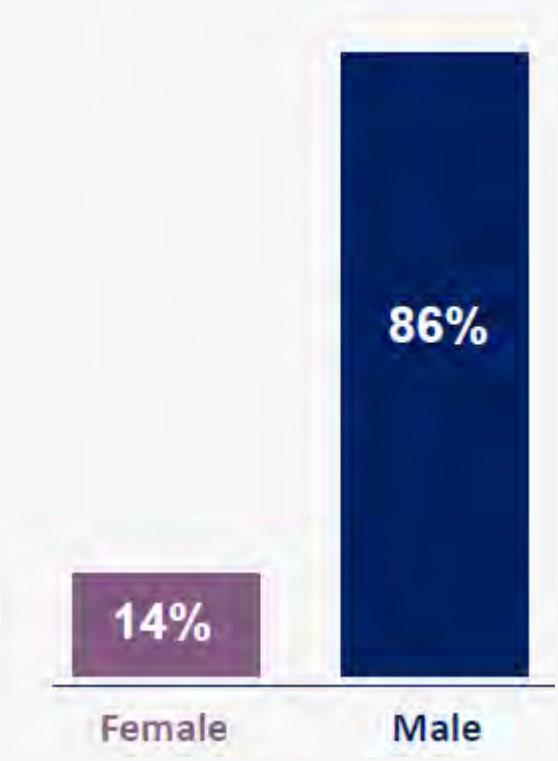
Projected Number to be Served:

- FY 2019/20
  - ◊ 66 Children
  - ◊ 134 TAY
  - ◊ 45 Adults

"I would like to take a moment to let the INFO staff know how grateful and thankful my family is to all of you. We appreciate everything that the staff and this program has done for us and it gives us so much more hope that second chances are really given to those who really put in effort and make positive changes."

- INFO Family

Program Demographics: Gender



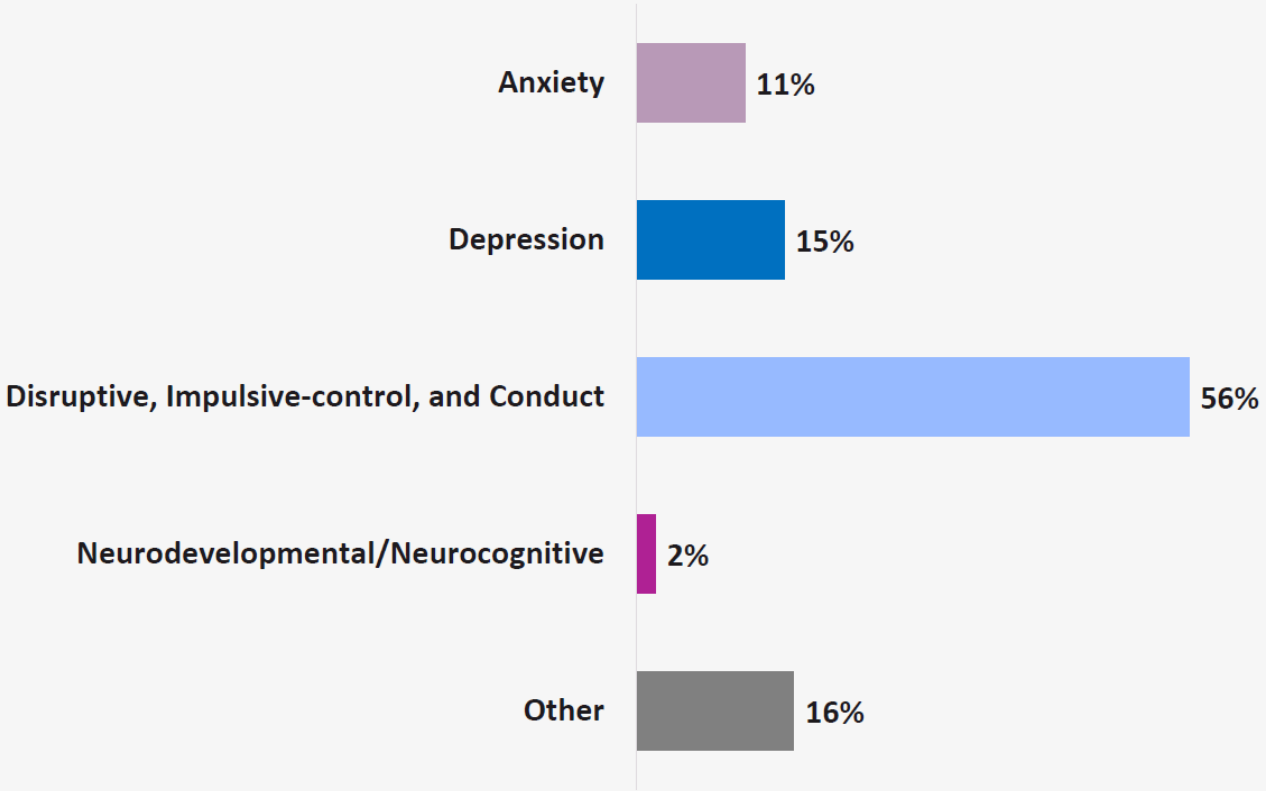
Program Demographics: Ethnicity

Positive Results

In Fiscal Year 2017/18, INFO provided **1,680** collateral contacts during the year. Youth that have successfully completed the program have experienced a:

- Decrease in sustained allegations by **82%** (allegations that are upheld or approved)
- Decrease in detention days by **1%**
- Reduction in recidivism by **64%** (tendency to relapse into a previous condition or more of a behavior)

Program Demographics: Primary Diagnosis

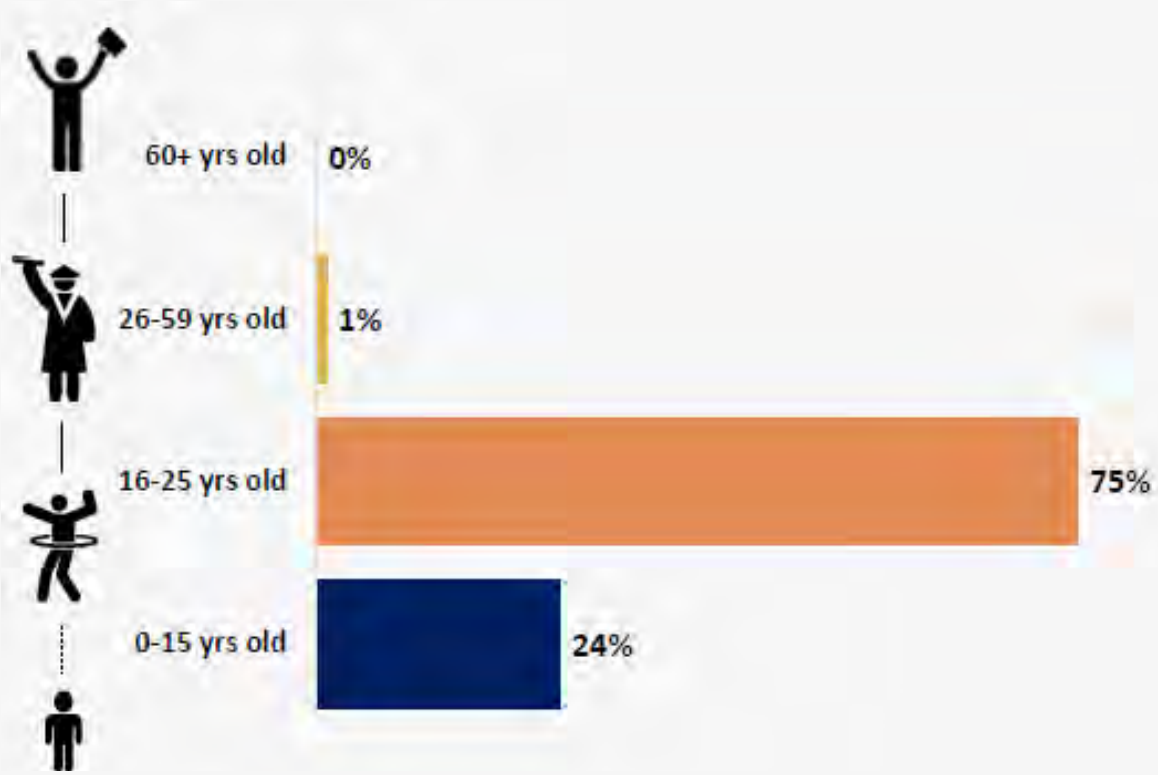


Success Story

"Scott" was a youth not performing well in school and he and his family reported difficulty communicating. Scott was also unable to follow the rules in the home and in the community which led to his involvement in the Juvenile Justice system. After being accepted into the INFO program, communication issues were identified and addressed. Shortly after, Scott regained motivation to attend school. By the time he had graduated from INFO, Scott had successfully completed his probation and joined a local organization. His family reports continued success and hope.

"Tristan" and his parent participated in the INFO program to address issues related to school and discord in the home. Through successfully completing the program, Tristan reintegrated into high school and is playing sports. His parent reported, "an improved relationship in the home."

Program Demographics: Age



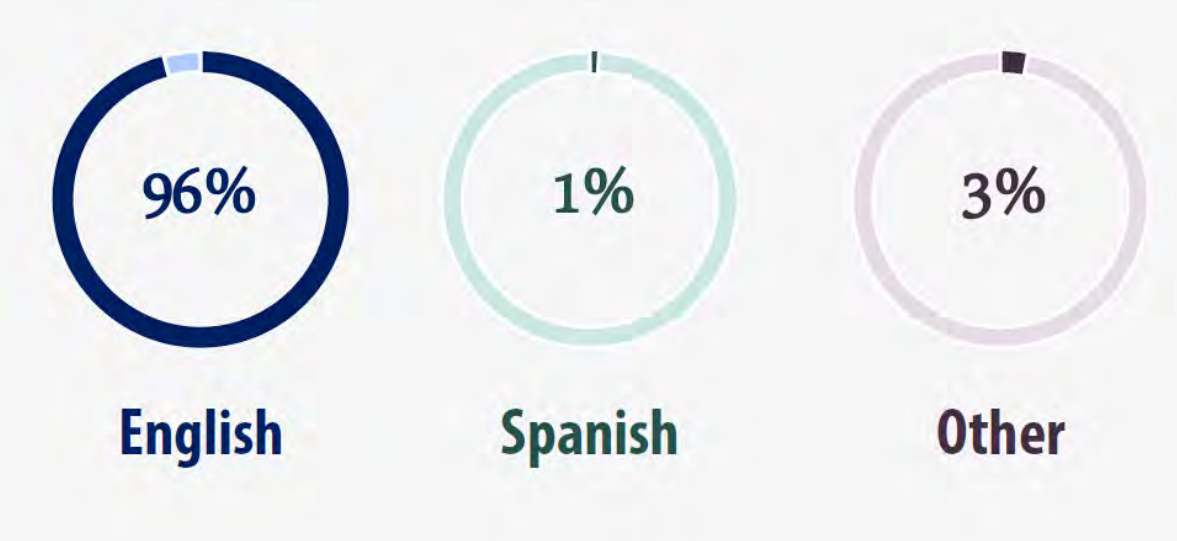
Challenges

Challenges faced during the previous fiscal year were related to recruiting, training, and implementing the Family Functional Therapy (FFT) treatment model to facilitate expansion to the High Desert without impacting existing services in the San Bernardino area. Another challenge was supporting generalization of FFT skills into daily living by the families who received services.

Solutions in Progress

A solution includes ensuring that all staffing candidates understand the concepts of delivery of services in a rural home setting of justice involved families. An additional solution is to increase FFT treatment episodes with frequent check-ins and sessions to monitor the continued application of learned skills and referring families for additional resources as needed.

Program Demographics: Primary Language



Collaborative Partners

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

"Through the INFO program, our very lives have been resurrected. We were at the end of our rope, hopelessness had begun to set in. The folks at INFO came along side of us and let us borrow their hope until we could believe for ourselves again. The housing and other resources they worked with us on achieving were like winning the lotto.

- INFO Family

One Stop Transitional Age Youth Centers (TAY-1)

The Department of Behavioral Health supports four One Stop Transitional Age Youth (TAY-1) Centers, one in each region of San Bernardino County. One Stop TAY Centers provide integrated services to the unserved, underserved, and inappropriately served children and adolescents ages 16 to 25 in the County. These TAY individuals are living with an emotional disturbance and/or severe and persistent mental illness, who may be or are at risk of:

- Homelessness
- Involuntary or high users of acute care facilities (e.g., hospitals, emergency departments)
- Suffering from co-occurring disorders
- Experiencing their first episode of serious mental illness
- Aging-out of the child welfare system or juvenile justice system
- Involved in the criminal justice system

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

Target Population:

- TAY

Projected Number to be Served:

- FY 2019/20
  - ◊ 6,158 TAY

Centers are modeled as drop-in centers in an effort to improve TAY participation and allow TAY to:
1) Selectively utilize services needed to maximize their individual potential (Recovery, Wellness, and Resilience Model) while living in the community; and
2) To prepare them for re-entry into the community.

Centers partner with the San Bernardino County Department of Probation, the Department of Children and Family Services (CFS), and numerous other community partners who assist TAY in achieving the goals of:

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

Centers provide drop-in services to TAY and when appropriate their families. These services address employment, educational opportunities, housing, behavioral health, physical well-being, drug and alcohol use, legal issues, trauma domestic violence, and physical, emotional, and sexual abuse.

Centers provide Full Service Partnership (FSP) services, which include behavioral health outpatient services for youth with serious emotional disturbances and/or serious mental illness. Services include, but are not limited to:

- Assessment
- Evaluation
- Treatment plan development (Individual Services and Supports Plan)
- Therapy (individual and group)
- Crisis intervention
- Medication support services
- Targeted case management
- Collateral services
- Rehabilitative activities of daily living
- Counseling
- Substance use disorder and co-occurring services
- Peer support and peer driven groups/activities
- Housing assistance
- Employment assistance
- Education assistance
- Legal assistance
- Transportation assistance and much more

FSPs operate under the “whatever it takes” mandate in providing the full spectrum of community services to assist consumers in achieving their goals.

Centers also offer TAY participants showers and laundry facilities, a resource room with computer and internet access, recreational activities, access to co-located services, and referrals to appropriate community based services, just to name a few of the many services provided.

Outreach and Engagement services and events are provided to unserved TAY and, when appropriate, their families to engage and educate them on the County’s behavioral health system. Services include, but are not limited to, health fairs, job fairs, street outreach, and weekly orientations.

Transitional Age Youth (TAY) Crisis Residential Treatment Program (The STAY)

The STAY is a short-term, voluntary 14 bed crisis residential treatment center for the TAY population between the ages of 18 to 25, who are experiencing an acute psychiatric episode or crisis, and are in need of a higher level of care than board and care residential, but lower level of care than psychiatric hospitalization. The program is currently contracted and services are provided by Valley Star Behavioral Health, Inc. (Valley Star). The STAY increases access to appropriate mental health services for the TAY population in a mental health crisis.

Valley Star has developed a psychiatric rehabilitation program for The STAY that is comprehensive, multidisciplinary/interdisciplinary, and designed to meet the following objectives:

- Improve residents' adaptive functioning through their acquisition of skills essential for successful independent or semi-independent living in the community (less restrictive environment)
- Prevent residents' regression to a lower level of functioning through their acquisition of skills essential to their recovery

Services include therapeutic and psycho-educational groups, activities that focuses on daily living skills-training, behavioral intervention/modification training, individual and group counseling, crisis intervention, medication support, substance use disorder counseling/referrals, recreational therapy, educational assistance, and pre-release and discharge preparation and planning.

The program bases itself within a structured, consistent, and therapeutic milieu designed to enhance the self-image of the residents, and to promote healthy and supportive interactions among the residents and staff. The multidisciplinary design includes diverse input from the psychiatric, nursing, social service, vocational, and recreational activity disciplines.

MHSA Legislative Goals and Related Key Outcomes

TAY

Reduce the subjective suffering from serious mental illness for adults and serious emotional disorders for children and youth:

- ◊ Increased resiliency
- ◊ Decreased impairment in general areas of life functioning (e.g., health/ self-care/housing, occupation/education, legal, managing money, interpersonal/social)

Reduce homelessness and increase safe and permanent housing:

- ◊ Decreased rate of homelessness for clients, as defined in Data Collection and Reporting System (DCR)

Increase a network of community support services:

- ◊ Increase in number of collaborative partners

The STAY

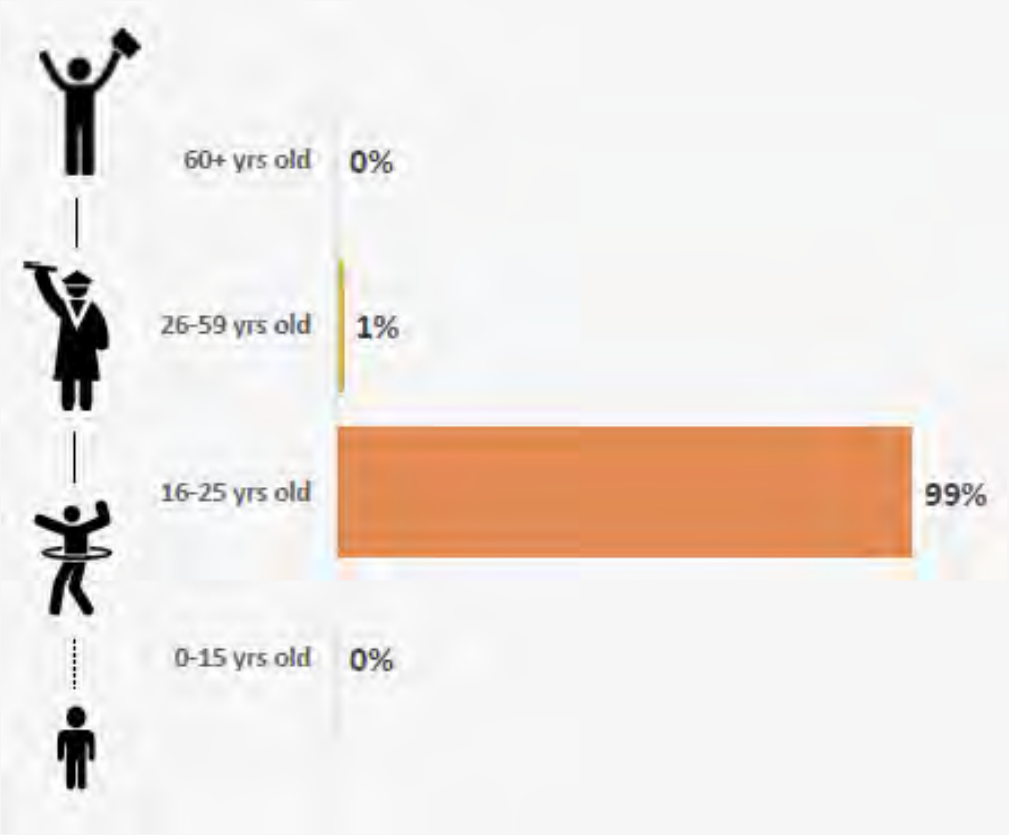
Reduce the subjective suffering from serious mental illness for adults and serious emotional disorders for children and youth:

- ◊ Decrease hopelessness/increased hope
- ◊ Increased resiliency
- ◊ Decreased impairment in general areas of life functioning (e.g., health/ self-care/housing, occupation/education, legal, managing money, interpersonal/social)

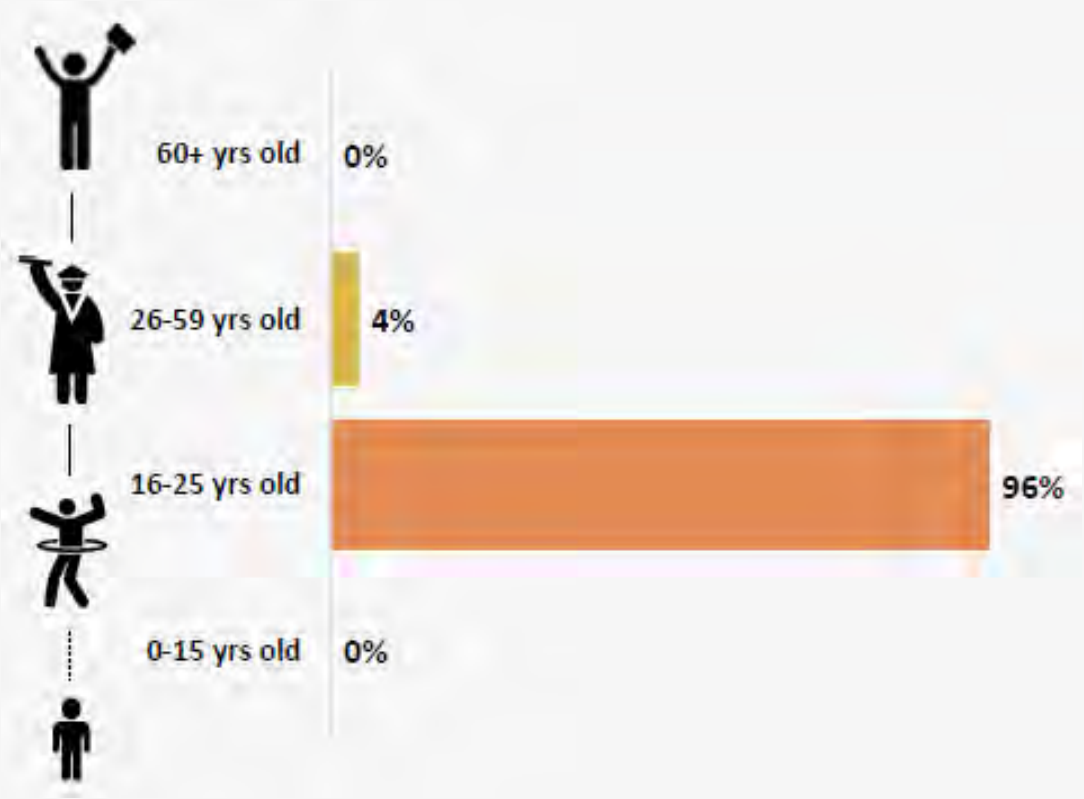
Reduce the frequency of emergency room visits and unnecessary hospitalizations:

- ◊ Reduced rate of emergency room visits for mental health concerns
- ◊ Reduced administrative hospital days
- ◊ Increased use of alternative crisis interventions (e.g., CWIC, CCRT, CSU)
- ◊ Increase in number of individuals diverted from hospitalization

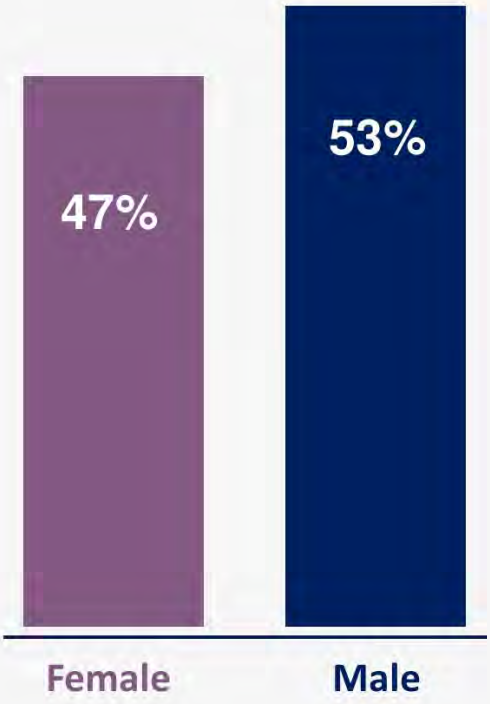
Program Demographics: Age - TAY



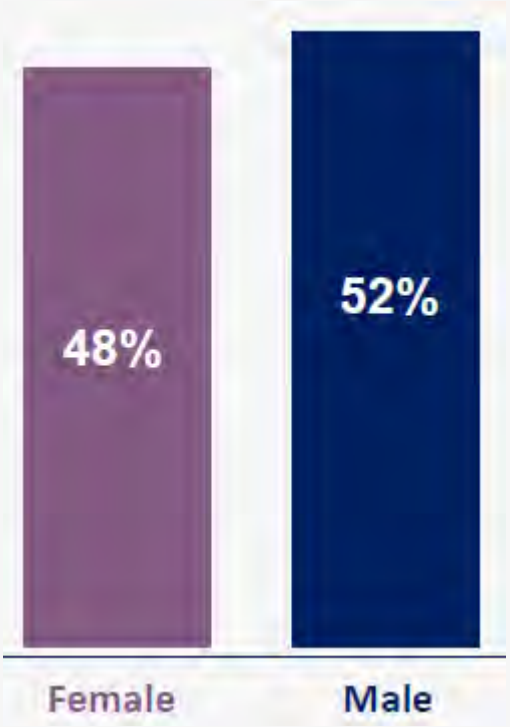
Program Demographics: Age - The STAY



Program Demographics: Gender - TAY

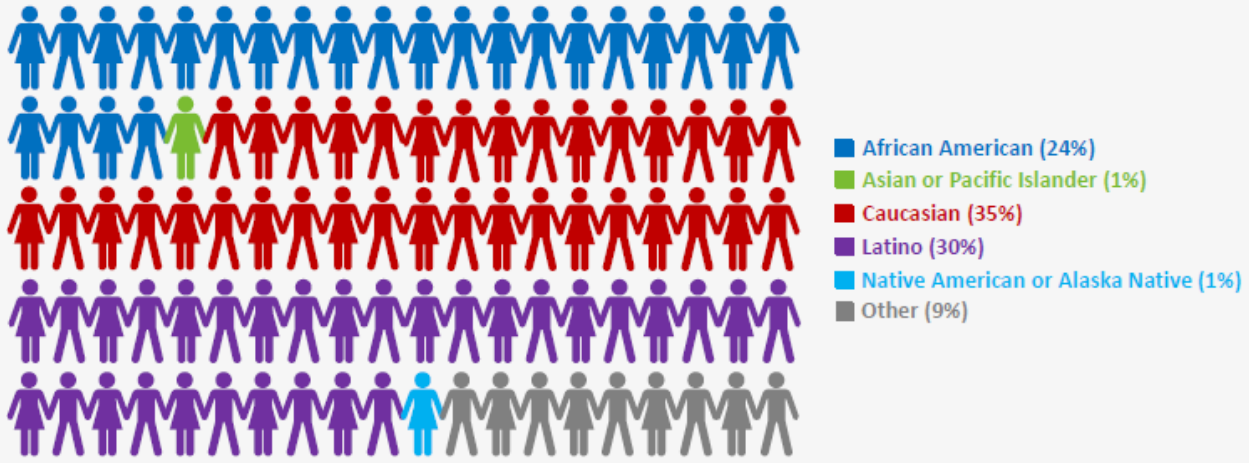


Program Demographics: Gender - The STAY

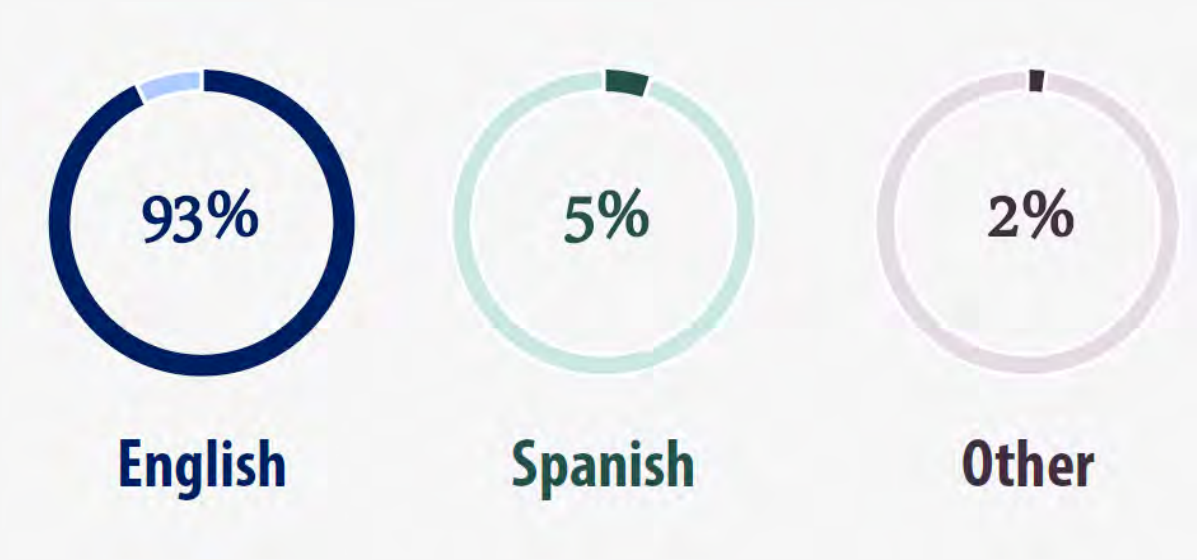


Program Demographics: Ethnicity - TAY

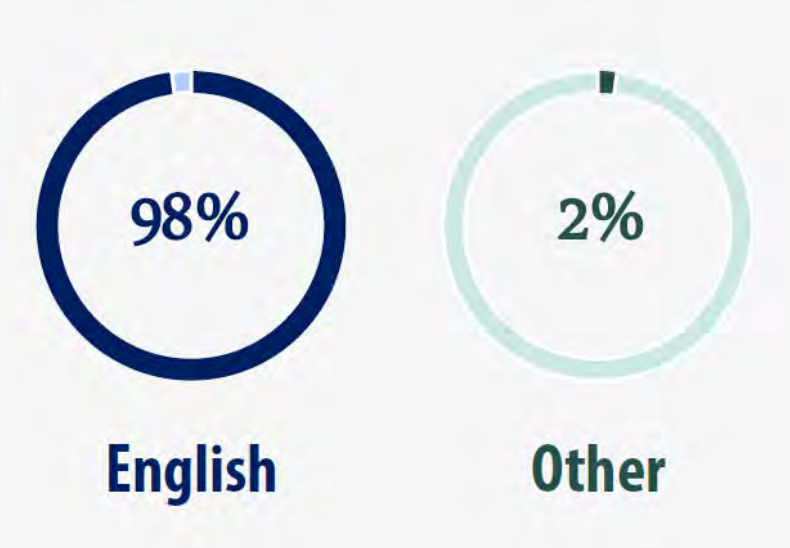
Program Demographics: Ethnicity - The STAY



Program Demographics: Primary Language - TAY



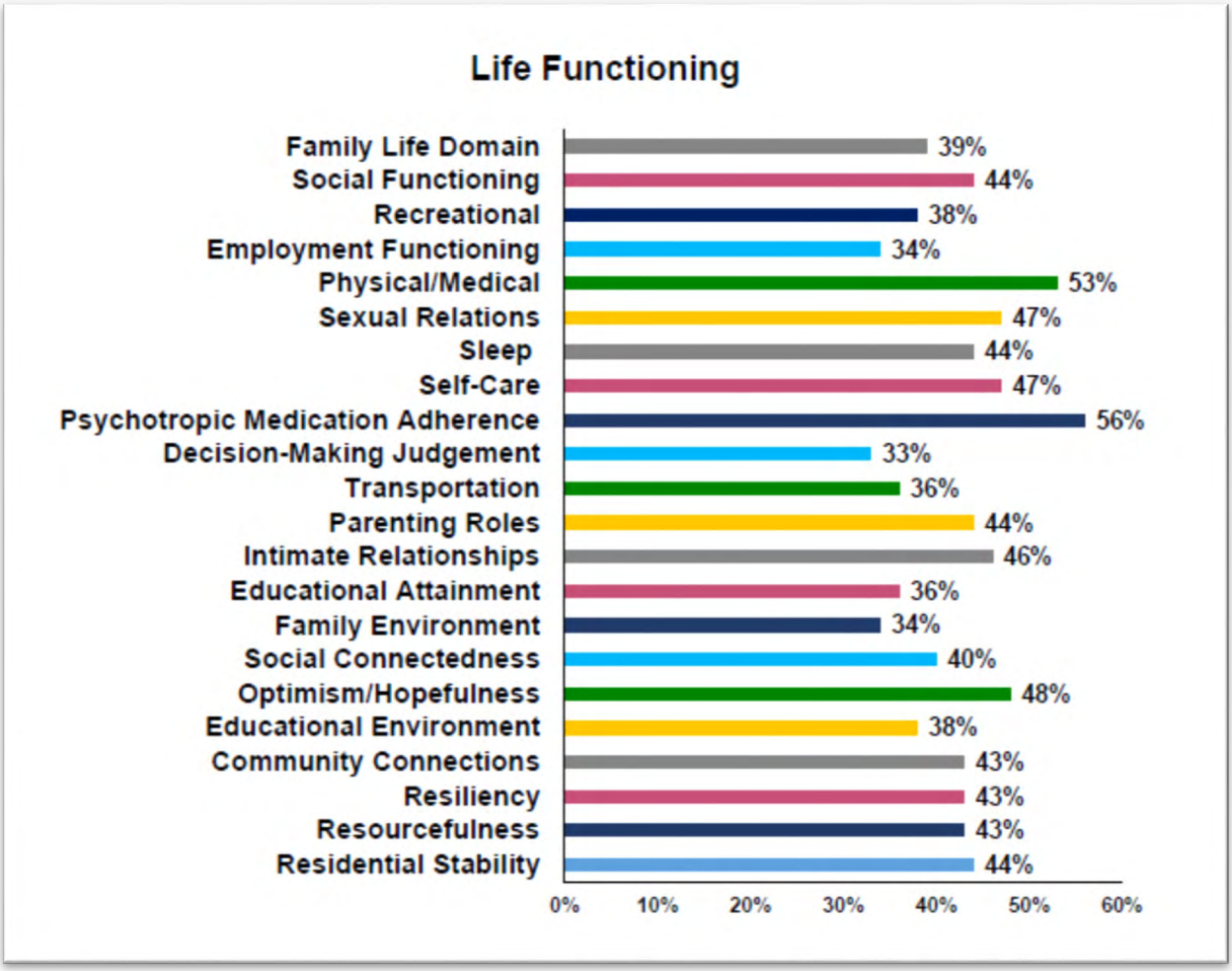
Program Demographics: Primary Language - The STAY



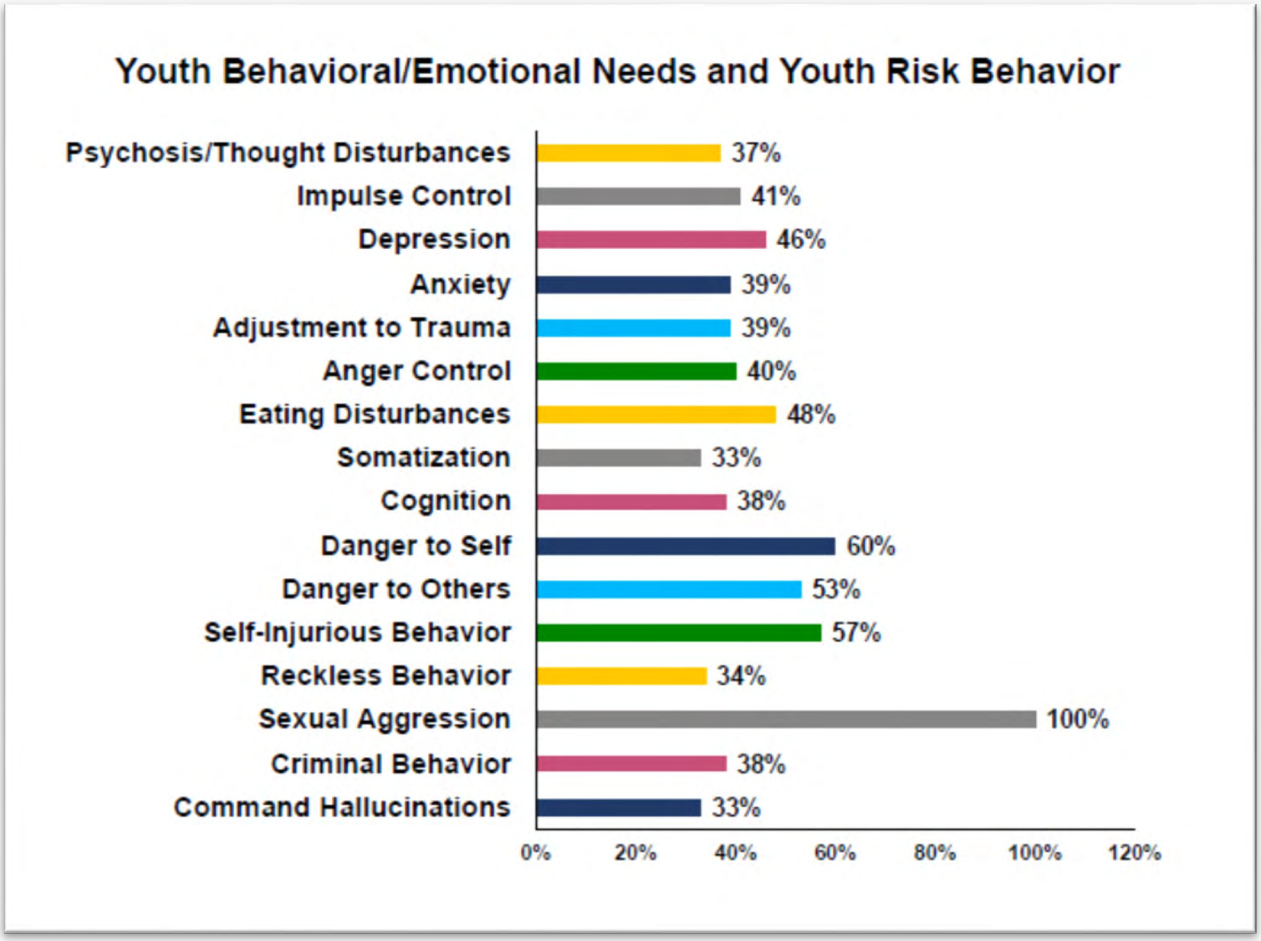
Positive Results

TAY

- The graph below represents the percentage of youth who presented with a significant issue on an item within the Life Functioning domain of the Adult Needs and Strengths Assessment (ANSA), a tool used to identify and track clinical progress, and had this issue resolved by the completion of the program in Fiscal Year 2017/18.



- The graphs below represent the percentage of youth who presented with a significant issue on an item within the Youth Behavioral/Emotional Needs and Youth Risk Behavior domain of the Adult Needs and Strengths Assessment (ANSA) and had this issue resolved by the completion of the program in Fiscal Year 2017/18.



"Be around people who make you want to be a better person, who make you feel good, make you laugh, and remind you what's important in life."

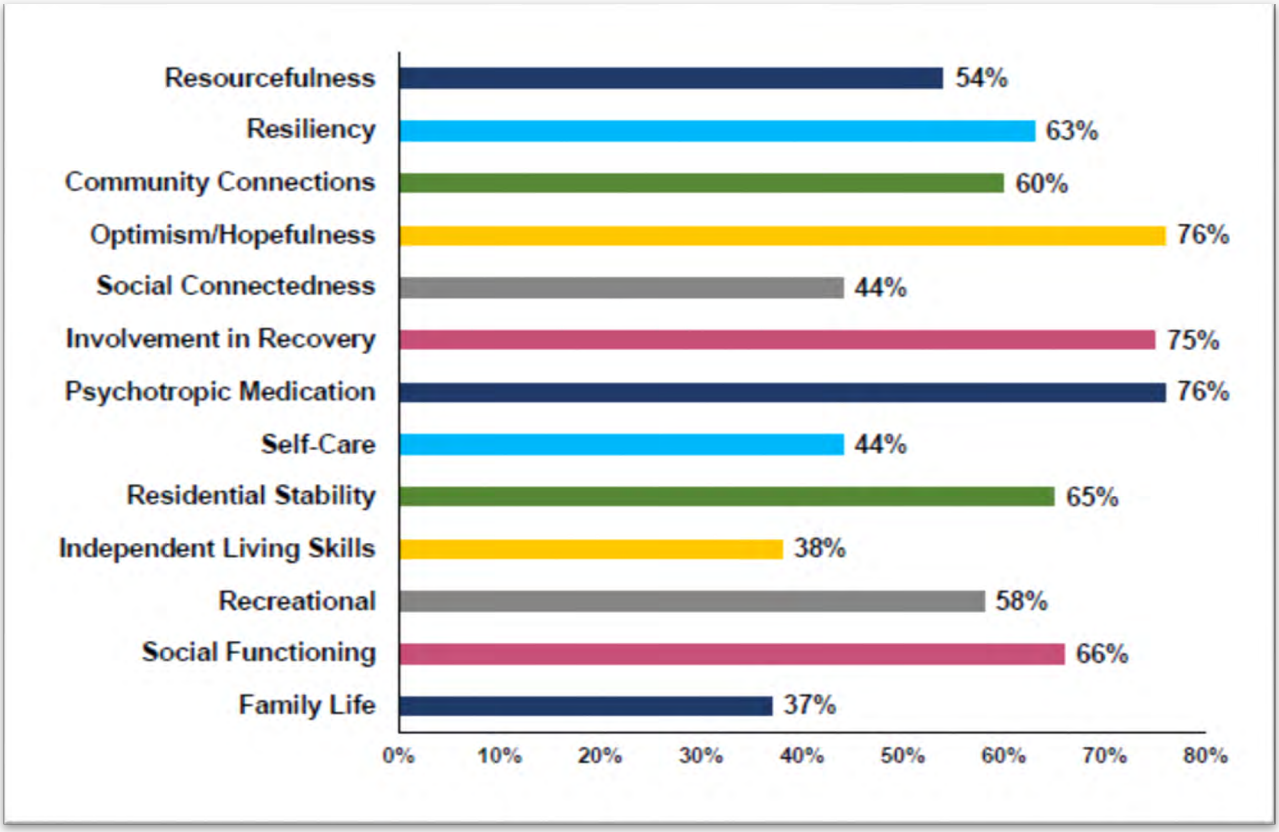
- TAY consumer

The STAY

Results from the Adult Needs and Strengths Assessment (ANSA) show the percentage of youth who presented with a significant issue on an item within the Life Functioning and Strengths domains, Behavioral Health Needs, Risk Behaviors, and Physical/ Medical domain, and those that had that issue improve by the completion in the program in Fiscal Year 2017/18:

Life Functioning

Youth who presented a significant issue in the Life Functioning Domain showed improvement in the following areas:



Risk Behaviors

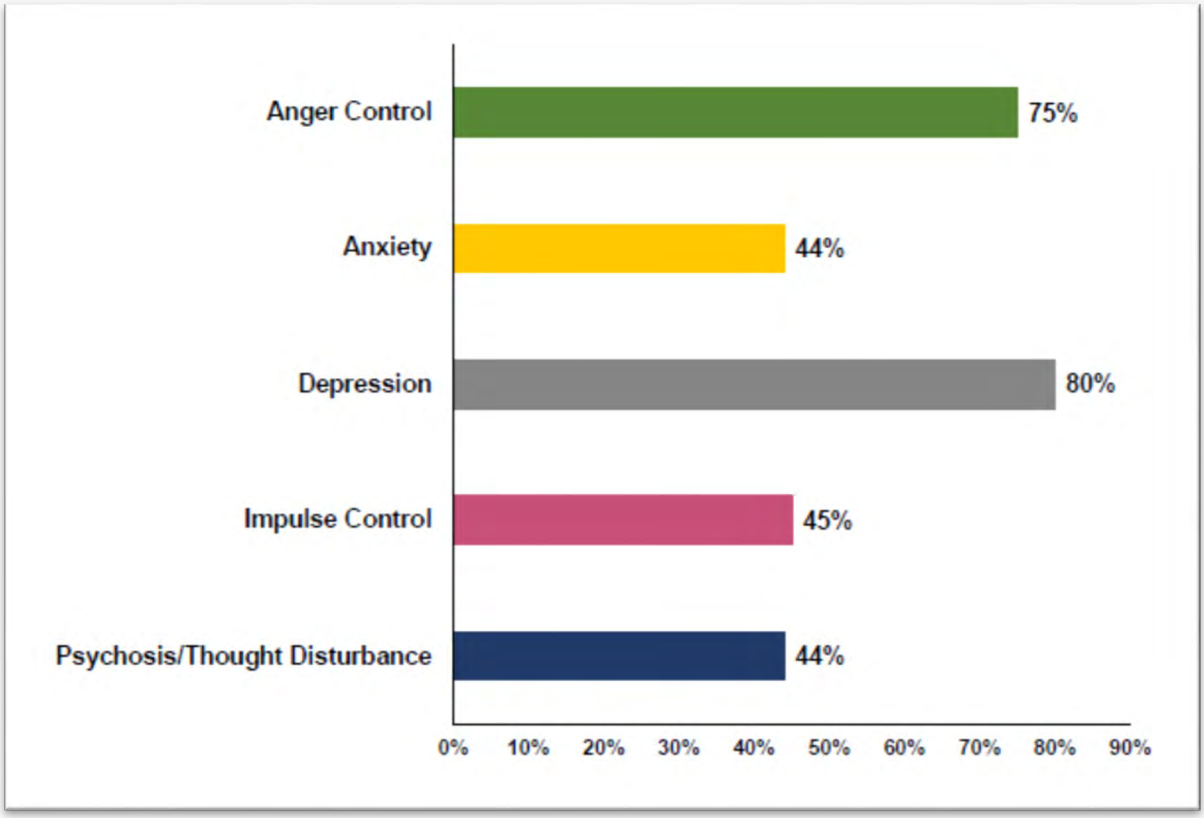
- **80%** of youth who presented a significant issue in Serious Injurious Behavior had this issue improve
- **59%** of youth who presented a significant issue in Reckless Behavior had this issue improve

Physical/Medical Domain

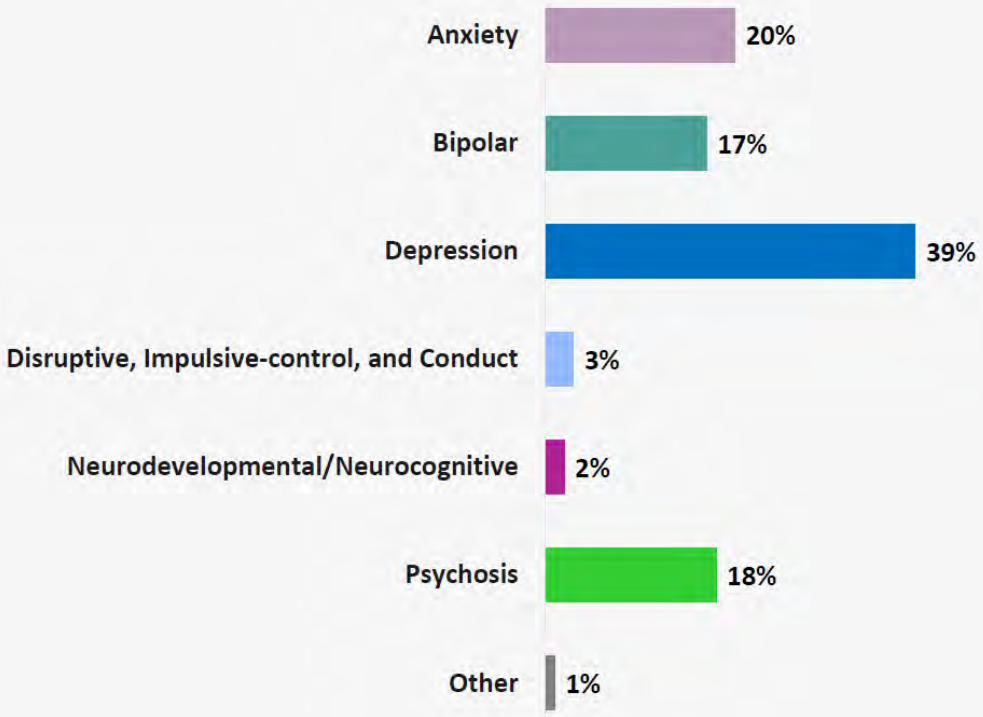
- **66%** of youth who presented a significant issue in connecting with their Primary Care Physician had this issue improve
- **35%** of youth who presented a significant issue in Health Care Adherence had this issue improve

Behavioral Health Needs

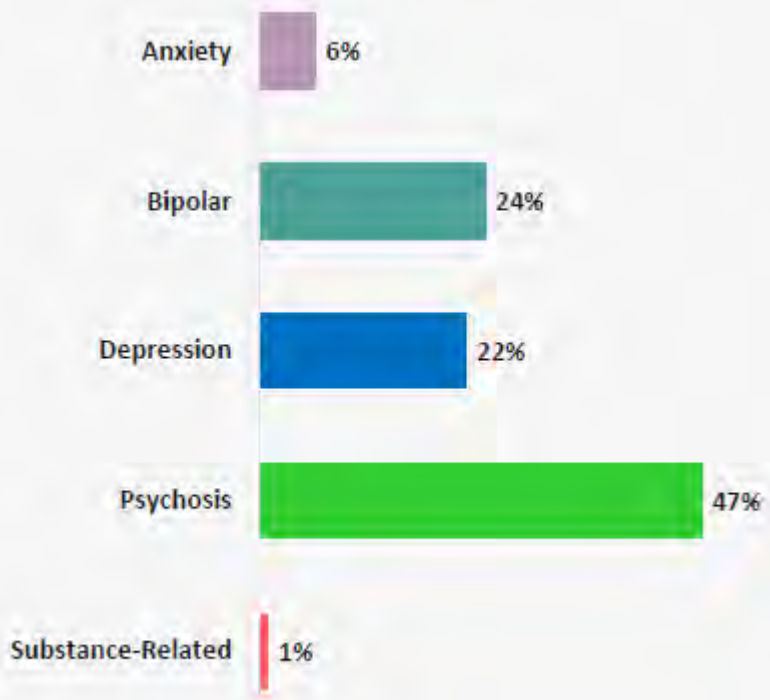
Youth who presented a significant issue with Behavioral Health Needs showed improvement in the following areas:



Program Demographics: Primary Diagnosis - TAY



Program Demographics: Primary Diagnosis - The STAY



Challenges

TAY

Housing:
There are limited housing options for homeless youth in the West End. Most shelters are full or clients do not meet criteria for immediate help. Additionally, there is limited housing for youth in the High Desert region. Other challenges include inappropriate referrals from youth wanting housing only and youth being unable to maintain housing due to substance use issues.

Employment:
In the High Desert region, the youth experience limited employment opportunities.

Psychiatrist:
Limited resources for psychiatric services are available.

Insurance and Medi-Cal:
There are out of county clients experiencing difficulty in transferring their Medi-Cal to San Bernardino County. Clients with private insurance provided by guardians also have difficulty getting the appropriate level of care for their mental health conditions. Private insurance does not provide the level of care that the County provides for mental health conditions.

Dental care:
Clients are challenged in acquiring ongoing dental health treatment beyond what Medi-Cal covers.

"Without my struggles I wouldn't be who I am today"

- TAY consumer

Solutions in Progress

TAY

Housing:
To address the housing issue on the West End, the program has partnered with a room and board which has taken in TAY clients. TAY has also worked with DBH's Homeless Outreach Support Team for TAY that meet homeless services eligibility criteria. The TAY program will also pay for hotel vouchers until shelter is found. A newly contracted housing provider came on board in the high desert area in Jan of 2018 and the program has been able to place 17 youth in the second half of the fiscal year. The program referred youth to 2-1-1 for appropriate housing assistance. TAY program staff encourage youth to be honest about substance use during substance use disorder assessments to ensure they receive the appropriate level of care.

Employment:
Employment continues to be an area of challenge however the program continues to maintain relationships with various Workforce Development providers, transports clients to Job Fairs in the region, and encourages clients to enroll in Department of Rehabilitation (DOR) services.

Psychiatrist
The program routinely calls psychiatrists in the area to see if they are accepting new clients. Program staff routinely accompany clients to psychiatric appointments to aid them in navigating the process and to assist them in being more comfortable with telemedicine providers (this is frequently being utilized in our community).

Insurance and Medi-Cal:
The program maintains continuous contact with counties of origin and with parents to evaluate a client's options under private insurance and Medi-Cal to ensure they receive appropriate mental health services.

Dental:
The program utilizes community resources and donations to assist youth in receiving dental health treatment.

Outreach and Engagement

In Fiscal Year 2017/18, the TAY and The STAY programs organized and/or participated in the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
TAY		
Career Conference	4	766
Resource Fair	15	742
Program Tours	27	269
Health Fair	5	273
Homeless Youth Summit	1	150
Presentation	142	2,448
Wellness Event	3	85
Total	**197**	**4,733**
The STAY		
Program Presentations	62	194
Facility Tours	1	4
Total	**63**	**198**

Success Story

"Derek" enrolled in his local One Stop TAY Center to address his substance use, unemployment, lack of housing, and help with navigating the process. With the support from the FSP staff, he gained motivation to achieve goals, including sobriety. Since his enrollment, he stopped engaging in substance use by developing healthier coping skills, including reaching out to his support system. He also secured long-term housing and gained full-time employment.

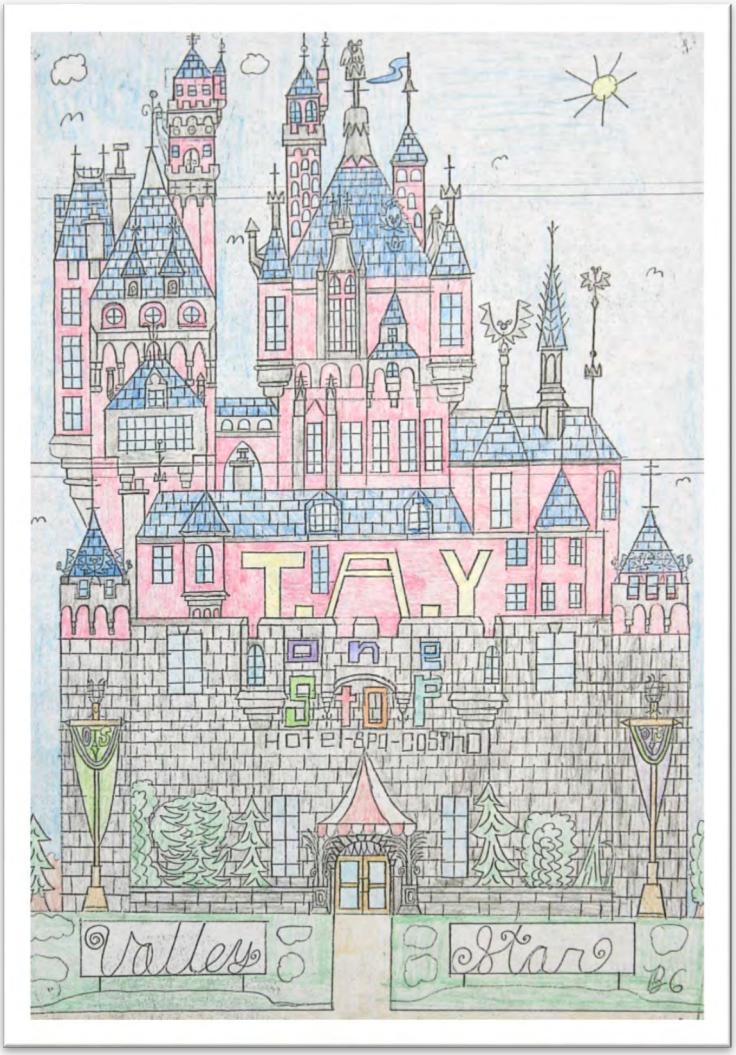
"Meredith" experienced depression and anxiety that affected her daily activities such as going out with friends. Meredith participated in therapy, case management, and medication support services. After a year at the One Stop TAY Center, Meredith started going out with friends and her relationships with family improved. After some time, she no longer needed medication support services because she was successfully using the skills she learned. Meredith also graduated from high school and was admitted to a local university.

Collaborative Partners

- Alta Loma High School
- Apple Valley Unified School District, Workforce Investment Opportunities Act (WIOA)
- Arrowhead Regional Medical Center (ARMC)
- Aspiranet
- Basin Wide Foundation
- CalWORKs Advisory Committee
- Canyon Ridge Hospital
- Cedar House
- Chaffey College, Independent Scholars and EOPS
- Chaffey High School
- Children's Fund
- Children's Network Collaborative
- Cobalt Institute of Math and Science
- Colony High School
- Copper Mountain College

- Davis Residential Living Room and Board Desert Mountain Children's Center
- Etiwanda High School
- Five Star Catering
- Helping Hearts
- Helendale Community Services District
- Hesperia Unified School District, Family Resource Center
- Hesperia Unified School District, Hispanic Community Liaison
- High Desert Children's Network
- High Desert Disability & Senior Collaborative
- Homeless Youth Taskforce
- House of Ruth
- Kiwanis Club – Greater Yucca Valley
- Los Osos High School
- Molding Hearts Housing
- Morongo Basin Community Coalition
- Morongo Basin Haven
- Morongo Basin Sexual Assault Services
- Morongo Unified School District
- Moses House
- Native American Resource Center
- Ontario High School
- Operation New Hope
- Options for Youth
- Orchid Court
- Premier Program
- Rancho Cucamonga Center
- Rancho Cucamonga High School
- Red Carnation
- Rotary Club of Joshua Tree
- Saint Phillip Neri Catholic Church
- San Bernardino Community Hospital
- San Bernardino County, Children and Family Services
- San Bernardino County, Department of Adult and Aging Services (DAAS)
- San Bernardino County, DBH Community Crisis Response Team (CCRT) and Crisis Walk-In Center (CWIC)
- San Bernardino County, Interagency Council on Homelessness (ICH)
- San Bernardino County, Probation Department
- San Bernardino County, Public Guardian
- Serenity Clubhouse in Victorville
- Silverado High School

- Snowline Joint Unified School District
- True Vines Women's Home
- Twenty-nine Palms High School
- Valley Star Crisis Walk-In Clinic
- Valley View High School
- Victor Community Support Services (VCSS) Victorville Campus – Family Resource Center
- Victor Valley College
- Victor Valley High School
- White Oak Hospital
- Yucca Valley Chamber of Commerce
- Yucca Valley High School



Artwork by Brian Cromwell

Adult Criminal Justice Continuum of Care (A-2)

The Adult Criminal Justice Continuum of Care covers the array of voluntary services that are offered to individuals involved in the criminal justice system. In 2017, the program expanded its services to include the Corrections To a Safer Community (CTASC) and Choosing Healthy Options to Instill Change and Empowerment (CHOICE) programs, expanding the array of re-entry services for the adult criminal justice population. Today, the Adult Criminal Justice Continuum of Care is composed of CTASC, CHOICE, Supervised Treatment After Release (STAR), Forensic Assertive Community Treatment (FACT), Community STAR, and Community FACT programs. The CTASC and CHOICE programs address the needs of participants living with a serious mental illness scheduled for release from County Type II Jails. The CHOICE program is a voluntary program that offers intensive case management and behavioral health treatment services to probationers on formal supervised probation with the San Bernardino County Probation Department. The STAR and FACT programs serve consumers under formal supervision of the Mental Health Courts located throughout San Bernardino County (Joshua Tree, Rancho Cucamonga, San Bernardino, and Victorville). The Community STAR and Community FACT programs serve consumers who are no longer on formal supervision.

Mental Health Courts

Beginning in the late 1990s, the establishment of Mental Health Courts throughout the United States began, pursuant to federal legislation and funding. With the growing community concern for more effective treatment for mentally ill offenders, the Mental Health Court system expanded, both nationally and locally in San Bernardino County. San Bernardino County currently has four Mental Health Courts located in the cities of San Bernardino, Rancho Cucamonga, Victorville, and Joshua Tree. These Mental Health Courts offer voluntary court-referred treatment programs for defendants living with severe and persistent mental illness who agree to make mental health treatment part of the terms and conditions of their probation.

Target Population:

- Adults

Projected Number to be Served:

- FY 2019/20
  - 75 STAR
  - 25 CSTAR
  - 25 FACT
  - 75 CFACT
  - 40 JT MHC

Additionally, Valley Star Behavioral Health is the contracted provider agency providing mental health treatment services to consumers participating in the Joshua Tree Superior Mental Health Court located in the Morongo Basin. A multidisciplinary treatment team is located at each of the courts and consists of representatives from the Mental Health Court, the Public Defender and District Attorney Offices, Sheriff and Probation Departments, and the STAR and FACT programs.

Supervised Re-Entry Services

The Choosing Healthy Options to Instill Change and Empowerment (CHOICE) program was developed as a result of Assembly Bill 109, and is a voluntary program that offers intensive case management and behavioral health treatment services to probationers on formal supervised probation with the San Bernardino County Probation Department. The program offers an Intensive Outpatient modality along with psychiatric and medication support services at the clinic located in Colton. Through the CHOICE program, behavioral health treatment services are provided at the Probation Department's Day Reporting Centers (DRC) located in Fontana, San Bernardino, Barstow, and Victorville to offer probationers a one-stop setting to meet with Probation personnel and receive behavioral health treatment services along with temporary housing, financial assistance, and medical and employment support. A comprehensive, recovery-oriented treatment plan is utilized to assist participants in reaching their individualized treatment goals. Substance Use Disorder Outpatient clinics are available at the DRCs located in Fontana and Victorville for individuals with substance use disorders or co-occurring (mental health and substance use disorder) disorders. The CHOICE program also works with the Correctional Mental Health Services (CMHS) program located in the San Bernardino County jails and the Public Defender's Office to coordinate behavioral health treatment services for individuals entering the community after a period of incarceration.

The Supervised Treatment After Release (STAR) program is a voluntary treatment program for individuals who suffer from severe and persistent mental illness (SPMI) along with a history of recidivism in the criminal justice system. Consumers must be referred by the multidisciplinary team (MDT) from the Mental Health Courts and accept participation in this program as a condition of their probation. The MDT consists of personnel from Mental Health Court, Public Defender and District Attorney Offices, Sheriff and Probation Departments, and the STAR program. The STAR program is a Full Service Partnership designed to reduce hospitalizations and incarcerations by assisting participants in re-entering society successfully. Through Day Treatment Rehabilitation or Intensive Outpatient modalities, consumers receive individual and group therapy, psychiatric and medication support services, and case management services, which include housing, medical, financial, and vocational assistance. For substance use disorders, drug and alcohol treatment services are also available and include assessment, individual, family and group counseling, crisis intervention, case management, drug education, and referral to aftercare services.

The Forensic Assertive Community Treatment (FACT) program is a voluntary treatment program that provides mental health services to adults living with serious and persistent mental illness who, as a result of their mental illness, have had repeated arrests and contacts with the criminal justice system, are now under the supervision of the Mental Health Court, have difficulties linking with and remaining engaged in the traditional outpatient clinic model, and may also have a co-occurring substance use disorder. FACT is a Full Service Partnership geared toward reducing recidivism in both jail and psychiatric hospitalization and includes community based, 24/7, intensive mental health and case management services to support recovery, self-management, and to increase public safety.

Case management, mental health rehabilitation, individual and group counseling/therapy, crisis intervention, and medication support services are provided primarily in the community where the consumers live, using a “whatever it takes” approach based on the consumer’s individualized treatment needs. The intensity of services is based on the consumer’s level of recovery, and may include in-home services. The FACT team also provides assistance with housing, social support, and outreach services to program consumers. The FACT program personnel are part of a multidisciplinary team that includes personnel from Mental Health Court, the Public Defender and District Attorney Offices, Sheriff and Probation Departments, and the STAR program. Since FACT services are approximately 75% community based, consumers who have trouble keeping appointments at outpatient clinics are referred to the FACT program across all four courts. These consumers are seen at their homes weekly, which may include a home visit by a psychiatrist for those who are not able to make it into the office.
Both FACT and STAR programs provide intensive case management and clinical treatment, medication support services, drug and alcohol treatment, residential placement/housing assistance, and periodic court reviews.

Unsupervised Re-Entry Services

The Corrections To A Safer Community (CTASC) program addresses the needs of individuals living with a Seriously Mental Illness (SMI) scheduled for release from County Type II Jails. CTASC works to link individuals living with an SMI and co-occurring substance use disorders to services necessary to reintegrate successfully back into the community. CTASC programming consists of reducing the likelihood of additional criminal behavior beginning at jail intake and extending beyond release by identifying and linking individuals with services specific to their needs through collaboration with community partners, justice professionals, and county partners. The CTASC Team works closely with the San Bernardino County Sheriff’s Department Type II Jails, the Probation Department, the Public Defender, and various Department of Behavioral Health (DBH) and community programs. CTASC provides case management, peer support, alternatives to hospitalization and incarceration, and housing and employment support to assist the participant in maintaining their independence in the community. The CTASC

Team works closely with the Sheriff's Correctional Mental Health Services (CMHS) to expedite the voluntary participant's release from Type II Jails to community treatment resources. CTASC participants in need of a higher level of care are transitioned to Full Service Partnership services.

In 2015, the Community STAR (CSTAR) and Community FACT (CFACT) programs were implemented as expansions of the STAR and FACT programs. They provide the same behavioral health services as STAR and FACT to include re-entry services for those consumers leaving county jails who are no longer being supervised by the criminal justice system, but still remain in need of specialty behavioral health services. Community STAR and Community FACT differ from STAR and FACT in that their consumers are no longer supervised by the criminal justice system yet remain in need of behavioral health services to reduce recidivism in the jails/prisons and the potential for psychiatric hospitalization.

The Community STAR (CSTAR) program offers behavioral health treatment services in an outpatient setting to consumers voluntarily seeking transitional assistance to help them maintain stabilization upon their re-entry to a community setting. Criteria for this target population include:

- Living with severe and persistent mental illness (SPMI)
- High users of the criminal justice system and psychiatric hospitals settings
- No felony probation or parole supervision, although may have misdemeanors interconnected to summary probation (Prop 47)
- In need of additional time to establish permanent supportive services that will help maintain independent self-care and linkage to stable support systems for continued successful reintegration into the community

The CSTAR program delivers mental health and substance use disorder treatment services in an outpatient setting, including psychiatric supportive services. Services include, but are not limited to screening, assessment, psychotherapy, medication support, group and individual therapy, case management, crisis intervention, and transportation. Also, assistance is offered with the transition to a lower level of care, including successful re-entry into the community for consumers enrolled in the program that are homeless or at risk of becoming homeless and/or require emergency shelter housing services.

Although CSTAR is intended to offer these services on a short-term basis, the length of participation in the program varies and is dependent on the severity of the individual's behavioral health conditions and level of need to sustain a healthy state of stabilization.

The goal of the CSTAR program is to support the recovery of individuals living with a chronic behavioral health condition(s) who remain at risk of recidivism in the criminal justice system and/or from having repeated psychiatric hospitalizations. CSTAR program staff collaborates with Correctional Mental Health (CMH), the Public Defender's Office, the Department of Public Health, DBH outpatient and specialty clinics, community based agencies, and philanthropic organizations to identify consumers who may benefit from the multifaceted services offered by the CSTAR program.

The Community FACT (CFACT) program provides behavioral health treatment services offered through an Intensive Assertive Outpatient Community Based modality. The target population for this program is:

- Individuals living with severe and persistent mental illness (SPMI)
- High users of the criminal justice system and psychiatric hospitals
- No felony probation or parole supervision, though may have misdemeanors and be on summary probation (Prop 47)
- In need of additional time to successfully reintegrate into the community

Individuals accessing this program are voluntarily seeking behavioral health treatment services that offer support and resources to help them remain emotionally and physically stable in their living environment. These individuals may not yet be able to function independently and require ongoing behavioral health care services to assist them in successfully transitioning into the community.

CFACT is an intensive outpatient Assertive Community Treatment based program, that offers mental health and substance use disorder treatment services, including psychiatric supportive services. Although CFACT is intended to be a short-term transitional program, the length of time a consumer is in the program is dependent on their individual needs.

The goal of the CFACT program is to support the recovery of mentally ill individuals who remain at risk of recidivism in the criminal justice system and/or have repeated psychiatric hospitalizations. CFACT program staff collaborates with Correctional Mental Health (CMH), the Public Defender's Office, other criminal justice programs, and community agencies to provide outpatient behavioral health treatment services. These services include, but are not limited to, screening, assessment, psychotherapy, medication support, group and individual therapy, case management, crisis intervention, and transportation. Program staff will assist with the transition to a lower level of care including successful re-entry into the community of consumers who are homeless or at risk of becoming homeless and/or require emergency shelter services.

MHSA Goals and Related Key Outcomes

Reduce homelessness and increase safe and permanent housing:

- ◊ Decreased rate of homelessness for clients, as defined in DCR
- ◊ Increased residence stability

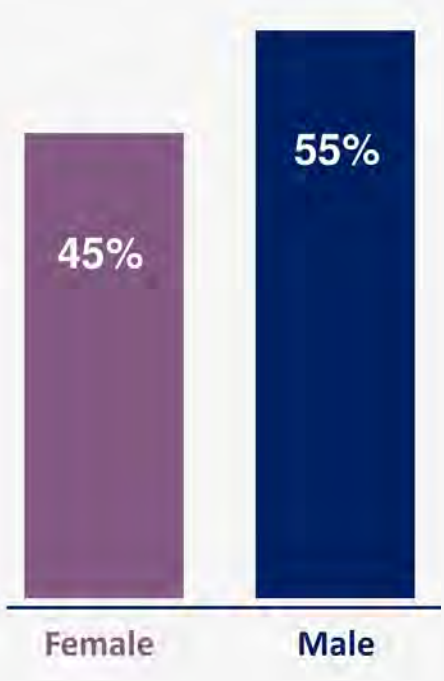
Reduction in criminal and juvenile justice involvement:

- ◊ Decreased rate of incarcerations
- ◊ Decreased arrests
- ◊ Decreased jail bookings
- ◊ Decreased sustained allegations
- ◊ Reduced jail/prison recidivism
- ◊ Decrease in jail days
- ◊ Reduce delinquent behaviors which increase likelihood of juvenile justice involvement

Reduce the frequency of emergency room visits and unnecessary hospitalizations:

- ◊ Reduced rate of emergency room visits for mental health concerns
- ◊ Reduced administrative hospital days
- ◊ Increased use of alternative crisis interventions (e.g., CWIC, CCRT, CSU)
- ◊ Increase in number of individuals diverted from hospitalization

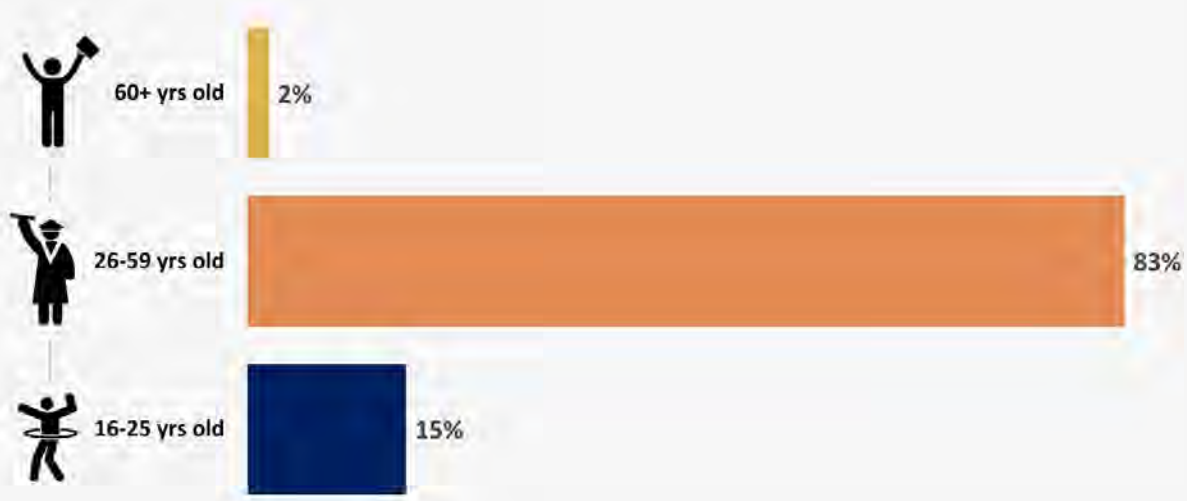
Program Demographics: Gender



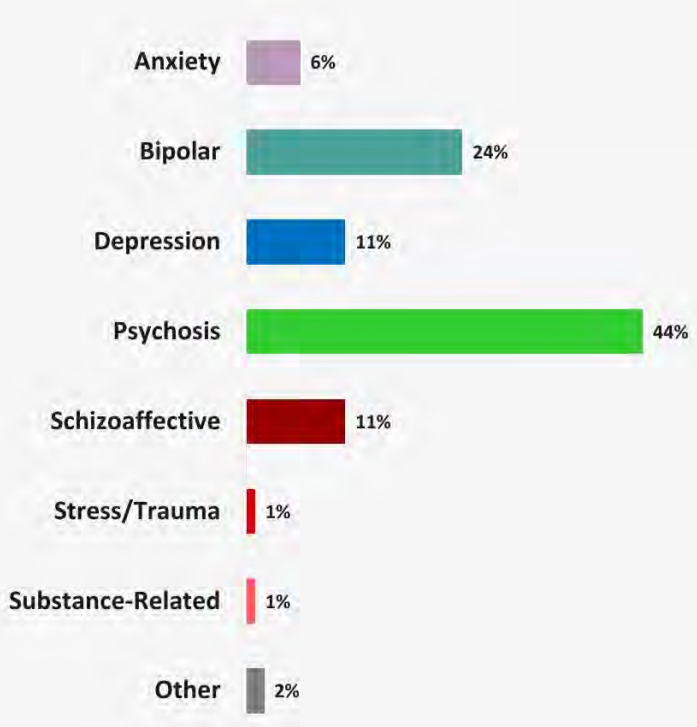
Program Demographics: Ethnicity

Program Demographics: Primary Language

Program Demographics: Age



Program Demographics: Primary Diagnosis



Positive Results

- Through participation in the program (typically 1.5 to 2 years), the number of participants experiencing homelessness decreased to nearly 0%.
- In comparison to pre-enrollment levels, participants enrolled in the Mental Health Court programs have shown high rates of diversion form incarceration resulting in a decrease in jail beds each year. The following data represents the reduction in jail days for Fiscal Year 2017/18:

Program	Percentage Reduction
STAR	89%
CSTAR	100%
JT MHC	74%
FACT	66%
CFACT	38%

- In comparison to pre-enrollment levels, participants enrolled in the Mental Health Court programs have shown high rates of diversion from psychiatric hospitalization, resulting in a decrease in unnecessary hospitalizations each year. The following data represents the reduction in psychiatric hospital admissions for Fiscal Year 2017/18:

Program	Percentage Reduction
STAR	56%
CSTAR	33%
JT MHC	23%
FACT	51%
CFACT	77%

Outreach and Engagement

In Fiscal Year 2017/2018, the Adult Criminal Justice Continuum of Care organized and/or participated in the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
STAR/CSTAR		
MH Court Graduations	3	16
Art Contest Entry	1	1
Participated in Supportive Housing and found job	1	7
DBH Recovery Happens	1	30
Collaborative Courts Ceremony	1	1
FACT/CFACT		
Mental Health Awareness Fair	1	70
Total	**8**	**125**

"If it wasn't for this program, I wouldn't have made it this far...even though I relapsed, the staff encouraged me to come back and try again."

- FACT/CFACT consumer

Challenges

STAR/CSTAR

- Lack of available shelter housing necessary to provide a stable living environment for severely and persistently mentally ill consumers so they may successfully engage in behavioral health treatment is a longstanding challenge.
- There is a challenge with emergency shelter providers and house managers not being adequately trained in dealing with severely and persistently mentally ill individuals, specifically de-escalation techniques. This lack of training has resulted in avoidable arrests and psychiatric hospitalizations.
- The STAR program has experienced a challenge with consumers being referred to the program who are in need of specialized treatment, e.g. sex offenders, arsonists, and those convicted of violent crimes. This is due to a lack of understanding by referring partners of STAR program requirements.
- The STAR program has experienced significant staff changes over the past year which has affected program operations.
- The STAR program has been challenged to increase the number of clients served by the STAR Substance Use Disorder (SUD) team with a reduction in staff.

Joshua Tree Mental Health Court

- Referring individuals to residential drug and alcohol programs upon being released from custody has been challenging due to not having resources in the Morongo Basin. Additionally, most treatment facilities are not equipped to provide services to consumers who have medical and mental health issues.
- Consumers not receiving medications while in custody or consumers being released from custody without medication or a prescription, which has required the program to rely on Crisis Walk In Clinics (CWICs) to provide medication.

FACT/CFACT

- Assisting consumers with obtaining and maintaining competitive employment has been a challenge, due to this population being on probation and having felonies on their criminal record, as well as a need for partnerships or referrals to “felon-friendly” employers.
- Locating affordable transitional housing in safe communities has been an on-going challenge in serving consumers who have a mental illness, a history of co-occurring substance use, and are on probation. Many consumers have lengthy histories of homelessness and multiple housing placements as a result of disruptive behaviors related to not managing the symptoms of their mental illness and active substance use. The need for stable, permanent housing is vital to a consumers’ recovery as they seek independence and meaningful roles in the community.

- Recruitment, hiring and retention of clinical positions have been long-standing issues within programs in this region, specifically as it relates to the Personal Service Coordinator II's (Level II case managers) and Licensed Vocational Nurse/ Licensed Psychiatric Technician (Team Nurse), as well as securing a permanent program psychiatrist. Recent turn-over during the past year has significantly impacted the program. This is due to various factors, including increasing competition with agencies/organizations in the field of mental health/behavioral health offering more desirable compensation and/or work settings to the same pool of qualified and skilled mental health workers.

Success Story

Joshua Tree Mental Health Court

"Janice" was a consumer who was well known by law enforcement, the probation office, and the court. She had regular police contact due to her aggressive behavior at home and in the community, as she was not taking her medication. Janice's condition seemed to be getting worse and her family was desperate for her to get assistance.

After an offense, Janice was arrested. Janice was given the option to participate and, agreed to participate in the Mental Health Court (MHC) program. During her time in the MHC program she experienced tremendous growth, acknowledged her mental illness and the necessity for medication to control her symptoms. Once Janice's condition stabilized, she was able to reconnect with her family and son. Today, Janice works full-time and notes that the program allowed her to get her life back and has given her son the opportunity to have a childhood."

Solutions in Progress

STAR/CSTAR

- The DBH management team continues to look into various contract and housing options to allow for more consumers to be housed.
- DBH continues to provide annual training for emergency shelter providers and house managers. This training includes a segment on identifying a behavioral health crisis and techniques to de-escalate an individual experiencing a behavioral health crisis, as well as providing information on community resources for mentally ill consumers. Training materials are regularly updated to provide the most current and relevant information and to meet the ongoing needs of emergency shelter providers and house managers.
- Provide housing managers with additional after hours resources that can be used in urgent situations.
- The program continues to collaborate with community and County partners to identify employment and training opportunities for consumers. Newly hired staff members have also brought a fresh perspective and new ideas to the program.

Joshua Tree Mental Health Court

- The program is working to secure an agreement with a contracted provider agency for residential drug and alcohol treatment services.
- The program continues to work closely with the Mental Health Court Liaison inside the West Valley Detention Center to ensure consumers receive their medications upon release.

FACT/CFACT

- Consumers who have experienced difficulty obtaining and maintaining competitive employment continue to be steered toward and assisted in enrolling into community colleges and vocational training programs to increase their education and to develop vocational skills that will make them more attractive in the job market.
- The FACT Program continues efforts to locate "felon-friendly" employers who are willing to give our consumers an opportunity to work. In addition, the FACT program encourages consumers to seek volunteer opportunities (or internships for those enrolled in community college or trade/vocational schools) in the community in hopes that these volunteer/internship opportunities will result in offers for paid employment.

- The FACT program has been actively networking in the community to locate and build relationships with potential housing vendors that are willing to work with our population and provide safe and satisfactory living conditions to them as residents. The FACT program has been successful in locating new housing vendors (unlicensed sober living homes and room and boards) and is rebuilding relationships with residential facilities, particularly the licensed board and cares that we have worked with in the past to accept our members.
- The FACT program has also been successful at enrolling a number of consumers who have a significant history of co-occurring substance abuse issues into residential substance abuse treatment programs upon or shortly after release from custody and transitioning them into appropriate sober living facilities after the completion of residential treatment.
- FACT has strived to include specific and detailed job descriptions and program descriptions in our job advertisements, as we have experienced that individuals interested in working in mental health are not always necessarily interested in working with the criminal justice population. Effective July 1, 2018, Telecare Corporation updated salary schedules with current market pricing in an effort to offer more competitive wages.
- Recent collaboration with Corrections to a Safer Community (CTASC) and Community Supervised Treatment After Release (CSTAR) has led to an increase in referrals to CFACT as well as discussions during monthly meetings with DBH Adult Criminal Justice staff.
- The CFACT program is re-establishing their relationships with the four Mental Health Courts in the county to ensure that referrals are screened, assessed, and enrolled in a timely manner.

"I accomplished things while in MHC that wouldn't have been possible if jail had been my only option"

- MHC consumer

Success Story

STAR/CSTAR

"Gerardo" came to the STAR program eager to get his life back and persistent to accomplish his career aspirations. Challenges with his mental health and minor criminal offenses had sidetracked him from his goals. He was passionate about helping others and was motivated about fulfilling his career goal of working in a first responder capacity. In working with his case manger, he was able to identify a State program that would afford him this opportunity to train and work as a wildfire fire fighter.

Gerardo worked on his physical conditioning and applied to the program. He was accepted into the program, completed the training and is now employed through this State organization as a wildfire fire fighter. Gerardo has fought many wildfires in California including the Yosemite and Redding fires. Gerardo continues to be employed with this agency and has been involved in fighting many of the recent wildfires that have impacted our State. Gerardo was recently recognized by his organization's Fire Commander with a certificate for his outstanding work in fighting the recent California fires.

Artwork by Bruce Long

Program Updates

- The employment services program has been restructured to include new employer partnerships and training opportunities for consumers. The program is working with consumers to get them enrolled into community colleges, vocational training programs, and other trainings provided by DBH and contracted providers.
- In response to the need for services and to increase referrals into the FACT program, the program was restructured and 25 FACT slots were appropriated to CFACT. The FACT program is currently at capacity with 25 FACT slots and 75 CFACT slots for a total of 100 slots.
- The program continues to increase its housing options and opportunities for consumers by conducting outreach with local landlords and property management companies in an effort to identify safe and supportive housing for consumers.

Artwork by Janet Barbagello

Collaborative Partners

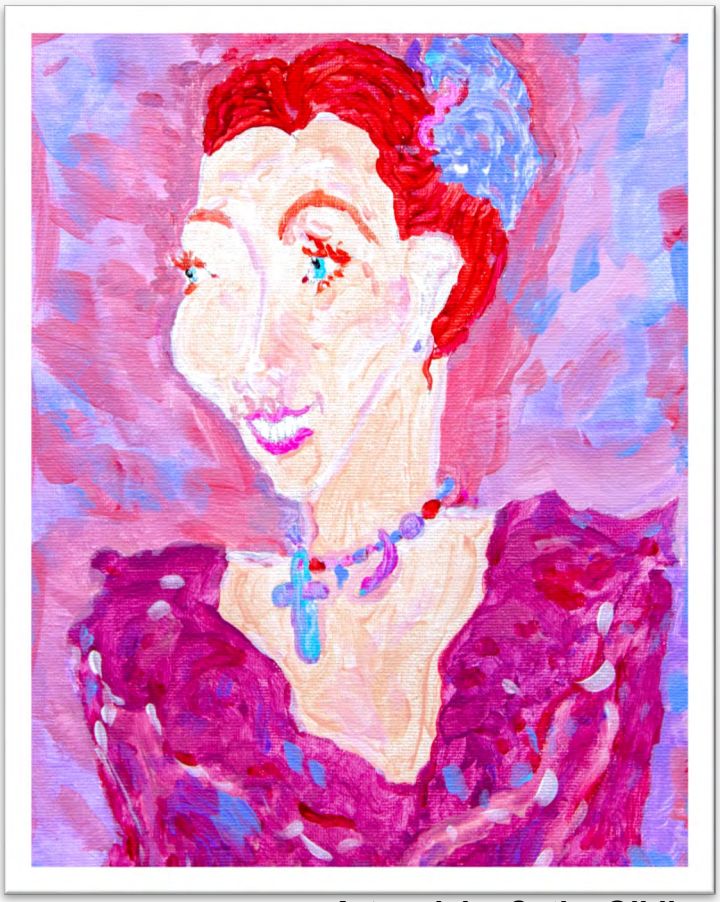
- Abria Del Cielo Assisted Living
- Alzheimer Association
- American Sports University Student Dormitory
- American Surgical Pharmacy
- Avila's Room and Board
- Abria Del Cielo Assisted Living
- Alzheimer Association
- American Sports University Student Dormitory
- American Surgical Pharmacy
- Avila's Room and Board
- Behavioral Health Commissioners
- California Department of Rehabilitation (DOR)
- California State University, San Bernardino – CARE Team
- Cedar House Life Change Center
- Cedar House Rehabilitation Center
- Center for Employment Training (CET)
- Chaffey College
- Coalition Against Sexual Exploitation (CASE)
- Comfort Place Room and Board
- CR Sober Living
- D'Langs Community Center Room and Board
- Del Rosa Villa Nursing Center
- Emergency Shelter Services Housing Providers
- Gibson House for Men
- Gibson House for Women
- Goodwill of Southern California
- Helping Hands 24/7 Sober Living Home
- Hernandez Room and Board
- Hi-Desert Behavioral Health Services
- Hope Homes
- House of Angels Sober Living
- Inland Empire Concerned African American Churches
- Inland Regional Center (IRC)
- Inland Valley Recovery Services
- Institute for Public Strategies
- J's Famous Residential Room and Board

- Judges/Commissioners of San Bernardino County Superior Courts
- Kai's Room and Board
- Legal Aid Society of San Bernardino
- Loma Linda Veteran's Affairs Healthcare System
- Mission Adult Day Health Care Center
- Mount San Antonio College
- National Alliance on Mental Illness (NAMI)
- New Hope Missionary Baptist Church
- NP Guest Home Room and Board
- Omnitrans
- Our Place Clubhouse (South Coast Community Services)
- Pacific Clinics
- Patton State Hospital
- Rialto Kiwanis Club
- SACHS Norton
- San Bernardino Adult Day Health Care Center (formerly Catleya Adult Day Health Care Center)
- San Bernardino Adult School
- San Bernardino City Police Department
- San Bernardino County, Adult Protective Services (APS)
- San Bernardino County, Correctional Mental Health Services
- San Bernardino County, Department of Aging and Adult Services (DAAS)
- San Bernardino County, Office of District Attorney
- San Bernardino County, Office of Public Defender
- San Bernardino County, Probation Department
- San Bernardino County, Sheriff's Department
- San Bernardino County, Superior Mental Health Courts
- San Bernardino County, Transitional Assistance Department (TAD)
- San Bernardino Valley College
- Saving Grace Sober Living
- Serenity Sisters Sober Living
- Shanti House Board and Care
- Social Security Administration's Institutions Unit – Representative Payee Program and Benefits Establishment Assistance
- Solvang Room and Board

"I would never have been clean and sober, gotten my kids back, and be working without the FACT program."

- FACT/CFACT Consumer

- St. John of God Health Care Services
- Steps 4 Life Sober Living
- TAY Center
- Telecare Crisis Walk-in Center, F.A.C.T.
- Tender Heart Adult Day Health Care
- The Center for Effective Change
- The Counseling Team International
- The Ranch Recovery Centers, Inc.
- US Department of Veteran Affairs
- Valley Healthcare Center Skilled Nursing Facility
- Veteran's Center of Colton
- Waterman Convalescent Hospital
- West Valley Detention Center
- Westside Action Group
- Women of Courage Sober Living



Artwork by Cathy Giblin

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

The **Members Assertive Positive Solutions (MAPS)** and **Assertive Community Treatment (ACT)** Full Service Partnership programs serve San Bernardino resident adults, 18 years and older, living with a behavioral health condition. These programs exist to assist consumers to live successfully in the community and supports positive progress towards achieving individual personal recovery goals, while avoiding unnecessary psychiatric hospitalization. The difference between the two programs is that ACT specializes in assisting those who may be transitioning from institutional settings, such as state hospitals, Institutes of Mental Disease (IMDs), or locked psychiatric facilities, whereas MAPS assists those who are historically high users of inpatient services and crisis services. These consumers may also have a history of co-occurring substance use disorder or a history of being homeless. In Fiscal Year 2017/18, MAPS served **54** and ACT served **68** unique full service partners.

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

The Recovery Model used for both programs build on traditional ACT standards. The Telecare Corporation has been contracted to provide both MAPS and ACT services for individuals with serious mental illness, and to create a recovery-centered experience for consumers served. Telecare's approach is based on the belief that "recovery can happen." The program and staff strive to create an environment where a person can recover. The program and staff are a multidisciplinary team that include psychiatrists, nurses, Master's level prepared clinical managers, team leads, and personal service coordinators. Some staff may be consumers who are in recovery themselves.

Target Population:

- Adults

Projected Number to be Served:

- FY 2019/20
  - ◊ 221 Adults

The services and supports include a comprehensive assessment, treatment, crisis intervention, and immediate support 24/7. Through these programs, consumers have access to:

- Development of individualized service plans
- Psychiatric assessment and treatment
- Medication management and support
- Focused assessment and intervention
- Physical health screening
- Care coordination and referral
- Substance use disorder intervention
- Vocational counseling services
- Social skills building activities
- Case management
- Housing support
- Benefits and entitlements assistance
- Family support, education, and life skills coaching.

Information and learning are provided to support individuals in their recovery. Staff support and consultation are available when consumers are hospitalized and upon discharge to aid their transition back to the community. All referrals are coordinated directly by the Department of Behavioral Health (DBH).

Helping Hearts

Helping Hearts California, LLC, provides specialized psychiatric mental health treatment services in a long-term or transitional residential setting for adult consumers discharged from hospitals, transitioning from Institutes of Mental Disease (IMD) or consumers for whom the traditional board and care level of care was unsuccessful. The need for long-term and transitional residential treatment facilities is necessary for consumers who are no longer in need of hospital-level care; however are determined to be in need of further rehabilitation prior to reintegration into the community.

Helping Hearts California, LLC provides a necessary level of treatment to consumers in a less restrictive environment, providing up to 18 months of residential treatment and rehabilitative services prior to reintegration into the community. These services minimize the risk of repeat hospitalizations, over utilization of emergency services, and non-compliance with outpatient treatment services post hospitalization.

MHSA Legislative Goals and Related Key Outcomes

MAPS/ACT

Reduce the subjective suffering from serious mental illness:

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

Reduce homelessness and increase safe and permanent housing:

- ◊ Decreased rate of homelessness for clients, as defined in DCR
- ◊ Increased residence stability

Increase in self-help and consumer/family involvement:

- ◊ Increase in ratio of voluntary mental health services to involuntary mental health services
- ◊ Decrease in no-show rate of appointments
- ◊ Increase in number of encounters with collateral contact, such as family members and informal supports
- ◊ Increase in program attendance and frequency per consumer

Increase access to treatment and services for co-occurring problems; substance abuse and health:

- ◊ Increased encounters in specialty co-occurring and substance abuse interventions
- ◊ Increased encounters in integrated health clinic and/or with primary care/health specialist providers
- ◊ Increased transportation to non-mental health co-occurring appointments (such as substance use disorder, integrated health, primary care, etc.) provided

Reduction in disparities in racial and ethnic populations:

- ◊ Reduction in mental health and health care disparities

Reduction in criminal and juvenile justice involvement:

- ◊ Decreased rate of incarcerations
- ◊ Decreased arrests
- ◊ Decreased jail bookings
- ◊ Decreased sustained allegations
- ◊ Reduced jail/prison recidivism
- ◊ Decrease in jail days
- ◊ Reduce delinquent behaviors which increase likelihood of juvenile justice involvement
- ◊ Reduced difficulties related to Conduct Disorders

Reduce the frequency of emergency room visits:

- ◊ Reduced rate of emergency room visits for mental health concerns
- ◊ Reduced number of emergency room visits for routine medical concerns
- ◊ Reduced administrative hospital days
- ◊ Increased use of alternative crisis interventions (e.g., CWIC, CCRT, CSU)
- ◊ Increase in number of individuals diverted from hospitalizations

Increase a network of community support services:

- ◊ Increase in number of collaborative partners
- ◊ Increased coordination of care

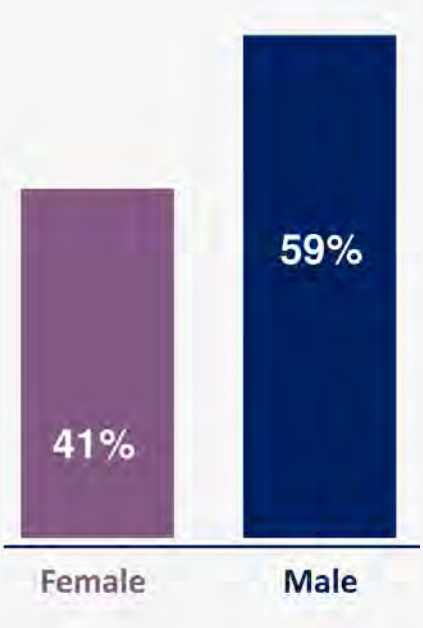
Helping Hearts

Reduce the frequency of emergency room visits:

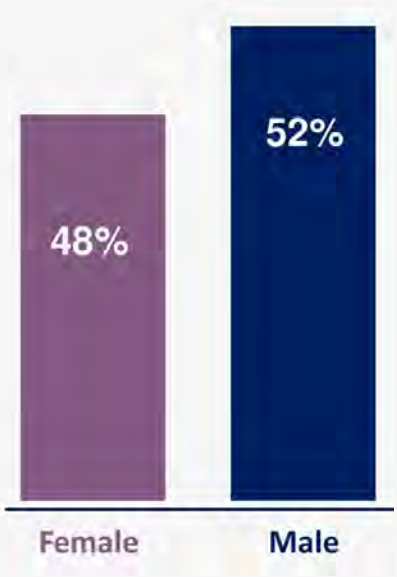
- ◊ Reduced rate of emergency room visits for mental health concerns
- ◊ Reduced number of emergency room visits for routine medical concerns
- ◊ Reduced administrative hospital days
- ◊ Increased use of alternative crisis interventions (e.g., CWIC, CCRT, CSU)
- ◊ Increase in number of individuals diverted from hospitalizations

Program Demographics: Gender

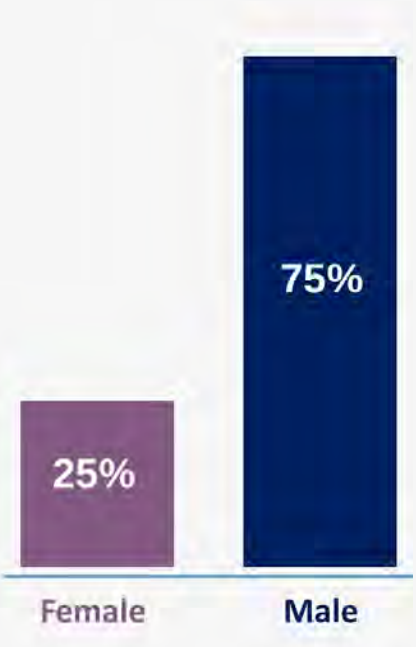
MAPS



ACT

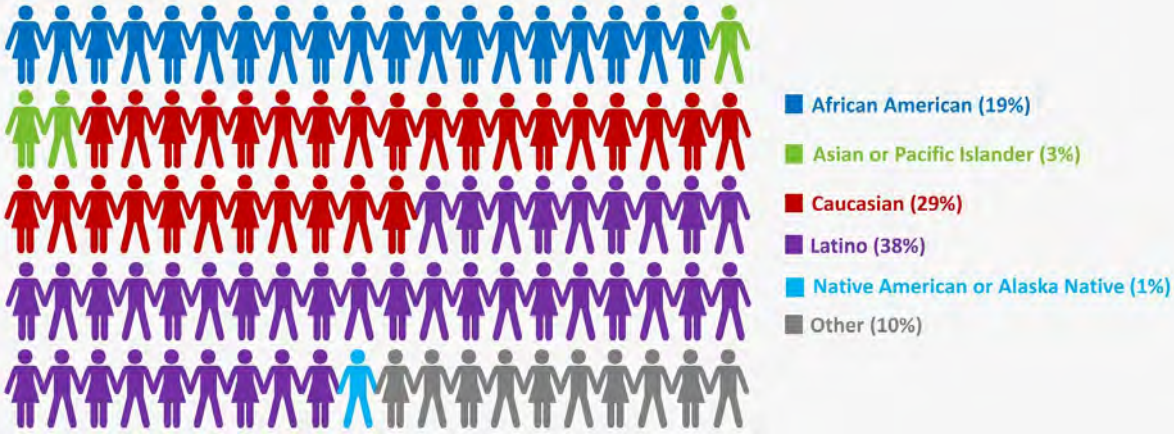


Helping Hearts

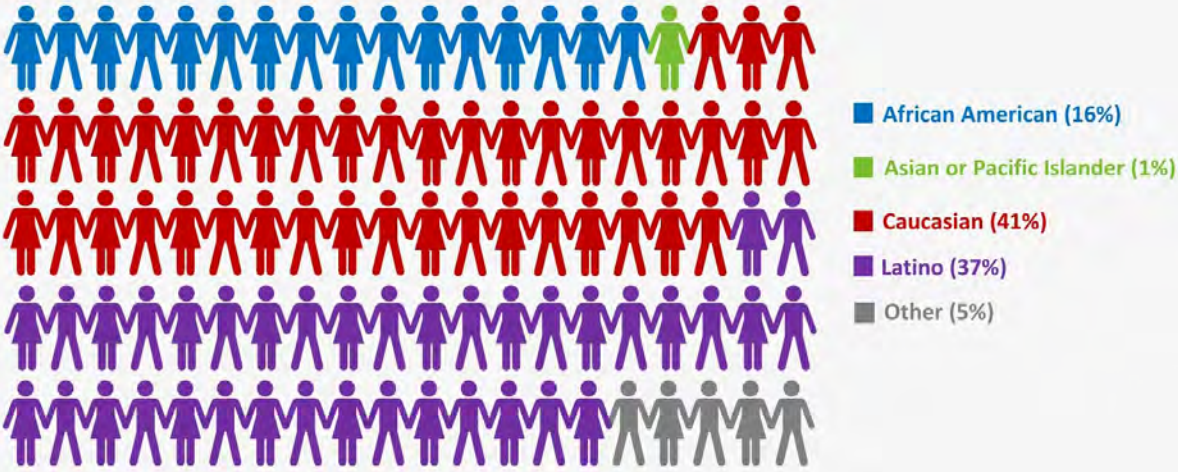


Program Demographics: Ethnicity

MAPS



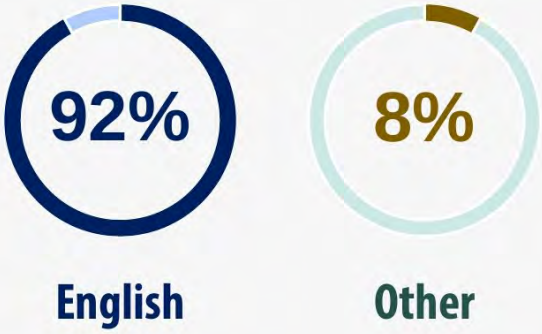
ACT



Helping Hearts

Program Demographics: Primary Language

MAPS

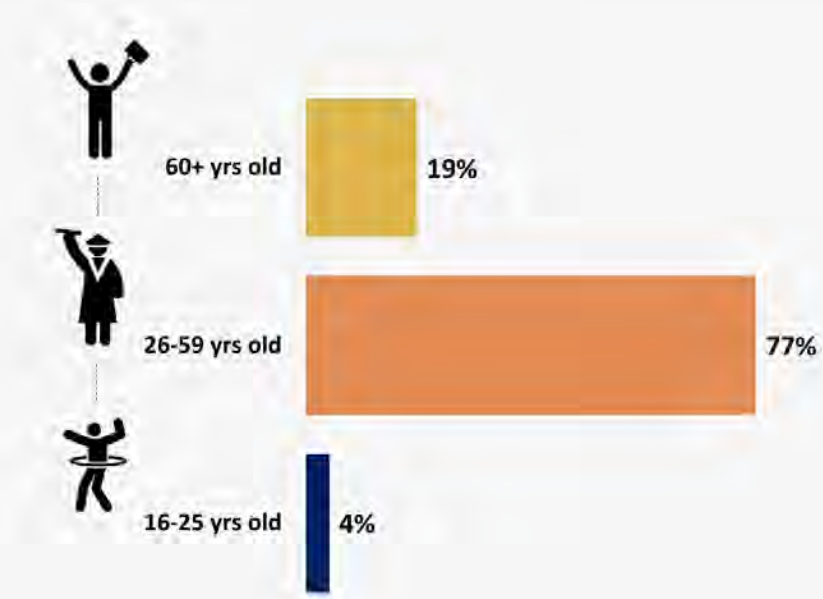


ACT

Helping Hearts

Program Demographics: Age

MAPS



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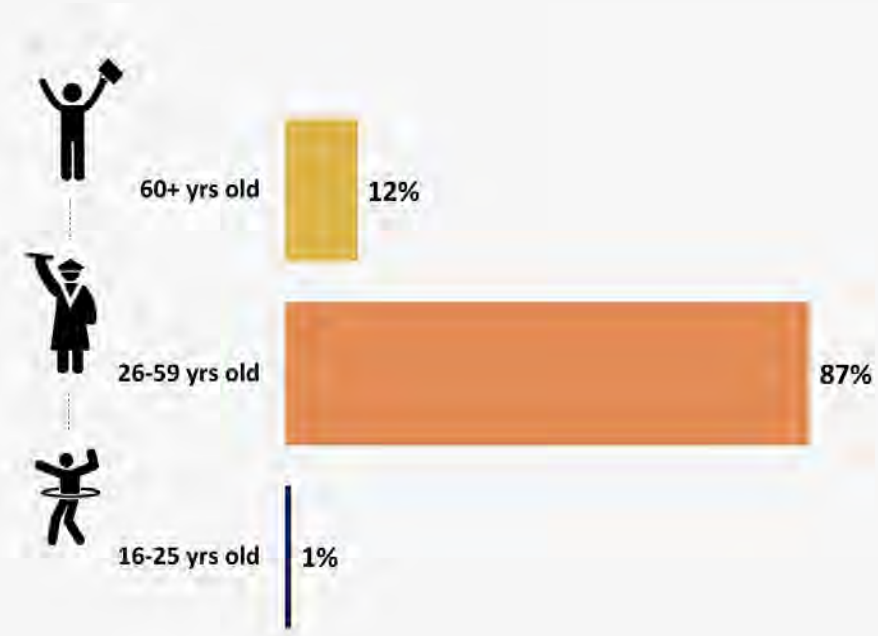
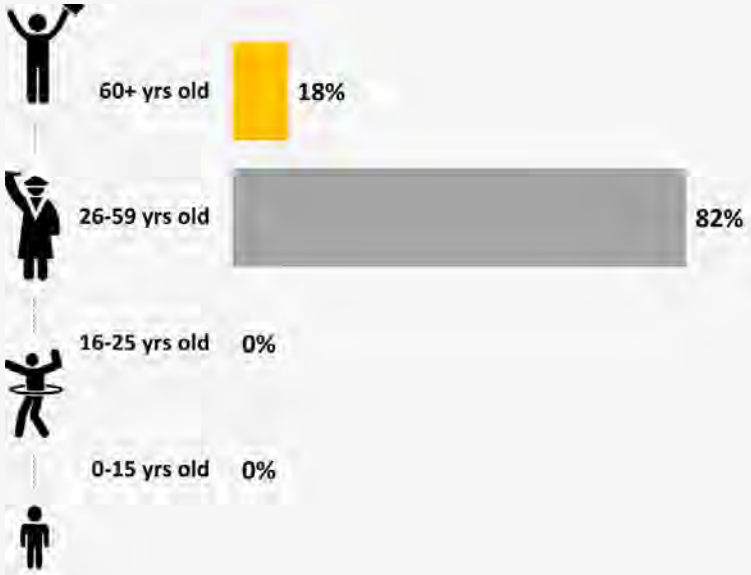
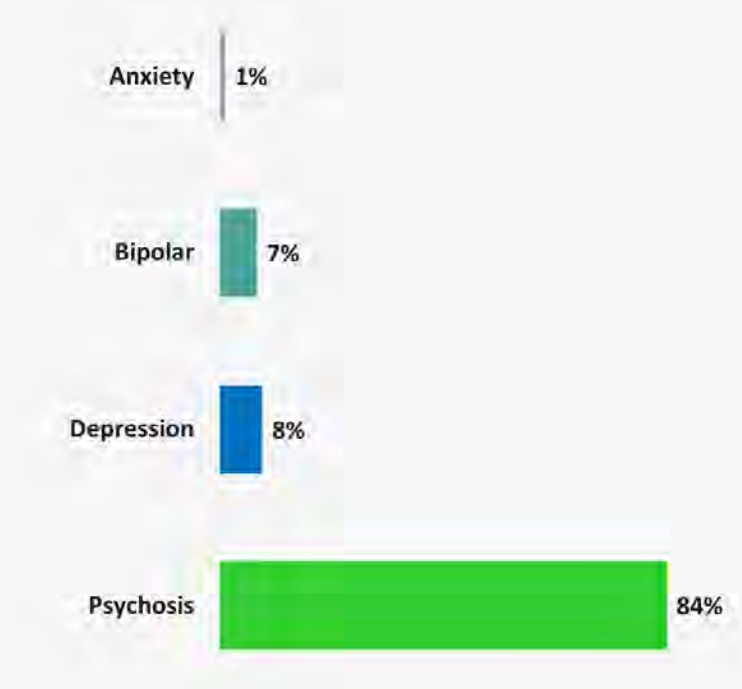


Helping Hearts



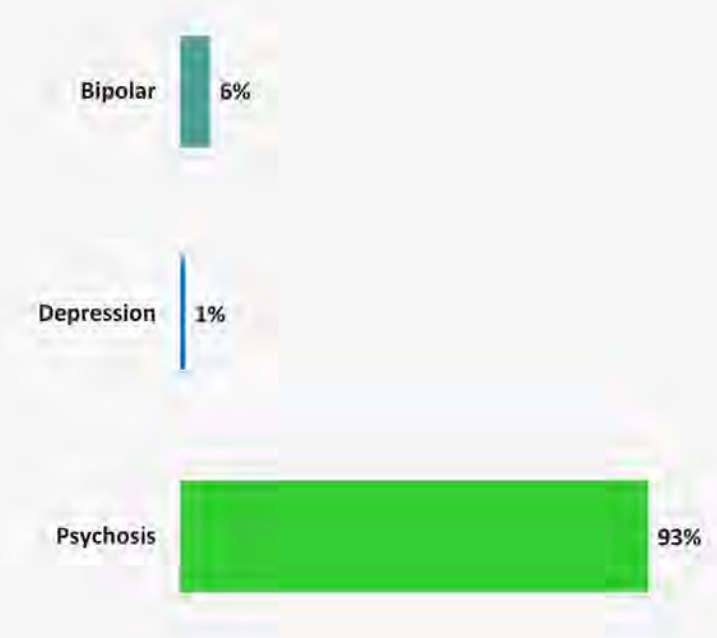
Program Demographics: Primary Diagnosis

MAPS



Program Demographics: Primary Diagnosis

ACT



Artwork by Robin Cline

Positive Results

MAPS

- Out of **54** consumers served during Fiscal Year 2017/18, **74%** have been able to manage their symptoms with medication and have not been hospitalized.
- Consumers experienced one or more of the following living arrangements in Fiscal Year 2017/2018:
    - ◊ Living independent, alone, or with adult family member: **13%**
    - ◊ Unlicensed facility, but supervised: **27%**
    - ◊ Licensed community setting: **27%**
    - ◊ Acute medical hospital: **6%**
    - ◊ Acute living facility: **2%**
    - ◊ Assisted living facility: **2%**
    - ◊ Jail: **2%**
    - ◊ With adult family members other than parents: **4%**
    - ◊ Licensed residential program: **2%**
    - ◊ Not recorded: **2%**
- Approximately **31%** of consumers have family involved in treatment.
- In Fiscal Year 2017/18, **13%** of the consumers served have been linked to residential programs, **6%** were encouraged to attend Alcoholics Anonymous (AA) support groups, and were encouraged to attend co-ed groups at the office, once they began.
- The MAPS program serves a diverse population as demonstrated in the demographics section of this report.
- In Fiscal Year 2017/18, **54** consumers were served. Of these, **25** of the consumers had been in a hospital setting for a total of **580** days. Maintained relationships with various pharmacies that provide delivery services to consumers to ensure continuity of care.
- Developed relationships with new room and board housing vendors in the County.

ACT

- Out of **68** consumers served, **79%** consumers have been able to manage their symptoms with medication without having to be hospitalized.

- Consumers experienced one or more of the following living arrangements through Fiscal Year 2017/18:
    - ◊ Living independent, alone or with adult family member: **6%**
    - ◊ Unlicensed facility, but supervised: **21%**
    - ◊ Licensed community setting: **52%**
    - ◊ Acute medical hospital: **2** consumers **3%**
    - ◊ Single room occupancy: **4%**
    - ◊ With adult family members other than parents: **4%**
    - ◊ With one or both biological/adoptive parents: **10%**
    - ◊ This results in **100%** of clients who maintained stable housing
- Approximately **36%** of consumers have family involved in treatment (an increase of 6% from last fiscal year).
- **5** consumers have been linked to residential programs in the community to help manage their substance use.
- Reduction in disparities in racial and ethnic populations.
- Reduce the frequency of emergency room visits and unnecessary hospitalizations:
    - ◊ 22 consumers went voluntarily to the hospital and 5 consumers went involuntarily.
    - ◊ Emergency intervention provided: 6 consumers were Mental Health related and 3 were substance use related.
- Consumers were linked to clubhouses, adult day health centers, food banks, and assistance with Omni disability bus pass.
- Maintained relationships with various pharmacies that provide delivery services to consumers to ensure continuity of care.
- Consumers worked with Behavioral Health Integrative Complex Care Initiative team, where they received assistance with the whole person care, physical health linkage and support.
- Established relationships with new room and board housing vendors in the county to add more vendors to the list of housing placements.

Helping Hearts

- The Department of Health Care Services (DHCS) Adult survey reported 16 out of 20 consumers reported improved life satisfaction and satisfaction with the housing by Helping Hearts California (HHCA). **80%** of consumers reported satisfaction in quality of life, an increase in consumer/family involvement and self-help.
- Consumers are participating in residential treatment services for an average length stay of 12-18 months. Consumers work with HHCA to establish a viable discharge plan for independent living. **Zero** consumers were discharged to homelessness.

- Consumers are assisted with scheduling their appointments and are accompanied by the HHCA Program Director.
- Social Rehabilitation groups are encouraged.
- DBH provided 36 Substance Use Disorder (SUD) groups in HHCA homes to support consumers with co-occurring diagnoses. HHCA and their consumers work closely with the primary care physicians and treating psychiatrist to ensure medication compliance and the appropriate medications are prescribed.
- The DHCS Adult survey reported 19 out of 20 consumers reported **zero** encounters with law enforcement, jail, arrest or crimes since they were admitted. **95%** of consumers reported zero police encounters and decreased jail activity. The stabilization and continued medication regimen along with appropriate interventions have reduced the number of consumers that engage in illegal activity and arrest. HHCA works with the Office of Public Guardian to help address consumers with existing warrants.
- Helping Hearts served a total of fifty-nine consumers.
- In Fiscal year 2017/2018, there were 21 consumer medical and psychiatric hospitalizations.
- HHCA assists consumers in accessing appropriate community services and avoids emergency room visits for issues that can be addressed in an outpatient setting. Consumers are educated on the appropriate use of 911 and emergency rooms. Regular primary care provider and psychiatric appointments reduce the use of emergency services.
- HHCA consumers participated in **48** community volunteer events as part of the HHCA vocational program. Consumers learn how to access public transportation and community resources.

Outreach and Engagement

In Fiscal Year 2017/18, MAPS/ACT organized and/or participated in the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Budgeting skills group outing	6	41
Social Skills Outing	8	38
Birthdays celebration offsite	12	63
Member recognition yearly event	1	58
NAMI Walk	1	16
Harvest Festival onsite	1	44
Holiday Party onsite	1	48
Thanksgiving Holiday offsite	1	53
Recovery Center Clinical Systems groups offsite	5	25
Total	**36**	**386**

In Fiscal Year 2017/2018, Helping Hearts organized and/or participated in the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Open House	3	33
Outreach Events	7	60
Educational Presentations	9	65
Neighborhood Watch Meetings	4	150
Total	**23**	**308**

Challenges

MAPS

The biggest challenge continues to be the difficulty in finding new placements within San Bernardino County once a consumer has exhausted all their resources.

Another challenge is the lack of licensed Board and Care (B&C) housing facilities in San Bernardino County. B&Cs are state licensed facilities that provide room and board, 24 hour supervision, and dispensing of medication. In comparison, room and boards are unlicensed, unsupervised facilities that generally offer a bed, food, and utilities, but do not dispense medication or have 24 hour supervision. Challenges continue with procuring Board and Care (B&C) housing for younger members/referrals and facilities that cannot accept members with complex medical issues.

Consumers who change their payee who are not conserved, also face challenges, especially when the consumers come in without funds and there is an inability to help these individuals manage their funds.

Transportation is also a challenge as some consumers are unable to navigate the bus system on their own, which has resulted in failure to follow through with their appointments. Consumers prefer to be provided with transportation to and from their appointments, and this becomes the only way to ensure that consumers are seen.

Inconsistency taking medications as prescribed has been a challenge, as well as administering injections by the nurses. Consumers, at times, do not inform their case managers when they are leaving their housing, making it difficult for the treatment team to provide services.

Family involvement is limited, and it has been challenging coordinating services with consumers' families who no longer wish to be involved in their care.

Additionally, consumers do not seek out the necessary medical care they should be accessing on a regular basis due to stigma and previous traumatic experiences when visiting medical providers. Scheduled appointments are not available at convenient times and consumers are diverted to seek medical care through urgent care facilities or emergency departments. Consumers are then subjected to long waits and costly services, often walking out without receiving the care they need.

ACT

The biggest challenges includes housing the consumers after they have exhausted all their housing resources in San Bernardino County. It remains difficult to find a new placement within the county once a consumer has exhausted all their resources. Also, the program continues to experience difficulty in procuring Board and Care housing for younger members and those with complex medical issues.

Transportation is also a challenge as some consumers are unable to navigate the bus system on their own, which has resulted in failure to follow through with their appointments. Consumers prefer to be provided with transportation to and from their appointments, and this becomes the only way to ensure that consumers are seen.

Another challenge is when consumers are discharged from the hospital, they return home with a different prescription, and the medications provided to members do not match the medication that the psychiatrists are prescribing.

An additional challenge includes consumers avoiding primary care provider medical follow ups. Family involvement is also limited and it has been challenging coordinating services. Last, substance use is another challenge the team faces.

Helping Hearts

- Challenges with neighbors and others not in favor of a residential treatment home in the community.
- The length of time Community Care Licensing Division takes to process a licensing application. The holding cost associated with waiting for license approval to operate is sometimes cost prohibitive for providers.
- The length of time it takes to process and receive a Conditional Use Permit from various cities throughout the county.
- Turnover and difficulties recruiting skilled direct care and administrative staff.

Success Story

MAPS

"Anthony" won an award for the most engaged member due to his continued success with maintaining employment at a nursing home. He plans to become a Nurse Practitioner.

"Manny" has continued to excel in his vocational program. He has not been hospitalized in over six months. Manny has also been consistent with taking his medications, meeting with his psychiatrist, and meeting with the program weekly.

"I feel support all the time."

- MAPS/ACT consumer

"You guys are like my family ."

- MAPS/ACT consumer

Solutions in Progress

MAPS

MAPS is working to coordinate additional resources in housing which are utilized by other Telecare programs in Riverside County. For those consumers who are unable to manage their funds, the treatment team will advocate with the psychiatrist, if needed, to change the payee.

Telecare staff work with consumers to feel comfortable taking public transportation and work in collaboration with IEHP (Inland Empire Health Plan) to also coordinate transportation. Consumers are encouraged to purchase bus passes. The team assists with completing the application and working on coping skills to help alleviate any stressors of using public transportation.

Medication compliance has been the focus of treatment. Nurses are encouraged to provide health awareness and introduce various tools to help consumers stay on track with taking medications as prescribed. Nurses are providing coordinated care with the facilities in which consumers reside to improve monitoring of daily medications. Nurses are increasing their home visits with consumers discharged from the hospital and are immediately reporting to the psychiatrist of any changes to medications. Nurses are also increasing communication with board and care operators to ensure that they are aware of the right medication regimen authorized by the program's psychiatrist.

The programs are integrating the Behavioral Health Initiative Complex Care Integrative (BHICCI) team to help provide Whole Person Care services. BHICCI and MAPS work in collaboration to ensure that consumers are linked to their primary care physician, and work towards developing treatment interventions to help improve consumer's well-being/health status.

Treatment teams are working to provide consumer's family with resources on services in the community, as well as for themselves to help with managing the consumer's symptoms without support. The treatment team is working towards motivating family members to take some moments to share how they will contribute to consumer's treatment and to increase their participation with the consumer's recovery.

ACT

Clinical staff are trained to provide ongoing psycho-education groups to consumers who struggle with any substance use issues throughout the year. Consumers are encouraged to attend groups and are introduced to coping skills to alleviate symptoms. Consumers are also provided with community resources to provide further education as needed.

ACT is working on coordinating additional resources in housing which are utilized by other Telecare programs in Riverside County.

Telecare staff work with consumers to feel comfortable taking public transportation, working in collaboration with IEHP (Inland Empire Health Plan) to also coordinate transportation. Consumers are encouraged to purchase bus passes, and the team assists with completing the application, and working on coping skills to help alleviate any stressors of using public transportation.

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Treatment teams are working to provide consumer's family with resources on services in the community, as well for themselves to help with managing the consumer's symptoms without support. The treatment team is working towards motivating consumers' families to take some moments to share how they will contribute to consumer's treatment and to increase their participation with the consumer's recovery.

ACT is working to develop co-occurring groups, and there will be open groups for anyone to participate. BHICCI teams are also administering Substance Use Disorder (SUD) tools with consumers to identify the risk factors in using substances, and the team is working with the ACT team to coordinate services that consumers can benefit from.

ACT continues to work with placements and keep communication open to monitor challenges with housing.

Helping Hearts

- Helping Hearts California made several presentations at the City of Colton Planning Commissioners meeting and City Council Meetings. The decision to increase client occupancy from 6 to 10 consumers was unanimous. On 11/21/18, Helping Hearts capacity to serve 4 additional consumers officially increased.
- Helping Hearts continues to act as Block Captains and participate in the Homeless Task Force Committee in the City of Colton.
- In an effort to retain quality direct care staff, HHCA implemented a **6%** increase in direct care staff's hourly rate. An enhanced benefit package was added to remain competitive with other agencies. HHCA will continue to strive to create an atmosphere employees enjoy in an effort to encourage staff retention.

"I am grateful for the opportunity to repair the relationship with my family. I was tired of being homeless and these hospitals. I am happy at Helping Hearts."

- Helping Hearts consumer

"Telecare has never given up on me and that gives me hope ."

- MAPS/ACT consumer

"I don't know where I would be without Telecare in my life, I would be likely in and out of the hospital."

- MAPS/ACT consumer

Success Story

ACT

"Juan" has been receiving services for about ten years. He began working on obtaining U.S. citizenship several years ago. He encountered several obstacles along the way, such as fears of eligibility, expenses, comprehension (memory) of the questions, and appropriate responses to complete the interview process. Often, these barriers would result in Juan's anxiety increasing. At one point, he stopped working on his U.S. citizenship due to the symptoms it caused him. The ACT team would often encourage Juan to pursue his goal and provide coping tools to help Juan manage his anxiousness. Once Juan was ready to resume, some of the staff members reviewed potential interview questions with him during the meetings to provide support. Juan was able to receive his citizenship several years ago.

Success Story

MAPS

"Amber" has a history of isolating herself because she was afraid to leave her home. Recently, she has been going out on short walks in her neighborhood; this is a huge success in her treatment process. Amber has been consistent with taking her medications, and meeting with the MAPS team regularly.

"Devin" had a history of law enforcement involvement resulting in miscellaneous tickets. Since his involvement with MAPS, he has not had a ticket, nor has he been hospitalized in quite some time. Devin has been consistent with taking his medications and meets with MAPS weekly.

Success Story

Helping Hearts California

"'Susan" is living with a behavioral health condition and has had a history of hospitalizations and placement failures. She has a young son who was living with her mother because she could not care for him. Due to frequent arrests, hospitalizations and need for placement at a State Hospital, she was placed on legal conservatorship. Susan was also diagnosed with a medical condition and experienced medical complications. After Susan's placement at a State Hospital, she was admitted to an Institution for Mental Disease (IMD) until she could demonstrate she was ready to transition back into the community. Susan was admitted in the Helping Hearts California program and has since flourished. Susan learned life skills, began exercising and losing weight. She learned how to manage her chronic health disease and took pride in making healthier eating choices. Towards the end of the program, Susan became an inspiration and a mentor to her peers. The judge determined Susan no longer needed to remain conserved. The staff celebrated with her and reminded her that she made this happen. She moved back home with her mother and son. She periodically keeps in contact with Helping Hearts and continues to do well.

Success Story

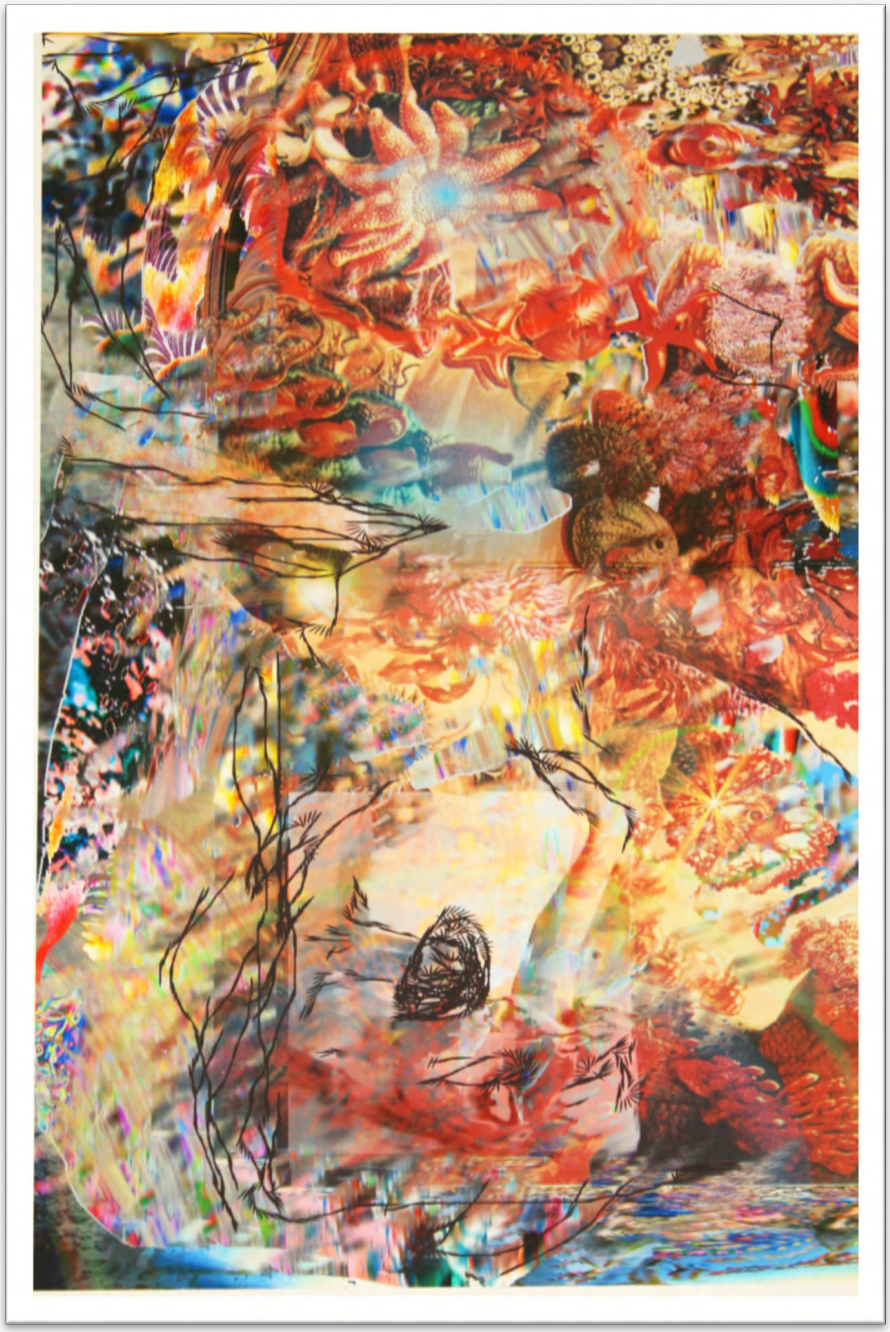
Helping Hearts California

"James" was diagnosed with a behavioral health condition. He was living in the community homeless. He was not receiving treatment or taking his medications. His behaviors in the community led to an arrest. After being released from jail, he was placed at a Crisis Residential Facility that helped to stabilize him. Helping Hearts California (HHCA) admitted James into the program and he remains compliant with his medication and doctor's appointments. HHCA continues to work with James in developing appropriate coping and life skills. He is no longer on legal conservatorship, and he is now focusing on a viable discharge plan.

Collaborative Partners

- Alpha Pharmacy
- ABC Pharmacy
- American Surgical Pharmacy
- Alta Vista Pharmacy
- Assisted living skill programs
- Azusa Pacific University, Master of Social Work program
- Bear Valley Community Healthcare District
- Bear Valley Unified School District
- California State University San Bernardino
- Center for Change (SUD treatment)
- Club Houses
- Cole Vocational Services (disabled adults)
- Colton Police department
- Curt's Pharmacy
- Day Programs
- Del's Pharmacy
- Richard DelaRosa, Mayor of Colton
- Domestic Violence Education and Services (DOVES)
- Elder Care Co.
- Gilbert's Drugs
- Josie Gonzalez, 5th District Supervisor, San Bernardino County
- Guardian Pharmacy
- Harper's Pharmacy
- Helping Hands Pantry
- Judy Henri-Farry, LMFT (private therapist)
- Loma Linda Pharmacy
- Loma Linda University, Doctoratel program
- John McMahon, Sheriff
- North Rialto Drug and Med Supply
- Prescription Station
- Residential programs
- San Bernardino County Board and Care Operators
- San Bernardino County Room and Boards
- San Bernardino County, Department of Behavioral Health, Community Crisis Response Team (CCRT)
- San Bernardino County, Sheriff's Department - Big Bear Station

- South Gate Rose Pharmacy
- St. Mina Pharmacy
- David Torro, Colton District 1 Council member
- University of Southern California, Master of Social Work program



Artwork by Peter Millar

Big Bear Full Service Partnership (A-8)

The Big Bear Full Service Partnership (FSP) is an alliance of mental health service providers in the geographically isolated mountain area of Big Bear Lake that provides mental health services to children and adults. The partnership began in May 2009 to help a traditionally underserved area for mental health services. This FSP allows for consumers in this geographic region to access a continuum of mental health services including intensive case management, co-occurring treatment, psychotherapy, medication services, and transportation services for low income and underserved clients in the Big Bear Valley. Having access to resources increases consumers' ability to function within the community, within families, and schools. In addition, the partnership provides linkage to community resources and assists in the case management of uninsured consumers by assisting with applications to Medi-Cal.

MHSA Legislative Goals and Related Key Outcomes

Increase access to treatment and services for co-occurring problems; substance abuse and health:

- ◊ Increased encounters in specialty co-occurring and substance abuse interventions.

Reduce the frequency of emergency room visits and unnecessary hospitalizations:

- ◊ Increase the number of individuals diverted from hospitalization.

Target Population:

- TAY
- Adults
- Older Adults

Projected Number to be Served:

- FY 2019/20
  - ◊ 14 TAY
  - ◊ 81 Adults
  - ◊ 15 Older Adults

"I wouldn't be here without this program. I would not be a functioning person if this program would not have come into my life."

- Big Bear FSP Consumer

Positive Results

Big Bear FSP served a total of 85 unduplicated consumers in Fiscal Year 2017/18.

Challenges

Since Big Bear is a small town of 5,262 residents (United States Census Bureau, 2017 population estimates), consumers have expressed concern that their participation in co-occurring treatment will not remain confidential and as a result are unwilling to engage and participate in services. Co-occurring treatment is normally a challenge, but it is even more so in the Big Bear area because the stigma associated with receiving behavioral health services acts as a barrier to treatment. Consumers are hesitant to seek services as it can affect their social life, housing situation, and access to appropriate care.

Success Story

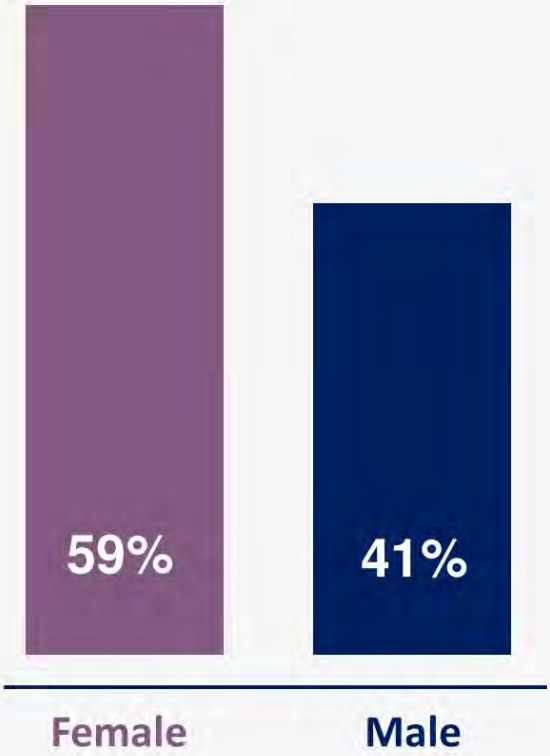
"Kate" was an individual living with a serious mental illness. Through working with her case manager at Big Bear FSP, it was identified that Kate had no close family and friends to support her and, as a result, her condition seemed to deteriorate when she was stressed, as she had no social or family support. Once this support need was identified, her case manager worked with program staff to ensure that Kate's needs were met and that she felt well supported and they worked with her to schedule her mental health appointments and social activities within the program, as well as her physical health appointments with other providers. The program staff also asked that Kate call them during business hours so that they could assist her however possible.

Through building rapport with Kate, the program was able to create a support network for her and an environment where she felt safe. Today, Kate continues to be active with program services, her anxiety is better controlled, and, as a result, she is able to maintain in the community independently.

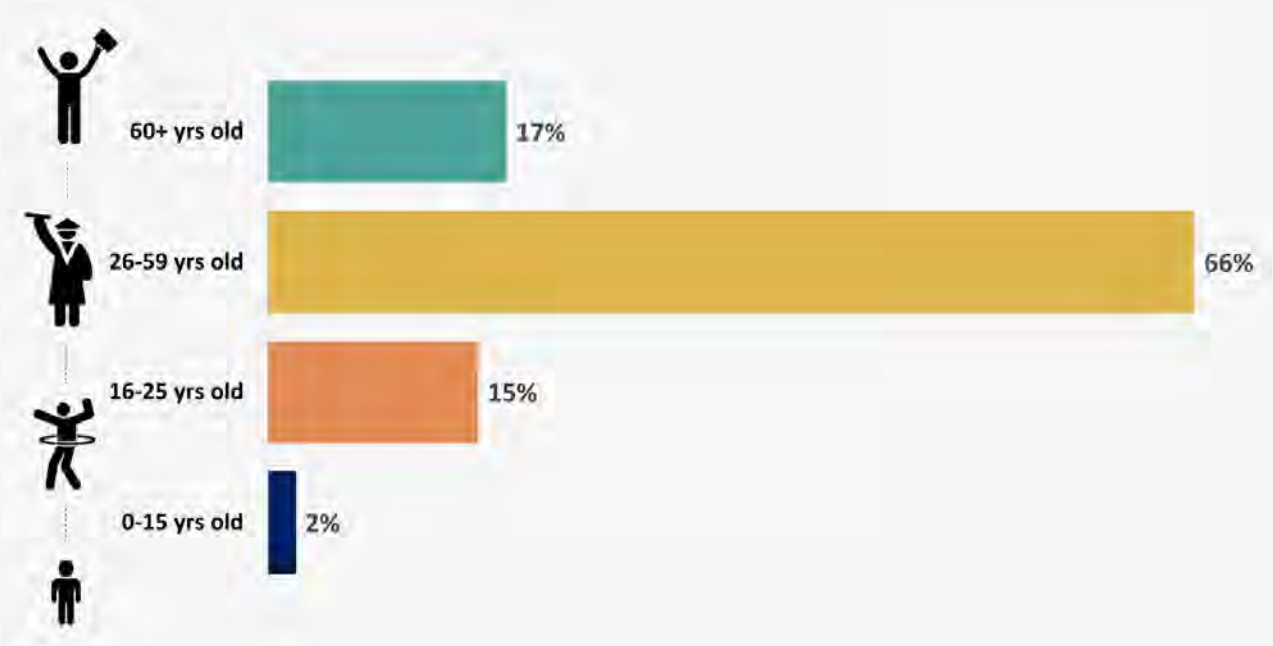
Solutions in Progress

Big Bear FSP staff continue to develop comprehensive co-occurring treatment interventions in an effort to make services more effective. The recent hiring of an "in- house" Alcohol and Other Drug (AOD) counselor will assist with access and treatment efforts. FSP staff also continue to network in the community to identify additional partners and resources and conduct outreach at local community events and meetings to promote services, educate the community, and to help reduce the stigma surrounding behavioral health treatment services.

Program Demographics: Gender



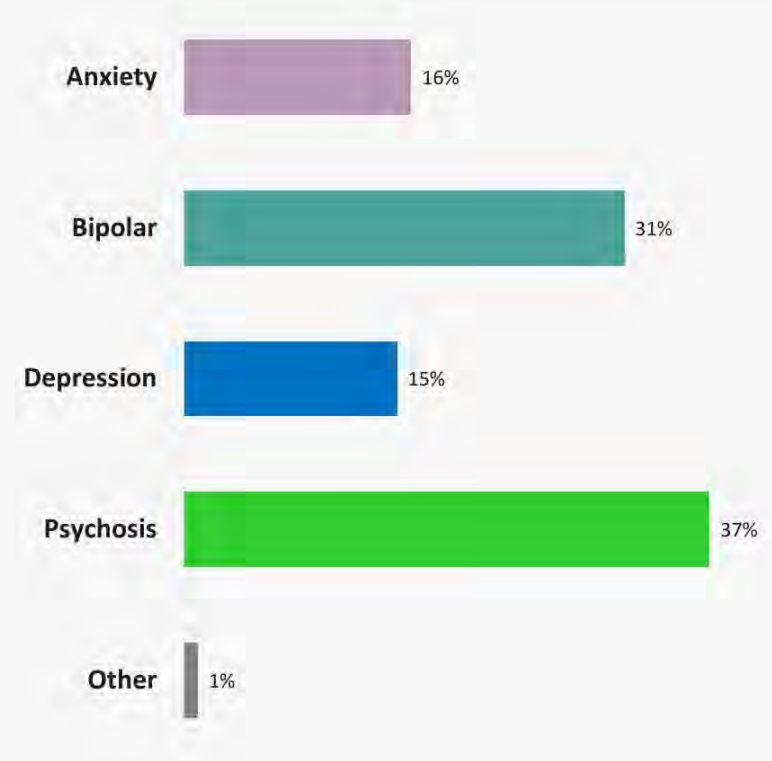
Program Demographics: Age



Program Demographics: Ethnicity

Program Demographics: Primary Language

Program Demographics: Primary Diagnosis



Program Updates

- The Big Bear FSP program continues to work with community and faith based partners to provide resources to consumers and to promote the behavioral health services offered at Lutheran Social Services.
- As Big Bear FSP is part of the continuum of adult Full Service Partnership (FSP) services, the Big Bear FSP program services and outcomes will be included as part of the Regional Adult Full Service Partnership (RAFSP) program in future MHSA Annual Updates and Three Year Plans.

"Having mental health services available locally, especially a the psychiatric services has been a Godsend."

- Big Bear FSP Consumer

Collaborative Partners

- Bear Valley Community Healthcare District
- Bear Valley Unified School District
- Mental Health Systems Inc., Center for Change (SUD treatment)
- Cole Vocational Services (disabled adults)
- Domestic Violence Education and Services (DOVES)
- Elder Care Co.
- San Bernardino County, Sheriff's Department - Big Bear Station

Artwork by Michael Mendez

Regional Adult Full Services Partnership (A-11)

The Regional Adult Full Service Partnership (RAFSP) offers Full Service Partnership (FSP) programs in the Barstow, Phoenix, Mesa, Mariposa, and Victor Valley DBH Community Clinics, and contracts for FSP Services with Hi-Desert Medical Center, Valley Star Behavioral Health, Inc., to provide additional FSP services throughout the various regions of San Bernardino County (Outpatient Clinics | DBH Internet Website). The RAFSP programs operate by linking clients to services in the community and providing full wraparound care to these individuals. These include intensive at home or field based services that assist individuals to access various levels of care and housing and/or step down to a lower level of care in the least restrictive setting possible.

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

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

Target Population:

- Adults

Projected Number to be Served:

- FY 2019/20
  - 930 Adults

Individuals requiring this level of care are often unable to maintain independence in the community without the assistance of intensive case management support. The ratio of staff to consumers is typically one to ten to allow for intense support of the consumers 24 hours a day/7 days per week, but can include larger numbers as appropriate.

The RAFSP offers full wrap-around services with the goal of connecting consumers to available resources such as housing, medication support services, therapy, intensive case management, and care coordination. RAFSP service providers help individuals cope with their behavioral health challenges by linking them to community programs and agencies through direct, one-to-one support. RAFSP treatment services include clinical assessments, risk assessments, assistance with obtaining housing, coordination of care and transportation with mental health and substance abuse outpatient clinics, and physical healthcare physicians and insurance providers.

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

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

RAFSP Target Population

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

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

MHSA Legislative Goals and Related Key Outcomes

Reduce the subjective suffering from serious mental illness for adults:

- ◊ Improve life satisfaction
- ◊ Decrease hopelessness
- ◊ Increased resiliency
- ◊ Decreased impairment in general areas of life functioning

Reduce homelessness and increase safe and permanent housing:

- ◊ Decreased rate of homelessness for clients, as defined in DCR
- ◊ Increased residence stability

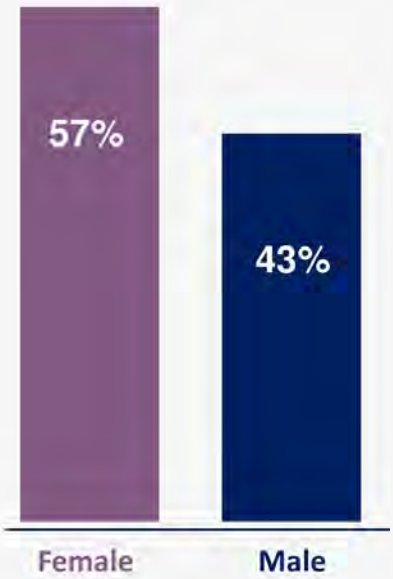
Increase access to treatment and services for co-occurring problems; substance abuse and health:

- ◊ Increased encounters in co-occurring and substance abuse interventions
- ◊ Increased encounters in integrated health clinic
- ◊ Increased transportation to co-occurring appointments provided

Reduce the frequency of emergency room visits and unnecessary hospitalizations:

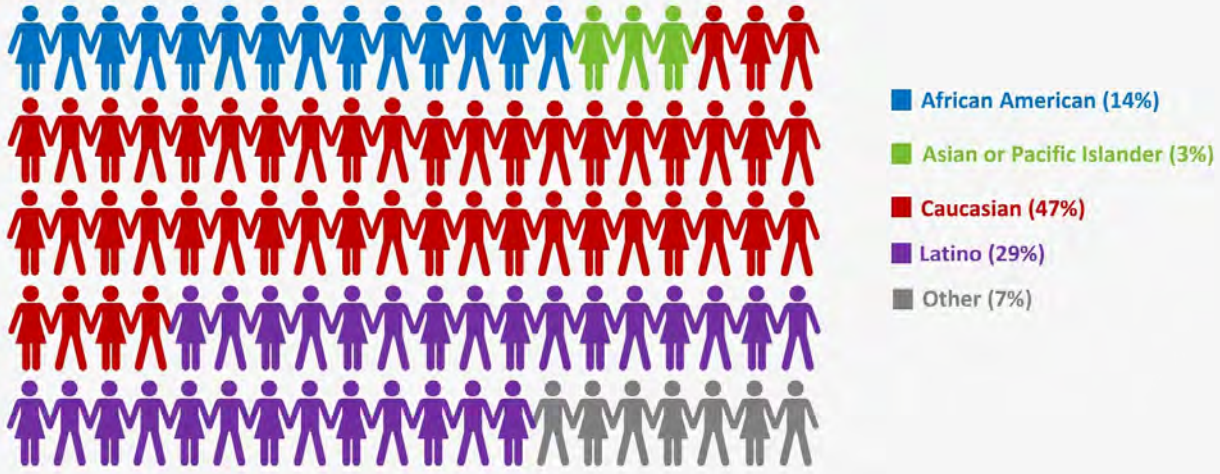
- ◊ Increased number of individuals diverted from hospitalization
- ◊ Reduced administrative hospital days
- ◊ Reduced rate of emergency room visits for mental health concerns

Program Demographics: Gender

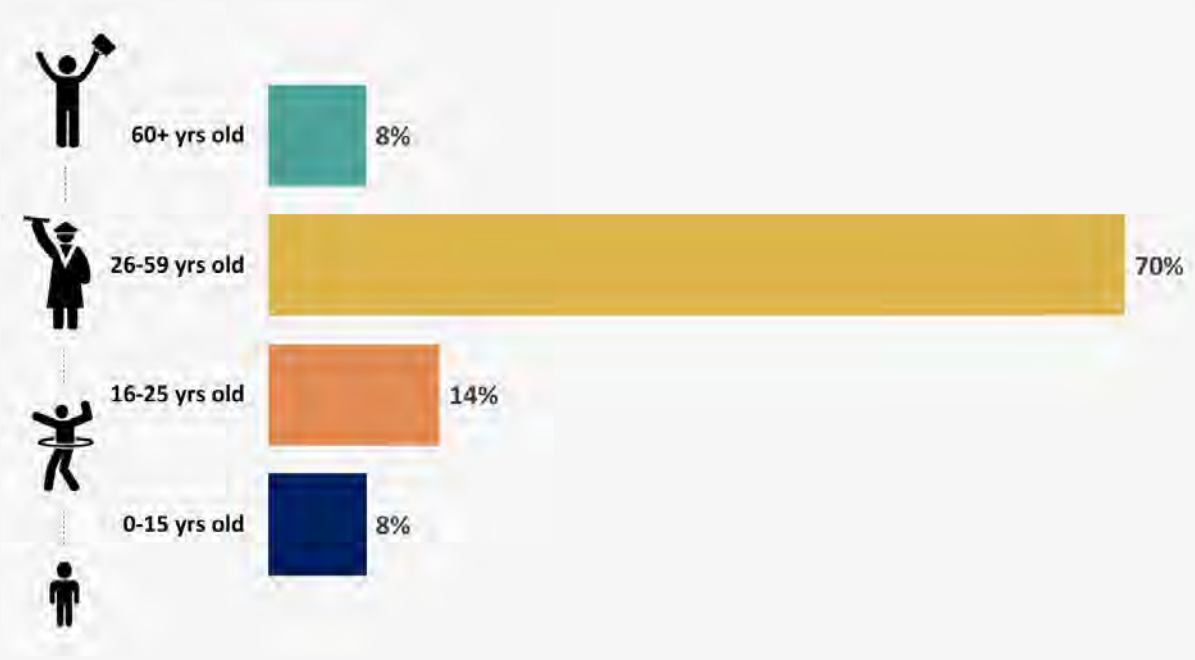


Program Demographics: Primary Language

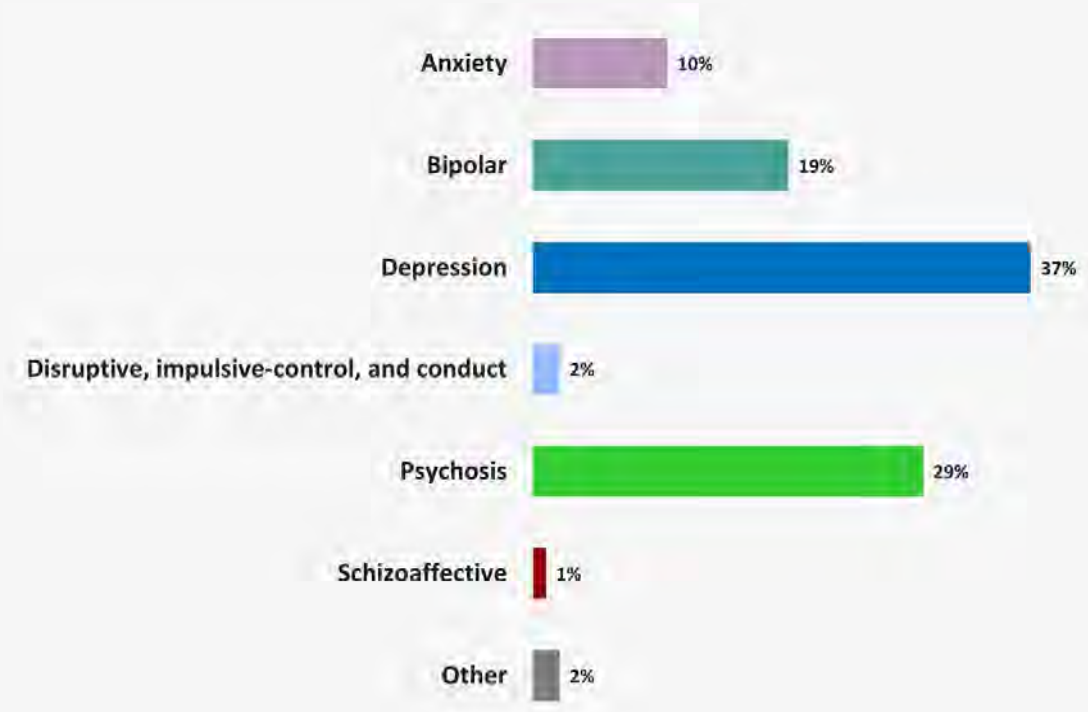
Program Demographics: Ethnicity



Program Demographics: Age



Program Demographics: Primary Diagnosis



Positive Results

Barstow Counseling Center

- In Fiscal Year 2017/18, there were **33** consumers that received FSP services, of which **79%** did not have a hospitalization for the fiscal year. This is a **5%** decrease in hospitalizations from the previous fiscal year.
- At this location, there was also an increase in the number of consumers served from **24** consumers for the previous fiscal year to **33** consumers for Fiscal Year 2017/18 representing a **38%** increase in FSP consumers served.

Hi-Desert Behavioral Health Services

- In Fiscal Year 2017/18, there were **56** consumers that received FSP services, of which **93%** did not have a hospitalization for the fiscal year. This is a **79%** decrease from the previous fiscal year.
- For these hospitalizations, there was a total of 13 bed days, which is a **84%** decrease from the previous fiscal year.
- For the consumers hospitalized, there was a **25%** decrease in the average length of stay in the hospital (bed days) from the previous fiscal year.

Phoenix Community Counseling Center

- In Fiscal Year 2017/18, there were **88** consumers that received FSP services, of which **68%** did not have a hospitalization for the fiscal year. This is a **11%** decrease in hospitalizations from the previous fiscal year.
- For the consumers hospitalized, there was a **31%** decrease in the average length of stay in the hospital (bed days) from the previous fiscal year.

Mariposa Community Counseling

- In Fiscal Year 2017/18, there were **42** consumers that received FSP services, of which **67%** did not have a hospitalization for the fiscal year. This is a **15%** decrease in hospitalizations from the previous fiscal year.
- For the consumers hospitalized, there was a **16%** decrease in the number of bed days from the previous fiscal year.

Mesa Counseling Center

- In Fiscal Year 2017/18, there were **66** consumers that received FSP services, of which **65%** did not have a hospitalization for the fiscal year.
- For the consumers hospitalized, there was a **38%** decrease in the number of bed days from the previous fiscal year.

Victor Valley Behavioral Health

- In Fiscal Year 2017/18, there were **138** consumers that received FSP services, of which **72%** of these consumers did not have a hospitalization for the fiscal year.
- At this location there was also an increase in the number of consumers served from **108** consumers for the previous fiscal year to **138** consumers for Fiscal Year 2017/18 representing a **28%** increase in FSP consumers served.
- For the consumers hospitalized, there was a **13%** decrease in the average length of stay in the hospital (bed days) from the previous fiscal year.

West End Family Counseling

- In Fiscal Year 2017/18, there were **30** consumers that received FSP services, of which **100%** did not have a hospitalization for the fiscal year.

Challenges

FSP staffing and retention of staff within the High Desert continues to be a challenge. A high ratio of consumer to therapist at some clinic locations makes it difficult to provide the intensive services required in an FSP program. Access to psychiatrists also continues to be an issue due to the regional and national psychiatrist shortage. FSP clients often require more frequent psychiatry visits but due to the psychiatrist shortage clinics are not able to accommodate clients or to fit in emergent appointments. A lack of housing options for consumers continues to be a challenge and the transition from an emergency shelter to an affordable housing option is challenging due to a consumer's income. Accessibility to resources for consumers in remote areas is also challenging.

"It's nice to know I have you guys (FSP) for things like this and for someone to talk to because honestly I have no one. No friends and no family, you're all I have."

- RAFSP consumer

Solutions in Progress

The RAFSP teams continue to work with the department's Human Resources Officer to advertise, recruit, and hire qualified staff for the program. To address consumer housing issues, the program has started working closely with the Housing Authority of the County of San Bernardino (HACSB) to identify available units that are affordable and to identify upcoming housing projects FSP consumers may be eligible for. In addition, the department has hired a Program Manager II to oversee Housing and to work with the RAFSP programs to facilitate housing solutions for DBH clients. The program continues networking with community and faith based organizations to identify additional resources and services that are accessible to its consumers. Finally, through the Request For Proposal (RFP) process, DBH selected two contract providers to expand its FSP services to better serve its consumers throughout the county.

Success Story

"Lisa" came to the program voluntarily, due to her mental health condition. At the time, she was living in her car and was experiencing disturbing symptoms related to her serious mental health condition. Lisa did not trust staff and would just periodically drop-in when she was in distress, but did not follow through on the medication or treatment provided. After some time, the staff were able to develop rapport and helped her stabilize. The staff also worked with her in securing benefits that she was eligible for and also helped her care for her failing physical health. Today, Lisa continues to be housed and is stable. Her mental and physical health have improved and she comes into the clinic as scheduled for her appointments.

Program Updates

To address the staffing challenges, the program continues to work with the department's Human Resources Officer and participated in recruitment events where on site interviews and job offers were made to staff some of the department's harder to fill positons. The department's Workforce Education and Training (WET) department has also expanded its internship program to include psychiatry residents from local hospitals in an effort to address the county and region's psychiatric medical shortages. To address the housing challenges faced by RAFSP consumers, the program continues working with the Housing Authority of the County of San Bernardino (HACSB) to identify units that are currently available and has identified additional housing options that will soon be available to RAFSP consumers through the completion of projects in Fiscal Year 2019/20 in various regions of the County. This will include countywide projects including the rehabilitation of buildings that will be used as transitional housing, the addition of DBH contracted emergency shelters, and additional funding that will be available for the construction and development of permanent supportive housing projects through the No Place Like Home Program (NPLH).

Artwork by Wanda Eggert

Collaborative Partners

- Arrowhead Regional Medical Center (ARMC)
- Board and Care providers
- California Department of Rehabilitation (DOR)
- Caring By Nature Room and Board
- Central City Lutheran Mission
- Community Behavioral Health Inpatient Hospitals
- Housing Authority of the County of San Bernardino (HACSB)
- Local charities
- Local hospitals
- Local law enforcement
- Local faith based organizations
- Lanterman-Petris-Short (LPS) designated facilities
- Mental Health Systems
- Salvation Army
- San Bernardino County, Department of Adult and Aging Services (DAAS) In-Home Supportive Services (IHSS)
- San Bernardino County, DBH Crisis Walk-In Clinic (CWIC), Substance Use Disorder and Recovery Services (SUDRS), and Recovery Based Engagement Support Team (RBEST)
- San Bernardino County, Sheriff's Department
- San Bernardino County, Superior Mental Health Courts
- San Bernardino County, Transitional Assistance Department (TAD)
- Shelter contract providers
- Social Security Administration (SSA)
- Tender Hearts Room and Board
- U.S. Department of Veterans Affairs-Veterans Administration (VA)
- ARMC-West Side Clinic

"We all share a common foundation"

- RAFSP consumer

Age Wise II: Mobile Outreach and Intensive Care Program (OA-2)

The Age Wise Mobile Outreach and Intensive Care program provides access to Full Service Partnership (FSP) mental health, substance use disorder, and case management services throughout San Bernardino County, and more specifically, to the vast desert region to serve older adults, aged 59 and older, living with a mental health condition or co-occurring disorder. The program works to increase access to services for the older adult population and to decrease the stigma that is associated with behavioral health conditions within the older adult community.

Through collaboration, the program focuses on helping unserved, underserved, and inappropriately served older adults to develop integrated care with respect to their physical and behavioral health needs. Additionally, this program provides outreach and engagement activities in the community to educate agencies, primary care providers, and the public about the behavioral health needs of the older adult population. Research shows older adults are especially vulnerable to the difficulties of accessing available services due to stigma, lack of behavioral health education, and other factors such as limited funds and transportation. The program addresses these vulnerabilities by providing therapy and case management in the home, thereby providing services that are more accessible to older adults.

To achieve the goals of attaining housing and preventing homelessness for older adults living with a behavioral health condition, DBH has enhanced the focus on wellness and recovery. This focus assists older adults in remaining independent and active in their communities for as long as possible. These supports require collaborative partnerships between staff and community agencies, including the Department of Aging and Adult Services (DAAS), the Social Security Administration (SSA) and other community organizations.

Target Population:

- Older Adults

Projected Number to be Served:

- FY 2019/20
  - ◊ 150 Older Adults

The program continues to collaborate with MHSA Housing to develop senior apartments, creating stable housing complexes for older adults experiencing a behavioral health condition. The Age Wise staff work with the apartment management staff to develop beneficial activities and programs keeping consumers engaged in stable housing.

MHSA Legislative Goals and Related Key Outcomes

Reduce the subjective suffering from serious mental illness:

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

Reduce homelessness and increase safe and permanent housing:

- ◊ Decreased rate of homelessness for clients, as defined in the Data Collection Reporting System
- ◊ Increased residence stability/number of days spent in single location

Increase in self-help and consumer/family involvement:

- ◊ Increase in ratio of voluntary mental health services to involuntary mental health services
- ◊ Increase in number of encounters with collateral contact, such as with family members and informal supports

Reduction in disparities in racial and ethnic populations:

- ◊ Reduction in mental health and health care disparities

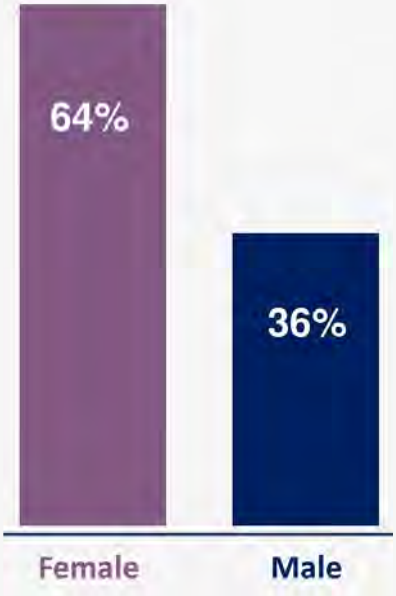
Reduce the frequency of emergency room visits and unnecessary hospitalizations:

- ◊ Reduced rate of emergency room visits for mental health concerns
- ◊ Increased use of alternative crisis interventions (e.g., Crisis Walk-In Center (CWIC), Community Crisis Response Team (CCRT), Crisis Stabilization Unit (CSU))
- ◊ Increase in number of individuals diverted from hospitalization

Increase a network of community support services:

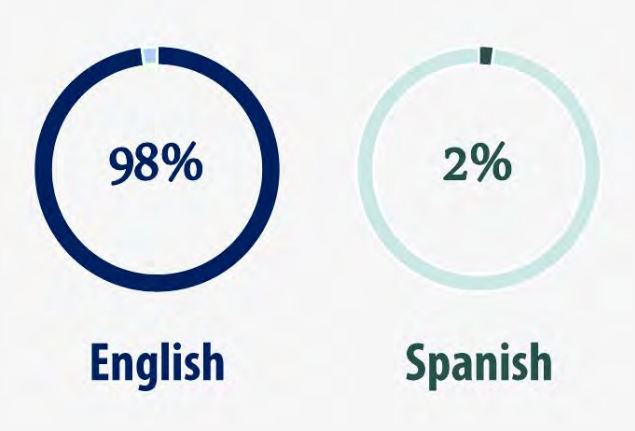
- ◊ Increase in number of collaborative partners
- ◊ Increased coordination of care

Program Demographics: Gender

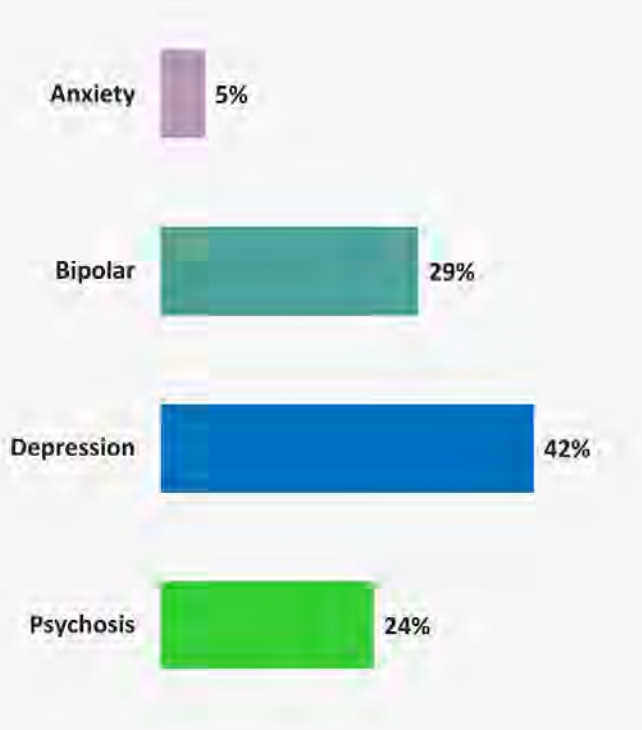


Program Demographics: Ethnicity

Program Demographics: Language



Program Demographics: Primary Diagnosis



Positive Results

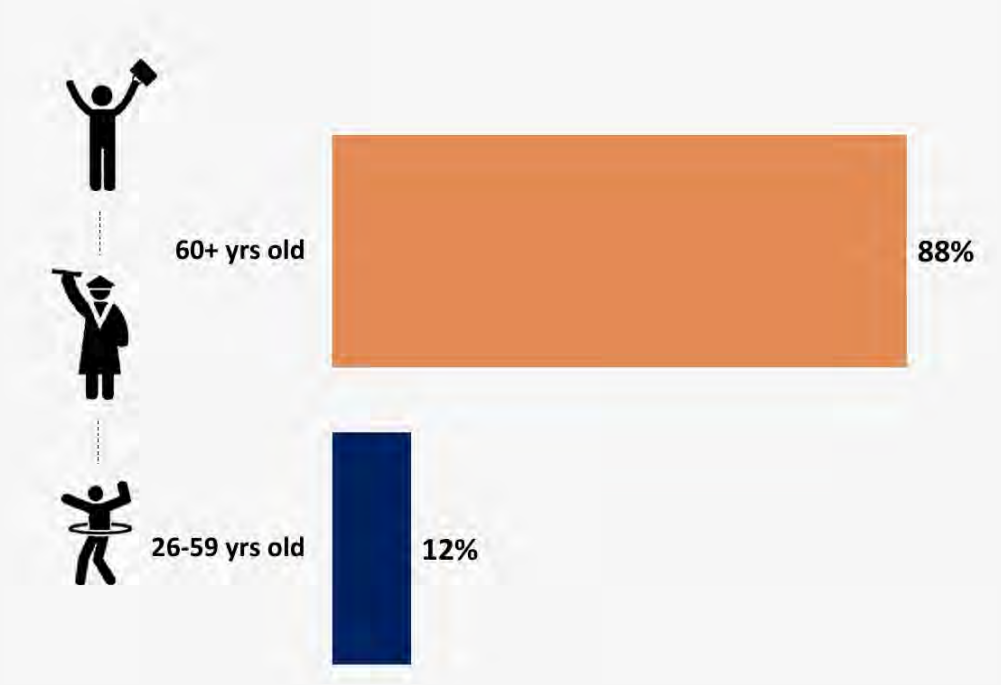
- In Fiscal Year 2017/18, **87%** of consumers have maintained low or reduced risk of subjective suffering.
- **100%** of consumers placed in housing have remained stable in their housing.
- The program stabilized **84%** of the consumers, as determined by the ability of consumers to seek outside assistance to support their wellness.
- Of the 105 consumers served through the program, only **four** consumers were high users of emergency services and only **three** were hospitalized for psychiatric care over the fiscal year.
- All FSP consumers were linked to community agencies such as Department of Aging and Adult Services, In-Home Support Services, Rolling Start, Salvation Army, St. Joan of Arc, St. John of God, Tender Hearts, Adult Protective Services, and Mission City for food, housing, clothing, medical care, psychiatric care and other resources.

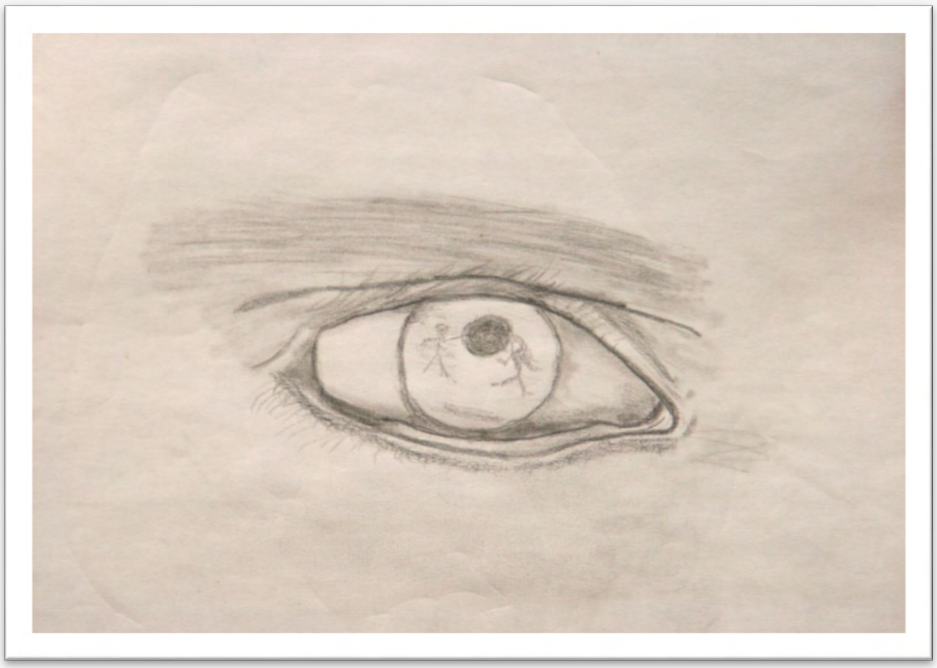
Outreach and Engagement

In Fiscal Year 2017/18, the Age Wise II program organized and/or participated in the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Senior Mental Health Fairs	3	623
Community Outreach	7	158
TOTAL	**10**	**781**

Program Demographics: Age





Artwork by Denise Smith

Challenges

The most pressing crisis for the older adult population, as they retire on a limited income, is affordable housing. Many of the older adult population, particularly those with behavioral health conditions, have limited housing options that may not meet their needs. The average wait time to gain safe and affordable housing can be lengthy. Locating appropriate and affordable housing continues to be a challenge, and as a result, the number of consumers who require intervention is increasing. Rural areas, such as the high desert area, are further challenged as they have minimal resources available to them and vast geographic distances to travel.

Solutions in Progress

The Age Wise Staff is working diligently to be proactive with this challenge by educating the consumers on the realities of finding affordable housing, being proactive about placing consumers on wait lists, continually monitoring for all possible solutions: apartments and rooms for rent, subsidized housing, and Section 8 listings. Additionally, staff seek out all available resources by signing up for email listings, monitoring classified ads, extending phone calls and visiting apartment sites to collaborate with apartment managers.

"I don't know what I would have done without Age Wise II. If they hadn't helped me I don't know what would have happened. A great group of people."

Age Wise II consumer

Success Story

"Jason" sought out services after the death of his spouse, eviction from his home, and moving in with a friend where the home was in disrepair. Jason felt reluctant to move because of his loyalty to his friend and unresolved grief and depression. The program provided Jason with counseling and support to process the loss of his spouse. He was also provided with tools to manage his symptoms of depression, linked to resources for food, provided assistance in completing applications for housing programs, and in navigating the health insurance system to address his medical needs. After numerous hours assisting Jason to find housing. Age Wise was successful in securing appropriate housing. Jason enrolled in the activity center adjacent to his housing where he socialized with others, learned to use computers, and gained experience to better manage his symptoms. With the help of the staff, Jason has worked through his grief and accepted the loss of his spouse. Since then, his symptoms have greatly decreased. Jason has expressed his gratitude in residing in a clean home and having three good meals a day.

Collaborative Partners

- Catholic Charities
- Community Action Partnership of San Bernardino County
- Mission City
- Rolling Start
- San Bernardino County, Department of Aging and Adult Services (DAAS)
- Salvation Army
- St. Joan of Arc and other community churches
- St. John of God
- St. Mary's Hospital
- Tender Hearts
- Victor Valley Behavioral Health

Housing, Long Term Supports, and Transitional Care

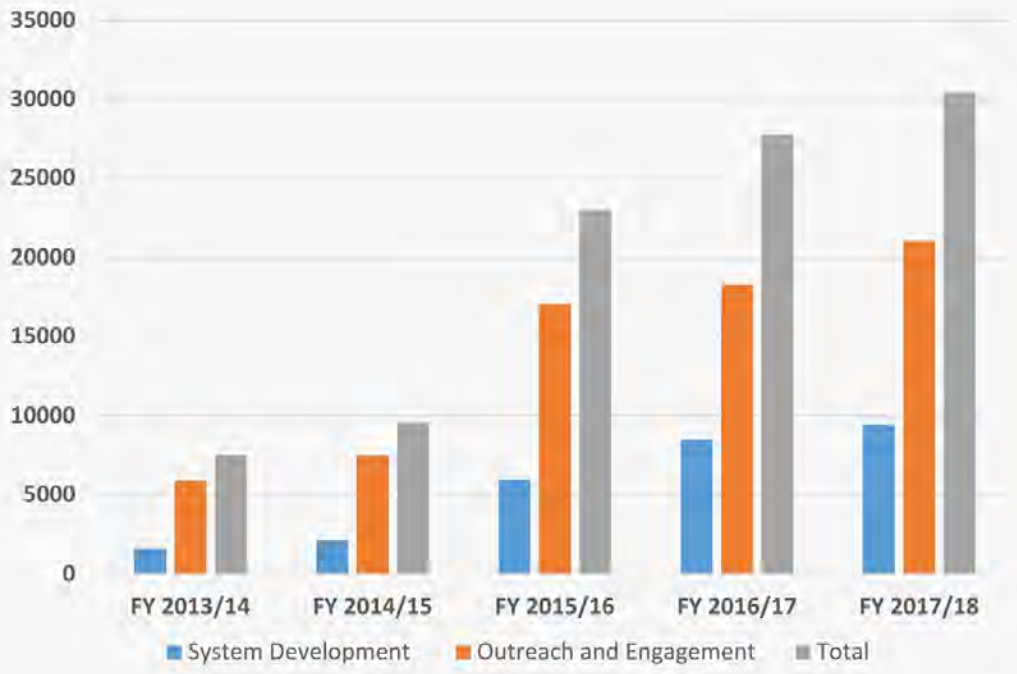
Housing, Long Term Supports, and Transitional Care programs are comprised of programs that include consumer and family services such as peer support, education, and advocacy services; provide intensive outreach and engagement and seamless transition to treatment for MHSA populations; and offer permanent supportive housing coupled with intensive treatment to serve persons living with serious mental illness and their families who are homeless or at risk of homelessness.

The intent of these programs are to engage consumers and families as active participants in their care, provide increased access to effective services that are continually reviewed and revised to meet the needs of underserved groups, increase self-help and consumer/family involvement, and increase a network of community supports.

Artwork by Darrin Newsted

One of the programs included as a long term support is the Clubhouse Expansion program. This program offers recovery oriented centers for members 18 years or older that operate with minimal support from department staff. They are primarily consumer operated and members have significant opportunity for input related to program and activity choices. Each clubhouse provides Recovery, Wellness, and Resilience Model programs in stigma-free environments for individuals living with a Serious Mental Illness in an effort to increase members' overall functioning and community integration. The chart below demonstrates the increased involvement in this peer support program.

Clubhouse Expansion Program Number of Consumers Served for Fiscal Year 2013/14 through Fiscal Year 2017/18



Clubhouse Expansion (A-1)

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

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

The program provides growth opportunities and activities for members, such as:

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

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

Target Population:

- Adults

Projected Number to be Served:

- FY 2019/20
  - ◊ 19,060 Adults

MHSA Legislative Goal(s) and Related Key Outcomes

Reduce the subjective suffering from serious mental illness for adults:

- ◊ Improved life satisfaction
- ◊ Increased resiliency

Increase in self-help and consumer/family involvement:

- ◊ Increase in program attendance and frequency per consumer
- ◊ Increase in self-help/support/12 step group attendance and frequency per consumer

Positive Results

The Clubhouse Expansion program experienced growth in the number of members attending, number of groups being offered, and the amount of participation in each group. The Clubhouse Expansion program continued to see an increase in group attendance with over 175 different groups being conducted per month with attendance totaling over 14,700.

Of the 175 groups that were run per month in the clubhouses, 165 (94%) were managed directly by members with no staff involvement. All nine clubhouses were conducted by an elected board of their peers. The boards made all decisions related to planning, budget, and cooperation issues. Consumers were consulted on all Clubhouse Expansion program staff hiring decisions.

Clubhouse members participated in 180 community integration excursions over the year with 1,470 total members in attendance. These excursions exposed members to resources in their community including job opportunities, historical outings, etc. These excursions gave the members the opportunity to work on their daily living skills in new and challenging environments.

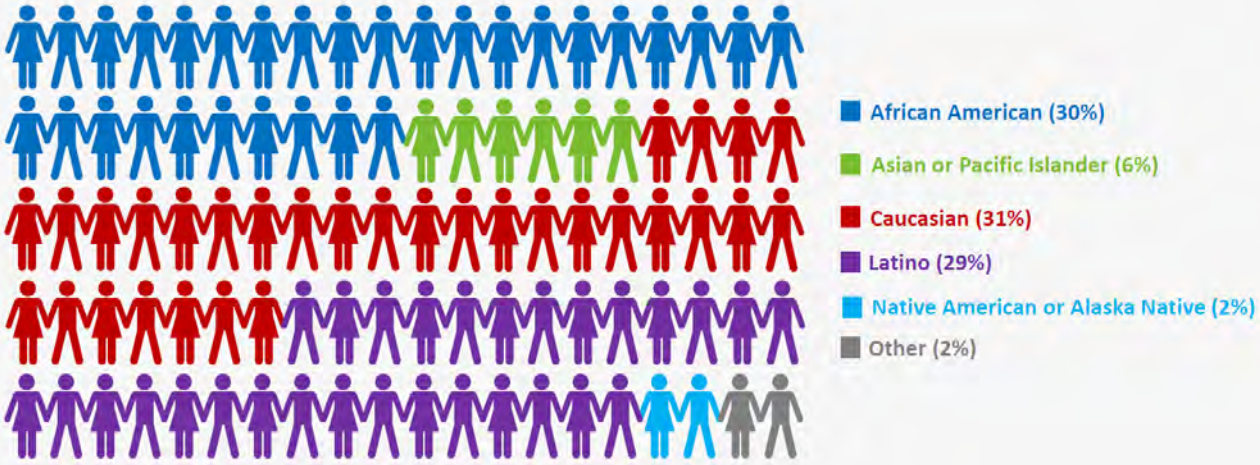
Consumers from each clubhouse participated in at least one community service activity. These ranged from community clean-ups, participating in resource fairs, outreach to law enforcement and hospitals, and making cards for local senior centers and individuals that were home or institution bound.

The Clubhouse Expansion program again saw a decrease in the amount of times consumers accessed emergency services for physical health challenges due to an increase in education and linkages to physical health and nutrition resources.

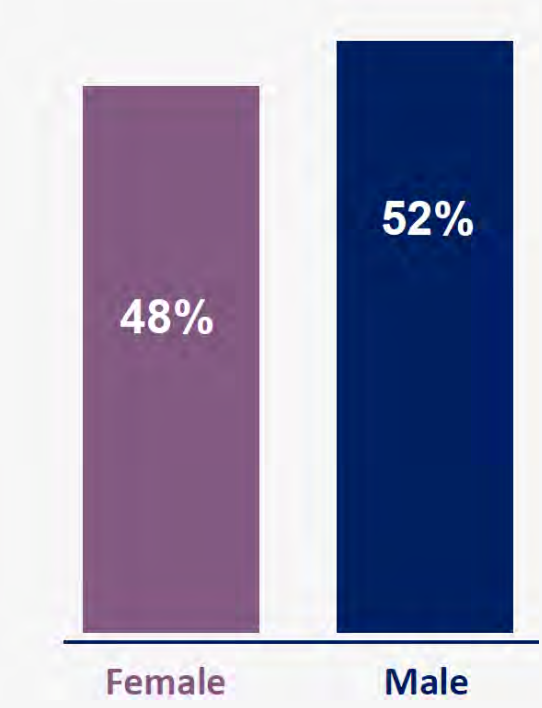
Partnerships with the National Alliance on Mental Illness (NAMI) continued and this included referring consumer family members to their family support classes. Members also held eight “Friends and Family” events where family members were able to spend some time at the clubhouse connecting with their loved ones who utilize the program.

Program Demographics: Age

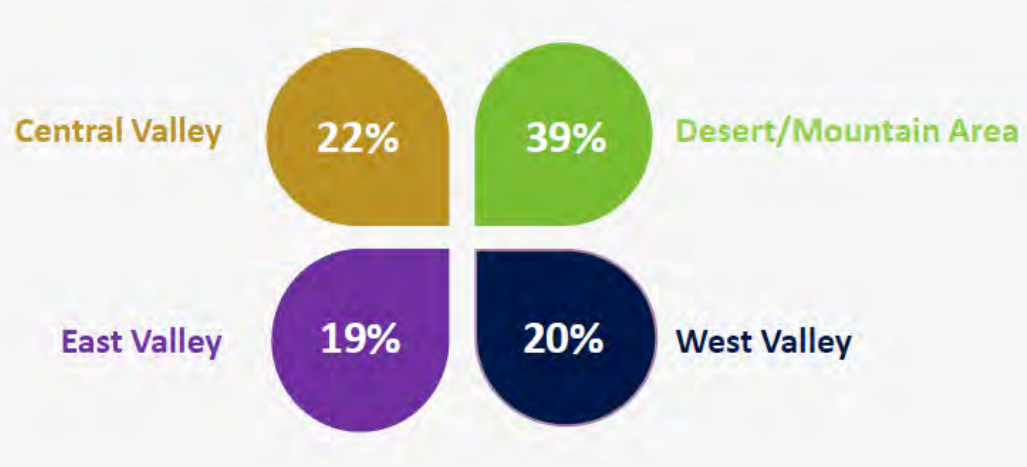
Program Demographics: Ethnicity



Program Demographics: Gender



Program Demographics: San Bernardino County Region



"Thank you for allowing me to be a part of the family at the clubhouse. Because of my involvement with the clubhouse, I got a job that I love and am renting a room on my own. Things have turned around for me and part of that is because of encouraging me to just do my best and be me.

- Clubhouse consumer

Artwork by Rosa Barraza

" I need this place for my wellness."

- Clubhouse consumer

Challenges

Establishing consistent outcome measures for consumer-run programs continued to be a challenge, as well as establishing reliable and consistent transportation partnerships for consumers. Meeting the need for a higher demand for services in all clubhouses continues to be a challenge for the Clubhouse Expansion program.

Outreach and Engagement

In Fiscal Year 2017/18, the Clubhouse program organized and/or participated in the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
All Clubhouse Holiday Gatherings	10	1,650
Health Fairs	8	3,140
Community Service Activities	10	1,068
Community Presentations	20	1,750
Crisis Intervention Team Building	15	900
Cultural Competency Events	20	1,380
Behavioral Health Wellness Triathlon	3	800
Evening With the Stars Education and Recognition Event	1	70
Clinic Appreciation Events	8	1,400
Community Food Distribution	36	1,950
Community Speakers	26	780
Mental Health Solidarity Day	1	525
Inter-Clubhouse Outreach Day	1	185
Homeless Outreach	8	675
Total	**167**	**16,273**

" If I do not come to Clubhouse, I use. This place is how I stay sober"

- Clubhouse consumer

Collaborative Partners

- Agua Caliente Clippers of Ontario
- Alcoholics Anonymous
- American Red Cross
- California Science Center
- California State University, San Bernardino
- California Association of Mental Health Peer Run Organizations (CAMHPRO)
- Catholic Charities
- City of Fontana
- City of Rialto
- Community Action Partnership of San Bernardino
- Del Taco Restaurants, Inc.
- Dr. Andrea Letamendi
- Fontana Police Department
- Fontana Senior Center
- Frazee Community Center
- Goodwill Industries International Inc.
- High Desert Outreach Center
- Hillside Community Church
- Inland Empire 66ers
- Inland Valley HOPE Partners Food Pantry
- Inland Valley Regional Services
- J. Paul Getty Museum
- Jet Propulsion Laboratory
- JFS SOVA Community and Resource Program
- Legal Aid Society
- Loma Linda University Behavioral Medicine Center
- Los Angeles Angels™
- Los Angeles Chargers
- Mental Health Systems, Inc.
- Mission San Juan Capistrano
- Morongo Band of Mission Indians
- Museum of Tolerance
- National Alliance on Mental Illness (NAMI) Inland Valley
- National Alliance on Mental Illness (NAMI) Riverside
- National Alliance on Mental Illness (NAMI) San Bernardino

- National Alliance on Mental Illness (NAMI) Victor Valley
- Narcotics Anonymous
- Natural History Museum of Los Angeles County
- Ontario Police Department
- Ontario Reign
- Pacific Clinics
- Panera Bread Company
- Planes of Fame Air Museum
- Rancho Cucamonga Library
- Rancho Cucamonga Quakes
- Reach Out.com
- Recovery International
- San Bernardino County Museum
- San Bernardino County Probation
- San Bernardino County Public Health
- San Bernardino County Sherriff's Department
- San Bernardino County Transitional Assistance Department
- San Bernardino Room and Board Coalition
- San Manuel Casino
- South Coast Community Services
- Sprouts Farmer's Market, Inc.
- Starbucks®
- The ROCK Church and World Outreach Center
- The Salvation Army
- Trader Joes
- United States Department of Veterans Affairs
- United Way
- Victor Community Support Services
- Volunteers of America

" I know I would be in jail without this place."

- Clubhouse consumer

Homeless Assistance Resources and Treatment (A-7)

The Homeless Assistance Resources and Treatment (HART) Program is a continuum of behavioral health services for individuals that are at-risk of homelessness, chronically homeless, or are homeless and living with a serious mental illness, including substance use disorders. In Fiscal Year 2016/17, the program was restructured as a stand-alone program and was expanded to include Full Service Partnership (FSP) services as well as seeking to support building connections to permanent supportive housing.

The subcomponents that comprise a continuum of services range from outreach and engagement, emergency shelter services, intensive case management, employment supports, intensive Full Service Partnership services, and permanent supportive housing. In alignment with the countywide Coordinated Entry System (CES), the HART program works with other County departments in coordinated field-based outreach and also provides intensive field-based FSP services for individuals that are eligible for behavioral health services.

The Homeless Assistance Resources and Treatment (HART) program is comprised of four focus areas:

- Community Reintegration Services
- Homeless Intensive Case Management and Outreach Services (HICMOS)
- Homeless Stabilization and Treatment conducted by the Homeless Outreach Support Teams (HOST)
- Housing and Employment Program

Target Population:

- TAY
- Adults
- Older Adults

Projected Number to be Served:

- FY 2019/20
  - ◊ 8 TAY
  - ◊ 522 Adults
  - ◊ 49 Older Adults

Community Reintegration Services

Community Reintegration Services (CRS) is designed to serve adults in San Bernardino County who are living with severe mental illness or untreated co-occurring disorders, and who are in many cases, recently released from state hospitals and/or institutionalized care. These adults are at imminent risk of homelessness, incarceration, hospitalization or re-hospitalization if appropriate levels of care and behavioral health services are not provided as part of transitional care and institutional discharge planning. CRS promotes the principles of recovery, wellness, and resilience to assist consumers in maintaining lives that are more satisfying, hopeful, and fulfilling based on their own values and cultural framework. Services utilize a strengths based approach by focusing on the consumer's strengths and possibilities in order to move toward new levels of functioning in the community.

Consumers requiring this level of care are often unable to maintain independence in the community without the assistance of intensive case management support. The ideal ratio of staff to consumers is one to 15 to allow for support of the consumers.

Community Reintegration Services offers a true one-stop center for all available resources in one location such as:

- Housing, including licensed board and care homes
- Medication support services
- Intensive case management

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

This holistic approach meets the consumer's needs by providing coordination of care with behavioral health and substance use outpatient clinics, as well as physical health care providers. CRS also assists in obtaining entitlements through programs, such as Supplemental Security Income (SSI), Housing Authority, and other assistance programs based on the consumer's eligibility. This client-centered approach of working with consumers ensures that each consumer's needs are met based on where the consumer is in their process of recovery.

MHSA Legislative Goal(s) and Related Key Outcomes

Reduce the subjective suffering from serious mental illness for adults:

- ◊ Improved life satisfaction
- ◊ Decreased hopelessness/increased hope
- ◊ Increased resiliency
- ◊ Decreased impairment in the general areas of life functioning

Reduce homelessness and increase safe and permanent housing:

- ◊ Decrease rates of homelessness for clients
- ◊ Increased residence stability and safe and permanent housing

Reduce criminal and juvenile justice involvement:

- ◊ Decreased rate of incarcerations
- ◊ Decreased arrests
- ◊ Reduced jail/prison recidivism

Reduce the frequency of emergency room visits and unnecessary hospitalizations:

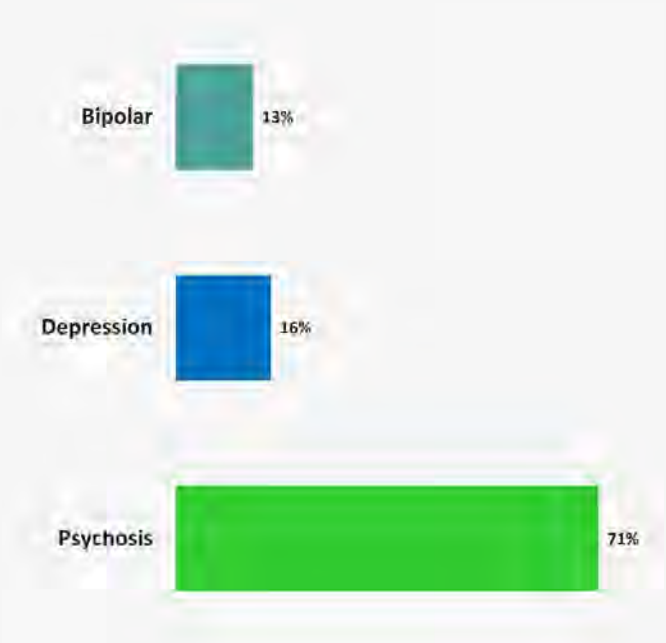
- ◊ Reduced rate of emergency room visits for mental health concerns
- ◊ Reduced number of emergency room visits for routine medical concerns
- ◊ Reduced administrative hospital days
- ◊ Increased use of alternative crisis interventions (e.g., CWIC, CCRT, CSU).
- ◊ Increase in number of individuals diverted from hospitalization

Increase network of community support services:

- ◊ Increase in number of collaborative partners
- ◊ Increase in self-help/support/12-step/community/school group or healthcare provider attendance and frequency per consumer
- ◊ Increased coordination of care

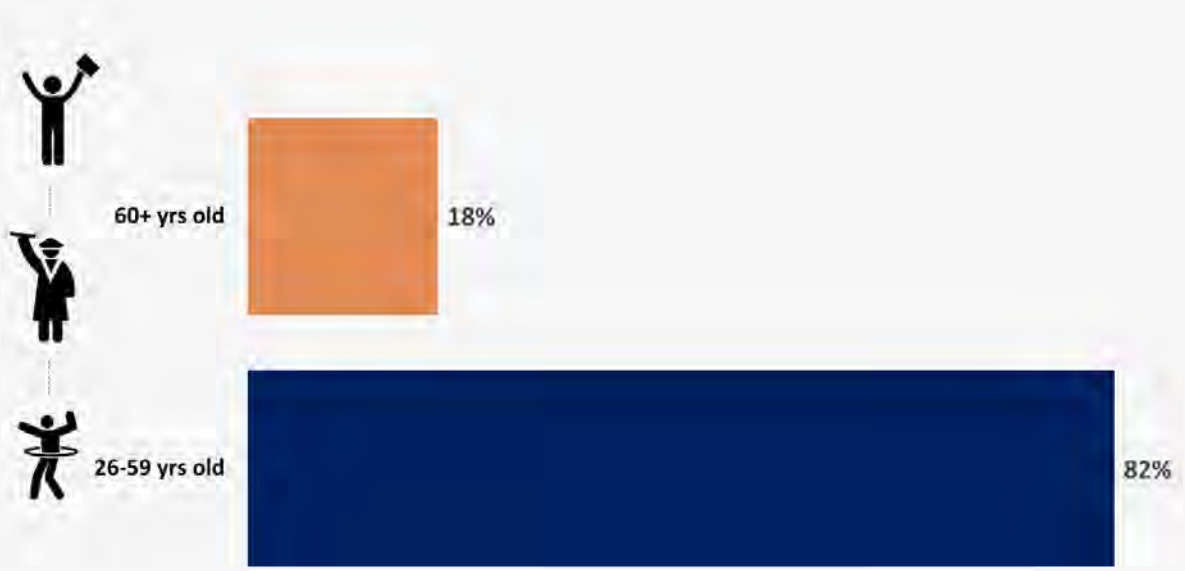
Program Demographics: Gender

Program Demographics: Primary Diagnosis



Program Demographics: Primary Language

Program Demographics: Age



Program Demographics: Ethnicity

Positive Results

- There were **51** Full Service Partnership consumers in Fiscal Year 2017/18.
- Of the **51** consumers assisted by the CRS program, **zero** consumers returned to homelessness following placement in a stable living environment.
- Of the **51** consumers assisted by the CRS program, **96%** did not have a hospitalization in Fiscal Year 2017/18, representing a **3%** decrease in hospitalizations form the previous fiscal year for these consumers.

Challenges

Shortages in available housing for consumers with severe mental illness and/or co-occurring disorders, especially those with additional medical issues, continues to be a challenge. The lack of access to needed community resources and supports has also created a challenge in serving consumer needs.

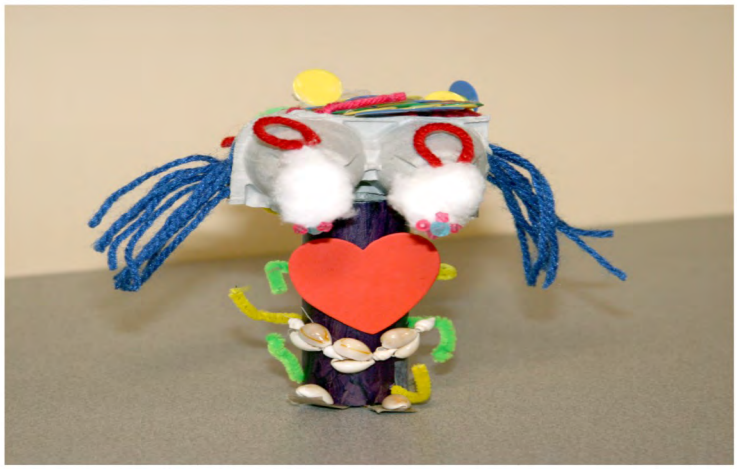
Solutions in Progress

The program has started matching program needs with resources in other similar DBH programs and has increased community collaboration and resource sharing in an effort to increase available resources for consumers. To address consumer housing, the program has increased its involvement and interaction with community board and care providers to identify and increase available housing options for its consumers. Finally, the program continues to collaborate with DBH's homeless programs and with other community based programs in to maximize and leverage shared resources.

Success Story

"Greg" was referred to the Community Reintegration Services (CRS) program due to his mental health and substance use issues. Greg had previously been homeless and was placed in the Department of Behavioral Health's Homeless Shelter program. Greg's continued drug use, suicidal ideations, and reluctance to actively be involved in any type of treatment or counseling caused him to be removed from the shelter program and referred to CRS. CRS staff worked with Greg to find housing, and he was placed in a board and care facility. During this time, he became open to treatment and involved with intensive case management services and individual therapy. Greg continued working towards his recovery and was admitted into a residential drug rehabilitation program where he completed the program and graduated. Through his treatment process, his medications were readjusted allowing him to become more stable. Greg also moved into a smaller board and care facility that better met his needs.

Today, Greg continues to manage his sobriety and attends group meetings approximately 2-3 times a week. He is now more optimistic about his life and future and he has reconnected with his family, which is a major part of his support network. Greg recently attended a family reunion and was really encouraged by feedback from family members who remarked on how good he looked and how much progress he had made in his recovery. Greg uses this experience as motivation to continue in his recovery and uses it to remind himself how far he has come and how much further he wants to go.



Artwork by Michele Castorena

Collaborative Partners

- Abria del Cielo board and care facility
- California Department of Rehabilitation (DOR)
- Catelya Day Treatment
- Frazee Community Center
- Goodwill of Southern California
- Health Advocates
- Inland Empire Health Plan (IEHP)
- Lab Corps
- Lutheran Mission
- Montclair Guest Home
- Mrs. G's room and board home
- Our Place Clubhouse
- Salvation Army
- San Bernardino County, DBH Integrated Complex Care Initiative and Clubhouses
- San Bernardino County, Transitional Assistance Department (TAD)
- Set Free Ministries
- Social Security Administration (SSA)
- Step-Up on Second
- Victory Outreach

"Thank you CRS for your support. I no longer wake up in the morning feeling like life is not worth living."

- CRS consumer

Homeless Intensive Case Management and Outreach Services (HICMOS)

The Homeless Intensive Case Management and Outreach Services (HICMOS) is an intensive case management and emergency shelter program designed to target services to unserved, underserved, and inappropriately served adults in San Bernardino County who are living with chronic and severe mental illness, untreated co-occurring disorders, and are experiencing homelessness.

The program promotes the principles of recovery, wellness, and resilience to support individuals on the road to living more satisfying, hopeful, and fulfilling lives, based on their own personal values and cultural framework. Services focus on the consumer's strengths and abilities and assists with linkage to appropriate community resources in order to minimize unnecessary use or interaction with law enforcement, emergency departments, and psychiatric inpatient facilities.

HICMOS consumers are provided intensive case management services at various levels of need. Through the mental health assessment process, individual needs are identified and individuals opt to participate into one or more of the following programs designed to target their goals:

- Employment Services - Consumers referred to these services are provided with an assessment for employment, group job skills training, and employment leads.
- Entitlements - The focus of the entitlements service is to assist the consumer in securing assistance from programs where they meet eligibility requirements, such as Social Security Income.
- Groups - Consumers participating in these services attend support group meetings to gain coping skills that help with personal and mental health obstacles that have become barriers to meeting their goals. The self-help mutual aid process also empowers consumers as they are able to support and guide each other through the transition process.

Consumers are also provided with ongoing intensive case management which includes medical care coordination for mental and physical health care and linkages to community and county resources for:

- Clothing
- Substance use disorder treatment
- Social supports such as DBH clubhouse and other entities, as deemed individually appropriate (on a case by case basis)

The transitional level of care provides a long term structured case management program to assist consumers with overcoming obstacles to employment and obtaining permanent housing. Consumers agree to this level of care and engage in a partnership with DBH to participate in an array of structured activities to enable them to move towards addressing their mental health and substance use issues as well as their recovery, medical, employment, and housing concerns.

The maintenance level of care provides continued case management to stabilize consumers living with mental illness and are preparing to transition to other housing programs, such as living in their own apartment, semi-independent living, and room and boards within the community. A major service provided by case managers at this juncture is relapse prevention and focus on consumer's recovery goals. Many consumers continue ongoing aftercare with the DBH outpatient clinics to support continued stability once discharged from HICMOS.

MHSA Legislative Goal(s) and Related Key Outcomes

Reduce the subjective suffering from serious mental illness for adults:

- ◊ Improved life satisfaction
- ◊ Decreased hopelessness/increased hope
- ◊ Increased resiliency

Reduce homelessness and increase safe and permanent housing:

- ◊ Decrease rates of homelessness for clients
- ◊ Increased residence stability and safe and permanent housing

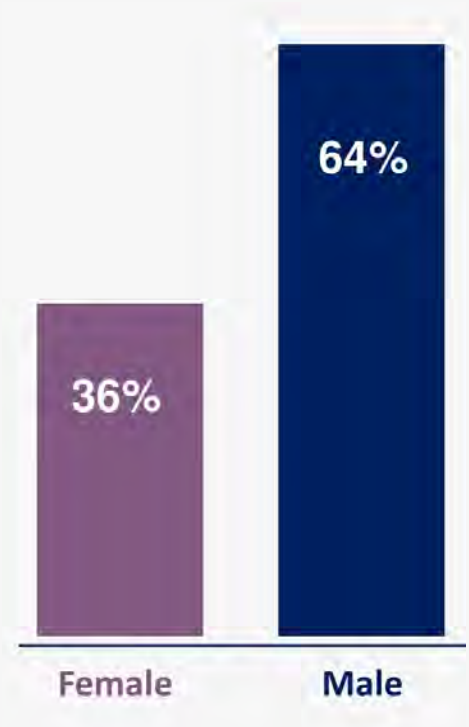
Reduce the frequency of emergency room visits and unnecessary hospitalizations:

- ◊ Reduced number of emergency room visits for mental health concerns
- ◊ Increased use of alternative crisis interventions

Increase network of community support services:

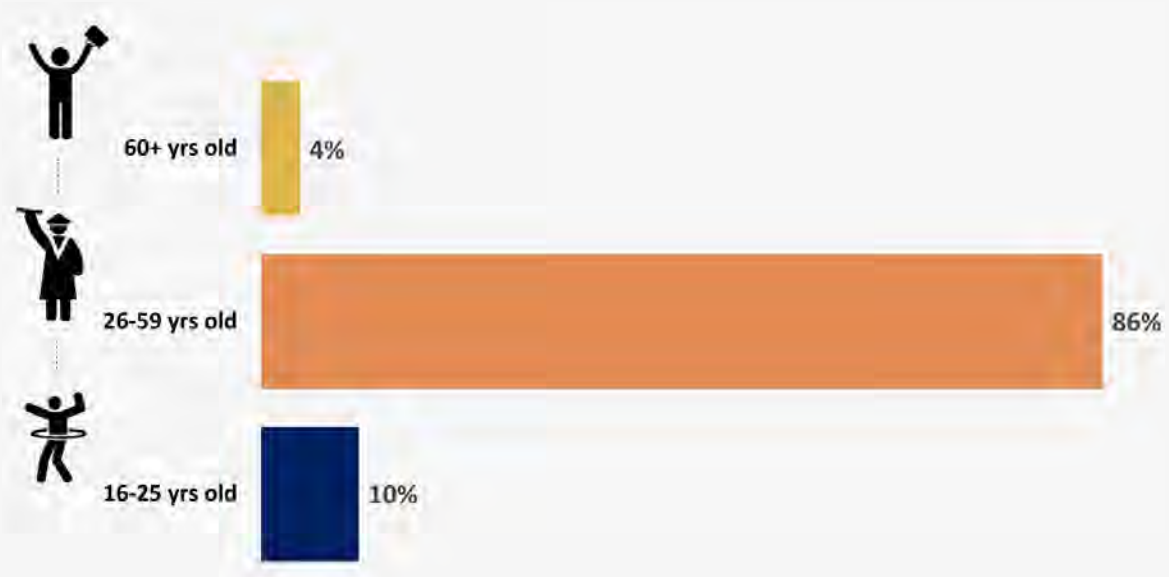
- ◊ Increase in number of collaborative partners
- ◊ Increase self-help/support/12-step/community/school group or healthcare provider attendance and frequency per consumer
- ◊ Increased coordination of care

Program Demographics: Gender



Program Demographics: Ethnicity

Program Demographics: Age



Program Demographics: San Bernardino County Region

Positive Results

- In Fiscal Year 2017/18, there were **138** consumers placed and assisted by the HICMOS program through contracted shelter providers. Of the **138** consumers, **100** were discharged during the year. Of the **100** whose discharge status was known, **51** were discharged to a stable living situation (not homeless), representing a **51%** reduction in homelessness.
- Of the **138** consumers assisted by the HICMOS program, through DBH's emergency shelters, **two** incidents of incarceration were reported, representing only **2%** of total consumers served.
- Of the **138** consumers assisted through the HICMOS program, there were only nine emergency calls (mostly for physical medical conditions), no emergency department visits and no psychiatric hospitalizations.
- The HICMOS program continues to be active and visible in the community in its outreach efforts and continues to collaborate with other County departments, community partners, faith-based entities, and with other community stakeholders. These connections and partnerships allow for the identification of homeless individuals who may be in need of services and also allows the HICMOS program to continually identify resources for the consumers they serve.

"I appreciate the regular attention and help that my case manager gives me, it makes me feel like I matter."

- HICMOS consumer

Success Story

"Sophia" was a consumer who was brought to the HICMOS program through a collaborative partnership with a county agency that offers family services, after giving birth at a homeless camp.

Sophia initially resided at The STAY (a DBH program that offers crisis residential services for Transitional Aged Youth ages 18-25) for a couple of months where she was able to receive medication support and counseling services. Once Sophia was stable, she continued working with the HICMOS team and was transitioned to a Board and Care facility to assist her in managing her mental and physical health. Today, Sophia continues to work towards her wellness and recovery and has been reunited with her child who she sees weekly on supervised visits. She has also reconnected with her family.

Artwork by Denise Smith

Challenges

The program has identified a need for shelter and housing for homeless families, which may include older adult parents and adult siblings. Consumers experiencing homelessness may also present with one or several pets (cats, dogs, etc.). Shelters in San Bernardino County do not allow pets and many housing options also have pet restrictions or requirements for payment, which is not feasible for most consumers who will refuse assistance unless their pets are also housed.

The program also experienced staff turnover as some staff transferred to other programs or reductions in staffing during the year due to retirements, and promotions.

Solutions In Progress

The HICMOS program continues working with the San Bernardino County Housing Authority to identify additional housing vouchers and continues collaborating with County partners and community stakeholders to identify solutions for consumers facing barriers to housing. Some of the proposed solutions have included leveraging resources among County partner agencies for the construction of collaborative housing developments that can serve the various needs of single individuals and families.
The HICMOS program continues to work with the department's human resources officer to recruit and identify qualified applicants. Most vacancies have now been filled.

Program Updates

The HICMOS program continues to collaborate and partner with the County of San Bernardino's Coordinated Entry System (CES) for Human and Social Service entities. This partnership and working relationship has allowed for the identification and triage of chronically homeless individuals with a mental illness into housing opportunities. It has also resulted in better consumer access to services and a smoother referral network, increasing the likelihood that community members will get linked to the appropriate service at the first point of contact, increasing efficiency, and establishing connections to needed services to encourage recovery and resiliency.

Collaborative Partners

- California Department of Rehabilitation (DOR)
- Central City Lutheran Mission
- Inland Empire Health Plan (IEHP)
- Molina Healthcare
- Red Carnation Homes
- San Bernardino County, DBH Adult Residential Services, Community Crisis Response Team (CCRT), Crisis Walk-In Clinic (CWIC), Housing and Employment Program, Outpatient Clinics, Therapeutic Alliance Program (TAP), Transitional Age Youth (TAY) Program, Triage Engagement and Support Teams (TEST) Program
- San Bernardino County, Housing Authority
- San Bernardino County, Transitional Assistance Department (TAD)
- State of California, Department of Rehabilitation (DOR)
- 2-1-1 Coordinated Entry System (CES)

Artwork by Christina Silva

Homeless Outreach Support Team (HOST)

The Department of Behavioral Health's (DBH) Homeless Outreach Support Team (HOST) is an outreach based program providing services in the field to engage chronically homeless individuals living with mental illness and/or substance use disorder into permanent supportive housing. HOST and Housing and Employment Programs, in collaboration with the Housing Authority of the County of San Bernardino (HACSB), receive funding from the Department of Housing and Urban Development (HUD) to assist homeless individuals with mental illness and their families find permanent supportive housing under the Homeless Assistance Shelter Plus Care grant. HACSB is the primary recipient of the HUD funding and provides the housing vouchers directly to the consumers. DBH staff provide service match in the form of wraparound case management services to include intensive case management services, brief therapy, rehabilitation, and work with landlords to help consumers find housing. HOST collaborates with the Sheriff's Homeless Outreach Proactive Enforcement (HOPE) team to conduct outreach events, go out into the field, and engage the most difficult and hard to reach consumers. HOST staff work with program eligible individuals to complete the necessary applications and assessments in the field and, upon receipt of a housing voucher (provided by HACSB), assist the individual to locate and move into housing. HOST continues to offer recovery-based wraparound case management services to the consumer to assist them to recover, gain wellness, and reintegrate into the community with the ultimate goal of independence and self-sufficiency.

Additionally, HOST oversees and coordinates with Step-Up on Second, a full service partnership contracted provider agency. Step-Up was awarded 112 housing vouchers through HUD to specifically serve chronically homeless individuals living with mental illness. DBH has partnered with Step-Up to support the intensive level of behavioral health services needed for individuals meeting this criteria to maintain their housing, health, and well-being.

"After 12 years of being homeless, I can appreciate a warm bath and a safe place to lay my head"

- HOST Consumer

MHSA Legislative Goals and Related Key Outcomes

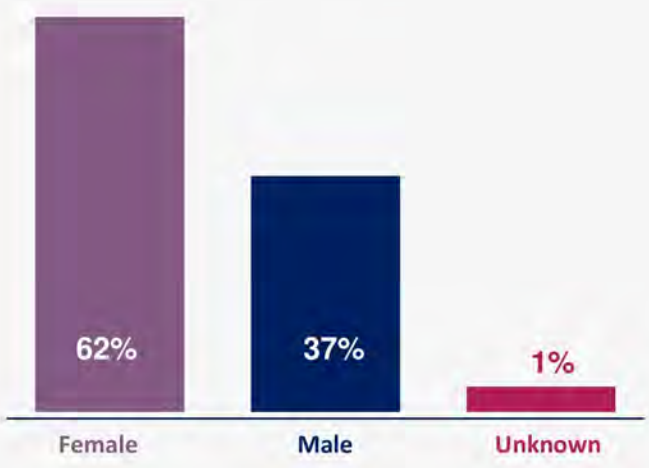
Reduce the subjective suffering from serious mental illness for adults:

- ◊ Improved life satisfaction
- ◊ Decreased hopelessness/increased hope
- ◊ Increased resiliency
- ◊ Decreased impairment in general areas of life functioning

Reduce homelessness and increase safe and permanent housing:

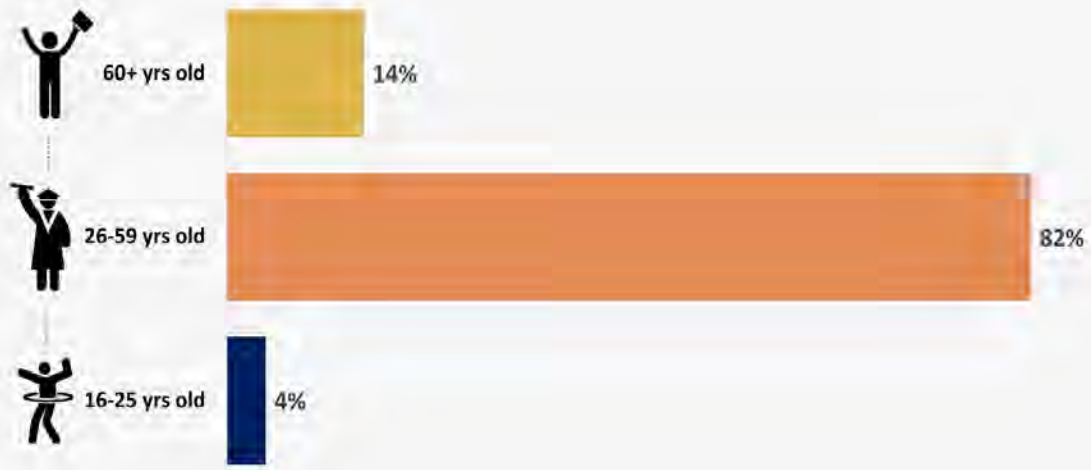
- ◊ Decrease rates of homelessness for clients
- ◊ Increased residence stability

Program Demographics: Gender

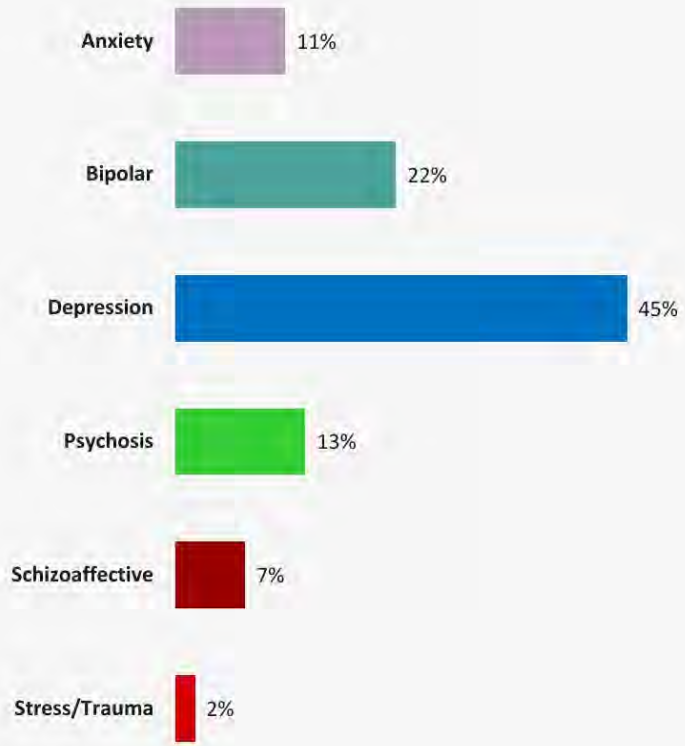


Program Demographics: Ethnicity

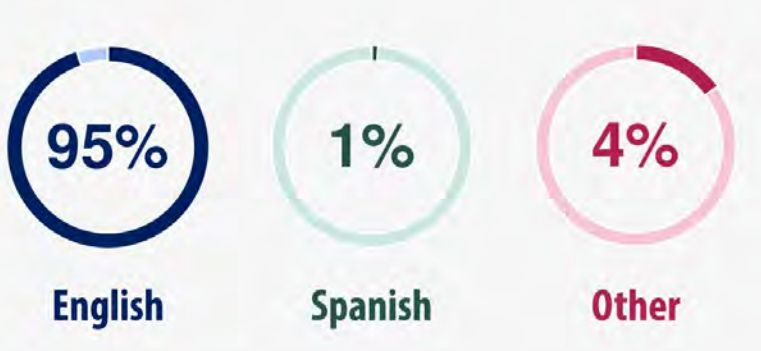
Program Demographics: Age



Program Demographics: Primary Diagnosis



Program Demographics: Primary Language



Positive Results

- HOST engaged **77** chronically homeless individuals during Fiscal Year 2017/18.
- HOST housed **15** chronically homeless individuals and their families living with a mental illness during Fiscal Year 2017/18.
- HOST currently manages and maintains a caseload of approximately **250** individuals which are placed in permanent supportive housing throughout San Bernardino County. Each individual/family receives on-going intensive case management services, in an effort to help them maintain housing.
- HOST provides outreach in the field alongside law enforcement at least three to four times per week.

"Thank you everyone. You gave me a second chance at life"

- HOST consumer

Outreach and Engagement

In Fiscal Year 2017/18, the HOST program organized and/or participated with the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Outreach/Engagement in the field alongside Law Enforcement	88	244
La Gran Fiesta Event	1	10
Native American Heritage Event	1	40
Shelter Training Presentations	2	80
Total	**92**	**374**

Challenges

Some of the challenges for the HOST program include the lack of permanent housing funding as there have been recent reductions to grants for these services. There is a lack of housing and shelter resources for individuals with pets and for unaccompanied women. There continues to be a lack of shelter services throughout the County for emergency shelter beds and lack of funding for other supportive services.

Solutions in Progress

The HOST program continues to collaborate with several law enforcement agencies, including the Sheriff's Homeless Outreach and Proactive Enforcement (HOPE) Team, Redlands Police Department, and the Rialto Police Department to identify and engage chronically homeless individuals. HOST also continues working with the 2-1-1's Coordinated Entry System (CES) to identify and streamline services for homeless individuals and to continually identify needed resources throughout the County. Finally, the HOST team continues to conduct outreach and engagement to partners in the

community to learn about new initiatives or policies, to identify resources and to collaborate with partner agencies on services. HOST staff attend the San Bernardino County Homeless Provider Network (SBCHPN) which includes a multitude of community providers and resources as well as the County's Interagency Council on Homelessness (ICH) to strategize on solutions to services and to give input and feedback on homeless policy.

Success Story

The HOST team engaged "Cynthia" while conducting outreach. Cynthia spent over 20 years of her life as an individual living with mental illness, a substance use disorder, and experiencing homelessness. More than half of those years had been extremely challenging for her, as she had to survive with little or no income.

When the HOST team found and engaged her, she was sleeping on the asphalt behind a public office building. During the engagement process, her case manager would often take food to Cynthia as she discussed the resources provided by the HOST program and the process to obtain housing. When Cynthia's case manager visited her just before the Thanksgiving holiday, Cynthia noted that, "I hope this will be the last holiday I spend on the street." Through working with the HOST team, Cynthia's wish was realized as she received the keys to her new apartment just days before Christmas.

Today, Cynthia continues to work on her recovery and wellness and is active in her treatment. She continues getting acclimated to her new living environment and her physical and mental health have greatly improved. Cynthia recently secured part-time employment and now spends her free time visiting friends and doing something she rarely did while homeless, watching television.

Collaborative Partners

- Housing Authority of the County of San Bernardino (HACSB)
- Knowledge and Education for your Success (KEYS)
- Lighthouse Social Services
- Redlands Police Department
- Rialto Police Department
- San Bernardino County, DBH Adult System of Care (ASOC) Program, Housing and Employment Program, Recovery Based Engagement Support Teams (RBEST), Outpatient Clinics, Full Service Partnership (FSP) Program
- San Bernardino County, Sheriff's HOPE Team
- San Bernardino County, Homeless Partnership
- Step-Up On Second, Inc.
- U.S. Department of Veterans Affairs (VA)
- U.S. Vets
- 2-1-1 Coordinated Entry System (CES)

Artwork by Chad Miller

Housing and Employment Program

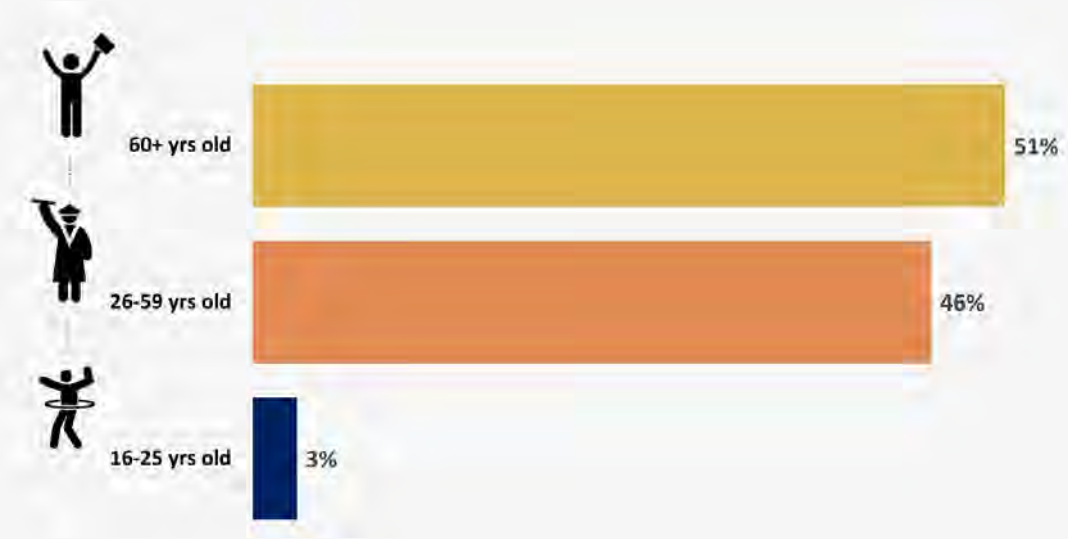
The Housing and Employment Program is comprised of three strategies that work together to make up the program:

- Housing staff consult with property managers and the Community Development and Housing Agency (CDHA) that work with developers to link FSP consumers to permanent supportive housing and to support access to a continuum of housing options, such as emergency housing and rental assistance funded under the continuum of care, when permanent supportive housing is not available.

- Once the consumer is established in housing, the program partners with outpatient clinics to provide behavioral health case management and supportive housing services to assist consumers in maintaining their housing and emotional well-being. Supportive services can include working with landlords, ensuring consumers have access to necessities, and linkage to community and clinical resources.

- Lastly, the employment staff, through an agreement with the Department of Rehabilitation (DOR), coordinate and provide consumers employment education to promote job seeking skills, education concerning the soft skills necessary for maintaining employment, and job seeking assistance and support. All of these strategies build on and work in conjunction with each other to provide the necessary supports needed to help the consumer in their path to recovery.

Program Demographics: Age



MHSA Legislative Goal(s) and Related Key Outcomes

Reduce the subjective suffering from serious mental illness for adults:

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

Reduction in criminal and juvenile justice involvement:

- ◊ Decreased rate of incarcerations
- ◊ Reduced jail/prison recidivism

Reduce the frequency of emergency room visits and unnecessary hospitalizations:

- ◊ Reduced number of emergency room visits for mental health concerns
- ◊ Increased use of alternative crisis interventions

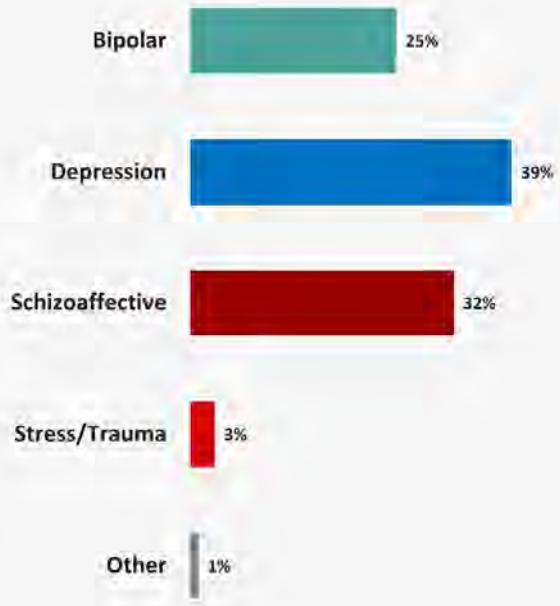
Reduce homelessness and increase safe and permanent housing:

- ◊ Decrease rates of homelessness for clients
- ◊ Increased residence stability and safe and permanent housing

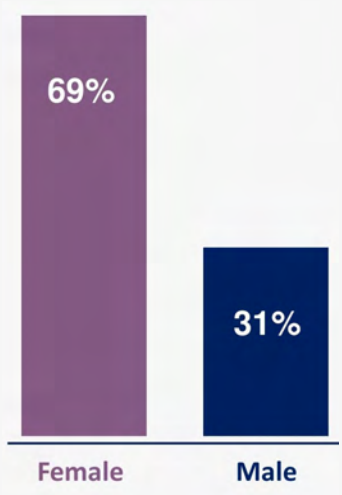
Increased network of community support services:

- ◊ Increase in number of collaborative partners

Program Demographics: Primary Diagnosis



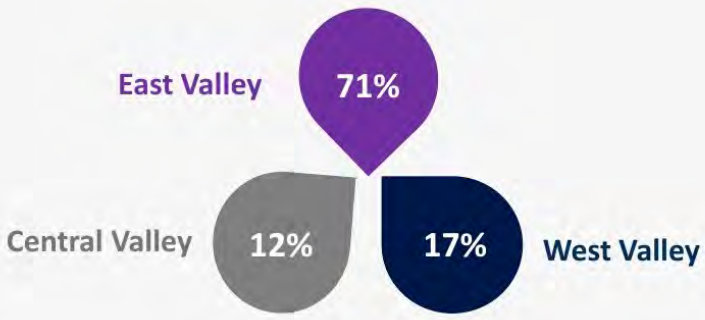
Program Demographics: Gender



Program Demographics: Primary Language

Program Demographics: Ethnicity

Program Demographics: San Bernardino County Region



Positive Results

- DBH Homeless programs have been successful in housing and maintaining individuals housed through Rental Assistance Grants (Shelter Plus Care), where **314** mentally ill individuals who were chronically homeless have been housed.
- In Fiscal Year 2017/18, DBH's seven approved MHSA Housing Projects for permanent supportive housing housed **94** individuals who are living with a severe mental illness.
- The Horizons at Yucaipa (55 and older) project in the City of Yucaipa received a 2018 National Association of Counties (NACo) Achievement Award, for the collaborative partnership between county agencies and private industry in the development of permanent supportive housing for seniors. The complex consists of a total of **50** units, in which ten were set aside for DBH Full Service Partnership (FSP) consumers.

"I am very grateful for the homeless employment program for getting me into a healthy routine and for assisting me in securing employment and having a place to stay. I liked having a case manager by my side to go with me to my doctor's appointments and to the pharmacy to pick up my medications. I have maintained employment with a good employer and now have my very own housing."

- Housing and Employment consumer

Outreach and Engagement

In Fiscal Year 2017/18, the Housing and Employment program organized and/or participated in the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
MHSA Housing Project Crosswalk Meetings	72	96
Field Based Outreach to DBH Clinics	6	45
Total	**78**	**141**

Challenges

Due to the large geographic area of the County, some remote areas still do not have adequate public transportation, making access to community resources, and job searching difficult. Given the limited number of staff, the engagement and repeated outreach to build rapport with consumers that are resistant to change and initially unwilling to participate or disclose information makes the activities of this program challenging, yet rewarding, when consumers are engaged in the continuum of care, are self-sufficient, and are actively managing their mental health and recovery.

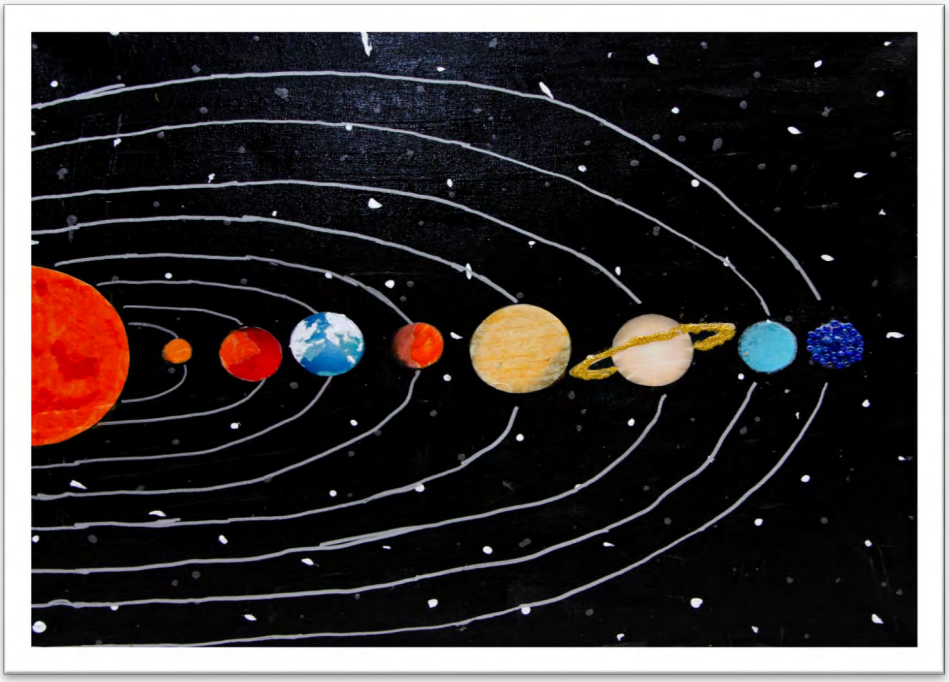
Solutions in Progress

Housing and Employment program staff meet on a regular basis to discuss consumer challenges and barriers and any changes to a consumer's case plan. This collective communication allows staff to identify and share housing opportunities, jobs, and resources for consumers with each other regularly. Staff also continue to be active and involved in the community and are active in various collaborative and work groups throughout the County to identify and leverage resources and services for consumers.

Success Story

"Josefina" was referred to the Housing and Employment program by Age Wise, a DBH Full Service Partnership (FSP) program for adults 59 and older, after her husband who was her primary caretaker passed away. Initially, Josefina was reluctant to any behavioral health services and moved in with one of her adult children. With encouragement from her family and support from DBH staff, Josefina was soon open to services and started receiving them in the comfort of her home.

Eventually, discussions began about transitioning Josefina to independent living for the first time. She was initially fearful about living on her own, but was encouraged by staff who explained the resources and supports that would be available to her and by her family who supported her. Josefina was able to move into a fully furnished senior apartment through MHSA funded housing. Today, Josefina is active with the senior classes provided at the complex and regularly visits the public library which is only a couple of blocks away. Josefina in now able to live independently and her family visits frequently. She has made many new friends at the senior complex and thanks the program and her family for giving her the opportunity to be independent.



Artwork by Trista Popkoff

Program Updates

The Mental Health Services Act (MHSA) Housing Program was jointly launched by the former California Department Mental Health (State DMH) and the California Housing Finance Agency (CalHFA) in August 2007 to support the capital development and capitalized operating subsidies of supportive housing for individuals with serious mental illness and their families who are homeless. Beginning in June 2008 and ending on May 31, 2016, San Bernardino County Department of Behavioral Health (DBH) made commitments of $20.9 million for seven housing developments resulting in 95 units of housing ranging from one to two bedroom units.

The MHSA Special Needs Housing Program (SNHP) was initiated on June 24, 2016, after the MHSA Housing Program ended in May 2016. SNHP is a loan product that was developed by the California Housing Finance Agency (CalHFA), at the request of some counties, in collaboration with the California Behavioral Health Directors Association. The SNHP built upon the highly successful MHSA Housing Program. It allows counties to assign MHSA funds to CalHFA for the development of new permanent supportive housing. Unallocated funds, interest, and loan repayments from the MHSA Housing Program can be transferred to the SNHP.

CalHFA administers the SNHP on behalf of the participating counties by providing loan underwriting, construction monitoring, and asset management services. Under this program, like the MHSA Housing Program, DBH has $4.7 million in capital development funding and Capitalized Operating Subsidy Reserves (COSR) for the development of new permanent supportive housing targeting individuals with a mental illness and their families, who are homeless or chronically homeless. DBH anticipates local funding commitments for two additional housing developments, accumulating into an additional 32 MHSA funded unites under the SNHP.

Finally, on November 6, 2018, California voters passed Proposition 2 known as the “No Place Like Home” program, which will reallocate and dedicate up to $2 billion in bond proceeds to invest in the development of permanent supportive housing to assist local communities in preventing and addressing homelessness through the construction, development, and rehabilitation of affordable housing projects. This program will also provide services for individuals with mental illness within close proximity to the housing community. The DBH plans on applying for NPLH funds and will work collaboratively with other County departments to leverage resources for the development and construction of permanent supportive housing for DBH consumers.
An update to last year’s MHSA annual update addressing NPLH was developed, circulated and posted for public comment prior to this annual update and can be accessed at http://wp.sbcounty.gov/dbh/blog/mhsa-plan-to-support-no-place-like-home/.

Collaborative Partners

- California Department of Rehabilitation (DOR)
- California Housing Finance Agency (CalHFA)
- Housing Authority of the County of San Bernardino (HACSB)
- Housing Developers
- Property Managers
- San Bernardino County, Community Development and Housing Agency (CDHA)
- San Bernardino County, DBH Full Service Partnership (FSP) Programs (Age Wise, Mesa, Phoenix, Mariposa, and TAY)
- San Bernardino County, Office of Homeless (OHS) and Homeless Management Information Systems (HMIS)
- San Bernardino County, Transitional Assistance Department (TAD)
- State of California, Department of Housing and Community Development (HCD)
- State of California, Department of Rehabilitation (DOR)
- Step-Up on Second, Inc.
- U.S. Department of Veterans Affairs (VA)
- 2-1-1 Coordinated Entry System (CES)

"Thank you for taking the time to listen to my needs and for always treating me with dignity and respect. You continued working with me and today I am housed."

- Housing and Employment consumer

Access, Coordination, and Enhancement (A-9)

The Access, Coordination, and Enhancement (ACE) for Quality Behavioral Health Services programs seeks to improve the timeliness of access to Department of Behavioral Health (DBH) outpatient services. The ACE Program was implemented in the four large regional outpatient clinics (Phoenix in San Bernardino, Mariposa in Ontario, Mesa in Rialto, and Victor Valley in Victorville) and in two rural outpatient clinics (Barstow and Needles) specifically for assessments, hospital discharges, and care coordination.

With the implementation of the Affordable Care Act (ACA) and Medi-Cal expansion, the ACE program enhanced the redesign of the outpatient care system to ensure consumers receive the right services to meet their needs. ACE program staff perform initial screenings, intake assessments, and evaluate the best level of care for the client. ACE provides psychiatrist evaluations within seven days of hospital discharge and with 14 days of walk-in requests as clinical indicated. The goal is to increase rapid access to mental health services, and provides individuals, who have been discharged from a psychiatric hospital, or walk-in to a regional outpatient clinic, a scheduled appointment as soon as possible.

Services provided through the ACE Program include:

- Mental health assessments
- Psychiatric evaluations
- Substance Use Disorder (SUD) screenings
- Referrals and linkage to Full Service Partnership (FSP), Crisis Stabilization Unit (CSU) or Crisis Residential Treatment (CRT)
- Access to appropriate services

Target Population:

- Children
- TAY
- Adults
- Older Adults

Projected Number to be Served:

- FY 2019/20
  - ◊ 1,607 Hospital Referrals

The ACE program operates at each clinic from 8:00 a.m. to 5:00 p.m. Monday through Friday. Individual consumers and families seeking mental health treatment can access services either by walking in without a scheduled appointment or by calling the clinic to request an initial assessment appointment.

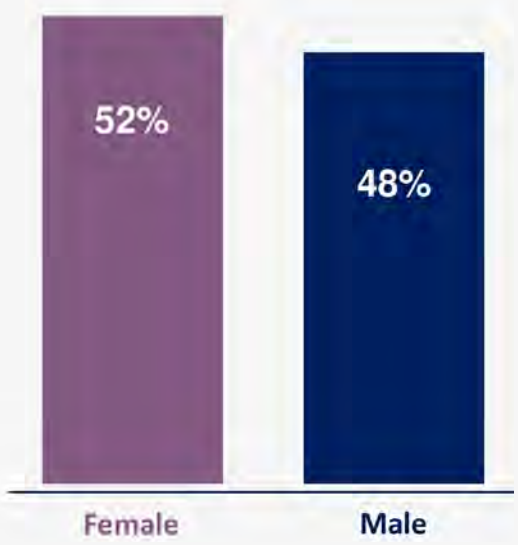
Additionally, the DBH Access Unit, Managed Care Plan Coordinators (Inland Empire Health Plan and Molina Healthcare), and psychiatric hospital discharge staff refer consumers for treatment at the clinics. Appointment priority is given to all patients discharging from a psychiatric hospital, and they are given an appointment within seven calendar days from discharge.

Consumers presenting for services are provided with an initial crisis screening by a clinical therapist. Consumers in crisis will be immediately evaluated to determine the most appropriate path for the consumer. All other individuals receive a mental health assessment or may be scheduled for a more convenient time for the consumer to return for their assessment.

Clinical therapists conduct initial assessments to determine if the consumer meets medical necessity criteria for Specialty Mental Health Services. For consumers meeting this criteria, clinical therapists will consult with the psychiatrist regarding the need for medication. Medical necessity is the state's criteria based on the consumer's diagnosis and the functional impairments caused by their mental disorder. Treatment will be based on their symptoms and their ability to function in the community.
Consumers who do not meet medical necessity for Specialty Mental Health Services can be assigned to a case manager for:

- Managed Care Plan referrals (IEHP/Molina)
- Financial assistance programs (Social Security Disability Income, Veterans Assistance, etc.)
- Transitional assistance programs (Medi-Cal, Cal-Fresh, etc.)
- Charitable organizations for other needs
- Access to Prevention and Early Intervention services

Program Demographics: Gender



MHSA Legislative Goals and Related Key Outcomes

Provide scheduled or non-scheduled appointments from inpatient referrals:

- ◊ Decrease the wait time from hospital discharge to first outpatient service.

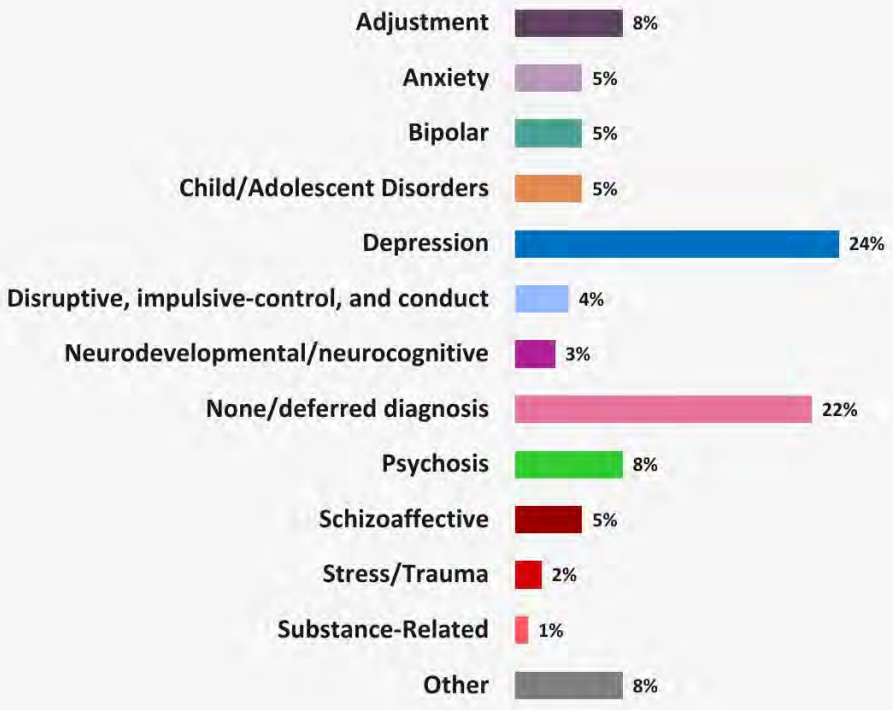
Provide capacity in response to the demand for care:

- ◊ Provide shorter waiting times and shorter times between appointments.
- ◊ Decrease the wait time from the first screening to first therapy appointment.
- ◊ Decrease the time from the first service to necessary/needed medication support service.

"I have a place to talk about my feelings. The staff make me feel comfortable and they were able to help me quickly."

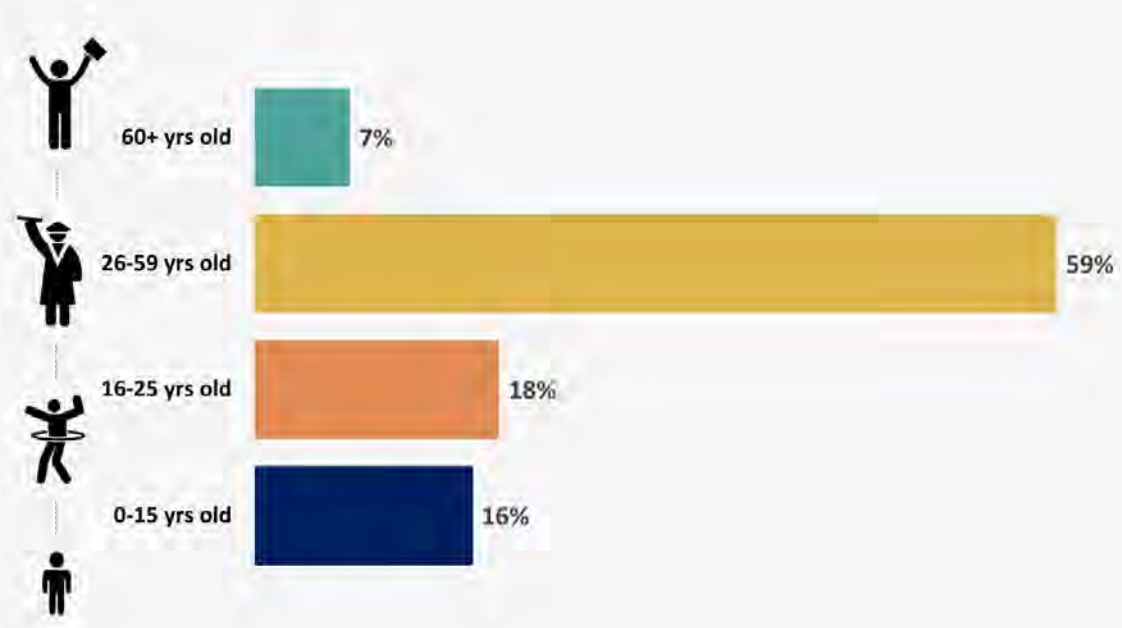
- ACE consumer

Program Demographics: Primary Diagnosis



Program Demographics: Primary Language

Program Demographics: Age



Positive Results

- There were a total of **2,538** referrals to the ACE program for new clients being discharged from acute care psychiatric hospitals in Fiscal Year 2016/17.
- Of the **2,538** referrals received by the ACE program, **37% (927)** were scheduled for an appointment within seven **(7)** days of discharge from the hospital and **69% (1,745)** of the referrals had an appointment within **14** days of discharge.
- ACE staff allow other clinical staff to focus their efforts on providing ongoing care, thus improving the overall care at each clinic.
- ACE program staff are an incredible resource for consumers, allowing them to access the necessary medical care that directly impacts their mental health and daily functioning in a timely and efficient manner. Staff link consumers to medical care, improve consumer access and communication with pharmacy service, and provide necessary education and access to reduce crisis situations and inpatient hospitalization.

Program Demographics: Ethnicity

Outreach and Engagement

In Fiscal Year 2017/2018, the ACE program organized and/or participated in the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Needles Community Health and Safety Fair	3	270
Las Vegas Forum for survivors	2	15
Needles Unified School District-Mental Health Awareness/Suicide Prevention Presentation	2	320
Recovery Happens	1	10
Total	**8**	**615**

Challenges

- The challenge of recruiting, hiring and retaining of qualified staff for the ACE positions is a struggle.
- ACE has identified a need to improve strategies for consumer hospital discharge coordination with DBH outpatient clinics.
- Given the shortage of qualified and trained psychiatric physicians, there is a challenge sometimes arranging a psychiatric evaluation within 14 days to provide timely medication support services to hospital discharged clients.
- The geographic distance and the lack of resources in extremely rural areas.
- Client accessibility to behavioral health resources and supportive services in remote or rural areas.
- Supportive services and training for staff that service rural or remote areas.

Solutions in Progress

- The expansion of outpatient clinic supports, including access to the Full Service Partnerships (FSPs), will allow for improved collaboration and increased contacts for consumer discharge coordination.
- Developing partnerships with regional outpatient clinics and crisis centers for psychiatric care.
- Maximization of telehealth technology to support long distance clinical care
- Continuous identification of resources and supportive services for clients, especially in remote or rural areas.
- The hiring of additional staff to assist with the transportation of clients as needed.
- Coordination with supportive resources in neighboring states for clients located in rural areas on the California border.
- Coordination with DBH Workforce Education and Training to provide more distance training opportunities for DBH and contracted staff.

Success Story

"Mary" was widowed and had recently lost her home in a fire. In doing her initial assessment, the Access, Coordination, and Enhancement (ACE) staff identified that she presented with symptoms related to anxiety and severe depression. Through the ACE teams referral and service coordination, Mary initially received a psychiatric assessment, medication management, and intensive case management to assist with some of her basic needs, housing needs, and individual therapy. Today, Mary lives in stable housing, has adequate access to clothing, food, and healthcare, attends groups weekly and is active in individual therapy. In speaking to a clinician recently about her experience with the ACE program and DBH, Mary stated, "You are my saviors. You saved my life. I didn't think I would make it through losing everything and now I have hope."

Collaborative Partners

- ABC Pharmacies
- Arrowhead Regional Medical Center (ARMC) - Behavioral Health Unit
- Association of Community Based Organizations (ACBO)
- California Department of Motor Vehicles (DMV)
- Canyon Ridge Hospital
- Catholic Charities
- Chemehuevi Indian Tribe
- Colorado River Medical Center
- Community Hospital of San Bernardino
- Croal's Pharmacy
- Desert Mana
- Fort Mohave Indian Tribe
- Goodwill Southern California
- Inland Empire Health Plan (IEHP)
- Kaiser Permanente
- Local law enforcement
- Local faith based organizations
- Local primary care physicians
- Loma Linda University Behavioral Medical Center
- Lutheran Social Services
- Molina Healthcare
- Needles Unified School District
- Needles Mental Health Services (MHS) Center for Change
- North Rialto Drug
- Other Designated Lanterman-Petris-Short (LPS) Hospitals
- Other local pharmacies
- Redlands Community Hospital
- Salvation Army
- San Antonio Community Hospital
- San Bernardino County, Department of Aging and Adult Services (DAAS), Adult Protective Services (APS)
- San Bernardino County, Children and Family Services (CFS)
- San Bernardino County, DBH Clubhouses, Community Crisis Response Team (CCRT), Crisis Stabilization Unit (CSU), Crisis Walk-In Clinic (CWIC) , Diversion Program, Recovery Based Engagement Support Team (RBEST)

- San Bernardino County Sheriff's Department
- San Bernardino County, Transitional Assistance Department (TAD)
- Social Security Administration
- St. Vincent de Paul Church
- U.S. Department of Veterans Affairs-Veterans Administration (VA)
- Westcare Arizona

"Your program gave me the confidence to try something that hadn't worked before."

- ACE consumer

Artwork by José Luis Méndez

Whole Person Care (A-12)

The San Bernardino County Whole Person Care (WPC) initiative focuses on engaging Med-Cal beneficiaries into navigating their health care and social service benefits in order to meet their holistic needs. WPC focuses on people who have the most complex health needs and those that are not accessing or utilizing the appropriate services as their needs continue to go unmet. The WPC is a demonstration project under California 115 Waiver Medi-Cal program for five years until 2020. This piloted program provides engagement and support through health navigation to coordination of services on behalf of county residents who meet criteria for having multiple, chronic conditions (physical and behavioral), as well as those who are homeless or are at-risk of homelessness. County Medi-Cal beneficiaries who enroll in the program, receive coordinated care services and facilitated transitions between the WPC team, County service providers, and community based organizations. This County-wide effort brings together major social services providers together with County health and social services to affect health outcomes and services utilization by positively impacting the social determinants of health, health disparities, and access to needed services. All services are coordinated with other health services, including emergency and inpatient medical services, ancillary support services, and specialty health care. A goal of WPC is to develop effective procedures and conduits for this population to locate care and services effectively. As the specialty behavioral health agency for WPC, behavioral health services include engagement, consultation and linkages to outpatient care, needs and medication assessment for referrals, crisis intervention, and referrals and linkages to drug and alcohol services. The participating partners include Arrowhead Regional Medical Center, the Department of Behavioral Health, the Department of Public Health, the Transitional Assistance Department, the Sheriff's Department's health services, the Office of Homeless Services, Inland Empire Health Plan, Molina Healthcare, and the Community Clinic Association, among other community and County Partners. As the WPC team is mobile and field-based, the team works to engage beneficiaries and

Target Population:

- Adults

Projected Number to be Served:

- FY 2019/20
  - ◊ 580 Adults

support beneficiaries in receiving access to the care they need to stabilize their chronic, persistent illness and to reduce the risk of hospitalization.

WPC activities focus on a population of Medi-Cal beneficiaries who are determined to be the highest users of multiple urgent, emergent, and hospital service systems due to the symptoms they experience from chronic persistent illnesses. It is anticipated to serve a minimum of 2,000 Medi-Cal beneficiaries by the end of the project, which goes through 2020. Although a participant's duration in the WPC varies, it is projected that the majority of participants will remain on average in the WPC for approximately 12 months. Central to the success of the program is ensuring appropriate staff to participant ratios for effective intensive care coordination and testing of strategies.

Appropriate WPC staffing includes:

- Three (3) Registered Nurses
- One (1) Clinical Therapist
- Four (4) Social Workers
- Three (3) Utilization Review Technicians
- Two (2) Alcohol and Drug Counselors
- Twelve (12) Patient Navigators

The WPC team not only works with beneficiaries on a one-to-one basis, but also works with all stakeholders and family members of participants to improve existing workflows, enhance education, and to advance the appropriate interactions between the target population and available resources.

Under the waiver demonstration program, many methods are being tested for outcomes in order to validate the efficacy of the intervention over a five year period. The Plan-Do-Study-Act cycle (PDSA) is consistently used to identify and refine these best processes and to determine the procedures for obtaining desired outcomes. The PDSA cycle is a systemic approach to testing a change in a real setting by planning a change, trying the change, studying the results, and acting on what was discovered so that the methodology of the intervention can be refined.

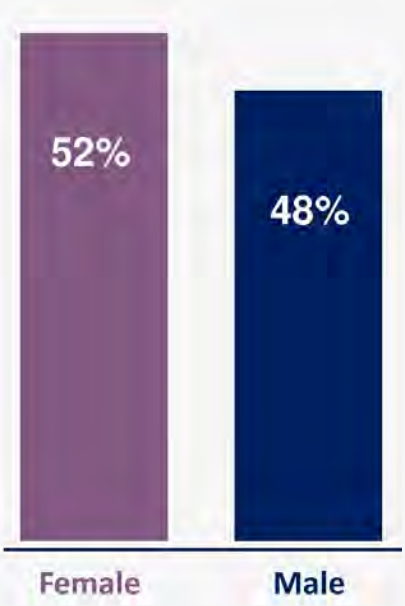
To test a change in the health status of the participants, essential health metrics are tracked and measured against a baseline in the program. Additionally, the participant's ability to manage their own care is monitored via the Patient Activation Measure (PAM). PAM is a tool that assesses participant knowledge, factors that influence their health, and how skilled and confident the participant is in their own self-efficacy in managing their care. The PAM scoring is from Level 1-"Disengaged and Overwhelmed" to Level 4-"Maintaining Behaviors and Pushing Further." It is expected

that the participants will end WPC as they maintain a Level 3-“Taking Action” on their PAM scoring or choose disenrollment in the program altogether.

It is expected that each entity involved with WPC provide organizational data related to reporting and evaluation metrics, including health services utilization, diagnosis, public assistance eligibility, and housing status. Through data sharing, the WPC teams have access to each participant’s information along with access to medical, behavioral health, and social service professionals to better and appropriately address the participants, their support team, and the participating entities. As a result of this information sharing, the WPC team is better informed to engage and encourage an individual’s involvement and participation in their health care.

All participants are engaged in-person by a patient navigator to establish rapport, build relationships and to encourage participation and adherence to the action plan. The established relationship enables the Patient Navigator to act as a liaison between the participant and services between all entities to facilitate access to services and improve the quality of services. To build personal and community capacity, the WPC team assists the participants in increasing their health knowledge and self-sufficiency through various activities and forums, including advocacy, informal counseling, and community education. These activities serve in linking the participants with community resources, provide in-person ongoing case management, and support to entities that provide the necessary resources.

Program Demographics: Gender



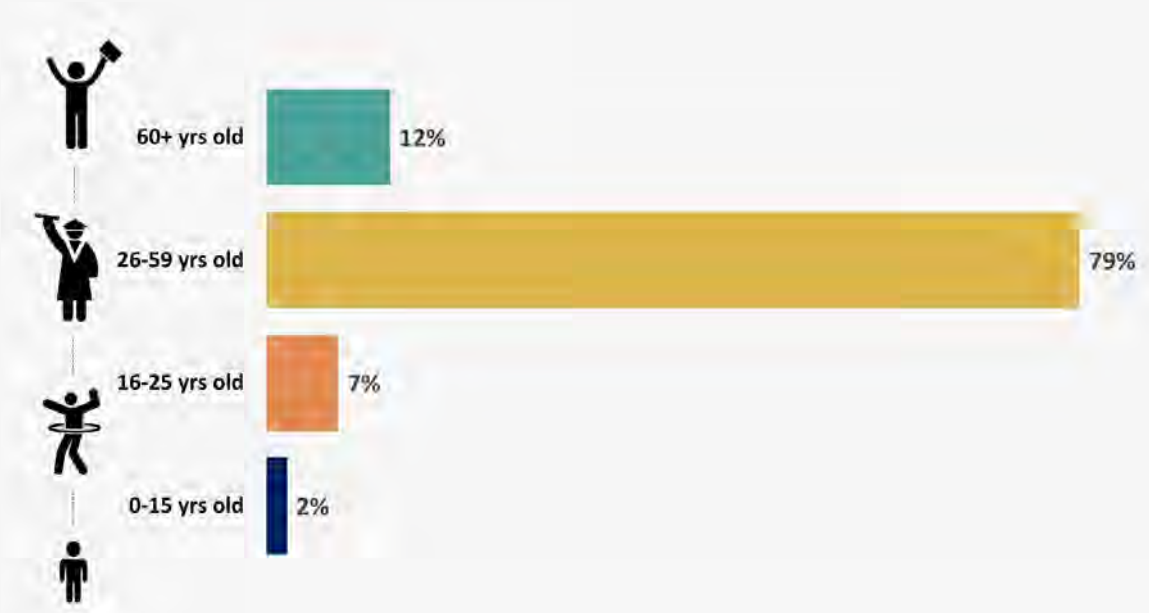
MHSA Legislative Goal(s) and Related Key Outcomes

Reduce the frequency of emergency room visits and unnecessary hospitalizations.

Increase network of community support services

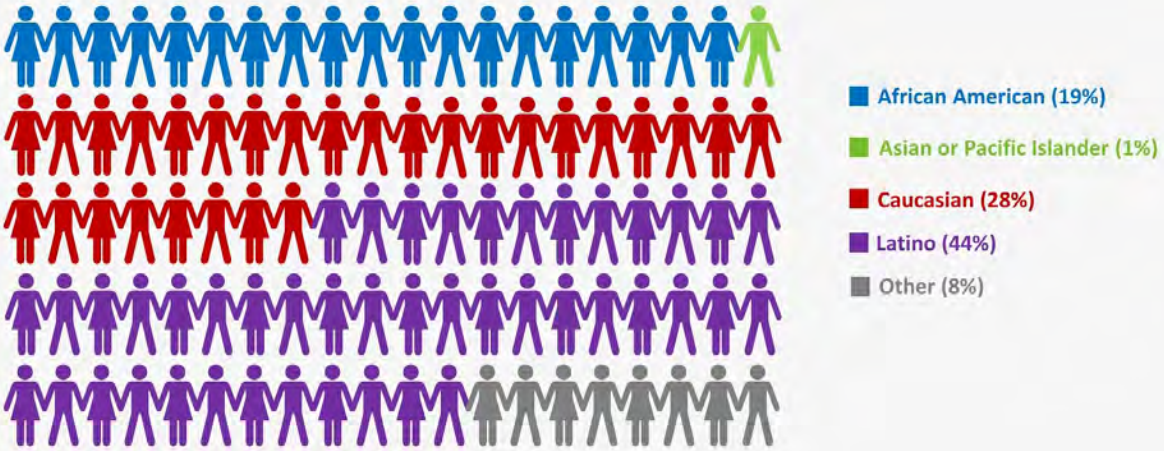
- ◊ Increase in number of collaborative partners.

Program Demographics: Age



Program Demographics: Primary Language

Program Demographics: Ethnicity



Positive Results

- The enrollment of new clients started into the WPC program started in June 2017.
- As of June 2018, **550** clients had been enrolled into the WPC program.
- **371** clients or **67%** of the clients that were enrolled in WPC are active with DBH.
- Increased client ability to self-manage health issues as measured by their Patient Activation Measure (PAM) score.
- Increased client care coordination across the spectrum of health services.
- Reduction of emergency department use due to better self-management of health needs and access to non-emergency health providers.

Challenges

- Process of matching, identifying and sharing client information through this project.
- The exchange of data with partners due to formatting inconsistencies.
- Client demographic data that was needed was not readily available using the current software.
- Changes in Release of Information (ROI) forms and procedures to adhere to new state policies.
- Multiple visits and resources needed to enroll clients into the program.
- DBH computers being used in the field by staff were not ideally set up for remote access.

Solutions In Progress

- The program continues to share information with County service providers, and with community based organizations for the continued identification of clients.
- The creation of a new reporting system to ensure that the collection of data is consistent, uniform, and collected in the same manner by all partners.
- Implementation of a new web based software program to collect client demographic information.
- Having clients sign new ROIs to allow mental health data to be available to DBH.
- Restructuring staff to include more Patient Navigators, a Clinical Therapist and an additional social worker to assist in the enrollment process.
- DBH field tablets have been reconfigured and updated to allow field staff to access information remotely.
- Partnering with an information exchange program that will allow the program to receive real-time alerts of client activity (e.g., client showed up at an emergency department).

Collaborative Partners

- Arrowhead Regional Medical Center (ARMC)
- Inland Empire Health Plan (IEHP)
- Manifest Medex Health Information Exchange
- Molina Health Plan
- San Bernardino County, Department of Behavioral Health (DBH)
- San Bernardino County, Office of Homeless Services
- San Bernardino County, Transitional Assistance Department (TAD)
- San Bernardino County, Sheriff's Department
- San Bernardino County, Information Services Department

Artwork by Barbara Mason

Age Wise I: Circle of Care (OA-1)

The Age Wise Circle of Care program provides access to mental health, substance use disorder, and case management services throughout San Bernardino County to older adults, 59 and older, living with mental illness or co-occurring disorders. The program works to increase access to services for the older adult community and decrease the stigma that is associated with mental illness within the older adult community.

Through collaboration, the program focuses on helping unserved, underserved, and inappropriately served older adults develop integrated care with respect to their physical and behavioral health needs. Additionally, this program provides outreach and engagement activities in the community to educate agencies, primary care providers, and the public about the behavioral health needs of the older adult population.

Target Population:

- Older Adults

Projected Number to be Served:

- FY 2019/20
  - ◊ 240 Older Adults

Research shows older adults are especially vulnerable to the difficulties of accessing available services due to stigma, lack of behavioral health education, and other factors such as limited funds and transportation. The program addresses these vulnerabilities by providing therapy and case management in the home, thereby providing older adults a more accessible form of care.

To achieve the goals of attaining housing and preventing homelessness of older adults living with mental illness, DBH has enhanced the focus on wellness and recovery. This focus assists older adults in remaining independent and active in their communities for as long possible. This component requires collaborative partnerships between staff and community agencies, the Department of Aging and Adult Services (DAAS), the Social Security Administration (SSA), and other community organizations to aid older adults in obtaining needed support.

The program continues to work with the MHSA Housing program to develop senior apartments and creating stable, affordable housing complexes for older adults living with mental illness. The staff work with the apartment management to develop beneficial activities and programs that help keep consumers engaged in stable housing.

MHSA Legislative Goals and Related Key Outcomes

Reduce homelessness and increase safe and permanent housing:

- ◊ Decreased rate of homelessness for clients, as defined in the Data Collection Reporting System
- ◊ Increased Residence stability and safe and permanent housing

Increase access to treatment and services for co-occurring problems; substance abuse and health:

- ◊ Increased encounters in integrated health clinic and/or with primary care/health specialist providers

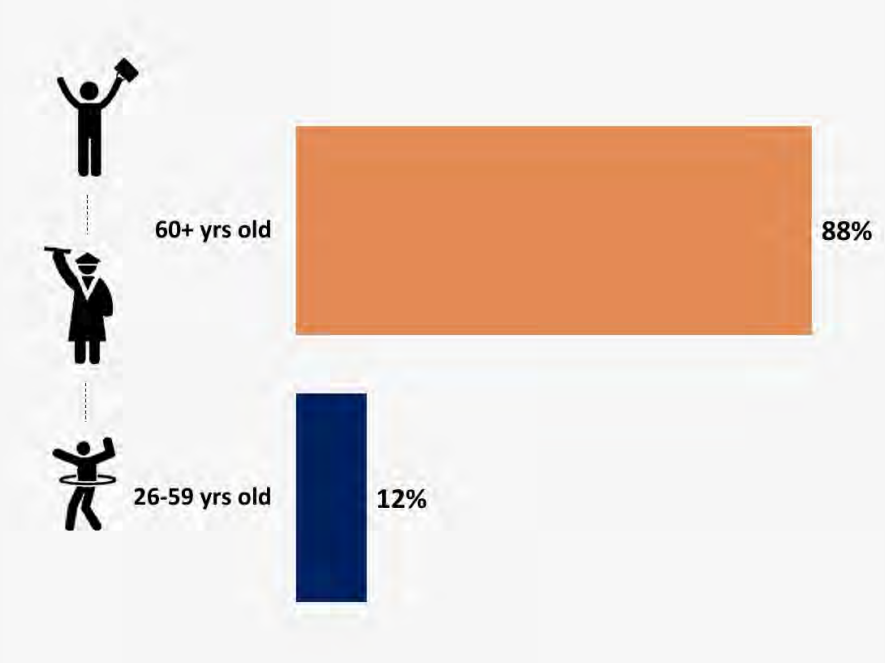
Reduction in disparities in racial and ethnic populations:

- ◊ Reduction in mental health and health care disparities

Increase a network of community support services:

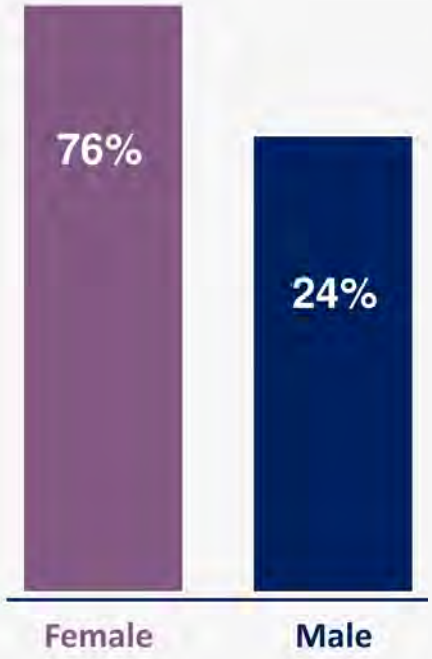
- ◊ Increase in number of collaborative partners
- ◊ Increased coordination of care

Program Demographics: Age

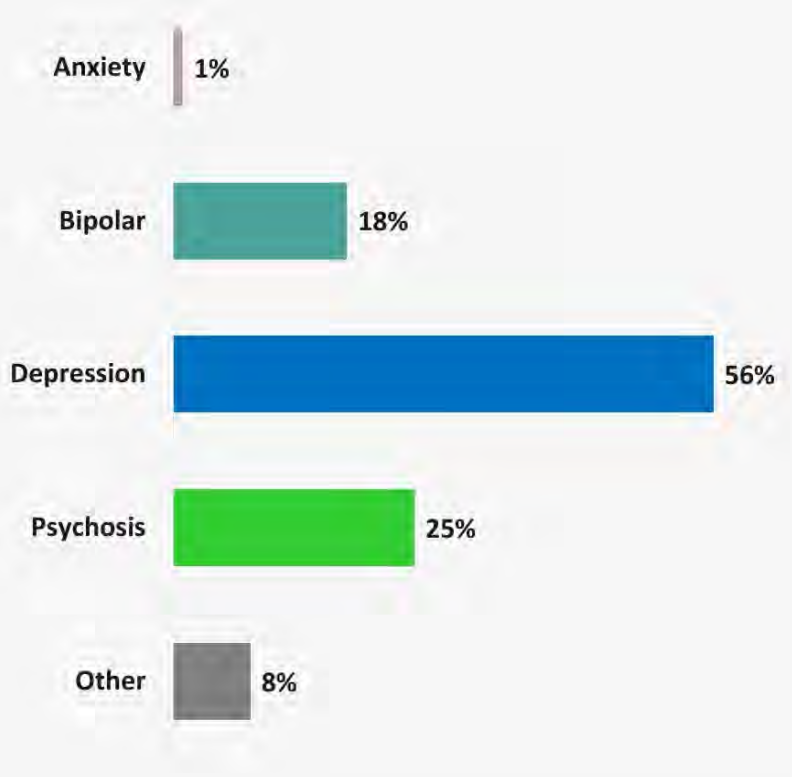


Program Demographics: Ethnicity

Demographics: Gender



Program Demographics: Primary Diagnosis



Positive Results

- **100%** of clients were linked to primary care physicians.
- In collaboration with Housing and Employment, one homeless older adult was placed in safe permanent subsidized housing and **38** maintained safe and permanent subsidized housing.
- **148** consumers were served in the Age Wise program. Of these, **58%** included underserved populations.
- Additional community partners included Community Action Partnership (CAP), Home Energy Assistance Program (HEAP), Habitat for Humanity, Humane Society, Catholic Charities, Mary's Table, and Rock Church.
- Our older adult clients were able to meet more consistently with primary care physicians and/or specialists, as needed, with the assistance of Behavioral Health's Integrated Complex Care program.

Challenges

As the older adult population retires on a limited income, affordable housing is a pressing concern. Challenges also include the loss of lifelong support persons through illness and death, as well as managing medical issues of their own. These issues present great challenges for our staff who are attempting to address multiple complex issues through case management and a mental health service plan. With the swelling in size of this age demographic, social service systems and programs are at the cusp of a likely era of being overwhelmed with a demand for services and resources.

Solutions in Progress

Age Wise is diligently filling approved positions (most recently a much needed bilingual Clinical Therapist), and tackling time management issues to maximize staff productivity. Additionally, Age Wise is presenting, educating and disseminating information continually, in order to empower other DBH and community based programs to enhance the capabilities of their existing case managers. Lastly, Age Wise continues to form pertinent partnerships with agencies who offer additional services to the older adult population.

Success Story

"Bianca" began her journey with the program several years ago when she was facing homelessness and was on the verge of crisis. She made a self-referral to Age Wise I and was quickly linked to a clinician, who provided her with an assessment leading to individual therapy and linkage to MHSA housing. Since then, Bianca has been receiving individual therapy and case management services to aid her in maintaining her housing status, emotional stability, and psychiatric appointments. She was later linked to another program to assist her with integrated health care needs for chronic medical conditions. She knew she could lean on Age Wise in a time of need. After the passing of her pet and a recent move which was particularly challenging (triggered grief and loss issues), she was provided extra support by the Age Wise I team to help her process her move and ensure that it was successful. She expressed her gratitude to Age Wise.

"I felt so comforted by the person on the other end of the phone. She gave me hope that I could overcome my problems."

Age Wise I consumer

Success Story

"Athena" has been an Age Wise client for many years. Throughout the duration of services, Athena was able to improve her functioning and manage her mental health symptoms to support an independent lifestyle. Prior to services, Athena had a history of co-occurring mental health issues, homelessness and experienced multiple hospitalizations. Following Age Wise services, she is stable, and has been sober for several years. Athena also has not experienced any psychiatric hospitalizations. She now demonstrates accountability and responsibility by paying expenses on time. She has expressed gratitude to the Age Wise staff for support and assistance throughout her progress. "I have been able to live in this apartment and continue to be independent. I'm never going back to the old Athena, I am the new improved Athena!"

"Words cannot express how grateful I am to receive support from Age Wise. You all have been so wonderful to me. Thank-you, thank-you, thank-you."

Age Wise I consumer

Outreach and Engagement

In Fiscal Year 2017/2018, the Age Wise I program organized and/or participated in the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Health Fairs	4	623
In-Services	1	30
Faith Based Meetings	4	105
Total	**9**	**758**

"I don't know where I would be right now if I didn't make that first call to Age Wise. My life has been changed for the better."

Age Wise I consumer

Collaborative Partners

- Cash Assistance Program for Immigrants (CAPI)
- Catholic Charities
- Community Action Partnership of San Bernardino County (CAP)
- Habitat for Humanity
- Home Energy Assistance Program (HEAP)
- Home of Neighborly Services
- Humane Society
- Inland Caregiver Resource Center
- Mary's Table
- Mental Health Services Act (MHSA) Senior Housing
- The ROCK Church and World Outreach Center
- San Bernardino County, Department of Aging and Adult Services (DAAS)
- San Bernardino County, DBH, Community Crisis Response Team (CCRT), Crisis Walk-In Centers (CWIC), and Housing and Employment Program

Innovation (INN)

The goal of the Innovation component of the Mental Health Services Act (MHSA) is to test methods that adequately address the behavioral health needs of unserved and underserved populations through short-term projects. This is accomplished by expanding or developing services and supports that are considered to be innovative, novel, creative, and/or ingenious behavioral health practices that contribute to learning rather than a primary focus on providing services.

Innovation projects create an environment for the development of new and effective practices and/or approaches in the field of behavioral health. Innovation projects are time-limited, must contribute to learning, and be developed through a process that is inclusive and representative, especially of unserved, underserved, and inappropriately served populations.

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

- Introduce a behavioral health practice or approach that is new to the overall behavioral health system, including, but not limited to, prevention and early intervention.
- Make a change to an existing practice in the field of behavioral health, including, but not limited to, application to a different population.
- Apply to the behavioral health system a promising community-driven practice or an approach that has been successful in a non-behavioral health context or setting.

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

MHSA Legislative Goals for the Innovation Component

The overall MHSA goal of the Innovation component is to implement and test novel, creative, time-limited, or ingenious mental health approaches that are expected to contribute to learning, transformation, and integration of the mental health system.

Every Innovation project must identify one of the following primary purposes as part of the project's design:

- Increase access to mental health services to underserved groups.
- Increase the quality of mental health services, including measurable outcomes.

- Increase access to mental health services.
- Promote interagency and community collaboration related to mental health services, supports, or outcomes.

Challenges and Solutions

The challenge inherent in the MHSA Innovation component is to test ideas that defy, alter, or even question previous ways of providing traditional behavioral health services. These challenges have included:

- Identifying appropriate evaluation strategies to gauge performance outcomes for unique and innovative projects where logic models and evaluation tools do not currently exist.
- Maintaining high levels of community interest and education surrounding continuing Innovation projects.
- Implementing programs within multiple organizational partners and complex relationships.
- Lastly, quantifying and applying knowledge learned in realistic cost effective ways that improve quality of services.

DBHs Research and Evaluation staff continue working on developing evaluation activities to obtain statistical information and assisting with data analysis needed to evaluate effectiveness of programs and other learning objectives for the purposes of future program planning. DBH has maintained on-going contact with the MHSOAC staff for guidance and direction with regard to all aspects of the administration of Innovation projects. Initiating Innovation stakeholder meetings to encourage and promote community involvement around all phases of the Innovation projects has been another helpful solution. Additionally, Innovation staff is 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.

New Innovation Projects

The Department of Behavioral Health (DBH) is currently working on developing new community supported Innovation projects. Through the Community Program Planning process, homelessness and increased collaboration amongst DBH partners has been identified as a means to improve the delivery of behavioral health services in San Bernardino County.

DBH has been successful in the ongoing engagement of stakeholders during the design, implementation, and evaluation of Innovation projects since 2005. The following stakeholder feedback has been captured and these have been identified according to the four Innovation primary purposes as identified in statute (WIC § 5830(b)(i)(A-D)).

To increase access to mental health services to underserved groups:

- Specific types of youth and children's programs
- Increased and specific services for vulnerable and unserved/underserved populations
- Increased, diverse, community outreach
- Efforts aimed at reducing stigma
- Increased family supports

To increase the quality of mental health services, including measurable outcomes:

- Increased community education
- Increased capacity building for providers
- Specific program elements, and service techniques for specific populations

To promote interagency and community collaboration:

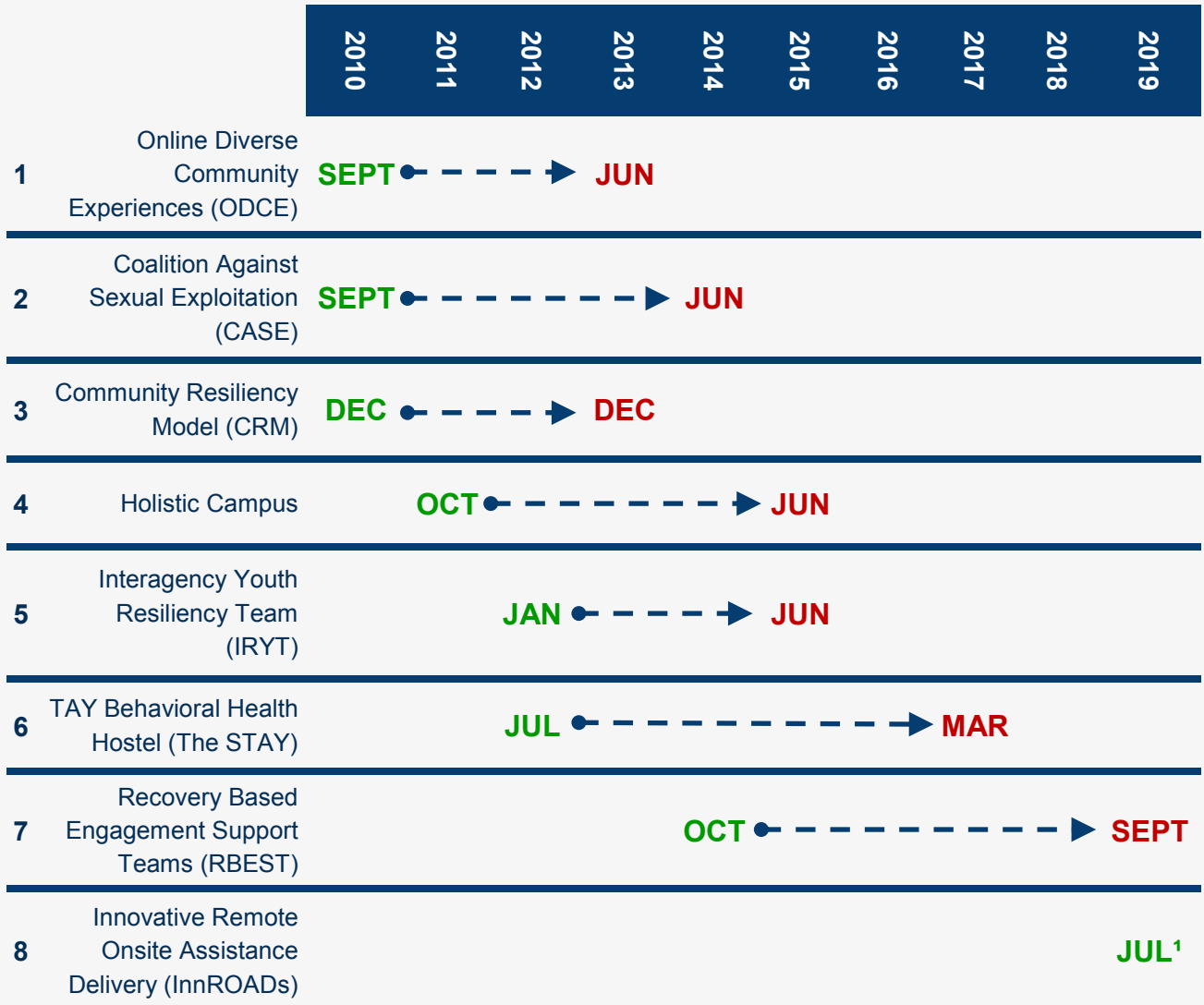
- Increased specific links with education
- Increased interagency information sharing
- Increased transportation and accessibility
- Increase collaboration with the health sector
- Increase collaboration with faith-based organizations

To increase access to mental health services:

- New and increased effective use of digital and online media
- Proactive community-based services with community defined approaches
- Use of mobile services
- Use of transportation for treatment

All Innovation projects have been developed through extensive collaboration with DBH partners, stakeholders, consumers, and community members. Innovation projects are subject to approval by the local Behavioral Health Commission, San Bernardino County Board of Supervisors, and the MHSOAC.

Previous and Current Innovation Projects



The following is a brief description of each Innovation project:

Online Diverse Community Experience (ODCE): Established the department's presence on social media sites (Facebook and Twitter).

Coalition Against Sexual Exploitation (CASE): A collaborative partnership between nine separate child-serving agencies within the County, along with many community partners, to provide a model of interventions and services with the goal of reducing the number of children being affected by sexual exploitation.

Community Resiliency Model (CRM): A community-based model of wellness skills to address the needs of the community members by providing mental health education, including coping skills, trauma response skills, and resiliency techniques.

Holistic Campus: Brought together a diverse group of individuals, family members, and community providers to create their own individual-focused resources, networks, and strategies, growing out of cultural strengths.

Interagency Youth Resiliency Teams (IYRT): Provided mentoring services to underserved and inappropriately served system-involved youth.

TAY Behavioral Health Hostel (The STAY): Short-term, 14 bed, crisis residential treatment program for the Transitional Age Youth (TAY) population who are experiencing an acute psychiatric episode or crisis, and are in need of a higher level of care than a board and care residential, but lower level than psychiatric hospital.

Recovery Based Engagement Support Teams (RBEST): Provides field-based services in the form of outreach, engagement, case management services, family education, support, and therapy for a diverse adult population in an effort to "activate" them into the appropriate treatment.

Innovative Remote Onsite Assistance Delivery (InROADs)[1]: Provides intensive,

field-based engagement model that supports multidisciplinary/multiagency teams that meet, engage, and provide treatment to consumers and their families where they live within homeless communities.

Bi-County Eating Disorder Collaborative[2]: A comprehensive flexible interagency model of interventions and services for those that have been diagnosed with an eating disorder.

Cracked Eggs[2]: A workshop that allows participants to discover, learn, and explore their mental states in a structured process of self-discovery through art.

[1] Project is tentatively scheduled to begin 7/1/2019 pending Board of Supervisors and Mental Health Services Oversight and Accountability Commission approval. The end date for the Innovation project will be calculated as 5 years from the date of implementation.

[2] Project is in the early stages of development. Implementation will not occur until after Board of Supervisors and MHSA Oversight and Accountability Commission approval.

Artwork by Vadim Firson

Recovery Based Engagement Support Teams

RBEST was approved in March 2014 by California's Mental Health Services Oversight and Accountability Commission as an innovation project under the Mental Health Services Act (MHSA) Innovation component. The Innovation component's main function is to design and fund short term projects for learning purposes. RBEST's primary purpose is to examine the viability of providing different outreach and engagement services to community members who are considered to be chronically mentally ill, are currently inappropriately served, and in some cases, are not served at all. The objectives of RBEST include:

- Learn and explore alternative options to the Assisted Outpatient Treatment (AOT) Law, otherwise known as Laura's Law, in order to meet the spirit and intent of the law;
- Activating individuals in the community into needed psychiatric care;
- Empowering families and caretakers to continue providing care for their mentally ill loved ones in their community-based environment; and
- Reducing the frequency and duration of hospitalizations for individuals who are hospitalized for psychiatric purposes without outpatient follow-up in the community.

RBEST is a voluntary, client-centered project which provides community (field-based) services which are not structured around any specific model of benefits, to individuals with untreated mental illness in an effort to activate them into appropriate treatment. RBEST is not a treatment model and does not intend to provide endless mobile services to identified consumers. The project is "non-clinical" in its orientation with a primary focus on the needs and goals of the consumer and helping that consumer meet those goals while eliminating obstacles through appropriate mental health treatment. The multidisciplinary nature of the engagement teams presents a

> *"It's been awesome! If I hadn't met [RBEST], I wouldn't be here"*
>
> *RBEST Consumer*

Innovation

holistic approach to the needs of the consumers and is highly flexible, unencumbered by traditional limits of services organized around benefit structures. RBEST staff provide an opportunity for shared decision making in an unstructured, field-based environment when presenting treatment options to consumers and families, encourages deliberation, and elicits care preferences within what is possible. RBEST staff are trained and utilize the Listening, Empathizing, Agreeing, and Partnering (LEAP) model to engage consumers into treatment. RBEST services include: outreach, engagement, linkage to services, advocacy, case management services, care navigation, family education and support.

The RBEST project was created to address a priority for the County in response to community stakeholder inquiries regarding how the Department of Behavioral Health (DBH) intended to address AB 1421, Assisted Outpatient Treatment (AOT) known as Laura's Law.

Addressing the Spirit of "Laura's Law"

Assisted Outpatient Treatment (AOT), also known as Laura's Law, was signed into California law in 2002. The purpose of AOT was to provide a legal procedure for the court to compel an individual to follow a behavioral health treatment plan. The goal was to improve access and adherence to behavioral health services. Court orders issued for AOT are for treatment services only and does not cover court-ordered medication delivery. In order to qualify, an individual must have a serious mental illness with a recent history of psychiatric hospitalization, imprisonments, or violent acts or threats of violence toward others or themselves. Additionally, the individual must have been offered an opportunity to voluntarily participate in a treatment plan, but *actively* fails to engage in any form of treatment.

Extensive stakeholder work groups were conducted concerning the implementation of this law, as well as possible alternatives which focused on community mental health and general treatment needs. Based on an analysis of the elements of AOT law and the different models of care, DBH determined that the spirit and intent of the law could be addressed by creating a voluntary, client-centered project that would address the issues associated with individuals who are not participating in effective psychiatric care.

The decision to implement RBEST versus a more judicially-driven AOT program, was based on the existing DBH service markets that offered traditional therapies requiring the consumer to leave their living environment and go to an alternative setting for services. While specific field-based services were available, they were not activating a small population of consumers into care, and therefore, did not meet the *spirit* and intent of the

AOT law. Additionally, current evidence-based, field-centered practices only targeted consumers and families already willing and motivated for treatment. AOT would require adapted strategies for County residents who had been inappropriately served, underserved, or unserved and suffer from untreated, severe, chronic and persistent mental illness. This includes historically resistant and "invisible" consumers who primarily receive care through their families and are not known to the public mental health system, but become more vulnerable as care givers age or other challenges arise. These consumers and families would not be served with existing DBH service markets and field-based strategies.

Target Populations

Adults over the age of 18, and:

- Not active or successful in seeking and receiving necessary psychiatric care.
- Known to the community and other safety net programs, but not known to the public mental health system.
- Individuals who access treatment at points in the health care system that do not deliver effective care in meeting the psychiatric needs of that individual (category added after project implementation).
- The "invisible" client who is being cared for by family members and not linked or known to the public mental health system.
- Resistant to traditional engagement strategies due to a neurological condition (i.e. anosognosia) which disallows insight into their own behavioral health condition (category added after program implementation).
- Unable to navigate the behavioral health system of care to obtain appropriate treatment (category added after program implementation).

Number of Consumers Served by Fiscal Year:

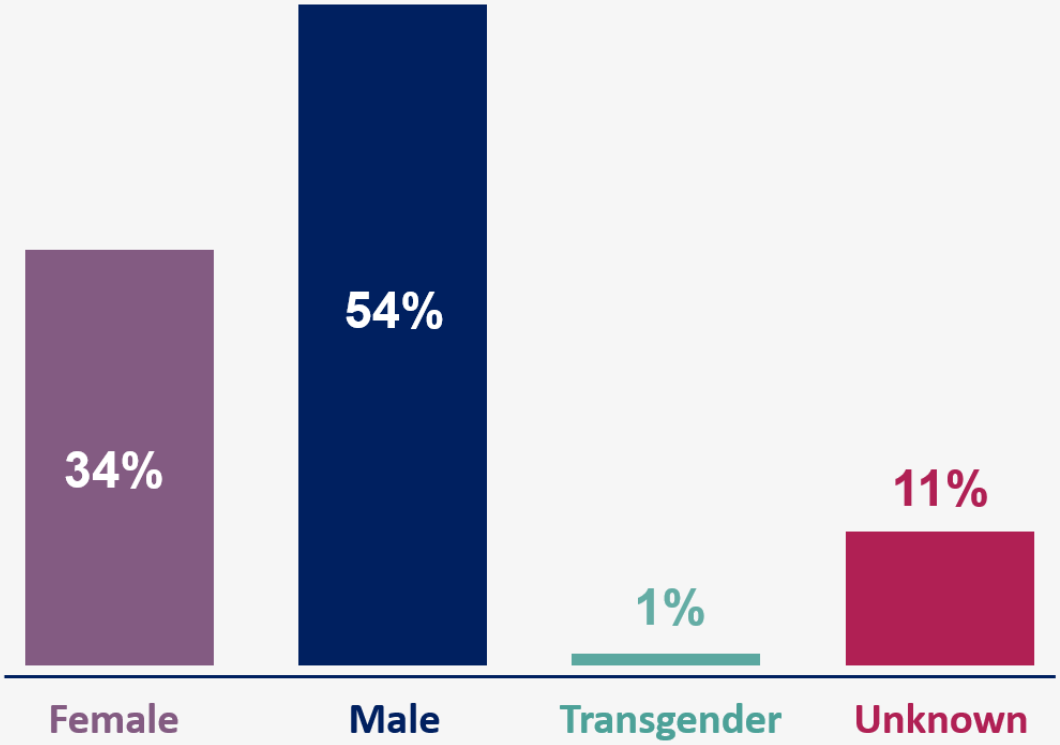
Fiscal Year	Projected No. of Consumers Served	No. of Unduplicated Consumers Served
2014 -15	300	186[1]
2015 -16	300	441
2016-17	300	421
2017-18	300	450
2018-19	300	
2019-20	75[2]	

[1]RBEST project was not fully implemented until the last quarter of Fiscal Year 2014-15, so only a partial year is reported.
[2]Projected number of consumers served for FY 2019-20 has been prorated to account for the sun setting of RBEST as an Innovation Project.

Target Population Breakdown by Category:

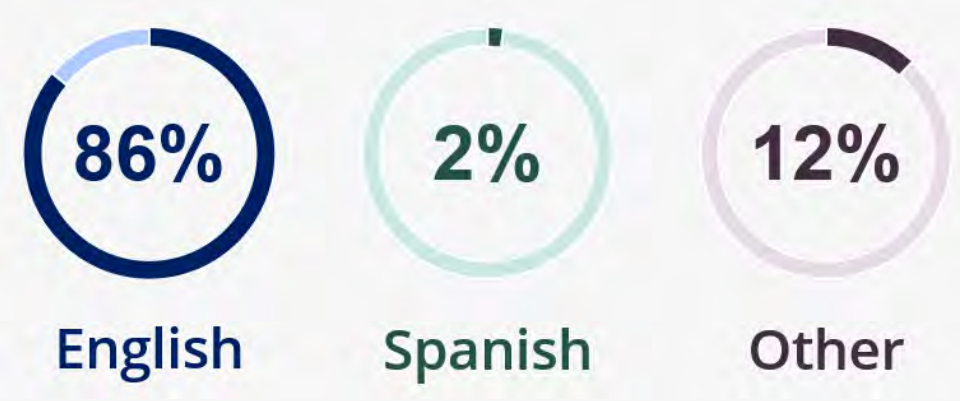
Population Type	Percentage Breakdown
Individuals who access treatment at points in the health care system that do not deliver effective care in meeting their psychiatric needs	5%
Unable to engage in traditional treatment and are known to the public mental health system	48%
The client who is being cared for by family members and not linked or known to the public mental health system	38%
Other/Unknown	9%

Project Demographics: Gender



Innovation

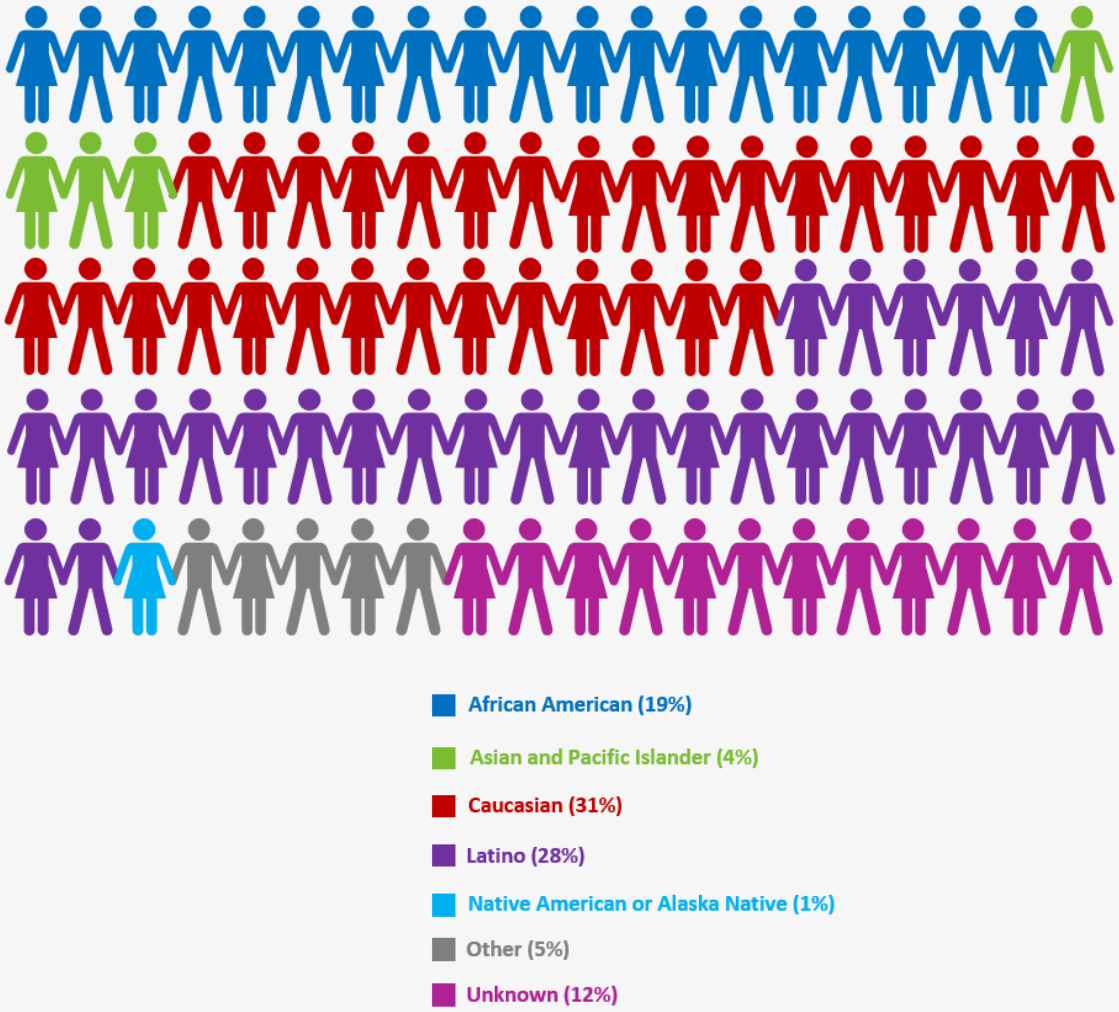
Project Demographics: Primary Language



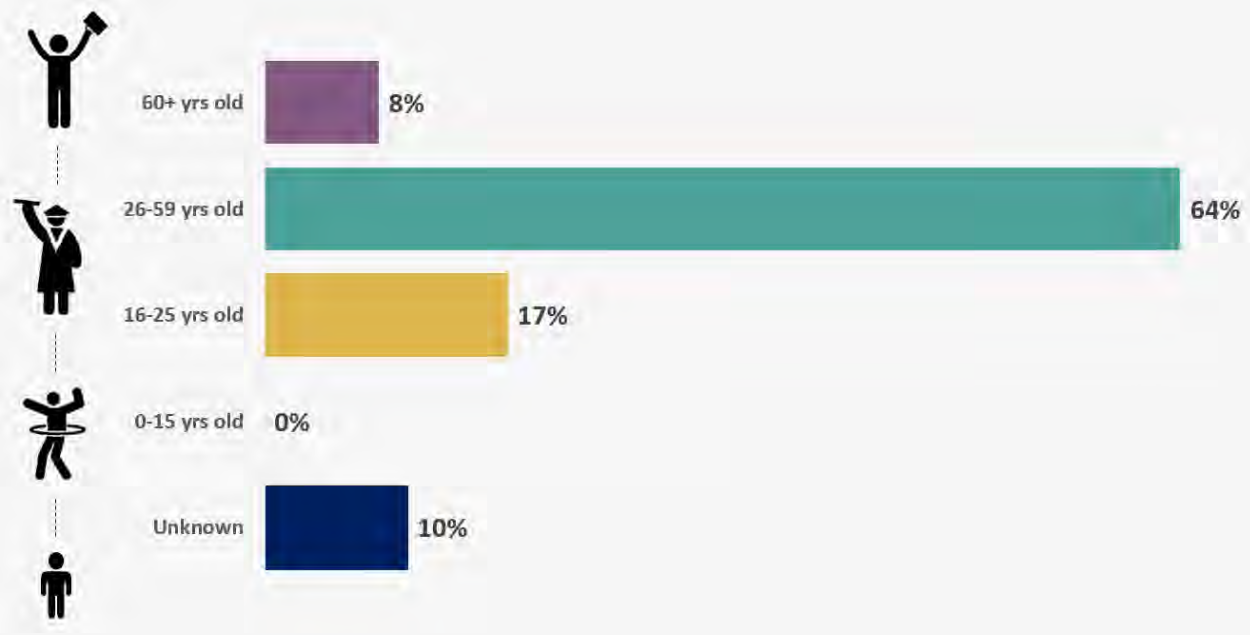
Other languages identified:

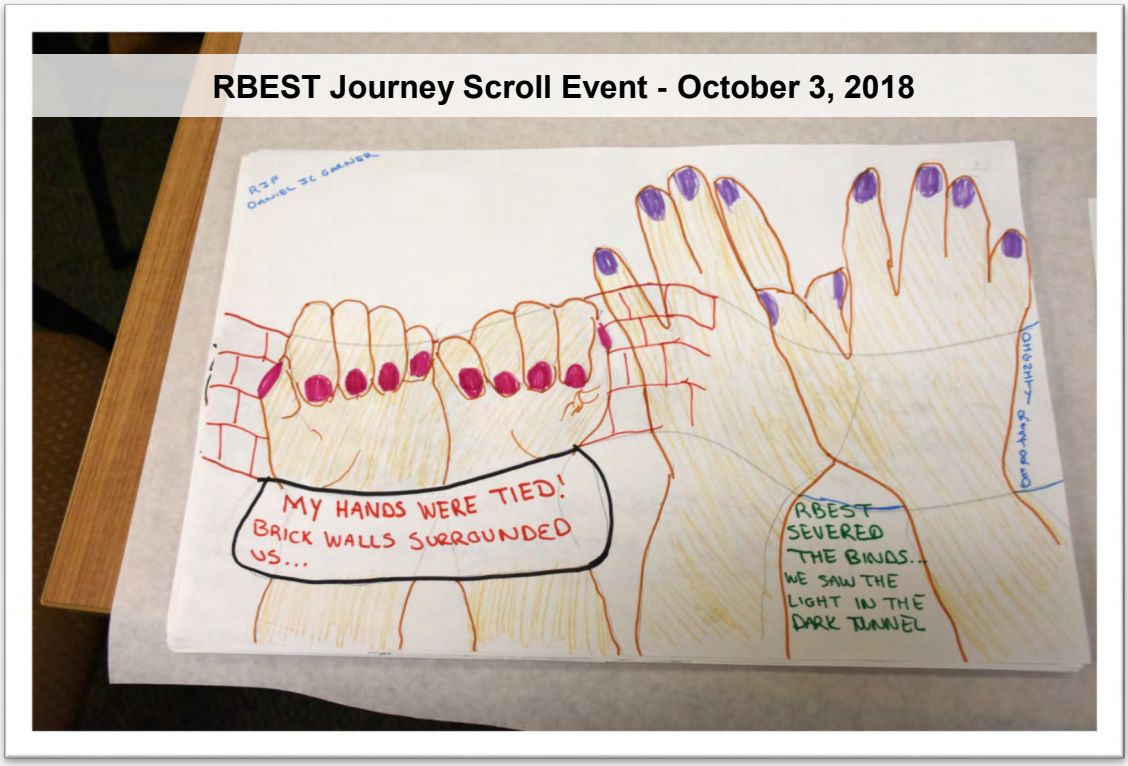
- American Sign Language
- Farsi
- Tagalog
- Korean
- Thai
- Vietnamese

Project demographics: Ethnicity



Project demographics: Age





Innovation

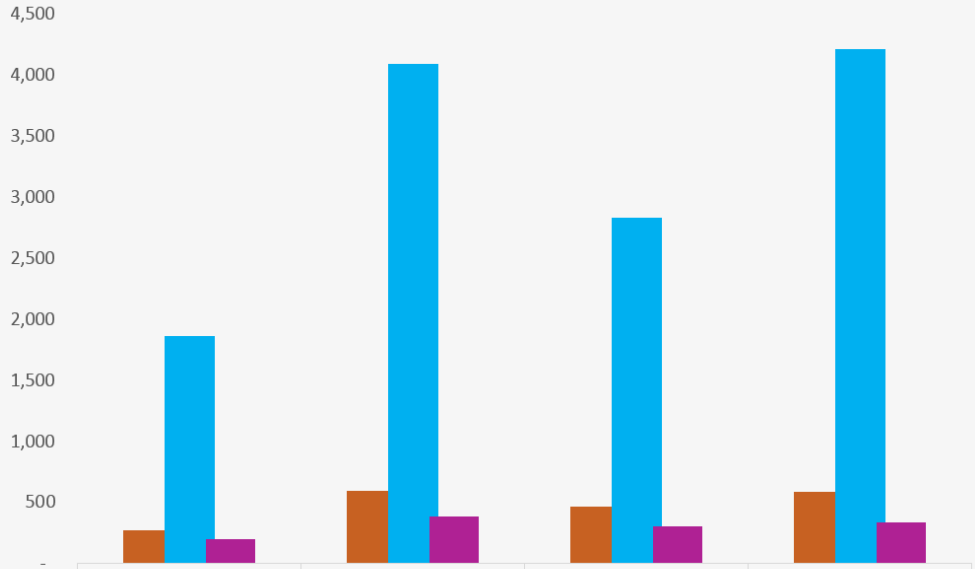
Project Results

Since the goal of every Innovation project is learning, each Innovation project establishes learning goals as part of the project design. The learning goals for the RBEST project are:

Learning Goals		
	1	Disruption of the existing system will occur through utilizing engagement and outreach strategies targeting individuals who are non-compliant and/or resistant to treatment.
	2	Identify individuals who are high users of inpatient psychiatric services, reducing the frequency and duration of inpatient admissions through activation strategies.
	3	Increase the understanding and knowledge regarding mental illness for families of individuals living with mental illness as well as improved and increase the strategies in caring for their loved ones.

In addition to monitoring outcomes related to the learning goals, the RBEST work plan also established a goal of 300 consumers served per fiscal year. As the following charts illustrate, the RBEST project far exceeded the original project design.

Referrals, Contacts/Encounters, & Open Cases by Fiscal Year

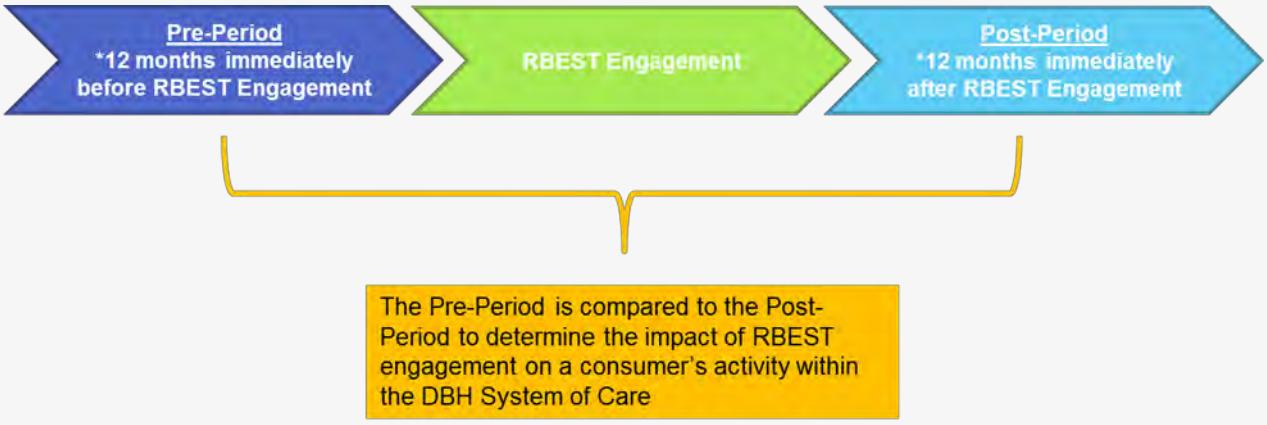


	FY 14-15	FY 15-16	FY 16-17	FY 17-18
Referrals	273	595	461	582
Contacts/Encounters	1,859	4,091	2,834	4,213
Open Cases	200	382	302	334

Methodology for Evaluating the Learning Goals

Service Utilization Before RBEST Engagement Compared to After RBEST Engagement (3-Tier Utilization Analysis)

The 3-tiered utilization methodology analyzes hospitalizations as well as crisis and outpatient services in the pre and post RBEST engagement (i.e. intervention) time period.



Focus Groups

As part of the evaluation process RBEST family members, and staff were assembled to participate in a guided discussion about RBEST services. The discussion questions and topics included family satisfaction of engagement strategies, effectiveness of the LEAP training, barriers to treatment, and consumer readiness for treatment.

Journey Scroll Event

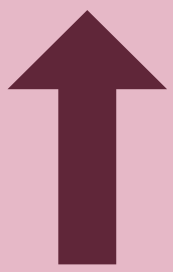
The Journey Scroll Event was an opportunity for RBEST consumers and family members to reflect on the ways that RBEST impacted their lives. This information was communicated through art and focused on a more relational way of interacting with project outcomes outside of the normal statistical data that is collected. This way of collecting information (i.e. data) supports a more conversational style that was more representative of the "unconditional" assistance approach that is the center of all RBEST interactions with family and consumers.

Outcomes by Learning Goal

Learning Goal #1: Disruption of the existing system will occur through utilizing engagement and outreach strategies targeting individuals who are non-compliant and/or resistant to treatment.

Routine Outpatient Services

Through engagement with RBEST, individuals that previously were not accessing the needed outpatient treatment were successfully linked and engaged in routine outpatient services.

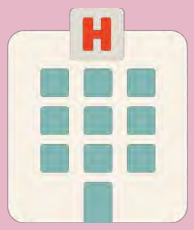


165.8% Increase in Routine Outpatient Services

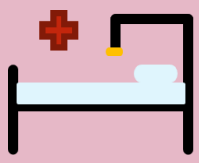
Learning Goal #2: Identify individuals who are high users of inpatient psychiatric services, reducing the frequency (how often) and duration (how long) of inpatient admissions through activation strategies.

Psychiatric Hospital Days and Admissions

Once linked and engaged in routine outpatient services, RBEST consumers no longer used local hospitals as their primary source of mental health care. This can be seen in the decrease of psychiatric hospital utilization (both the number of psychiatric hospitals days used and by the number of psychiatric hospital admissions) that occurred after RBEST engagement.



54.8% Decrease in Psychiatric Hospitalizations Admissions



48.2% Decrease in Acute Psychiatric Hospital Days

Learning Goal #3: Increase the understanding and knowledge regarding mental illness for families of individuals living with mental illness as well as improve and increase the strategies in caring for their loved ones.

Empowering Families and Support Systems

In FY 17-18, 198 families had encounters with RBEST. RBEST provided a total of 806 family engagements, which is an average of four (4) encounters for each participating family during the year.

198 families engaged by RBEST

General satisfaction with services their loved one receives is one indicator of someone's understanding and knowledge regarding mental illness. Because of RBEST's focus on family education, the family expectations of the type and duration of behavioral health treatment are more in line with the realities of the treatment needed by their loved one.

Based on the Family Experience Interview Schedule (FEIS) given to RBEST families in FY 17-18, family satisfaction about services their loved one received improved from an average of 1.6 prior to their engagement with RBEST to 4.6 points after RBEST engagement and family education (on a 5-point scale). In addition, family satisfaction with mental health professionals responding to their concerns improved from an average of 1.6 prior to their engagement with RBEST to 4.8 after RBEST engagement and family education (on a 5-point scale), satisfaction with the amount of services available improved from an average of 1.6 prior to their engagement with RBEST to 4.4 after RBEST engagement and family education (on a 5-point scale), and satisfaction with the convenience of mental health services improved from an average of 2.0 prior to their engagement with RBEST to 4.8 after RBEST engagement and family education (on a 5-point scale).

Learning Achieved

Consumer Readiness for Treatment and the "Unconditional" Approach: In order for treatment to have the best chance at lasting success, the individual in need of treatment must be ready for treatment. In an ideal world, an individual would be ready for treatment at the same time that treatment is first being offered, but this is often not the case. The RBEST staff found that establishing a consistent presence in an individual's life and offering assistance, not only with accessing treatment but also with other activities of daily living, was the best way to

establish trust. During FY 17-18, approximately 18 engagements (i.e. interactions) over the course of 268 days was needed to establish the trust necessary for an individual to begin treatment based on an RBEST staff members recommendation and/or encouragement.

The framework that the RBEST staff use for this "unconditional" approach is based on the LEAP® (Listen-Empathize-Agree-Partner) communication program which focuses on transforming the relationship first and provides the tools needed to partner with someone who lacks understanding (i.e. someone experiencing anosognosia) about the seriousness of their mental illness in order to accept treatment and services. Using LEAP® as a framework is essential to the RBEST project because the symptom of anosognosia is not responsive to traditional treatment and education. Quite often attempts to educate and confront a person will only result in anger, alienation, and continued avoidance of treatment, which can be common characteristics of the target population of RBEST.

RBEST Recognition

"Let's Get Healthy California" Innovative Challenge

The RBEST project was selected from nearly **100** innovative project submissions from community, health and human services advocates, health care and human services providers, community and faith-based organizations, and non-profits from across the State of California.

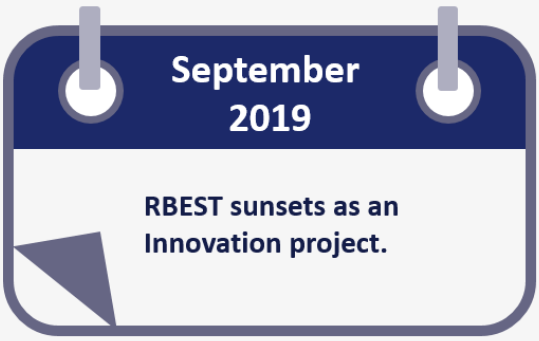
The goal of the Innovation Challenge is to engage, empower, and recognize change makers who seek to positively impact the problems that they care about and prove that we can work together to support innovation and improve community health and health care systems.

2017 Achievement Award from the National Association of Counties (NACo)

The RBEST project was recognized with a 2017 Achievement Award presented by the National Association of Counties (NACo). For the last 48 years, NACo has used the Achievement Award to recognize innovative county government programs and provide an opportunity for counties to come together to promote successes and share best practices.

RBEST Next Steps

The RBEST project was scheduled to sunset in February 2019 after four and ½ years. On 9/28/2018, a letter was sent to the Mental Health Services Oversight and Accountability Commission as notification that the RBEST project was going to continue for the full five years and therefore sunset September 2019. No other adjustments to the project's timeline or budget were made.

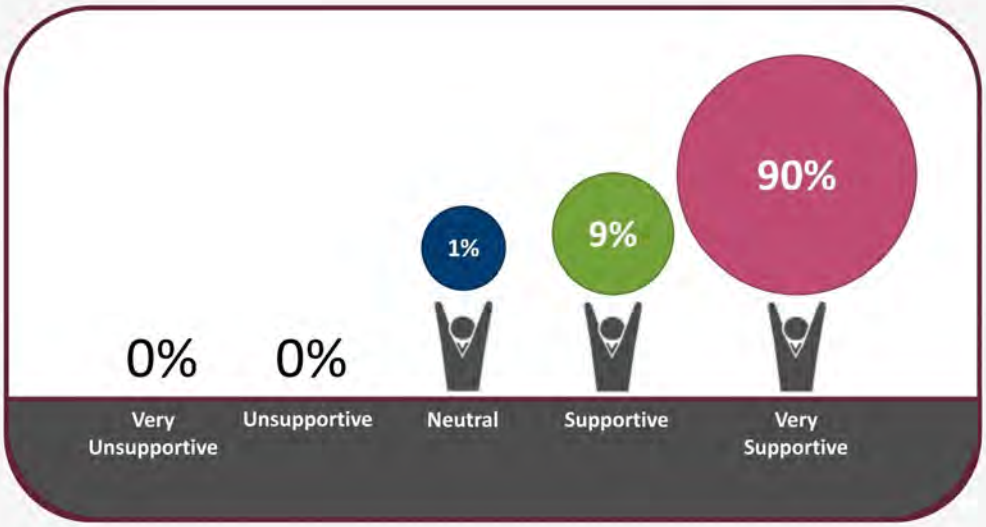


Previously, sustainability planning was kicked-off with the preliminary project outcomes being presented at the January 2018 Community Policy Advisory Committee meeting. During this meeting, stakeholders were asked the following:

- Based on the information presented, how supportive are you of the continuation of the successful elements of the RBEST project into the existing DBH services?
- Based on the learning presented, how do you feel the successful elements of RBEST can be best integrated into the existing DBH services?

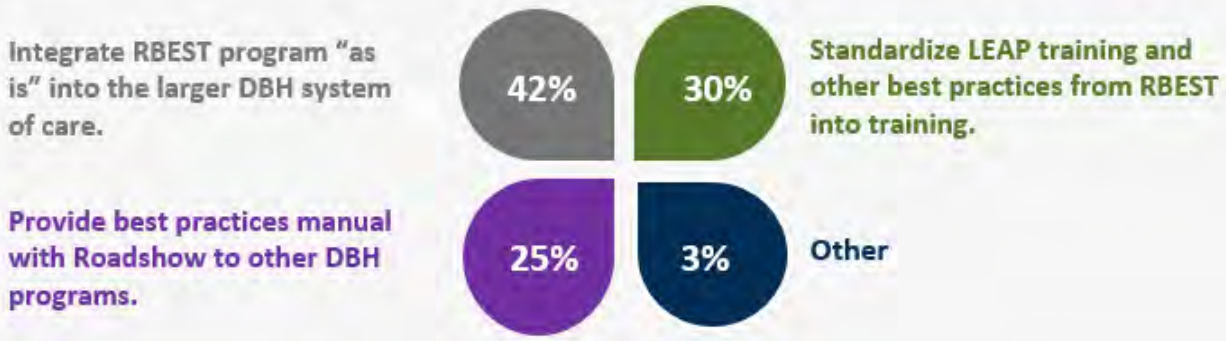
The responses to these questions will inform discussions about RBEST's transition away from being strictly an Innovation project. Upon completion of the RBEST project, a Final Report will be developed and published. Successful elements of RBEST model are anticipated to continue.

How supportive are you of the continuation of the successful elements of the RBEST project?



Innovation

Based on the learning presented, how do you feel the successful elements of RBEST can be best integrated into the existing DBH services?



Community Program Planning (CPAC) Meeting

Success Story

In December 2015, the RBEST staff began working with "Bill." Initially Bill was not interested in any assistance or treatment that was offered by RBEST. At the time of initial contact, Bill had already been homeless for a number of years within the San Bernardino community, along with his wife "Mary." Bill was known for being disruptive and both he and Mary had many encounters with Law Enforcement. Many of these encounters began as concerns from neighbors about the many shopping carts full of belongs that Bill and Mary kept with them. When asked, both Bill and Mary were reluctant to abandon any of these items (many of which were valuable for sentimental reasons), which resulted in a number of citations.

Over the next 2½ years, RBEST staff members continued to engage both Bill and Mary with offers of unconditional support and assistance. In the beginning Bill remained uninterested and dubious of RBEST's offers. Mary, on the other hand, was receptive to the idea of mental health services. The RBEST staff was able to link her to the needed treatment and services, and she was able to make additional connections through a local DBH Clubhouse, which is primarily run by other adult consumers of mental health services.

Bill continued to remain resistive to the RBEST offers of assistance. Because Bill is an older man who experiences a psychotic disorder with paranoia and delusional thoughts, the RBEST staff knew that building trust was going to be key in helping Bill find resolution to his and Mary's homelessness.

Based on the positive work that the RBEST staff was able to accomplish with Mary and the consistent and unconditional offers of support and assistance, Bill began to trust RBEST staff. In his own words, he even became "fond" of the team members. Once that trust was established, Bill and RBEST completed the application process for Bill to begin receiving Social Security Benefits based on his age and previous work history. RBEST was also able to assist Bill in completing the required paperwork that would allow Bill to utilizing the medical benefits afforded to him through the US Department of Veterans Affairs in order to seek both medical and behavioral health treatment. In the end, RBEST was able to successfully transition both Bill and Mary to supportive housing.

Workforce Education and Training (WET)

Artwork by Alyssa Iniow

Workforce Education and Training (WET)

The passage of the Mental Health Services Act (MHSA) in November 2004, provided a unique opportunity to increase staffing and other resources to support public behavioral health programs. MHSA funds increased access to much needed services, and progress toward statewide goals for serving children, Transitional Age Youth (TAY), adults, older adults, and their families.

California's public behavioral health system has suffered from a shortage of behavioral health workers, changes in mental health occupational classifications, and underrepresentation of diversity of professionals with consumer and family member experience. To address challenges faced by the public behavioral health workforce, the MHSA included a component for Mental Health Workforce Education and Training (WET) programs.

WET is a program that provides various training opportunities to the Department of Behavioral Health's (DBH) staff and contract agency staff, promotes the hiring of a culturally diverse workforce, offers financial incentives to recruit and retain staff, recruits volunteers for the department, facilitates clinical intern programs, supports the inclusion and incorporation of consumers and their family members into the behavioral health workforce, and is committed to addressing workforce shortage within San Bernardino County through utilization of various strategies to recruit and retain qualified behavioral health employees.

WET carries forth the vision of the MHSA to create a transformed, culturally-competent system that promotes wellness, recovery, and resilience across the lifespan of all age groups and all cultural backgrounds.

MHSA Legislative Goals and Related Key Outcomes

Address workforce shortages and deficits identified in the workforce needs assessment:

- ◊ Increase in the number of employees hired in identified needs assessment areas
- ◊ Increase in pre-licensed to licensed baseline statistics
- ◊ Increase in the number of qualified applications received for clinical positions
- ◊ Increase in DBH pre-licensed clinicians hired (interns vs. non-interns)

Designate a WET Coordinator:

- ◊ WET Coordinator designated

Educate the workforce on incorporating the general standards:

- ◊ Training documented addressing these standards
- ◊ Training evaluations

Increase the number of clients and family members of clients employed in the public mental health system:

- ◊ Increased number of Peer and Family Advocates (PFAs) hired

Conduct focused outreach recruitment to provide equal employment opportunities in the public mental health system for individuals who share the racial/ethnic, cultural and/or linguistic characteristics of clients, family members of clients, and others in the community who have serious mental illness and/or serious emotional disturbance:

- ◊ Documented efforts that target the identified population
- ◊ Documented career fairs including locations

Recruit, employ, and support the employment of individuals in the public mental health system who are culturally and linguistically competent, or at a minimum, are educated and trained in cultural competence:

- ◊ Documented efforts that target the identified populations
- ◊ Adherence to cultural competency training requirement
- ◊ Increase in hiring of culturally competent staff
- ◊ Increase in the number of bilingual staff, bilingual applicants, and bilingual interns

Provide financial incentives to recruit or retain employees within the public mental health system:

- ◊ Financial incentives implemented
- ◊ Tracking for employee scholarship applicants
- ◊ License Exam Prep Program (LEPP) statistics

Incorporate the input of clients and family members of clients, and when possible utilize them as trainers and consultants in public mental health WET programs and/or activities:

- ◊ Documented meetings with clients and family members
- ◊ Documented trainings facilitated by clients and family members

Incorporate the input of diverse racial/ethnic populations that reflect California's general population into WET programs and/or activities:

- ◊ Documented meetings with diverse racial/ethnic populations

Establish regional partnerships:

- ◊ Partnerships with other counties established

Coordinate WET programs and/or activities:

- ◊ Coordinated WET program/activities

Positive Results

To meet the Legislative Goal, *Address workforce shortages and deficits identified in the workforce needs assessment,* a needs assessment was completed in 2008. Psychiatrists, child psychiatrists, licensed clinical therapists, and internists were identified as hard-to-retain and hard-to-recruit positions in the County. A new needs assessment was completed in July 2013 again identifying child psychiatrists and psychiatrists as hard-to-fill and hard-to-retain positions.

The progress made in San Bernardino County in the occupational shortage areas and in other clinical positions is a credit to the various WET programs in place. DBH has been successful in increasing the number of applications received for qualified licensed staff. This is imperative in order to adequately equip the DBH workforce to serve an ever growing and diverse population within San Bernardino County. More progress is needed however, as there are still occupational shortages.

Number of Qualified Applications Received for DBH Positions per Fiscal Year										
Job Title	FY 08/09	FY 09/10	FY 10/11	FY 11/12	FY 12/13	FY 13/14	FY 14/15	FY 15/16	FY 16/17	FY 17/18
Alcohol and Drug Counselor	N/A	N/A	43	44	27	N/A	39	45	32	117
Child Psychiatrist	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	6	8
Clinic Assistant	N/A	N/A	N/A	N/A	N/A	N/A	47	239	116	103
Clinic Supervisor	14	10	57	N/A	N/A	30	37	64	44	25
Clinical Therapist, LCSW	N/A	3	5	12	3	6	3	4	11	7
Clinical Therapist, MFT	N/A	6	5	12	10	8	9	14	18	16
Clinical Therapist, Psychologist	N/A	1	3	5	1	N/A	1	4	8	0
Clinical Therapist II	N/A	8	12	32	N/A	54	44	39	48	35
Licensed Vocational Nurse	N/A	N/A	N/A	N/A	N/A	N/A	N/A	53	30	160
Mental Health Education Consultant	N/A	N/A	24	20	N/A	N/A	77	N/A	27	45
Mental Health Nurse II	2	8	4	7	N/A	29	32	47	31	24
Mental Health Specialist	72	15	13	120	N/A	90	70	226	370	430
Nurse Manager	N/A	N/A	N/A	N/A	N/A	N/A	6	N/A	N/A	N/A
Nurse Supervisor	4	6	N/A	10	N/A	N/A	N/A	9	11	5
Peer and Family Advocate I	N/A	N/A	N/A	96	279	187	141	196	146	146
Peer and Family Advocate II	N/A	N/A	N/A	32	0	52	35	66	66	66
Peer and Family Advocate III	N/A	N/A	N/A	N/A	0	53	31	42	48	48
Pre-Licensed Clinical Therapist, LCSW	37	50	65	92	81	105	69	223	165	152
Pre-Licensed Clinical Therapist, MFT	92	82	86	109	112	128	90	375	233	201
Pre-Licensed Clinical Therapist, Psychology	27	22	21	23	21	20	43	50	43	50
Pre-Licensed Clinical Therapist, LPCC	N/A	N/A	N/A	N/A	14	2	17	49	31	39
Program Manager I	75	N/A	N/A	38	N/A	20	38	38	64	13
Program Manager II	6	11	8	6	N/A	6	18	16	31	5
Psychiatric Technician I	N/A	43	54	66	59	N/A	46	106	94	24
Psychiatrist	N/A	N/A	N/A	1	6	9	8	5	16	14
Research and Planning Psychologist	N/A	N/A	N/A	3	N/A	N/A	N/A	N/A	1	2

As seen in the **Table 1** (to the left), the WET program has received an increase in applications for licensed positions in Fiscal Year 2017/18. As a result of the department's year round recruitment, there was a significant increase in the number of qualified applicants for Clinic Assistants, Mental Health Specialists, Pre-Licensed Clinical Therapists, Licensed Clinical Social Workers, Licensed Marriage and Family Therapists, and Psychiatric Technician I's.

Another program that WET oversees is the License Exam Prep Program (LEPP). LEPP was created to help pre-licensed clinicians become licensed. The table below illustrates the progress that LEPP has had to help staff obtain licensure for their discipline.

Table 2

San Bernardino County DBH WET License Exam Prep Program (LEPP) Statistics

Program	Date Materials Received	# of Participants	# of Licensed Participants	% Licensed
LEPP 1	July 2009	60	41	68%
LEPP 2	January 2011	38	24	63%
LEPP 3	January 2012	32	19	59%
LEPP 4	Fiscal Year 2013/14	18	7	39%
LEPP 5	Fiscal Year 2014/15	41	6	15%
LEPP 7	Fiscal Year 2015/16	58	10	17%
LEPP 7	Fiscal Year 2016/17	63	39	62%
LEPP 8	Fiscal Year 2017/18	45	26	58%
Totals		**355**	**172**	**48%**

As seen in **Table 2** above, for LEPP 1-8, there has been, on average, an approximate **48%** licensure rate among the participants.

DBH expects the percentage of pre-licensed to licensed clinicians to continue to increase with the benefit of LEPP.

Table 3

Through 8 Cohorts of LEPP, Prior to Implementation of Revised LEPP			
	Clinical Therapist I	**Clinical Therapist I – Psychologists**	**Total**
Licensed	55	5	60
Pre-licensed	105	6	111
Total	160	11	171
% Licensed	**34.4%**	**45.5%**	**35.1%**

*DBH has seen a slight increase of 5.4% in the percentage of licensed staff since Fiscal Year 2016/17.

With the passage of the MHSA and the creation of WET, DBH was able to consolidate and expand the Internship Program. WET coordinates all aspects of the internships and practicums placed within DBH. Currently, the Internship Program trains students who are enrolled in the following bachelor and graduate programs:

- Social Work
- Marriage and Family Therapy (MFT)
- Psychology

Depending on their discipline, interns participate in the Internship Program for **12** to **18** months. During that time, they learn to provide clinical services in a public community behavioral health setting.

In Fiscal Year 2017/18, there were a total of **38** interns in the intern program across the three disciplines. Also, the MFT program expanded to include one doctoral MFT Graduate Student intern (students of other doctoral disciplines can also apply for this internship opportunity).

The program continues to grow and receive positive feedback from participants who report that they received comprehensive training and a valuable experience during their time at DBH. It is hoped that integrating psychiatric residents into the clinical staff and supporting their understanding of the therapeutic process, as well as increasing their clinical skills, will lead to an increase in the retention and hiring of psychiatrists who complete their residency at DBH. DBH is committed to hiring applicants that were previously interns. As seen in the following table, 42% of clinical hires were DBH interns. These 10 DBH interns were hired as pre-licensed Clinicians with the department in Fiscal Year 2017/18.

Table 4

Pre-Licensed Clinicians Hired	FY 11/12	FY 12/13	FY 13/14	FY 14/15	FY 15/16	FY 16/17	FY 17/18
Total Number of Interns Hired	13	18	13	18	13	19	10
Total Number of Non-Interns Hired	11	9	16	22	33	21	14
Total # of Clinical Staff Hired	44	27	29	40	46	40	24
% of Interns Hired	**54%**	**67%**	**45%**	**45%**	**28%**	**48%**	**42%**

The Board of Supervisors created the MSW Assist Program, which later became known as the DBH Employee Educational Internship Program. This program was created to support current DBH staff in pursuing their MSW or MFT degrees, by allowing them to intern for up to 20 hours per week in a DBH program as part of their degree program requirements. The program was created to support the WET initiative of building a more skilled workforce by "growing our own" qualified staff to fulfill the identified clinical shortages within the department, in order to serve the community and offer quality services to consumers seeking services within our county. In April 2015, WET expanded the program to add Alcohol and Drug Counselor and Bachelor of Social Work as additional intern career path options, as a result of the program's popularity.

Also in FY 2017/18, the Medical Education Program, which currently offers rotations to medical students and psychiatry residents, had its first Nurse Practitioner (NP) student complete a psychiatry rotation in DBH clinics. WET foresees the number of NPs completing rotations with the department increasing in the future to support the growth of more Behavioral Health Nurse Practitioners in our community.

To meet the Legislative Goal, *Designate a WET Coordinator*, DBH continues to support and employ an Administrative Manager for Workforce Education and Training.

To meet the Legislative Goal of *Educate the Workforce on Incorporating the General Standards*, DBH continues to incorporate Wellness, Recovery, and the Resilience Model in trainings.

The General Standards set by the Mental Health Services Act (MHSA) are wellness, recovery and a resilience model that is culturally competent, supports the philosophy of a consumer/family driven behavioral health system, integrates services, and includes community collaboration.

Clinical Trainings	• 5150 Certification Training • Chart Documentation for Interns • Chart Documentation Series-Assessment • Chart Documentation Series-Case Management • Chart Documentation Series-Recovery Plan • Clinical Conference • Clinical Supervision • Cognitive Behavioral Therapy (CBT) and Relapse Prevention • Drug Medi-Cal Title 22 Requirements & Trafficking Victims Protection Act of 2000 • DSM-5 Training • Eating Disorders • Initial Contact Log (ICL) Training • Law & Ethics • Maternal Mental Health • Play Therapy • Residential Treatment for Those with Substance Use Disorder (SUD) • Seeking Safety • Transformation Collaborative Outcomes Management • Trauma Resiliency Model I • Treatment Planning
Non-Clinical Trainings	• Appointment Scheduler Training • Celebrating Our Cultures • Consumer Participation Survey • CPR & First Aid • Crisis Intervention Training (CIT) • CSS-DBH Collaboration • Dr. First Prescriber Training • Dr. First Prescriber Support Staff Training • Deaf Sensitivity • Diversity Film Series • Homeless Outreach and Engagement • IMPACT • Incedo-Comprehensive Training • Incedo-General Overview • Incedo-Impatient Treatment Authorization Request Forms (TARS) & General Information Training • Incedo-TARS & Letters • Integration Strategies • Introduction to Stress and Recovery • LGBTQ-Being an Active Ally • Mental Health First Aid • New Employee Orientation • Non-Violent Crisis Intervention: Initial • Non-Violent Crisis Intervention: Refresher • Objective Arts • Objective Arts-Subject Matter Expert (SME) Training • Peer Support 101 • PFA Training Series • Provider Orientation • Southern California Regional Partnership (SCRP) Interpreter Training • SEIU Memorandum of Understanding Training • Services for Children and TAY Training • Spirituality 101 • Suicide Prevention, Intervention, and Resources • Un Momento Por Favor/One Moment Please • Wellness Course: Health Eating • Wellness Course: Stress Reduction • Work Performance Evaluation Training

The table (to the left) provides additional information regarding trainings provided by WET in Fiscal Year 2017/18.

Among the trainings provided in Fiscal Year 2017/18, the following trainings are some of the trainings that incorporate the General Standards set by MHSA:

- Bridges Out of Poverty
- Celebrating Our Cultures
- Hearing Voices
- Hoarding Disorders
- Homeless Outreach and Engagement
- Mental Health First Aid
- Moral Reconation Therapy

Table 5

Fiscal Year	Attendance	Classes	CEUs	Evaluation (Avg.)
2013/14	3,095	136	989.45	4.6
2014/15	3,524	108	703	4.6
2015/16	3,867	120	391	4.6
2016/17	4,296	234	494.5	4.6
2017/18	4,477	231	281.5	4.7

Table 5 indicates that the evaluation average of the trainings in Fiscal Year 2017/18 is 4.7 out of 5. This rating reflects an increase in average trainee satisfaction for the first time in over 5 years. There was also a **4%** increase in attendance in Fiscal Year 2017/18, and WET maintained a consistent high volume of offered courses across the last two consecutive fiscal years.

In June 2018, WET was pleased to bring to DBH staff the renowned Bridges Out of Poverty training presented by Kathy Estes. The two-day training offered a unique and in depth look at the realities of economic diversity and the way poverty shapes human experiences and behaviors. The training was very successful, as evidenced by the considerable volume of positive trainee feedback.

Peer and Family Advocates (PFAs) are behavioral health consumers or family members of behavioral health consumers who provide crisis response services, peer counseling, linkages to services, and support for consumers of DBH services. They also assist with the implementation, facilitation, and on-going coordination of activities of the MHSA plan in compliance with MHSA requirements and perform related duties as required. The Peer

and Family Advocate position also fulfills the MHSA Workforce Education and Training legislative goal to Increase the Number of Clients and Family Members of Clients Employed in the Public Mental Health System.

As seen in the table below, there has been a significant increase in Peer Family Advocates (PFAs) hired in DBH over the last several years. This is largely due to increasing knowledge and evidence of the benefits resulting from the inclusion of PFAs in many DBH programs and the positive outcomes it has yielded on the consumers served by these programs. DBH strives to continue to increase the number of PFAs being hired and maintained on staff in DBH programs and hosts an open recruitment for PFA levels I, II, and III annually. The recruitment, which includes advertising on social media, flyers, and emails circulated throughout the community, and posting on Jobinsocal.com, is widely popular amongst members of the community and garners between 150 to 200 applications annually. By utilizing different outlets to advertise for the PFA positions, especially social media and word of mouth through current DBH employees, the department increases the public's knowledge of the Peer and Family Advocate position, as well as increases the number of qualified applicants applying for these vacancies each year.

Table 6

	FY 05/06	FY 06/07	FY 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12	FY 12/13	FY 13/14	FY 14/15	FY 15/16	FY 16/17	FY 17/18
Total PFAs with DBH	04	19	24	24	21	20	24	25	23	29	28	26	36

Once a PFA starts working for DBH, they are encouraged to develop professionally and promote to a higher classification. The following table shows the number of PFAs promoted since 2008.

Table 7

	FY 07/08	FY 11/12	FY 12/13	FY 13/14	FY 14/15	FY 15/16	FY 16/17	FY 17/18
PFAs promoted	3	1	1	4	3	4	3	5

The contract agencies that work with DBH are required to employ PFAs as well, although they may be given different working titles. The number of PFAs employed with DBH contract agencies continues to increase as more programs are choosing to utilize the benefits presented by incorporating peer support and advocacy into their practices. Not all contract agencies use the PFA title. A few other titles they use are:

- Family Partner
- Youth Partner
- Peer Partner
- Parent Partner
- Family Support Partner
- Parent Family Advocate

To meet the Legislative Goal, *Conduct Focused Outreach and Recruitment to Provide Equal Employment Opportunities in the Public Mental Health System for Individuals who Share Racial/Ethnic, Cultural and/or Linguistic Characteristics of Clients and Family Members*, the Volunteer Services Coordinator participates in career fairs throughout the County including remote areas such as Barstow and Morongo Basin. As illustrated in the table below, the coordinator increases the number of participants in outreach efforts every year, and this amount increased by more than 2,345 participants from Fiscal Year 2016/17 to 2017/18.

Table 8

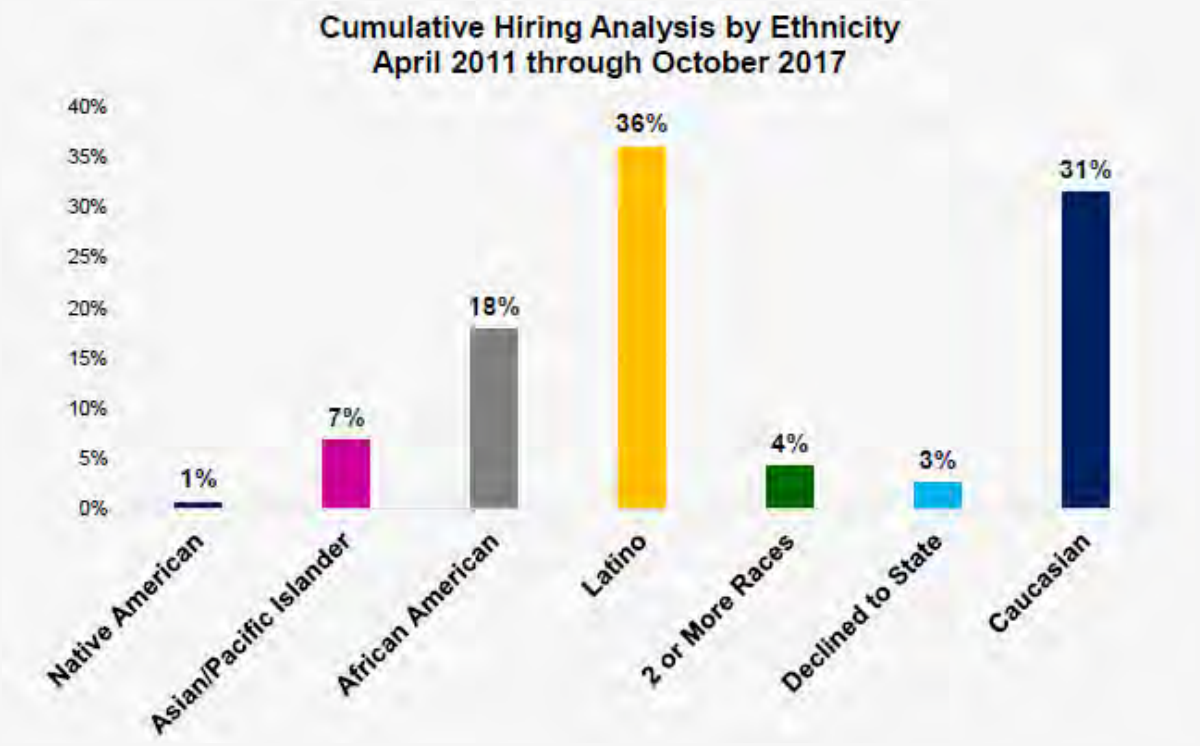
	FY 11/12	FY 12/13	FY 13/14	FY 14/15	FY 15/16	FY 16/17	FY 17/18	**Total**
Number of Schools Visited	13	16	23	35	35	70	82	**274**
Number of Participants	2,470	2,479	1,706	2,770	4,139	6,958	9,303	**29,825**

To help reach the Spanish speaking community, the coordinator has partnered with a bilingual co-presenter and translated presentations and handouts into Spanish. The co-presenter also helps to explain behavioral health career opportunities to monolingual parents that may not have a full understanding of what kind of career options are available for their children.

To meet the Legislative Goal, *Recruit, employ and support the employment of individuals in the public mental health system who are culturally and linguistically competent or, at a minimum, are educated and trained in cultural competence,* DBH strives to have staff that provide culturally and linguistically competent services to consumers. To ensure the measure is met, all staff are required to take either online or live cultural competency trainings (2 hours for non-clinicians and 4 hours for clinicians), annually.

To help ensure DBH provides culturally and linguistically competent services DBH continually recruits new employees that represent the diverse population of San Bernardino County, as can be seen in the chart below.

Chart 1



To help provide culturally and linguistically competent services to consumers, DBH actively recruits applicants who are bilingual and bicultural. As can be seen below, DBH has continued to maintain the number of bilingual staff employed in Fiscal Year 2017/18. However, it remains a top priority of the department to continue to recruit and retain bilingual staff.

Table 9

	FY 12/13	FY 13/14	FY 14/15	FY 15/16	FY 16/17	FY 17/18
Number of Bilingual Staff	150	165	162	171	171	170

The majority of bilingual staff speak Spanish, but other languages spoken by staff include:

- Tagalog
- Vietnamese
- French
- German

WET has actively recruited bilingual interns to help provide services in other languages. Since Fiscal Year 2008/09, on average **34%** of interns are bilingual. In Fiscal Year 2017/18, **32%** of interns were bilingual. Of the bilingual interns, **60%** are Spanish speakers.

Table 10

Number of Bilingual Interns	FY 08/09	FY 09/10	FY 10/11	FY 11/12	FY 12/13	FY 13/14	FY 14/15	FY 15/16	FY 16/17	FY 17/18	Total
BSW	3	3	2	0	3	3	5	2	2	4	27
MSW	5	3	9	5	5	8	6	11	7	4	63
MFT	6	3	6	2	5	1	2	8	5	2	40
Psychology	2	1	1	1	0	2	3	3	2	0	15
Total – Bilingual	16	10	18	8	13	14	16	24	16	10	145
Total Interns	39	46	41	44	47	51	43	47	39	31	428
Percentage that are bilingual	**41%**	**22%**	**44%**	**18%**	**28%**	**27%**	**37%**	**51%**	**41%**	**32%**	**34%**

Artwork by Janet Barbagello

To meet the Legislative Goal, *Provide financial incentives to recruit or retain employees within the public mental health system*, the Employee Scholarship Program (ESP) was piloted in 2013. $25,000 in funds is budgeted per year to be distributed among the awardees. The funding for ESP has been allocated to provide scholarships designed to pay student tuition (not to include books, travel, or other expenses) for employees who are working to earn a clinical or non-clinical certificate, associate or bachelor's degree, or a non-clinical master's or doctorate degree. This opportunity is expressly designed to promote the development of a strong, stable, and diverse workforce within DBH.

In Fiscal Year 2012/13, 12 ESP awardees were selected, in Fiscal Year 2013/14, 11 awardees were selected, eight in Fiscal Year 2014/15, ten in Fiscal Year 2015/16, nine in Fiscal Year 2016/17, and ten in Fiscal Year 2017/18. The table below provides a breakdown of which degrees the awardees were pursuing.

Table 11

Degrees	FY 12/13	FY 13/14	FY 14/15	FY 15/16	FY 16/17	FY 17/18
Associates	2	0	0	0	1	0
Bachelors	5	5	4	5	5	6
Masters	5	6	3	4	2	4
Certificate	0	0	1	1	1	0
Total Recipients	**12**	**11**	**8**	**10**	**9**	**10**

Additionally, **Table 12** (below) illustrates the number of ESP awardees whom have promoted to new positions.

	FY 12/13	FY 13/14	FY 14/15	FY 15/16	FY 16/17	FY 17/18
Awardees Promoted	1	2	2	0	1	3

To meet the Legislative Goal, *Incorporate the input of clients and family members of clients, and when possible utilize them as trainers and consultants in public mental health WET programs and/or activities*, the Office of Consumer and Family Affairs (OCFA) is invited to the Workforce Development Discussion (WDD) meeting, to provide input on the implementation of the MHSA WET Plan component. The meeting was previously on hold, but is set to resume in April 2019. OCFA is a Peer and Family Advocate office that provides advocacy and support to consumers and family members.

Peer and Family Advocates (PFAs) train in collaboration with the Training and Development Specialists (TDS) at WET. As part of the Crisis Intervention Training (CIT), PFAs also conduct the Shaken Tree training. The training is an award-winning documentary film tat illuminates, through a collection of stories, the journey families experience when one of its members has chronic, persistent mental illness. The film addresses their journey of pain, grief, feelings of helplessness, despair, and stigma associated with mental illness, while giving the viewer hope and ways to survive and live life fully while sharing it with someone who has a mental illness. Aftr the documentary is viewed, the PFA leads a discussion regarding the film, and connects their own experiences with mental illness as a person in recovery and/or as a family member of someone with a mental illness.

As of Fiscal Year 2014/15, the Shaken Tree training is shown in DBH New Employee Orientation in order to familiarize all new staff with the perspective of family members of consumers battling mental illness. PFAs also participated in the "Get Psyched" conference in October 2017 to encourage youth to consider careers in the behavioral health field.

To meet the Legislative Goal, *Incorporate the input of diverse racial/ethnic populations that reflect California's general population into WET programs and/or activities*, DBH uses multiple methods. DBH uses the Workforce Development Discussion (WDD) meeting and partners with the Office of Cultural Competency and Ethnic Services (OCCES) to help maximize the ability of the existing and potential workforce, contract agencies, and fee-for-service providers, to provide culturally and linguistically appropriate services to County residents by:

- Providing Cultural Competence training to all staff
- Developing policies that clarify the usage of bilingual staff for interpretation services, as well as provide guidelines on providing appropriate services for diverse cultural groups
- Providing interpreter training to all bilingual staff
- Recruiting and retaining multilingual and multicultural staff
- Working with the communities we serve to address the cultural needs of the community
- Cultural Competency Advisory Committee and thirteen **(13)** Culture-Specific Awareness Subcommittees.

OCCES also works closely with the Workforce Development Discussion (WDD) committee to ensure the needs of the diverse racial/ethnic populations of San Bernardino County are being met.

To meet the Legislative Goal, *Establish regional partnerships*, the Southern Counties Regional Partnership (SCRP) was created in 2009. SCRP is a collaborative effort between ten Southern California counties. The Partnership's goals are to coordinate regional education programs, disseminate information and strategies throughout the region, develop common training opportunities and share programs that increase diversity of the public behavioral health system workforce when those programs are more easily coordinated at a regional level. The ten member counties include:

- Kern
- Imperial
- Orange
- Riverside
- San Bernardino
- San Diego
- San Luis Obispo
- Santa Barbara
- Tri Cities
- Ventura

San Bernardino County was the fiscal agent of SCRP until June 30, 2014. Santa Barbara County assumed responsibility as the fiscal agent during Fiscal Year 2014/15. San Bernardino County continues to participate in SCRP as a member county.

To meet the Legislative Goal, *Coordinate WET programs and/or activities*, the WET staff continues to coordinate all WET programs/activities.

Workforce Education and Training (WET) continues to conduct outreach and engagement activities throughout San Bernardino County.

Outreach and Engagement

Activity Type	Number of Activity Type	Total Number of Participants
WET		
School College & Career Fairs (Elementary/ Middle/High Schools)	31	2,834
College Career Fairs	8	383
Classroom Presentations	41	5,938
Mock Interviews - Colton/Redlands/Yucaipa Regional Occupational Program	1	21
Get Pysched Seminar - Inland Coalition/Riverside County/San Bernardino County	1	82
TOTAL	**82**	**9,258**

Challenges

The Department continues to have difficulty retaining licensed clinical staff due to challenges presented by the Memorandum of Understanding (MOU) for the Professional bargaining unit. Although the new MOU has increased compensation for clinical staff, the retention challenges remain, as other employers have competitive wages and benefits. DBH continues to lose Psychiatrists to retirement or to other employers again due to competitive wages and benefits.

Solutions in Progress

The MOU last approved in July 2016 for the Profession Occupational Unit helped improve DBH's industry competitiveness. However, the department is working closely with County Human Resources to develop creative solutions to address the issue of retaining qualified licensed clinicians by implementing creative strategies to retain staff in clinical positions and working diligently through outreach efforts to increase the interest of students and community members. The department recently held a hiring fair with same day job offers to recruit staff, and there are plans to hold additional hiring fairs throughout Fiscal Year 2018/19.

Collaborative Partners

- Alder School of Professional Psychology
- American Career College
- American University of Antigua
- Argosy University
- Arrowhead Regional Medical Center (ARMC)
- Azusa Pacific University
- Brandman University
- California Baptist University
- California State University, Fullerton
- California State University, San Bernardino
- Colton-Redlands-Yucaipa Regional Occupational Program (CRY ROP)
- Inland Coalition
- Loma Linda University Medical Center (LLUMC)
- Loma Linda University School of Medicine (LLUSM)
- Pomona Valley Hospital Medical Center (PVHMC)
- Touro University College of Osteopathic Medicine (TUCOM)
- University of San Diego
- Western University of Health (WUH)

Capital Facilities and Technological Needs (CFTN)

Each County's Capital Facilities and Technological Needs Component must support the goals of the Mental Health Services Act (MHSA) and the provision of MHSA services. The planned use of the Capital Facilities and Technological Needs' funds produce long-term impacts with lasting benefits, that support the behavioral health system's movement towards the recovery, resiliency, cultural competence, a help first model, and expansion of opportunities for accessible community-based services for consumers and their families. These efforts include the development of a variety of technology uses and strategies and/or community-based facilities that support integrated service experiences that are culturally and linguistically appropriate. Funds may also be used to support an increase in:

- Peer-support and consumer-run facilities,
- Development of community-based, less restrictive settings that will reduce the need for incarceration or institutionalization, and
- The development of technological infrastructure for the public behavioral health system to facilitate high quality, cost-effective services and supports for consumers and their families.

The San Bernardino County Department of Behavioral Health (DBH) has embraced the transformational concepts inherent to MHSA to develop a wellness focused Capital Facilities and Technological Needs component that supports the public behavioral health system and infrastructure to improve the delivery of services across the county.

MHSA Legislative Goals and Related Key Outcomes

Expansion of the capacity and access of existing services or the provision of new services:

- ◊ Increased capacity
- ◊ Increased access to services
- ◊ Increased provision of new services

Increase the county mental health infrastructure on a permanent basis:

- ◊ Permanent capital asset obtained
- ◊ Modernize and transform clinical and administrative information systems to ensure quality of care, parity, operational efficiency and cost effectiveness
- ◊ Implement, maintain, and improve Electronic Health Record (EHR)
- ◊ Maintain and utilize data warehouse

Capital Facilities

Capital facility expenditures must result in a capital asset which increases the San Bernardino County Department of Behavioral Health's infrastructure on a permanent basis. Simply stated, a building or space where MHSA services can be provided.

The Crisis Residential Treatment (CRT) Program

The new Crisis Residential Treatment (CRT) facilities are modeled after DBH's previously approved Capital Facilities Project, The STAY. The CRTs will be unlocked, voluntary, short-term crisis residential programs for San Bernardino residents ages 18 to 59 specialized in providing 24-hour crisis residential treatment to individuals experiencing an acute psychiatric episode or crisis. The CRTs will provide 24-hours a day, seven days a week care.

The first of the CRTs opened on September 15, 2017. The Casa Paseo CRT is located in the City of San Bernardino at 720 Gilbert Street. The CRT contains 16 adult beds. Three additional CRTs will open in the fall of 2018.

The programs supported under the Community Services and Supports component, provide structured recovery-based, enriched treatment services and activities. Services for these facilities include, but are not limited to:

- Assessments
- Treatment plan development
- Collateral services
- Crisis intervention
- Medication support services
- Individual and group therapy
- Case management

The Crisis Stabilization Unit (CSU)

The Crisis Stabilization Units (CSUs) are voluntary and unlocked, 23-hour psychiatric urgent care centers that are open 24 hours per day, seven days a week that provide a positive, safe, quiet, and calm home-like environment. Individuals experiencing a mental health crisis can be assessed for stabilization services, including a medication evaluation, or can be assessed for hospitalization, if necessary. The CSUs provide the same services as the Crisis Walk-In Centers (CWICs). Both CSUs will have 20 spaces to serve 16 adults ages 18 and older and four adolescent spaces for individuals aged 13 to 17.

Technological Needs

The overarching goal of the technological needs portion of the Capital Facilities and Technological Needs component is to support the modernization of information systems and to increase consumer/family empowerment by providing the tools for secure access to health and wellness information. These projects will result in improvements in the quality of care, operational efficiency, coordination of care, and cost effectiveness across the Department.

Behavioral Health Management Information Systems (BHMIS) Replacement – Electronic Health Record (EHR)

DBH is in the implementation phase of a Behavioral Health Management Information System (BHMIS) that will support secure access and exchange of health information by providers. Replacement of the Department of Behavioral Health's (DBH) 25 year old information system that is used to track clients as they progress through the treatment system will consist of implementing a new integrated BHMIS that incorporates an Electronic Health Record (EHR). This will improve technological efficiencies, allowing DBH to meet modern State and Federal expectations.

The purpose of the EHR is to provide an efficient system to support better capturing of information, allowing providers to fully document care in a manner that fosters client and family interactions, enables highly functional reporting and data aggregation, as well as enhances coordination of care between internal and external providers.

Behavioral Health has entered into a contract for the implementation of a new integrated billing system and EHR solution that will be implemented in two phases. DBH began the first phase of this project through the initiation of the implementation phase of the billing system and full self-hosted hardware infrastructure in April of 2017. This includes all elements required to submit claims to the Department of Health Care Services (DHCS), Medicare, and other health insurances, and the ability to upload service and other required data to state and local systems, including but not limited to: Client and Service Information (CSI) and CalOMS (California Outcomes Measurement System) reporting. Phase I is currently working to determine when go-live can occur based on outstanding tasks.

The implementation of the second phase is a parallel process being developed simultaneously with Phase I, which will culminate to result in the implementation of the full EHR solution. This includes implementing all remaining functionality such as electronic treatment plans, assessments, progress notes, etc. The EHR includes all medical record elements required by Federal and State regulations, Medi-Cal and Medicare chart documentation requirements as well as DBH chart documentation standards.

Data Warehouse

The purpose of a data warehouse is to bring information together from different sources so services and trends can be analyzed to help improve overall service delivery. The data warehouse is a repository of information collected from a variety of data systems, including DBH's current billing system, the hospitalization tracking system, pharmacy data, and the Full Service Partnership Data Collection and Reporting (DCR) system. This data will expand to include more clinical information from the upcoming Electronic Health Record and other performance outcomes systems such as Children's Assessment of Needs and Strengths (CANS) and Adult Needs and Strengths (ANSA).

The data warehouse has been updated to allow for a more robust and efficient data analysis, focused on improving service delivery to consumers and family members. The warehouse is also prepared to accept new data, from changes to our diagnostic system, new outcome measure systems, as well as the new Electronic Health Record. These additional data elements will allow DBH to better analyze the efficiency and effectiveness of services across multiple domains.

Reports generated from data in the warehouse have helped drive evaluation of, and decision making around, program planning across the system of care and has been central to current and upcoming conversations about program development. This data also becomes useful and is necessary in the application process when the County seeks to secure additional funds for the expansion of behavioral health services.

Dr. First®

Behavioral Health identified a need to implement the electronic prescription application known as DrFirst®. This system allows physicians to send prescriptions electronically, which reduces wait times for clients at pharmacies, helps prevent prescription drug errors, and enhances safety by removing the possibility of misinterpretation of a handwritten order.

In 2017, Phase II of the e-prescribing for the DrFirst® solution was completed and the DrFirst® system was fully implemented at all DBH clinics throughout the County via a phased approach to ensure a smooth transition for consumers, clinics and staff. This approach was applied clinic by clinic over the course of a seven (7) month period, to allow for the implementation and coordination of training for providers and DBH clinic staff.

Today, the DrFirst® system is live in all 19 of the behavioral health outpatient clinics throughout the County which included seven DBH run outpatient clinics and 12 outpatient clinics administered by contracted providers. This system has the potential to add up to 60 contracted providers and an indefinite number of clinical support staff. In addition, printers at all outpatient clinics have been configured with a manual lock to secure pre-printed, prescription paper should a pharmacy not accept electronic prescriptions and/or as a backup in the event of the system cannot read the prescription electronically.

Program Updates

Capital Facilities

The Crisis Residential Treatment (CRT) Program

DBH has four Capital Facilities projects to support the expansion of crisis services. All of the projects are part of DBH's grant application to the California Health Facilities Financing Authority (CHFFA), for capital funding for the construction of Crisis Residential Treatment (CRT) facilities. Each CRT will contain 16 beds.

The Crisis Residential Treatment facilities will provide a home-like setting designed to provide an additional access point for individuals experiencing a serious psychiatric crisis. These centers serve adults aged 18-59, 24 hours a day, seven days a week.

The Desert Hill Center CRT is located at 16552 Sunhill Drive, in the city of Victorville. Construction began on January 30, 2017. Substantial construction was completed on April 3, 2018 and a Temporary Occupancy Certificate (TOC) was issued by the County of San Bernardino's Building Inspector on June 14, 2018. The CRT is expected to open Fall 2018.

The Wellspring Center CRT is located at 15217 San Bernardino Avenue, in the city of Fontana. Construction began on March 7, 2017. Substantial construction was achieved on May 4, 2018 and a Temporary Occupancy Certificate (TOC) was issued on June 14, 2018. The CRT is expected to open Fall 2018.

The Morongo Oasis Center CRT is located at 60805 29 Palms Highway, in the city of Joshua Tree. Construction began on June 19, 2017. Substantial construction was completed on April 5, 2018 and a Temporary Occupancy Certificate (TOC) was issued by the County of San Bernardino's Building Inspector on May 3, 2018. The CRT is expected to open Fall 2018.

Wellspring Center, Fontana

Crisis Stabilization Unit (CSU)

DBH has two additional Capital Facilities projects for the expansion of crisis services. All of the projects are part of DBH's grant application to the California Health Facilities Financing Authority (CHFFA), for capital funding for the construction of Crisis Stabilization Units (CSUs).

The Crisis Stabilization Unit will provide voluntary urgent care services for adults and adolescents in a safe, quiet, and calm environment where staff will seek to stabilize an individual's symptoms for safety and take the steps necessary to prepare the individual for their recovery. The CSUs will provide services 24 hours a day, seven days a week to adolescents (13-17) and adults, 18 and older.

The Windsor CSU is located in the City of San Bernardino. Construction began on March 23, 2017. Substantial construction was completed on May 22, 2018. The CRT is expected to open Fall 2018.

The Merrill CSU is located in Fontana. Construction began on March 27, 2017. Substantial construction completion was granted on April 23, 2018. The CRT is expected to open Fall 2018.

Merrill Center, Fontana

The San Bernardino County Department of Behavioral Health would like to invite you to celebrate the Grand Opening of the following Crisis Residential Treatment (CRT) and Crisis Stabilization Unit (CSU) Centers.

July 19, 2018
Windsor Center
Crisis Stabilization Unit
Thursday
2:30 - 4:30 p.m.
1481 North Windsor Drive
San Bernardino

July 23, 2018
Merrill Center
Crisis Stabilization Unit
Monday
1:00 - 3:00 p.m.
14677 Merrill Avenue
Fontana

July 31, 2018
Morongo Oasis Center
Crisis Residential Treatment
Tuesday
10:00 a.m. - 12:00 p.m.
60805 29 Palms Highway
Joshua Tree

August 6, 2018
Desert Hill Center
Crisis Residential Treatment
Monday
10:00 a.m. - 12:00 p.m.
16552 Sunhill Drive
Victorville

August 14, 2018
Wellspring Center
Crisis Residential Treatment
Tuesday
10:00 a.m. - 12:00 p.m.
15217 San Bernardino Avenue
Fontana

RSVP now by visiting http://eepurl.com/dqD_UD
For more information, call (909) 388-0801 or email Jessica Aguilar at JAguilar@dbh.sbcounty.gov

SAN BERNARDINO COUNTY | Behavioral Health

www.sbcounty.gov/dbh

Positive Results

Electronic Health Record (EHR)

- Standardization of workflow and documentation and availability of client information electronically throughout the organization will promote access by providers with current consumer information and treatment notes.
- Increased network infrastructure to support the BHMIS project
- Implemented system infrastructure hardware enhancements/upgrades in support of the BHMIS project.
- Updated and analyzed the business process to ensure that BHMIS implementation is successful.

Data Warehouse

- The use of the data warehouse has enhanced decision support in regard to quality of care, access to services, performance outcomes, and effectiveness of services.
- Performs analysis of the program outcomes to determine the impact of the MHSA three year plan. Information is used to advocate for policies affecting consumers, department and county.
- In response to changes to the diagnosis system requirements, the ICD-10-CM diagnosis system replaced the previously used diagnosis system.
- Analyze data for better coordination of care within the Children's and Family Services, Arrowhead Regional Medical Center, Department of Public Health and Transitional Assistance Department. The reports that were previously generated manually have been automated.

DrFirst®

- Successful full implementation of the system into standard business operations
- Helped prevent prescription drug errors
- Automated clinical support
- Increased medication reconciliation
- Instant notification of allergies and drug interactions
- Reduced risk of readmissions

Challenges

Some of the challenges encountered while updating the department's technology in regards to the Electronic Health Record system and the data warehouse include:

Electronic Health Record (EHR)

Sufficient staffing to assist in the migration of data currently maintained in several legacy and supporting systems where data is stored present challenges. The transfer of data from the legacy and supporting systems into the new system is also challenging due to the difference in configuration and compatibility between the two.

Retention of staff with project-based knowledge due to limited staffing and attrition continues to be a challenge.

DBH continues to face challenges meeting implementation milestones and goals due to the simultaneous changes of enhancements to the BHMIS system at the State and Federal level while the data in the new system is being configured. These changes pertain to the requirements for billing and claiming and continue to impact and affect the current business processes which continue to change and evolve while we are still in the development and implementation.

Data Warehouse

The transformation and modernization of the existing source system infrastructure which includes aging equipment and the inclusion and development of additional analytic techniques and components to account for qualitative as well as quantitative information.

The continued development, improvement, and expansion of self-serve dashboards, visual analytics, and statistics to provide real-time decision support tools for both clinical as well as managerial purposes.

The integration of future Electronic Health Records and additional clinical outcomes measures and other data sources to provide a richer data environment for outcomes measurements and information development, data governance to address continued data quality improvement, and converting existing active dashboards to Visual Analytics, allowing greater access, use and security for the sharing of data with programs.

Developing a system to report outcomes for the Pediatric System Checker (PSC-35) and Children's Assessment of Needs and Strengths (CANS).

DrFirst®

Challenges with DrFirst® include being able to keep up with staffing requirements. It has proven to be time intensive to train both existing and new staff. Staff turnover is a continuous challenge. Another barrier in utilizing DrFirst® is the time constraint felt by staff, in large part due to low and inconsistent staffing for the number of patients seen. Additional challenges include system security requirements and logistics related to day to day operations.

Solutions in Progress

Electronic Health Record (EHR)

The Behavioral Health Management Information System (BHMIS) integrated solutions infrastructure has been established. Continue to configure new BHMIS base software, data conversion testing and validation, Managed Services Organization (MSO) configuration and initiate the Data Warehouse interface. Review of business processes and workflows for incorporation into the new BHMIS. Staff is being trained to use the Netsmarts California Billing and Claims module, Avatar CalPM. Establishing work groups and sub-project teams across professional disciplines to foster collaborative solutions and to design efficient workflows to be incorporated into the BHMIS.

Data Warehouse

The older servers that the data warehouse runs on have also started to be incrementally replaced as they are older models that have reached their life expectancy. This has allowed for the smooth transition to replace the older servers while still having the Data Warehouse available for use.

Mapping and programming has begun for continuity to bring data to the new Behavioral Health Management Information Systems (BHMIS) to the Data Warehouse providing compatibility of data between the old system and the new system.

DrFirst®

The department has continued the refinement of the implementation of the e-prescribing, Dr. First®, system. Staff training is being conducted for newly hired medical staff and cross-training of support staff required to address staff turnover of this new application and process has continued.

Program Updates

Electronic Health Record (EHR)

The new BHMIS system will incorporate an Electronic Health Record (EHR) making this system more effective and efficient in the delivery and analysis of services and will be current with Federal and State regulations and expectations. The department is currently simultaneously implementing Phase I and Phase II of the project.

Data Warehouse

The Data Warehouse has been used to respond to various aspects of the special terms and conditions related to the 1115 Waiver Medi-Cal Program (Medi-Cal 2020), including mapping time and distances for Medi-Cal clients to evaluate contract performance, expanding and modifying the existing children's program report called the Specialized Programs Report for Outcomes Utilization and Treatment (SPROUT) to cover and fit screenings implemented at DBH mental health clinics, the development of contract monitoring tools to provide early warning when service levels are not being met or are being exceeded, and automating and streamlining the processing of shared data for continued care reform. The program was expanded to now include adults and older adults.

Information Technology

The development of the programming and analytics for matching and scoring of potential enrollees in the County's Whole Person care project, which is a demonstration project under California's 1115 Waiver Medi-Cal program, continues to be an application in process to assist in the identification, engagement, navigation and coordination of care for county residents who meet criteria for having multiple, chronic conditions (physical and behavioral), as well as those who are homeless or are at-risk of homelessness.

Dr. First®

The Dr. First® system was successfully implemented into the standard business operations.

Collaborative Partners

- San Bernardino County, County Administrative Office (CAO)
- San Bernardino County, Arrowhead Regional Medical Center (ARMC)
- San Bernardino County, Children and Family Services (CFS)
- San Bernardino County, County Counsel
- San Bernardino County, DBH, contracted service providers and vendors
- San Bernardino County, Human Services (HS)
- San Bernardino County, Information Services Department (ISD)
- San Bernardino County, Information, Technology and Support Division (ITSD)
- San Bernardino County, Public Health (DPH)
- San Bernardino County, Purchasing
- San Bernardino County, Sheriff's Department
- Environmental System Research Institute (Esri)
- Inland Empire Health Plan (IEHP)
- Molina Health Care (MHC)
- Statistical Analysis System (SAS)

Ribbon Cutting at Desert Hill Center's CRT Grand Opening

Artwork by Unknown

Fiscal

Funding Summary
County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Annual Update FY 2019/2020

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2019/20 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	$ 49,552,304	$ 10,549,051	$ 9,805,433	$ 462,442	$ 5,590,699	
2. Estimated New FY 2019/20 Funding	$ 77,478,806	$ 19,348,269	$ 5,090,240			
3. Transfer in FY 2019/20[1]	$ (8,648,023)			$ 3,998,230	$ 4,649,793	
4. Access Local Prudent Reserve in FY 2019/20						
5. Estimated Available Funding for FY 2019/20	$ 118,383,087	$ 29,897,320	$ 14,895,673	$ 4,460,672	$ 10,240,492	
B. Estimated FY 2019/20 MHSA Expenditures	$ 81,106,248	$ 21,096,774	$ 4,010,868	$ 4,460,672	$ 8,486,024	
G. Estimated FY 2019/20 Unspent Fund Balance	$ 37,276,839	$ 8,800,546	$ 10,884,805	$ 0	$ 1,754,468	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2019	$ 22,152,363
2. Contributions to the Local Prudent Reserve in FY 2019/20	$ -
3. Distributions from the Local Prudent Reserve in FY 2019/20	$ -
4. Estimated Local Prudent Reserve Balance on June 30, 2020	$ 22,152,363

Estimated Total Mental Health Expenditures FY 2019/2020
County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
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PREVENTION AND EARLY INTERVENTION

PEI State and County Programs	Estimated PEI Funding					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Access and Linkage to Treatment						
1. Child and Youth Connection	$ 22,978,905	$ 1,600,649	$ 6,769,345		$ 7,950,361	$ 6,658,550
Outreach for Recognition of Early Signs of Mental Illness						
1. Community Health Workers / Promotores de Salud	$ 1,150,000	$ 1,150,000				
Sigma and Discrimination Reduction						
1. Native American Resource Center	$ 500,000	$ 500,000				
Prevention						
1. Coalition Against Sexual Exploitation	$ 506,366	$ 506,366				
2. Lift - Home Nurse Visitation Program	$ 396,000	$ 396,000				
3. Older Adult Community Services	$ 1,088,306	$ 1,088,306				
4. Preschool PEI Program	$ 425,000	$ 425,000				
5. Resilience Promotion in African American Children	$ 972,477	$ 972,477				
Prevention and Early Intervention						
1. Community Wholeness and Enrichment	$ 1,498,102	$ 1,498,102				
2. Family Resource Centers	$ 3,350,000	$ 3,350,000				
3. Military Services and Family Support	$ 725,000	$ 725,000				
4. Student Assistance Program	$ 4,997,676	$ 3,650,131	$ 1,347,545			
PEI Programs	**$ 38,587,832**	**$ 15,862,031**	**$ 8,116,890**	**$ -**	**$ 7,950,361**	**$ 6,658,550**
PEI Administration	**$ 5,376,066**	$ 4,623,417	$ 752,649			
National Crossroads Training Institute Crossroads Education Licensing and Reproduction Costs	**$ 49,432**	$ 49,432				
PEI Assigned Funds	**$ 561,894**	$ 561,894				
Total PEI Program Estimated Expenditures	**$ 44,575,224**	**$ 21,096,774**	**$ 8,869,539**	**$ -**	**$ 7,950,361**	**$ 6,658,550**

Estimated Cost Per Client Fiscal Year 2019/2020
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PREVENTION AND EARLY INTERVENTION

Program Name		Abbreviation	Estimated Total Mental Health Expenditures	Estimated Clients Served by Age Group				Estimated Number of Clients	Estimated Cost Per Client
				Children/ Youth (0-15)	TAY (16-25)	Adult (26-59)	Older Adult (60+)		
PEI SI-1	Student Assistance Program	SAP	$ 4,997,676	21,250	2,750	3,500		27,500	$ 182
PEI SI-2	Preschool PEI Program	PPP	$ 425,000	924	42	542		1,508	$ 282
PEI SI-3	Resilience Promotion in African American Children	RPIAAC	$ 972,477	2,400	500	1,000		3,900	$ 249
PEI CI-1	Promotores de Salud	PdS	$ 1,150,000	650	2,300	25,680	1,900	30,530	$ 38
PEI CI-2	Family Resource Centers	FRC	$ 3,350,000	7,000	4,000	13,245	2,700	26,945	$ 124
PEI-CI-3	Native American Resource Center	NARC	$ 500,000	542	509	538	162	1,751	$ 286
PEI SE-1	Older Adult Community Services	OACS	$ 1,088,306				6,339	6,339	$ 172
PEI SE-2	Child and Youth Connection	CYC	$ 22,978,905	6,992	552	1,656		9,200	$ 2,498
PEI SE-3	Community Wholeness and Enrichment	CWE	$ 1,498,102		1,013	2,990		4,003	$ 374
PEI SE-4	Military Services and Family Support	MSFS	$ 725,000	84	113	812	73	1,082	$ 670
PEI SE-5	Lift - Home Nurse Visitation Program	Lift	$ 396,000	60	30	30		120	$ 3,300
PEI SE-6	Coalition Against Sexual Exploitation	CASE	$ 506,366	10	75	3,000		3,085	$ 164
Total Program Costs			$ 38,587,832					115,963	$ 333
PEI Administration			$ 5,376,066						
National Crossroads Training Institute Crossroads Education Licensing and Reproduction Costs			$ 49,432						
PEI Assigned Funds			$ 561,894						
PEI Total			$ 44,575,224						

Total clients served = 115,953 or $333 per person

Estimated Total Mental Health Expenditures FY 2019/2020
County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
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COMMUNITY SERVICES AND SUPPORTS (CSS) FUNDING

		Estimated CSS Funding					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs							
1. C-1	Comprehensive Child and Family Support System	$ 36,231,275	$ 7,469,101	$ 17,834,026		$ 10,428,148	$ 500,000
2. C-2	Integrated New Family Opportunity Program	$ 1,651,552	$ 1,367,464	$ 108,331		$ 175,757	
3. TAY-1	TAY One Stop Center	$ 10,156,996	$ 4,719,138	$ 4,461,801		$ 905,554	$ 70,503
4. A-2	Forensic Integrated Mental Health Services	$ 8,270,341	$ 4,498,468	$ 3,139,722		$ 29,117	$ 603,034
5. A-3	Forensics Continuum of Care	$ 9,259,260	$ 2,791,667	$ 6,411,524			$ 56,069
6. A-7	Homeless Assistance Resources and Support Program	$ 7,858,556	$ 6,747,631	$ 613,574			$ 497,351
7. OA-1	Age Wise (Older Adult Case Management)	$ 5,752,081	$ 2,809,453	$ 2,942,628			
8. A-11	Regional Adult	$ 8,183,478	$ 6,167,978	$ 1,990,940		$ 24,560	
Non-FSP Programs							
1. A-1	Clubhouse	$ 3,921,025	$ 3,921,025				
2. A-4	Crisis Walk-In Center/Crisis Stabilization Unit	$ 19,658,677	$ 9,401,015	$ 8,842,132		$ 1,088,441	$ 327,089
3. A-5	Triage Transitional Services (TTS)	$ 5,785,505	$ 3,694,674	$ 1,777,267		$ 88,681	$ 224,883
4. A-6	Community Crisis Response Team	$ 11,238,728	$ 3,978,549	$ 4,277,640		$ 2,920,456	$ 62,083
5. OA-2	Age Wise (Circle of Care Mobile Outreach)	$ 575,303	$ 399,442	$ 167,064			$ 8,797
6. A-9	Assessment, Coordination & Enhancement	$ 3,577,828	$ 1,310,284	$ 2,267,544			
7. A-10	Crisis Residential Treatment Program	$ 10,397,326	$ 4,830,801	$ 4,567,374		$ 926,980	$ 72,171
8. A-12	Whole Person Care	$ 1,100,000	$ 1,100,000				
9.	Housing Authority MOU/Housing Consultant (ECD-MOU)	$ 1,177,171	$ 1,177,171				
10.	Recovery Based Engagement Support Teams (RBEST)	$ 1,285,047	$ 1,285,047				
	CSS Programs	$ 146,080,149	$ 67,668,908	$ 59,401,567	$ -	$ 16,587,694	$ 2,421,980
	CSS Administration	$ 15,683,701	$ 13,437,340	$ 959,906			$ 1,286,455
	CSS MHSA Housing Program Assigned Funds	$ -					
	Total CSS Program Estimated Expenditures	$ 161,763,850	$ 81,106,248	$ 60,361,473	$ -	$ 16,587,694	$ 3,708,435
	FSP Programs as Percent of Total	54.0%					

Estimated Cost Per Client Fiscal Year 2019/2020
County of San Bernardino
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COMMUNITY SERVICES AND SUPPORTS

Program Name		Abbreviation	Estimated Total Mental Health Expenditures	Estimated Clients Served by Age Group				Estimated Number of Clients	Estimated Cost Per Client
				Children/Youth (0-15)	TAY (16-25)	Adult (26-59)	Older Adult (60+)		
A-1	Clubhouse Expansion Program		$ 3,921,025			19,060		19,060	$ 206
A-2	Adult Criminal Justice Continuum of Care	STAR/CSTAR FACT/CFACT HDMC	$ 8,270,341			240		240	$ 34,460
A-3	Members Assertive Positive Solutions/Assertive Community Treatment	MAPS ACT	$ 9,259,260			221		221	$ 41,897
A-4	Crisis Walk-in Centers / Crisis Stabilization Unit	CWIC / CSU	$ 19,658,677	677	1,774	5,445	258	8,154	$ 2,411
A-5	Triage Transitional Services	TTS	$ 5,785,505	285	946	2,950	709	4,890	$ 1,183
A-6	Community Crisis Response Team	CCRT	$ 11,238,728	3,391	1,456	4,456	696	10,399	$ 1,081
	Crisis Intervention Training	CIT				360	40		
A-7	Homeless Assistance Resources and Treatment	HART	$ 7,858,556		8	522	49	579	$ 13,573
A-9	Access, Coordination and Enhancement of Quality Behavioral Health Services	ACE	$ 3,577,828	191	271	1,034	111	1,607	$ 2,226
A-10	Crisis Residential Treatment Program	CRT	$ 10,397,326		158	1,359		1,517	$ 6,854
A-11	Regional Adult Full Service Partnership	RAFSP	$ 8,183,478		14	1,011	15	1,040	$ 7,869
A-12	Whole Person Care	WPC	$ 1,100,000			580		580	$ 1,897
C-1	Comprehensive Children and Family Support Services	CCFSS	$ 36,231,275	2,050	525	30		2,605	$ 13,908
C-2	Integrated New Family Opportunities	INFO	$ 1,651,552	66	134	45		245	$ 6,741
OA-1	Age Wise I: Circle of Care		$ 5,752,081				240	240	$ 23,967
OA-2	Age Wise II: Mobile Outreach and Intensive Care Program		$ 575,303				150	150	$ 3,835
TAY-1	One Stop Transitional Age Youth Centers	TAY	$ 10,156,996		6,158			6,158	$ 1,649
	Recovery Based Engagement Support Team	RBEST	$ 1,285,047			225		225	$ 5,711
		Total Program Costs	$ 144,902,978					57,910	$ 2,502
		CSS Administration	$ 16,860,872						
		CSS Total	$ 161,763,850						

Total clients served = 57,895 or $2,503 per person

Estimated Total Mental Health Expenditures FY 2019/2020
County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
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INNOVATION (INN) FUNDING

	Estimated Innovation Funding					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Recovery Based Engagement Support Teams	$ 642,524	$ 642,524				
2. Innovative Remote Onsite Assistance Delivery	$ 2,518,253	$ 2,518,253				
INN Programs	$ 3,160,777	$ 3,160,777	$ -	$ -	$ -	$ -
INN Administration	$ 850,091	$ 850,091		$ -		
Total INN Program Estimated Expenditures	$ 4,010,868	$ 4,010,868	$ -	$ -	$ -	$ -

Estimated Cost Per Client Fiscal Year 2019/2020
County of San Bernardino
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INNOVATION

Program Name	Abbreviation	Estimated Total Mental Health Expenditures	Estimated Clients Served by Age Group				Estimated Number of Clients	Estimated Cost Per Client
			Children/Youth	TAY	Adult	Older Adult		
			(0-15)	(16-25)	(26-59)	(60+)		
Innovative Remote Onsite Assistance Delivery	InnROADS	$ 2,518,253		25	193	62	280	$ 15,449
Recovery Based Engagement Support Teams	RBEST	$ 642,524			75		75	$ 8,567
Total Program Costs		$ 3,160,777					355	$ 8,904
INN Administration		$ 850,091						
INN Total		$ 4,010,868						

Total clients served = 355 or $8,904 per person

Estimated Total Mental Health Expenditures FY 2019/2020
County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Annual Update FY 2019/2020

Workforce, Education and Training (WET) FUNDING

	Estimated Workforce, Education, and Training Funding					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Workforce Staffing and Support	$ 1,609,176	$ 1,609,176				
2. Training and Technical Support	$ 326,675	$ 326,675				
3. Leadership Development	$ 35,000	$ 35,000				
4. Internship Program	$ 1,139,382	$ 1,139,382				
5. Psychiatric Residency Program	$ 1,209,084	$ 1,209,084				
6. Financial Incentive Program	$ 49,200	$ 49,200				
WET Programs	$ 4,368,517	$ 4,368,517	$ -	$ -	$ -	$ -
WET Administration	$ 92,155	$ 92,155		$ -	$ -	$ -
Total WET Program Estimated Expenditures	$ 4,460,672	$ 4,460,672	$ -	$ -	$ -	$ -

Estimated Total Mental Health Expenditures FY 2019/2020
County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Annual Update FY 2019/2020

Capital Facilities/Technological Needs (CFTN) FUNDING

	Estimated Capital Facilities/Technological Needs Funding					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Remaining CHFFA Cost	$ 1,055,956	$ 1,055,956				
	$ -					
	$ -					
	$ -					
CFTN Programs - Technological Needs Projects	$ -					
1. Data Warehouse Continuation Project						
Empowered Communication/SharePoint Project	$ 1,094,794	$ 1,094,794				
2. Techology Empowered Communication/Sharepoint (ECM)	$ 8,250	$ 8,250				
3. Electronic Health Record Project	$ 1,308,456	$ 1,308,456				
4. BHMIS Replacement Project	$ 2,975,398	$ 2,975,398				
	$ -					
CFTN Programs	$ 6,442,854	$ 6,442,854	$ -	$ -	$ -	$ -
CFTN Administration	$ 2,043,170	$ 2,043,170				
Total CFTN Program Estimated Expenditures	$ 8,486,024	$ 8,486,024	$ -	$ -	$ -	$ -

REPORT/RECOMMENDATION TO THE BOARD OF SUPERVISORS OF SAN BERNARDINO COUNTY, CALIFORNIA AND RECORD OF ACTION

MAY 21, 2019

FROM: **VERONICA KELLEY, Director**
Department of Behavioral Health

SUBJECT: **MENTAL HEALTH SERVICES ACT ANNUAL UPDATE 2019-20**

RECOMMENDATION(S)

1. Approve the Mental Health Services Act Annual Update 2019-20, including a decrease in MHSA expenditures of $10,689,957 from $129,850,543 to $119,160,586, for the period of July 1, 2019 through June 30, 2020.
2. Authorize the Director of the Department of Behavioral Health, as the County Mental Health Director, to sign the Mental Health Services Act County Compliance Certification annual update form, as required by the California Department of Health Care Services, for the Mental Health Services Act Annual Update 2019-20, on behalf of the County.
3. Authorize the Director of the Department of Behavioral Health, as the County Mental Health Director, and the Auditor-Controller/Treasurer/Tax Collector to sign the Mental Health Services Act County Fiscal Accountability Certification annual update form, as required by the California Department of Health Care Services, for the Mental Health Services Act Annual Update 2019-20, on behalf of the County.
4. Authorize the Director of the Department of Behavioral Health, as the County Mental Health Director, to sign the Mental Health Services Act County Prudent Reserve Assessment/Reassessment Certification form, as required by the California Department of Health Care Services, for the Mental Health Services Act Annual Update 2019-20, on behalf of the County.
5. Authorize the Director of the Department of Behavioral Health, as the County Mental Health Director, to execute and submit the Mental Health Services Act Annual Update 2019-20 documents and any subsequent non-substantive amendments necessary, as required by the California Department of Health Care Services, to the State of California Department of Health Care Services, Mental Health Services Oversight and Accountability Commission, on behalf of the County, subject to review by County Counsel.
6. Direct the Director of the Department of Behavioral Health, as the County Mental Health Director, to transmit all documents and amendments in relation to the Mental Health Services Act Annual Update 2019-20, to the Clerk of the Board of Supervisors within 30 days of execution.

(Presenter: Veronica Kelley, Director, 388-0801)

cc: DBH- Kelley
DBH- Kessee
CAO- Lange
File – Behavioral Health w/attachments
vh 6/3/19

ITEM 31

Record of Action of the Board of Supervisors

APPROVED (CONSENT CALENDAR)
COUNTY OF SAN BERNARDINO
Board of Supervisors

MOTION	MOVE	ABSENT	SECOND	AYE	ABSENT
	1	2	3	4	5

LAURA H. WELCH, CLERK OF THE BOARD

BY _____

DATED: May 21, 2019

COUNTY AND CHIEF EXECUTIVE OFFICER GOALS AND OBJECTIVES
Operate in a Fiscally-Responsible and Business-Like Manner.
Provide for the Safety, Health and Social Service Needs of County Residents.
Pursue County Goals and Objectives by Working with Other Agencies.

FINANCIAL IMPACT
This item does not impact Discretionary General Funding (Net County Cost). The submission and approval of the Mental Health Services Act (MHSA) Annual Update (Plan Update) to the California Department of Health Care Services (DHCS), Mental Health Services Oversight and Accountability Commission (MHSOAC) is required by the State in order to expend State funds for the upcoming program year. The Plan will not exceed $119,160,586 in 2019-20 for MHSA program services and will be funded 100% by MHSA funding in the approximated annual amounts below.

MHSA Component	MHSA Expenditures for 2019-20		
	Current Amount	Recommended Increase / Decrease	Total Recommended Amount
Community Services and Supports	$96,618,938	($15,512,690)	$81,106,248
Prevention and Early Intervention	$19,260,107	$1,836,667	$21,096,774
Innovation	$1,010,970	$2,999,898	$4,010,868
Workforce Education and Training	$4,434,665	$26,007	$4,460,672
Capital Facilities and Technological Needs	$8,525,863	($39,839)	$8,486,024
Total	**$129,850,543**	**($10,689,957)**	**$119,160,586**

Adequate appropriation and revenue will be included in the Department of Behavioral Health's (DBH) 2019-20 recommended budget.

BACKGROUND INFORMATION
DBH developed the MHSA Plan Update according to the guidelines provided by MHSOAC, including following the stakeholder process in Welfare and Institutions Code (WIC 5848) and California Code of Regulations Title 9, Division 1, Chapter 14, Section 3300, 3315, and 3320, which included a 30-day public review and comment period from February 20, 2019 through March 22, 2019 and a public hearing held by the County of San Bernardino Behavioral Health Commission on April 4, 2019.

MHSOAC has directed the DBH Director, as the County Mental Health Director and responsible for the administration of the County's mental health services, to execute and submit the Annual Plan Update to MHSOAC within 30 days of adoption by the Board of Supervisors (Board). The MHSOAC maintains evaluation responsibilities over all MHSA components and maintains approval authority over the Innovation (INN) component only. After approval by the Board and

Plan submission to the MHSOAC, MHSA program services and operations will proceed with implementation. An MHSA Three-Year Integrated Program and Expenditure Plan (Three Year Plan) or an annual update to the Three Year Plan is submitted each year to report evaluation outcomes and any required changes.

The Plan Update provides an overview of the programs supported through the MHSA that make up DBH's continuum of services and highlights trends, program goals, and outcomes, providing a roadmap to this comprehensive system of care. The emphasis of the Plan is to link MHSA components, programs, and funding with Medi-Cal and other behavioral health programs to create an integrated service experience for County residents.

In 2004, California voters passed Proposition 63, which established a state personal income tax surcharge of one percent on the portion of taxpayers' annual taxable income that exceeds $1 million. Since 2005, MHSA (also known as Proposition 63) has provided funding to the County for services and resources that promote wellness, recovery, and resiliency for adults and older adults with serious mental illness and for children and youth with serious emotional disturbances and their family members. The WIC Section 5847 states that DBH must submit a Board approved MHSA Three-Year Program and Expenditure Plan and annual updates.

The Plan consists of six MHSA components including: Community Program Planning (CPP), Prevention and Early Intervention (PEI), Community Services and Supports (CSS), Innovation (INN), Workforce Education and Training (WET), and Capital Facilities and Technological Needs (CFTN).

- The CPP is not a specific "programmatic component", but rather includes countywide stakeholder input and involvement in the planning, implementation, evaluation, and improvement of all MHSA components.
- The PEI component is intended to reduce risk factors, increase protective factors, and intervene early in the progression of an illness.
- The CSS component contributes to the ongoing transformation of the public mental health system by: augmenting existing services; establishing a system of care for crisis services; developing programming to address the needs of transitional age youth; developing supportive housing and maximizing MHSA funds for housing opportunities; and enhancing and expanding wraparound services to children, youth, and adults.
- INN projects are unique, as they are intended to contribute to learning and test the implementation of novel, creative, ingenious mental health approaches expected to contribute to learning for integration into the mental health system. All INN projects are time-limited and part of rigorous evaluation process, which can include transitioning INN activities into other funded programs or ending activities depending on lessons learned.
- The WET component is intended to develop and maintain an appropriately educated and culturally competent workforce.
- The CFTN component provides funding to purchase or rehabilitate County-owned buildings that will be utilized in the provision of behavioral health services, such as the construction of Crisis Residential Treatment centers, and to support the implementation of

new electronic and technological enhancements such as the new Electronic Health Record system.

On June 13, 2017 (Item No. 19), the Board approved DBH's MHSA Three-Year Integrated Plan for 2017-18 through 2019-20 in the amount of $394,902,861, for the period of July 1, 2017 through June 30, 2020.

On June 12, 2018 (Item No. 23), the Board approved DBH's MHSA Annual Plan Update for 2018-19, including an increase in expenditures of $11,049,077, from $118,801,466 to $129,850,543, for the period of July 1, 2018 through June 30, 2019.

The recommended decrease of $10,689,957 in MHSA expenditures for 2019-20 will decrease the total amount of MHSA funds expended from $405,951,938 to $395,261,981 for the total period of July 1, 2017 through June 30, 2020. The adjustments in expenditures are the result of maximizing leveraged funds such as Medi-Cal and grants. While utilization of MHSA funds will decrease, the overall Plan represents an expansion of crisis services, expansion of services for school-aged children and youth, and a new approach to homeless services.

Program changes identified through stakeholder input include continued support for crisis services, additional supportive housing opportunities, enhanced programming for individuals living with mental illness and experiencing homelessness, and the implementation of targeted community forums to discuss identified needs as well as the implementation of programs. Component updates include expanded PEI outcome reporting based on new requirements, changes to program names, expansion of crisis stabilization and crisis residential services, and completion of building of crisis service facilities.

In accordance with WIC Section 5848, a public hearing was held on April 4, 2019 by the San Bernardino County Behavioral Health Commission, and no substantive recommendations or changes to the Plan Update were suggested. Non-substantive text edits were identified and updated during the stakeholder process.

DHCS has the responsibility of releasing the fully executed State Agreement to the County, and MHSOAC continues to provide DBH with direction on the preparation and submission of the MHSA Three-Year Integrated Program and Expenditure Plan and annual updates. Items requiring Board approval, such as acceptance of funding, or requests for changes in departmental appropriation or staffing will continue to be presented to the Board.

PROCUREMENT
Not applicable.

REVIEW BY OTHERS
This item has been reviewed by Behavioral Health Contracts (Natalie Kessee, Contracts Manager, 388-0869) on April 22, 2019; County Counsel (Dawn Martin, Deputy County Counsel, 387-5455) on April 24, 2019; Finance (Christopher Lange, Administrative Analyst, 386-8393) on

May 6, 2019; and County Finance and Administration (Tanya Bratton, Deputy Executive Officer, 388-0332) on May 6, 2019.