Program Description and Target Population

Clubhouses are peer-driven support centers for adults aged 18 and over in recovery. Clubhouses provide peer-run programs using a Recovery, Wellness, and Resilience model in a stigma free environment for adults, referred to as members, managing their behavioral health. Members do not need to be receiving clinical services in order to attend the program.

There are currently nine clubhouses located throughout the county that are dedicated to enhancing and supporting recovery. The Clubhouses are located in the cities of Barstow, Fontana, Lucerne Valley, Yucca Valley, Ontario, Rialto, San Bernardino, Victorville, and Needles.

The main objectives of the Clubhouse program are to assist members in making their own choices, provide peer support, and connect with the community as contributing members, thereby achieving a fulfilling life in alignment with their personal recovery goals. Clubhouses also serve as an important access point for building community and re-building daily living skills for individuals who are unhoused or recently housed.

Clubhouses are operated by the members through peer-elected governing boards. In an effort to increase overall independence and community connection, members meet regularly and are encouraged to provide input to programing and operations choices.

Demographics

Age

0% Children
0% TAY
100% Adult
0% Older Adult

N=3,010

Gender Identity

58% Male
39% Female
3% Other

Race/Ethnicity

18% African American/Black
2% Asian/Pacific Islander
39% Caucasian/White
32% Latinx/Hispanic
3% American Indian/ Alaska Native
6% Other

N=2,915

Note: Ages served are 18 and older. Current data collection does not differentiate between age categories. Future metrics will be implemented to better breakdown age demographics. This number does not include Outreach & Engagement data.

Program Description and Target Population, cont.

Members plan and facilitate daily activities and determine workshop topics. Clubhouses also sponsor social and recreational activities, both on-site and in the community, which increases the members' ability to interact and develop skills that improve their relationships in the community and with each other. In addition, the program provides transportation to stakeholder meetings, as well as virtual options, to ensure the consumer's feedback is being captured in the stakeholder process.

The Community Connection program provides participants with the opportunity to develop and improve pre-employment skills. The program also assists with coordinating opportunities for members to volunteer, gain paid employment experience, and engage in peer support while keeping the goal of contributing to the community in mind.

Participants partner with staff to determine the area of focus that most suits their wellness goals. Participants build on existing strengths and work in conjunction with Employment Specialists, Social Workers, Mental Health Specialists, Peer and Family Advocates, and their peers to provide the necessary skills and supports needed to secure a paid or volunteer position as they move towards self-efficacy and self-sufficiency as part of their path towards recovery.

The Peer Provider Workforce Support Program coordinates, monitors, and develops DBH's internal supports for peer providers. The designated position Peer and Family Advocate (PFA) is a growing provider type, and a dedicated support structure was put in place based on internal stakeholder feedback.

Demographics

Primary Language

94% English
4% Spanish
2% Other

N=3,010

Region

25% Central Valley
46% Desert/Mountain
17% East Valley
12% West Valley
<1% Decline to provide

Note: not all numbers add to 100 due to rounding. Number does not include Outreach & Engagement data.

Program Description and Target Population, cont.

This unit monitors the certification and ongoing renewal of Medi-Cal Peer Support Certification for all peer providers, identifies and develops system supports, and works with the PFAs and their supervisors to monitor and improve ongoing implementation efforts. PFA Engagement Meetings, Supervisor Collaboration Meetings, and ongoing trainings to meet the continuing education requirements for certification are currently in the design and implementation phase. Currently, 18 of the 40 filled PFA positions have received certification, and an additional 16 are in process.

Additionally, this unit coordinates DBH efforts to reduce the vacancy rate of this position and has already implemented a continuous recruitment strategy, standardized classification, and is actively engaged in communication with Human Resources to implement other equity measures.

> "I don't think I would have survived the last year without you guys!"
>
> - Clubhouse Member

Services Offered

Services provided through the Clubhouse and Community Connections program include:

- System navigation assistance
- Supportive group meetings
- Social activities
- Life skills classes
- Physical health classes
- Job skills classes
- Nutrition classes
- Cooking demonstrations
- Clothing closet
- Food distribution
- Laundry machine access
- Showers (at select Clubhouses)
- Volunteer opportunities
- Transportation to stakeholder meetings
- Technical support for virtual platforms
- Education
- Career assessment
- Employment counseling
- Job coaching
- Linkage to other community supports

Positive Results

In FY 2023/24, Clubhouses averaged over 77 groups per site per month, with an average of nine members per group. Additionally, Clubhouses served an average of 268 unhoused members per month for a 22% increase for a second year in a row. Sites averaged 1,448 service deliveries per month for a 28% increase compared to the previous fiscal year.

The Community Connections program served 327 participants in FY 2023/24 with 46 successful connections to sustained paid employment, and 80 individuals received resume assistance.

Both Clubhouse and Community Connections continue to utilize the "Consumer Empowerment Evaluation" consumer-created outcomes metrics tool created in FY 2021/22. This was created in partnership with the Consumer Evaluation Council (CEC) and Research and Evaluation. After researching validated evaluation tools, the CEC combined elements of a variety of evaluation measures and adapted wording to be focused on recovery model, peer led, and strengths-based outcome metrics. All metrics are self-reported to preserve the integrity of measuring subjective suffering. Two hundred fifty-five members took the evaluation with the following results for FY 2023/24.

As a result of clubhouse participation:

- 95% reported being satisfied with themselves.
- 95% reported having respect for themselves and others.
- 79% reported being hopeful about their future.
- 91% reported having goals they want to reach.
- 91% reported being able to develop positive relationships with other people.
- 88% reported being able to ask for help when needed.
- 93% reported knowing that if they keep trying they will get better.
- 95% reported being able to use positive coping skills when feeling unwell.

Positive Results, cont.

As the number of members identifying as unhoused continues to rise, Clubhouses have expanded their support services. In addition to weekly community meals, all locations offer daily meal support. Clubhouses have access to mobile jump starters for members who are living in their vehicle and encounter battery issues. Increased hygiene support including laundry soap, dryer sheets, shampoo, conditioner, oral hygiene items, deodorant, emergency clothing, condoms, etc. are available at all locations. Clubhouses also offer tarps, ponchos, sunscreen and other weather-related supports for those exposed to the elements.

Clubhouses partnered with the Office of Homeless Services to designate three locations as cooling centers when activated by the Office of Emergency Management. During activation, Clubhouses offered cooling towels, water, ice, cooling outdoor areas equipped with misters, emergency food, emergency clothing, and other supports to assist in maintaining safety in excessive heat.

Additionally, this fiscal year Clubhouses served the community through public Narcan Distribution Centers, Cooling Centers and Community Food Distribution.

Challenges/Solutions

Expanding facilities to adequately serve the growing population is a lengthy process and as a result, High Desert facilities continue to be without shower amenities or adequate space for programming. Progress has been made on the pending relocations of the Victorville, Barstow, and San Bernardino Clubhouses. Selections for the locations have been identified and construction on the San Bernardino facility is due to start this winter. The Victorville location is pending landlord negotiations, and the Barstow location is pending architect review.

Clubhouses continue to work toward addressing the expressed need for more space at several of the sites. Facilities and Project Management staff are actively working to finalize negotiations for pending relocations.

The program also faced challenges with demographic data collection, storage, and analysis due to staffing changes and technical issues. Program staff are working with Research and Evaluation (R&E) staff and MHSA administration to streamline and improve the data collection process. To ensure accuracy in future reporting, Peer Programs are working with other DBH units to ensure that program staff are trained and familiar with all aspects of the data collection, analysis, and reporting process.

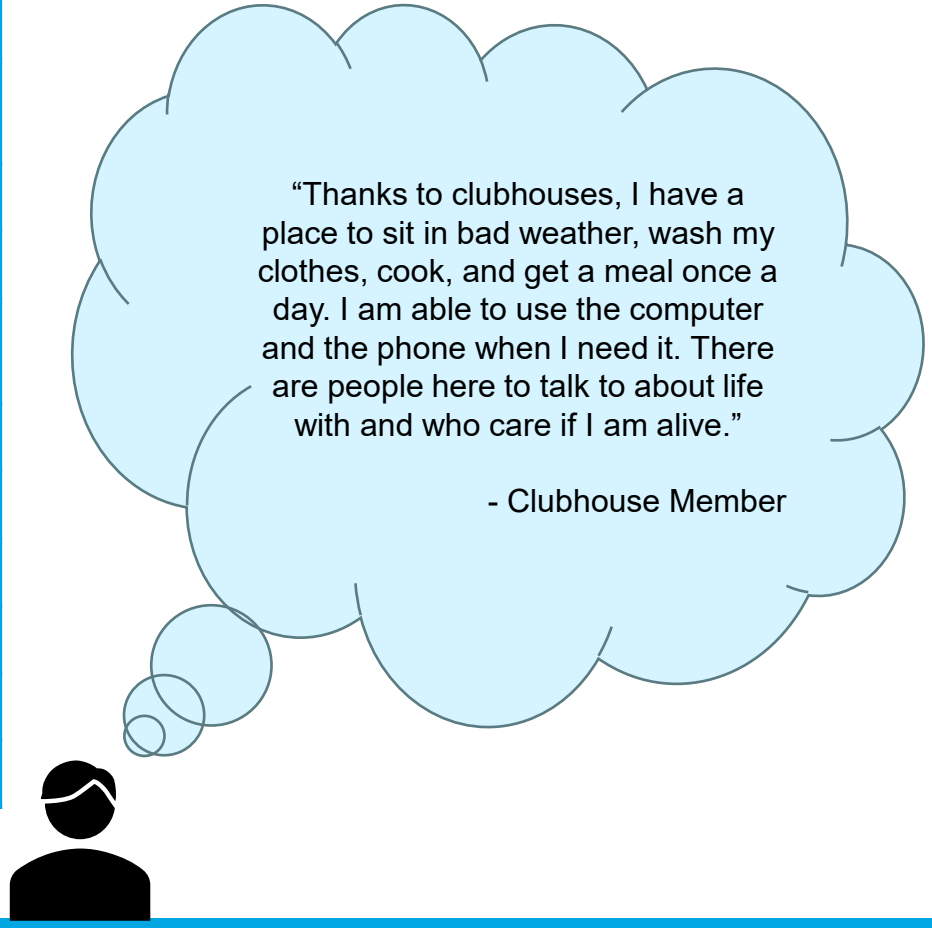
Outreach and Engagement

During FY 2023/24, Clubhouses and Community Connections conducted the following outreach and engagement activities:

Activity Type	Number of Activities	Total Number of Participants
Community Integration Excursions	60	600
Crisis Intervention Training	12	750
Cultural Celebrations	60	1,800
Behavioral Health Wellness Triathlon	3	425
NAMI Walk	1	120
Community Food Distribution	48	23,650
Consumer Evaluation Council	24	360
Unhoused Outreach	Daily	4,660
Community Connections	12	423
Totals	**208**	**32,788**

Program Updates

In FY 2023/24, expansion of the Apple Valley and Yucaipa locations was delayed. These locations are now expected to open for services in FY 2024/25. In addition, the Needles Clubhouse is now open for in-person services.



CSS: Outreach, Access, and Engagement Programs

Introduction

Outreach, Access, and Engagement programs provide linkage to mental health and other necessary services, as well as advocacy, case management services, care navigation, family education, and support. These programs also provide consumers who have been discharged from a psychiatric hospital or a walk-in clinic with referrals to regional outpatient clinics where follow up services can be scheduled.

The Outreach, Access, and Engagement programs include the **Access, Coordination, and Enhancement (ACE) of Quality Behavioral Health Services** and **Recovery Based Support Teams (RBEST)**. The ACE program provides psychiatric evaluations within seven days of a hospital discharge and within fourteen days of a walk-in clinic request. The RBEST program is a voluntary, consumer-centered program which provides community (field-based) services to individuals with untreated mental illness in an effort to encourage them to participate in appropriate treatment and services.

Target Populations

The table below identifies the target population of consumers to be served by Outreach, Access, and Engagement programs for Fiscal Year 2025/26.

Program Name	Target Population			
	Children	TAY	Adult	Older Adult
Access, Coordination, and Enhancement (ACE) of Quality Behavioral Health Services	X	X	X	X
Recovery Based Engagement Support Teams (RBEST)			X	

CSS: Outreach, Access, and Engagement Programs

Number of Consumers to be Served

The table below indicates the number of individuals projected to be served by ACE and RBEST for FY 2025/26.

Program Name	Service Area*	Total to be Served
Access, Coordination, and Enhancement (ACE) of Quality Behavioral Health Services	• 36 FSP • 2,646 GSD • 880 O&E	**3,562**
Recovery Based Engagement Support Teams (RBEST)	• 300 GSD • 700 O&E	**1,000**

*Full Service Partnership (FSP) consumers represent the number of consumers participating in FSP programs and services.

*General System Development (GSD) references consumers served in activities related to improving the County's mental health service delivery system for all consumers. Activities may or may not be provided to consumers enrolled in an FSP.

*Outreach and Engagement (O&E) references the number of consumers served while educating the community about the mental health services offered and linking consumers to the appropriate services.

Artwork by Alcira Mendoza

Access, Coordination, and Enhancement (ACE) of Quality Behavioral Health Services

Program Name	Actual Number Served FY 2023/24	Estimated Number to be Served FY 2025/26	Annual Budgeted Funds FY 2025/26	Estimated Annual Cost per Person FY 2025/26
ACE	2,086	3,562	$1,724,506	$484

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
All ages	SMI*	Clinic based 	Experiencing a behavioral health crisis

*SMI = serious mental illness

Program Description and Target Population

The Access, Coordination, and Enhancement (ACE) for Quality Behavioral Health Services program seeks to improve the timeliness of access to the Department of Behavioral Health (DBH) outpatient services. The ACE program enhances the outpatient care system to ensure that consumers receive the appropriate services to meet their needs.

The ACE program is implemented at the four large regional outpatient clinics (Phoenix in San Bernardino, Mariposa in Ontario, Mesa in Rialto, and Victor Valley in Victorville) and at the two rural outpatient clinics (Barstow and Needles).

Demographics

Age

10% Children
15% TAY
61% Adult
14% Older Adult

Gender Identity

46% Male

54% Female

<1% Other

Race/Ethnicity

16% African American/Black
43% Caucasian/White
1% American Indian/ Alaska Native
1% Asian/Pacific Islander
36% Latinx/Hispanic
3% Other/Unknown

Primary Language

96% English
3% Spanish
1% Other

N=1,613

Note: not all numbers add to 100 due to rounding.

Program Description and Target Population, cont.

ACE program staff perform initial screenings, intake assessments, and evaluate the best level of care for each consumer. ACE provides evaluations within seven days of a hospital discharge and within 14 days of walk-in clinic requests. The goal is to provide rapid access to mental health services and to provide consumers, who have been discharged from a psychiatric hospital or walk-in clinic, with a referral to an outpatient clinic for a follow up appointment as soon as possible.

The ACE program includes case managers who assist consumers in connecting to:

- Managed Care Plans (IEHP/Molina) via referrals
- Financial assistance programs (Social Security Disability Income, Veteran's Assistance, etc.)
- Transitional assistance programs (Medi-Cal, Cal-Fresh, etc.)
- Prevention and Early Intervention services
- Charitable organizations for other needs via referrals

Services Offered

- 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) programs

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 267-273.

Demographics

N=1,613

Primary Diagnosis

7.9% Anxiety	**1.3%** Disruptive/Impulse control and conduct	**26.8%** Psychosis
15.9% Bipolar	**4.5%** Neurodevelopmental/neurocognitive	**9.1%** Substance related
27.2% Depression	**1.0%** None/deferred diagnosis	**6.3%** Other

Positive Results

During FY 2023/24, seventeen staff members of the ACE program provided 9,181 services, including 469 assessments.

The ACE program successfully linked hospital discharges to appointments during FY 2023/24, as shown below:

2,048 Referrals from Acute Psychiatric Hospitals to ACE	
1,886	Scheduled appointments within 7 days of discharge
106	Scheduled appointments within 14 days of discharge

Challenges/Solutions

The ACE program continued to face challenges related to legislative changes and staffing during FY 2023/24. To address these challenges, ACE program staff and DBH are continuing to seek solutions to stabilize staffing and meet the changing legislation.

Outreach and Engagement

The ACE program did not participate in any engagement activities during FY 2023/2024.

Program Updates

There are no planned updates for this program.

Recovery Based Engagement Support Teams (RBEST)

Program Name	Actual Number Served FY 2023/24	Estimated Number to be Served FY 2025/26	Annual Budgeted Funds FY 2025/26	Estimated Annual Cost per Person FY 2025/26
RBEST	338	1,000	$4,300,473	$4,300

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
18+	N/A	Field-based	Serious mental illness

Program Description and Target Population

Recovery Based Engagement Support Teams (RBEST) is a voluntary, consumer-centered program that provides community (field-based) services to adults living with untreated or inappropriately treated mental illness. The primary focus of the program is meeting the needs and supporting the goals of the consumer and helping them eliminate obstacles to recovery.

RBEST seeks to assist adults over the age of 18 who are:

- Not active or successful in seeking and receiving necessary psychiatric care.
- The “invisible” consumer 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.
- Unable to navigate the behavioral health system of care to obtain appropriate treatment.

Demographics

Age

0% Children
16% TAY
71% Adult
13% Older Adult

N=303

Gender Identity

63% Male

37% Female

Race/Ethnicity

20% African American/ Black

25% Caucasian/ White

<1% American Indian/ Alaska Native

3% Asian/ Pacific Islander

47% Latinx/Hispanic

4% Other/Unknown

Primary Language

94% English
6% Spanish
<1% Other

Note: not all numbers add to 100 due to rounding.

Program Description and Target Population, cont.

RBEST strives to connect and activate consumers into appropriate ongoing treatment and services. Multidisciplinary engagement teams use a holistic, highly flexible approach based on the needs of each consumer. RBEST staff provide an opportunity for shared decision making in an unstructured, field-based environment when presenting treatment options to consumers and families; they also encourage deliberation and elicit possible care preferences.

Connecting Families is a component of the RBEST program. It is an educational support group for families and caretakers of individuals living with severe and persistent mental illness. The goal is to increase awareness and knowledge among family members and caretakers about issues relating to mental illness while providing a safe space for sharing and peer support. Topics include boundary setting, communication techniques, sharing of ideas, and general support.

Services Offered

Services offered by the RBEST program include:

- Outreach and engagement
- Access and linkage
- Advocacy
- Case management services
- Care navigation
- Family/caretaker education and support in English and Spanish
- Listen, Empathize, Agree, Partner (LEAP) communication technique training for families and caregivers

Demographics

Primary Diagnosis

3.6% Anxiety disorders
5.9% Bipolar disorders
8.6% Depressive disorders
25.4% Other
<1% None/deferred
51.8% Psychosis disorders
4.0% Substance use disorders

N=303

Note: not all numbers add to 100 due to rounding.

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 274-278.

Positive Results

During FY 2023/24, 65 RBEST consumers surveyed during the 30 days post-RBEST engagement in comparison to the 30 days pre-RBEST engagement showed:

- 90% decrease in psychiatric hospital bed days
- 75% decrease in psychiatric hospital admissions
- 31% increase in routine outpatient services, including individual therapy, medication services, rehabilitation, activities of daily living, and residential services.

RBEST works to address ethnic and cultural disparities by offering Connecting Families groups conducted entirely in Spanish. Many of the group's participants are Spanish speaking, so RBEST has been able to eliminate language barriers and increase access to psychoeducation.

Additionally, RBEST recently published a new version of the program's Referral Form in English, Spanish, Mandarin, and Vietnamese and is actively working to expand its resource library with translated materials in these threshold languages.

Success Story

"Daniel" is a male with initial symptoms of agoraphobia, including being withdrawn, isolating, experience delusions, paranoia, and possible tactile hallucinations. According to his mother, Daniel had not left home in more than 9 years. The RBEST nurse began visiting Daniel at his home and building rapport, while the Clinical Therapist provided psychoeducation and discussed the LEAP technique with his mother. After several months of engagements with RBEST, Daniel agreed to attend Crisis Residential Treatment (CRT) for 90 days. By the 60th day, Daniel was medication and treatment compliant. He is pending transition to a DBH housing program, where he can continue treatment and live independently.

Challenges/Solutions

During FY 2023/24, RBEST faced staffing challenges and a high turnover rate. As a field-based program, most training takes place in the field, making it difficult to coordinate and find appropriate training opportunities for new staff. Low staffing levels occasionally led to a back log of paperwork/data entry.

To address these issues, RBEST leadership continues to work to fill vacancies and address staff concerns. Certain positions have been shared/borrowed from other programs when necessary.

Another significant challenge is the limited availability of psychiatric services and Full Service Partnership (FSP) programs. Many outpatient clinics are scheduling psychiatric appointments for 4-5 months in the future due to a shortage of psychiatrists. The RBEST population is typically unwilling to attend outpatient services, so when a consumer is ready but there is no availability, it can deter their progress in accepting treatment.

RBEST is addressing the challenges with availability of services by working to increase partnerships with DBH clinics and programs. The program is also working towards increasing collaboration with community partners to fill areas of need. Additionally, the RBEST-AOT and Community Assistance, Recovery and Empowerment (CARE) Act programs will offer in-house FSP services, which will increase access and availability.

The implementation of Laura's Law and the mandated requirements for an Assisted Outpatient Treatment (AOT) program resulted in the expansion of the RBEST program. Previously RBEST has focused on engagement and linkage, it will now include treatment and care coordination. In addition to treatment and care coordination, RBEST will also be responsible for implementing processes for the courts. Program requirements and required treatment services also lead to additional challenges in determining where AOT and CARE Act fit into the DBH continuum of care, and how RBEST should be adapted to accommodate these changes.

RBEST leadership has collaborated with county partners, such as County Counsel, Public Defender, Superior Court, and Office of the Public Guardian to establish workflows and processes for implementation. Additionally, RBEST has consulted with neighboring counties who have already implemented these programs to identify successful strategies and key areas of improvement. RBEST will focus on training and preparing staff for new treatment and court processes as the program expands to include these new components.

Outreach and Engagement

In FY 2023/24, the RBEST program organized and/or participated in the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Connecting Families Group – English	28	294
Connecting Families Group – Spanish	28	159
Total	**56**	**453**

Program Updates

There are no planned updates for this program.

Success Story

"Bobby" is an adult male diagnosed with schizophrenia. He was a user of methamphetamine and marijuana. Bobby experienced extreme delusions and spoke in metaphors that only he could understand. Over 6 months, RBEST staff built rapport and established trust with Bobby by utilizing LEAP. Bobby's mother attended Connecting Families, which helped her set boundaries and ultimately brought about change in Bobby's life. At one point, Bobby became unhoused, but RBEST continued to engage with him regularly. Staff worked with Bobby to establish wellness goals. Bobby was placed in a DBH-contracted residential facility, where he stopped using drugs and started taking his prescribed medication. His symptoms have subsided, and he no longer speaks in metaphors. He is being trained as a peer advocate and his long-term goals include paying off student debt and gaining independence.

CSS: Full Service Partnerships

Introduction

Full Service Partnership (FSP) programs provide intensive case management and treatment services for consumers living with serious mental illness (SMI) or children with serious emotional disturbance (SED). The FSP framework is based on a “no fail” philosophy and does “whatever it takes” to meet the needs of consumers, and when appropriate their families, including supports, providing strong connections to community resources, and 24 hours per day, 7 days per week (24/7) field-based services. The primary goal of FSP programs is to improve consumers’ quality of life by implementing practices which consistently promote good outcomes for the consumer. These outcomes include: reducing the subjective suffering associated with mental illness, increasing safe and permanent housing, reducing out of home placement for children and youth, avoiding criminal or juvenile justice involvement, and reducing high frequency use of psychiatric hospitalizations or emergency and crisis services. FSP programs strive to provide stabilizing services for the consumer at the lowest level of care allowing for maximum flexibility to support wellness, resilience, and recovery.

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 279-281.

Services Offered

The full continuum of care is provided for FSP consumers with services including, but not limited to:

- FSP programs in all outpatient clinics in every region of the County
- Substance use treatment services (co-occurring disorders)
- Food, clothing, and transportation
- Outreach and engagement
- Clinical and risk assessments
- Case management and intensive case management
- Coordination of care
- Emergency shelter
- Counseling services (individual and/or family)
- Employment services (job search and coaching)
- Entitlement obtainment (SSI, subsidized housing, etc.)
- Crisis intervention/stabilization services
- Medication support services (intensive if needed)
- Recreation activities
- Linkage to community programs and agencies
- Interagency collaboration with other County departments
- Vocational/educational training
- Peer mentoring (Peer Support Specialist)
- Housing assistance/placement supports, including but not limited to, rent subsidies, housing vouchers, house payments, residence in a drug/alcohol rehabilitation program, and transitional and temporary housing
- Respite care

CSS: Full Service Partnerships

Number of Consumers to be Served

The table below demonstrates the number of consumers to be served by age and service categories for Fiscal Year 2025/26:

Program Name	Ages to be Served	Service Area*	Total
Comprehensive Children and Family Support Services (CCFSS)	11,541 Children 4,859 TAY	2,400 FSP 14,000 O&E	16,400
Integrated New Family Opportunities (INFO)	105 Children 155 TAY	150 FSP 110 GSD	260
One Stop Transitional Age Youth (TAY) Centers	10,786 TAY	595 FSP 557 GSD 9,634 O&E	10,786
Forensic Services Continuum of Care	110 TAY 1,010 Adults 80 Older Adults	1,200 FSP	1,200
Assertive Community Treatment (ACT) Model Full Service Partnership (FSP) Services	135 Adults	135 FSP	135
Regional Adult Full Service Partnership (RAFSP)	33 Children 43 TAY 323 Adults 69 Older Adults	468 FSP	468
Age Wise	1,920 Older Adults	120 FSP 1,800 O&E	1,920
Collaborative Adult Full Service Partnership Services	232 Adults 40 Older Adults	122 FSP 150 O&E	272

*Full Service Partnership (FSP) consumers represent the number of consumers participating in FSP programs and services.

*General System Development (GSD) references consumers served in activities related to improving the County's mental health service delivery system for all consumers. Activities may or may not be provided to consumers enrolled in an FSP.

*Outreach and Engagement (O&E) references the number of consumers served while educating the community about the mental health services offered and linking consumers to the appropriate services.

Comprehensive Children and Family Support Services (CCFSS)

Program Name	Actual Number Served FY 2023/24	Estimated Number to be Served FY 2025/26	Annual Budgeted Funds FY 2025/26	Estimated Annual Cost per Person FY 2025/26
CCFSS	2,896*	16,400**	$51,690,012	$3,152

*This number does not include Outreach and Engagement (O&E).
**This number includes Outreach and Engagement.

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Ages 0-15 16-25	SED and/or SMI*	Clinic and Field	Probation or Children and Family Services Involvement

*SED = serious emotional disturbance and SMI = serious mental illness

Program Description and Target Population

The Comprehensive Children and Family Support Services (CCFSS) program uses the Integrated Core Practice Model (ICPM) and provides services to children and youth living with serious emotional disturbance (SED) or intensive mental health needs. CCFSS provides culturally competent "wraparound" services to children and their families in their natural environment in order to achieve a positive set of outcomes through unconditional care. The target population for this program is children (ages 0-15) and TAY (ages 16-25) living with serious emotional disturbance and/or serious mental illness who have Probation or Children and Family Services (CFS) involvement.

CCFSS is comprised of three unique Full Service Partnership (FSP) subprograms and a C-1 component of Children and Youth Collaborative Services (CYCS). All utilize the Integrated Core Practice Model (ICPM) to serve children and youth.

Demographics

Age

76% Children
24% TAY
0% Adult
0% Older Adult

Gender Identity

53% Male
47% Female
<1% Other

Race/Ethnicity

<1% American Indian/Alaskan Native
2% Asian/ Pacific Islander
19% African American/Black
18% Caucasian/White
49% Latinx/Hispanic
12% Other

N=2,494

Note: not all numbers add to 100 due to rounding.

Program Description and Target Population, cont.

The three individualized and targeted FSP subprograms are:

- **Children's Residential Intensive Services (ChRIS)**
- **SB163 Wraparound**
- **Success First/Early Wrap**

All CCFSS subprograms utilize the Therapeutic Behavioral Services (TBS) program as a short-term service to provide comprehensive community-based services to children and their families, one-on-one coaching, and develop tailored service plans that focus on individual strengths. Each subprogram is designed to assist children and youth in avoiding out-of-home placements or loss of current placement due to the severity of their emotional disturbance.

Positive Results

The Child and Adolescent Needs and Strengths (CANS) assessment is utilized within all C-1 programs. In FY 2023/24, CANS data was used by all C-1 FSP programs and analyzed in two ways: (1) Global Measurement and (2) Specific Area/Construct. The Global Measure analysis incorporates specific items in a domain (e.g., Life Functioning) and compares scores from the onset of services to planned discharge. The Specific Area analysis considers only those children and youth who presented with a significant need for help on that item/construct and reports what percentage of those children and youth that no longer needed help at the conclusion of service.

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 282-288.

Demographics

Primary Language

91% English
6% Spanish
4% Other

N=2,494

Primary Diagnosis

<1% Psychosis
1.5% Bipolar Disorders
23.9% Depressive Disorders
1.2% Substance Related
16.1 % Other
24.6% Anxiety Disorders
13.5% Disruptive Disorders
14.6% Neurodevelopmental/ Cognitive
<1% Childhood/Adolescent Onset
3.5% None/Deferred Diagnosis

Positive Results, cont.

Global Measurement of Life (Progression Report):

Item/Issue	Presented with a Need	Improvement of the Need
Having at least one area of impaired life functioning	98.0%	70.2%

Specific Areas of Life Functioning (Impact Report):

Of the children and youth who started a C-1 FSP program, 70% of them successfully completed the program and had a planned discharge. Of those children and youth, the following presentation and improvement percentages were seen:

Item/Issue	Presented with a Need	Improvement of the Need
Family Difficulties	82%	65%
Social Functioning	77%	63%
Recreational	50%	60%
Sleep	51%	64%
School Behavior	55%	69%
School Achievement	58%	61%
School Attendance	34%	69%
Decision Making	78%	61%

Positive Results, cont.

Global Measurement of Behavioral and Emotional Needs (Progression Report):

Item/Issue	Presented with a Need	Improvement of the Need
Having at least one significant behavioral or emotional need	99.2%	64.6%

Specific Areas of Behavioral and Emotional Needs (Impact Report):

Of the children and youth who started a C-1 FSP program, 65% of them successfully completed the program and had a planned discharge. Of those children and youth, the following presentation and improvement percentages were seen:

Item/Issue	Presented with a Need	Improvement of the Need
Impulsivity/Hyperactivity	60%	56%
Depression	60%	68%
Anxiety	54%	61%
Anger Control	66%	66%
Adjustment to Trauma	63%	55%
Emotional and/or Physical Dysregulation	73%	65%

Positive Results, cont.

Specific indicators likely to increase residential stability (Caregiver Impact Report):

The concept of residential stability differs significantly for children compared to adults. Children coming to the CCFSS programs are in a variety of situations regarding their residence. Some are living with biological families and do not have any Child Welfare involvement while others are with biological families and do have Child Welfare involvement. Some children are placed into a family by Child Welfare and others are placed into group homes by Child Welfare. In addition to the basic question of residential stability for the caregiver, the Key Outcomes likely to increase residential stability for a child are (1) being with a caregiver likely to be involved once the child has grown, (2) how well the child is functioning within the family home, and (3) how involved and knowledgeable the caregiver is in regard 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.

Of the caregivers of C-1 FSP consumers with a planned discharge, the following presentation and improvement percentages were seen:

Item/Issue	Presented with a Need	Improvement of the Need
Caregivers indicated needing help to obtain a more stable residence	5%	80%
Children needing help improving their functioning within their living situation	60%	70%
Caregivers significantly uninvolved with the mental health needs of their children at time of admission	12%	100%
Caregivers showing a detrimentally low level of knowledge regarding the child's mental health needs at the start of services	40%	57%

Positive Result, cont.

Specific indicators likely to increase juvenile justice involvement:

A significant number of children seen in a CCFSS program (i.e., 64.8%) needed help with issues that could easily lead to criminal or juvenile justice involvement; however, only 10% had specific difficulties related to formal legal charges.

Evaluating the effectiveness of CCFSS in reducing the likelihood of juvenile justice involvement focuses on the impact made on these specific issues which could lead to juvenile justice involvement.

Of the children and youth identified with specific indicators likely to increase juvenile justice involvement, the following presentation and improvement percentages, at the time of a planned discharge, were seen:

Item/Issue	Presented with a Need	Improvement of the Need
Delinquency	13%	52%
Danger to Others	25%	66%
Runaway	17%	54%
Conduct Disorder Behaviors	22%	67%
Oppositional Behaviors	51%	65%

Recognizing the unique needs of LGBTQ+ youth, the program has established specialized residential programs tailored to their specific requirements. For example, our program for natal male trans youth has been successful in providing targeted support. Additionally, we offer consultation sessions for clinicians working with trans youth and are exploring the launch of a web-based therapy group, despite challenges in identifying consistent participants. These initiatives are crucial in addressing the specific mental health needs of LGBTQ+ youth, who are often underserved in traditional settings.

Challenges/Solutions

Wraproud Clinical Staffing Shortages

In FY 2023/24, our MHSA-funded Wraparound programs faced significant staffing challenges that deeply affected service delivery and overall program performance. Due to the staffing shortfall, we were forced to limit new admissions, which significantly reduced our capacity to serve children and families in need. The impact on existing cases was also considerable; staff were overwhelmed with increasing caseloads, leading to fewer individual therapy sessions and home visits. Core services such as case management and crisis intervention were stretched thin, and multidisciplinary team meetings—critical for coordinated, comprehensive care—were delayed, which further hindered service delivery.

To address the staffing shortages in our Wraparound programs, Children's is taking proactive steps to enhance communication with providers regarding current staffing levels and referral numbers. CYCS has centralized the referral process to ensure a more efficient distribution of cases, redirecting referrals to programs that have openings or can offer the earliest available appointments. The program has also engaged with providers to revisit and potentially revise the minimum job requirements for key positions, which could widen the pool of qualified candidates. This collaborative approach may uncover further strategies to expand our candidate pool and improve staffing levels.

Administrative Oversight Shortages

CYCS Administrative staff have experienced a significant increase in workload demands due to new and pending legislation and while fully staffed, the program did not have the staffing capacity to always meet these new demands in a timely manner. Communication with external agencies, including child welfare services, schools, and healthcare providers, was prioritized, leading to a more focused approach to data collection, reporting, and compliance. Although CYCS managed to continue evaluating program effectiveness and adherence to MHSA guidelines, this was done at a reduced scale. The Administrative staff had to shift its focus to the most pressing provider issues, ensuring that critical needs were met and that case concerns were addressed promptly. These staffing challenges have highlighted areas in need of improvement to sustain long-term effectiveness and ensure compliance with MHSA standards.

Children's is exploring the integration of clerical staff, wherever feasible, to assist with data entry and tracking from providers. Clerical staff will flag any data that meets established concern criteria, ensuring Administrative staff can address issues promptly. However, there is a clear need for additional Administrative personnel to effectively oversee and monitor the operations of over 30 agencies

Challenges/Solutions, cont.

across more than 50 sites with likely 20-30 more being added with AB 1051.

Increased Acuity of Youth

In addition to these staffing issues, the past year saw a sharp increase in the acuity of mental health needs among the children and families we serve, alongside a growing demand for services. This surge necessitated the deployment of specialized resources and expertise to manage more complex cases, putting further strain on our limited staff and financial resources. As a result, our ability to manage typical caseloads was compromised, leading to longer wait times for new admissions. The increased complexity of cases required more frequent updates and modifications to treatment plans, adding pressure to our multidisciplinary teams.

In response to the rising acuity levels among our consumers, Children's is committed to enhancing both training and monitoring efforts. Given that many of our staff are early in their careers, we will focus on delivering intensive training that equips them to manage the highest-risk youth effectively. Achieving training goals will be a joint responsibility between Children's and our providers. To better track and respond to the needs of these youth, CYCS is also developing dashboards to monitor key metrics, including Child and Adolescent Needs and Strengths (CANS) scores, which will help us more easily assess risks and behavioral and emotional needs.

AB 1051 Legislation

Adding further complexity, the uncertainty surrounding AB 1051 has significantly affected our MHSA-funded residential treatment program for foster youth. This legislation, which proposes changes to funding mechanisms and regulatory requirements for mental health services, created a climate of uncertainty as we awaited clarity on the future regulatory landscape. This lack of guidance complicated long-term planning and made it difficult to finalize contracts or establish policies and procedures that could be impacted by legislative outcomes. Providers have also taken a cautious stance, delaying the development of strategic plans.

As the program prepares to implement changes required by AB1051, Children's is developing new policies, procedures, and practices to align with the legislation. This includes establishing funding relationships with new providers, many of whom are located outside our County. To ensure CYCS maintains high standards, the program will create detailed business processes for monitoring youth, services, and overall program performance. Training these new providers to meet our County’s operational standards will be a key focus in the upcoming fiscal years.

Outreach and Engagement

For FY 2023/24, the CCFSS program conducted the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Consultations/Screenings, Presentations, Outreach Efforts, Coordination (e.g., AB1299, Administrative Sub-Committee (of Wraparound), Healthy Homes Prescreens, Interagency Placement Council, Qualified Individual)	15,107	28,167
Total	**15,107**	**28,167**

Program Updates

There are no planned updates for this program.

Success Story

"Monique" began working with the Success First/Early Wrap team after running away from home, engaging in risky behaviors, and exhibiting disrespectful language towards her parents. She struggled to engage at the beginning of treatment, but the team demonstrated persistence, follow through in showing up, and openness in whatever the sessions brought. During treatment, she moved schools, and the team supported her through this transition. She began to engage in services and the entire family was invested in seeing her succeed. Parents and sibling became actively involved in Child and Family Team meetings. By implementing the coping skills and strategies taught within the Success First/Early Wrap program, she was able to manage her emotions differently. She started to see changes in how successful she was in school, academically and socially. Her parents and sibling also expressed what a difference it made in how everyone got along in the home.

Integrated New Family Opportunities (INFO)

Program Name	Actual Number Served FY 2023/24	Estimated Number to be Served FY 2025/26	Annual Budgeted Funds FY 2025/26	Estimated Annual Cost per Person FY 2025/26
INFO	*99	150*	$1,732,183	$11,548

*This number includes FSP services only

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Ages 13-17	SED*	Clinic and Field	Probation Involvement

*SED = serious emotional disturbance

Program Description and Target Population

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

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 289-291.

Demographics

Age

46% Children
54% TAY
0% Adult
0% Older Adult

N=96

Gender Identity

88% Male
13% Female

Race/Ethnicity

0% American Indian/ Alaskan Native
1% Asian/ Pacific Islander
20% African American/ Black
4% Caucasian/White
72% Latinx/Hispanic
3% Other/Unknown

Primary Language

76% English
21% Spanish
3% Other/ Unknown

CSS: Integrated New Family Opportunities C-2

Services Offered

- Intensive probation supervision
- Evidence-based Functional Family Therapy (FFT)

Positive Results

The program has worked to expand the screening and referral process to include more families who could be appropriately served by INFO. In FY 2023/24, the program expanded screenings and increased services to youth by 15% compared to the previous fiscal year.

During FY 2023/24, youth who completed the program served significantly fewer days (mean 14.25 days) in detention after the program (relative to before the program) compared to youth who terminated (mean 52.13 days) from the program or declined (mean 28.23) to participate in the program.

Challenges/Solutions

Due to an influx of new Probationary staff who were unfamiliar with the referral process, the INFO program saw a decrease in INFO referrals during the first two quarters of FY 2023/24.

To improve the referral process, the Juvenile Justice Programs (JJP) updated the process to screen for INFO services from any referral received by JJP, rather than only screening those referrals sent directly to INFO to ensure that the most appropriate services were provided to youth and their families.

Program Updates

There are no planned updates for this program.

Demographics

N=197

Primary Diagnosis

12.5% Anxiety disorders

0% Bipolar disorders

17.7% Depressive disorders

27.1% Disruptive disorders

3.1% Neurodevelopmental/cognitive disorders

0% None/deferred

0% Psychosis disorders

1.0% Substance use disorders

38.5% Other

One Stop Transitional Age Youth (TAY) Centers

Program Name	Actual Number Served FY 2023/24	Estimated Number to be Served FY 2025/26	Annual Budgeted Funds FY 2025/26	Estimated Annual Cost per Person FY 2025/26
TAY	454*	595*	$7,477,785	$12,568

*This number includes FSP services only

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Ages 16-25	SED and/or SMI*	One Stop Centers	Youth below 200% Federal poverty Level living with Mental illness

*SED = serious emotional disturbance and SMI = serious mental illness

Program Description and Target Population

The One Stop Transitional Age Youth (TAY) Centers provide integrated services to the unserved, underserved, and inappropriately served TAY population in San Bernardino County. These youth may be emotionally disturbed, with significant functional impairment, severely and persistently mentally ill or at-risk of mental health issues, high users of acute facilities, homeless or at risk of being homeless (due to an existing out of home placement), have co-occurring disorders, and have a history of incarceration, institutionalization, and recidivism.

The One Stop TAY Centers are mental health clinics modeled as drop-in centers to improve TAY participation and allow TAY to utilize the services needed. They maximize their individual potentials through the Recovery, Wellness, and

Demographics

Age

0% Children
97% TAY
3% Adult
0% Older Adult

N=388

Gender Identity

43% Male
57% Female

Race/Ethnicity

14% African American/ Black
3% Asian/Pacific Islander
24% Caucasian/White
52% Latinx/Hispanic
0.5% American Indian or Alaskan Native
6% Other/Unknown

Primary Language

96% English
2% Spanish
2% Other/ Unknown

CSS: One Stop Transitional Age Youth Centers

Program Description and Target Population, cont.

Resiliency Model, while already in the community, and prepare for re-entry into the community. One Stop TAY Centers, in partnership with the Department of Probation, Children and Family Services, and numerous community partners, assist TAY in achieving their goals of becoming independent, staying out of the hospital or higher levels of care, reducing involvement in the criminal justice system, and reducing homelessness.

The target population for the program is youth (ages 16-25) who are under 200% of the federal poverty level and with or at-risk of mental health issues. Two of the targeted sub-populations are Latinx/Hispanic and African American/Black youth who are disproportionately over-represented in the justice system and out-of-home placements (Foster Care, group homes, and institutions).

Demographics

Primary Diagnosis

25.3% Anxiety disorders

14.7% Bipolar disorders

36.9% Depressive disorders

2.1% Disruptive disorders

0.8% Neurodevelopmental/cognitive disorders

0.5% None/deferred

11.6% Psychosis disorders

1.3% Substance use disorders

6.9% Other

N=388

Services Offered

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
- Groups/Activities
- Housing assistance
- Employment assistance
- Education assistance
- Legal assistance
- Transportation assistance
- Shower and laundry facilities
- Resource room with computer and internet access

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 292-297.

Positive Results

Results from the Adult Needs and Strengths Assessment – San Bernardino County (ANSA-SB) for the period of July 1, 2021, through June 30, 2024*, show the number of youth who presented with a significant issue on an item within the Life Functioning and Strengths domains and the percentage who had that issue improve by the completion of the TAY program:

Item/Issue	Presented with a Need	Improvement of the Need
Family Relationships	297	55%
Social Functioning	319	64%
Recreational	266	65%
Legal	24	38%
Physical/Medical	42	33%
Sleep	209	62%
Living Skills	218	59%
Residential Stability	128	57%
Self-Care	219	62%
Medication Compliance	33	52%
Decision-Making/Judgement	237	54%
Involvement in Recovery/ Motivation for treatment	52	62%
Transportation	107	39%

Item/Issue	Presented with a Need	Improvement of the Need
Parenting Roles	25	48%
Intimate Relationships	185	58%
Educational Attainment	171	63%
Family/Family Strengths/ Support	263	51%
Interpersonal/Social Connectedness	304	59%
Optimism	198	66%
Educational Setting	138	59%
Vocational	183	50%
Community Connection	276	55%
Natural Supports	235	52%
Resilience	157	57%
Resourcefulness	156	55%
Sexual Relations	32	34%

*Due to the length of time most TAY consumers spend in the program, data was pulled for July 1, 2021, through June 30, 2024, (the completed fiscal years of the current contract) to showcase the level of progression that TAY members experience over time.

Positive Results, cont.

The One Stop TAY programs added 34 new collaborative partners in FY 2023/24.

Challenges/Solutions

Contractor Relinquished TAY Center Program Contract -

During FY 2023/24, Mental Health Systems, Inc., dba TURN Behavioral Health Services (MHS, Inc.), discontinued all DBH contracted programs as of December 31, 2023. The One Stop TAY Center in Ontario was one of these programs. Ontario TAY Center staff experienced some administrative challenges in transferring the program from MHS, Inc. to Valley Star Behavioral Health.

Valley Star Behavioral Health, Inc. (Valley Star) assumed the contract for One Stop TAY Center Services in Ontario. DBH and Valley Star worked together to get the Ontario TAY program operational by January 1, 2024. Valley Star hired all staff who wanted to remain working at the Ontario TAY Center, and these remaining staff (almost all the original staff) worked together to successfully transfer TAY consumers from the TAY program under MHS to the TAY program under Valley Star.

Staffing -

All TAY centers experienced challenges with maintaining and hiring clinical and/or medical staff for their programs, causing staffing shortages.

To address these shortages, program staff took on additional workloads to continue to serve clients. Recruitment efforts were made and will continue for vacant positions, and additional recruitment strategies are being investigated to add to current efforts.

Bed Bug Infestation -

One of the TAY Centers experienced a bed bug infestation caused by consumers bringing them in from the emergency shelter facility in which they lived. The TAY program facility and cars were affected, as well as some employee's cars.

To address this, the TAY center purchased a bed bug oven for clothes to kill bed bugs that may be in sheets, clothes, and other belongings. The shelter facility purchased bed bug foggers to address the bugs in their facility.

"I come to TAY so I can meet friends."

- TAY Consumer

Outreach and Engagement

For FY 2023/24, the One Stop TAY Centers program conducted the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Agency/Org/Program Tour	13	104
Collaborative Meetings	141	4,438
Community Outreach	346	1,405
Conference Resource Booth	42	3,029
Health/Resource Fair	2	15
Mental Health Events Attended	3	31
Online Media	32	31
Orientation	38	120
Other (e.g., Community Client Contact)	17	328
Presentations	7	133
Total	**641**	**9,634**

Program Updates

There are no planned updates for this program.

Success Story

The Victorville TAY Center held their first ever career day. There were guest speakers of varying professions who provided insight to their careers. There were 16 guest speakers including firefighters, nurses, correctional officers, school psychologists, IT support, college professors, cosmetologists, film makers, musicians, and mental health providers.

"I know I made poor decisions, and now I am willing to find a solution."

- TAY Consumer

Adult Forensic Services (AFS)

Program Name	Actual Number Served FY 2023/24	Estimated Number to be Served FY 2025/26	Annual Budgeted Funds FY 2025/26	Estimated Annual Cost per Person FY 2025/26
AFS	1,047	1,200	$8,788,225	$7,324

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Ages 18-59	SMI*	Clinic and Field	Justice Involvement

*SMI = serious mental illness

Program Description and Target Population

The Forensic Services Continuum of Care program is designed to serve adults living with serious mental illness (SMI) who are involved in the justice system. The program consists of eight sub-programs designed to target specific populations. The targeted subprograms are:

- Supervised Treatment After Release (STAR)
- Community Supervised Treatment After Release (CSTAR)
- Joshua Tree Mental Health Court (JTMHC)
- Forensic Assertive Community Treatment (FACT)
- Community Forensic Assertive Community Treatment (CFACT)
- Corrections Outpatient Recovery Enhancement (CORE)
- Re-integrative Supportive Engagement Services (RISES)
- Choosing Healthy Options to Instill Change and Empowerment (CHOICE)

As of July 1, 2023, Adult Forensics Programs refer consumers

Demographics

Age

<1% Children
9% TAY
85% Adult
6% Older Adult

N=851

Gender Identity

78% Male

22% Female

Race/Ethnicity

<1% American Indian/ Alaskan Native
2% Asian/Pacific Islander
29% African American/Black
30% Caucasian/White
36% Latinx/Hispanic
3% Other/Unknown

Primary Language

97% English
<1% Spanish
2% Other

Program Description and Target Population, cont.

to be housed at an Enhanced Board and Care facility and Augmented Residential Facility. These facilities provide a stable, structured treatment program in a community setting.

The Supervised Treatment After Release (STAR) and **Forensic Assertive Community Treatment (FACT)** Full Service Partnership (FSP) programs serve consumers living with SMI who are under formal supervision of the Mental Health Courts (MHC) and agree to voluntarily participate in the programs as a condition of their probation. Currently, there are four participating MHC jurisdictions located in the cities of San Bernardino, Rancho Cucamonga, Victorville, and Joshua Tree. STAR provides both intensive day treatment and outpatient mental health services to individuals with a history of recidivism (reincarcerations) who are living with severe and persistent mental illness. MHC participants usually participate in the STAR/FACT program for 18 to 24 months. The FACT program is operated by Telecare and differs from STAR as it assists consumers who have difficulty participating in traditional outpatient mental health services. FACT services are community based, with some services taking place in the office: group rehabilitation, prescriber appointments, individual rehabilitation. However, intensive program services, supportive case management, and psychiatric services are provided in the home for those individuals who need a higher level of care.

Joshua Tree Mental Health Court (JTMHC) is operated by Valley Star and provides program activities and services similar to the STAR program for consumers referred through the Joshua Tree Mental Health Court.

The Community STAR (CSTAR) and Community FACT (CFACT) Full Service Partnership programs operate in the same capacity as STAR and FACT; however, consumers are no longer under formal supervision but would still benefit from voluntarily participating in mental health and substance use services for a short period of time. CSTAR is a community-based referral program that also provides mental health treatment services to consumers transitioning from the

Demographics

Primary Diagnosis

46.5% Psychosis	**3.3%** Anxiety disorders
12.2% Bipolar disorder	**17.2%** Substance related
13.3% Depressive disorder	**4.0%** Other
<1% Neurodevelopmental/ Cognitive disorders	**3.3%** None/Deferred diagnosis

N=851

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 298-304.

Program Description and Target Population, cont.

Choosing Healthy Options to Instill Change and Empowerment (CHOICE) program, STAR, and CSTAR Mental Health Diversion (MHD) Court. The program also serves Mental Health Diversion (MHD) individuals determined to be appropriate by Diversion Courts under PC 1001.36 who live with Serious Mental Illnesses. CFACT consumers transition from either Mental Health Court, other Forensic Services programs, or general community but must be referred through Department of Behavioral Health (DBH) Forensic Services (FS). During FY 2023/24, CFACT began to provide services to consumers in Mental Health Diversion.

The Corrections Outpatient Recovery Enhancement (CORE) program is an FSP program that provides intensive behavioral health treatment services to adult parolees diagnosed with a SMI and who were designated by the California Department of Corrections and Rehabilitation (CDCR) as receiving Enhanced Outpatient Program (EOP) or Correctional Case Management System (CCCMS) services prior to release from state prison. The CORE program provides this population with intensive case management services, for 12-14 months, in addition to other wraparound support. The program serves individuals who are often not admitted to other community-based services as they have complex and unique treatment needs, which are further compounded by criminogenic factors.

The Choosing Healthy Options to Instill Change and Empowerment (CHOICE) program provides necessary services to probationers, including linkages and referrals to the Mental Health Services Act (MHSA) funded programs and services provided by DBH Forensic Services. While the whole program is not MHSA funded, CHOICE has several MHSA funded staff at each of the San Bernardino County Probation Day Reporting Center (DRC) locations. The CHOICE program is co-located at DRCs in Fontana, San Bernardino, and Victorville, as well as in the probation office in Barstow. The CHOICE program design enables a “one stop shop” for individual therapy, Substance Use Disorder (SUD) outpatient services, group therapy, housing services, case management, intensive mental health treatment, screening, and linkage to services.

The Re-Integrative Supportive Engagement Services (RISES) program serves as a key entry point/linkage to all Forensic Services programs. While the whole program is not MHSA funded, RISES currently has three MHSA funded positions providing services. RISES serves individuals living with a severe and persistent mental illness scheduled for release from county jails to integrate back into the community successfully. The goal is to reduce the likelihood of additional criminal behavior, beginning at pre-release from custody, by assessing the consumer’s needs and extending to after-release services. RISES coordinates and/or provides transportation immediately after consumer release from custody directly to services that best suit their needs, decreasing the likelihood of reincarceration.

Positive Results

While participating in Forensics Services programs, consumers are provided with emergency shelter housing as needed and linkages to permanent housing options through their case management.

Data related to the rate of homelessness and residential stability is being collected within the Behavioral Health Information Management System. The Adult Needs and Strengths Assessment (ANSA) results and updated caseload logs for Forensics Services programs will yield data that can be analyzed to report on these goals for upcoming fiscal years.

Through participation in the program (typically 18 months to 24 months), the number of participants experiencing homelessness decreased by 7%.

Consumers remain housed and receive support to maintain housing stability, allowing them to focus on other key areas of their well-being, physical health, mental health, overall wellness and satisfaction.

During the shift from FY 2022/23 to FY 2023/24, there was a 45% decrease in the total number of consumers (28 consumers). This also translated to a 45% decrease in the number of unique consumers (25 consumers). Additionally, there was a decrease of 164 consumers in the total number of hospital visits, leading to a 31% reduction in total hospital visits. Furthermore, noteworthy reductions were observed: a 73% decrease in consumer hospitalizations for individuals in the STAR program, a 77% drop in consumer hospitalizations for individuals in the STAR Day treatment program, a 1% decrease in consumer hospitalizations for individuals in the FACT/CFACT program, and a 100% reduction in hospitalizations in Valley Star program. Furthermore, with increased support and skill development, consumers are better able to handle any possible urgent situations and reach out to their provider for help and avoid over utilizing medical providers.

Positive Results, cont.

Participants enrolled in the Forensics Services programs have shown high rates of diversion from incarceration. Consumers spend less time in traditional justice systems that do not properly address their mental health needs and cause incarceration. Due to a data breach within the San Bernardino Sheriff's Department for Fiscal Year 2022/23, data was not fully available to represent this.

The following table represents the rise in incarcerations correlated with the increase in population and lack of data from FY 2022/23.

Program	Rise in Consumers Incarcerated
MHC (STAR, FACT, JT)	33%

The following table represents the recidivism rate for consumers participating in Forensic Services programs.

Program	Rise in Consumers Incarcerated (% of consumers who were incarcerated during FY 23/24 after admittance to program)
MHC (all consumers)	38%

Success Points

CSTAR

- Found permanent housing for fifteen consumers, of which four developed a budget from employment and gained independent housing, four were able to re-establish a connection and move in or back in with family members, three established housing in Board & Care Facilities, one gained acceptance into a Sober Living Facility and three were placed in temporary Emergency Shelters.
- Ten consumers successfully completed Mental Health Diversion and graduated.
- Eight participants found regular employment; two gained secondary employment and two completed truck driving school and obtained their commercial truck driving license.
- Seventeen participants completed Residential Treatment programs; two are currently enrolled in the 5 Keys program to obtain their high school diploma, one is enrolled in community college.

Challenges/Solutions

Across all programs, several general challenges are evident, including staffing issues, dependency on public transportation, and limited housing options. These challenges highlight the complexities involved in providing effective support and services to a diverse consumer base with various needs. Addressing these challenges is crucial to ensuring the success and effectiveness of the programs.

Programs struggled to maintaining a stable and consistent staff, with frequent vacancies and high staff turnover, which can impact the continuity and quality of services. The program remains committed to addressing the growing demands of our consumers and actively exploring avenues to expand our staff capacity, including specialized forensic recruitments.

Many consumers lack their own personal transportation and rely on public assistance or public modes of transportation, which can be a barrier to accessing services. Some consumers do not have access to Transitional Assistance Department (TAD) benefits such as Medi-Cal upon release and/or are not enrolled with a Medical Managed Care Plan such as IEHP or Molina, making it difficult to access rideshare services. Despite these resource constraints, Forensic Services continues to provide essential transportation and public assistance.

Additionally, the program faced difficulties in securing appropriate housing for justice-involved consumers, including challenges in finding housing solutions for individuals with PC 290 (Registered Sex Offender) status, arson charges (as charge may have been due to their mental illness), and the female population. In anticipation of this increasing need, we are in the process of soliciting proposals from potential vendors interested in partnering with DBH to offer emergency shelter services, while also fostering collaboration with Homeless and Supportive Services to tackle housing-related challenges. The program is dedicated to upholding cleanliness standards within our shelters, conducting regular inspections, and working closely with service providers to promptly address any cleanliness concerns that may arise.

<u>STAR</u>

The STAR program faced staffing changes within Probation and Mental Health Court. This also created delays while new staff were trained, became acclimated to treatment courts, and learned about the needs for mental health consumers. Additionally, this impacted the messages consumers received from court, delayed needed legal interventions for probation violations and program non-compliance, and disrupted the consistency of the treatment and court collaboration.

Additionally, with the implementation of Mental Health Diversion, STAR referrals have decreased; and Proposition 47, Assembly Bill 1950, and Assembly Bill 1810 have impacted the number of referrals sent to the STAR program. Due to new program requirements, some

Challenges/Solutions, cont.

consumers' Probation time was reduced and terms and conditions affected participation in treatment.

The program is actively engaged in several collaborative efforts to enhance Mental Health Court services. The program is working closely with Probation to increase the number of referrals that are suitable for Mental Health Court but are currently directed towards other department programs. Additionally, we are fostering collaboration with the Mental Health Court Judge/Commissioner, Substance Use Disorder and Recovery Services, and Veteran's Court to address the complex needs of consumers dealing with both mental health and substance use issues, facilitating a smooth transition from Mental Health Court to Drug Court once their mental health concerns are stabilized. Notably, in FY 2023/24, STAR received a referral from Veteran's Court to Mental Health Court and successfully completed Mental Health Court. Furthermore, we are collaborating with the courts to refer AB1810 Diversion consumers who were unsuccessful in their initial diversion attempts to a supervised Mental Health Court setting, providing them with another opportunity for treatment under formal probation with FSP level services.

CSTAR

CSTAR faced staffing changes within Probation and the Court leading to delays while new staff were trained, acclimated to treatment courts, and learned about the needs for mental health consumers. To address these challenges, the program is actively exploring avenues to expand staff capacity, including specialized forensic recruitments.

Additionally, CSTAR transitioned from providing support to MHD consumers to becoming a MHD provider for consumers Likely Incompetent to Stand Trial. To manage this transition, the CSTAR Program developed a program with structure and educated consumers, Probation, Court, and collaborative partners on the structure including treatment phases and requirements.

FACT, CFACT

The FACT/CFACT programs faced challenges housing individuals who are registered as PC 290 (Registered Sex Offenders) and maintaining a consistent census of 50 for the Mental Health Court program. Additionally, there has been a decrease in availability of appropriate housing providers/vendors.

To address the housing challenges, the programs have been actively researching additional housing vendors to expand the list of options and find vendors that provide housing to PC 290 registrants. Simultaneously, we are in the process of developing Memorandums of Understanding (MOUs) for all existing vendor partnerships. Furthermore, we are engaged in ongoing dialogues with the mental health collaborative team to explore strategies for boosting referrals to our mental health program in addition to initiating conversations with our contract monitor about the possibility of referring diversion court members to the program.

Challenges/Solutions, cont.

Like CSTAR, CFACT added MHD services, becoming a MHD provider for consumers Likely Incompetent to Stand Trial. CFACT also worked to develop a program with structure and to educate consumers, Probation, Court, and collaborative partners on the structure including Treatment Phases and treatment requirements.

JTMHC

JTMHC experienced a decrease in MHC referrals, primarily attributed to legislative changes, compounded by our rural location which imposes resource constraints such as limited housing options, transportation, and access to specialty medical care. As contracted providers, our housing alternatives are further restricted without access to county housing vouchers. Coordinating screening interviews for referrals has proven challenging, partly due a decrease in communication and to fluctuating assignment changes among probation officers, resulting in delays in applicant decision-making.

JTMHC is actively collaborating with our contract monitor to streamline referrals expanding service to “aftercare” support to help ensure continued success of our consumers. We are continuing to partner with local providers for services and transportation to meet our consumers' needs. We are also facilitating access to housing vouchers when necessary. In conjunction with the Probation Officer (PO) and the Sheriff's liaison, we are coordinating transportation to the Joshua Tree jail for pre-court date screenings. Additionally, we are working closely with the PO to deliver psychoeducation, clarify enrollment criteria, and review our services to enhance acceptance rates. We conduct a multidisciplinary, collaborative meeting on Microsoft Teams with other contract providers in the region and all JTMHC affiliates to discuss referrals and prescreening as a collective group.

Success Points

JTMHC

JTMHC had six graduations this year and two are still active in the program. Four consumers have gotten jobs while in the program. Group participations have grown, and our group offerings have more variety since a Men’s Empowerment Group and Women’s Empowerment Group were added.

FACT/CFACT/CORE

FACT had 12 graduates from Mental Health Court for the FY2023/24. FACT graduates also worked on securing housing. CORE had 23 individuals who successfully discharged/graduated from parole for FY 2023/24.

Outreach and Engagement

In FY 2023/24, the Forensic Services Continuum of Care programs conducted the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Telecare (FACT/CFACT)		
Annual member picnic	1	21
Member graduation party	1	13
Halloween member event	1	9
Member holiday party	1	18
Total	**4**	**61**
Valley Star (JTMHC)		
Student attendance review board (SARB)	5	66
Community member outreach	20	30
Resource fair	6	636
Community coalitions	4	89
School presentations	5	11
Youth Coordinated Entry System (YCES)	4	34
Community partner collaborations	113	260
Total	**157**	**1,126**

Program Updates

Effective FY 2024/25, the Choosing Healthy Options to Instill Change and Empowerment (CHOICE) program will add a Clinical Therapist I Psychologist staff position to be funded under the AB 109 funding source. This position was transferred from the Homeless Outreach Support Team (HOST) program within the Housing and Homeless Services Continuum of Care program.

Artwork by Desiree Caudillo

Success Story

"Mr. S" was referred to Mental Health Court after being unable to successfully participate in Veteran's Court due to mental health symptoms and began services with STAR January of 2023. He was struggling with isolation, growing sense of hopelessness, psychosis spectrum symptoms, and substance use which led to criminal activity. Mr. S initially had difficulties adhering to program structure and gaining insight due to his mental health symptoms and addiction, which impacted his activities of daily living and sobriety. His consistent behaviors of isolation and being resistant to medication compliance made his journey towards recovery more difficult. Overtime, he was able to utilize treatment to stabilize his mental health symptoms, regularly attended all treatment appointments, and adjusted to more supportive housing in a Board and Care. He was able to reconnect with other Veterans through the assistance of Treatment Court staff, as well as rebuilding family relationships and creating new social relationships. Mr. S graduated from Mental Health Court in June of 2024. He was actively volunteering in the community, had successfully connected to the VA for all Mental Health Services, sustained mental health stability, was pursuing academic goals, and making plans to live with family.

Assertive Community Treatment (ACT) Model Full Service Partnership (FSP) Services

Program Name	Actual Number Served FY 2023/24	Estimated Number to be Served FY 2025/26	Annual Budgeted Funds FY 2025/26	Estimated Annual Cost per Person FY 2025/26
ACT Model FSP Services	164	135	$2,616,921	$19,385

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Ages 18-59	SMI*	Clinic and Field	High Users of Hospitalization Services

*SMI = serious mental illness

Program Description and Target Population

The Assertive Community Treatment (ACT) Model Full Service Partnership (FSP) Services program serves San Bernardino County resident adults,18 years and older, living with a behavioral health condition. This program exists to assist consumers in living successfully within the community and support positive progress toward achieving individual personal recovery goals, while avoiding unnecessary psychiatric hospitalization. The program consists of two sub-programs: the Assertive Community Treatment (ACT) program and the Members Assertive Positive Solutions (MAPS) program.

The Assertive Community Treatment (ACT) program serves consumers transitioning from institutional settings, such as State Hospitals, Institutions for Mental Disease (IMDs), or locked psychiatric facilities.

The Members Assertive Positive Solutions (MAPS) program serves consumers who are historically high users of acute psychiatric inpatient and crisis services. These consumers may also have a history of a co-occurring substance use disorder (SUD) or a history of identifying as homeless.

Demographics

Age

0% Children
3% TAY
85% Adult
12% Older Adult

N=164

Gender Identity

65% Male

35% Female

Race/Ethnicity

0% American Indian/Alaskan Native
6% Asian/Pacific Islander
18% African- American/Black
31% Caucasian/White
40% Latinx/Hispanic
5% Other

CSS: Assertive Community Treatment Model FSP Services A-3

Program Description and Target Population, cont.

The Recovery Model used for both programs builds on traditional Assertive Community Treatment standards. The program's approach is based on the belief that "recovery can happen," creating an environment that promotes personal resiliency. Key components of the ACT model include treatment and support services that are individualized and guided by the consumer's hopes, dreams, and goals for behavioral health and overall wellness.

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 305-308.

Services Offered

Services and supports include comprehensive assessment, treatment, crisis intervention, case management, 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 services
- Housing support
- Benefits and entitlements assistance
- Family support
- Education

Demographics

Primary Language

98% English

2% Spanish

<1% Other

N=164

Primary Diagnosis

2.4% Anxiety

8.5% Depressive disorder

77.4% Psychosis

4.3% Bipolar disorder

1.9% Substance related

4.9% Other

<1% Neurodevelopmental/Cognitive disorders

Note: not all numbers add to 100 due to rounding.

Positive Results

In FY 2023/24, 82% of the ACT consumers and 77% of the MAPS consumers avoided acute psychiatric hospitalization through the provision of Full Service Partnership services provided by the program.

A total of nine (9) consumers were homeless upon entry into the program during FY 2023/24. The program assisted all consumers in obtaining safe and stable housing. All consumers served maintained safe and stable housing while in the program.

All consumers who identify a substance use concern are referred for substance use treatment. Substance Use Disorder groups are held at the program's administration office weekly and focus on managing and coping with symptoms. Additionally, consumers are linked to primary care providers for their medical needs.

42% of ACT consumers' services and 8% of MAPS consumers' services focused on working in collaboration with family, the Office of the Public Guardians, and support systems.

Artwork by Keith Benitez

CSS: Assertive Community Treatment Model FSP Services A-3

Positive Results, cont.

The Community Mental Health Statistics Improvement Program (MHSIP) Survey collects Consumer Perception Survey data from clients receiving mental health services from publicly funded mental health programs in California.

In FY 2023/24, 35 consumers completed the Community MHSIP Survey. Below are the responses:

Survey Question	Percent Agree
Staff believed I can grow, change, and recover	94%
Staff helped me obtain the information I needed so I can take charge of managing my illness	87%
Staff were willing to see me as often as I felt it necessary	83%
I, not staff, decided my treatment goals	84%
Staff encouraged me to take responsibility for how I live my life	96%
I'm getting along better with my family	76%
I am better able to deal with crisis	89%
Services were available at times that were good for me	89%
I deal more effectively with daily problems	89%

Survey Question	Percent Agree
I felt comfortable asking questions about my treatment	86%
My symptoms are not bothering me as much	85%
I do things that are meaningful to me	94%
I felt free to complain	80%
I was encouraged to use client run-programs	83%
I was able to see a psychiatrist when I wanted to	88%
I feel I belong in my community	75%
I do better in social situations	82%
I like the services that I receive here	96%
Staff were sensitive to my cultural background (race, religion, language, etc)	82%

Challenges/Solutions

During FY 2023/24, transportation continued to be an ongoing issue, particularly in the high desert area. The Office of the Public Guardian restricts conserved consumers from utilizing any public transportation (e.g., Uber/Lyft, IEHP transport, BUS, etc.) to attend their appointments in the community.

The program will continue to educate consumers on how to utilize public transportation, link consumers to obtain reduced-cost bus passes, etc. to ensure that consumers learn how to utilize community transit to help increase their visits with the Psychiatrist and nurses at the office. For consumers who are unable to use public transportation, the programs will provide a week's advanced notice to assist the member with transportation to the office for their scheduled Psychiatrist appointments, and the psychiatrist will also be coordinating home visits as needed to support members who aren't able to come into the office. Telehealth services are also provided as needed to ensure consumers are seen in a timely manner. Case Managers will also be assigned to coordinate dates when they can assist consumers by accompanying them to their appointments to support their recovery goals.

DBH, Office of the Public Guardian, and other vendors continue to schedule ongoing collaborative meetings working towards problem resolution. The office is working on exploring alternative transportation options that ACT/MAPS programs have presented to help improve the consumers' quality of life and increase independence as the program prepares to graduate members to a lower level of care.

Consumers continue to face housing challenges, with some having been unsuccessful in prior attempts to remain housed, unable to access housing due to medical conditions, or unable to find housing due to payment concerns. Additionally, obtaining SSI benefits has been difficult for consumers due to denials.

The ACT/MAPS team continues to support consumers in locating new placements, collaborating with vendors out in the community, and strengthening relationships to help expedite securing placement for consumers as needed. The program is currently assisting consumers with no financial resources with housing and linkage to SSI benefits. The program is working by connecting consumers to other financial resources to help support their living situations while they work towards collecting benefits as needed.

Challenges/Solutions, cont.

Long-term consumers have experienced challenges when preparing for graduation/discharge from the FSP program. Some consumers have relapsed, resulting in re-hospitalization to prevent discharge from the program.

To mitigate the challenges and anxiety experienced by consumers who are preparing for graduation/discharge, the program conducts ongoing education and has implemented a tier system at enrollment and throughout their service provision. Consumers start on the highest tier and gradually step down in the level of needed services, until they are well prepared for graduation and discharge. This ensures comfort and readiness for discharge into community-based independence.

Outreach and Engagement

For FY 2023/24, a combined total of 53 participants attended 5 presentations where staff members from the ACT Model FSP Services program were available to discuss their program and offer their services.

Program Updates

There are no planned updates for this program.

Success Story

"Nancy" entered the program extremely guarded and reluctant to engage with team members. The ACT Team nevertheless was very persistent in meeting with Nancy and monitoring her mental and physical health. When a rash was spotted on her hands, the ACT Team immediately notified her residential provider and requested a primary care appointment. When Nancy's rash continued to spread, the ACT Team assisted Nancy to secure a visit with a dermatologist. The Team Nurse accompanied Nancy to the appointment and subsequent follow-ups, where she was eventually diagnosed with a skin allergy. The Team Nurse worked with the provider to formulate a plan to help Nancy address the skin allergy and decrease her mental health symptoms. This experience allowed Nancy to develop a positive rapport with the Team Nurse, who became a consistent source of support when Nancy did not want to meet with anyone else. This, in turn, made Nancy more open about her mental health symptoms and drug use, enabling the program to better support her.

Regional Adult Full Service Partnerships (RAFSP)

Program Name	Actual Number Served FY 2023/24	Estimated Number to be Served FY 2025/26	Annual Budgeted Funds FY 2025/26	Estimated Annual Cost per Person FY 2025/26
RAFSP	471	468	$15,506,317	$33,133

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Ages 26-59*	SMI**	Clinic and field	Adults Living With SMI

*The Phoenix FSP serves the entire adult population
**SMI = serious mental illness

Program Description and Target Population

The Regional Adult Full Service Partnership (RAFSP) offers Full Service Partnership (FSP) programs in the Department of Behavioral Health's Barstow, Phoenix, Mesa, Mariposa, and Victor Valley community clinics. Additionally, DBH contracts FSP services with Valley Star Behavioral Health, Inc., Mental Health Systems (MHS)/TURN, and Step-Up to provide additional FSP services throughout various regions of San Bernardino County. The RAFSP programs provide access and linkage, as well as full wraparound treatment to consumers.

These services include intensive level of care provided at clinics and in the field, assistance to help in accessing various levels of care and housing, and/or step down to a lower level of care in the least restrictive setting possible. Individuals requiring this level of care are often unable to maintain independence in the community without the assistance of intensive treatment and intensive case management support.

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 309-312.

Demographics

Age

7% Children
9% TAY
69% Adult
15% Older Adult

N=468

Gender Identity

45% Male

54% Female

Race/Ethnicity

0.4% American Indian/ Alaskan Native
3% Asian/Pacific Islander
16% African American/Black
38% Caucasian/White
35% Latinx/Hispanic
7% Other

Program Description and Target Population, cont.

The ratio of staff to consumers is typically 1 to 10, allowing for intense support for consumers 24 hours a day, 7 days a week, but can include larger numbers as appropriate. RAFSP encourages individualized decision-making 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 through the Wellness, Recovery, and Resilience Model, and by providing culturally competent, evidence-based practices.

Services Offered

- Food, clothing, and transportation
- Outreach and engagement
- Clinical and risk assessments
- Case management and intensive case management
- Coordination of care
- Emergency shelter
- Counseling services (individual and/or family)
- Employment services (job search and coaching)
- Entitlement obtainment (SSI, subsidized housing, etc.)
- Crisis intervention/stabilization services
- Housing assistance/placement
- Medication support services (intensive if needed)
- Recreation activities
- Linkage to community programs and agencies
- Interagency collaboration with other County departments
- Vocational/educational training
- Peer mentoring (Peer Support Specialist)
- Housing supports, including but not limited to, rent subsidies, housing vouchers, house payments, residence in a drug/alcohol rehabilitation program, and transitional and temporary housing
- Substance use treatment services (co-occurring disorders)
- Cost of health care treatment
- Respite care

Demographics

Primary Language

95% English

4% Spanish

1% Other

N=468

Primary Diagnosis

6.8% Anxiety disorders

13.7% Bipolar disorders

23.9% Depressive disorders

7.5% Other

1% None/deferred

39.1% Psychosis disorders

5.6% Substance related

1.9% Neurodevelopmental/cognitive disorders

Positive Results

Consumers are provided the full array of FSP treatment services in order to reduce hospitalizations and hospital bed days. In the chart below, the percent of consumers who avoided hospitalizations in FY 2023/24 are reported by provider.

Provider Name	Unduplicated Consumers Served	% of Consumers Who Avoided Hospitalization Completely in FY 23/24
Barstow Counseling	26	85%
Mesa Counseling Services	59	85%
Victor Valley Counseling Center	105	85%
Phoenix FSP (Clinic Based)	128	80%
Step Up On Second FSP*	628	98%
Valley Star FSP	126	91%
Valley Star Behavioral Health	133	92%
MHS*	114	89%
Mariposa Counseling Center	28	71%

* These providers are not included in the actual number served total for RAFSPs and are represented in the Housing and Homeless Services Continuum of Care count.

Challenges/Solutions

In Fiscal Year 2023/24 the RAFSP program faced staffing challenges.

To address these issues, DBH has begun conducting hiring fairs twice a year.

Program Updates

There are no planned updates for this program.

Introduction

The Collaborative Adult FSP Services (A-20) program is a CSS component under MHSA. It consists of the Community Reintegration Services (CRS) program and the Recovery Based Engagement Support Teams (RBEST) – Assisted Outpatient Treatment (AOT) program.

The Community Reintegration Services (CRS) program is a Full-Service Partnership (FSP) designed to serve adults living with serious mental illness or untreated co-occurring disorders who, in many cases, have recently been discharged from State Hospitals and/or secure psychiatric facilities.

The Recovery Based Engagement Support Teams (RBEST) – Assisted Outpatient Treatment (AOT) program is designed to provide the FSP-level services to those consumers who have been court-ordered to AOT and provides intensive, consumer-directed treatment and case management services, including obtaining community residential housing, coordination of services (medications, psychiatric and psychological services, substance use treatment), education/understanding and management of symptoms, and advocacy.

Artwork by Frankie Greco

Target Population

The table below identifies the target population of consumers to be served by the Collaborative Adult FSP Services programs for FY 2025/26.

Program Name	Target Population			
	Children	TAY	Adult	Older Adult
Community Reintegration Services (CRS) program			X	
The Recovery Based Engagement Support Teams (RBEST) – Assisted Outpatient Treatment (AOT) program			X	

Number of Consumers to be Served

The tables below represent the projected number of consumers to be served by the Collaborative Adult FSP Services programs for FY 2025/26.

Program Name	Ages to be Served	Service Area*
Community Reintegration Services (CRS) program	70 Adult 22 Older Adult TOTAL = 92	92 FSP TOTAL = 92
The Recovery Based Engagement Support Teams (RBEST) – Assisted Outpatient Treatment (AOT) program	162 Adult 18 Older Adult TOTAL = 180	30 FSP 150 O&E TOTAL = 180

*Full Service Partnership (FSP) consumers represent the number of consumers participating in FSP programs and services.

*Outreach and Engagement (O&E) references the number of consumers served while educating the community about the mental health services offered and linking consumers to the appropriate services.

Community Reintegration Services (CRS)

Program Description and Target Population

The Community Reintegration Services (CRS) program is a Full Service Partnership (FSP) designed to serve adults who are living with serious mental illness or untreated co-occurring disorders who, in many cases, have recently been discharged from State Hospitals and/or secure psychiatric facilities. These adults are at imminent risk of homelessness, incarceration, or re-hospitalization.

Services utilize a strengths-based approach by focusing on the consumer's strengths and goals to move towards a new level of functioning in the community. Additionally, CRS embraces a consumer-centered approach that ensures that each consumer's needs are met based on where the consumer is in the process of recovery.

Program Name	Actual Number Served FY 2023/24	Estimated Number to be Served FY 2025/26	Annual Budgeted Funds FY 2025/26	Estimated Annual Cost per Person FY 2025/26
Community Reintegration Services	67	92	$4,273,574*	$15,712*

*Annual budget and cost per consumer represent both CRS and RBEST-AOT.

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Ages 18-59	**SMI***	**Field-based**	**At risk of homelessness, incarceration, or hospitalization/ rehospitalization**

*SMI = serious mental illness

Demographics

Age

0% Children
0% TAY
72% Adult
28% Older Adult

Gender Identity

67% Male
33% Female

Race/Ethnicity

25% African American/Black
39% Caucasian/White
0% American Indian/ Alaska Native
4% Asian/Pacific Islander
31% Latinx/Hispanic
0% Other/Unknown

Primary Language

100% English

N=67

Note: not all numbers add to 100 due to rounding.

Community Reintegration Services (CRS), cont.

Services Offered

- Housing, including licensed board and care homes
- Medication support services
- Intensive case management
- Individual psychotherapy where clinically indicated
- Individual rehabilitation skills building

Positive Results

In FY 2023/24, 67 consumers received services from the CRS program.

Of the consumers served:

- 93% did not require psychiatric hospitalizations
- 95% did not require any crisis intervention services

Challenges/Solutions

The CRS program continues to experience an increased numbers of State Hospital referrals and referrals from various programs due to limited resources available for housing for consumers with severe and persistent symptoms.

To address this challenge, CRS has continued to research, explore, and utilize housing outside of DBH programs (i.e., referral and linkage to housing provided by Managed Health Care Plans, Veteran Affairs, Assisted Living Waiver).

Legislation changes (Senate Bill 43) and the initiation of CARE Court, along with regulatory changes, have complicated the Assisted Living Waiver (ALW) process, which serves as a housing barrier.

To minimize these barriers, CRS has conducted research to identify and incorporate Assisted Living Waiver alternatives.

Demographics

Primary Diagnosis

N=67

3% Bipolar disorders
7.5% Depressive disorders
73.1% Psychosis disorders
7.5% Substance Use disorders
1.5% Anxiety
3% None/Deferred
4.5% Other

Community Reintegration Services (CRS), cont.

Outreach and Engagement

For FY 2023/24, a combined total of 32 participants attended 6 events where staff members from the CRS program were available to discuss their program and offer resources.

Program Updates

There are no planned updates for this program.

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 330-332.

Success Story

With the support of coordinated treatment services between Community Reintegration Services (CRS), Adult Continuing Care Program, and Enhanced Care Management (ECM), an older adult consumer who has been struggling with psychotic symptoms for many years (including hearing voices and fixed paranoid delusions) with medical issues continues to successfully maintain their own subsidized apartment. This has been a positive demonstration of resilience and recovery as the consumer transitioned from living in various board and care and assisted living facilities. Despite episodic instability with spikes in symptoms that could potentially put their housing at risk, the consumer has managed to persevere through various medication adjustments and on-going medical issues. The consumer actively participates in a day treatment program and works with In-Home Support Services. The consumer continues to demonstrate desire/motivation and success living on their own with various supports in place.

The Recovery Based Engagement Support Teams (RBEST) – Assisted Outpatient Treatment (AOT)

Program Description and Target Population

Assisted Outpatient Treatment (AOT), commonly known as Laura's Law, was signed into law in 2002. Laura's Law authorizes court-ordered outpatient treatment pursuant to Welfare and Institutions Code (WIC) Sections 5345-5349.5 for those individuals who have a history of untreated mental illness. This program serves seriously mentally ill individuals who are at substantial risk of deterioration and/or detention under WIC5150 as a direct result of poor psychiatric treatment compliance. The program outreaches to these individuals in an effort to engage them in voluntary treatment. If the individual continues to decline treatment, the program may petition the court to order outpatient treatment. The Recovery Based Engagement Support Teams – Assisted Outpatient Treatment (RBEST-AOT) program coordinates with the San Bernardino County Public Defender and collaborates with the Sheriff's Homeless Outreach and Proactive Enforcement (H.O.P.E.) Team.

RBEST-AOT is an expansion of the current RBEST program (A-15), which is designed to provide voluntary engagement services. RBEST does not provide FSP services; however, the

Program Name	Actual Number Served FY 2023/24	Estimated Number to be Served FY 2025/26	Annual Budgeted Funds FY 2025/26	Estimated Annual Cost per Person FY 2025/26
RBEST-AOT	N/A	180	$4,273,574*	$15,712*

*Annual budget and cost per consumer represent both CRS and RBEST-AOT.

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
18+	SMI*	Field-based 	Serious Mental Illness

*SMI = serious mental illness

The Recovery Based Engagement Support Teams (RBEST) – Assisted Outpatient Treatment (AOT), cont.

Program Description and Target Population, cont.

expanded RBEST-AOT program is designed to provide the FSP level services to those consumers who have been court ordered to AOT. The RBEST-AOT program launched July 1, 2024, and therefore has no data to report for Fiscal Year 2023/24.

RBEST-AOT provides intensive, consumer-directed treatment and case management services, including obtaining community residential housing, coordinating services (medications, psychiatric and psychological services, substance use treatment), education and management of symptoms, and advocacy. The RBEST-AOT team will monitor those receiving services to ensure follow-through with treatment services.

Laura's Law authorizes court-ordered outpatient treatment pursuant to Welfare and Institutions Code (WIC) Sections 5345-5349.5 for individuals who have a history of untreated mental illness and meet all of the following criteria stipulated in the Code:

1. The person is at least 18 years of age.
2. The person is suffering from a serious mental disorder as defined in WIC.
3. The person is clinically determined to be unlikely to survive safely in the community without supervision and their condition is substantially deteriorating **or** AOT is needed to prevent relapse/substantial deterioration that would result in grave disability or serious harm to self or others.
4. The person has a history of treatment non-compliance, as evidenced by one of the following:
    - Two occurrences of hospitalization or mental health treatment in prison or jail within the last 36 months - **or-**
    - One occurrence of serious and violent behavior (including threats) within the last 48 months.
5. The person has been offered the opportunity to participate in treatment (including services described in WIC Section 5348) and continues to fail to engage in treatment.
6. Assisted Outpatient Treatment must be the least restrictive placement to ensure the person's recovery and stability.
7. The person is expected to benefit from AOT.

The Recovery Based Engagement Support Teams (RBEST) – Assisted Outpatient Treatment (AOT), cont.

Services Offered

RBEST-AOT provides engagement services, working to identify appropriate resources, which may include outpatient treatment, housing placements, and social supports. FSP treatment services will be offered to consumers who meet the AOT legislative criteria.

FSP services may include:

- Initial assessment completed to verify individual meets program requirements
- Evaluations
- Individualized Treatment Plan development
- Case management services which includes:
    - Placement
    - Linkage and consultation
    - Assistance in identifying long term income, housing, vocational opportunities, etc.
    - Aftercare planning and referrals
- Family engagement and education
- Crisis intervention
- Individual therapy
- Group therapy/Group rehabilitation
- Medication support services
- Transportation services

Challenges/Solutions

The RBEST-AOT expansion was previously reported to begin in December 2023, during FY 2023/24; however, the program was rolled out on July 1, 2024 (FY 2024/25), as collaborative efforts between DBH and San Bernardino Superior Court highlighted the need for changes in procedures and adjustment to court processes as required through Laura's Law. The program required additional time to adapt to these changes and to coordinate and collaborate with key stakeholders.

The Recovery Based Engagement Support Teams (RBEST) – Assisted Outpatient Treatment (AOT), cont.

Outreach and engagement

For FY 2023/24, the RBEST-AOT program conducted the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
All Agency AOT Training	3	135
CPAC (1/18/2024) – RBEST-AOT Program Presentation	1	108
Behavioral Health Commission (6/06/2024) – RBEST-AOT Program Presentation	1	83
Total	**5**	**326**

Program Updates

The program was initially scheduled to begin services in early 2024; however, implementation was delayed and it launched July 1, 2024 (FY 2024/25).

Artwork by Stacey McDaniel

Age Wise

Program Name	Actual Number Served FY 2023/24	Estimated Number to be Served FY 2025/26	Annual Budgeted Funds FY 2025/26	Estimated Annual Cost per Person FY 2025/26
Age Wise	2,732*	1,920	$2,507,857	$1,306

*This number includes FSP (99), GSD (307), and O&E (2,326) services.

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Ages 59+	SMI*	Clinic and Field	Older Adults Living With SMI

*SMI = serious mental illness

Program Description and Target Population

The Age Wise program provides Full Service Partnership (FSP) mental health and case management services throughout San Bernardino County to older adults living with behavioral health and/or co-occurring disorders. Age Wise works to increase access to services for the older adult community and decrease the stigma associated with mental illness. The Age Wise program is managed through the Department of Adult and Aging Services – Public Guardian (DAAS – PG) of San Bernardino County.

Through collaboration, Age Wise focuses on assisting 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.

Demographics

Age

0% Children
0% TAY
0% Adult
100% Older Adult

Gender Identity

28% Male
72% Female

Race/Ethnicity

15% African American/Black
32% Latinx/Hispanic
5% Other
2% Asian/Pacific Islander
46% Caucasian/White

N=94 Note: This number only includes Full Service Partnership consumers.

Positive Results

The following table reports the measured Age Wise outcome domains and the percentage of consumers served in FY 2023/24 who met the criteria in each category:

Outcome Domain	Percentage of consumers
Maintained low or reduced risk of subjective suffering	67%
Maintained safe and stable housing	99%
Are stable and able to seek outside assistance to locate their own resources	68%
Consumers linked to a Primary Care Physician	99%
Diverted from hospitalizations related to a behavioral health diagnosis	100%

It was announced that the only pharmacy in Needles, CA, was closing with only one week notice given. Individuals who used this pharmacy had no other location to purchase their medications. The nearest pharmacies to Needles were in the state of Arizona and did not accept insurances from California. DAAS – PG. With the help of the Age Wise program, DAAS – PG contacted all Older Adults engaged in its programs and facilitated plans to help consumers obtain the medications they needed. DAAS -PG was able to obtain 90-day supplies of necessary medications which allowed additional time to locate other solutions. They arranged for medical coverage in the neighboring state of Arizona and, when possible, arranged for home delivery of medications.

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 313-318.

Demographics

Primary Language

80% English
17% Spanish
3% Other

N=94

Primary Diagnosis

16.0% Psychosis
8.5% Bipolar disorder
10.6% Other
8.5% Anxiety disorders
54.3% Depressive disorder
2.1% Substance use disorders

Positive Results, cont.

Age Wise also participated in an event hosted by the City of San Bernardino, where they helped older adults during a foreclosure and closure of a building where several homeless individuals were living in unsafe and unsanitary conditions. Age Wise provided information, accepted referrals, and had a therapist onsite for crisis intervention.

Challenges/Solutions

Throughout FY 2023/24, Age Wise experienced staffing challenges that impacted line staff and leadership. Despite these challenges, Age Wise worked quickly to address them and continued to provide high-quality services to consumers and handle referrals.

To promote staff retention, the Age Wise Management Team focused on enhancing work engagement. This includes encouraging employees to enlarge service provision by initiating creative ideas that benefit Age Wise consumers, such as beginning therapy groups or strengthening their collaboration with other County programs.

Additionally, training was provided to the Age Wise Team with a focus on identification and prevention of compassion fatigue and burnout. Age Wise also helped employees to utilize their personal resources; an effort that began with the rollout of Wellness Wednesdays. These are evidence-based methods to keep an employee engaged and energized about their job while managing vicarious trauma and knowing how to recover from compassion fatigue and potential burn-out.

Continued inflation was a challenge that impacted older adults in multiple ways. The rising costs of necessities such as food, utilities, and gas heightened distress over the difficulty of living on limited income.

To help older adults manage the continued challenge of inflation on a fixed income, the Age Wise program continues to collaborate with other social service and County programs. Age Wise will continue to maintain the award winning 24/7 Senior Hotline, staffed by clinical staff to provide immediate support to older adults struggling with mental health issues, isolation, a need for food, transportation and other services. In FY 2023/24, the Age Wise Program responded to 192 calls during nontraditional hours.

Challenges/Solutions, cont.

The legalization of cannabis and the growing number of ways to use cannabis have contributes to increased substance use among older adults. The Age Wise program collaborates with Substance Use Disorder and Recovery Services (SUDRS) to help consumers address any substance use issues. Additionally, since older adults often respond well to psychoeducation and basic interventions provided by their medical providers, Age Wise staff encourages all older adults to address any substance use issues with those providers.

Another challenge has been the increase in the number of referrals, which is expected to keep growing. In FY 2023/24, Age Wise saw a significant increase in referrals moving from 119 in FY 2022/23 to 194 in FY 2023/24. It is projected that FY 2024/25 will see 323 referrals, which is a substantial increase that aligns with the rapidly growing older adult population in San Bernardino County.

> "I never received the help and support that Age Wise has provided."
>
> - Age Wise Consumer

To manage the complex needs of the aging older adult community, Age Wise continues to collaborate with other partners to provide comprehensive wraparound care.

These include partnerships with the Department of Behavioral Health, Mental Health Services Act (MHSA) housing programs, the Department of Aging and Adult Services (DAAS) – Public Guardian, entities such as Adult Protective Services (APS) and the In-Home Supportive Services (IHSS) program, Innovative Remote Onsite Assistance Delivery (InnROADs) and County Substance Use Disorder and Recovery Services (SUDRS).

Age Wise continues to promote and provide Telehealth Home-Based Behavioral Health Care for Older Adults. All clinical staff are trained and certified to provide Telehealth services. The use of Telehealth services by older adults living in remote and rural areas is ongoing, with approximately 1 in 10 Age Wise consumers participating in this flexible service delivery. Additionally, Age Wise Clinicians continue to deploy when urgent and emergent situations arise with the transient population, including when homeless encampments and/or motels are closed by local law enforcement.

Outreach and Engagement

During FY 2023/24, the Age Wise program conducted the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Nutrition Events	5	353
Conferences	2	375
Health Fairs	2	205
Community Events	3	466
Job and Resource Fair	1	60
Total	**13**	**1,459**

Age Wise has continued to participate in local Health & Wellness Fairs, Senior Community Events, and other community-based events to educate and raise awareness of older adult behavioral health services. Age Wise staff provide information, brochures, and flyers promoting the Age Wise 24/7 Senior Hotline and program services.

Program Updates

There are no planned updates for this program.

Artwork by Jason Hanson

Success Story

In early July 2023, Age Wise received a referral from Adult Protective Services (APS) for a female consumer who had been attacked by a family member. This was the latest incident in her lifetime of experiencing abuse and trauma. She was unable to work due to a physical injury, which left her with no income and the likelihood of becoming homeless.

When Age Wise began working with the consumer, there was no support system in place. She reported symptoms of severe depression, hopelessness, and intense fear over the possibility of becoming homeless.

At first, the consumer's response to therapy was negligible, but as her sense of safety and hope grew, she began to respond to Cognitive Behavioral Therapy (CBT) and Acceptance and Commitment Therapy (ACT). With an improved outlook on life, she became a more resilient person and stated, "My trust in others is so much better since I have been working with Age Wise; it's like my trust in people has been restored."

Age Wise also provided Case Management Services. With their assistance, the consumer was able to have a car loan and back rent completely forgiven. She was guided through the process of applying for Social Security Disability Insurance (SSDI), was placed on a list for MHSA housing, and helped to obtain General Relief, to pay bills. Age Wise supported her during the wait for housing and, when an apartment was available, Age Wise helped her with moving expenses, found resources to provide household necessities, and continued to work with her. She states, "I don't know where I would be if it weren't for you guys," referencing the help Age Wise staff has provided. With continued assistance, her prognosis is favorable, and her recovery remains firm.

Introduction

The Housing and Homeless Services Continuum of Care Program (HHSCCP) is a robust continuum of care of services for individuals who are at-risk of homelessness, chronically homeless, or are homeless and living with a serious mental illness and/or substance use disorder. The target population to be served includes transitional age youth, adults, older adults, and families.

The HHSCCP works collaboratively with the county-wide Coordinated Entry System (CES) and other County and community partners to provide comprehensive services. The Homeless Continuum has adapted and changed to meet the expanding needs of the homeless population and incorporate new and changing funding options.

The HHSCCP is comprised of the Homeless Outreach and Support Team (HOST), Supportive Services, Full Service Partnership, and Innovative Remote Onsite Assistance Delivery (InnROADs).

Artwork by Colleen Rowan

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 319-324.

Component Descriptions

Homeless Outreach Support Team (HOST)

The Homeless Outreach Support Team (HOST) offers community outreach and response, as well as housing navigation.

HOST staff assist unhoused DBH consumers in being entered into the Coordinated Entry System (CES). CES is the County system that matches residents to available housing resources.

HOST staff also partner with the Housing Authority of the County of San Bernardino (HACSB) to provide the housing navigation and housing search services to residents that have been matched to a HACSB voucher through CES. Services include assistance with obtaining necessary documentation, completing rental applications, housing search, and assisting with the move into their new home.

Full Service Partnership (FSP) Supportive Services Program

The Supportive Services program provides tenancy supports and case management for consumers living in Permanent Supportive Housing (PSH). The goal of the program is to provide the support needed to maintain housing and improve wellness.

Consumers with more intensive needs are referred to a contracted Permanent Supportive Housing (PSH) Full Service Partnership (FSP).

Innovative Remote Onsite Assistance Delivery (InnROADs)

InnROADs is a multi-disciplinary, multi-agency, field-based program that offers community outreach and response. From 2019-2024, it was an MHSA Innovation project.

Regionally based teams are currently comprised of a Sheriff Deputy, Department of Public Health Nurse, Department of Aging and Adult Services Social Service Practitioner, and DBH Alcohol and Drug Counselor and Clinical Therapist. Teams provide outreach, engagement, services, and linkages to other resources for our county's homeless residents.

In addition, the InnROADs Mobile Medical Team (MMT) consists of a Psychiatric Nurse Practitioner and Psychiatric Technician from DBH. They provide psychiatric evaluations and medication support services.

Number of Consumers to be Served

The table below demonstrates the number of consumers to be served for FY 2025/26:

Program Name	Ages to be Served	Service Area*	Total to be Served
Housing and Homeless Services Continuum of Care Programs (HHSCCP)	• 40 TAY • 1,025 Adult • 445 Older Adult	• 10 TAY O&E • 15 TAY GSD • 15 TAY FSP • 175 Adult O&E • 300 Adult GSD • 550 Adult FSP • 45 Older Adult O&E • 125 Older Adult GSD • 275 Older Adult FSP	1,510

Target Population

The table below identifies the target population of consumers to be served for FY 2025/26:

Program Name	Target Population			
	Children	TAY	Adult	Older Adult
Homeless Outreach Support Team (HOST)		X	X	X
Full Service Partnership (FSP) Supportive Services Programs		X	X	X
Innovative Remote Onsite Assistance Delivery (InnROADs)		X	X	X

*Full Service Partnership (FSP) consumers represent the number of consumers participating in FSP programs and services.

*General System Development (GSD) references consumers served in activities related to improving the County's mental health service delivery system for all consumers. Activities may or may not be provided to consumers enrolled in an FSP.

*Outreach and Engagement (O&E) references the number of consumers served while educating the community about the mental health services offered and linking consumers to the appropriate services.

CSS: Housing and Homeless Services Continuum of Care A-7

Program Name	Actual Number Served FY 2023/24	Estimated Number to be Served FY 2025/26	Annual Budgeted Funds FY 2025/26	Estimated Annual Cost per Person FY 2025/26
HHSCCP	1,665	1,510	$22,918,450	$15,178

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
18+	SMI*	Field-based	Homeless

*SMI = serious mental illness

Services Offered

HOST:

- Housing navigation and housing search
- Bridge housing
- Links consumers to supportive services and treatment
- Community outreach
- Consultation to community partners
- Housing deposits

Full Service Partnership (FSP) Supportive Services Programs:

- FSP and/or mental health services for residents in Permanent Supportive Housing (PSH)
- Tenancy supports
- Eviction prevention
- Financial management
- Support Brokerage
- Housing deposits

Demographics

Age

0% Children
2% TAY
66% Adult
32% Older Adult

Gender Identity

40% Male
60% Female
<1% Other

Race/Ethnicity

30% African American/ Black
1% Asian/Pacific Islander
36% Caucasian/White
28% Latinx/Hispanic
1% American Indian/ Alaska Native
4% Other/Unknown

Primary Language

95% English
4% Spanish
2% Other

N=1,499

Note: not all numbers add to 100 due to rounding.

Services Offered cont.

InnROADs:

- Outreach and Engagement
- Nursing interventions
- Case Management
- Substance Use Disorder (SUD) Assessment and Linkage
- Mental Health treatment
- Psychiatric Evaluation
- Medication Management

Positive Results

During FY 2023/24, a total of 40 consumers were housed, and 71 emergency utility payments were provided in addition to rent and deposit assistance when needed to keep consumers housed.

To meet the needs of the unserved/underserved older adult population identified in the current Cultural Competency Plan, all services provided to consumers are field-based, either in the community where the consumers are comfortable or at their homes for those in Permanent Supportive Housing. This approach helps accommodate the impact of disparities in social determinants (such as housing and transportation). Additionally, older adults are matched with FSP services that specialize in the population.

Results for the InnROADs program are included in the Innovation section, page 366.

Challenges/Solutions

A primary goal of the HHSCCP is to reduce homelessness and increase safe and permanent housing. There was a decrease in Permanent Supportive Housing vouchers through partner agencies, which is the main source of HOST housing navigation referrals.

DBH Homeless and Supportive Services began placing more consumers into emergency shelters, including InnROADs consumers and Clubhouse members. While in shelter, consumers received ongoing case management, housing navigation services, and SSI application assistance.

Demographics

Primary Diagnosis

12.2% Anxiety disorders	**<1%** None/deferred
12.3% Bipolar disorders	**17.6%** Psychosis disorders
25.6% Depressive disorders	**3.9%** Substance use disorders
<1% Disruptive disorders	**27.9%** Other
<1% Neurodevelopmental/cognitive disorders	

N=1,499 **Note**: not all numbers add to 100 due to rounding.

Success Story

"Jonathan" was a consumer that had been referred to HOST for Permanent Supportive Housing opportunities three times over the past four years. Each time he was referred to HOST, his case was assigned to a Social Worker who, like Jonathan, was a Veteran. When he received each of first two housing vouchers, Jonathan wasn't ready to leave his current life behind. His Social Worker knew that receiving a referral for Permanent Supportive Housing was valuable since there is more need in the community than units available, but also that consumers need to have housing as their goal for it to be successful long-term.

Most recently, Jonathan was offered a Veteran-specific opportunity and this time he was ready to embrace it wholeheartedly. His Social Worker kept him motivated and focused through the process, reminding him that they have been incredibly fortunate and received opportunities that are not often available to everyone. Jonathan expressed his readiness through the process and took the initiative by gathering all the necessary documents and meeting every deadline and appointment. It was a long journey to Permanent Supportive Housing, but through his hard work, and the tenacity and patience of his Social Worker, he has now enthusiastically moved into a new apartment.

Reflecting upon his experience during move-in, he was deeply emotional and grateful for having a supportive team that never gave up on him. Throughout these four years, he experienced many ups and downs, and now everyone can celebrate that he is finally home.

Outreach and Engagement

InnROADs provides outreach and engagement services. Activities include educating the community about mental health and substance use services and linking homeless community members to the appropriate resources.

Program Updates

Effective FY 2024/25, one Clinical Therapist I Psychologist position under the Homeless Outreach Support Team (HOST) program will be transferred to the Choosing Healthy Options to Instill Change and Empowerment (CHOICE) program under the Forensic Services Continuum of Care program. The position under the CHOICE program will be funded by AB 109 funding source.

Success Story

"Rick" is a consumer in Permanent Supportive Housing that had challenges leaving his home. For more than a year his Social Worker would pick him up and take him to different places around town. One day he received notification that his 20-year high school reunion was happening out of state. He had not been back to his town in 15 years since his mother died - not even to see his sister who is his only surviving family member. For the next few months, his Social Worker would remind him of the reunion, talk with him about his sister, and encourage him to think about all the good times he had with his friends.

One day Rick called his Social Worker and said, "I really want to go to this reunion and try to reconnect with my sister, but I don't have the money to go." Rick and his Social Worker explored possible options for travel, and the consumer decided a train trip would be fun. His Social Worker was able to help him secure funding for the train ticket. Rick was nervous about taking the 2-day train and bus ride, so for a month before his trip, his Social Worker would pick him up and drive him to the train station. Together they would go through the process of boarding the train and making transfers when needed; Each time Rick became more comfortable with the process.

On the day of the trip his Social Worker took him to the train station, Rick boarded the train and started his adventure. A week later Rick called his Social Worker and was initially upset because he had the wrong date for the reunion and had arrived a week after the reunion. Rick's Social Worker reminded him of all the successes the trip did have, including him taking the 2-day trip alone and getting to visit his sister and stay with her for a few days in their family home. After some reflection, Rick was able to recognize his accomplishment and because of this experience, Rick has continued taking on new challenges and is able to recognize his successes and growth.

Introduction

Adult Transitional Care programs provide a continuum of behavioral health services designed to serve consumers with serious behavioral health conditions who are exiting from higher levels of care and require additional services to reintegrate into the community. Services for this target population are intensive and specialized; therefore, the programs described have been grouped together to streamline services and improve overall care. Services under this continuum implement a strengths-based approach, promoting the principles of recovery, wellness, and resilience by maximizing the consumer's functioning to help them maintain a more satisfying quality of life.

The Adult Transitional Care programs are comprised of:

- Adult Residential Facilities Certified in Social Rehabilitation Services
- Enhanced Assisted Living Program
- Enhanced Board and Care Program
- Centralized Hospital Aftercare Services (CHAS) - Placement and Coordination of Enhanced Services (PACES)

Services in this continuum include comprehensive medical and psychiatric services designed to promote skill building and activities of daily living to assist consumers to move toward improved levels of functioning in the community. The services provided include specialized rehabilitative psychiatric mental health care in a long-term or transitional residential setting, services to assist consumers transition and reintegrate as contributing members of their community, and enhanced behavioral health services that provide comprehensive medical and psychiatric services for consumers with more severe conditions.

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 thru Fiscal Year 2025/2026, pages 325-337.

Program Name	Actual Number Served FY 2023/24	Estimated Number to be Served FY 2025/26	Annual Budgeted Funds FY 2025/26	Estimated Annual Cost per Person FY 2025/26
Adult Transitional Care Programs	454	595	$30,275,559	$50,883

Target Population

The table below identifies the target population of consumers to be served by the Adult Transitional Care programs for FY 2025/26.

Adult Transitional Care Programs				
Program Name	Target Population			
	Children	TAY	Adult	Older Adult
Adult Residential Facilities (ARF) Certified in Social Rehabilitation Services			X	
Enhanced Assisted Living Program			X	X
Enhanced Board and Care Program		X	X	
Centralized Hospital Aftercare Services (CHAS) - Placement and Coordination of Enhanced Services (PACES)		X	X	X

Number of Consumers to be Served

The table below represents the projected number of consumers to be served by the Adult Transitional Care programs for FY 2025/26.

Program Name		Ages to be Served	Service Area*
Adult Transitional Care Programs	Adult Residential Facilities Certified In Social Rehabilitation Services	100 Adult TOTAL = 100	100 GSD TOTAL = 100
	Enhanced Assisted Living Program	5 Adult 5 Older Adult TOTAL = 10	10 GSD TOTAL = 10
	Enhanced Board and Care Program	285 Adult 10 Older Adult TOTAL = 295	295 GSD TOTAL = 295
	Centralized Hospital Aftercare Services (CHAS) - Placement and Coordination of Enhanced Services (PACES)	25 TAY 135 Adult 30 Older Adult Total = 190	100 GSD 90 O&E Total = 190

*General System Development (GSD) references consumers served in activities related to improving the County's mental health service delivery system for all consumers. Activities may or may not be provided to consumers enrolled in an FSP.

*Outreach and Engagement (O&E) references the number of consumers served while educating the community about the mental health services offered and linking consumers to the appropriate services.

Adult Residential Facilities Certified in Social Rehabilitation Services

Program Description and Target Population

Adult Residential Facilities (ARF) provide 24/7 nonmedical care and supervision to residents. The particular ARFs funded through MHSA are also licensed and certified through the state to deliver social rehabilitation services, which are provided in a long-term or transitional residential setting for adult consumers.

Adults who enter into this program have been discharged from higher level placements such as acute psychiatric hospitals and Institutions for Mental Disease (IMDs) or are consumers for whom the traditional board and care level of care was unsuccessful, including enhanced board and care.

DBH contracts for these structured services to provide a necessary level of treatment to consumers in an unlocked, home-like, less restrictive environment, providing up to 18 months of residential treatment and rehabilitative services prior to reintegration into the community. These services assist consumers in achieving significant independence and minimize the risk of repeat hospitalizations, overutilization of emergency services, and non-compliance with outpatient treatment services post-hospitalization.

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Ages 18-59	SMI*	Facility-based 	Discharged from higher level of care placements or lower level of care placements have been unsuccessful

*SMI = serious mental illness

Demographics

Age

0% Children
6% TAY
90% Adult
5% Older Adult

Gender Identity

62% Male

38% Female

Race/Ethnicity

24% African- American/ Black

37% Caucasian/White

4% Other/Unknown

4% Asian/Pacific Islander

32% Latinx/Hispanic

Primary Language

98% English

<1% Spanish

<1% Other/Not reported

N=106

Note: not all numbers add to 100 due to rounding.

Adult Residential Facilities Certified in Social Rehabilitation Services, cont.

Services Offered

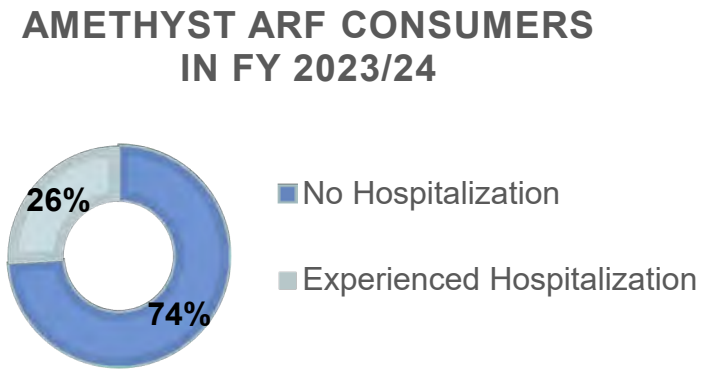
- Residential treatment
- Rehabilitative services
- Individual therapy/crisis management
- Group therapy
- Recovery groups
- Vocational groups
- Social activities

Positive Results

During FY 2023/24, a total of 120 consumers were served throughout the contracted Social Rehabilitation facilities.

The Helping Hearts program served a total of 85 consumers during FY2023/24, with a consumer success rate of approximately 90%. This level of participation and success means consumers are not utilizing emergency psychiatric placement for community needs. CCRT and other community alternatives are provided with staff support as needed. While in the program, all consumers participate in day programming that includes psychoeducation, vocational rehabilitation, and therapeutic services.

Amethyst served a total of 35 consumers throughout FY 2023/24. Of these, 9 consumers were hospitalized for varying psychiatric or medical reasons, which means 74% were able to avoid hospitalization due to the stability and interventions provided by this program.



Adult Residential Facilities Certified in Social Rehabilitation Services, cont.

Challenges/Solutions

Due to the high cost of independent living for consumers on a fixed income who are unable to work due to mental health conditions, the program continued to experience difficulties in locating available lower-level of care placements, such as room and board or board and care. In response, staff continue to collaborate with various county departments to identify new appropriate lower-level care placements and continue to build relationships in the community to identify resources for consumers.

Outreach and Engagement

For FY 2023/24, the Adult Residential Facilities Certified in Social Rehabilitation Services program conducted the following outreach and engagement activities:

Activity Type	Number of Activities	Total Number of Participants
Health Fairs	5	7
Program Presentations	6	90
Social Community Services	74	345
Community Outreach	339	513
Total	**424**	**955**

Demographics

Primary Diagnosis

2.8% Bipolar disorders

1.9% Depressive disorders

93.4% Psychosis disorders

1.9% Other

N=106

Success Stories

- One consumer completed the program and his conservatorship was discontinued.
- Twelve consumers successfully completed/graduated the program and were placed in a lower-level care (board and care).

Adult Residential Facilities Certified in Social Rehabilitation Services, cont.

Program Updates

There are no planned updates for this program.

Success Story

"Sasha" is a young woman diagnosed with Schizophrenia. She had been separated from her child due to being off her medications and using substances which led to hospitalization and legal conservatorship. While in our program, she was able to work with staff and her therapist to create a plan of action to submit to court during conservatorship re-establishment hearing. Due to her high level of performance in the program, proven stability, and the letter presented to the judge, she was taken off conservatorship. She was soon after able to graduate and discharge from our program successfully. She returned to live with family and have more involvement in her son's life.

Success Story

"Harry" is an adult male who was initially placed with a provider in the summer of 2021. Upon admission, Harry presented with auditory hallucinations, history of substance use and previous incarceration, depression (isolation), paranoia, and physical aggression due to voices. Program staff were able to build good rapport with Harry and, as a result, he became more engaged by participating in groups, following rules, learning independent living skills, learning the purpose of his medications, learning to track and make appointments, cooking, budgeting, and proper hygiene. Harry was very involved in his treatment process and readily identified coping skills for managing his depression and auditory hallucinations. He was a strong advocate for himself, and he successfully stepped down to a board and care. Harry was very thankful and expressed feeling excited and eager to take the next steps towards independence.

Enhanced Assisted Living Program

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Ages 50+	SMI*	Facility Based	Experiencing both behavioral health and critical medical concerns

*SMI = serious mental illness

Program Description and Target Population

The Enhanced Assisted Living Program serves consumers typically over the age of 50 who have serious behavioral health conditions coupled with critical medical concerns. The program is licensed to provide both behavioral health and medical services to consumers who require a structured setting for their psychiatric and medical care. The program supports consumers' ability to remain in a less restrictive placement in a community setting, allowing them to be closer to loved ones and family support.

Services Offered

- 24-hour observation
- Comprehensive medical and psychiatric services
- Medication management
- Social/life enrichment activities
- Therapeutic intervention and groups
- Case management services
- Rehabilitation and Activity of Daily Living Skill training
- Collateral services with consumers' caregivers

Demographics

Age

0% Children
0% TAY
24% Adult
76% Older Adult

N=17

Gender Identity

71% Male

29% Female

Race/Ethnicity

18% African American/Black

6% Asian/Pacific Islander

59% Caucasian/ White

18% Latinx/Hispanic

Primary Language

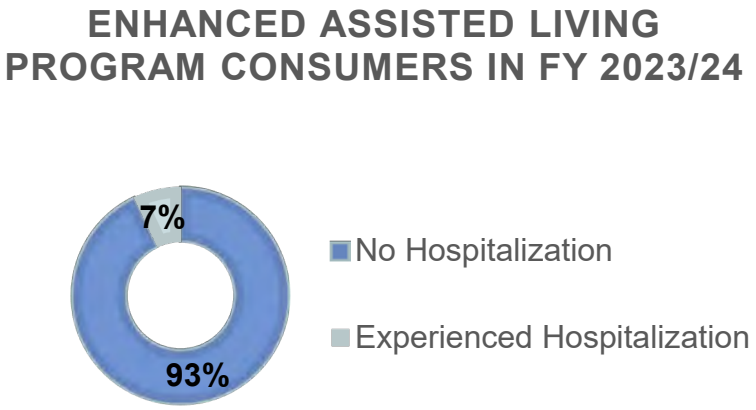
100% English

Note: not all numbers add to 100 due to rounding.

Enhanced Assisted Living Program, cont.

Positive Results

Of the consumers served during FY 2023/24, 100% did not require use of Alternative Crisis Intervention Services. Additionally, 93% were able to avoid psychiatric hospitalization.



Challenges/Solutions

In FY 2023/24, the program experienced challenges with regulatory changes that have complicated the Assisted Living Waiver (ALW) process creating a housing barrier. The ALW process has been placed on a hold through March 2025, so other resources for housing/funding needed to be located while consumers who qualify are on the waitlist on hold through next year.

To address these challenges, the program researched to identify and incorporate Assisted Living Waiver alternatives.

Demographics

Primary Diagnosis

17.7% Depressive disorders

70.6% Psychosis disorders

5.9% None/Deferred

5.9% Other

N=17

Note: not all numbers add to 100 due to rounding.

Enhanced Assisted Living Program, cont.

Outreach and Engagement

For FY 2023/24, the Enhanced Assisted Living Program conducted the following outreach and engagement activities:

Activity Type	Number of Activities	Total Number of Participants
Collaborative Community Partner Presentation	3	9
Program Presentation	1	20
Total	**4**	**29**

Success Story

"Ben" entered the program with persistent and pervasive mental health needs with limited supports in place. Since receiving support from Enhanced Assisted Living, Ben has worked diligently to identify personal strengths, goals, and skills and reports significant reduction with mental health concerns. He has reengaged with family and is using his writing and drawing ability as a tool to reduce mental health symptoms and to encourage his peers. Due to continued growth and progress, Ben was just accepted to move to a lower level of housing that will support his on-going goals and independent living skills.

Program Updates

There are no planned updates for this program.

Enhanced Board and Care Program

Program Description and Target Population

The Enhanced Board and Care Program is an expanded MHSA program to enhance the residential support of adult consumers experiencing complex, challenging, and/or chronic mental health conditions and severe co-occurring disorders, including the provision of treatment services specializing in hearing and communication impairments.

As a result of a consumer's long length of stay in a locked psychiatric residential facility, as well as their impulsive and aggressive behavior, additional supportive services and staff are provided on site to maintain stability and positively impact the consumer's reintegration into the community. This level of care provides the consumer with a community step-down opportunity, when clinically appropriate, into an unlocked setting with enhanced staffing to ensure a seamless transition back into the community.

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Ages 18-59	**SMI***	**Facility Based** 	**Experiencing both mental health and co-occurring concerns**

*SMI = serious mental illness

Services Offered

- Residential services
- Special dietary and medical needs
- Transportation
- Facilitate access to needed services
- Recovery-oriented social education classes/groups
- Crisis intervention
- Medication support
- Case management
- Individual therapy as clinically indicated

Demographics

Age

0% Children
8% TAY
84% Adult
7% Older Adult

Gender Identity

62% Male

38% Female

Race/Ethnicity

24% African American/ Black

4% Asian/Pacific Islander

34% Caucasian/White

33% Latinx/Hispanic

5% Other/Unknown

Primary Language

94% English
2% Spanish
4% Other/Not reported

N=165

Note: not all numbers add to 100 due to rounding.

Enhanced Board and Care Program, cont.

Positive Results

The program served a total of 203 consumers throughout FY 2023/24. Of the consumers served, 85% (173) were able to avoid psychiatric hospitalization through use of crisis intervention, alternative crisis interventions, and support by program staff.

ENHANCED BOARD AND CARE PROGRAM CONSUMERS IN FY 2023/24

Demographics

Primary Diagnosis

3.0% Bipolar disorders	**4.2%** Depressive disorders
1.8% Anxiety	**5.5%** Other
83.6% Psychosis disorders	**1.8%** Substance use disorders

N=165 **Note:** not all numbers add to 100 due to rounding.

Bed capacity was increased by 150 beds at the enhanced board and care level of care in July 2023. Timely access to the necessary appropriate level of care reduces the amount of time a consumer spends in a locked psychiatric facility.

One contractor began a new Aviary and Horticulture Therapy program within their newly developed therapeutic gardens, promoting healing and well-being through nature-based interventions. These new programs allow consumers additional options for coping with increased mental health symptoms.

Challenges/Solutions

In FY 2023/24, the lack of available housing tailored to consumers with higher level of acuity made stepping down from the program difficult. To address this challenge, DBH has expanded contracts to allow for increased housing programs.

Staff continue to face challenges in placing consumers who are on Lanterman-Petris-Short (LPS) conservatorships into Substance Use Disorder (SUD) treatment programs. The program is continuing its collaboration between the Office of the Public Guardian and local SUD treatment programs to eliminate barriers for these consumers.

Enhanced Board and Care Program, cont.

Challenges/Solutions, cont.

Assisting consumers with linkage to benefits from the Social Security Administration is a lengthy process that prevents them from stepping down to a lower level of care, as they do not have funding for housing without these benefits. To better support consumers through this process, training was provided to staff on the process of assisting consumers in applying for Social Security benefits.

Additionally, there were delays in accessing treatment due to difficulties with Medi-Cal transferring to the appropriate providers in San Bernardino County. DBH Long-Term Care (LTC) is working closely with the Office of the Public Guardian (OPG) to identify the need to change Medi-Cal County of residence upon date of move. LTC is also providing written request for OPG to initiate application for Medi-Cal and SSI benefits for consumers transitioning out of the State Hospital system.

Outreach and Engagement

During FY 2023/24, the Enhanced Board and Care Program conducted six program presentations for a total of 35 participants.

Program Updates

There are no planned updates for this program.

Success Story

"Zack" entered into the Enhanced Board and Care Program with an outstanding warrant on his record. Each month, the case manager escorted him to his court appearances, submitted a mandatory report on his progress, spoke on his behalf when needed, and reassured him in his progress. Zack was highly anxious about these proceedings because he was convinced that the court was going to detain him and place him in jail. After approximately six months of the case manager attending court with the consumer and providing support at a court that was about 90 minutes away from the facility, Zack's case was dropped, and he was allowed to proceed in furthering his well-being.

Centralized Hospital Aftercare Services (CHAS) – Placement and Coordination of Enhanced Services (PACES)

Program Description and Target Population

The CHAS-PACES team provides on-site services to consumers housed at a contracted 150 bed Enhanced Adult Residential Facility. The facility provides a stable, structured treatment program in a community setting. The CHAS-PACES team provides coordinated ongoing case management and therapeutic services to consumers in the program, including linkage to community resources and providers, enrollment in benefits, psychoeducational groups, and individual therapy.

CHAS-PACES serves adults aged 18 and older who are living with a behavioral health condition and could benefit from enhanced services in a community setting.

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
18+	SMI*	Facility Based 	Living with a behavioral health condition

*SMI = serious mental illness

Demographics

Age

0% Children
9% TAY
84% Adult
7% Older Adult

N=140

Gender Identity

66% Male

34% Female

Race/Ethnicity

24% African American/Black
1% Asian/Pacific Islander
39% Caucasian/ White
31% Latinx/Hispanic
4% Other/Unknown

Primary Language

97% English
<1% Spanish
2% Other/Not Reported

Note: not all numbers add to 100 due to rounding.

Centralized Hospital Aftercare Services (CHAS) – Placement and Coordination of Enhanced Services (PACES), cont.

Services Offered

While the specific services offered to each consumer will depend on their specialized needs, CHAS-PACES will tailor a plan that is both flexible and comprehensive to address all needs as they arise. The services and goals will be developed in partnership with the consumer and will be directed towards utilizing a strength-based approach.

Services include:

- Psychoeducational groups and activities
- Case management services
- Individual therapy
- Referral and linkage
- Assistance to step down and transition to lower levels of care when appropriate

Demographics

Primary Diagnosis

2.1% Anxiety disorders	**2.9%** Bipolar disorders
1.4% Depressive disorders	**87.9%** Psychosis disorders
1.0% Substance Use disorders	**5.0%** Other

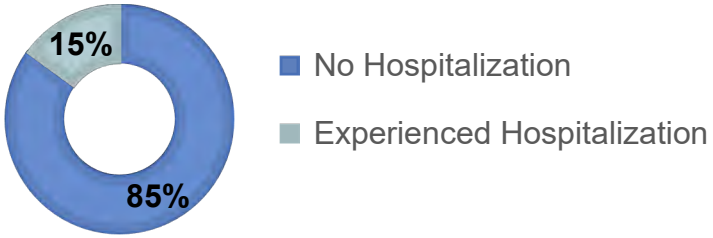
N=140

Note: not all numbers add to 100 due to rounding.

Positive Results

During FY 2023/24, of the 140 consumers served, 85% of consumers avoided acute psychiatric hospitalization. Additionally, twenty-three consumers increased their use of alternative crisis interventions (such as CWICs, CCRT, CRTs, and CSUs).

CHAS-PACES CONSUMERS IN FY 2023/24



Centralized Hospital Aftercare Services (CHAS) – Placement and Coordination of Enhanced Services (PACES), cont.

Challenges/Solutions

FY 2023/24 was the first year the program was implemented, and there were many challenges inherent in the implementation phase. The program gradually increased the consumer population to allow for slow expansion without overwhelming the staff or negatively affecting the services provided.

Turnover in key positions with the contracted provider caused some instability and delays in establishing the partnership between the provider and County. To facilitate the building of this partnership, regular meetings were established between the County and contracted provider.

There was some concern in the community regarding new services available in their area and a lack of community awareness of the purpose/function of the program. In response, DBH Executive staff attended city meetings to provide prompt responses and address any concerns from the community.

Additionally, delays in filling funded positions resulted in delays of processing referrals. The County changed the referral process to include additional staff who were able to conduct referrals resulting in a quicker processing time. The contracted provider also presented information on the program to potential referral sources.

Outreach and Engagement

For FY 2023/24, the CHAS-PACES program conducted the following outreach and engagement activities:

Activity Type	Number of Activities	Total Number of Participants
Intake Assessments	50	50
Referral Presentations	8	60
Total	**58**	**110**

Centralized Hospital Aftercare Services (CHAS) – Placement and Coordination of Enhanced Services (PACES), cont.

Program Updates

There are no planned updates for this program.

Success Story

"Queen" entered the CHAS-PACES program and residential site willing to address her mental health. Before entering the program, she set fire to her family's home, which she attributed to auditory and visual hallucinations. She received biweekly personalized therapy sessions. During the initial sessions, she articulated a sense of justification for her actions and an absence of remorse regarding the fire, despite the consequential loss of her family's residence and possessions. As the sessions continued, Queen attained an awareness of the impact of her mental health on her family and acknowledged the repercussions of her actions on them. She has taken the initiative to reach out to her family members and apologize for how her actions have impacted their lives. She has repaired her relationship with her sisters by allowing them to discuss how her mental health has affected them. She has had the opportunity to reconnect with her family and has established regular communication with her sisters, with whom she had previously sensed feelings of resentment. Queen has made significant strides and remains dedicated to achieving her mental health objectives. She remains stable and successful in maintaining her housing and progress towards treatment objectives.

SAN BERNARDINO COUNTY
Behavioral Health

MHSA Annual Update for FY 25/26: Innovation

Innovation

Introduction

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 primarily focusing 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 to five years, 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 heath, 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), which was renamed to Commission for Behavioral Health (CBH) in January 2025.

MHSA Legislative Goals

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 its 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.

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 San Bernardino County Board of Supervisors and the MHSOAC (now renamed the Commission for Behavioral Health [CBH] as of January 2025), with the local Behavioral Health Commission being responsible for confirming that the stakeholder process was complete.

Innovation

INNOVATIVE PROJECTS

2012

Interagency Youth Resiliency Teams (IYRT): **January 2012 – June 2015**
Provided mentoring services to underserved and inappropriately served system-involved youth.

TAY Behavioral Health Hostel (The STAY): **July 2012 – March 2017**
Short-term, 14 bed, crisis residential treatment program for the Transitional Age Youth (TAY) population experiencing an acute psychiatric episode or crisis.

2014

Recovery Based Engagement Support Teams (RBEST): **October 2014 – September 2019**
Provided field-based services in the form of outreach, engagement, case management services, family education, support, and therapy to "activate" individuals into the appropriate treatment.

2019

Innovative Remote Onsite Assistance Delivery (InnROADs): **April 2019 – March 2024**
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.

2020

Multi-County Full-Service Partnership (FSP) Initiative: **July 2020 – December 2024**
A collaborative partnership between multiple counties and Third Sector to create a data-informed approach to improving FSP consumer outcomes.

2021

Eating Disorder Collaborative: **January 2021 – January 2026**
A comprehensive flexible interagency model of interventions and services for those diagnosed with an eating disorder.

Cracked Eggs: **July 2021 – June 2026**
A workshop that allows participants to discover, learn, and explore their mental states in a structured process of self-discovery through art.

2024

Progressive Integrated Care Collaborative: **April 2024 – March 2029**
A collaborative project that will deliver integrated behavioral and physical health services to Medi-Cal enrollees who have IEHP as their managed care plan, at pilot clinic located in Apple Valley.

Innovative Remote Onsite Assistance Delivery (InnROADs)

Innovation Projects	Actual Number Served FY 2023/24	Estimated Number Served FY 2025/26	Annual Budgeted Funds FY 2025/26	Estimated Annual Cost per Person FY 2025/26
InnROADs INN Project	1,807	N/A*	N/A*	N/A*

*As of April 2024, InnROADs has transitioned to CSS; all future data will be reported in the CSS section.

Target Population and Project Description

InnROADs is a voluntary, consumer-centered project that provides field-based services to individuals with untreated mental illness and experiencing homelessness. The InnROADs team meets with individuals experiencing homelessness at their location, coordinating mental health services as needed.

The target population served by this project include youth, adults, older adults, and families that are:

- Prevented from living independently due to traumatic experiences as a result of homelessness, which has either led to substance use and mental illness or exacerbated a pre-existing condition;
- Experiencing homelessness within San Bernardino County rural and unincorporated communities; and/or
- Experiencing unsheltered homelessness within San Bernardino County.

Consumer Demographics Highlights FY 2023/24

Age

1% Children
3% TAY
77% Adult
19% Older Adult

Sexual Orientation

3% of consumers identified as LGBTQ+

Gender Identity

64% Male
35% Female
OTHER **1%**

Race/Ethnicity

16% African American/ Black
1% Asian/Pacific Islander
55% Caucasian/White
23% Latinx/Hispanic
1% American Indian/ Alaska Native
4% Multiple Races/ Other

Information represented is based on data collected and may not represent of the number of unique consumers served.

InnROADs Collaborative Partners

- Department of Aging and Adult Services
- Department of Public Health
- Sheriff's Department

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
18+	N/A	Field based	Homeless

What have we learned during FY 2023/24?

The goal of every Innovation project is learning and during the last fiscal year, SBC-DBH learned the following:

InnROADs Regional Outreach Team Reinstated:

In 2022 InnROADs was divided into two separate teams: a Regional Response Team (RRT), and a Rapid Engagement Team (RET). This change successfully increased services; however, it was decided that the original integrated model of care would have a greater impact. As a result, the regional outreach teams were reinstated. Teams were divided by regions to create a responsive and supportive environment for individuals and families across the communities in the West Valley, East Valley, High Desert, and Morongo Basin, addressing a variety of needs and promoting overall well-being. Staff were supportive of this change and the reestablishment of the integrated team, which aided in response and delivery times when serving clients.

An encampment visited by the InnROADs team.

What have we learned during FY 2023/24?, cont.

Each Regional Outreach team consists of a diverse set of professionals, ensuring comprehensive support and resources for the communities they serve. The team members include:

- Clinical Therapist
- Alcohol and Drug Counselor
- Peer and Family Advocate
- Social Worker Practitioner
- Registered Nurse
- Sheriff's Deputy

Homeless Point in Time Count:

The 2024 Homeless Point-in-Time Count was completed in January 2024 and revealed a 1.4% increase in the number of homeless individuals compared to the previous year. Approximately three-fourths (75.2%)–or 3,200 of the 4,237 homeless adults and children–are located within the seven cities of San Bernardino, Redlands, Colton, Fontana, Ontario, Victorville and Barstow. Although still providing services to all regions of the County, there is a continued focused approach in providing services in the seven most impacted cities within the County.

Additional Consumer Demographics Highlights FY 2023/24

Veterans

6% of consumers identified as veterans

Language

97% English
2% Spanish
1% Other

Information represented is based on data collected and may not represent of the number of unique consumers served.

InnROADs staff contacting a participant under a freeway overpass.

InnROADs Services

InnROADs provides the following field-based services:

Mobile Treatment Options

- Counseling services;
- Substance use disorder (SUD) services;
- Medication services;
- Linkage to other local resources as needed for the individuals and families.

Mobile Linkages

- Public assistance eligibility;
- Pet care assistance;
- Housing assistance;
- Employment services;
- Probationary services;
- Legal linkage and assistance for those with existing cases with the San Bernardino County District Attorney (DA) and referrals to Legal Aid or the Family Law Facilitator for other non-DA related matters;
- Linkage to routine vaccinations and/or flu shots.

Project Learning Goals

Learning Goal #1: What makes a mobile, multi-agency team effective in serving and supporting the needs of those individuals experiencing homelessness – as individuals, as family units, and as communities? How does collaboration to address multiple, interrelated needs "save" time, and resources, for both consumers and partner agencies?

Learning Goal #2: What techniques build trust with those who are experiencing homelessness in order to support/encourage openness to engaging in (behavioral health) services (including overcoming barriers to engagement in services)? What are the different techniques that are particularly well-suited for different age groups, cultural groups, family structures, and diagnoses?

Learning Goal #3: What services, treatments, and ways of relating in the field are most effective for those who are experiencing homelessness, including medication, therapy, rehabilitation, and enhancing/strengthening support systems? What are the different services, treatments, and ways of relating that are particularly well-suited for different age groups, cultural group, family structures, and diagnoses?

Learning Goal #4: How can geographic information system (GIA) be used as a collaborative tool to better understand pattern, needs, and opportunities for continuous quality improvement by front-line staff, supervisors, administrators, and county-level agencies?

7,579
Records of Engagement for FY 2023/24

41
Medical Assessments documented

72
Crisis Activities

2,266
No. of total Referral/Linkage Activities

722
Counseling and/or Therapy Activities

1,807
unduplicated consumers received services during FY 2023/24

Note: A consumer may have more than one linkage.

Program Updates

- InnROADs ended as an Innovation Project in March 2024 but will continue as a program with multidisciplinary staff serving the most vulnerable populations in San Bernardino County under the Community Services and Supports component.
- The Department of Behavioral Health (DBH) has officially taken over staffing for the Nurse Practitioner (NP) and Psychiatric Technician (Psychiatric Technician) positions. Previously, these roles were managed by the Department of Public Health (DPH), which struggled to find qualified candidates due to the specialized nature of the roles and ongoing staffing shortages. DBH's involvement aims to better address the staffing needs specific to the program and enhance service delivery.
- InnROADs has been incorporated into the DBH Continuum of Care under the Homeless and Supportive Services unit. InnROADs will continue to serve the homeless population by regions: East Valley, West Valley, High Desert and Morongo Basin.
- Program learning outcomes have been complied and will be shared.
- Community and stakeholder feedback has been incorporated into the InnROADs Final Report. The InnROADs Final Report will be sent to the Mental Health Services Oversight and Accountability Commission (MHSOAC), which was renamed to Commission for Behavioral Health (CBH) in January 2025, and be posted to the San Bernardino County DBH website.

Eating Disorder Collaborative (EDC)

Innovation Projects	Actual Number Served FY 2023/24	Estimated Number Served FY 2025/26	Annual Budgeted Funds FY 2025/26	Estimated Annual Cost per Person FY 2025/26
EDC INN Project	50	134	$2,815,958	$21,015

Program Serves	Symptom Severity	Location of Services
All ages	**N/A**	

Target Population and Project Description

The Eating Disorder Collaborative focuses on increasing the regional understanding of eating disorders (EDOs) to facilitate early identification and access to effective treatments for those consumers needing higher levels of care. The goal of this project is to improve the system of care to better meet the physical and mental health needs of people with EDOs by achieving the following:

- Developing and distributing trainings and informational materials.
- Establishing a more robust initial eating disorder assessment tool.
- Creating and activating specialized, multidisciplinary eating disorder treatment teams.

Consumer Demographics Highlights FY 2023/24

Age

22% Children
58% TAY
20% Adult
0% Older Adult

Sexual Orientation

6% of consumers identified as LGBTQ+

Gender Identity

8% Male

88% Female

OTHER
4%

Language

90% English
6% Spanish
4% Unknown

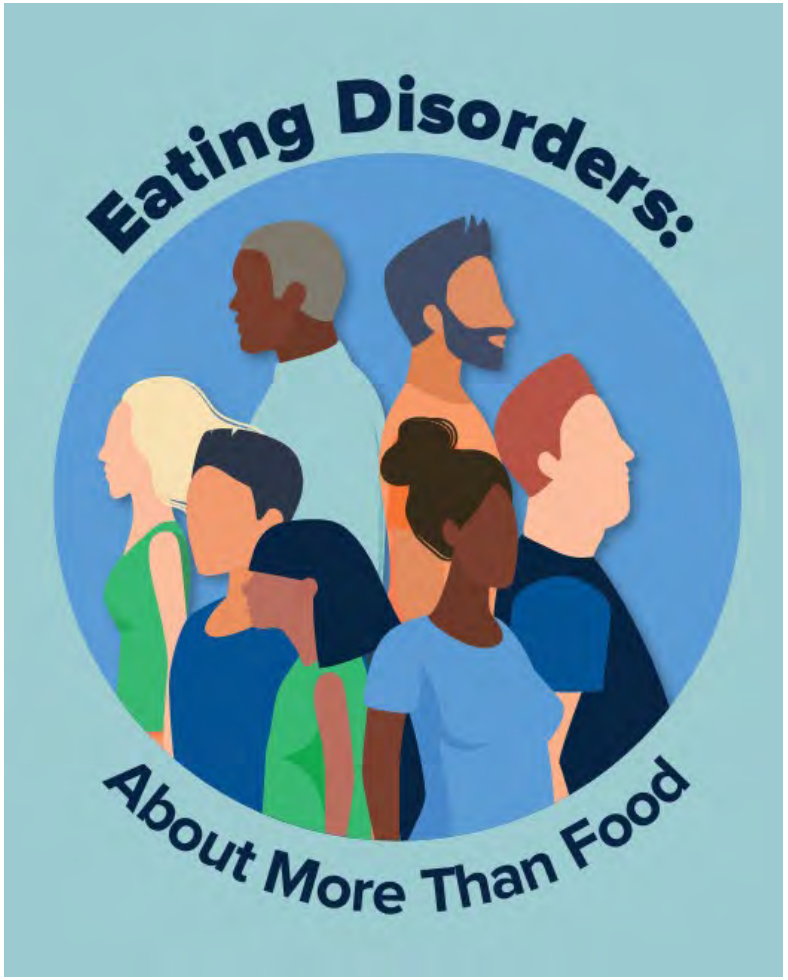
Race/Ethnicity

6% African-American/Black
4% Asian/Pacific Islander
10% Caucasian/White
60% Latinx/Hispanic
0% American Indian/Alaska Native
20% Multiple Races/Other

Information represented is based on data collected and may not represent of the number of unique consumers served.

Challenges/Solutions

- Although staff retention and turnover has affected the EDC program, staffing levels have improved, as hiring in Fiscal Years 2023/24 and 2024/25 have been successful and the EDC is almost fully staffed.
- In FY 23/24, a procurement for a dietician was not successful; however, the program is making headway in partnering with local dietitians in the area to work with EDC clients and provide individual assessments, nutrition therapy and group classes. Clients will benefit from working with a dietician by improving access to groups and other services.
- In the next fiscal year, EDC will begin a marketing campaign throughout the DBH outpatient clinics, informing staff of the program and offering resources for clients who may need eating disorder services.
- The EDC team continues to work with the local managed care plans to provide higher level of care services for clients in need of eating disorder treatment and services. These services include:
    - Residential Treatment Centers
    - Intensive Outpatient Program
    - Partial Hospitalization Program



Program Updates

The current initiatives and updates include:

- **Staffing Improvements**: Although staffing has been challenging, improvements have been made toward the end of Fiscal Year 2023/24.
- **Clinic Manual Development**: A clinical manual is being developed that includes Policies & Procedures, Forms (such as referral and screening), and process flows.
- **Collaborative Relationships**: Efforts are ongoing to strengthen partnerships with Managed Care Plans (MCPs).
- **Training Plan**: A training plan has been developed to ensure DBH staff and contracted providers receive training in Family-based treatment (FBT) and Dialectical behavior therapy (DBT). This training will commence in the upcoming fiscal year.
- **Higher Level of Care:** For clients who require a higher level of care for eating disorder treatment, DBH is working collaboratively with the local MCPs. In FY 2023/24, EDC provided over $897,000 in funds to support 55 clients who were in need of higher level of care services.
- EDC is slated to end as an Innovation project on December 31, 2025.

Project Learning Goals

Learning Goal #1: Examine the factors that make collaboration with local colleges effective for the development and utilization of public information campaigns/materials to educate populations most at risk for developing disordered eating.

Learning Goal #2: Examine the benefits and challenges of developing and disseminating a screening and referral tool which may be used in a variety of settings (e.g., college student centers, health centers, physician's offices); examine the effectiveness of the screening and referral tool at increasing the number of individuals assessed for disordered eating.

Learning Goal #3: Examine the effectiveness of engagement assessments in facilitating participation in treatment services.

Learning Goal #4: Examine the multiple dimensions of the best practices established for a multidisciplinary team, all comprised of MHP staff, effectively liaising with a variety of organizations (e.g. colleges, college health centers, individual physician's offices, Independent Physicians Associations, Managed Care Plans, and behavioral health providers) to (1) provide additional assessment services, (2) facilitate effective referrals, and (3) provide ongoing care as needed.

Multi-County Full-Service Partnership (FSP) Initiative

Innovation Projects	Actual Number Served FY 2023/24	Estimated Number Served FY 2025/26	Annual Budgeted Funds FY 2025/26	Estimated Annual Cost per Person FY 2025/26
Multi-County FSP Project	N/A	N/A	$0	N/A

Target Population and Project Description

The Multi-County Full-Service Partnership (FSP) Initiative aims to implement a more uniform data-driven approach that provides counties with an increased ability to use data to improve FSP services and outcomes. Counties will leverage the collective power and shared learnings of a cohort to collaborate on how to provide the most impactful FSP programs and ultimately drive transformational change in the delivery of mental health services.

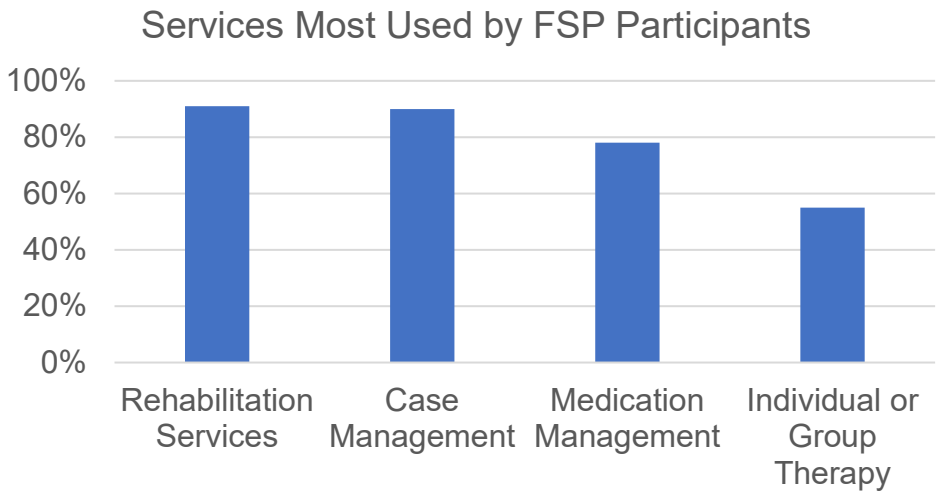
A cohort of six diverse counties — Fresno, Sacramento, San Bernardino, San Mateo, Siskiyou, and Ventura, in partnership with Third Sector, the California Mental Health Services Authority (CalMHSA), the Mental Health Services Oversight and Accountability Commission [(MHSOAC), which was renamed to Commission for Behavioral Health (CBH) in January 2025], and RAND Corporation, are participating in a 4.5-year Multi-County FSP Innovation Initiative that will leverage counties' collective resources and experiences to improve FSP service delivery across California.

In this next fiscal year, the Multi-County FSP initiative is focusing on continuous improvement and implementation and working with project partners.

Milestones in FY 2023/24

RAND Evaluation Summary

The California Mental Health Services Authority (CalMHSA) contracted with RAND, a non-profit research institute, to conduct an independent evaluation of the Multi-County FSP Innovation Project examining the period following implementation of 2021 through 2023. This is a summary from the report provided by RAND.



RAND analyzed electronic health records and program data to examine service utilization by FSP participants and the potential impact of FSP programs on participant outcomes. FSP participants receive services including case management, rehabilitation, medication management and psychotherapy, among others. The number of services received was counted during the first 12 months of FSP enrollment. Services most used include rehabilitation services, utilized by 91% of FSP participants at an average of 22 services in the first year of enrollment. Case management was the second most used service at 90% and an average of 11 services in the first year of enrollment. Medication management and individual or group therapy are the third and fourth most use services at 78% and 55% respectively.

The impact of FSP participation on stable housing, arrests and psychiatric admission outcomes was assessed by comparing the values one year prior to enrollment to the first year of enrollment. While on FSP, participants experienced an average increase of 100 days of stable housing compared to prior to FSP enrollment. Additionally, FSP participants experienced a 36% decrease in likelihood to be admitted for psychiatric inpatient care, compared to prior to FSP enrollment. Number of arrests were not affected as FSP enrollees did not have any arrests prior to enrollment nor after enrollment. This is a summary of the service utilization and changes in outcomes for FSP participants specific to San Bernardino County. The full report can be found on rand.org.

Project Learning Goals

Learning Goal #1: Develop a shared understanding and more consistent interpretation of FSP's core components across counties, creating a common FSP framework.

Learning Goal #2: Increase the clarity and consistency of enrollment criteria, referral, and transition processes through developing and disseminating readily understandable tools and guidelines across stakeholders.

Learning Goal #3: Improve how counties define, collect, and apply priority outcomes across FSP programs.

Learning Goal #4: Develop a clear strategy for tracking outcomes and performance measures through various state-level and county-specific reporting tools.

Learning Goal #5: Develop new and/or strengthen existing processes that leverage data to foster learning, accountability, and meaningful performance feedback in order to drive continuous improvement in program operations and outcomes.

Stakeholder Engagement Lessons Learned and Best Practices:

- Ground decisions about policies and operational practices in consumer experience, including data reporting and outcomes measurement.
- Engage stakeholders early and often to ensure their voices are included.
- Compensate consumers for their participation.
- Leverage both county advocates and third-party facilitators as necessary to ensure consumers feel safe sharing their thoughts.
- Use trauma-informed and healing-centered techniques to reduce harm and avoid re-traumatization.
- Staff must be culturally competent.

Cross-County Collaboration Lessons Learned:

- It is essential to consider which activities are appropriate for statewide vs. local customization.
- Pursue a shared vision with flexibility tailored to individual county needs.
- Consider staff turnover and information gaps for long term projects.
- Counties with more developed data infrastructure may face more challenges in implementing changes.
- Embrace informal learning for counties to share information, challenges, and best practices with each other.

This project is now in its final evaluation stage where San Bernardino County will be working with RAND over the next fiscal year to collect, analyze, and share outcomes data for the determined populations in order to ensure continuous improvement.

Cracked Eggs

Innovation Project	Actual Number Served FY 2023/24	Estimated Number Served FY 2025/26	Annual Budgeted Funds FY 2025/26	Estimated Annual Cost per Person FY 2025/26
Cracked Eggs	44	30	$185,241	$6,175

Project Description

Cracked Eggs is a workshop series designed around teaching participants to utilize the symptoms from their mental illness as techniques to create art. This workshop empowers peers to not view their symptoms as negative but as aspects of themselves that can be used as a creative tool. Using a strength-based approach helps a participant find a form of expression, beyond words, that can be used to describe their lived experiences. The workshops are 100% peer-owned and operated by a production company, Bezerk Productions. Linda Sibio, the creator of Cracked Eggs, is an accomplished artist who lives with mental health challenges herself and has utilized art to help her cope.

Target Population

The target population for this project are individuals living with mental illness over the age of 16.

Consumer Demographics Highlights FY 2023/24

Age

0% Children
100% TAY
0% Adult
0% Older Adult
0% Unknown

Sexual Orientation

36% of consumers identified as LGBTQ+

Gender Identity

29% Male

55% Female

*11% identify as other

Language

100% English
0% Spanish

Race/Ethnicity

20% African American/Black
2% Asian/Pacific Islander
32% Caucasian/ White
28% Latinx/Hispanic
2% American Indian/Alaska Native
16% Multiple Races/ Other

Information represented is based on data collected and may not represent of the number of unique consumers served.

Cracked Eggs

Program Serves	Symptom Severity	Location of Services
16+	N/A	Various Clubhouses and TAY centers

Positive Results

In FY 2023/24, two successful cohorts were held, both held in person. These cohorts had consistent attendance with positive feedback.

- Cohort 5 was held from 08/14/2023 to 12/13/2023 and was hosted by San Bernardino One Stop Transitional Age Youth (TAY) Center. This cohort was successfully extended from a 12-week program to a 16-week program due to the overwhelming positive feedback from participants and TAY staff. This extension reflects the program's flexibility and the clients' willingness to continue engagement and progress. The additional weeks provided more opportunities for skill development in the variety of mediums including painting, charcoal and drawing.
- Cohort 6 was held from 01/22/2024 to 04/17/2024 and was hosted by the Victorville Campus TAY Center. In an effort to include the Barstow Campus TAY satellite location, an innovative hybrid format was implemented to increase participation and make the classes accessible to Barstow TAY. The hybrid classes was held once a week via zoom.

Challenges/Solutions

Cohort 6 faced challenges in delivering an immersive experience to students due to audio and participation issues during the hybrid sessions. In-person classes were held in Victorville and through a virtual platform, students joined the class remotely from Barstow. Due to school and staffing conflicts, Barstow students participated only one day a week instead of two. This caused participants to miss out on key lessons and valuable interactions. Based on the analysis of attendance and feedback from staff and participants, the decision for the program to be an in-person class only moving forward was made to ensure a more cohesive and effective learning environment.

Artwork from Cohort 5 Final Show

"I've never used paint before, but I got to use it during this cohort, ink is so fun and then there's this technique that you do where you put the water first and you take the ink, and you throw it on the paper. Something about that really does visualize some part of your mental health." Cohort 6 Victorville TAY Participant

"I think Cracked Eggs helped me understand my mental health symptoms better because It helped me be creative in my own way and express it on paper." Cohort 5 San Bernardino TAY Participant

Artwork from Cohort 6 Final Show

Program Updates

- In FY 2023/24, two cohorts were held at the San Bernardino One Stop and Victorville Campus TAY centers. This was due to the success with the Valley Star Community Services One Stop TAY Center in Yucca Valley last fiscal year. Working with the TAY (16-25) group has had a positive impact on the overall quality and effectiveness of the cohorts, as well as the experience of the participants.
- Cohort 6 implemented the use of somatic exercises that can be used as self-regulation tools outside of class For example, using movement and breathing techniques during panic attacks, times of high anxiety or to provide deeper relaxation.
- The train-the-trainer portion of this project is in the beginning planning stages with the plan to implement in the next fiscal year.
- Cracked Eggs partnered with local businesses to host engaging art shows for participants and the community. Cohort 5 showcased their work at the Garcia Center for the Arts in San Bernardino for a week, while Cohort 6's art was displayed for a month at R&B Tea shop in Victorville. These collaborations have enhanced visibility for Cracked Eggs and contributed to efforts aimed at reducing stigma within the community.
- Cracked Eggs will be ending as an Innovation project on June 30, 2026, when the contract with Bezerk Productions expires.

Cracked Eggs Community Partners:
The Garcia Center for the Arts *(top)*
R & B Tea in Victorville *(bottom)*

Evaluations

In addition to art workshops, three evaluation sessions are incorporated within the class. These evaluations are an important part of the Cracked Eggs Project, as student's feedback is used to determine how to proceed with the programs. For each cohort, the following mixed methodology was implemented to evaluate the Cracked Eggs program.

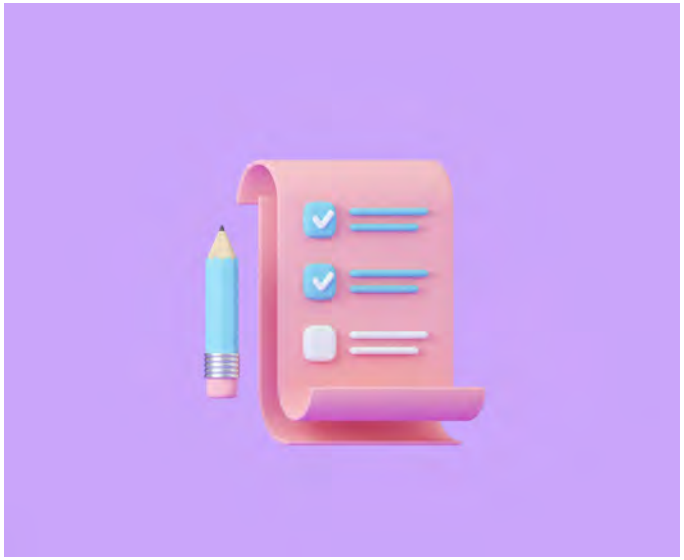
- Initial Evaluation
  - Introduction
  - Full scale Survey
  - Initial Goal Cards
- Mid-Point Evaluation
  - Goal Card Follow-up
  - Learning Goal Survey
  - Focus Group Discussion
- Final Evaluation
  - Full Scale Survey
  - Goal Card Follow-up
  - Learning Goal Survey
  - Focus Group Discussion

For the qualitative analysis component of the evaluation, focus group discussions were recorded and transcribed for both the midpoint and final assessments.

What have we learned though the evaluations thus far?

Participants in the study expressed agreement with the benefits of class activities for managing symptoms, enhancing creativity, and acquiring coping skills. The structured nature of class activities allowed them to have a sense of control over their symptoms. The evaluation showed notable findings that there was the substantial increase in self-perception among participants.

- There was a significant increase of 22% in individuals viewing their own mental illness through a more informed and empowered lens by the end of the cohort, compared to their initial learning goals.
- The majority of students (93%) agree that the program helped them with personal feelings and expression through art and taught them wellness techniques.
- Most students (92%) felt the instructor provided a comforting, stress free environment, and they were able to draw what they felt.
- Seventy-two percent of the students evaluated agree that they were able to portray feelings through art, use art as a coping mechanism, and have acquired valuable skills such as utilizing different tools, techniques and outlets after participating in the program.
- Three-fourths of students stated agree that participating in Cracked Eggs improved their confidence and allowed them to express themselves better.



Quotes from students during the Focus Group Discussion portion of the evaluation:

"I feel like it has helped me through focusing on something, doing something more productive and creative. I know I am creating. Creating plays a big role in recentering, keeping you from thinking too hard about things."

"You can draw out your thoughts."

"[Cracked Eggs] made me view people differently with mental illness because it made me realize that everyone has their own point of view."

"[Cracked Eggs] opened my eyes to the fact that I can like do anything and I reap what I sow, I get what I give, and I can put out in the world what I can put out into the world my very best and I'll get the reward from it."

"I feel like I've gotten very comfortable with this group of people that I have had to dance in front of them, so it definitely gives you self-esteem."

"Well, it made me feel comfortable knowing that the teacher has schizophrenia just like me and she accomplished a lot."

"I feel like I got to open up more and use art as another form of coping."

Project Learning Goals

These project goals are currently in progress as the program continues into its 7th cohort.

Learning Goal #1: Examine if participation in Cracked Eggs leads to consumers reaching treatment, social, educational/vocational, and other goals. Examine how participation in Cracked Eggs influences consumers' goals.

Learning Goal #2: Examine if participation in Cracked Eggs leads to improved consumer outcomes.

Learning Goal #3: Examine if Cracked Eggs, and not least of all Cracked Eggs exhibits and performances, lead to stigma reduction and increased understanding about mental health issues for both consumers and community participants.

Learning Goal #4: Examine the challenges and opportunities in scaling-up Cracked Eggs, including developing a train-the-trainer model/curriculum/toolkit.

Learning Goal #5: Examine how program evaluation can adapt to best capture emerging themes that consumers find important from their Cracked Eggs experience. Is there a way to include and centralize art as a leading indicator in an evaluation?

Progressive Integrated Care Collaborative (PICC)

Innovation Projects	Actual Number Served FY 2023/24	Estimated Number Served FY 2025/26	Annual Budgeted Funds FY 2025/26	Estimated Annual Cost per Person FY 2025/26
PICC INN Project	n/a	160	$2,816,114	$17,601

Project Overview

Escalating healthcare costs have prompted managed healthcare plans, county health care agencies, and consumers to seek ways to improve overall health while reducing the overall cost of care. One such initiative is the integration of medical and behavioral healthcare. The San Bernardino County Department of Behavioral Health (DBH) has developed the Progressive Integrated Care Collaborative (PICC) project to deliver integrated behavioral and physical health services to Medi-Cal enrollees at pilot clinic sites. The project will benefit these individuals through the delivery, coordination and payment for care related to the full continuum of their physical and behavioral health needs.

The lack of best practices disproportionally effects those with advanced behavioral health needs since those suffering from serious mental illness (SMI) or addiction face many obstacles when seeking and receiving needed medical care. This lack of timely and consistent medical treatment often results in preventable deaths decades earlier than the general population. The causes of death are often treatable medical conditions. Additionally, the lack of consistent, ongoing care forces these individuals to utilize hospital and emergency department services at rates far higher than if a primary care physician provided the care.

San Bernardino County Department of Behavioral Health (SBC-DBH) seeks to address these challenges through the implementation of the PICC Innovation Project.

Project Approval

The PICC project was approved by the Mental Health Services Oversight and Accountability Commission [(MHSOAC), which was renamed to Commission for Behavioral Health (CBH) in January 2025] on May 25, 2023, and the San Bernardino County Board of Supervisors on June 13, 2023. PICC is currently in the first phase of development. More information regarding PICC can be found in the Innovation Plan 2023 online.

Progressive Integrated Care Collaborative (PICC)

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
18+	N/A	Apple Valley Clinic	SMI

Target Population

Individuals 18 years and older experiencing serious mental illness, who are Medi-Cal beneficiaries enrolled with Inland Empire Health Plan as the managed care provider.

Innovative Components

The PICC clinic is the newest innovation project that will provide the following physical health services to consumers of mental health and/or substance use services:

- On-site laboratory specimen collection (blood draws)
- On-site electrocardiograms
- On-site chronic disease management for example management of diabetes or hypertension
- Direct referral to physical health specialists through Managed Care Plan referral network
- Peer navigation and support
- Comprehensive medication reconciliation by clinical pharmacist
- On-site group nutritional education
- Individual nutrition coaching
- Direct referral for preventive health services

PICC will be located at DBH's Apple Valley Community Clinic.

Project Overview

The PICC Project will introduce the innovative concept of *Progressive Integration,* based on a strategy of selecting best practices from a given discipline and applying that uniformly across practice specialties.

- ***Laboratory Studies*:** Physical health, mental health and substance use treatment rely on the collection of laboratory specimens to evaluate and monitor patients' organ function, sobriety, medication effect, medication levels and other critical parameters. Onsite collection of urine, blood and other body fluids with pickup by a contracted laboratory partner will allow all disciplines to have reliable and timely access to this information. The first goal of the PICC project is to facilitate this either through nursing or through the addition of a trained phlebotomist.
- ***Electrocardiograms:*** Electrocardiograms provide critical insight into cardiac function, which is frequently altered by psychotropic medications, potentially leading to medical complications. Electrocardiogram results can offer a preliminary interpretation in the clinic but should be verified by a contracted cardiology service for final results.
- ***Data Sharing:*** Health information related to physician and staff notes, outside laboratory studies, medical imaging studies, specialist procedures and inpatient psychiatric visits greatly inform high-quality primary care, substance use treatment and mental health services. Uniform releases of information permitting bidirectional exchange of health information may be developed in the service of this goal. Initially, expansion of mutual read-only electronic health record access for healthcare providers and nursing staff would facilitate this goal. Constructing or implementing a data exchange infrastructure for regulated flow of health information across various electronic health record systems would permit integration into the greater system of care while upholding compliance with applicable regulations of disclosure of protected health information.
- ***Physical Health Specialist Consultation and Referrals:*** Provision of primary care requires a network of medical sub specialists for routine screenings as well as in addressing a variety of medical conditions beyond the scope of primary care. These may include cardiology, gastroenterology, infectious disease, oncology, dermatology, endocrinology, rheumatology, OB/GYN, urology, general surgery, otolaryngology, pain management, neurology, interventional radiology and orthopedic surgery. Optimally, PICC would establish a mechanism in which integrated care clinic staff can consult specialists for guidance on diagnosis and treatment recommendations.

Project Overview, cont.

- ***Billing:*** Cost data related to laboratory services, electrocardiogram and medical imaging, data-sharing infrastructure, specialist consultation and referral fees, as well as direct costs related to staffing, facilities, and consumables will be collected on an ongoing basis. This cost data will be aggregated and will inform a cost model for integrated care inclusive of mental health, substance use treatment, primary care and specialty physical health needs. Progressive gains in efficiency are anticipated as additional layers of integration accumulate.

Program Updates

- Space at the Apple Valley Clinic has been allocated for the PICC clinic and PICC staff.
  - This includes offices and cubicles for medical providers and clinic staff as well as two exam rooms, one medication room and one lab draw/vital signs room.

- Hiring of staff has commenced, with four staff already on board. PICC's physicians will be coming on through a contract with Vituity. Vituity is a physician partnership and healthcare staffing group the Department of Behavioral Health has contracted with to provide psychiatrists and primary care physicians to the department.

- Innovation staff have begun working collaboratively with DBH's biomedical technician to outfit the PICC clinic with all necessary medical and office equipment and supplies.

- Project development continues in collaboration with DBH's Facilities and Project Management unit, as well as the Information Technology (IT) unit, to ensure that all workspaces are setup and ready for staff's arrival.

SAN BERNARDINO COUNTY
Behavioral Health

MHSA Annual Update for FY 25/26: Workforce Education and Training

Workforce Education and Training

Introduction

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 the 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 training opportunities to the Department of Behavioral Health's (DBH) staff and contract agency staff, promotes the recruitment and 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 the workforce shortage within San Bernardino County through the utilization of various strategies to recruit and retain qualified behavioral health employees.

Artwork by Catherine Sutton

Workforce Education and Training

Introduction, cont.

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.

Success Story

The Training Unit partnered with Riverside University Health System to offer Solution-Focused Brief Therapy for staff from both San Bernardino and Riverside Counties. The training offered staff the chance to learn an effective, evidence-based modality to enhance consumer services. It was very successful and elicited positive feedback in the anonymous evaluation, such as the comment below:

"The trainer and her team were amazing. This is the first training that I felt I could walk away using these concepts the next day. I would 100% recommend to have other trainings by them or for my colleagues to do this training. It was such an interactive learning environment with competent and patient trainers."

Positive Results

To meet the goal of addressing workforce shortages, needs assessments were completed in July of 2008 and 2013. Both assessments identified child psychiatrists and psychiatrists as hard-to-fill and retain positions. Since 2008, the WET program has been successful in increasing the number of applications received for qualified licensed staff. The WET program received an increase in applications for licensed positions in FY 2023/24, including Child Psychiatrist, Clinic Assistant, Nurse Manager, Nurse Supervisor, and Program Manager II.

"The rotation was extremely formative for me. I found that my patients had more to teach me than the text. Sharing their pain and joy helped me realized that we cannot control when or how we're hurt, but we can control how it shapes us. This realization helped me see life and suffering through a more positive perspective."

- Western University Medical Student

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 355-370.

Workforce Education and Training

Positive Results, cont.

The table below shows the number of qualified applications received for specific job positions in FY 2023/24:

Job Title	Number of Qualified Applications Received in FY 2023/24	Job Title	Number of Qualified Applications Received in FY 2023/24
Alcohol and Drug Counselor	78	Nurse Supervisor	22
Child Psychiatrist	7	Peer and Family Advocate I	N/A
Clinic Assistant	101	Peer and Family Advocate II	N/A
Clinic Supervisor	46	Peer and Family Advocate III	305
Clinical Therapist, LCSW	60*	Pre-Licensed Clinical Therapist, Licensed Clinical Social Worker (LCSW)	81
Clinical Therapist, Marriage and Family Therapist (MFT)	60*	Pre-Licensed Clinical Therapist, MFT	340**
Clinical Therapist, Psychology	60*	Pre-Licensed Clinical Therapist, Psychology	340**
Clinical Therapist II	4	Pre-Licensed Clinical Therapist, Licensed Professional Clinical Counselor (LPCC)	340**
Licensed Vocational Nurse	69	Program Manager I	32
Mental Health Education Consultant	87	Program Manager II	51
Mental Health Nurse II	65	Psychiatric Technician I	27
Mental Health Specialist	110	Psychiatrist	25
Nurse Manager	98	Research and Planning Psychologist	23

*Clinical Therapists recruited together (LMFT, LCSW, and LPCC)

**Pre-Licensed Clinical Therapists recruited together (LMFT, LCSW, and LPCC)

Workforce Education and Training

Positive Results, cont.

Another program that WET oversees is the License Exam Preparation Program (LEPP). LEPP was created to help pre-licensed clinicians become licensed.

The table below illustrates the progress that LEPP has had in helping staff obtain licensure for their discipline. For LEPP 1-14, there has been, on average, an approximately **77%** licensure rate among the participants.

Program	Fiscal Year	# of Applicants	# Who Became Licensed	% Licensed
LEPP 1	2009/10	60	41	68%
LEPP 2	2011/12	38	24	63%
LEPP 3	2012/13	32	19	59%
LEPP 4	2013/14	18	18	100%
LEPP 5	2014/15	41	39	95%
LEPP 6	2015/16	59	55	93%
LEPP 7	2016/17	65	59	91%
LEPP 8	2017/18	49	39	80%
LEPP 9	2018/19	41	33	80%
LEPP 10	2019/20	35	32	91%
LEPP 11	2020/21	26	23	88%
LEPP 12	2021/22	31	23	74%
LEPP 13	2022/23	15	11	73%
LEPP 14	2023/24	40	9	23%
Grand Total		**550**	**425**	**77%**

Workforce Education and Training

Positive Results, cont.

DBH expects the percentage of pre-licensed to licensed clinicians to continue to increase with the benefit of LEPP as seen below.

Through 14 Cohorts of LEPP, Prior to Implementation of Revised LEPP*

	Clinical Therapist I	Clinical Therapist I Psychologist	Total
Licensed	45	2	**47**
Pre-Licensed	111	6	**117**
Total	156	8	**164**
Percentage Licensed	28.8%	25.0%	**28.7%**

*DBH has seen a decrease of 5.1% in the percentage of licensed staff in FY 2023/24.

Success Points

- Two of the three 20/20 MFT interns in FY 2023/24 successfully completed the 20/20 MFT program and were hired on as Clinical Therapist Trainees. The third will end the program this December.
- One non-Employee Education Internship Program (EEIP) intern was also hired on as a Clinical Therapist Trainee after ending the internship.

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 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 FY 2023/24, there was a total of 27 interns in the Internship program across the Social Work and MFT disciplines. The Psychology program did not accept applications in FY 2023/24 while the program was in a transitional phase; however, the program has resumed the application process.

The Internship program continues to grow and receive positive feedback from participants, who report 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.

Workforce Education and Training

Positive Results, cont.

DBH is committed to hiring applicants who were previous DBH interns. As seen in the following table, 16% of clinical hires in FY 2023/24 were DBH interns; twelve DBH interns were hired as pre-licensed Clinicians with the department in FY 2023/24.

Pre-Licensed Clinicians Hired	FY 2023/24
Total Number of Interns Hired	12
Total Number of Non-Interns Hired	61
% of Interns Hired	16%

The DBH Employee Educational Internship program was created to support current DBH staff in pursuing their Master of Social Work (MSW) or Marriage and Family Therapy (MFT) degree by allowing them to intern for up to 20 hours per week at DBH as part of their degree 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. Since its implementation, the program has increased in popularity, and in April 2015, was expanded by adding the Alcohol and Drug Counselor (AOD) and Bachelor of Social Work (BSW) intern career path options.

Additionally, in FY 2016/17, 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 within the DBH clinics. Since then, WET has seen 87 NP students with seven of those in FY 2023/24.

To meet the goal of educating the workforce according to the general standards, DBH continues to incorporate the Wellness, Recovery, and Resilience Model in trainings.

The general standards set by the Mental Health Services Act (MHSA) include a Wellness, Recovery, and Resilience model that is culturally competent, supports the philosophy of a consumer/family driven behavioral health system, integrates services, and includes community collaboration.

Among the trainings provided in FY 2023/24, the following are examples of trainings that incorporate MHSA standards:

- Human Trafficking
- Law and Ethics for County Healthcare Providers
- Motivational Interviewing
- Objective Arts
- Transformational Collaborative Outcomes Management
- Trauma Informed Housing During Disasters and Homelessness
- Trauma and Eating Disorders
- Trauma and Post-traumatic Stress Disorder (PTSD)/Complex PTSD

Positive Results, cont.

The training information table below shows that the average evaluation score for the trainings in FY 2023/24 was 4.62 out of 5. This rating reflects a similar average trainee satisfaction as the previous two years. There was an 18% decrease in attendance of Live/Virtual trainings in FY 2023/24 largely due to the growth of DBH developed Interactive Online Modules which has seen an increase in learner completions from 328 in FY 2022/23 to 1,378 in FY 2023/24.

In FY 2023/24, WET began offering Reality Based Leadership, LLC, for leadership training and employee development. Reality Based Leadership, LLC, provides the Executive Leadership team support through quarterly one-on-one coaching sessions, interactive learning sessions, and group coaching sessions. The Leadership Development and Employee Development components included interactive learning sessions, books and support materials, and group coaching sessions (Leadership component). WET also offered courses centered around Trauma and Eating Disorders, and a new course titled Indirect Trauma & Empathy-Based Stress for Helping Professionals in an effort to improve the wellness of the care providers.

The table below provides further details regarding trainings provided by WET in FY 2023/24.

Fiscal Year	Attendance	Classes Offered	Continuing Education Credits	Evaluation Average
FY 2013/14	3,095	136	939.45	4.5
FY 2014/15	3,524	108	703	4.6
FY 2015/16	3,867	120	391	4.6
FY 2016/17	4,296	234	494.5	4.6
FY 2017/18	4,477	231	281.5	4.64
FY 2018/19	4,371	283	567.5	4.74
FY 2019/20	4,173	221	886.5	4.7
FY 2020/21	4,467	245	92	4.2
FY 2021/22	3,812	293	177	4.6
FY 2022/23	4,313	223	327	4.67
FY 2023/24	3,658	235	540	4.62

Positive Results, cont.

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 ongoing coordination of activities with the Community Services and Supports (CSS) plan in compliance with MHSA requirements. The Peer and Family Advocate position also fulfills the MHSA Workforce Education and Training goal of increasing the number of consumers and family members of consumers employed in the public mental health system.

As shown in the table to the right, there has been a significant increase in PFAs hired in DBH over the last several years. This is largely due to increasing knowledge and evidence of the benefits when including Peer and Family Advocates in 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 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 public awareness of the PFA role and attracts a greater pool of qualified applicants each year.

Total Peer and Family Advocates with DBH

Fiscal Year	Positions	**Fiscal Year**	Positions
FY 2005/2006	4	FY 2015/2016	28
FY 2006/2007	19	FY 2016/2017	26
FY 2007/2008	24	FY 2017/2018	36
FY 2008/2009	24	FY 2018/2019	28 (Plus 7 Vacancies)
FY 2009/2010	21	FY 2019/2020	35 (Plus 7 Vacancies)
FY 2010/2011	20	FY 2020/2021	35 (Plus 7 vacancies)
FY 2011/2012	24	FY 2021/2022	29 (Plus 20 vacancies)
FY 2012/2013	25	FY 2022/2023	34 (Plus 21 vacancies)
FY 2013/2014	23	FY 2023/2024	40 (Plus 16 vacancies)
FY 2014/2015	29		

Workforce Education and Training

Positive Results, cont.

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.

PFAs Promoted			
Fiscal Year	Promotions	**Fiscal Year**	Promotions
FY 2007/2008	3	FY 2017/2018	5
FY 2011/2012	1	FY 2018/2019	6
FY 2012/2013	1	FY 2019/2020	11
FY 2013/2014	4	FY 2020/2021	2
FY 2014/2015	3	FY 2021/2022	5
FY 2015/2016	4	FY 2022/2023	5
FY 2016/2017	3	FY 2023/2024	7

"I also appreciated the support from [the] WET supervisor and CYCS supervisor as they were significantly helpful in clarifying doubts, concerns, and questions related to the practice of my work and assisted in enhancing my knowledge."

- 20/20 Program Intern

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

In FY 2023/24, DBH implemented the Southern Counties Regional Partnership (SCRP) PFA pipeline development program intended to support PFAs who have achieved certification by offering stipends to retain them within the Public Mental Health System. These funds have been set aside specifically to address DBH's need to recruit and retain PFAs. Additionally, the stipends will address a gap in DBH's pipeline development and succession planning by creating a path for this classification to other positions within DBH.

Positive Results, cont.

To meet the goal of conducting 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 consumers and family members, the Volunteer Services Coordinator participates in career fairs throughout the County, including remote areas such as Barstow and the Morongo Basin. As illustrated in the table below, the coordinator increased the number of participants in outreach efforts every year through FY 2017/18, subsequent years were impacted due to the COVID-19 pandemic, which caused the Volunteer Services Coordinator to attend fewer outreach events than in previous years. It had increased again every year since 2020 until FY 2023/24 when no new events were scheduled during the search for a new Volunteer Services Coordinator due to promotion.

Fiscal Year	Number of Schools Visited	Number of Participants
FY 2011/12	13	2,470
FY 2012/13	16	2,479
FY 2013/14	23	1,706
FY 2014/15	35	2,770
FY 2015/16	35	4,139
FY 2016/17	70	6,958
FY 2017/18	82	9,303
FY 2018/19	63	6,377
FY 2019/20	59	5,818
FY 2020/21	25	2,070
FY 2021/22	32	3,093
FY 2022/23	39	4,222
FY 2023/24	21	1,582
Total	**513**	**52,987**

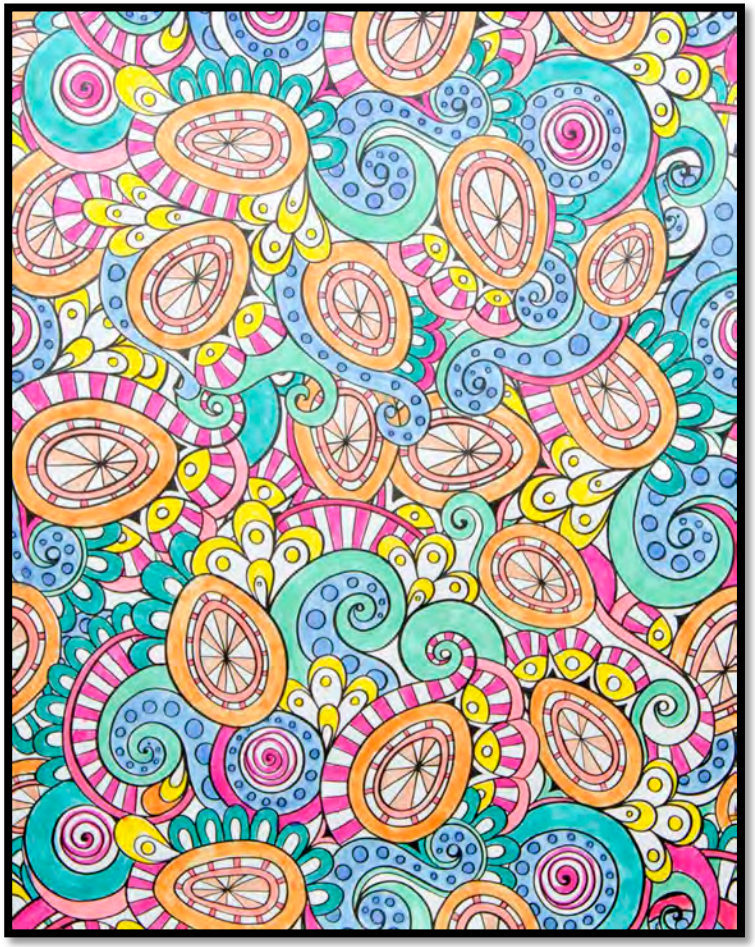
Positive Results, cont.

To reach the Spanish speaking community, the Volunteer Service Coordinator partnered with a bilingual co-presenter and translated presentations and handouts into Spanish. The co-presenter also helped 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 goal of recruiting, employing, and supporting individuals in the public mental health system who are culturally and linguistically competent—or, at a minimum, educated and trained in cultural competence—DBH strives to ensure that its staff provides culturally and linguistically competent services to consumers. To ensure that this measure is met, all staff are required to take either online or in-person cultural competency trainings (2 hours for non-clinicians and 4 hours for clinicians) annually.

"I had minimal desire to work with the adolescent population. After doing a rotation with Dr. Wigfall, I felt like the adolescent population was not so difficult to manage and that there was a great need to manage the mental health of the children."

- Charles R. Drew University Nurse Practitioner Student

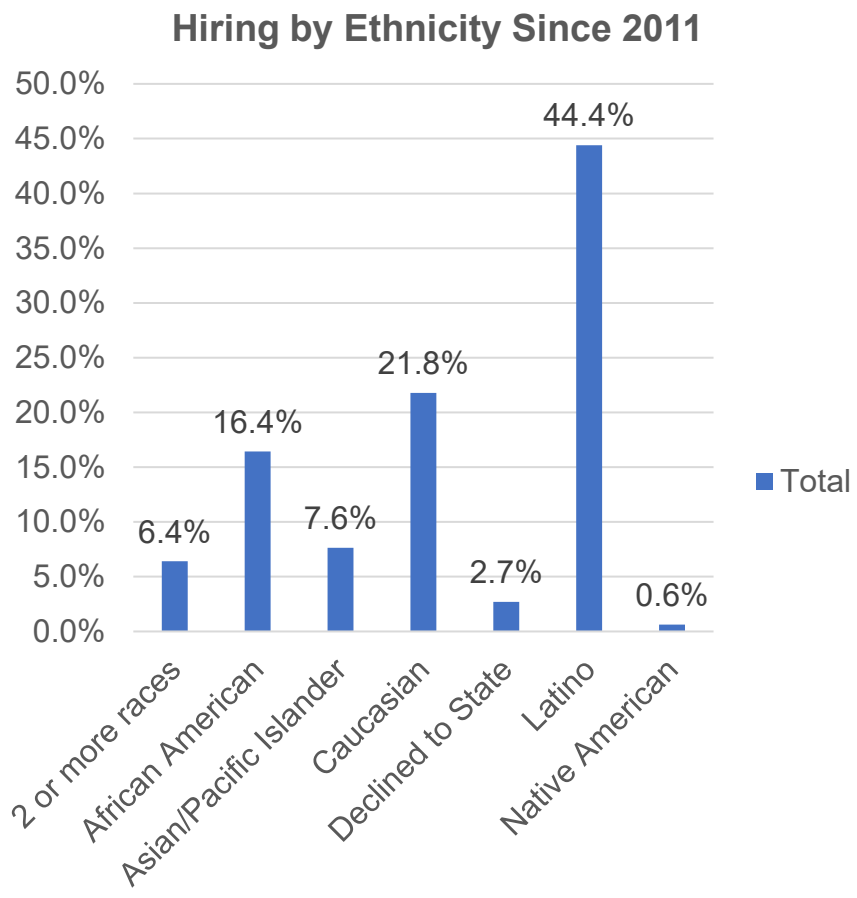


Artwork by Betsy Pruitt

Workforce Education and Training

Positive Results, cont.

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.



To provide culturally and linguistically competent services to consumers, DBH actively recruits applicants who are bilingual and bicultural. As can be seen below, DBH has increased the number of bilingual staff employed in FY 2023/24. It remains a top priority of the department to continue to recruit and retain bilingual staff.

Fiscal Year	Number of Bilingual Staff
FY 2012/13	150
FY 2013/14	165
FY 2014/15	162
FY 2015/16	171
FY 2016/17	171
FY 2017/18	170
FY 2018/19	172
FY 2019/20	211
FY 2020/21	208
FY 2021/22	214
FY 2022/23	203
FY 2023/24	247

Most bilingual staff speak Spanish, but other languages spoken by staff include Tagalog, Vietnamese, French, and German.

Workforce Education and Training

Positive Results, cont.

WET has actively recruited bilingual interns to help provide services in other languages. Since FY 2008/09, on average, **35%** of interns are bilingual. In FY 2023/24, **31%** of interns were bilingual. Of the bilingual interns, **85%** were Spanish speakers.

The table below indicates the bilingual intern information:

Fiscal Year	Total Bilingual	Total Interns	% of Bilingual Interns
2008/09	16	39	41%
2009/10	10	46	22%
2010/11	18	41	44%
2011/12	8	44	18%
2012/13	13	47	28%
2013/14	14	51	27%
2014/15	16	43	37%
2015/16	24	47	51%
2016/17	16	39	41%
2017/18	10	31	32%
2018/19	15	39	38%
2019/20	19	35	54%
2020/21	14	33	42%
2021/22	11	34	32%
2022/23	11	41	27%
2023/24	13	42	31%
Total	**228**	**652**	**35%**

Historically, most bilingual staff speak Spanish, but other languages spoken by staff include Tagalog, Vietnamese, French, and German.

Workforce Education and Training

Positive Results, cont.

The Employee Scholarship Program (ESP) was piloted in 2013 to meet the goal of providing financial incentives to recruit or retain employees within the public mental health system. Within the ESP program, $25,000 in funds are budgeted per year to be distributed among the awardees. The funding for ESP has been allocated to provide scholarships designed to pay student tuition (not to include books, travel, or other expenses) for employees who are working to earn a clinical or non-clinical certificate, associate or bachelor's degree, or a non-clinical master's or doctorate degree. This opportunity is expressly designed to promote the development of a strong, stable, and diverse workforce within DBH.

The table below provides a breakdown of which degrees the awardees were pursuing:

Fiscal Year	Certificate	Associate	Bachelors	Masters		Total Recipients
12/13	0	2	5	5	0	12
13/14	0	0	5	6	0	11
14/15	1	0	4	3	0	8
15/16	1	0	5	4	0	10
16/17	1	1	5	2	0	9
17/18	0	0	6	4	0	10
18/19	0	0	2	1	0	3
19/20	0	0	0	0	0	0
20/21	0	0	1	2	1	4
21/22	0	0	2	5	1	8
22/23	0	0	2	1	0	3
23/24	0	0	2	3	0	5
Total	**3**	**3**	**39**	**36**	**2**	**83**

Note: In FY 2019/20, the program was paused due to budget concerns related to COVID-19 but resumed in FY 2020/21.

Workforce Education and Training

Positive Results, cont.

The following table illustrates the number of ESP awardees who have promoted to new positions.

Fiscal Year	Awardees Promoted	Fiscal Year	Awardees Promoted
2012/13	1	2018/19	10
2013/14	2	2019/20	1
2014/15	2	2020/21	1
2015/16	0	2021/22	3
2016/17	1	2022/23	4
2017/18	3	2023/24	3

Awardees were given money up to their tuition amount. Sometimes their tuition was less than the award amount.

Success Points

- Of the six third-year Psychiatric Residents, three were accepted into Child Psychiatry Fellowship.
- All fourth-year Psychiatric Residents graduated from their program.

WET was able to add the following DBH sites as approved National Health Service Corps (NHSC) designated sites in FY 2023/24, allowing DBH employees working at those sites to continue to be eligible for NHSC Financial Incentive programs including the Loan Repayment Programs:

- Apple Valley Community Clinic
- Juvenile Justice

"Seeing how the Attendings approached various patients, regardless of their background, to provide them with excellent care had a lasting impact on my career choice. Witnessing their dedication to patient-centered care and their ability to connect with individuals from diverse backgrounds taught me invaluable lessons in empathy, communication, and professionalism. This experience reinforced my commitment to delivering high quality care and will undoubtedly influence my approach to patient interactions, regardless of the specialty I ultimately choose."

- Western University Medical Student

Workforce Education and Training

Positive Results, cont.

DBH uses multiple methods to meet the goal of incorporating the input of diverse racial/ethnic populations that reflect California's general population into WET programs and/or activities. DBH uses the Workforce Development Discussion (WDD) meeting and partners with the Office of Equity and Inclusion (OEI) 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 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 served to address the cultural needs of the community
- Participating in Cultural Competency Advisory Committee and fourteen culturally-specific awareness subcommittees

OEI also works closely with the WDD committee to ensure the needs of San Bernardino County's diverse racial/ethnic populations are being met.

To meet the goal of establishing regional partnerships, the Southern Counties Regional Partnership (SCRP) was created in 2009. SCRP is a collaborative effort between the 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 since FY 2014/15. San Bernardino County continues to participate in SCRP as a member county.

Challenges/Solutions

In FY 2023/24, the WET program continued to face the challenge of maintaining a strong training curriculum across the department. However, with a fully staffed training division, WET successfully kept up with the latest training trends and implemented several new trainings that incorporated e-learning components using software like RISE and Articulate 360.

The employee scholarship program experienced only a slight increase in participation during FY 2023/24. To further address this ongoing challenge, WET will continue discussions to expand the program's eligibility criteria to boost employee involvement. WET broadened its advertising strategies by including direct advertisements to clinics and engaging clinic supervisors to serve as direct communication channels. WET also introduced information sessions to raise awareness and collaborated with the Public Relations Office for ongoing promotion during enrollment periods. To combat high turnover rates, WET plans to offer the scholarship opportunity twice per year and will review the application requirements to potentially include employees who were previously excluded due to being new to the department or on probation.

The shortage of placement sites for the Volunteer Services program and Internship program remains a significant challenge for WET. Additionally, the vacancy and subsequent hiring of a new Volunteer Service Coordinator led to a decrease in outreach efforts. Now that the position has been filled, WET will focus on enhancing outreach and pipeline development efforts. The Volunteer Service Coordinator role is now managed by the Public Relations Office to streamline outreach and volunteer activities on behalf of the department.

The addition of interactive online modules continues to highlight the high completion rates of online training in the department. While online training via the Learning Management System (LMS) has been utilized for many years, the data for this digital content was not being captured and utilized as only live trainings were reported. The development of online curriculum, especially that which includes interactive elements, is a time-intensive process. All digital content produced by DBH training staff must be maintained and updated regularly. This work produces measurable training hours that should be reported alongside live training for an accurate representation of WET. To account for the online training hours, WET continues to use newly-developed evaluation forms for all online courses to track staff completion within the fiscal year and collects feedback to help improve the online courses and their effectiveness.

Workforce Education and Training

Outreach and Engagement

In FY 2023/24, WET organized and/or participated in the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Community Event – Recovery Happens	1	77
College Career Fairs	8	465
Classroom Presentations	9	862
Mock Interviews	3	178
Total	**21**	**1,582**

Program Updates

During this reporting year, WET received two new positions: an Administrative Supervisor, and a Staff Training Instructor. With the addition of these two positions, WET is able to expand administrative support and increase the number of recurring trainings.

"All the faculty I've interacted with were very nice and welcoming. I'm excited to work with psychiatrists in the future. I feel that from their teachings, I have a better understanding for how to prescribe psych medications for patients as a primary care provider."

- California University of Science and Medicine Medical Student

"During my rotation, I had the opportunity to work closely with underrepresented patients. Connecting with the patients on a personal and cultural level was incredibly rewarding. I continue to recognize the significant need for culturally competent healthcare professionals in our community. This experience continues to influence my career choice and fuel my commitment to serving underrepresented patient populations."

- ARMC Resident

Workforce Education and Training

Collaborative Partners

- Alder School of Professional Psychology
- American Career College
- American University of Antigua
- Argosy University
- Arrowhead Regional Medical Center (ARMC)
- Azusa Pacific University – High Desert Campus
- UMass Global University
- Cajon High School, San Bernardino – Get Psyched
- California Baptist University
- California State University, San Bernardino
- California State University, Fullerton
- Chaffey Joint Union High School District
- Colton-Redlands-Yucaipa Regional Occupational Program (CRY ROP)
- Fontana Unified School District
- Loma Linda University Medical
- Loma Linda University School of Medicine (LLUSM)
- Mountain Desert Career Pathways
- Pomona Valley Hospital Medical Center (PVHMC)
- Reach Out-Inland Health Professional Coalition (IEPC)
- Redlands Unified School District Collaborative
- San Bernardino City Unified School District
- San Bernardino Superintendent of Schools (SBSS)
- San Bernardino Valley College
- Touro University College of Osteopathic Medicine (TUCCOM)
- University of San Diego
- Western University of Health (WUH)

Artwork by Tabithia Wilkins

SAN BERNARDINO COUNTY
Behavioral Health

MHSA Annual Update for FY 25/26: Capital Facilities and Technological Needs

Capital Facilities and Technological Needs

Introduction

The Capital Facilities and Technological Needs (CFTN) component must support the goals of the Mental Health Services Act (MHSA) and the provision of MHSA services. The planned use of CFTN funds willl produce long-term impacts with lasting benefits that support the behavioral health system's movement towards recovery, resiliency, culturally competent, and help first models, as well as opportunities for accessible community-based services for consumers and their families. These efforts include the development of various technological advancements, strategies, and/or community-based facilities that support culturally and linguistically appropriate integrated service experiences. Funds may also be used to support an increase in:

- Peer-support and consumer-run facilities,
- Development of community-based, least restrictive settings that 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.

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 371-374.

The San Bernardino County Department of Behavioral Health (DBH) has embraced these transformational concepts inherent to MHSA to develop a wellness focused Capital Facilities and Technological Needs component that supports the public behavioral health system and the infrastructure to improve delivery of services across the county.

Program Description

Capital Facilities

Capital facility expenditures must result in a capital asset that permanently increases the San Bernardino County Department of Behavioral Health's infrastructure. Simply stated, a building or space where MHSA services can be provided.

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 of the quality and coordination of care, operational efficiency, and cost-effectiveness across the Department.

Capital Facilities and Technological Needs

Program Description, cont.

Data Warehouse

Research and Evaluation (R&E) manages the Data Warehouse which houses data from diverse sources that are then combined to provide consistency in advanced analytics and data mining. This framework supports the requirements of the California Advancing and Innovating Medi-Cal (CalAIM) program and the foundation for informed program planning across the continuum of care. By incorporating information about consumers and the services they receive with externally captured outcomes data, the Data Warehouse is uniquely poised to provide the next generation of analytics, dashboard reporting, and clinical decision support, needed to meet the County's vision for wellness.

Behavioral Health Management Information Systems (BHMIS) Replacement – Electronic Health Record (EHR)

Innovative Health Information Technology (iHIT) manages all technical solutions associated with the integrated BHMIS - with Billing, Claiming, & EHR functions. The BHMIS supports consumer care by providing secure access and exchange of health information by providers. The purpose of BHMIS is to provide an efficient system to support information collection and enhance coordination of care between internal and external providers. This allows providers to document care in a manner that fosters consumer and family interactions and enables highly functional reporting and data aggregation.

Services Offered

Capital Facilities

- Obtains permanent capital assets to deliver behavioral health services

Technological Needs

- Manage, maintain, and improve the Electronic Health Record (EHR)
- Maintain and utilize the Data Warehouse to
    - Generate Reports
    - Power Business Intelligence Dashboards
    - Conduct Statistical Analysis
    - Develop Outcomes data models
    - Monitor and report on Network Adequacy
- Respond to various aspects related to the 1115 Waiver Medi-Cal Program (Medi-Cal 2020)
- Support the delivery of services for clinicians onsite and remotely
- Provide 24/7 support to the DBH Call Center and Crisis Response Unit
- Support the connectivity, security, and access to resources for staff working remotely
- Support all deployments of staff in response to emergency incidents
- Support DBH's adherence to County directives in compliance with local State of Emergencies

Positive Results

Technological Needs

To address the goal of increasing access to services, DBH's Research and Evaluation (R&E) unit used the power of the Data Warehouse to streamline electronic Provider Directory development and reporting. Additionally, new timely access reports were created to assist with capacity planning and informed decision-making to ensure access to care. R&E also specifically monitors and reports on access to services for specialized populations such as foster youth, unsheltered individuals, and consumers shared by the Managed Care Plans. Data from the Data Warehouse supports grant requests and contract negotiations, which are instrumental in maintaining and expanding the DBH network of care.

The renewal of Statistical Analysis System (SAS) software licensing and maintenance agreement to support and expand the Data Warehouse, including text analytics, continues to improve data collection and reporting of new and existing requirements (MHSA, SB1291, Final Rule, CalAIM, Healthcare Effectiveness Data and Information Set (HEDIS), and Coronavirus Aid, Relief, and Economic Security (CARES) Act, etc.), and data modeling designed for use in clinical support tools. Due to the resilience of the programming for the Data Warehouse, the change to CalAIM service codes was smoothly transitioned, and the analytics staff using the Data Warehouse were able to continue to use it to provide information for decision makers.

The Data Warehouse also supports the monitoring and implementation of:

- Data quality improvement initiatives
- Data reporting and analysis for DBH housing programs
- Data reporting for MHSA annual reports, utilization, equity, audits, and reviews
- Expanded reporting to meet Network Adequacy requirements including monthly electronic submissions of the Provider Directory to the Department of Healthcare Services (DHCS).

To maintain and utilize the Data Warehouse, DBH incorporates the DHCS Plan Data Feed, containing Medi-Cal service and pharmacy data for DBH consumers from external providers along with the measurement of outcomes data over time. This data provides a more comprehensive view of DBH consumers for clinical and medical staff when utilized alongside the DBH EHR data.

The use of the DBH Data Warehouse has proven invaluable in establishing the positive outcomes of programs that originated through MHSA Innovations from Recovery Based Engagement Support Teams (RBEST) to Triage Engagement and Support Teams (TEST) and Innovative Remote Onsite Assistance Delivery (InnROADS), providing the information necessary to support program continuation of these key programs for high-needs populations.

Challenges/Solutions

Technological Needs
The Data Warehouse challenges continue to be:

- The integration of the wide range of data, including new clinical data sources;
- The development and use of data mining in clinical support; and
- Integration of text analytics to extract data from text-based systems.

To address these continuing challenges, the Research and Evaluation (R&E) unit has formed a team to foster the development of data mining solutions.

The Plan Data Feed, which is based on services for consumers from other sources than DBH, has been integrated into R&E's processes for calculating a variety of HEDIS measures. Additionally, Emergency Department data coming from the Managed Care Plans is being processed and delivered to programs to assist in effective continuity of care efforts.

Innovative Health Information Technology (iHIT)
We face several challenges as we enhance and support technology systems to support programs like CalAIM, Payment Reform, and the Justice-Involved Reentry Initiative. These challenges include:

- **Updating data systems** to meet new Medi-Cal billing rules for Specialty Mental Health and Drug Medi-Cal services. This is critical to ensure we receive full payment for the services we provide.
- **Implementing the Justice-Involved Reentry Initiative,** a groundbreaking program that offers Medi-Cal services to youth and adults in state prisons, county jails, and youth correctional facilities.
- **Improving data sharing** with Medi-Cal Managed Care Plans to better coordinate care and streamline services.

These challenges require continuous system updates to ensure compliance and provide technology solutions that enhance health outcomes for our residents. The Department of Behavioral Health will continue to explore possible solutions to address the identified challenges in the upcoming year.

Capital Facilities and Technological Needs

Program Updates

Systems Operations and Support Team (SOaS) Expansion

- SOaS added an Application Specialist position during FY 2023/24.

Data Warehouse Maintenance and Support

The Data Warehouse is instrumental in the development of new HEDIS measure reporting requirements from DHCS. Additionally, the Data Warehouse provides the processing power to develop systemwide key performance indicators (KPI) dashboards as part of the Departments ongoing commitment to use data to better serve San Bernardino County residents.

Artwork by Judy Whiting

SAN BERNARDINO COUNTY
Behavioral Health

MHSA Annual Update for FY 25/26: Fiscal

Introduction

As part of Department of Behavioral Health's (DBH) continued fiscal accountability, management, and transparency of MHSA funds, DBH has revised the reporting of program expenditures and revenues for this State Plan Update to align with actual anticipated utilization values based on historical trends and anticipated growths. This revision ensures more accurate reporting of usages and availabilities of MHSA funds allotted to DBH consistent with County of San Bernardino's ongoing goal of responsible resource use to ensure financial sustainability. This change does not affect the commitments approved by the Board of Supervisors.

Artwork by Tracy Hutchinson

Funding Summary FY 2025/26
County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Annual Update Fiscal Year 2025/26

	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
Estimated FY 2025/26 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	$ 136,874,251	$ 47,956,191	$ 22,914,693	$ -	$ -	$
2. Estimated New FY 2025/26 Funding	$ 102,814,398	$ 25,727,368	$ 6,886,856			$
3. Transfer in FY 2025/26	$ (12,736,153)	$	$	$ 5,791,060	$ 6,945,093	$
4. Access Local Prudent Reserve in FY 2025/26	$	$	$	$	$	$
5. Estimated Available Funding for FY 2025/26	$ 226,952,496	$ 73,683,560	$ 29,801,549	$ 5,791,060	$ 6,945,093	$
Estimated FY 2025/26 MHSA Expenditures	$ 148,517,355	$ 29,562,079	$ 3,665,585	$ 5,791,060	$ 6,945,093	$
FY 2025-26 Unspent Fund Balance	$ 78,435,141	$ 44,121,481	$ 26,135,964	$ -	$ -	$

Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2025	$ 21,655,429.00
2. Contributions to the Local Prudent Reserve in FY 2025/26	$
3. Distributions from the Local Prudent Reserve in FY 2025/26	$
4. Estimated Local Prudent Reserve Balance on June 30, 2026	$ 21,655,429.00

PREVENTION AND EARLY INTERVENTION FY 2025/26
County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Annual Update Fiscal Year 2025/26

PEI State and County Programs	Estimated PEI Funding					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated Prevention and Early Intervention Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Access and Linkage to Treatment						
1. PEI SE-2 Child and Youth Connection	$ 27,634,088	$ 14,575,691	$ 11,980,962			$ 1,077,434
Outreach for Recognition of Early Signs of Mental Illness						
1. PEI CI-1 Promotores de Salud/Community Health Worker	$ 1,028,860	$ 1,028,860				
2. PEI CI-4 Behavioral Health Ministries Pilot Project	$ -	$ -				
3. PEI CI-5 Substance Use Prevention & Pathways to Outreach and Treatment (SUPPOrT)	$ 318,852	$ 165,296	$ 153,557			
Suicide Prevention						
1. PEI SE-8 Office of Suicide Prevention	$ 391,919	$ 391,919				
Stigma and Discrimination Reduction						
1. PEI CI-3 Native American Resource Center	$ 336,673	$ 336,673				

PREVENTION AND EARLY INTERVENTION FY 2025/26, cont.

County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Annual Update Fiscal Year 2025/26

PEI State and County Programs	Estimated PEI Funding					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated Prevention and Early Intervention Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Prevention						
1. PEI SI-2 Preschool PEI Program	$ 481,463	$ 481,463				
2. PEI SI-3 Resilience Promotion in African-American Children	$ 587,373	$ 587,373				
3. PEI SE-1 Older Adult Community Services	$ 946,096	$ 946,096				
4. PEI SE-5 Lift Program	$ 471,616	$ 471,616				
5. PEI SE-6 Coalition Against Sexual Exploitation (CASE)	$ 258,403	$ 258,403				
Prevention and Early Intervention						
1. PEI CI-2 Family Resource Center	$ 4,441,873	$ 4,441,873				
2. PEI SE-3 Community Wholeness and Enrichment	$ 827,807	$ 827,807				
3. PEI SE-4 Military Services and Family Support	$ 652,176	$ 652,176				
4. PEI SI-1 Student Assistance Program (SAP)	$ 5,334,646	$ 1,358,706	$ 3,130,791			$ 845,149
5. PEI SE-7 Improving Detection and Early Access (IDEA)	$ 302,794	$ 302,794				
PEI Programs	$ 44,014,640	$ 26,826,746	$ 15,265,310	$ -	$ -	$ 1,922,583
PEI Administration	$ 2,547,117	$ 2,547,117				$ -
PEI Assigned Funds	$ 188,215	$ 188,215				$ -
Total PEI Program Estimated Expenditures	$ 46,749,972	$ 29,562,079	$ 15,265,310	$ -	$ -	$ 1,922,583

COMMUNITY SERVICES AND SUPPORTS FY 2025/26
County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Annual Update Fiscal Year 2025/26

CSS Program Name	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 Children and Family Support Program (CCFSS)	$ 51,690,012	$ 33,702,858	$ 17,987,153			
2. C-2 Integrated New Family Opportunities Program (INFO)	$ 1,732,183	$ 1,047,441	$ 684,743			
3. TAY-1 One Stop TAY Centers	$ 7,477,785	$ 5,063,215	$ 2,414,571			
4. A-2 Forensic Services Continuum of Care	$ 8,788,225	$ 5,614,467	$ 2,539,632			$ 634,126
5. A-3 Assertive Community Treatment Model FSP	$ 2,616,921	$ 1,611,968	$ 1,004,952			
6. A-7 Homeless Services, Long-Term Supports, and Transitional Care Programs	$ 22,918,450	$ 15,776,207	$ 6,469,889			$ 672,354
7. OA-1 Age Wise	$ 2,507,857	$ 1,694,998	$ 812,859			
8. A-11 Regional Adult Full Service Partnership (RAFSP)	$ 15,506,317	$ 2,995,483	$ 7,516,763			$ 4,994,071
9. A-20 Collaborative Adult Full Service Partnership Services	$ 4,273,574	$ 2,815,549	$ 1,458,025			
FSP Programs Total	$ 117,511,323	$ 70,322,186	$ 40,888,586	$ -	$ -	$ 6,300,551

COMMUNITY SERVICES AND SUPPORTS FY 2025/26, cont.
County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Annual Update Fiscal Year 2025/26

CSS Program Name	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
Non-FSP Programs						
1. A-1 Peer Programs	$ 5,897,718	$ 5,897,718				
2. A-4 Crisis Stabilization Units (CSU)/Crisis Walk-In Centers (CWIC)	$ 13,383,661	$ 8,675,601	$ 4,708,060			
3. A-5 Triage Transitional Services (TTS)	$ 2,033,100	$ 847,487	$ 1,185,613			
4. A-6 Community Crisis Services	$ 10,501,558	$ 6,941,805	$ 3,559,753			
5. A-9 Access, Coordination, and Enhancement (ACE) of Quality Behavioral Health Services	$ 1,724,506	$ 653,784	$ 1,070,722			
6. A-10 Crisis Residential Treatment Program (CRT)	$ 16,610,099	$ 9,403,937	$ 5,465,838			$ 1,740,324
7. A-13 Adult Transitional Care Programs	$ 30,275,559	$ 17,901,601	$ 12,373,957			
8. A-15 Recovery Based Engagement Support Teams (RBEST)	$ 4,300,473	$ 3,455,038	$ 845,435			
9. A-16 Crisis Intervention Collaborative Programs	$ 6,996,318	$ 4,491,022	$ 2,167,626			$ 337,671
10. A-17 Eating Disorder Collaborative	$ 2,815,958	$ 2,815,958				
11. A-18 Cracked Eggs	$ 185,241	$ 185,241				
Non-FSP Programs Total	$ 94,724,192	$ 61,269,192	$ 31,377,005	$ -	$ -	$ 2,077,995
CSS Programs	$ 212,235,515	$ 131,591,378	$ 72,265,591	$ -	$ -	$ 8,378,545
CSS Administration	$ 21,483,785	$ 16,925,976	$ 4,557,809			
Total CSS Program Estimated Expenditures	$ 233,719,300	$ 148,517,355	$ 76,823,400	$ -	$ -	$ 8,378,545
FSP Programs as Percent of Total	50.3%					

INNOVATION FY 2025/26
County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Annual Update Fiscal Year 2025/26

Innovation Program Name			Estimated INN 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.	INN-08	Innovative Remote Onsite Assistance Delivery (InnROADS)*	$ -					
2.	INN-09	Eating Disorder Collaborative	$ -	$ -				
3.	INN-10	Multi County Full Service Partnership (FSP)	$ -					
4.	INN-11	Cracked Eggs	$ -	$ -				
5	INN-12	Progressive Integrated Care Collaborative (PICC)	$ 2,816,114	$ 2,816,114				
6	INN-13	Vyvanse in Stimulate Addiction (VISA)	$ -	$ -				
		INN Programs	$ 2,816,114	$ 2,816,114	$ -	$ -	$ -	$ -
		INN Administration	$ 849,471	$ 849,471	$ -			$ -
		Total INN Program Estimated Expenditures	$ 3,665,585	$ 3,665,585	$ -	$ -	$ -	$ -

*Transitioned to CSS A-7-effective April 2024

WORKFORCE EDUCATION AND TRAINING FY 2025/26
County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Annual Update Fiscal Year 2025/26

WET Program Name	Estimated WET 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
WET FSP Programs						
1. Training and Technical Support	$ 608,563	$ 608,563				
2. Internship Program	$ 1,306,841	$ 1,306,841				
3. Psychiatric Residency Program	$ 1,309,684	$ 1,309,684				
4. Financial Incentive Program	$ -					
WET Programs	$ 3,225,088	$ 3,225,088				
WET Administration	$ 2,369,519	$ 2,369,519				
WET Contribution	$ 196,453	$ 196,453				
Total WET Program Estimated Expenditures	$ 5,791,060	$ 5,791,060	$ -	$ -	$ -	$ -

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS FY 2025/26

County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Annual Update Fiscal Year 2025/26

Capital Facilities/Technological Needs	Estimated Capital Facilities/Technological Needs 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
CFTN Programs - Capital Programs - Capital Facilities Projects						
1. Comprehensive Treatment Campus	$ -					
2. Community Care Expansion - Facility Preservation	$ -					
CFTN Programs - Technological Needs Projects						
1. Data Warehouse Continuation Project Empowered Communication/SharePoint Project	$ 365,270	$ 365,270				
2 Behavioral Health Management Information Systems (BHMIS), Electronic Health Record (EHR), Telemedicine Project	$ 4,834,785	$ 4,834,785				
CFTN Projects	$ 5,200,055	$ 5,200,055	$ -	$ -	$ -	$ -
CFTN Administration	$ 1,745,038	$ 1,745,038				
Total CFTN Program Estimated Expenditures	$ 6,945,093	$ 6,945,093	$ -	$ -	$ -	$ -

SAN BERNARDINO COUNTY
Behavioral Health

MHSA Annual Update for FY 25/26: Attachments

Attachments Table of Contents

Attachment A

SAN BERNARDINO COUNTY | Behavioral Health

MHSA Annual Update FY 2025/2026

Planning Meetings

Please join us at a **Mental Health Services Act (MHSA) Annual Update FY 2025/26** stakeholder engagement meeting! Learn about service data from the last fiscal year and get information on program changes and enhancements.

Event will be held in-person

January 2025

08 — **10 a.m.**

Mental Health and Substance Use Awareness Subcommittee
Call-In: 1-415-655-0002
WebEx Meeting Number: 961 777 142

Join Meeting

08 — **Noon**

QMAC CEC & Family Member Advisory Subcommittee
Call-In: 1-669-444-9171
Zoom Meeting ID: 959 6126 4010 **Passcode:** 421362

Join Meeting

09 — **1 p.m.**

PEI Quarterly Provider Meeting
Call-In: 1-415-655-0002
WebEx Meeting Number: 2485 096 9219

Join Meeting

09 — **10 a.m.**

Disabilities Awareness Subcommittee
Call-In: 1-415-655-0002
WebEx Meeting Number: 146 434 2208

Join Meeting

09 — **3:30 p.m.**

Second District Advisory Committee
Call-In: 1-415-655-0002
WebEx Meeting Number: 2483 823 7369
Password: pxYctfry353

Join Meeting

10 — **10 a.m.**

Asian Pacific Islander Awareness Subcommittee
Call-In: 1-415-655-0002
WebEx Meeting Number: 968 187 539

Join Meeting

13 — **10 a.m.**

Suicide Prevention Awareness Subcommittee
Call-In: 1-415-655-0002
WebEx Meeting Number: 146 264 6760

Join Meeting

13 — **10 a.m.**

Victor Community Support Services
Call-In: 1-669-444-9171
Zoom Meeting ID: 237 481 4005 **Passcode:** 865178

Join Meeting

13 — **2 p.m.**

African American Awareness Subcommittee
Call-In: 1-415-655-0002
WebEx Meeting Number: 146 893 8322

Join Meeting

14 — **1 p.m.**

Spirituality Awareness Subcommittee
Call-In: 1-415-655-0002
WebEx Meeting Number: 961 357 009

Join Meeting

14 — **10:30 a.m.**

Desert Stars Clubhouse
1841 E. Main St., Barstow

15 — **11 a.m.**

Pathways to Recovery Clubhouse
17053 E. Foothill Blvd. Suite B, Fontana

15 — **2 p.m.**

Transitional Age Youth (TAY) Awareness Subcommittee
Call-In: 1-415-655-0002
WebEx Meeting Number: 960 523 715

Join Meeting

15 — **Noon**

Ontario Montclair School District - Health & Wellness Services Family Resource Center
1556 S. Sultana Ave. Ontario

15 — **6 p.m.**

Fourth District Advisory Committee
Call-In: 1-415-655-0002
WebEx Meeting Number: 2495 776 5577
Password: fBw5HAvQH23

Join Meeting

15 — **11 a.m.**

First District Advisory Committee
Call-In: 1-415-655-0002
WebEx Meeting Number: 187 662 3366

Join Meeting

16 — **1 p.m.**

Cultural Competency Advisory Committee (CCAC)
Call-In: 1-415-655-0002
WebEx Meeting Number: 969 101 891

Join Meeting

21 11 a.m.

Amazing Place Clubhouse
2940 Inland Empire Blvd., Ontario

21 2 p.m.

Native American Awareness Subcommittee
Call-In: 1-415-655-0002
WebEx Meeting Number: 146 996 4635
Join Meeting

21 10 a.m.

MHSA Administration
Call-In: 1-415-655-0002
WebEx Meeting Number: 2498 681 4350
Join Meeting

21 5 p.m.

MHSA Administration
Call-In: 1-415-655-0002
WebEx Meeting Number: 2495 495 7647
Join Meeting

22 11 a.m.

Serenity Clubhouse
12625 Hesperia Rd. Suite B, Victorville

22 1 p.m.

Women's Awareness Subcommittee
Call-In: +1-415-655-0002
WebEx Meeting Number: 967 920 279
Join Meeting

23 10 a.m.

Older Adults Awareness Subcommittee
Call-In: 1-415-655-0002
WebEx Meeting Number: 961 983 483
Join Meeting

23 10 a.m.

Latino Awareness Subcommittee
Call-In: +1-415-655-0002 - Spanish Only
WebEx Meeting Number: 966 009 041
Join Meeting

24 12:30 p.m.

Pacific Clinics Family Resource Center
58457 Twenty Nine Palms Hwy, Suite 102, Yucca Valley

27 11 a.m.

Consumer and Family Members Awareness Subcommittee
Call-In: +1-415-655-0002
WebEx Meeting Number: 2495 614 6844
Join Meeting

28 11 a.m.

TEAM House Clubhouse
201 W. Mill Street, San Bernardino

28 11:30 a.m.

Central Valley Fun Clubhouse
1501 S. Riverside Ave., Rialto

28 12:30 p.m.

LGBTQ Awareness Subcommittee
Call-In: +1-415-655-0002
WebEx Meeting Number: 960 570 704
Join Meeting

28 5 p.m.

Fifth District Advisory Committee
Call-In: 1-415-655-0002
WebEx Meeting Number: 187 027 1608
Join Meeting

29 11:30 a.m.

Santa Fe Wellness Club Clubhouse
56020 Santa Fe Trail, Suite M, Yucca Valley

30 11:30 a.m.

A Place to Go Clubhouse
32770 Old Woman Springs Rd. Suite B, Lucerne Valley

February 2025

3 3 p.m.

Veterans Awareness Subcommittee
Call-In: 1-415-655-0002
WebEx Meeting Number: 2482 788 1413
Join Meeting

6 9 a.m.

Rim Family Services
Zoom Meeting ID: 825 7790 5597 **Passcode:** 1800
Join Meeting

12 10 a.m.

Victor Community Support Services (San Bernardino)
600 N. Arrowhead Ave. Suite 300, San Bernardino

12 11 a.m.

Third District Advisory Committee
Call-In: 1-415-655-0002
WebEx Meeting Number: 146 962 9460
Join Meeting

19 1 p.m.

Senior Affairs Commission
784 E. Hospitality Lane, San Bernardino

20 10 a.m.

Community Policy Advisory Committee
720 E. Carnegie Dr. Suite 150, San Bernardino

Event will be held in-person

If you speak another language, language assistance services are available free of charge by dialing (888) 743-1478. TTY users dial 711. DBH complies with applicable federal, civil rights laws and does not discriminate based on race, color, national origin, sex, gender identity, age, disability, or the inability to speak English (LEP).

For more information, please visit sbcounty.gov/dbh/

SAN BERNARDINO COUNTY | Behavioral Health

Actualización annual de la MHSA para el año fiscal 2025/2026

Reunión de Planificación

¡Le invitamos a unirse a una reunión de participación de las partes interesadas de la Actualización Anual de la Ley de Servicios de Salud Mental (Mental Health Services Act - MHSA) AF 2025/26! Conozca los datos de servicio del último año fiscal y obtenga información sobre los cambios y mejoras en los programas.

☐ **El evento se llevará a cabo en persona**

Enero 2025

08 — **10 a.m.**

Subcomité de Concientización sobre la Salud Mental y el Uso de Sustancias
Llamada telefónica: 1-415-655-0002
Número de reunión de WebEx: 961 777 142

Ingresar a la reunión

08 — **mediodía**

Subcomité Asesor de la CCA y Miembros de la Familia de QMAC
Llamada telefónica: 1-669-444-9171
ID de reunión de Zoom: 959 6126 4010
Código de acceso: 421362

Ingresar a la reunión

09 — **1 p.m.**

Reunión Trimestral de Proveedores de PEI
Llamada telefónica: 1-415-655-0002
Número de reunión de WebEx: 2485 096 9219

Ingresar a la reunión

09 — **10 a.m.**

Subcomité de Concientización de Discapacidades
Llamada telefónica: 1-415-655-0002
Número de reunión de WebEx: 146 434 2208

Ingresar a la reunión

09 — **3:30 p.m.**

Comité Asesor del Segundo Distrito
Llamada telefónica: 1-415-655-0002
Número de reunión de WebEx: 2483 823 7369
Código de acceso: pxYctfry353

Ingresar a la reunión

10 — **10 a.m.**

Subcomité de Concientización de Asiáticos/Isleños del Pacifico
Llamada telefónica: 1-415-655-0002
Número de reunión de WebEx: 968 187 539

Ingresar a la reunión

13 — **10 a.m.**

Subcomité de Concientización de Prevención del Suicidio
Llamada telefónica: 1-415-655-0002
Número de reunión de WebEx: 146 264 6760

Ingresar a la reunión

13 — **10 a.m.**

Servicios de Apoyo Comunitario de Victor
Llamada telefónica: 1-669-444-9171
Zoom Meeting ID: 237 481 4005
Código de acceso: 865178

Ingresar a la reunión

13 — **2 p.m.**

Subcomité de Concientización de Afroamericanos
Llamada telefónica: 1-415-655-0002
Número de reunión de WebEx: 146 893 8322

Ingresar a la reunión

14 — **1 p.m.**

Subcomité de Concientización de Espiritualidad
Llamada telefónica: 1-415-655-0002
Número de reunión de WebEx: 961 357 009

Ingresar a la reunión

14 — **10:30 a.m.**

Casa Club Desert Stars
1841 E. Main St., Barstow

15 — **11 a.m.**

Casa Club Pathways to Recovery
17053 E. Foothill Blvd. Suite B, Fontana

15 — **2 p.m.**

Subcomité de Concientización de Jóvenes en Edad de Transición (TAY)
Llamada telefónica: 1-415-655-0002
Número de reunión de WebEx: 960 523 715

Ingresar a la reunión

15 — **mediodía**

Distrito Escolar Ontario Montclair – Centro de Servicios de Salud y Bienestar de Recursos Familiares
1556 S. Sultana Ave. Ontario

15 — **6 p.m.**

Comité Asesor del Cuarto Distrito
Llamada telefónica: 1-415-655-0002
Número de reunión de WebEx: 2495 776 5577
Código de acceso: fBw5HAvQH23

Ingresar a la reunión

15 — **11 a.m.**

Comité Asesor del Primer Distrito
Llamada telefónica: 1-415-655-0002
Número de reunión de WebEx: 187 662 3366

Ingresar a la reunión

16 — **1 p.m.**

Comité Consultivo de Competencia Cultural (CCAC)
Llamada telefónica: 1-415-655-0002
Número de reunión de WebEx: 969 101 891

Ingresar a la reunión

21 11 a.m.

Casa Club Amazing Place
2940 Inland Empire Blvd., Ontario

21 2 p.m.

Subcomité de Concientización de Nativos Americanos
Llamada telefónica: 1-415-655-0002
Número de reunión de WebEx: 146 996 4635

Ingresar a la reunión

21 10 a.m.

Administración de MHSA
Llamada telefónica: 1-415-655-0002
Número de reunión de WebEx: 2498 681 4350

Ingresar a la reunión

21 5 p.m.

Administración de MHSA
Llamada telefónica: 1-415-655-0002
Número de reunión de WebEx: 2495 495 7647

Ingresar a la reunión

22 11 a.m.

Casa Club Serenity
12625 Hesperia Rd. Suite B, Victorville

22 1 p.m.

Subcomité de Concientización de Mujeres
Llamada telefónica: +1-415-655-0002
Número de reunión de WebEx: 967 920 279

Ingresar a la reunión

23 10 a.m.

Comisión de Asuntos para Adultos Mayores
Llamada telefónica: 1-415-655-0002
Número de reunión de WebEx: 961 983 483

Ingresar a la reunión

23 10 a.m.

Subcomité de Concientización de Latinos
Llamada telefónica: +1-415-655-0002 - En español
Número de reunión de WebEx: 966 009 041

Ingresar a la reunión

24 12:30 p.m.

Centro de Recursos Familiares de las Clínicas del Pacífico
58457 Twenty Nine Palms Hwy, Suite 102, Yucca Valley

27 11 a.m.

Subcomité de Concientización de Consumidores y Miembros de Familias
Llamada telefónica: +1-415-655-0002
Número de reunión de WebEx: 2495 614 6844

Ingresar a la reunión

28 11 a.m.

Casa Club TEAM house
201 W. Mill Street, San Bernardino

28 11:30 a.m.

Casa Club del Valle Central
1501 S. Riverside Ave., Rialto

28 12:30 p.m.

Subcomité de Concientización de LGBTQ
Llamada telefónica: +1-415-655-0002
Número de reunión de WebEx: 960 570 704

Ingresar a la reunión

28 5 p.m.

Comité Asesor del Quinto Distrito
Llamada telefónica: 1-415-655-0002
Número de reunión de WebEx: 187 027 1608

Ingresar a la reunión

29 11:30 a.m.

Casa Club del Bienestar de Santa Fe
56020 Santa Fe Trail, Suite M, Yucca Valley

30 11:30 a.m.

Casa Club A Place To Go
32770 Old Woman Springs Rd. Suite B, Lucerne Valley

Febrero 2025

3 3 p.m.

Subcomité de Concientización de Veteranos
Llamada telefónica: 1-415-655-0002
Número de reunión de WebEx: 2482 788 1413

Ingresar a la reunión

6 9 a.m.

Servicios Familiares de RIM
Zoom Meeting ID: 825 7790 5597
Código de acceso: 1800

Ingresar a la reunión

12 10 a.m.

Servicios de Apoyo Comunitario de Victor (San Bernardino)
600 N. Arrowhead Ave. Suite 300, San Bernardino

12 11 a.m.

Comité Asesor del Tercer Distrito
Llamada telefónica: 1-415-655-0002
Número de reunión de WebEx: 146 962 9460

Ingresar a la reunión

19 1 p.m.

Comisión de Asuntos para Adultos Mayores
784 E. Hospitality Lane, San Bernardino

20 10 a.m.

Comité Comunitario Consultivo de Políticas
720 E. Carnegie Dr. Suite 150, San Bernardino

El evento se llevará a cabo en persona

Si habla otro idioma, hay servicios de asistencia lingüística disponibles de forma gratuita llamando al (888) 743-1478. Los usuarios de TTY marcan 711. DBH cumple con las leyes federales y de derechos civiles aplicables y no discrimina por motivos de raza, color, origen nacional, sexo, identidad de género, edad, discapacidad o incapacidad para hablar inglés (LEP).

Para obtener más información, visite sbcounty.gov/dbh/

CPP Meeting Web Blast

DEPARTMENT OF
BEHAVIORAL HEALTH UPDATES

January 8, 2025

Mental Health Services Act

Community Program Planning Meetings

Join one of our upcoming meetings and give your feedback!

MHSA Annual Update FY 2025/26 Meeting Schedule

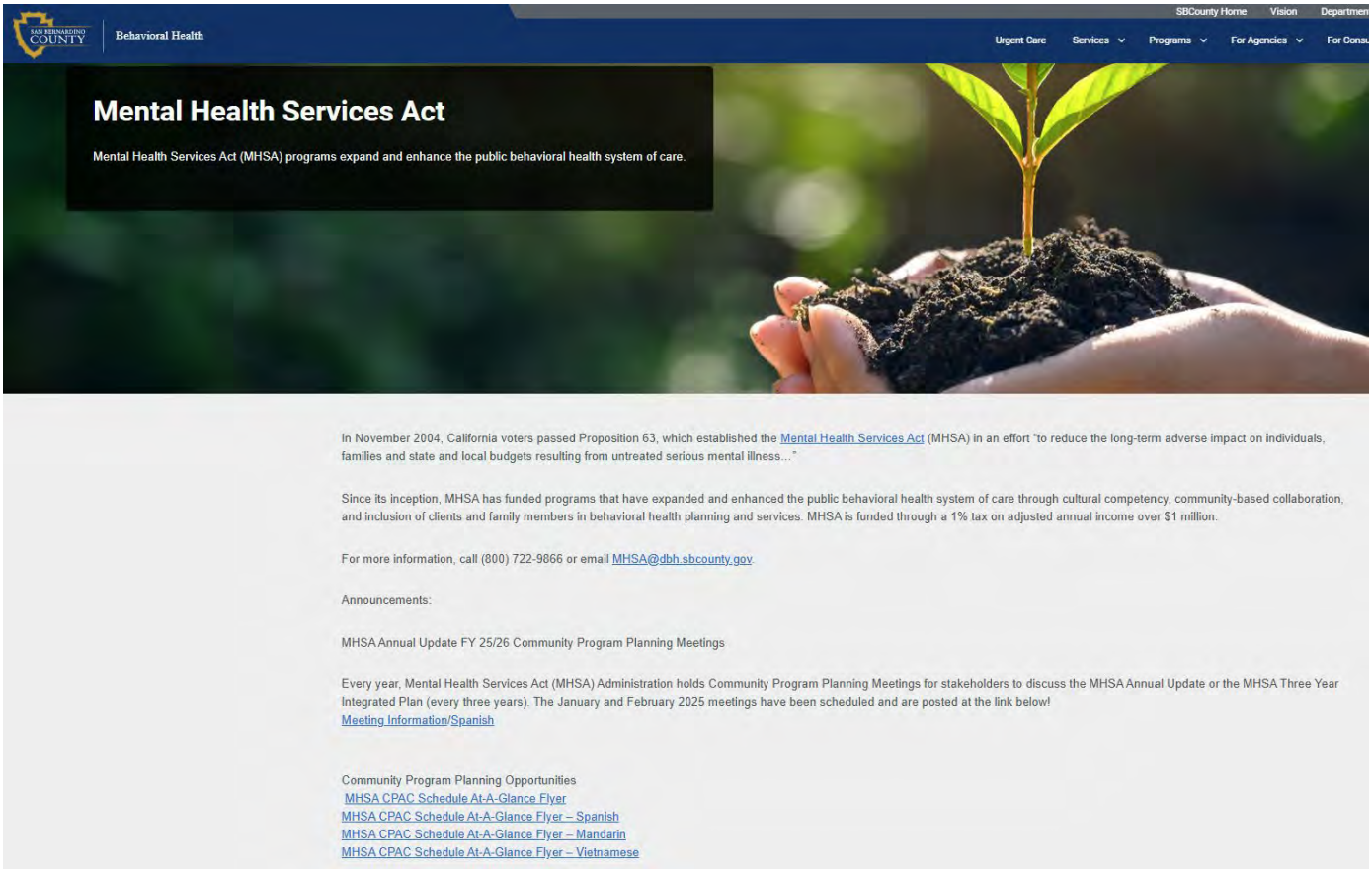
Every year, Mental Health Services Act (MHSA) Administration holds Community Program Planning Meetings for stakeholders to discuss the MHSA Annual Update or the MHSA Three Year Integrated Plan (every three years). The January and February MHSA Annual Update FY 2025/26 meetings have been scheduled and are posted to the Announcements section and the MHSA page of the DBH Website. If you have any questions regarding these meetings, please contact MHSA Administration at (909) 252-4021. We hope to see you at one of the 39 meetings.

Spanish MHSA CPP Flyer
Vietnamese MHSA CPP Flyer
Mandarin MHSA CPP Flyer

**The link below has been corrected to include the MHSA CPP flyer in English.*

English MHSA CPP Flyer

MHSA Website Announcement:



DHB Website Announcement:

Behavioral Health

Mental Health Services Act Annual Update

Fiscal Year 2025/26

Community Program Planning Stakeholder Meeting

1

Meeting **Objectives**

- Provide an overview of the Mental Health Services Act
- Provide an overview of the Mental Health Services Act Annual Plan Update
- Learn about program changes and updates
- Share the community program planning schedule
- Share the community program planning survey
- Provide an overview on Proposition 1
- DBH Capacity Assessment

2

We Want to Know **More!**

- Later in today's presentation, we are asking that you complete a survey. This survey lets us know 'who' is in the audience.
- This information will also be used to identify community needs, determine Mental Health Services Act funding priorities, and guide the creation, implementation, and evaluation of programs.

3

What is the Mental Health Services **Act?**

- The Mental Health Services Act, Prop 63, was passed by California voters in November 2004 and went into effect in January 2005.
  - The Act provides increased funding for mental health programs across the state.
  - The Act is funded by a 1% tax surcharge on personal income over $1 million per year.
- Fluctuations in tax payments impact fiscal projections and available funding.

4

Mental Health Services Act Three Year **Plan**

- It is required by Mental Health Services Act regulations (Welfare Institution Code § 5847).
- Highlights trends, program goals, and outcomes of the Department of Behavioral Health programs and provides a roadmap to a unified system of care.
- Current plan covers the time period of Fiscal Years (FYs) 2023/24 through 2025/26.
- Approved on June 13, 2023, by the County Board of Supervisors.

5

Annual Plan Update **Overview**

6

What is an Annual Plan **Update?**

An Annual Plan Update provides:

- Service data for the prior fiscal year.
  - The data reported is for fiscal year 2023/24.
- Information on program planning for the upcoming fiscal year to our stakeholders.
- Updates to the Mental Health Services Act Three-Year Integrated Plan for FY 2023/2024 through 2025/2026.

The purpose of the Annual Plan Update is to:

- Evaluate short-term and long-term impacts of Mental Health Services Act funded programs.
- Use the document as evidence to demonstrate that we are meeting the regulatory requirements.

This year we will develop an Annual Plan Update for fiscal year 2025/26.

7

The Mental Health Services Act Plan and Annual Updates are constructed out of five components as well as a budget summary and component detail:

Community Services and Supports

Programs and services intended for serious mental illness (SMI) populations with focus on individuals at risk of psychiatric hospitalization and/or homelessness due to the severity of the illness they are living with.

76% • • • Mental Health Services Act funds

Prevention and Early Intervention

Services are intended to stop a mental illness from becoming severe or to even deter the onset if possible. Target populations are those experiencing signs of symptoms or risk factors.

19% • • • Mental Health Services Act funds

8

Innovation

Time-limited projects intended for us to do some short-term research that will help us improve the public mental health system. These programs test different strategies and allow us to incorporate successful strategies into public mental health services.

5% • • • Mental Health Services Act funds

Workforce Education and Training

Allows us to train and recruit staff at all levels to provide services across the continuum.

One time allocation-sustained through transferred CSS funding

Capital Facilities and Technological Needs

Space to provide services and technology to assist in collecting and storing consumer information and to assist in treatment planning.

One time allocation-sustained through transferred CSS funding

9

Community Program **Planning**

10

Community Program **Planning**

As part of the continuous feedback and improvement process, we meet with our stakeholders every month in many ways.

- Meetings take place via online platforms, such as Webex and Zoom, as well as in-person.
- This allows continuous communication between the department and our stakeholders regarding our services, outcomes, and other information related to the public behavioral health system.

11

Who are DBH's **Stakeholders?**

WIC §5848 identifies who our stakeholders are, and beginning in January 2025, the required stakeholder groups are expanding. This includes individuals representing diverse viewpoints, including, but not limited to:

Eligible adults and older adults	Families of eligible children and **youth**, eligible adults, and eligible older adults	Youths or youth mental health or **substance use disorder organizations**	Providers of mental health services and **substance use disorder treatment services**	Public safety partners, including juvenile justice agencies	Local education agencies
Higher education partners	**Early childhood organizations**	**Local public health jurisdictions**	County social services and child welfare agencies	**Local representative organizations**	Veterans
Representative from Veterans organizations.	Health care organizations, including hospitals	Health care service plans, including Medi-Cal managed plans	**Disability insurers**	**Tribal and Indian Health Program designees**	**The five most populous cities in counties with a population greater than 200,000**
Area agencies on aging	**Independent living centers**	**Continuums of care, including representatives from the homeless service provider community**	**Regional centers**	**Emergency medical services**	**Community-based organizations serving culturally and linguistically diverse constituents**

*Newly added

12

Examples of Stakeholder **Meetings**

- Cultural Competency Advisory Committee
- Cultural Competency Awareness Subcommittees
- Community Policy Advisory Committee (CPAC)
- Behavioral Health Commission Meeting
- District Advisory Committee Meetings (DACs)
- Consumer Clubhouse Governing Boards
- Association of Community Based Organizations (ACBO)

13

Program Changes and Updates **FY 2025/26**

14

Mental Health Services Act Program **Updates**

- The Department of Behavioral Health continuously reviews current expenditures, utilization, and availability of funding for stakeholder supported program updates and development.
- The review of feedback and stakeholder engagement is a continuous process that allows us to learn what programs and services best meet the needs of our community.
- The Department of Behavioral Health will continue using existing Mental Health Services Act funds to support existing programs.

15

Prevention and Early Intervention (PEI) **Updates**

Child and Youth Connection – Budget Increase

- The Children's Assessment Center (CAC), administered by Loma Linda University Children's Hospital (LLUCH) under the Child and Youth Connection (CYC) program, will increase funding from $62,000 to $165,000 per year. This funding change will increase early access and linkage to medically necessary care and treatment. It connects children and youth with severe mental health conditions to care as early in the onset of these conditions as practicable, to medically necessary care and treatment. It includes, but is not limited to, care provided by county mental health programs.
  - **Goals of the project:**
    - Pre-forensic examination counseling services to help minimize the children's/youths' trauma from the examination and decrease the psychological distress associated with child abuse allegations.
    - Provide pre-forensic examination counseling services to an estimated 900 unduplicated children and adolescents.
  - This program serves consumers ages 0-18 years old throughout San Bernardino County.

16

Prevention and Early Intervention (PEI) **Updates, cont.**

Family Resource Center (FRC) – Expansion Update

- Department of Behavioral Health, Prevention and Early Intervention (PEI) Family Resource Center is expanding their services to include a Family Wellness Center (FWC). The FWC expansion will include prevention and early intervention services as well as Specialty Mental Health Services for children, youth, and adults with mental health concerns. This expansion will increase the annual FRC budget by $1,500,000 from $2,774,774 to $4,274,774, previously budgeted increase in the MHSA Annual plan for FY 2022/23. This expansion will enable DBH to broaden its scope of services by providing a comprehensive approach to family wellness while continuing to offer essential services to promote wellness, recovery, and resiliency for its clients.
  - FRC programs offer:
    - Services tailored to individualized communities' specific needs and cultural requirements.
    - Services and activities at non-traditional locations, such as community centers, where other collateral services are also provided.
    - A reduction in stigma associated with seeking mental health services, increasing the likelihood that community members will use the services.
  - Population served will be children and their families throughout San Bernardino County.

17

Community Services and Supports (CSS) **Updates**

Housing and Homeless Services Continuum of Care Program – Position Transfer

- The Homeless Outreach Support Team (HOST) under the Housing and Homeless Services Continuum of Care Program is transferring a Clinical Therapist I Psychologist position to the Choosing Healthy Options to Instill Change and Empowerment (CHOICE) program under the Forensic Services Continuum of Care program.
  - This change will allow the CHOICE program to provide psychiatric services directly to consumers enrolled in the CHOICE Mental Health Outpatient program at the Probation Department Day Reporting Centers rather than referring them to another clinic.
  - This position will be funded under the AB109 Realignment funding.

18

Innovation (INN) Updates

Eating Disorder Collaborative – Project Sunset

- Eating Disorder Collaborative (EDC) is scheduled to sunset in December 2025. DBH is in the process of reviewing project data and outcomes to determine continuation of the project. DBH is considering options to continue the project or project services under Community Services and Supports (CSS) Full Service Partnership (FSP) program and/or other opportunities with Managed Care Plans (MCPs) to continue to provide project services where appropriate.

Cracked Eggs – Project Sunset

- The contract for Cracked Eggs ends June 2026 and will not continue as a standalone program. Low enrollment rates combined with the substantial operational costs have rendered it unsustainable. However, the project highlighted that art can be a therapeutic tool. DBH will explore ways to incorporate some of the artistic strategies learned during this Innovation project to include in our system of care where appropriate. The final report will be released in FY 2026/27.

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2025-Mental Health Services Act Annual Update Community Program Planning Schedule

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Community Program Planning Schedule 2025

JANUARY - FEBRUARY
The CPP process is scheduled for January through February 2025.

FEBRUARY – MARCH
The Mental Health Services Act Annual Update is tentatively scheduled to be posted for public review and comment from February 14 - March 17, 2025.

APRIL
Public Hearing is tentatively set to be conducted at the regular Behavioral Health Commission Meeting on April 3, 2025.

MAY
The Annual Update is tentatively scheduled to be presented to the Board of Supervisors for approval in May 2025.

- 39 meetings will be held in all geographic regions of the County.
- Schedule will include all DBH's regular CPP Stakeholder meetings (CPAC, DACs, CCAC subcommittees, etc.).
- Schedule includes the Clubhouses - all regions.

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Upcoming Community Planning Meetings

Please use the link below for upcoming MHSA Community Program Planning Meetings:

English: 2025-26 MHSA CPPFINAL.pdf

Spanish: 25-26 MHSA FINAL Span 1.7.25.pdf

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We Want to Know More!

This information will be used to identify community needs, determine Mental Health Services Act funding priorities, and guide the creation, implementation, and evaluation of Mental Health Services Act -funded programs.

Survey Link:
https://survey123.arcgis.com/share/dc731d5c7c754ab7a18a69af3601764b?portalUrl=https://maps.sbcounty.gov/sbcgis

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Paper Surveys

Paper surveys can be scanned and emailed to MHSA@dbh.sbcounty.gov.

Attendees may also mail a hard copy of the completed survey back to us at:

- Mental Health Services Act Administration
  1950 S. Sunwest Lane, Suite 200
  San Bernardino, CA 92415

Or via Interoffice mail:

- Mental Health Services Act Administration
  WET/Training Institute
  Attn: Mental Health Services Act Admin
  #0019

- If you did not receive a paper survey, please email us at MHSA@dbh.sbcounty.gov or you can add your email address to the chat.
- The deadline for receipt of the completed forms is close of business **February 25, 2025**.
- Items mailed in must be postmarked no later than **February 25, 2025**.

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Proposition 1 **Update**

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Proposition 1, which passed in March 2024, is a two-part measure that:

- Amends California's Mental Health Services Act (SB 326), and
- Creates a $6.38 billion general obligation bond (AB 531).

SB 326	AB 531
Changes MHSA to BHSA (Behavioral Health Services Act) • Includes treatment for people with substance use disorders	Also known as the Behavioral Health Infrastructure Bond Act of 2024
Directs the funding "buckets" into 3 major components: • Behavioral Health Services and Support • Full-Service Partnerships • Housing Interventions	Creates a $6.38 billion bond to build 11,150 new behavioral health beds and housing units to meet the current and future needs of Californians. $1 billion is set aside specifically for veterans' housing.
Directs more money to the State (10% vs. 5%) and less to Counties (90% vs. 95%). • Prevention 4%; Workforce 3%; Oversight & Monitoring 3% • Increased costs to counties to continue current programs. • Increases required stakeholder groups for Community Program Planning. • Three-year plans no longer focus on MHSA funds only, it will be an Integrated Plan & will include all behavioral health programs & funding sources. • The MHSA Annual Revenue and Expenditure Report (ARER) is replaced by the new County Behavioral Health Outcomes, Accountability, and Transparency Report (CBHOATR).	Will provide placement for complex patients with severe mental illness in need of subacute care and long-term support outside of the hospital setting.
Prioritizes investments in housing interventions for individuals experiencing homelessness or at risk of homelessness.	Aimed at resolving the dire shortage of subacute mental health beds.

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Priority Populations for **BHSA**

Behavioral Health Services Act funding targets individuals living with a range of behavioral health needs and prioritizes those disproportionately affected by mental health and/or SUD challenges with unmet needs. These priority populations mirror those for other statewide behavioral health initiatives and programs.

- Individuals experiencing homelessness or at risk of experiencing homelessness
- Justice-involved individuals or individuals at risk of criminal justice system involvement
- Children and youth, including those involved in the child welfare system
- Individuals in or leaving institutional settings, or those at risk of institutionalization

Per California Welfare and Institutions Code § 5892.(d)(1) & § 5892.(d)(2)

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BHSA Components and Funding **Allocation**

Housing Interventions (30%)	Includes rental subsidies, operating subsidies, shared housing, family housing for eligible children and youth, the nonfederal share for transitional rent, capital development projects, and project-based housing assistance. Housing interventions will not be limited to those in FSP or those enrolled in Medi-Cal.
Full-Service Partnerships (35%)	Includes mental health services, supportive services, and substance use disorder treatment services, to be provided pursuant to a whole-person approach that is trauma informed, age appropriate, and in partnership with families or an individual's natural supports. Services are provided in a streamlined and coordinated manner to help reduce any barriers to services.
Behavioral Health Services and Supports (35%)	Includes services for the children's system of care and for the adult and older adult system of care (excluding housing intervention services and FSPs), early intervention programs, outreach and engagement, WET, CFTN, and INN projects.

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BHSA **Changes**

Outreach and Engagement (O&E)	Outreach and Engagement activities will be funded by the Behavioral Health Services and Supports category. • 35% of funding for entire BHSS category.
General System Development (GSD)	The BHSA does not include language about General System Development. • CSS GSD as we know it today will not continue under the BHSA.
Full-Service Partnerships (FSP)	Full-Service Partnerships will be a dedicated category under the BHSA. • 35% of funding that counties receive.

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Where We are **Now**

- Current MHSA Programs and services will continue as approved through June 30, 2026.
- Expanding stakeholder engagement by identifying and connecting with new partners to ensure inclusive participation in the CPP process and program planning.
- Educating stakeholders on Proposition 1, discussing its program impacts, and soliciting actionable feedback to address community needs and guide future planning during monthly CPAC meetings.
- Continuing to meet with county partners and discuss program impacts.
- Developing mitigation plans to ensure a smooth transition.
- Maintaining a proactive role in the BHSA transition, engaging in Behavioral Health Transformation (BHT) listening sessions led by the state, and staying up-to-date on evolving policies and regulations to ensure informed decision-making and community alignment.

Additional information on stakeholder engagement can be found on the Department of Health Care Services (DHCS) website here: Stakeholder-Engagement

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DBH Capacity **Assessment**

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Capacity **Assessment**

- In November 2023, DBH partnered with Health Management Associates (HMA), an independent national research and consulting firm in the healthcare industry, to complete a behavioral health needs and capacity assessment and an assessment of DBH's Community Program Planning (CPP) process for developing the MHSA Three-Year Integrated Plan and Annual Updates.
- The final report identifies strengths, challenges, and recommendations for areas of opportunity within the Mental Health Services Act (MHSA) programming in San Bernardino County.
- The project ran from November 2023 to August 2024.
- The full report will be included as an attachment in the MHSA Annual Update for FY 2025/26.

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Assessment **Methods**

HMA used a combination of data analysis, document review, and community engagement throughout the project to conduct the assessments. Some strategies used for qualitative and quantitative data collection included:

- Collected and analyzed available data on consumer services, demographics, capacity data, and workforce needs.
- Conducted interviews with outpatient and residential behavioral health providers, culturally specific organizations, social service agencies, and school district representatives, amongst others, to solicit their input on system strengths and areas for improvement.
- Facilitated focus groups with 200+ participants, where the groups included individuals with lived experiences.
- Administered a community survey that received 232 responses regarding system strengths, barriers, and unmet needs, as well as awareness and participation in the CPP.
- Convened townhalls as a forum to hear additional input from community members.

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Behavioral Health Needs & Capacity **Assessment**

The qualitative feedback key findings of the behavioral health needs and capacity assessment are organized in the categories below:

Strengths

- Provider Collaboration
- Service Availability and Accessibility
- County Engagement Efforts
- Effectiveness of Services

Opportunities for Improvement and Unmet Needs

- Access and Service Availability
- Cultural Responsiveness and Disparity Reduction
- Workforce recruitment and retention
- Implementation of New Initiatives
- Internal and External Collaboration
- Operations
- Community Engagement

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Behavioral Health Needs & Capacity **Assessment**

HMA provided recommendations that could have a significant impact on behavioral healthcare delivery in San Bernardino County. These are categorized into the five areas below:

1) Expand Access to High-Quality Services
2) Improve Service Integration and Coordination
3) Enhance External Communication and Engagement
4) Strengthen Administrative and Operational Processes
5) Address Workforce Challenges

DBH is reviewing the recommendations and developing strategies to help improve behavioral healthcare delivery in our County. This is a continuous process, and updates will be shared in future meetings.

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Community Program Planning Process **Assessment**

Some key findings related to the observations of the Community Program Planning (CPP) process are listed below by strengths and opportunities for improvement:

Strengths

- Meetings were well attended, there were plenty of opportunities for constituent questions and feedback, and participants were engaged.
- A wide array of special population meetings were held.
- Information shared met Culturally and Linguistically Appropriate Services Standards.

Opportunities for Improvement

- There was a disconnect among constituents regarding the context and goal of the meetings and the connection between the Mental Health Services Act (MHSA) and the CPP.
- The process of submitting comments could be streamlined.
- The County could leverage online tools to improve interactions and engagement during meetings.

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Community Program Planning Process Assessment

Some key findings related to the feedback on the Community Program Planning (CPP) process are listed below by strengths and opportunities for improvement:

Strengths

- The County has tested multiple strategies for outreach, including partnering with organizations to host meetings, virtual forums, surveys, etc.
- The intent behind the process and sub-committees is good, even if they are not always as effective and well-attended as participants would like.
- The County promotes the sessions to providers and the community and is generally good about receiving feedback.

Opportunities for Improvement

- Stakeholders have many competing requirements for their time and resources and want clearly defined goals, objectives, and action items for meetings with a stronger focus on operational application rather than statistics.
- There is a need for clearer communication on the objective of the CPP process.
- There is a desire to increase participation from individuals who have not traditionally been a part of the process, such as those who may have behavioral health needs but do not access services for one reason or another.

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Community Program Planning Process Assessment

Some of the HMA recommendations for improvement on the Community Program Planning (CPP) process are listed below:

- Enhance External Communication and Engagement
  - Build awareness of the Community Program Planning process
  - Improve CPP progress and outcomes tracking
  - Leverage trusted partners to support information sharing
  - Improve connections with marginalized communities
  - Offer engagement opportunities in community settings
  - Leverage technology to support engagement

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Current Steps

DBH is taking the following steps to address the assessment recommendations:

- Providing more context about MHSA and the CPP process during meetings to help educate stakeholders on the planning process and how their engagement and feedback helps to guide DBH programs.
- Expanding stakeholder groups to include more unserved/underserved populations, community members, service partners, faith-based organizations, children and youth groups, etc., to increase community engagement and feedback and to involve more service partners to increase information sharing with the community.
- Coordinating with other departments and organizations to participate in their community/patient needs assessments to identify the needs of the County and expand access and services to meet those needs.
- Holding the monthly Community Policy Advisory Committee (CPAC) meetings in more locations throughout the county to engage with stakeholders in community settings.

DBH leadership is working on identifying additional opportunities for improvement and continues to encourage stakeholder engagement and feedback to guide its programs and services.

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Questions?

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Concerns

To report any concerns related to MHSA Community Program Planning, please refer to the MHSA Issue Resolution Process located at:

https://wp.sbcounty.gov/dbh/wp-content/uploads/sites/121/2021/08/COM0947.pdf?x62087

To report concerns related to receipt of behavioral health services, please contact the DBH Access Unit at:

(909) 386-8256
Toll Free 1 (888) 743-1478
or 7-1-1 for TTY users.

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Thank You!

For questions or comments, please contact:

Dr. Rebecca Scott Young, MBA, PHR
Mental Health Services Act
Administrative Manager
MHSA@dbh.sbcounty.gov
909-252-4021

www.SBCounty.gov/DBH

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Salud conductual

Actualización anual de la Ley de Servicios de Salud Mental

Reunión de partes interesadas en la planificación del programa comunitario

1

Objetivos de la reunión

- Proporcionar una descripción general de la Ley de Servicios de Salud Mental
- Proporcionar una descripción general de la actualización del plan anual de la Ley de Servicios de Salud Mental
- Informar sobre los cambios y actualizaciones del programa
- Compartir el cronograma de planificación del programa comunitario
- Compartir la encuesta de planificación del programa comunitario
- Proporcionar una descripción general de la Proposición 1
- Evaluación de la capacidad del DBH

2

¡Queremos saber más !

- Más adelante en la presentación de hoy, le pediremos que complete una encuesta. Esta encuesta nos permite saber "quién" está entre la audiencia.
- Esta información también se utilizará para identificar las necesidades de la comunidad, determinar las prioridades de financiación de la Ley de Servicios de Salud Mental y guiar la creación, implementación y evaluación de programas.

3

¿Qué es la Ley de Servicios de Salud Mental ?

- La Ley de Servicios de Salud Mental, Prop 63, fue aprobada por los votantes de California en noviembre de 2004 y entró en vigor en enero de 2005.
  - La Ley prevé una mayor financiación para los programas de salud mental en todo el estado.
  - La Ley se financia mediante un recargo fiscal del 1% sobre los ingresos personales superiores a un millón de dólares al año.
- Las fluctuaciones en los pagos de impuestos impactan las proyecciones fiscales y el financiamiento disponible.

4

Plan trienal de la Ley de Servicios de Salud Mental

- Lo exigen las reglamentaciones de la Ley de Servicios de Salud Mental (Código de Instituciones de Bienestar § 5847).
- Destaca las tendencias, los objetivos del programa y los resultados de los programas del Departamento de Salud Conductual y proporciona una hoja de ruta hacia un sistema de atención unificado.
- El plan actual cubre el período de los años fiscales (AF) 2023/24 a 2025/26.
- Aprobado el 13 de junio de 2023 por la Junta de Supervisores del Condado.

5

Resumen de la actualización del plan anual

6

¿Qué es una **actualización del plan anual?**

Una actualización del plan anual proporciona:

- Datos de servicio del año fiscal anterior.
  - Los datos informados corresponden al año fiscal 2023/24.
- Información sobre la planificación del programa para el próximo año fiscal a nuestros grupos de interés.
- Actualizaciones del Plan Integrado Trienal de la Ley de Servicios de Salud Mental para los años fiscales 2023/2024 a 2025/2026.

El propósito de la Actualización del Plan Anual es:

- Evaluar los impactos a corto y largo plazo de los programas financiados por la Ley de Servicios de Salud Mental.
- Utilice el documento como evidencia para demostrar que estamos cumpliendo con los requisitos reglamentarios.

Este año desarrollaremos una Actualización del Plan Anual para el año fiscal 2025/26.

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El Plan de la Ley de Servicios de Salud Mental y las Actualizaciones Anuales se construyen a partir de cinco componentes, así como un resumen del presupuesto y detalles de los componentes:

Servicios y apoyos comunitarios

Programas y servicios destinados a poblaciones con enfermedades mentales graves (SMI) con foco en individuos en riesgo de hospitalización psiquiátrica y/o falta de vivienda debido a la gravedad de la enfermedad con la que viven.

76% • • • Fondos de la Ley de Servicios de Salud Mental

Prevención e intervención temprana

Los servicios tienen como objetivo evitar que una enfermedad mental se agrave o incluso impedir su aparición si es posible. Las poblaciones objetivo son aquellas que experimentan signos de síntomas o factores de riesgo.

19% • • • Fondos de la Ley de Servicios de Salud Mental

8

Innovación

Proyectos de duración limitada cuyo objetivo es que realicemos investigaciones a corto plazo que nos ayuden a mejorar el sistema de salud mental pública. Estos programas prueban diferentes estrategias y nos permiten incorporar estrategias exitosas en los servicios públicos de salud mental.

5% • • • Fondos de la Ley de Servicios de Salud Mental

Educación y capacitación de la fuerza laboral

Nos permite capacitar y reclutar personal en todos los niveles para brindar servicios en todo el espectro.

Asignación única, sostenida mediante fondos CSS transferidos

Instalaciones de capital y necesidades tecnológicas

Espacio para proporcionar servicios y tecnología para ayudar en la recopilación y almacenamiento de información del consumidor y para ayudar en la planificación del tratamiento.

Asignación única, sostenida mediante fondos CSS transferidos

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Planificación de programas comunitarios

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Planificación de programas comunitarios

Como parte del proceso continuo de retroalimentación y mejora, nos reunimos con nuestras partes interesadas cada mes de muchas maneras.

- Las reuniones se llevan a cabo a través de plataformas en línea, como Webex y Zoom, así como en persona.
- Esto permite una comunicación continua entre el departamento y nuestras partes interesadas con respecto a nuestros servicios, resultados y otra información relacionada con el sistema de salud conductual pública.

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¿Quiénes son los **interesados** de DBH ?

El §5848 del WIC identifica quiénes son nuestras partes interesadas y, a partir de enero de 2025, los grupos de partes interesadas requeridos se expandirán. Esto incluye a personas que representan diversos puntos de vista, incluidos,

Adultos elegibles y adultos mayores	Familias de niños y jóvenes elegibles , adultos elegibles y adultos mayores elegibles	Organizaciones para jóvenes o para personas que padecen trastornos de salud mental o consumo de sustancias.	Proveedores de servicios de salud mental y servicios de tratamiento de trastornos por consumo de sustancias	Socios de seguridad pública, incluidas las agencias de justicia juvenil	Agencias locales de educación
Socios de educación superior	Organizaciones de la primera infancia	Jurisdicciones locales de salud pública	Servicios sociales del condado y agencias de bienestar infantil	Organizaciones representativas locales	Veteranos
Representante de organizaciones de veteranos.	Organizaciones de atención médica, incluidos hospitales	Planes de servicios de atención médica, incluidos los planes administrados por Medi-Cal	Aseguradoras de invalidez	Designados para el Programa de Salud Tribal e Indígena	Las cinco ciudades más pobladas en condados con una población mayor a 200.000 habitantes
Agencias locales sobre el envejecimiento	Centros de vida independiente	Continuos de atención, incluidos representantes de la comunidad de proveedores de servicios para personas sin hogar	Centros regionales	Servicios médicos de emergencia	Organizaciones comunitarias que prestan servicios a grupos de personas cultural y lingüísticamente diversos

*Recién añadido

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Ejemplos de **reuniones** de partes interesadas

- Comité Asesor de Competencia Cultural
- Subcomités de Concienciación sobre Competencia Cultural
- Comité Asesor de Políticas Comunitarias (CPAC)
- Reunión de la Comisión de Salud Conductual
- Reuniones del Comité Asesor Distrital (DAC)
- Juntas directivas de Consumer Clubhouse
- Asociación de Organizaciones Comunitarias (ACBO)

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Cambios y actualizaciones del programa **Año fiscal 2025/26**

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Actualizaciones del programa de la Ley de Servicios de Salud Mental

- El Departamento de Salud Conductual revisa continuamente los gastos actuales, la utilización y la disponibilidad de fondos para las actualizaciones y el desarrollo de programas apoyados por las partes interesadas.
- La revisión de la retroalimentación y la participación de las partes interesadas es un proceso continuo que nos permite conocer qué programas y servicios satisfacen mejor las necesidades de nuestra comunidad.
- El Departamento de Salud Conductual continuará utilizando los fondos existentes de la Ley de Servicios de Salud Mental para apoyar los programas existentes.

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Actualizaciones sobre prevención e intervención temprana (PEI)

Conexión de Niños y Jóvenes – Aumento de Presupuesto

El Centro de Evaluación Infantil (CAC), administrado por el Hospital Infantil de la Universidad de Loma Linda (LLUCH), bajo el programa Conexión entre Niños y Jóvenes (CYC), aumentará los fondos del programa de $62,000 a $165,000 por año. Este cambio de financiación aumentará el acceso temprano y la vinculación con la atención y el tratamiento médicamente necesarios. Conecta a los niños y jóvenes con afecciones graves de salud mental con la atención lo más pronto posible desde la aparición de estas afecciones, con la atención y el tratamiento médicamente necesarios. Incluye, entre otros, la atención proporcionada por los programas de salud mental del condado.

- **Objetivos del proyecto:**
  - Servicios de asesoramiento previo al examen forense para ayudar a minimizar el trauma que sufren los niños/jóvenes durante el examen y disminuir la angustia psicológica asociada con las acusaciones de abuso infantil.
  - Brindar servicios de asesoramiento previo al examen forense a aproximadamente 900 niños y adolescentes no duplicados.
- Este programa atiende a consumidores de 0 a 18 años en todo el condado de San Bernardino.

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Actualizaciones sobre prevención e intervención temprana (PEI)

Centro de Recursos Familiares (FRC) - Actualización de Expansión

El Centro de Recursos Familiares del Departamento de Salud Conductual, Prevención e Intervención Temprana (PEI) está ampliando sus servicios para incluir un Centro de Bienestar Familiar (FWC). La expansión del FWC incluirá servicios de prevención e intervención temprana, así como servicios de salud mental especializados para niños, jóvenes y adultos con problemas de salud mental. Esta expansión aumentará el presupuesto anual del FRC en $1,500,000 de $2,774,774 a $4,274,774, un aumento presupuestado previamente en el plan anual de la MHSA para el año fiscal 2022/23. Esta expansión permitirá al DBH ampliar su alcance de servicios al brindar un enfoque integral al bienestar familiar mientras continúa ofreciendo servicios esenciales para promover el bienestar, la recuperación y la resiliencia de sus clientes.

- Los programas de FRC ofrecen:
  - Servicios adaptados a las necesidades específicas y los requisitos culturales de cada comunidad.
  - Servicios y actividades en lugares no tradicionales, como centros comunitarios, donde también se ofrecen otros servicios complementarios.
  - Una reducción del estigma asociado con la búsqueda de servicios de salud mental, lo que aumenta la probabilidad de que los miembros de la comunidad utilicen los servicios.
- La población atendida serán niños y sus familias en todo el condado de San Bernardino.

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Servicios y apoyos comunitarios (CSS) **Actualizaciones**

Programa de Atención Continua para Viviendas y Servicios a Personas Sin Hogar – Transferencia de Posición

El Equipo de Apoyo de Extensión para Personas sin Hogar (HOST, por sus siglas en inglés) bajo el Programa de Continuidad de Atención de Servicios de Vivienda y Personas sin Hogar está transfiriendo un puesto de Terapeuta Clínico/Psicólogo al programa de Elección de Opciones Saludables para Inculcar el Cambio y el Empoderamiento (CHOICE, por sus siglas en inglés) bajo el programa de Continuidad de Atención de Servicios Forenses.

- Este cambio permitirá que el programa CHOICE brinde servicios psiquiátricos directamente a los consumidores inscritos en el programa ambulatorio de salud mental CHOICE en los Centros de informes diurnos del Departamento de Libertad Condicional en lugar de derivarlos a otra clínica.
- Este puesto se financiará con el financiamiento de la Realineación AB109.

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Actualizaciones de Innovación (INN)

Colaboración para los trastornos alimentarios – Proyecto Sunset

Está previsto que el proyecto colaboración para los trastornos alimentarios (EDC) finalice en diciembre de 2025. DBH está en proceso de revisar los datos y los resultados del proyecto para determinar la continuación del mismo. DBH está considerando opciones para continuar con el proyecto o los servicios del proyecto en el marco del programa de Asociación de servicios completos (FSP) de Servicios y apoyos comunitarios (CSS) y/u otras oportunidades con planes de atención administrada (MCP) para continuar brindando servicios del proyecto cuando corresponda.

Cracked Eggs – Proyecto Sunset

El contrato de Cracked Eggs finaliza en junio de 2026 y no continuará como un programa independiente. Las bajas tasas de inscripción combinadas con los importantes costos operativos lo han vuelto insostenible. Sin embargo, el proyecto destacó que el arte puede ser una herramienta terapéutica. DBH explorará formas de incorporar algunas de las estrategias artísticas aprendidas durante este proyecto de innovación para incluirlas en nuestro sistema de atención cuando sea apropiado. El informe final se publicará en el año fiscal 2026/27.

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Actualización anual de la Ley de Servicios de Salud Mental de 2025: calendario de planificación de programas comunitarios

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Cronograma de planificación del programa comunitario 2025

ENERO - FEBRERO
El proceso del CPP está programado para enero-febrero de 2025.

FEBRERO – MARZO
Está previsto tentativamente publicar la Actualización Anual de la Ley de Servicios de Salud Mental para revisión y comentarios públicos del 14 de febrero al 17 de marzo de 2025.

ABRIL
Se ha programado tentativamente una audiencia pública para realizarse en la reunión regular de la Comisión de Salud Conductual el 3 de abril de 2025.

MAYO
Está previsto tentativamente presentar la Actualización Anual a la Junta de Supervisores para su aprobación en mayo de 2025.

- Se llevarán a cabo 39 reuniones en todas las regiones geográficas del Condado.
- El calendario incluirá todas las reuniones regulares de las partes interesadas del CPP del DBH (CPAC, DAC, subcomités del CCAC, etc.).
- El calendario incluye las Casas Club - todas las regiones.

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Próximas reuniones de planificación comunitaria

Utilice el siguiente enlace para las próximas reuniones de planificación del programa comunitario de MHSA:

Inglés: 2025-26 MHSA CPPFINAL.pdf

Español: 25-26 MHSA FINAL Span 1.7.25.pdf

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¡Queremos saber más!

Esta información se utilizará para identificar las necesidades de la comunidad, determinar las prioridades de financiación de la Ley de Servicios de Salud Mental y guiar la creación, implementación y evaluación de los programas financiados por la Ley de Servicios de Salud Mental.

Enlace de la encuesta:
https://qualtricsxmc3prhdp6w.qualtrics.com/jfe/form/SV_0ujJIQiY3VSZrF4

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Encuestas en papel

Las encuestas en papel se pueden escanear y enviar por correo electrónico a MHSA@dbh.sbcounty.gov.

Los asistentes también pueden enviarnos por correo una copia impresa de la encuesta completa a:

- Administración de la Ley de Servicios de Salud Mental
  1950 S. Sunwest Lane, Suite 200
  San Bernardino, CA 92415

O por correo interno:

- Administración de la Ley de Servicios de Salud Mental
  Instituto de Formación WET
  A la atención de: Ley de Servicios de Salud Mental Admin
  #0019
- Si no recibió una encuesta en papel, envíenos un correo electrónico a MHSA@dbh.sbcounty.gov o puede agregar su dirección de correo electrónico al chat.
- La fecha límite para recibir los formularios completos es el cierre de operaciones **el 25 de febrero de 2025**.
- Los artículos enviados por correo deben tener matasellos a más tardar **el 25 de febrero de 2025**.

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Actualización de la Proposición 1

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La Proposición 1, que se aprobó en marzo de 2024, es una medida de dos partes que:

- Modifica la Ley de Servicios de Salud Mental de California (SB 326) y
- Crea un bono de obligación general por $6.38 mil millones (AB 531).

Ley SB 326	AB 531
Cambia la MHSA a BHSA (Ley de Servicios de Salud Conductual) • Incluye tratamiento para personas con trastornos por consumo de sustancias.	También conocida como Ley de Bonos de Infraestructura de Salud Conductual de 2024
Dirige los "cubos" de financiación en tres componentes principales: • Servicios y apoyo de salud conductual • Asociaciones de servicios completos • Intervenciones en materia de vivienda	Crea un bono de $6.38 mil millones para construir 11,150 nuevas camas y unidades de vivienda para la salud conductual para satisfacer las necesidades actuales y futuras de los californianos. $1 mil millones están reservados específicamente para viviendas para veteranos.
Destina más dinero al Estado (10% frente a 5%) y menos a los condados (90% frente a 95%). • Prevención 4%; Fuerza laboral 3%; Supervisión y monitoreo 3% • Aumento de los costos para los condados para continuar con los programas actuales. • Aumenta los grupos de partes interesadas necesarios para la planificación de programas comunitarios. • Los planes trienales ya no se centrarán únicamente en los fondos MHSA, serán un Plan Integrado e incluirán todos los programas de salud conductual y fuentes de financiación. • El Informe Anual de Ingresos y Gastos (ARER) de la MHSA se reemplaza por el nuevo Informe de Resultados, Responsabilidad y Transparencia de Salud Conductual del Condado (CBHOATR).	Proporcionará ubicación para pacientes complejos con enfermedades mentales graves que necesitan atención subaguda y apoyo a largo plazo fuera del entorno hospitalario.
Prioriza las inversiones en intervenciones de vivienda para personas sin hogar o en riesgo de quedarse sin hogar.	Destinado a resolver la grave escasez de camas para atención de salud mental subaguda.

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Poblaciones prioritarias para BHSA

El financiamiento de la Ley de Servicios de Salud Conductual se dirige a personas que viven con una variedad de necesidades de salud conductual y prioriza a aquellos afectados desproporcionadamente por problemas de salud mental y/o SUD con necesidades no satisfechas. Estas poblaciones prioritarias reflejan aquellas de otros programas e iniciativas de salud conductual a nivel estatal.

- Personas sin hogar o en riesgo de quedarse sin hogar
- Personas involucradas con la justicia o en riesgo de involucrarse en el sistema de justicia penal
- Niños y jóvenes, incluidos aquellos involucrados en el sistema de bienestar infantil
- Personas que se encuentran o salen de entornos institucionales, o que corren riesgo de institucionalización.

Según el Código de Bienestar e Instituciones de California § 5892.(d)(1) y § 5892.(d)(2)

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Componentes y asignación de fondos de la BHSA

Intervenciones en materia de vivienda (30%)	Incluye subsidios de alquiler, subsidios operativos, vivienda compartida, vivienda familiar para niños y jóvenes elegibles, la parte no federal para alquiler de transición, proyectos de desarrollo de capital y asistencia de vivienda basada en proyectos. Las intervenciones de vivienda no se limitarán a aquellos en FSP o aquellos inscritos en Medi-Cal.
Asociaciones de servicios completos (35%)	Incluye servicios de salud mental, servicios de apoyo y servicios de tratamiento de trastornos por uso de sustancias, que se brindarán de conformidad con un enfoque integral que tenga en cuenta el trauma, sea apropiado para la edad y en asociación con las familias o los apoyos naturales de un individuo. Los servicios se brindan de manera optimizada y coordinada para ayudar a reducir cualquier barrera a los servicios.
Servicios y apoyos de salud conductual (35%)	Incluye servicios para el sistema de cuidado de niños y para el sistema de cuidado de adultos y adultos mayores (excluidos los servicios de intervención de vivienda y los FSP), programas de intervención temprana, extensión y participación, proyectos WET, CFTN e INN.

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CAMBIOS en la BHSA

Difusión y participación (O&E)	Las actividades de divulgación y participación se financiarán mediante la categoría de Servicios y apoyo de salud conductual. • 35% de financiación para toda la categoría BHSS.
Desarrollo de sistemas generales (GSD)	La BHSA no incluye lenguaje sobre el desarrollo del sistema general. • El CSS GSD tal como lo conocemos hoy no continuará bajo la BHSA.
Asociaciones de servicios completos (FSP)	Las asociaciones de servicio completo serán una categoría dedicada bajo la BHSA. • 35% de la financiación que reciben los condados.

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Donde estamos ahora

- Los programas y servicios actuales de MHSA continuarán según lo aprobado hasta el 30 de junio de 2026.
- Ampliar la participación de las partes interesadas mediante la identificación y conexión con nuevos socios para garantizar una participación inclusiva en el proceso del CPP y la planificación del programa.
- Educar a las partes interesadas sobre la Proposición 1, discutir los impactos de su programa y solicitar comentarios prácticos para abordar las necesidades de la comunidad y guiar la planificación futura durante las reuniones mensuales del CPAC.
- Continuamos reuniéndonos con los socios del condado y discutiendo los impactos del programa.
- Desarrollar planes de mitigación para garantizar una transición sin problemas.
- Mantener un rol proactivo en la transición de la BHSA, participar en sesiones de escucha de Transformación de Salud Conductual (BHT) lideradas por el estado y mantenerse actualizado sobre las políticas y regulaciones en evolución para garantizar una toma de decisiones informada y la alineación con la comunidad.

Puede encontrar información adicional sobre la participación de las partes interesadas en el sitio web del Departamento de Servicios de Atención Médica (DHCS) aquí: Participación de las partes interesadas

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Evaluación de la capacidad del DBH

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Evaluación de capacidad

- En noviembre de 2023, DBH se asoció con Health Management Associates (HMA), una empresa de investigación y consultoría nacional independiente en la industria de la atención médica, para completar una evaluación de las necesidades y la capacidad de salud conductual y una evaluación del proceso de Planificación del Programa Comunitario (CPP) del DBH para desarrollar el Plan Integrado Trienal y las Actualizaciones Anuales de la MHSA.
- El informe final identifica fortalezas, desafíos y recomendaciones para áreas de oportunidad dentro de la programación de la Ley de Servicios de Salud Mental (MHSA) en el condado de San Bernardino.
- El proyecto se desarrolló desde noviembre de 2023 hasta agosto de 2024.
- El informe completo se incluirá como archivo adjunto en la Actualización Anual de la MHSA para el año fiscal 2025/26.

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Métodos de evaluación

HMA utilizó una combinación de análisis de datos, revisión de documentos y participación de la comunidad durante todo el proyecto para realizar las evaluaciones. Algunas estrategias utilizadas para la recopilación de datos cualitativos y cuantitativos incluyeron:

- Recopilación y analisis de datos disponibles sobre servicios al consumidor, datos demográficos, datos de capacidad y necesidades de fuerza laboral.
- Realización de entrevistas con proveedores de salud conductual ambulatorios y residenciales, organizaciones culturalmente específicas, agencias de servicios sociales y representantes del distrito escolar, entre otros, para solicitar sus comentarios sobre las fortalezas del sistema y las áreas de mejora.
- Proporcionar grupos focales con más de 200 participantes, donde los grupos incluían personas con experiencias vividas.
- Se administró una encuesta comunitaria que recibió 232 respuestas sobre las fortalezas, barreras y necesidades insatisfechas del sistema, así como sobre la concientización y la participación en el CPP.
- Se organizaron asambleas comunitarias como un foro para escuchar aportes adicionales de los miembros de la comunidad.

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Necesidades de salud conductual & Evaluación de capacidad

Los hallazgos clave de la retroalimentación cualitativa de la evaluación de las necesidades y la capacidad de salud conductual se organizan en las siguientes categorías:

Fortalezas

- Colaboración de proveedores
- Disponibilidad y accesibilidad del servicio
- Esfuerzos de participación del condado
- Eficacia de los servicios

Oportunidades de mejora y necesidades insatisfechas

- Acceso y disponibilidad del servicio
- Sensibilidad cultural y reducción de la disparidad
- Reclutamiento y retención de personal
- Implementación de nuevas iniciativas
- Colaboración interna y externa
- Operaciones
- Compromiso comunitario

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Necesidades de salud conductual & Evaluación de capacidad

HMA proporcionó recomendaciones que podrían tener un impacto significativo en la prestación de servicios de atención médica conductual en el condado de San Bernardino. Estos se clasifican en las cinco áreas siguientes:

1) Ampliar el acceso a servicios de alta calidad
2) Mejorar la integración y coordinación de servicios
3) Mejorar la comunicación y el compromiso externos
4) Fortalecer los procesos administrativos y operativos
5) Abordar los desafíos de la fuerza laboral

DBH está revisando las recomendaciones y desarrollando estrategias para ayudar a mejorar la prestación de atención médica conductual en nuestro condado. Este es un proceso continuo y se compartirán actualizaciones en reuniones futuras.

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Evaluación del proceso de planificación de programas comunitarios

A continuación se enumeran algunos hallazgos clave relacionados con las observaciones del proceso de Planificación del Programa Comunitario (CPP), ordenados por fortalezas y oportunidades de mejora:

Fortalezas

- Las reuniones tuvieron buena concurrencia, hubo muchas oportunidades para que los constituyentes formularan preguntas y ofrecieran sus comentarios, y los participantes se mostraron comprometidos.
- Se celebraron una amplia gama de reuniones especiales de población.
- La información compartida cumplió con los estándares de servicios cultural y lingüísticamente apropiados.

Oportunidades de mejora

- Hubo una desconexión entre los electores con respecto al contexto y el objetivo de las reuniones y la conexión entre la Ley de Servicios de Salud Mental (MHSA) y el CPP.
- Se podría agilizar el proceso de envío de comentarios.
- El condado podría aprovechar las herramientas en línea para mejorar las interacciones y la participación durante las reuniones.

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Evaluación del proceso de planificación de programas comunitarios

A continuación se enumeran algunos hallazgos clave relacionados con la retroalimentación sobre el proceso de Planificación del Programa Comunitario (CPP), ordenados por fortalezas y oportunidades de mejora:

Fortalezas

- El condado ha probado múltiples estrategias de divulgación, incluida la asociación con organizaciones para organizar reuniones, foros virtuales, encuestas, etc.
- La intención detrás del proceso y los subcomités es buena, incluso si no siempre son tan efectivos y concurridos como los participantes desearían.
- El condado promueve las sesiones entre los proveedores y la comunidad y, en general, recibe comentarios positivos.

Oportunidades de mejora

- Las partes interesadas tienen muchos requisitos que compiten por su tiempo y recursos y desean metas, objetivos y elementos de acción claramente definidos para las reuniones con un enfoque más fuerte en la aplicación operativa que en las estadísticas.
- Es necesario que haya una comunicación más clara sobre el objetivo del proceso del CPP.
- Existe un deseo de aumentar la participación de personas que tradicionalmente no han sido parte del proceso, como aquellas que pueden tener necesidades de salud conductual pero no acceden a los servicios por una razón u otra.

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Evaluación del proceso de planificación de programas comunitarios

A continuación se enumeran **algunas de las recomendaciones de HMA para mejorar el proceso de planificación de programas comunitarios (CPP):**

- Mejorar la comunicación y el compromiso externos
  - Crear conciencia sobre el proceso de planificación de programas comunitarios
  - Mejorar el seguimiento del progreso y los resultados del CPP
  - Aprovechar socios confiables para respaldar el intercambio de información
  - Mejorar las conexiones con las comunidades marginadas
  - Ofrecer oportunidades de participación en entornos comunitarios.
  - Aprovechar la tecnología para respaldar la participación

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Pasos actuales

DBH está tomando las siguientes medidas para abordar las recomendaciones de la evaluación:

- Proporcionar más contexto sobre MHSA y el proceso CPP durante las reuniones para ayudar a educar a las partes interesadas sobre el proceso de planificación y cómo su participación y comentarios ayudan a guiar los programas de DBH.
- Ampliar los grupos de partes interesadas para incluir más poblaciones desatendidas o marginadas, miembros de la comunidad, socios de servicios, organizaciones religiosas, grupos de niños y jóvenes, etc., para aumentar la participación y la retroalimentación de la comunidad e involucrar a más socios de servicios para aumentar el intercambio de información con la comunidad.
- Coordinar con otros departamentos y organizaciones para participar en las evaluaciones de las necesidades de sus comunidades y pacientes para identificar las necesidades del condado y ampliar el acceso y los servicios para satisfacer esas necesidades.
- Celebrar reuniones mensuales del Comité Asesor de Políticas Comunitarias (CPAC) en más lugares del condado para interactuar con las partes interesadas en entornos comunitarios.

El liderazgo de DBH está trabajando para identificar oportunidades adicionales de mejora y continúa fomentando la participación y la retroalimentación de las partes interesadas para guiar sus programas y servicios.

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¿Preguntas?

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Preocupaciones

Para informar cualquier inquietud relacionada con la planificación del programa comunitario de la MHSA, consulte el proceso de resolución de problemas de la MHSA que se encuentra en:

https://wp.sbcounty.gov/dbh/wp-content/uploads/sites/121/2021/08/COM0947.pdf?x62087

Para informar inquietudes relacionadas con la recepción de servicios de salud conductual, comuníquese con la Unidad de Acceso del DBH llame al:

(909) 386-8256
Línea gratuita 1 (888) 743-1478
o 7-1-1 para usuarios de TTY.

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¡Gracias!

Para preguntas o comentarios, por favor contactar a:

Dra. Rebecca Scott Young, MBA, PHR
Gerente Administrativo de la Ley de Servicios de Salud Mental
MHSA@dbh.sbcounty.gov
909-252-4021

www.SBCounty.gov/DBH

MENTAL HEALTH SERVICES ACT (MHSA)

Stakeholder Survey Form

MHSA Annual Update
Fiscal Year 2025/2026
Community Program Planning Meeting

SAN BERNARDINO COUNTY | Behavioral Health

1. What is your age?
- ☐ 0-15 years
- ☐ 16-25 years
- ☐ 26-59 years
- ☐ 60+ years
- ☐ Prefer not to answer

2. What sex were you assigned at birth?
- ☐ Female
- ☐ Male
- ☐ Prefer not to answer

3. How do you describe yourself?
- ☐ Female
- ☐ Male
- ☐ Trans Female/Woman
- ☐ Trans Male/Man
- ☐ Genderqueer
- ☐ Nonbinary
- ☐ Questioning or Unsure of Gender Identity
- ☐ Other/Not Listed: _____
- ☐ Prefer not to answer

4. Do you consider yourself:
- ☐ Straight/Heterosexual
- ☐ Gay/Lesbian
- ☐ Bisexual
- ☐ Queer
- ☐ Questioning or Unsure about Orientation
- ☐ Other/Not Listed: _____
- ☐ Prefer not to answer

5. What is the primary language spoken in your home?
- ☐ English
- ☐ Mandarin
- ☐ Spanish
- ☐ Vietnamese
- ☐ Other/Not Listed: _____
- ☐ Prefer not to answer

6. Are you a consumer of mental health services?
- ☐ Yes (currently)
- ☐ No
- ☐ Yes (previously)
- ☐ Prefer not to answer

7. Are you a consumer of alcohol and/or drug services?
- ☐ Yes (currently)
- ☐ No
- ☐ Yes (previously)
- ☐ Prefer not to answer

8. Are you a friend, family member, or loved one of a consumer of mental health services and/or alcohol and drug services?
- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

9. Have you ever served in the military?
- ☐ Yes (currently)
- ☐ No
- ☐ Yes (previously)
- ☐ Prefer not to answer

10. Which category best describes your race (i.e., physical/ancestral characteristics)?
(Check all that apply)
- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ African American/Black
- ☐ Caucasian/White
- ☐ Latinx/Hispanic
- ☐ Native Hawaiian
- ☐ Pacific Islander
- ☐ Multiple races
- ☐ Other (please specify):_____
- ☐ Decline to state

11. Which best describes your employer:
- ☐ Community Based Service Provider
- ☐ Federal, State, County, or City Government
- ☐ Nonprofit
- ☐ Private Business
- ☐ Self
- ☐ Student/Intern
- ☐ Not Employed
- ☐ Other/Not Listed: _____
- ☐ Prefer not to answer

Please continue to next page.

Updated 12/2024

SAN BERNARDINO COUNTY | Behavioral Health

Stakeholder Survey Form

MHSA Annual Update
Fiscal Year 2025/2026
Community Program Planning Meeting

12. Are you connected to any of the following stakeholder groups (Employed, Affiliated, Represent)? (Check all that apply)

- ☐ Alcohol and Drug Service Program Providers
- ☐ Area Agencies on Aging
- ☐ Continuum of Care
- ☐ Disability Insurers
- ☐ Education – Early Childhood Organizations
- ☐ Education – K-12 (direct child service)
- ☐ Education – School Districts, and other Agencies (no direct child services)
- ☐ Education – Higher Education Partners, Colleges, Trade Schools
- ☐ Emergency Medical Services
- ☐ Faith Based Organization
- ☐ Healthcare – Behavioral/Mental Health
- ☐ Healthcare – Physical Health
- ☐ Healthcare service plans, including Medi-Cal managed care plans (MCPs)
- ☐ Independent Living Centers
- ☐ Labor Representative Organizations
- ☐ Law Enforcement
- ☐ Regional Centers
- ☐ Social or Human Service Program/Agency
- ☐ Tribal and Indian Health Program designees established for Medi-Cal Tribal consultation purposes
- ☐ Veterans Organization
- ☐ Youth or Youth Mental Health or Substance Use Disorder Organizations/Providers
- ☐ Not Employed
- ☐ Other/Not Listed: _____
- ☐ Prefer not to answer

13. Do you have a disability or other impairment that is expected to last longer than 6 months and substantially limits a major life activity, which is not the result of a severe mental illness?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

14. Do you live or work in San Bernardino County? If both, list the region you live in:

- ☐ Central Valley Region
  e.g., Bloomington, Fontana, Grand Terrace, Rialto
- ☐ Desert/Mountain Region
  e.g., Adelanto, Amboy, Apple Valley, Baker, Big Bear City, Cima, Earp, Fort Irwin, Hesperia, Hinkley, Joshua Tree, Landers, Lucerne Valley, Ludlow, Morongo Valley, Mountain Pass, Needles, Nipton, Parker Dam, Phelan, Pioneertown, Sky Forest, Sugarloaf, 29 Palms, Wrightwood, Yermo, Yucca Valley
- ☐ East Valley
  e.g., Green Valley Lake, Highland, Lake Arrowhead, Loma Linda, Lytle Creek, Mentone, Patton, Redlands, Rimforest, Running Springs, San Bernardino, Yucaipa
- ☐ West Valley
  e.g., Chino Hills, Chino, Guasti, Mt. Baldy, Montclair, Ontario, Rancho Cucamonga
- ☐ I live and work in a neighboring California County
  Zip Code: _____
- ☐ Prefer not to answer

15. In the future how would you like to receive MHSA updates? (Check all the apply)

- ☐ Community Policy Advisory Committee Meetings
- ☐ Webinar
- ☐ Email (Provide email address below)
  Name: _____
  Email: _____
- ☐ Social Media
- ☐ Special meeting in your community
- ☐ Other/Not Listed: _____
- ☐ Prefer not to answer

Thank you for taking the time to complete this survey. Your feedback will help us improve the community planning process to better meet the needs of our community. **All information provided will be kept confidential.**

Please continue to next page.

SAN BERNARDINO COUNTY | Behavioral Health

Stakeholder Survey Form

MHSA Annual Update
Fiscal Year 2025/2026
Community Program Planning Meeting

Meeting Name: _____

1. **Were you satisfied that the MHSA Annual Update presentation met its goals and/or objectives?**
   - ☐ Very Satisfied
   - ☐ Satisfied
   - ☐ Neutral
   - ☐ Unsatisfied
   - ☐ Very Unsatisfied

2. **What did you learn about the MHSA Annual Plan Update?**

3. **What else would you like to learn about the MHSA process?**

4. **Do you have other concerns not addressed in this discussion?**

Please continue to next page.

Behavioral Health

Stakeholder Survey Form

MHSA Annual Update
Fiscal Year 2025/2026
Community Program Planning Meeting

5. Any additional comments or feedback?

Thank you again for taking the time to review and provide feedback.

LEY DE SERVICIOS DE SALUD MENTAL (MHSA)

Formulario de Comentarios para las Partes Interesadas

Actualización Anual de la MHSA
Año Fiscal 2025/2026
Reunión de Planificación del Programa Comunitario

SAN BERNARDINO COUNTY | **Departamento de Salud Mental**

1. ¿Cuántos años tiene?
- ☐ 0-15 años
- ☐ 16-25 años
- ☐ 26-59 años
- ☐ +60 años
- ☐ Prefiero no responder

2. ¿Qué sexo le asignaron al nacer?
- ☐ Femenino
- ☐ Masculino
- ☐ Prefiero no responder

3. ¿Cómo se describiría a usted mismo?
- ☐ Mujer
- ☐ Hombre
- ☐ Mujer transgénero
- ☐ Hombre transgénero
- ☐ Queer
- ☐ No binario
- ☐ Me cuestiono mi identidad de género o no estoy seguro de ella
- ☐ Otro/No está en la lista: _____
- ☐ Prefiero no responder

4. ¿Cómo se considera a usted mismo?
- ☐ Heterosexual
- ☐ Gay/Lesbiana
- ☐ Bisexual
- ☐ Queer
- ☐ Me cuestiono mi orientación o no estoy seguro de ella
- ☐ Otro/No está en la lista: _____
- ☐ Prefiero no responder

5. ¿Qué idioma principal se habla en su casa?
- ☐ Inglés
- ☐ Mandarín
- ☐ Español
- ☐ Vietnamita
- ☐ Otro/No está en la lista: _____
- ☐ Prefiero no responder

6. ¿Es usted consumidor de servicios de salud mental?
- ☐ Sí (actualmente)
- ☐ No
- ☐ Sí (en el pasado)
- ☐ Prefiero no responder

7. ¿Es usted consumidor de servicios de tratamiento de alcohol y/o drogas?
- ☐ Sí (actualmente)
- ☐ No
- ☐ Sí (en el pasado)
- ☐ Prefiero no responder

8. ¿Es usted amigo, familiar o ser queridos de un consumidor de ser servicios de salud mental y/o servicios de tratamiento de alcohol y/o drogas?
- ☐ Sí
- ☐ No
- ☐ Prefiero no responder

9. ¿Ha servido alguna vez en el ejército?
- ☐ Sí (actualmente)
- ☐ No
- ☐ Sí (en el pasado)
- ☐ Prefiero no responder

10. ¿Qué categoría describe mejor su raza (es decir, características físicas/ancestrales)?
(Marque todas las opciones que correspondan):
- ☐ Nativo de los Estados Unidos/ Nativo de Alaska
- ☐ Asiático
- ☐ Afroamericano/negro
- ☐ Caucásico/blanco
- ☐ Hispano/Latino
- ☐ Hawaiano nativo
- ☐ Isleño del Pacífico
- ☐ Más de una raza
- ☐ Otra/No está en la lista: _____
- ☐ Prefiero no responder

11. ¿Qué opción describe mejor a su empleador?
- ☐ Proveedor de servicios comunitarios
- ☐ Gobierno federal, estatal, del condado o de la ciudad
- ☐ Organización sin fines de lucro
- ☐ Empresa privada
- ☐ Trabajador por cuenta propia
- ☐ Estudiante/practicante
- ☐ No tengo empleo
- ☐ Otra/No está en la lista: _____
- ☐ Prefiero no responder

Favor de continuar a la próxima página.

SAN BERNARDINO COUNTY | Departamento de Salud Mental

Formulario de Comentarios para las Partes Interesadas

Actualización Anual de la MHSA
Año Fiscal 2025/2026
Reunión de Planificación del Programa Comunitario

12. ¿Está conectado a alguno de los siguientes grupos de partes interesadas (empleados, afiliados, representantes)? (Marque todas las opciones que correspondan):

☐ Proveedores de programa de servicios de alcohol y drogas
☐ Agencias para la tercera edad
☐ Continuidad de atención
☐ Aseguradores de invalidez
☐ Educación- Organizaciones de primeria infancia
☐ Educación- K-12 (servicio directo de niños)
☐ Educación- Distritos escolares y otras agencias (sin servicios directos a niños)
☐ Educación- Socios de educación superior, universidades, colegios, y escuelas de oficios
☐ Servicios médicos de emergencia
☐ Organización religiosa
☐ Cuidado de salud – Salud mental/del comportamiento
☐ Cuidado de salud – Salud física
☐ Planes de salud, incluyendo los planes de salud administrados de Medi-Cal
☐ Centros de vida independiente
☐ Organizaciones de representación laboral
☐ Fuerzas policiales
☐ Centros regionales
☐ Programa/agencia de servicios sociales o humanos
☐ Programas de salud tribales e indios establecidos para el propósito de consultas tribales de Medi-Cal
☐ Organización de veteranos
☐ Organizaciones/proveedores de servicios de salud mental y/o servicios de alcohol y drogas para jóvenes
☐ No tengo empleo
☐ Otra/No está en la lista: _____
☐ Prefiero no responder

13. ¿Tiene alguna discapacidad o deficiencia que dure más de 6 meses y que limita considerablemente la realización de actividades de vida diaria, que no sea consecuencia de una enfermedad mental grave?

☐ Sí ☐ No
☐ Prefiero no responder

14. ¿Vive o trabaja en el condado de San Bernardino? Si es así, indique la región:

☐ Región del valle central
p. ej., Bloomington, Fontana, Grand Terrace, Rialto

☐ Región desértica/montañosa
p. ej., Adelanto, Amboy, Apple Valley, Baker, Big Bear City, Cima, Earp, Fort Irwin, Hesperia, Hinkley, Joshua Tree, Landers, Ludlow, Morongo Valley, Mountain Pass, Needles, Nipton, Parker Dam, Phelan, Pioneertown, Sky Forest, Sugarloaf, 29 Palms, Wrightwood, Yermo, Yucca Valley

☐ Región del valle del este
p. ej., Green Valley Lake, Highland, Lake Arrowhead, Loma Linda, Lytle Creek, Mentone, Patton, Redlands, Rimforest, Running Springs, San Bernardino, Yucaipa

☐ Región del valle del oeste
p. ej., Chino Hills, Chino, Guasti, Mt. Baldy, Montclair, Ontario, Rancho Cucamonga

☐ Vivo o trabajo en otro condado en California
Código postal: _____

☐ Prefiero no responder

Favor de continuar a la próxima página.

Formulario de Comentarios para las Partes Interesadas

Actualización Anual de la MHSA
Año Fiscal 2025/2026
Reunión de Planificación del Programa Comunitario

SAN BERNARDINO COUNTY | **Departamento de Salud Mental**

15. En el futuro, ¿cómo le gustaría recibir las actualizaciones de la MHSA?
(Marque todas las opciones que correspondan)

☐ En las reuniones del Comité Asesor de Políticas Comunitarias
☐ En un seminario por internet (reunión virtual)
☐ Por correo electrónico (proporcione su dirección de correo electrónico a continuación)
Nombre: _____
Correo electrónico: _____
☐ Por redes sociales
☐ En una reunión especial en la comunidad
☐ Otra/No está en la lista: _____
☐ Prefiero no responder

Gracias por tomarse el tiempo para completar esta encuesta. Sus comentarios nos ayudarán a mejorar el proceso de planificación comunitaria para satisfacer mejor las necesidades de nuestra comunidad. **Toda la información proporcionada será confidencial.**

Favor de continuar a la próxima página.

SAN BERNARDINO COUNTY | Departamento de Salud Mental

Formulario de Comentarios para las Partes Interesadas

Actualización Anual de la MHSA
Año Fiscal 2025/2026
Reunión de Planificación del Programa Comunitario

Preguntas sobre la Actualización Anual de la MHSA Año Fiscal 2025/2026

1. **¿Quedo satisfecho/a que la presentación de la Actualización Anual de la MHSA cumplió con sus metas y/o objetivos?**
   - ☐ Muy satisfecho/a
   - ☐ Satisfecho/a
   - ☐ Neutral
   - ☐ Instaisfecho/a
   - ☐ Muy instaisfecho/a

2. **¿Qué aprendió sobre la actualización del plan anual de la MHSA?**

3. **¿Qué más le gustaría aprender sobre el proceso de la MHSA?**

4. **¿Tiene otras inquietudes que no se abordan en esta discusión?**

Favor de continuar a la próxima página.

Departamento de Salud Mental

Formulario de Comentarios para las Partes Interesadas

Actualización Anual de la MHSA
Año Fiscal 2025/2026
Reunión de Planificación del Programa Comunitario

5. ¿Algún comentario o sugerencia adicional?

Gracias de nuevo por tomarse el tiempo para revisar la encuesta y hacer comentarios.

From: DBH - MHSA
Subject: FW: Courtesy Copy: Behavioral Health Seeks Input on Annual Update Plan
Attachments: SBCounty News Outlet Listserv CONFIDENTIAL.xlsx

From: [redacted]
Sent: Tuesday, February 18, 2025 11:12 AM
To: [redacted]
Cc: [redacted]
Subject: FW: Courtesy Copy: Behavioral Health Seeks Input on Annual Update Plan

Good Morning,

The MHSA press release was published. The listserv of news outlets to which this was sent is also attached.

Thank you,

Having trouble viewing this email? View it as a Web page.

SAN BERNARDINO COUNTY

News Release

For Immediate Release
February 18, 2025

Contact
Miranda Canseco-Ochoa
Administrative Manager
Department of Behavioral Health
miranda.canseco@dbh.sbcounty.gov

Behavioral Health Seeks Input on Annual Update Plan

Behavioral Health Commission Meeting - May 2024

The San Bernardino County Department of Behavioral Health (DBH) invites community members to review and comment on the draft Mental Health Services Act (MHSA) Annual Update for Fiscal Year 2025/26.

The draft plan is a comprehensive report that illustrates the impact made by DBH and its contracted partners in addressing the behavioral health needs of San Bernardino County. This report also includes the proposed changes to MHSA programming for the upcoming fiscal year. View and comment on the draft plan by visiting

https://wp.sbcounty.gov/dbh/programs/mhsa/ starting February 14, 2025, **through March 17, 2025**.

Comment forms will be available in English and Spanish. For additional information on the update or to request interpretation services or disability-related accommodations, please call (800) 722-9866 (dial 7-1-1 for TTY users) or email mhsa@dbh.sbcounty.gov.

“Engaging stakeholders in the development of the Annual Update is crucial because their insights and experiences directly inform our approach, ensuring that we address the real needs of our communities. This feedback not only enhances the relevance and effectiveness of our programs but also fosters a sense of community ownership and trust in the solutions we provide” said DBH Director Dr. Georgina Yoshioka.

The MHSA was passed by California voters in November 2004 and is funded by a one percent tax surcharge on personal incomes over $1 million per year. Utilizing MHSA funding, DBH supports the Countywide Vision by providing behavioral health services and ensuring residents have the resources they need to promote wellness, recovery, and

resilience in the community. Information on the Countywide Vision and on DBH can be found at main.sbcounty.gov.

About San Bernardino County: San Bernardino County is a diverse public service organization serving America's largest county that for two consecutive years has led the nation in awards for innovation, efficiency, and outstanding public service. We are governed by an elected Board of Supervisors and dedicated to creating a community where nearly 2.2 million residents can prosper and achieve well-being in fulfillment of the Countywide Vision. It is comprised of 42 departments and agencies, which are staffed by more than 23,000 public service professionals who provide a wide range of vital services in the areas of public safety, health care, social services, economic and community development and revitalization, fiscal services, infrastructure, recreation and culture, and internal support. For more information, visit sbcounty.gov.

View the DRAFT MHSA Annual Update

30 Day Posting Press Release on San Bernardino County Website

- Assessor-Recorder-County Clerk
- Auditor-Controller/Treasurer/Tax Collector
- Behavioral Health
- Big Bear Alpine Zoo
- Board of Supervisors
- Census
- Child Support Services
- Children and Family Services
- Children's Fund
- Children's Network
- Clerk of the Board
- Coalition Against Sexual Exploitation
- Code Enforcement
- Community Development and Housing
- Community Vital Signs
- County Administrative Office
- County Fire
- County History
- County Library
- County Museum
- County Surveyor
- Countywide Plan
- CountyWire
- Disasters
- District Attorney
- Economic Development Agency
- Environment
- Environmental Health Services
- Equal Opportunity Commission
- Facilities Management
- First 5 San Bernardino
- Fleet Management
- Government Works
- Grand Jury
- Homeownership Protection Program JPA
- Housing Authority
- Human Resources
- Human Services
- Innovation and Technology Department
- Land Use Services
- Office of Emergency Services
- Office of Homeless Services
- Photos
- Preparedness
- Preschool Services
- Probation Department
- Public Defender
- Public Health
- Public Works
- Purchasing Department
- Real Estate Services
- Redistricting Commission
- Regional Parks

Behavioral Health Commission meeting – May 2024.

The San Bernardino County Department of Behavioral Health (DBH) invites community members to review and comment on the draft Mental Health Services Act (MHSA) Annual Update for fiscal year 2025-26.

The draft plan is a comprehensive report that illustrates the impact made by DBH and its contracted partners in addressing the behavioral health needs of San Bernardino County. This report also includes the proposed changes to MHSA programming for the upcoming fiscal year. View and comment on the draft plan by visiting wp.sbcounty.gov/dbh/programs/mhsa through March 17.

Comment forms will be available in English and Spanish. For additional information on the update or to request interpretation services or disability-related accommodations, please call 1-800-722-9866 (dial 7-1-1 for TTY users) or email mhsa@dbh.sbcounty.gov.

"Engaging stakeholders in the development of the Annual Update is crucial because their insights and experiences directly inform our approach, ensuring that we address the real needs of our communities. This feedback not only enhances the relevance and effectiveness of our programs but also fosters a sense of community ownership and trust in the solutions we provide," said DBH Director Dr. Georgina Yoshioka.

The MHSA was passed by California voters in November 2004 and is funded by a one percent tax surcharge on personal incomes over $1 million per year. Utilizing MHSA funding, DBH supports the Countywide Vision by providing behavioral health services and ensuring residents have the resources they need to promote wellness, recovery, and resilience in the community. Information on the Countywide Vision and on DBH can be found at cao-vision.sbcounty.gov and wp.sbcounty.gov/dbh.

San Bernardino County is a diverse public service organization serving America's largest county that for three consecutive years has led the nation in awards for innovation, efficiency, and outstanding public service. We are governed by an elected Board of Supervisors and dedicated to creating a community where nearly 2.2 million residents can prosper and achieve well-being in fulfillment of the Countywide Vision. It is comprised of 42 departments and agencies, which are staffed by more than 23,000 public service professionals who provide a wide range of vital services in the areas of public safety, health care, social services, economic and community development and revitalization, fiscal services, infrastructure, recreation and culture and internal support. For more information, visit main.sbcounty.gov.

SAN BERNARDINO COUNTY

Interoffice Memo

DATE: January 14, 2025 **PHONE:** 909-252-5142

FROM: **DR. GEORGINA YOSHIOKA,** Director
Behavioral Health

TO: **MEMBERS**
Board of Supervisors

LUTHER SNOKE, Chief Executive Officer
County Administrative Office

DIANE RUNDLES, Assistant Executive Officer
County Administrative Office

SUBJECT: POSTING OF THE DRAFT MENTAL HEALTH SERVICES ACT ANNUAL UPDATE FISCAL YEAR 2025-2026

The purpose of this memo is to provide information regarding the posting of the Draft Mental Health Services Act (MHSA) Annual Update for Fiscal Year 2025/26. The development and public posting of this report to the San Bernardino County Department of Behavioral Health (DBH) Internet site is a statutory requirement to allow the public an opportunity to review and provide input concerning the programs funded through MHSA. Any substantive changes related to MHSA programs or budget require a 30-Day public review and comment period. The posting meets the required 30-day public review and comment period in accordance with Welfare and Institutions Code 5848 and can be accessed at https://wp.sbcounty.gov/dbh/programs/mhsa/.

BACKGROUND

Welfare and Institutions Code 5847 requires the development of a Three Year Integrated MHSA Plan, and subsequent Annual Updates to the Plan, for the purpose of highlighting the progress, accomplishments, and anticipated budget of MHSA programs. Each plan is required to be developed via a stakeholder engagement process, which includes a public posting and comment period; a Public Hearing hosted by the Behavioral Health Commission to affirm adherence to the stakeholder process; and approval by the Board of Supervisors. In our efforts to support the Countywide Vision initiative, DBH is connecting the general standards and principles of MHSA to the Wellness Component of our Countywide Vision. These programs serve to reduce health disparities through behavioral health education, promotion of healthy lifestyles, development of outcome-based services, and increased collaboration between and among providers, community-based organizations, and county departments.

DBH continues to utilize an effective, year-round community planning process to seek input from stakeholders. The department continues the use of best practices in our community planning process by:

- Publishing stakeholder meeting schedules as part of the draft plan, via public postings, hosting recurring meetings, email distribution lists, websites, and through the use of social media tools, such as Instagram, Facebook, and Twitter.
- Conducting thirty-nine special stakeholder engagement meetings in all regions (i.e., supervisory districts) to review proposed programmatic changes and new programs (please see attachment for list of meetings).
- Utilizing webinar technology to allow stakeholders to participate from home.
- Facilitating meetings in Spanish for monolingual community members in addition to providing translation services, as needed, at the other scheduled meetings.

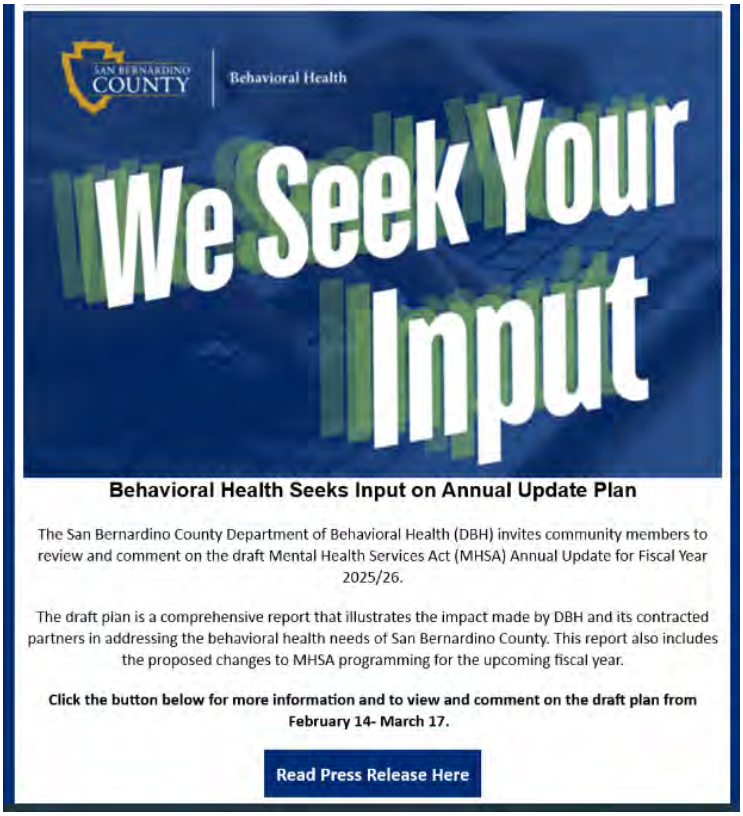
STATUS / IMPLEMENTATION

Per Welfare and Institutions Code 5848, the MHSA Annual Update for Fiscal Year 2025/26 will be available for a minimum 30-day public review and comment period on the DBH website from February 14, 2025, through March 17, 2025. Upon completion of the review period, all public input will be considered and incorporated into the report to reflect any substantive changes resulting from feedback received. A public hearing is scheduled to take place on April 3, 2025, at the regularly scheduled Behavioral Health Commission Meeting for a formal review of the community program planning process. The MHSA Annual Update is tentatively scheduled for Board approval in May 2025. Should you have any questions or need further information regarding the submission of the MHSA Annual Update for San Bernardino County, please contact my office. Thank you for your continued support!

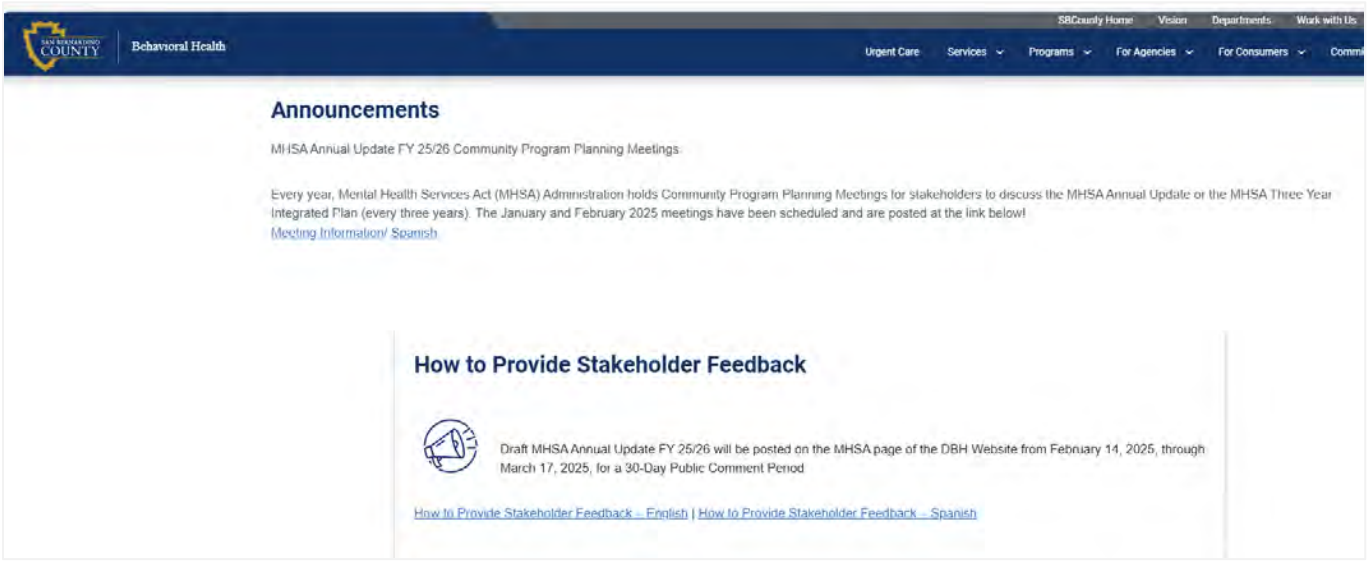
GY:RSY:mv

C: Victor Tordesillas, Deputy Executive Officer
Paul Garcia, Administrative Analyst III, Human Services
Members, Behavioral Health Commission
MHSA Community Policy Advisory Committee
Executive Management Team, Department of Behavioral Health
Roger Uminski, President, Association of Community Based Organizations
Maribel Gutierrez, Deputy Director, Community Engagement and Equity Services
Sonia Navarro, Senior Program Manager, MHSA Administration
Dr. Rebecca Scott Young, Department of Behavioral Health, MHSA Administrative Manager

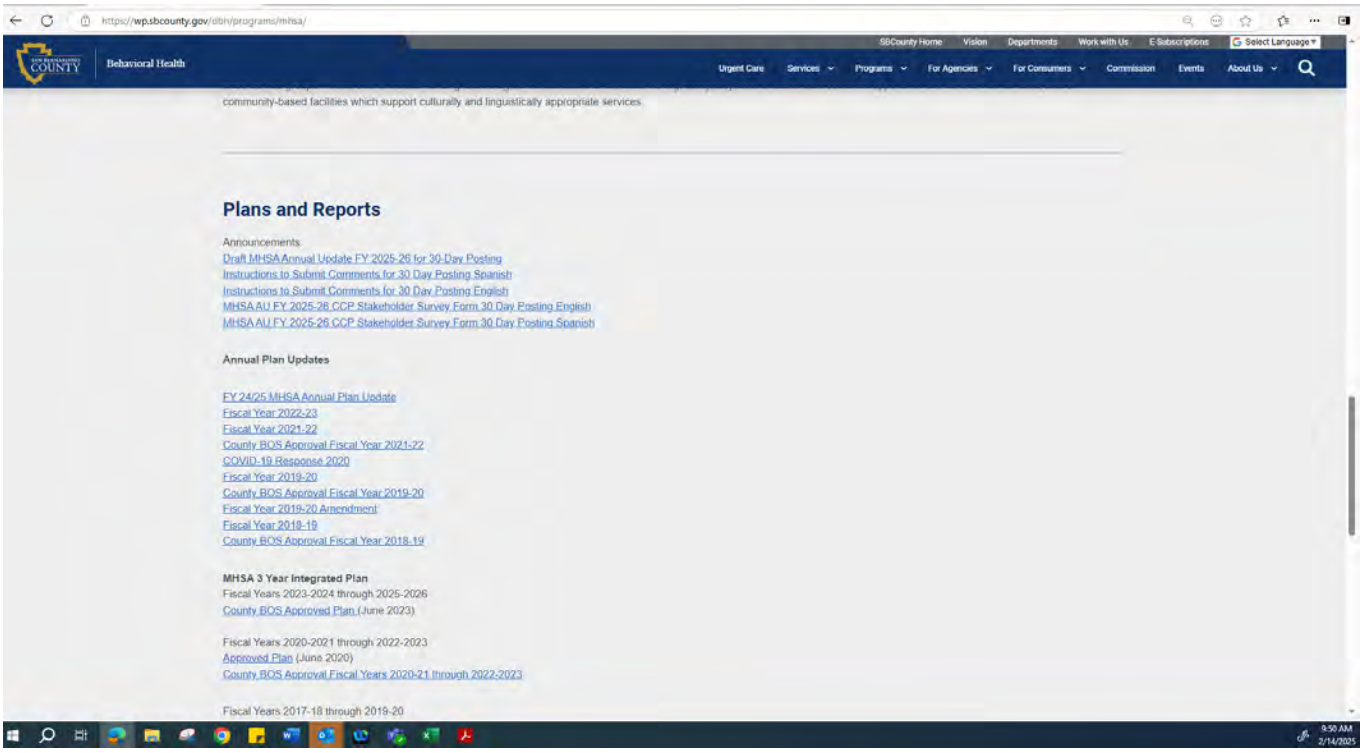
30 Day Posting Web Blast



30 Day Posting DBH Website Announcement



30 Day Posting MHSA Website Announcement



MENTAL HEALTH SERVICES ACT (MHSA)

Stakeholder Survey Form

MHSA Annual Update
Fiscal Year 2025/2026
30-Day Public Comment

SAN BERNARDINO COUNTY | Behavioral Health

1. What is your age?
- ☐ 0-15 years
- ☐ 16-25 years
- ☐ 26-59 years
- ☐ 60+ years
- ☐ Prefer not to answer

2. What sex were you assigned at birth?
- ☐ Female
- ☐ Male
- ☐ Prefer not to answer

3. How do you describe yourself?
- ☐ Female
- ☐ Male
- ☐ Trans Female/Woman
- ☐ Trans Male/Man
- ☐ Genderqueer
- ☐ Nonbinary
- ☐ Questioning or Unsure of Gender Identity
- ☐ Other/Not Listed: _____
- ☐ Prefer not to answer

4. Do you consider yourself:
- ☐ Straight/Heterosexual
- ☐ Gay/Lesbian
- ☐ Bisexual
- ☐ Queer
- ☐ Questioning or Unsure about Orientation
- ☐ Other/Not Listed: _____
- ☐ Prefer not to answer

5. What is the primary language spoken in your home?
- ☐ English
- ☐ Mandarin
- ☐ Spanish
- ☐ Vietnamese
- ☐ Other/Not Listed: _____
- ☐ Prefer not to answer

6. Are you a consumer of mental health services?
- ☐ Yes (currently)
- ☐ No
- ☐ Yes (previously)
- ☐ Prefer not to answer

7. Are you a consumer of alcohol and/or drug services?
- ☐ Yes (currently)
- ☐ No
- ☐ Yes (previously)
- ☐ Prefer not to answer

8. Are you a friend, family member, or loved one of a consumer of mental health services and/or alcohol and drug services?
- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

9. Have you ever served in the military?
- ☐ Yes (currently)
- ☐ No
- ☐ Yes (previously)
- ☐ Prefer not to answer

10. Which category best describes your race (i.e., physical/ancestral characteristics)?
(Check all that apply)
- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ African American/Black
- ☐ Caucasian/White
- ☐ Latinx/Hispanic
- ☐ Native Hawaiian
- ☐ Pacific Islander
- ☐ Multiple races
- ☐ Other (please specify):_____
- ☐ Decline to state

11. Which best describes your employer:
- ☐ Community Based Service Provider
- ☐ Federal, State, County, or City Government
- ☐ Nonprofit
- ☐ Private Business
- ☐ Self
- ☐ Student/Intern
- ☐ Not Employed
- ☐ Other/Not Listed: _____
- ☐ Prefer not to answer

Please continue to next page.

Updated 12/2024

SAN BERNARDINO COUNTY | Behavioral Health

Stakeholder Survey Form

MHSA Annual Update
Fiscal Year 2025/2026
30-Day Public Comment

12. Are you connected to any of the following stakeholder groups (Employed, Affiliated, Represent)? (Check all that apply)

- ☐ Alcohol and Drug Service Program Providers
- ☐ Area Agencies on Aging
- ☐ Continuum of Care
- ☐ Disability Insurers
- ☐ Education – Early Childhood Organizations
- ☐ Education – K-12 (direct child service)
- ☐ Education – School Districts, and other Agencies (no direct child services)
- ☐ Education – Higher Education Partners, Colleges, Trade Schools
- ☐ Emergency Medical Services
- ☐ Faith Based Organization
- ☐ Healthcare – Behavioral/Mental Health
- ☐ Healthcare – Physical Health
- ☐ Healthcare service plans, including Medi-Cal managed care plans (MCPs)
- ☐ Independent Living Centers
- ☐ Labor Representative Organizations
- ☐ Law Enforcement
- ☐ Regional Centers
- ☐ Social or Human Service Program/Agency
- ☐ Tribal and Indian Health Program designees established for Medi-Cal Tribal consultation purposes
- ☐ Veterans Organization
- ☐ Youth or Youth Mental Health or Substance Use Disorder Organizations/Providers
- ☐ Not Employed
- ☐ Other/Not Listed: _____
- ☐ Prefer not to answer

13. Do you have a disability or other impairment that is expected to last longer than 6 months and substantially limits a major life activity, which is not the result of a severe mental illness?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

14. Do you live or work in San Bernardino County? If both, list the region you live in:

- ☐ Central Valley Region
  e.g., Bloomington, Fontana, Grand Terrace, Rialto
- ☐ Desert/Mountain Region
  e.g., Adelanto, Amboy, Apple Valley, Baker, Big Bear City, Cima, Earp, Fort Irwin, Hesperia, Hinkley, Joshua Tree, Landers, Lucerne Valley, Ludlow, Morongo Valley, Mountain Pass, Needles, Nipton, Parker Dam, Phelan, Pioneertown, Sky Forest, Sugarloaf, 29 Palms, Wrightwood, Yermo, Yucca Valley
- ☐ East Valley
  e.g., Green Valley Lake, Highland, Lake Arrowhead, Loma Linda, Lytle Creek, Mentone, Patton, Redlands, Rimforest, Running Springs, San Bernardino, Yucaipa
- ☐ West Valley
  e.g., Chino Hills, Chino, Guasti, Mt. Baldy, Montclair, Ontario, Rancho Cucamonga
- ☐ I live and work in a neighboring California County
  Zip Code: _____
- ☐ Prefer not to answer

15. In the future how would you like to receive MHSA updates? (Check all the apply)

- ☐ Community Policy Advisory Committee Meetings
- ☐ Webinar
- ☐ Email (Provide email address below)
  Name: _____
  Email: _____
- ☐ Social Media
- ☐ Special meeting in your community
- ☐ Other/Not Listed: _____
- ☐ Prefer not to answer

Thank you for taking the time to complete this survey. Your feedback will help us improve the community planning process to better meet the needs of our community. **All information provided will be kept confidential.**

Please continue to next page.

SAN BERNARDINO COUNTY | Behavioral Health

Stakeholder Survey Form

MHSA Annual Update
Fiscal Year 2025/2026
30-Day Public Comment

1. **What did you learn about the MHSA Annual Plan Update?**

2. **What else would you like to learn about the MHSA process?**

3. **Do you have any concerns that were not addressed?**

4. **Any additional comments or feedback?**

Thank you again for taking the time to review and provide feedback.

LEY DE SERVICIOS DE SALUD MENTAL (MHSA)

Encuesta para las partes interesadas

Actualización anual de la MHSA

Año fiscal 2025/2026

Comentario público de 30 días

SAN BERNARDINO COUNTY | Departamento de Salud Mental

1. ¿Cuántos años tiene?

☐ 0-15 años ☐ 26-59 años
☐ 16-25 años ☐ +60 años
☐ Prefiero no responder

2. ¿Qué sexo le asignaron al nacer?

☐ Femenino ☐ Masculino
☐ Prefiero no responder

3. ¿Cómo se describiría a usted mismo?

☐ Mujer ☐ Hombre
☐ Mujer transgénero ☐ Hombre transgénero
☐ Queer ☐ No binario
☐ Me cuestiono mi identidad de género o no estoy seguro de ella
☐ Otro/No está en la lista: _____
☐ Prefiero no responder

4. ¿Cómo se considera ~~a~~ usted mismo?

☐ Heterosexual ☐ Gay/Lesbiana
☐ Bisexual ☐ Queer
☐ Me cuestiono mi orientación o no estoy seguro de ella
☐ Otro/No está en la lista: _____
☐ Prefiero no responder

5. ¿Qué idioma principal se habla en su casa?

☐ Inglés ☐ Mandarín
☐ Español ☐ Vietnamita
☐ Otro/No está en la lista: _____
☐ Prefiero no responder

6. ¿Usa los servicios de salud mental?

☐ SÍ (actualmente) ☐ NO
☐ SÍ (en el pasado) ☐ Prefiero no responder

7. ¿Usa los servicios para consumidores de alcohol o drogas?

☐ SÍ (actualmente) ☐ NO
☐ SÍ (en el pasado) ☐ Prefiero no responder

8. ¿Alguno de sus amigos, familiares o seres queridos usa los servicios de salud mental o los servicios para consumidores de alcohol o drogas?

☐ SÍ ☐ NO
☐ Prefiero no responder

9. ¿Alguna vez estuvo en el ejército?

☐ SÍ (actualmente) ☐ NO
☐ SÍ (en el pasado) ☐ Prefiero no responder

10. ¿Qué categoría describe mejor su raza (es decir, características físicas/ancestrales)?

(Marque todas las opciones que correspondan):

☐ Nativo de los Estados Unidos o nativo de Alaska
☐ Asiático
☐ Afroamericano/negro
☐ Caucásico/blanco
☐ Hispano/latino
☐ Nativo de Hawái o de otra isla del Pacífico
☐ Más de una raza
☐ Otra/No está en la lista: _____
☐ Prefiero no responder

11. ¿Qué opción describe mejor a su empleador?

☐ Proveedor de servicios comunitarios
☐ Gobierno federal, estatal, del condado o de la ciudad
☐ Organización sin fines de lucro
☐ Empresa privada
☐ Trabajador por cuenta propia
☐ Estudiante/practicante
☐ No tengo empleo
☐ Otra/No está en la lista: _____
☐ Prefiero no responder

Continúe en la próxima página.

SAN BERNARDINO COUNTY | Departamento de Salud Mental

Encuesta para las partes interesadas

Actualización anual de la MHSA
Año fiscal 2025/2026
Comentario público de 30 días

12. ¿Está usted conectado a alguno de los siguientes grupos de partes interesadas (empleados, afiliados, representantes)? (Marque todas las opciones que correspondan):

☐ Programa de servicios para consumidores de alcohol y drogas
☐ Agencias de la Tercera Edad
☐ Continuidad de la atención
☐ Aseguradoras de discapacidad
☐ Educación - Organizaciones de la primera temprana infancia
☐ Educación – K-12 (servicios directos de niños)
☐ Educación – Distritos escolares y otras agencias (sin servicios directos de niños)
☐ Educación – Socios de educación superior, colegios, escuelas vocacionales
☐ Servicios de urgencias medicas
☐ Organización religiosa
☐ Atención médica – Salud mental/de comportamiento
☐ Atención médica – Salud física
☐ Planes de servicios de Atención medica, incluidos los planes de atención administrada de Medi-Cal
☐ Centros de vida independiente
☐ Organización sindical representativa
☐ Fuerzas policiales
☐ Centros regionales
☐ Programa/agencia de servicios sociales o humanos
☐ Programa de Salud Tribales y Indígenas de personas designadas establecidas con propósito de consultas para Medi-Cal tribal
☐ Organización de veteranos
☐ Organización/Proveedores de salud mental o trastornos por consumo de sustancias para jóvenes
☐ No tengo empleo
☐ Otra/No está en la lista: _____
☐ Prefiero no responder

13. ¿Tiene alguna discapacidad o deficiencia que se espera que dure más de 6 meses y que limita considerablemente la realización de una actividad de la vida diaria como resultado de una enfermedad mental grave?

☐ SÍ ☐ No
☐ Prefiero no responder

14. ¿Vive o trabaja en el condado de San Bernardino? Si vive y trabaja allí, indique la región en la que vive:

☐ Región de Central Valley
p. ej., Bloomington, Fontana, Grand Terrace, Rialto

☐ Región desértica/montañosa
p. ej., Adelanto, Amboy, Apple Valley, Baker, Big Bear City, Cima, Earp, Fort Irwin, Hesperia, Hinkley, Joshua Tree, Landers, Ludlow, Morongo Valley, Mountain Pass, Needles, Nipton, Parker Dam, Phelan, Pioneertown, Sky Forest, Sugarloaf, 29 Palms, Wrightwood, Yermo, Yucca Valley

☐ East Valley
p. ej., Green Valley Lake, Highland, Lake Arrowhead, Loma Linda, Lytle Creek, Mentone, Patton, Redlands, Rimforest, Running Springs, San Bernardino, Yucaipa

☐ West Valley
p. ej., Chino Hills, Chino, Guasti, Mt. Baldy, Montclair, Rancho Cucamonga

☐ Vivo y trabajo en un condado vecino de California
Código postal: _____

☐ Prefiero no responder

15. En el futuro, ¿cómo le gustaría recibir las actualizaciones de la MHSA? (Marque todas las opciones que correspondan)

☐ En las reuniones del Comité Asesor de Políticas Comunitarias
☐ En un seminario por internet (reunión virtual)
☐ Por correo electrónico (escriba su correo electrónico abajo)
Nombre: _____
Correo electrónico: _____
☐ Por redes sociales
☐ En una reunión especial de la comunidad (escriba su información de contacto abajo)
Nombre: _____
Correo electrónico: _____
Número de teléfono: _____
☐Otra/No está en la lista: _____
☐ Prefiero no responder

Continúe en la próxima página.

SAN BERNARDINO COUNTY | Departamento de Salud Mental

Encuesta para las partes interesadas

Actualización anual de la MHSA

Año fiscal 2025/2026

Comentario público de 30 días

Gracias por tomarse el tiempo para completar esta encuesta. Sus comentarios nos ayudarán a mejorar el proceso de planificación comunitaria para satisfacer mejor las necesidades de nuestra comunidad. **Toda la información brindada será confidencial.**

Continúe en la próxima página.

Departamento de Salud Mental

Encuesta para las partes interesadas

Actualización anual de la MHSA

Año fiscal 2025/2026

Comentario público de 30 días

1. **¿Qué aprendió sobre la actualización del plan anual de la MHSA?**

2. **¿Qué más le gustaría saber del proceso de la MHSA?**

3. **¿Tiene alguna otra inquietud que no se haya tratado en este debate?**

4. **¿Tiene algún otro comentario?**

Gracias de nuevo por tomarse el tiempo para revisar la encuesta y hacer comentarios.

303 E. Vanderbilt Way, San Bernardino, CA 92415-0026 | Phone: 909.252.5142 Fax: 909.890.0435
www.SBCounty.gov

SAN BERNARDINO COUNTY

Behavioral Health Commission

GENERAL SESSION AGENDA
Thursday April 3, 2025, 12:00pm – 2:00pm
County of San Bernardino Behavioral Health Services Auditorium
850 East Foothill Boulevard Rialto, CA 92376
Satellite Locations:
Apple Valley Clinic 18818 Highway 18 Apple Valley, CA 92307
Yucca Valley/Morongo 58945 Business Center Drive Yucca Valley, CA 92284
*If you require ADA accommodations (ASL Interpreter, other communication devices, or other interpreter services), please contact the Office of Equity and Inclusion at (909) 252-5150 prior to the meeting.

ALL MEETINGS OPEN TO THE PUBLIC

District 1
Lorrie Denson
Amanda Uptergrove
Jonathan C. Cahow

District 2
Dr. Valerie Samuel
Jennifer Oglesby, *Secretary*
Michael A. Hall

District 3
Allie Mink, *Chair*
Troy Mondragon
VACANT

District 4
Jennifer Spence
Delinia Lewis
VACANT

District 5
Veatrice Jews
Lynn Summers, *Treasurer*
Eloisa Contreras

Board of Supervisors
Jesse Armendarez, 2nd District

Clerk of the Commission
John Granado

	POST IN PUBLIC VIEW
CALL TO ORDER Pledge of Allegiance Roll Call / Introductions Satellite Location Introductions	Allie Mink, Chair
MINUTES *Tab 5:* Review and approve General Session minutes from February 6, 2025 & March 6, 2025	Members of the Commission
PUBLIC COMMENTS Rialto Public Comments Satellite Location Public Comments	
CHAIR'S REPORT	Allie Mink, Chair
COMMISSIONER REPORTS	Members of the Commission
SUBJECT MATTER PRESENTATION *Tab 6:* MHSA Annual Update	Dr. Rebecca Scott Young
DIRECTOR'S REPORT *Tab 1a:* Report and BOS Items	Dr. Georgina Yoshioka, Director
ADJOURNMENT	Allie Mink, Chair

To request information/data regarding services, demographics, or to submit a Public Records Act Request, visit: https://sanbernardinocounty.nextrequest.com/.

Written materials for this meeting are available by request or at:

https://wp.sbcounty.gov/dbh/bhc.

From: San Bernardino County <sbcounty@public.govdelivery.com>
Sent: Friday, March 28, 2025 2:58 PM

Subject: Public Hearing for Mental Health Services Act (MHSA) Annual Update

SAN BERNARDINO COUNTY

News Release

For Immediate Release
March 28, 2025

Miranda Canseco
Administrative Manager
Department of Behavioral Health

miranda.canseco@dbh.sbcounty.gov

Public Hearing for Mental Health Services Act (MHSA) Annual Update

Behavioral Health Commission Meeting

The San Bernardino County Department of Behavioral Health (DBH) invites community members to a public hearing on Thursday, April 3, 2025, from noon to 2 p.m. The hearing will cover topics related to behavioral health services, program goals, and other relevant outcomes described in the draft Mental Health Services Act (MHSA) annual update for fiscal year 2025/26.

The public hearing will be conducted at the Behavioral Health Commission general session meeting on Thursday, April 3, 2025, from noon to 2 p.m. at the County of San Bernardino Health Services Building Auditorium, 850 E. Foothill Blvd., Rialto, CA 92376. A satellite location will also be available at the Department of Behavioral Health Apple Valley Community Clinic, 18818 Highway 18, Apple Valley, CA and the Family Resource Center at 58945 Business Center Drive Yucca Valley, CA 92284.

The draft plan is a comprehensive report that illustrates the impact made by DBH and its contracted partners in addressing San Bernardino County's behavioral health needs. This report also includes the proposed changes to MHSA programming for the upcoming fiscal year.

For more information on the public hearing, language interpretation services, and/or requests for disability-related accommodations, please call (800) 722-9866 or dial 7-1-1 for TTY users.

The Department of Behavioral Health supports the Countywide Vision by providing behavioral health and substance use disorder services that promote community wellness, recovery and resiliency. Information on the Countywide Vision and DBH can be found at www.sbcounty.gov.

About San Bernardino County: San Bernardino County is a diverse public service organization serving America’s largest county that for two consecutive years has led the nation in awards for innovation, efficiency, and outstanding public service. We are governed by an elected Board of Supervisors and dedicated to creating a community where nearly 2.2 million residents can prosper and achieve well-being in fulfillment of the Countywide Vision. It is comprised of 42 departments and agencies, which are staffed by more than 23,000 public service professionals who provide a wide range of vital services in the areas of public safety, health care, social services, economic and community development and revitalization, fiscal services, infrastructure, recreation and culture, and internal support. For more information, visit sbcounty.gov.

Public Hearing DBH email notice

MEETINGS

County Inviting Community to Mental Health Public Hearing

San Bernardino County's Department of Behavioral Health (DBH) invites community members to a public hearing from noon to 2 p.m. Thursday, April 3, at the DBH Apple Valley Community Clinic (18818 Highway 18, Apple Valley).

The meeting is to discuss behavioral health services, program goals, and outcomes outlined in the draft Mental Health Services Act (MHSA) annual update for fiscal year 2025/26.

This comprehensive report details the impact of DBH and its partners on the county’s behavioral health needs and proposed programming changes.

For more details on the hearing, call (800) 722-9866.

303 E. Vanderbilt Way, San Bernardino, CA 92415-0026 | Phone: 909.252.5142 Fax: 909.890.0435
www.SBCounty.gov

SAN BERNARDINO COUNTY

Behavioral Health
Administration

Dr. Georgina Yoshioka, DSW, MBA, LCSW
Director

Jennifer Alsina, MBA
Assistant Director

Marina Espinosa, MPA
Assistant Director

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Tri-Community NewsPlus
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Victorville Daily Press
Westside Story Newspaper
Yucaipa/Calimesa News Mirror
Yucca Valley TV

Assessment of Behavioral Health Needs and Capacity

PREPARED FOR
SAN BERNARDINO COUNTY

BY
HEALTH MANAGEMENT ASSOCIATES

CHARLES ROBBINS, MBA
ROB MUSCHLER, MPA
RACHEL JOHNSON-YATES, MA, LMHC, LAC
PAUL FLEISSNER
GABRIEL VELAZQUEZ, MPH
CAMI COLLINS

DATE
AUGUST 30, 2024

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EXECUTIVE SUMMARY

Health Management Associates (HMA) was contracted by the San Bernardino Department of Behavioral Health (DBH) to assess behavioral health needs and capacity, including workforce needs, and utilize a methodology for determining near-real-time system capacity for SUD residential services.

HMA utilized a mixed-method approach to conduct the assessments. Strategies for qualitative and quantitative data collection are highlighted below:

- Collected and analyzed available data on client services, demographics, capacity data, and workforce needs.
- Conducted interviews with outpatient and residential behavioral health providers, culturally specific organizations, social service agencies, and school district representatives, amongst others to solicit their input on system strengths and areas for improvement.
- Facilitated focus groups where 220+ individuals with lived experience shared their stories and experiences.
- Administered a community survey that received 232 responses regarding system strengths, barriers, and unmet needs.
- Convened townhalls as a forum to hear additional input from community members.

The qualitative and quantitative data gathered was presented to a team of DBH staff – called the Core Team – that represented a cross-section of departments to review, discuss, and inform recommendation development. These same data were also presented to a Community Advisory Group (CAG) that was convened to support this process. The CAG included representatives from community-based organizations working in and around the behavioral health system. Findings from the data collection efforts are summarized in this document, with additional details provided in the addendum.

HMA used the collected data and insights from discussions with the Core Team and CAG to develop recommendations for addressing identified areas in need of improvement. The recommendations are organized under the following areas:

1) Expand Access to High-Quality Services
2) Improve Service Integration and Coordination
3) Enhance External Communication and Engagement
4) Strengthen Administrative and Operational Processes
5) Address Workforce Challenges

The recommendations outlined in this report will build on the strong foundation of behavioral health services in San Bernardino County and help to support further enhancements to the behavioral health system and the CPP.

INTRODUCTION

The San Bernardino Department of Behavioral Health (DBH) provides mental health and substance use disorder services to county residents who are experiencing serious mental illnesses (SMI) and/or substance use issues and are uninsured or insured through Medi-Cal, as well as individuals experiencing a behavioral health crisis. DBH serves all age groups and provides an array of prevention, early intervention, and treatment services for both mental health and substance use.

Nearly fifty DBH programs, services, and actions are supported through the Mental Health Services Act (MHSA), a state funded program designed to "reduce the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness". All MHSA programs are stakeholder informed and developed via a required Community Program Planning (CPP) process.

The Behavioral Health Continuum Infrastructure program (BHCIP), funded through the Department of Health Care Services (DHCS) provides investments in infrastructure funding alongside significant new state and federal resources to address homelessness, support healthcare delivery reform, and strengthen the social safety net. Together these commitments will address historic gaps in the behavioral health continuum to meet growing demand for services and supports. This funding opportunity allows DBH the ability to meet the needs of vulnerable populations with the greatest barriers to access, including people experiencing homelessness and justice involvement, utilizing direct stakeholder engagement and feedback.

Substance Use Disorder and Recovery Services (SUDRS) supports the recovery efforts of individuals by providing a drug and alcohol free sober social environment and other recovery resources by providing a full range of substance use disorder (SUD) treatment services and education. SUDRS services are offered through contracts with community-based organizations (CBOs) and county-operated clinics to promote prevention, intervention, recovery and resiliency for individuals (adolescents ages 12-17 and adults 18+) and families. SUD treatment services utilize the American Society of Addiction Medicine (ASAM) Criteria to determine appropriate level of care for covered SUD treatment services. SUDRS services are funded by multiple funding sources, which are informed by stakeholder engagement.

Health Management Associates (HMA) was contracted by DBH to assess behavioral health needs and capacity, including workforce needs, and utilize a methodology for determining near-real-time system capacity for SUD residential services. The following analysis highlights program strengths, challenges, and provides recommendations for areas of opportunity.

METHODOLOGY

HMA utilized a mixed-method approach to conducting the assessment of the behavioral health system in San Bernardino County. Below is a summary of the primary domains of the assessments:

- Behavioral health system and workforce needs
- Behavioral health needs of unserved and under-served residents
- Cultural and linguistic needs of residents
- Linguistic capacity, provider diversity, and education and training needs for the behavioral health workforce

HMA met early in the process with key members of the San Bernardino Department Behavioral Health (DBH) to build a thorough understanding of the behavioral health ecosystem and current CPP. San Bernadino County, with a diverse array of public, private, and non-profit partners, provides a dynamic portfolio of behavioral health services that is ever evolving to meet the needs of San Bernadino residents. The unique geographic nature, including the sheer size of the county, creates unique demands on the behavioral health system.

The County plays a critical role in identifying behavioral health needs, disparities, and inequities across the behavioral health service system. The County also distributes funds, develops partnerships, networks of services, identifies, and supports the creation of evidence-based practices, and provides services. Because of the heightened need for behavioral health services since the COVID-19 pandemic and the availability of increased state and federal funding San Bernadino has added new partners and new services with a strong focus on equity leveraging these funds, but they continue to experience service gaps and barriers.

HMA leveraged these early discussions and collaboratively designed the project approach outlined below.

Project Oversight

HMA and DBH created a project oversight structure to ensure the effective gathering of information and a collaborative approach to conducting the assessments. Three distinct groups were formed:

- A **Core Team** with representatives from a cross-section of DBH programs was convened to support data collection, review findings, and inform recommendation development. The Core Team met six times.
- A **Community Advisory Group (CAG)** with representatives from community-based organizations was convened to similarly review findings and inform recommendation development, but from an external perspective. The CAG met twice.
- Lastly, a **Project Management Team** with representatives from DBH leadership and various programs was established to support project management, coordination, and oversight. This group was tasked with supporting data collection and access to individuals and organizations to

engage in the assessment effort. The Project Management Team met approximately bi-weekly from December 2023 to June 2024.

Data Collection Methods

Below is a brief overview of the primary quantitative and qualitative data collection efforts utilized in the assessment process. This is not meant to capture everything that was reviewed or incorporated into this effort, but instead offer an overview of primary sources and engagement efforts.

Quantitative Data Collection and Document Review: HMA relied on DBH staff to provide available data on client services, demographics, capacity data, and workforce needs to better understand the behavioral health system and needs. The analysis below is based on the data received. Additional information and materials were also collected and reviewed, such as the Mental Health Services Act Plan and Annual Updates, Cultural Competency Plan, applicable regulations, presentations to the Behavioral Health Commission and other bodies, and other previously developed reports and presentations outlining behavioral health and workforce needs.

Community Planning Process Observation: HMA consultants attended several meetings (both virtually and in-person) that were a part of the Community Planning Process. During these meetings, HMA consultants gathered and tracked several observational findings outlined in the section below.

Stakeholder Interviews: HMA interviewed individuals from nine separate organizations to build an understanding of the landscape and inform future data collection efforts.[1] Organizations engaged included outpatient and residential behavioral health providers, culturally specific organizations, social service agencies, and school district representatives, amongst others. In several instances, multiple individuals from an organization were interviewed. The interviews were broadly structured around an assessment of Strengths, Weaknesses, Opportunities, and Threats, as well as questions about the Community Planning Process. Interviewees were assured confidentiality to allow for candid responses. Their feedback was summarized and presented to the Core Team and CAG to review and reflect on.

Community Survey: HMA developed a web-based survey specifically designed to collect qualitative information in a person-centered, transparent, and culturally sensitive way. This survey was advertised through the distribution of a flyer in both English and Spanish. DBH distributed the flyers which included links/QR codes to the survey. The survey asked questions about the respondent's relationship to behavioral health services and their perspectives on the strengths, unmet needs, and barriers of the local behavioral health system, as well as disparities in care and opportunities for improvement. The survey was anonymous with the results analyzed by HMA. Data was disaggregated by respondent type – i.e., consumers of behavioral health services vs. providers of services – to better analyze findings. Findings were presented to the Core Team and CAG to review and reflect on. The community survey received 232 responses, with the demographic profile of respondents aligning with the overall demographics of the community.

[1] Asian American Resource Center, Boys Republic, Inland Empire Health Plan, Ontario-Montclair School District Counseling Center, Pacific Clinics, Reach Out, Riverside-San Bernardino County Indian Health, San Bernardino County Behavioral Health, South Coast Counseling Services

Focus Groups: HMA conducted a series of focus groups with individuals with lived experience with behavioral health conditions to gather their perspectives. These focus groups included individuals engaged in a variety of mental health and substance use services – including services funded by DBH. Focus groups were convened with the support of local behavioral health service providers, word-of-mouth information sharing, and the distribution of flyers in both English and Spanish.

Three focus groups were convened in person with another four convened virtually, and participants were compensated for their time and wisdom (30 gift cards of $50 value were provided to participants of the in-person focus groups and 90 gift cards of $25 value were provided electronically to participants of the virtual focus groups for a total of $3,750). In-person focus groups were attended by an HMA consultant who could interpret in Spanish, as needed. When registering for the virtual focus group(s) participants were asked to indicate if language interpretation was needed and if so, whether they preferred Zoom auto-translation or interpretation from an HMA team member. Auto-translation and/or interpretation services were then offered to those who requested them.

During the focus group(s), participants were asked about their experiences with the behavioral health system, barriers to access, unmet needs, and strengths. They were also asked to score – on a scale from 1 to 5 – the county's ability to engage clients in developing programs/services and in communicating about programs/services. HMA conducted seven focus groups (3 in-person and 4 virtually) with a total of 222 participants. Below is a list of the groups engaged:

- Yucca Valley Clubhouse – Monday, July 8th, *in person*
- Yucca Valley Family Resource Center – Monday, July 8th, *in person*
- Rialto Clubhouse – Tuesday, July 9th, *in person*
- Individuals who have experience with substance use and mental health services
    - Monday, August 12th, *virtual*
    - Monday, August 12th, *virtual*
    - Wednesday, August 14th, *virtual*
    - Monday, August 19th, *virtual*

Subcommittee Meeting: HMA also attended and facilitated a discussion at the African American Awareness Subcommittee meeting on August 19th, convened by DBH. Participants were encouraged to share their personal experiences with mental health and behavioral health services in San Bernardino County.

Townhalls (2): HMA promoted and convened two virtual townhall meetings on August 19th and August 21st. The townhalls were intended to be opportunities to share findings from the assessment process as well as solicit additional feedback from the community. Flyers in English and Spanish were created by HMA and distributed by San Bernardino County to promote the event. A total of 6 individuals were in

attendance between the two townhalls. As a result, limited additional data was collected from these efforts.

FINDINGS

HMA utilized a combination of data analysis, document review, and community engagement throughout the project to assess trends and identify areas of need within the Mental Health Services Act (MHSA) programming in San Bernardino County. These engagements allowed HMA to gather diverse perspectives from data, individuals with lived experience, community members, service providers, and other key stakeholders. Through these efforts, valuable insights were gained regarding the effectiveness of current programs and critical gaps in services across the county.

Key findings are outlined in the sections below. They are broken down by the strengths and opportunities for improvement/unmet needs that emerged from the qualitative data collection methods, with findings related to the assessment of behavioral health system capacity, followed by sections that focus on the cultural, linguistic, and workforce needs identified through data analysis, as well as the residential substance use services capacity assessment.

Qualitative Feedback- Strengths

Feedback from the community survey, interviews, focus groups, and discussions with the Core Team and CAG revealed numerous strengths of the behavioral health system and the County's behavioral health services. The feedback has been organized by four primary themes:

1) Provider Collaboration
2) Service Availability and Accessibility
3) County Engagement Efforts
4) Effectiveness of Services

Provider Collaboration

Provider collaboration was indicated as one of the primary strengths during the evaluation process. It was reported that, despite some gaps in the system, providers work closely together to support collaboration and effective care. There is also a sense of comradery and collaborative problem-solving that are seen as assets to the local community. Some specific examples include the following:

- Providers in the county reported that they have a strong network of provider organizations that support one another in terms of meeting agency goals and providing care for clients.
- Forums for collaboration are in place and operating smoothly to ensure collaboration and partnership across agencies.
- Providers are motivated to expand their knowledge regarding the array of services that may be available to clients. Often this connection and networking is done via word of mouth.

- Service recipients report feeling supported by their recovery and treatment networks and that they are actively being connected with the resources they need.

Service Availability and Accessibility

Many of the interviewees described an acknowledgment of the County's efforts over the past several years to improve access and availability of services to the community. They reported that these areas of inquiry have improved recently in many high-need areas.

- Providers report that there is a diverse set of services across the continuum available to the community.
- The community appreciates the recent expansion of services including:
    - School-based treatment
    - Telehealth
    - Clubhouses
- Service recipients stated that they were generally knowledgeable about and aware of the various types of services in the county that may benefit them.

County Engagement Efforts

Providers reported valuing their relationship with the County and appreciated their ongoing efforts to be collaborative partners through communication efforts, pursuit of funding, and dedication to county-wide behavioral health progress.

- Providers perceived the County to be invested in the well-being and outcomes of providers and persons served.
- Providers noted that the County proactively seeks ongoing funding to support the maintenance and enhancement of services in the county.
- The County is recognized for becoming more data-driven, though this is an ongoing effort.
- The County is perceived to generally be open to receiving feedback.
- The County actively works to build partnerships between provider organizations.

Effectiveness of Services

The qualitative analysis revealed that the community values the behavioral health services offered and believes them to be effective. They responded that the myriad of services offers a strong foundation for recovery and that providers are generally regarded with high esteem.

- One-on-one therapy services are highly valued, with participants noting significant positive impacts on their mental health and well-being.

- Participants reported a high appreciation of available services such as mental health providers, clubhouses, and social security benefits.
- Interviewees found significant value in clubhouse support groups (e.g., grief, mindfulness support, co-dependency, and substance use groups).
- Participants highlighted effective programs including sober living facilities (e.g., Cedar House, River Community, Caso Paseo), supportive social workers, and coordinated primary care services.

Qualitative Feedback- Opportunities for Improvement and Unmet Needs

In addition to the strengths identified through the survey, interviews, focus groups, and engagement with the Core Team and CAG, these efforts also revealed opportunities for improvement and unmet needs. Each of the areas listed is perceived to have a significant impact on provider efficacy and client outcomes. Respondents indicated that enhancements in these areas would significantly improve the continuum of care and the overall well-being of behavioral healthcare consumers in San Bernadino County. The feedback has been organized by seven primary themes:

1) Access and Service Availability
2) Cultural Responsiveness and Disparity Reduction
3) Workforce
4) Implementation of New Initiatives
5) Internal and External Collaboration
6) Operations
7) Community Engagement

Access and Service Availability

While access and service availability have significantly improved over the past several years, gaps in the county's continuum of care persist. Respondents identified several areas with opportunities for improvement.

- There is a need for centralized communication and advertisement of resources in the community to minimize duplication of effort and ensure that providers and service recipients are aware of the services available to better access and coordinate care.
- Waitlists for care can be significant, particularly when they require an appointment with a psychiatrist. One interviewee estimated that it could take up to 6 months to receive intensive services given staffing shortages and bureaucratic delays.
- While the continuum of care is improving, there are several gaps that continue to exist. Areas identified by community partners and subject matter experts include:

    - Substance use disorder treatment
        - School-based
        - Residential
        - Medication management
        - Incentive-based programs
    - Inpatient psychiatric treatment
    - Crisis walk-in centers (sites in additional geographies)
    - Suicide prevention
    - Mental health management
    - Children/youth services
    - Clubhouses
- Providers often have limited hours of operation which restricts access to those who have daytime employment.
- Participants also described differences in access based on geographic location. San Bernardino is the largest in the United States, which creates a unique set of challenges. Providers noted a need for greater creativity and flexibility in how services are offered to improve access.
- Members of the African American Awareness Subcommittee expressed that services are not being brought or offered to them directly (through schools, health centers, etc.), but rather required them to seek out and navigate the complexities of access, eligibility, and outreach on their own.

Cultural Responsiveness and Disparity Reduction

Respondents noted several behavioral health outcome disparities that are present in the county. During the qualitative inquiry, HMA learned of many specific opportunities for improvement in this area that could promote more equitable outcomes for the community.

- There is a need for more specialized, culturally responsive services that are tailored to the specific needs of underserved populations, specifically the Black, Indigenous, and People of Color (BIPOC) population and the LGBTQIA+ population.
    - Members of the African American Awareness Subcommittee noted feeling an 'outside in' perspective of the resources and services available to their community.
- The County and Providers have limited outreach and trust with marginalized communities, especially the BIPOC community, potentially contributing to existing disparities.
- There is a significant need to increase language access to services for people who have limited English proficiency.

- There is a need for increased sign language interpreters.
- Social Determinants of Health can hinder access. Lack of transportation and need for stable housing were mentioned the most frequently with food insecurity and lack of clothing also identified in discussions.
    - Respondents also indicated that the public bus system has limited service hours, especially on weekends, and that the wait for a bus can be lengthy.

Workforce

Similar to national trends, San Bernadino County providers are struggling to recruit and retain qualified and skilled behavioral health professionals. This leads to significant gaps in client services, long waitlists, and decreased access across the system.

- Behavioral Health workforce continues to be a primary barrier to meeting the needs of persons served. Respondents noted two primary areas of concern:
    - General behavioral health staffing shortages, with the lack of psychiatrists and experienced therapists being the most significant concern.
    - Inability to pay competitive wages leading to trouble with recruiting and retention of staff.

Implementation of New Initiatives

Respondents were knowledgeable and understanding of the many intersecting requirements involved in the county-wide implementation of new initiatives but expressed that past initiatives could have benefitted from more intentional project oversight and communication. The lack of these efforts resulted in frustrating complications and administrative burden for providers.

- Providers reported that implementation of new initiatives could be more effective, and completed in a shorter timeframe if there were stronger planning, project management, and coordination.
- Lack of coordination and clarity of expectations has resulted in anxiety-inducing uncertainties and often extra administrative burden on providers. This burden impacts the accessibility of care for persons served.
- CalAIM and related initiatives were perceived to have slower and less clearly communicated rollouts in San Bernardino than in other counties which led to confusion, challenges, and implementation delays that were seen as bad for organizations and consumers.

Internal and External Collaboration

Participants acknowledged that the County has been continually improving collaboration efforts with the State and providers over the past several years, however, there continue to be opportunities for increased efficacy in this area.

- Providers report that there is often a delay in responses to questions, contract amendments, and decision-making within the County. Providers described not being able to get answers to – what they viewed as simple questions – which has had negative impacts on their financial stability and ability to provide services. One participant noted waiting over a year to get approval to use a subcontracted psychiatrist, which delayed patient care. While many providers noted that this was likely due to County staffing vacancies, they also named the lack of department-to-department coordination as another primary cause.

County Operations

Participants described experiences of systemic fragmentation unnecessarily complicating access to services. It appeared that various systems had been designed and implemented over the years but did not work together in a smooth manner. Thus, referrals are negatively impacted, and potential service recipients discontinue efforts to engage before they are connected with care.

- Interviewees reported that accessing County services can be complicated for clients and ultimately results in clients not accessing the care that they need.
- Respondents indicated that they felt that service connection required too many calls, steps, and requirements to access care.
- It was also indicated that there are linguistic, cultural, and educational barriers to the care connection process. They felt that the process should be simplified and designed with the target audience in mind, namely, historically underserved communities.
- Providers reported that the financial review and audit processes are punitive and do not reflect the realities of service provision. Interviewees gave examples of audit-based repayments occurring years after service delivery that felt unreasonable and jeopardized the financial stability of their organization. Substantial delays in review limit the provider's ability to satisfy County requests for additional information/documentation.

Community Engagement

Participants described an expectation similar to the national trend of "nothing about us without us." In practice, this concept means that services are designed and progressively adjusted based on ongoing, meaningful engagement and feedback from the community.

- Interviewees stated that they would like the County to have more engagement with its community to gain input and feedback regarding new and existing programming.

Summary of Qualitative Findings

Below is a summary of key findings from the qualitative assessment process, outlined in a Strengths, Weaknesses, Opportunities, and Threats (SWOT) table.

Table 1. Qualitative SWOT Analysis

Strengths	Weaknesses
• Consumers value the services they receive • Strong network of local providers • Existing forums for collaboration • Historically strong relationship between providers and the County • Diverse continuum of services • Increasing openness to behavioral health services among youth • A willingness to learn and improve shown by the County	• Limited awareness of available services • Need for more culturally-specific services, particularly for BIPOC and LGBTQIA+ communities • Need for expanded SUD, residential, and crisis services • Long waitlists and delays in care • Slow implementation of new initiatives (e.g., CalAIM-related services) • Significant administrative burden and duplication of effort • Need for improved collaboration/ coordination between the state, county, and providers • Overly punitive financial audits • Complicated processes to access care • More intentionality and clarity regarding the Community Planning Process
Opportunities	**Threats**
• Explore creative and flexible strategies to increase access to services • Expand/expand access to culturally-specific services • Improve the project management and communication around the implementation of new initiatives • Improve coordination between County departments	• Behavioral health workforce challenges • County size is a challenge to access • Continuing changes tied to statewide behavioral health transformation (e.g., CalAIM, Prop 1, etc.)

Data Analysis – Population Assessment, Cultural and Linguistic Needs

HMA reviewed available data provided by the Department of Behavioral Health (DBH) – as well as data from other publicly available sources – to support an assessment of the cultural and linguistic needs of served and unserved county residents.

The initial domain for review was a comparison between the demographic of the county, compared to DBH clients (see table 2 below). Reviewing these data shows that Black residents are overrepresented in

the client population compared to county residents as a whole, as well as Other/Unknown. Hispanic/Latino residents are underrepresented by nearly 11%, while Asians are underrepresented by 6.3%. White residents are also underrepresented in the client population served by DBH, but to a lesser degree (1.3%).

Table 2. Race/Ethnicity of Clients, Staff, and Community (2023/24)

Race/Ethnicity	SB County Residents*	DBH Clients	County Resident/Client Differential
Hispanic/Latino	56.2%	45.3%	-10.90%
White	24.1%	22.8%	-1.30%
Black/African American	7.3%	14.7%	7.40%
Asian	8.5%	2.2%	-6.30%
Native American	0.2%	0.4%	0.20%
Other/Unknown	3.7%	14.5%	10.80%

**U.S. Census Bureau, American Community Survey 2022, 1-Year Estimates, Demographic and Housing Estimates (DP05)*
Source: San Bernardino County, Department of Behavioral Health

While county-wide race/ethnicity data is important to review and understand, the racial/ethnic breakdown of Medi-Cal enrollees may be a better indicator to review as this is the primary funding mechanism/eligibility criteria for DBH services. Table 3 below captures statewide Medi-Cal enrollee data as well as San Bernardino-specific data, compared to the race/ethnicity of DBH clients. The data show that 57.7% of Medi-Cal enrollees in San Bernardino are Hispanic/Latino, compared to only 45.3% of clients. We also see fewer Asian/Pacific Islander clients compared to the proportion of county-wide enrollees. Conversely, we see an overrepresentation in the White and Black client population as compared to Medi-Cal enrollees.

Table 3. Statewide and County Medi-Cal Enrollees, by Race/Ethnicity, and DBH Clients (2023/24)

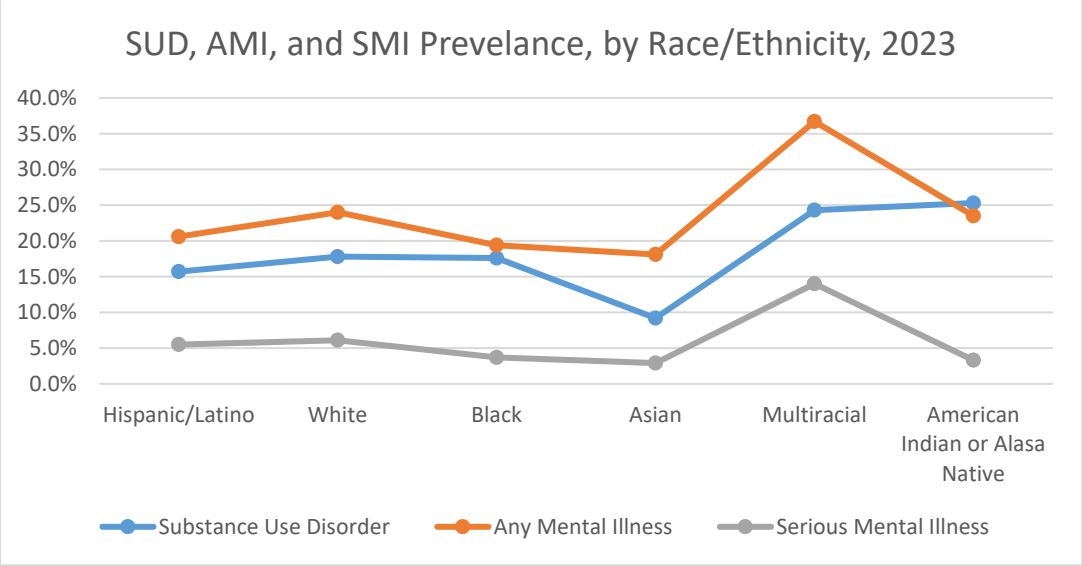
Race/Ethnicity	Statewide Medi-Cal Enrollees*	San Bernardino Medi-Cal Enrollees*	DBH Clients	SB Medi-Cal Enrollees/Client Differential
Hispanic/Latino	51.5%	57.7%	45.3%	-12.4%
White	16.0%	15.1%	22.8%	7.7%
Black/African American	6.8%	9.8%	14.7%	4.9%
Asian/Pacific Islander	9.3%	5.1%	2.2%	-2.9%
American Indian/Alaska Native	0.0%	0.2%	0.4%	0.2%
Not Reported	16.1%	12.1%	14.5%	2.4%

Sources: California Health and Human Services, California Department of Healthcare Services, San Bernardino County, Department of Behavioral Health
**Medi-Cal enrollment data for April 2024.*

According to prevalence data produced by the Substance Abuse and Mental Health Services Administration (SAMHSA), rates of substance use and mental health conditions by race/ethnicity are fairly similar, with some notable exceptions (see figure 1 and table 4 below). For substance use disorder, we see the highest rates for the American Indian or Alaska Native populations (25.3%) and Multiracial (24.3%), with much lower than average rates for Asians (9.2%). For Serious Mental Illness (SMI), we see much higher than average rates for Multiracial (14.0%), with similar rates for other races/ethnicities. This same national survey also found that Asian, Black, and Hispanic adults were less likely than White adults to have received mental health treatment for either an SMI or any mental health disorder. There were only minimal differences in SUD treatment by race/ethnicity. While these data are imperfect, they provide a general sense of anticipated prevalence of mental health and substance use disorders and treatment.

Given these data, we would expect to see a larger proportion of Native American individuals engaged in substance use services. We would also expect to see engagement rates in mental health services that are proportional to the overall population. This would signify an underrepresentation of the Hispanic/Latino populations in current behavioral health services.

Figure 1. Substance Use Disorder, Any Mental Illness, and Serious Mental Illness, by Race/Ethnicity (2023)



Source: National Survey on Drug Use and Health, SAMHSA, 2023

Table 4. Substance Use Disorder, Any Mental Illness, and Serious Mental Illness, by Race/Ethnicity (2023)

Race/Ethnicity	Substance Use Disorder*	Any Mental Illness**	Serious Mental Illness***
Hispanic/Latino	15.7%	20.6%	5.5%
White	17.8%	24.0%	6.1%
Black	17.6%	19.4%	3.7%
Asian/Pacific Islander	9.2%	18.1%	2.9%
Multiracial	24.3%	36.7%	14.0%
American Indian or Alasa Native	25.3%	23.5%	3.3%
Overall	**17.1%**	**22.8%**	**5.7%**

Source: National Survey on Drug Use and Health, SAMHSA, 2023
**People aged 12 or older with substance use disorder in the past year*
***Adults aged 18 or older with any mental illness in the past year*
****Adults aged 18 or older with a serious mental illness in the past year*

In reviewing more localized data produced through the California Health Interview Survey, we see that of individuals with a self-reported mental health or substance use issue, Hispanic/Latino individuals were least likely to receive help (51.1%), followed by Asian (50.9%), and Black (48.3%). Compared to the statewide rates, we see that Black residents of San Bernardino County are less likely to receive help compared to Black residents statewide. The same is true for White residents and Hispanic/Latino residents to a lesser extent. Asian residents and residents that identify as Two or More Races were more likely to receive care then their statewide peers. Although local data is not available for the American Indian/Alaska Native population due to data instability, this population is least likely to receive treatment statewide.

Table 5. Individuals with Self-Reported Mental/Emotional and/or Alcohol/Drug Issues Who Did Not Receive Help, by Race/Ethnicity (2018 - 2022)

Race/Ethnicity	San Bernardino County	California	County/State Differential
Hispanic/Latino	51.1%	47.9%	3.20%
White	45.6%	38.8%	6.80%
Black/African American	48.3%	40.5%	7.80%
Asian/Pacific Islander	50.9%	52.4%	-1.50%
Two or More Races	40.9%	46.4%	-5.50%
American Indian/Alaska Native	N/A*	48.0%	N/A

**Data for AI/AN statistically unstable*
Source: California Health Interview Survey, 2018 – 2022

Data on services provided in different threshold languages was not provided to analyze. Data on the linguistic capabilities of county and contract providers compared to the county as a whole is analyzed below, however.

Data Analysis – Workforce Needs Assessment

HMA conducted a workforce assessment, focused on linguistic capability, provider diversity, and education and training needs.

HMA first reviewed the racial/ethnic breakdown of county residents, DBH clients and DBH staff (see table 6 below). In the section above, the difference between county residents and the DBH client population were noted. From a workforce perspective, however, we see that there is very close alignment between the race/ethnicity of DBH clients and staff. As a top line statistic, this is quite impressive. We also analyze race/ethnicity by job categories, however, which shows areas for improvement.

Table 6. Race/Ethnicity of Clients, Staff, and Community (2023/24)

Race/Ethnicity	SB County Residents*	DBH Clients	DBH Staff	Client/Staff Differential
Hispanic/Latino	56.2%	45.3%	45.1%	-0.3%
White	24.1%	22.8%	21.5%	-1.2%
Black/African American	7.3%	14.7%	16.9%	2.2%
Asian	8.5%	2.2%	6.5%	4.3%
Native American	0.2%	0.4%	0.7%	0.3%
Other/Unknown	3.7%	14.5%	9.3%	-5.3%

**U.S. Census Bureau, American Community Survey 2022, 1-Year Estimates, Demographic and Housing Estimates (DP05)*
Source: San Bernardino County, Department of Behavioral Health

Table 7 below captures the breakdown of each job category by race/ethnicity. We found disparities where the Hispanic/Latino population were underrepresented across a number of job categories. The largest disparities were in the Management Unit (26% Hispanic/Latino staff vs 45% of all clients), Nursing (19% vs 45%), and the Supervisory Nursing (20% vs 45%) job categories. Interestingly, there is a large Asian representation in the nursing profession (31% of nursing staff vs 2% of the total population). There may be some best practices that can be learned from the Asian nursing pipeline to develop a stronger nursing pipeline for the Hispanic/Latino population.

The Black population is overrepresented in behavioral health services, making up a larger proportion of clients compared to the community as a whole. At the same time, they are well represented across job categories. There is a large representation of Black people as Supervisory Nurses (40%) although the total number of staff small. That pipeline should also be examined to determine if there are recruiting, training, and retaining best practices.

Table 7. Race/Ethnicity by Job Category (2023/24)

Job Category	Hispanic/ Latino	White	Black	Asian	Native Hawaiian or Other Pac. Islander	Native American	Two or More Races	Other/ Unknown
Administrative Svcs Unit (449)	45%	20%	20%	5%	1%	1%	6%	2%
Clerical Unit (232)	60%	13%	14%	5%	1%	1%	5%	1%
Craft, Labor & Trade (26)	46%	27%	19%	0%	0%	4%	0%	4%
Exempt Group (20)	45%	25%	10%	10%	5%	0%	5%	0%
Management Unit (63)	26%	46%	14%	2%	0%	2%	5%	5%
Nurses Unit (36)	19%	27%	14%	31%	3%	0%	6%	0%
Professional Svcs Unit (247)	40%	21%	17%	10%	0%	1%	7%	4%
Supervisory Unit (95)	45%	28%	12%	3%	0%	0%	8%	4%
Supervisory Nurses Unit (5)	20%	40%	40%	0%	0%	0%	0%	0%
Technical & Inspection (58)	52%	15%	17%	7%	0%	0%	9%	0%
DBH Client Demographics	45%	23%	15%	2%	N/A	0.4%	N/A	14%

Source: San Bernardino County, Department of Behavioral Health

San Bernadino County also has linguistic gaps in its behavioral health service system. The largest and most significant gap is related to a lack of Spanish-speaking providers. 37.4% of the population in the county speaks Spanish as their primary language, but only 14.7% of county providers and 18.6% of contracted providers speak Spanish (see table 8 below). There are smaller gaps related to Mandarin/Cantonese/Other Chinese languages and Tagalog.

Table 8. Linguistic Capacity by Provider Type (2023/24)

Language*	San Bernardino Residents**	County Provider #	County Provider %	Contract Provider #	Contract Provider %
English	54.3%	665	81.9%	1,274	80.4%
Spanish	37.4%	119	14.7%	294	18.6%
Mandarin/Cantonese/Other Chinese	2.1%	5	0.6%	4	0.3%
Tagalog	1.2%	6	0.7%	4	0.3%
Arabic	0.9%	7	0.9%	3	0.2%
Vietnamese	0.7%	2	0.2%	1	0.1%
Russian	0.1%	1	0.1%	N/A	N/A
Farsi	N/A	3	0.4%	4	0.3%
American Sign Language	N/A	2	0.2%	N/A	N/A
Armenian	N/A	2	0.2%	N/A	N/A
Total		**812**	**100.0%**	**1,584**	**100.0%**

**Linguistic counts do not reflect unduplicated figures as a provider could be both a "county" and "contract" provider and thus be double counted in the data. While the general theme of underrepresentation of Spanish-speaking providers is valid, further analysis of these figures should be done with caution.*

***U.S. Census Bureau, American Community Survey 2022, 1-Year Estimates, Language Spoken at Home for Population Over the Age of 5 (C16001)*

Source: San Bernardino County, Department of Behavioral Health

Looking by job category, we see that in the largest provider job categories – direct service job categories with 50+ county and/or contracted staff – none have a proportional number of Spanish-speaking providers. The closest is Licensed Clinical Social Workers at 23.6%, which is still 13%+ less than the community as a whole. The lowest proportion was found in Registered Nurses, of whom only 1.4% speak Spanish.

Table 9. Proportion of Languages Spoken in Largest Provider Job Categories (2023/24)**

Language ***	LMFT*	ACSW*	Assoc. MFT*	LCSW*	Physician	Registered Nurse	Social Worker	CHW*
English	83.9%	75.6%	73.5%	72.8%	82.1%	97.9%	77.5%	79.8%
Spanish	12.3%	23.3%	23.5%	23.6%	7.7%	1.4%	21.6%	20.2%
Mandarin/ Cantonese/ Other Chinese	1.3%	0.0%	0.0%	0.5%	5.1%	0.0%	0.0%	0.0%
Tagalog	0.3%	0.4%	0.9%	0.5%	2.6%	0.7%	0.0%	0.0%
Arabic	1.0%	0.7%	0.9%	2.1%	0.0%	0.0%	0.0%	0.0%
Vietnamese	0.0%	0.0%	0.0%	0.0%	2.6%	0.0%	0.0%	0.0%
Russian	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%
Farsi	1.0%	0.0%	0.4%	0.5%	0.0%	0.0%	0.0%	0.0%
American Sign Language	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Armenian	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%	1.0%	0.0%

**Acronym Definitions: Licensed Marriage and Family Therapist (LMFT), Academy of Certified Social Workers (ACSW), Associate Marriage and Family Therapist (Assoc MFT), Licensed Clinical Social Worker (LCSW), Community Health Worker (CHW).*
***Direct service job categories with 50+ staff*
****Linguistic counts do not reflect unduplicated figures as a provider could be both a "county" and "contract" provider and thus be double counted in the data. While the general theme of underrepresentation of Spanish-speaking providers is valid, further analysis of these figures should be done with caution.*

To further inform recommendations to improve provider diversity and linguistic capacity, it is important to consider applicant and hiring data. DBH provided summary data for the 58,000+ applicants received in 2023-24. Table 10 below reflects the racial/ethnic breakdown of applicants, as compared to the county demographics as a whole. Looking strictly at the applicant pool, we see a smaller proportion of White, Hispanic/Latino, and Asian applicants compared to the county demographics, and an overrepresentation of Black applicants.

Table 10. DBH Applicants by Race/Ethnicity (2023/24)

Race/Ethnicity	SB County Residents	Applicant Pool	County/Applicant Differential
Hispanic/ Latino	56.2%	52.5%	-3.70%
White	24.1%	15.7%	-8.40%
Black/African American	7.3%	14.8%	7.50%
Asian	8.5%	5.4%	-3.10%

Native Hawaiian or Other Pac. Isldr.	N/A	0.5%	N/A
Native American	0.0%	0.6%	0.60%
Two or More Races	N/A	8.9%	N/A
Other/ Unknown	3.7%	1.7%	-2.00%

Source: San Bernardino County, Department of Behavioral Health

Looking now at hiring data by race/ethnicity, we see the highest hiring percentage about Native American applicants (3.8%), followed by White (2.7%), and Black (2.5%). The lowest hiring percentage beside Other/Uknown was Native Hawaiian/Pacific Islanders (.7%) and Hispanic/Latino applicants (1.9%).

Table 11. DBH Hires by Race/Ethnicity (2023/24)

Race/Ethnicity	Number of Applicants	Number Hired	Percentage Hired
Hispanic/ Latino	30,723	575	1.9%
White	9,186	246	2.7%
Black/African American	8,667	215	2.5%
Asian	3,187	66	2.1%
Native Hawaiian or Other Pac. Isldr.	276	2	0.7%
Native American	346	13	3.8%
Two or More Races	5193	119	2.3%
Other/ Unknown	977	3	0.3%

Source: San Bernardino County, Department of Behavioral Health

HMA also reviewed the racial/ethnic breakdown of internal vs external hire. We see from these data that internal hires are more likely to be White and Hispanic/Latino, and less likely to be Black/African American or Asian, compared to external hires. Although, rates are somewhat similar proportionally.

Table 12. DBH Internal vs External Hires by Race/Ethnicity (2023/24)

Race/Ethnicity	External Hires	Internal Hires	Internal/External Differential
Hispanic/ Latino	46%	48%	2%
White	19%	22%	3%
Black/African American	20%	17%	-3%
Asian	6%	4%	-2%
Native Hawaiian or Other Pac. Isldr.	1%	1%	0%
Native American	1%	1%	0%
Two or More Races	7%	5%	-2%
Other/ Unknown	0%	2%	2%

Source: San Bernardino County, Department of Behavioral Health

Data Analysis – Assessment of SUDRS Program Capacity, Including Residential Programs

HMA reviewed the **Drug Medi-Cal Organized Delivery System (DMC – ODS) FY23** Report produced by Behavioral Health Concepts, Inc. that provides data related to penetration rates for systems.

Penetration Rate (PR) – The penetration rate is the calculation of members served based on the total Medi-Cal eligible population. San Bernadino has a lower DMC-ODS PR rate than comparable counties and the state as a whole (see table 13 below). The lower penetration rates exist across age categories. The County has the highest PR amongst 18 – 64 year olds, but this age category also reflects the greatest discrepancy when compared to similar counties.

Table 13. San Bernardino DMC-ODS Medi-Cal Eligible Population, Members Served, and Penetration Rates by Age, CY 2022

Age Groups	# Members Eligible	# Members Served	SB County PR	County Size Group PR	SB/ Comparable County Differential	Statewide PR
Ages 12 - 17	126,047	147	0.12%	0.29%	-0.17%	0.25%
Ages 18 - 64	524,441	4,167	0.79%	1.29%	-0.50%	1.19%
Ages 65+	75,287	257	0.34%	0.56%	-0.22%	0.49%
Total	**725,775**	**4,571**	**0.63%**	**1.04%**	**-0.41%**	**0.95%**

Source: FY 2023/24 Medi-Cal Specialty Behavioral Health External Quality Review, Behavioral Health Concepts, Inc.

San Bernardino also has a lower PR for all racial/ethnic groups compared to similar counties and the state as a whole. The County has the highest PRs amongst White and Native American residents and the lowest amongst Asian/Pacific Islanders. Despite having the second highest PR within the county, Native American PR reflects the greatest discrepancy when compared to similar counties.

Table 14. San Bernardino DMC-ODS Medi-Cal Eligible Population, Members Served, and Penetration Rates by Racial/Ethnic Group, CY 2022

Racial/Ethnic Group	# Members Eligible	# Members Served	SB County PR	County Size Group PR	SB/ Comparable County Differential	Statewide PR
African American	79,379	421	0.53%	1.29%	-0.76%	1.19%
Asian/Pacific Islander	39,911	47	0.12%	0.15%	-0.03%	0.15%
Hispanic/Latino	412,148	2,148	0.52%	0.74%	-0.22%	0.69%
Native American	1,855	21	1.13%	2.34%	-1.21%	2.01%
Other	57,064	262	0.46%	1.34%	-0.88%	1.26%
White	135,419	1,672	1.23%	1.89%	-0.66%	1.67%

Source: FY 2023/24 Medi-Cal Specialty Behavioral Health External Quality Review, Behavioral Health Concepts, Inc.

San Bernardino is doing very well on their readmission rates after discharge from withdrawal management programs. The readmission rate within 30 days of discharge was 4.21% in CY 2022, which is half the statewide readmission rate of 8.79%.

Table 15. San Bernardino DMC-ODS Residential Withdrawal Management Readmissions, CY 2022

Total	County		Statewide	
Total DMC-ODS admissions into WM	404		13,062	
	#	%	#	%
WM readmissions within 30 days of discharge	17	4.21%	1,148	8.79%

Source: FY 2023/24 Medi-Cal Specialty Behavioral Health External Quality Review, Behavioral Health Concepts, Inc.

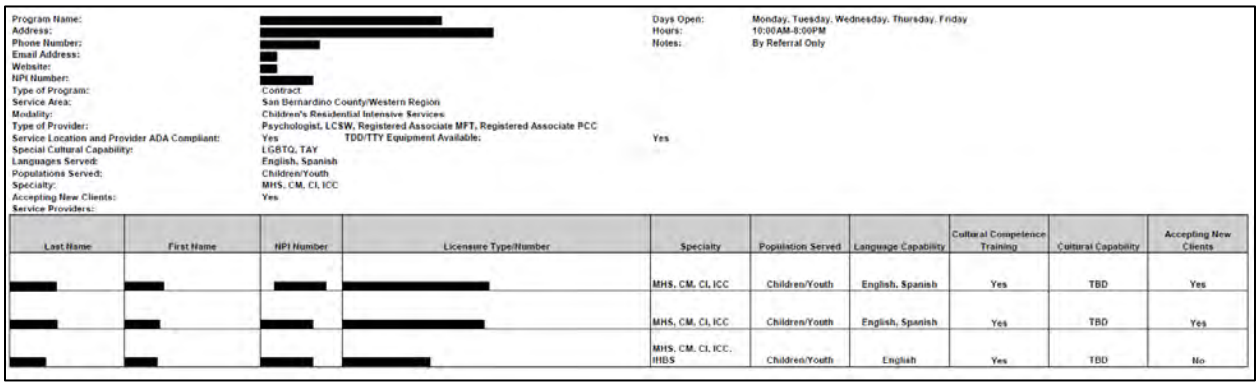
San Bernardino has gaps in rural areas, which could be addressed in part through a recommendation that emerged from the community engagement process to create enhanced clubhouse models. The County may also want to explore expanded telehealth and mobile clinics.

There is a gap with providers offering follow-up appointments for youth. This may be a system, training, or operational issue that should be analyzed. For example, in the DMC-ODS FY23-24 Final Report (page 30) it takes 13 business days for a child to be offered MAT (Medications for Addiction Treatment) services and 15 business days to get services delivered. Adults received their first offered service within 4 business days and received services within 8 business days.

The International Journal of Environmental Research and Public Health published a 2021 article **"Benchmarks for Needed Psychiatric Beds for the U.S. – A Test of Predictive Analytics."** The article highlights the need for beds at 34.9 per 100,000 people.

HMA analyzed the Provider Directory data. The information did not list total beds, bed days, or any other capacity information. It also does not include waiting list information. The Provider Directory does provide information about the organization, program/program modality, days of week/hours of day, clinicians, their specialty areas, population served, language capacity, cultural competency training, various cultural capabilities, and whether they are accepting new clients. See example below.

Figure 2. Excerpt of Provider Directory



Program Name: [redacted]
Address: [redacted]
Phone Number: [redacted]
Email Address: [redacted]
Website: [redacted]
NPI Number: [redacted]
Type of Program: Contract
Service Area: San Bernardino County/Western Region
Modality: Children's Residential Intensive Services
Type of Provider: Psychologist, LCSW, Registered Associate MFT, Registered Associate PCC
Service Location and Provider ADA Compliant: Yes TDD/TTY Equipment Available: Yes
Special Cultural Capability: LGBTQ, TAY
Languages Served: English, Spanish
Populations Served: Children/Youth
Specialty: MHS, CM, CI, ICC
Accepting New Clients: Yes
Service Providers:
Days Open: Monday, Tuesday, Wednesday, Thursday, Friday
Hours: 10:00AM-8:00PM
Notes: By Referral Only

Last Name	First Name	NPI Number	Licensure Type/Number	Specialty	Population Served	Language Capability	Cultural Competence Training	Cultural Capability	Accepting New Clients
[redacted]	[redacted]	[redacted]	[redacted]	MHS, CM, CI, ICC	Children/Youth	English, Spanish	Yes	TBD	Yes
[redacted]	[redacted]	[redacted]	[redacted]	MHS, CM, CI, ICC	Children/Youth	English, Spanish	Yes	TBD	Yes
[redacted]	[redacted]	[redacted]	[redacted]	MHS, CM, CI, ICC, IHBS	Children/Youth	English	Yes	TBD	No

Source: San Bernardino County, Department of Behavioral Health

In looking at clinicians providing Residential Intensive Services, most indicated an ability to accept new clients, but several did not. Several providers that seemed to specifically take more diverse clients had clinicians indicating they were not taking any new clients. This included Blissful Living Group Home and Father's Hearth Ranch.

Based on the penetration rates for the DMH-ODS system as a whole, however, HMA has found that there is insufficient capacity to meet the needs of eligible county residents. HMA was unable to assess the true SURDS residential system capacity, however, as capacity information was not available. In the recommendation section, HMA will outline steps that should be taken to better understand capacity, starting with gathering additional information on current waitlists and gaps for specific populations.

RECOMMENDATIONS

Through this evaluation, it was clear that San Bernadino County has been making great strides in improving behavioral health care within its geography. As such, the County has a strong foundation from which focused enhancements could be implemented to improve the quality of care and access in the community and reduce disparities.

Based on the findings from this analysis, HMA has developed several recommendations that could have a significant impact on behavioral healthcare delivery in San Bernadino County. Recommendation areas are as follows, with additional details and strategies provided further below:

1) Expand Access to High-Quality Services
2) Improve Service Integration and Coordination
3) Enhance External Communication and Engagement
4) Strengthen Administrative and Operational Processes
5) Address Workforce Challenges

Recommendation #1: Expand Access to High-Quality Services

San Bernadino County has spent the past several years investing in program expansion to ensure that community members have access to a variety of supportive services to address behavioral health concerns. However, gaps in the continuum of care persist. The County could significantly benefit from enhancing access to high-quality care that is more data-driven, culturally responsive, evidence-based, and innovative in-service delivery.

This may be accomplished through the following recommendations:

- *Asset Mapping and Strategic Planning:* First, it is recommended to complete a comprehensive asset mapping and strategic planning initiative to better understand the full array of service resources available in the community. This process would include both county-funded and independent programs that are being used by service recipients.

  The asset mapping process would include information regarding (1) type of service, (2) utilization of EBPs, (3) capacity and wait times, (4) gaps in the continuum of care for behavioral health services, (5) workforce trends, (6) disparity tracking, (7) other items as determined by the County.

Through this process, the County would develop a clear blueprint of existing resources, their quality, and areas for additional attention and/or investment. As a result, the County could develop a strategic plan to methodically improve the landscape and efficacy of behavioral health treatment in the county.

- *Expand the Use of Evidence-Based Practices (EBPs):* It is recommended that the County expand the use of EBPs in treatment programs. Interviewees reported that use of EBPs are limited and that many providers are not connecting their populations with EBPs that have been demonstrated to be effective with that particular group. The county could benefit from expanding access to training, and requiring reporting on use of EBPs with documented clinical supervision. The expansion of EBPs should include the use of culturally-specific or culturally-neutral tools and practices.

- *Enhance Data-Driven Reporting:* By enhancing the utilization of data-driven approaches, the County can better understand community needs, track outcomes, and allocate resources more effectively, leading to more targeted and efficient interventions.

  To enhance data-driven reporting, the County should consider implementing continuous quality improvement (CQI) efforts both internally, and for providers. Once this process is fully implemented, it will help ensure that County dollars are being dedicated to effective programs and will support providers in operating programs that are improving outcomes and decreasing disparities.

- *Improve Connections with Marginalized Communities:* It is recommended that the County build intentional pathways to improve outreach, communication, and trust with marginalized communities – specifically the BIPOC communities and the LGBTQIA+ community. These efforts will positively impact engagement in services and reduce disparities in the county.

- *Expand Access to Culturally-Specific Interventions:* Many respondents indicated a shortage of culturally-specific interventions for communities experiencing disparities in their communities. Specifically the Black, Indigenous, and People of Color (BIPOC) communities and the LGBTQIA+ communities. It is recommended that the County invest in increasing the presence and access to interventions for these communities to reduce disparities and improve outcomes for these and other populations.

- *Explore Utilization of Innovative Engagement Strategies to Improve Access:* It was reported that many social determinants of health barriers exist that limit people's access to services across the county. Transportation was listed among the top barriers.

To improve access to care for those with transportation barriers, it is recommended that the County explore innovative service delivery options that have been demonstrated to improve access in similar geographies. These may include initiatives such as mobile services, street outreach, behavioral health services co-located with other programs in rural communities, and/or expansion of telehealth.

- *Enhance Data Collection and Utilization for SURDS Residential Programs:* The County should improve data collection related to residential programs, to better understand utilization, waitlists, and gaps in care. We recommend developing a **Real-Time Capacity Roadmap** with the steps listed below. This is a long-term commitment to a process that will yield actionable information that will help the County maximize and prioritize resources. It would require incremental investments of phases to develop a comprehensive approach. Current reporting tools offer only limited information on residential beds/use, which restricts the County's ability to make data-informed decisions. The real-time tool would allow for tracking total beds, types of beds, bed utilization, and waitlists. This would help to improve access to care, support better coordination/collaboration across providers, and allow for stronger management and oversight by Department of Behavioral Health staff.

  1. Data Collection

  - *Admission and Discharge Data:* Continuously collect data on admissions, discharges, and current occupancy levels. This includes the number of beds available, occupied, and reserved.
  - *Service Utilization Data:* Track the types of services provided, including length of stay, service intensity, and patient demographics.
  - *Staffing Levels:* Monitor staffing availability and shifts, as these can impact capacity and service delivery.

  2. Real-Time Data Integration

  - *Electronic Health Records (EHRs):* Utilize EHR systems to get real-time updates on patient status, bed availability, and service utilization.
  - *Management Information Systems:* Employ software that integrates data from various sources for a comprehensive view of system capacity.

  3. Predictive Analytics

  - *Historical Data Analysis:* Analyze historical data to identify trends and patterns in admissions, discharges, and capacity usage.
  - *Predictive Models:* Use statistical models and machine learning algorithms to predict future demand and identify potential bottlenecks. Consider factors like seasonal variations, treatment outcomes, and referral sources.

4. Capacity Forecasting

- *Demand Forecasting:* Estimate future demand based on current trends, seasonal factors, and external influences (e.g., changes in referral sources or policy changes).
- *Scenario Analysis:* Develop scenarios to understand how different factors (e.g., a sudden increase in admissions) might impact system capacity.

5. Real-Time Monitoring

- *Dashboard and Alerts:* Implement dashboards that provide real-time visibility into system capacity and performance metrics. Set up alerts for when capacity thresholds are approaching or when there are significant changes in demand.
- *Dynamic Resource Allocation:* Use real-time data to adjust resources and staffing levels dynamically to address fluctuations in capacity and demand.

6. Feedback Loops

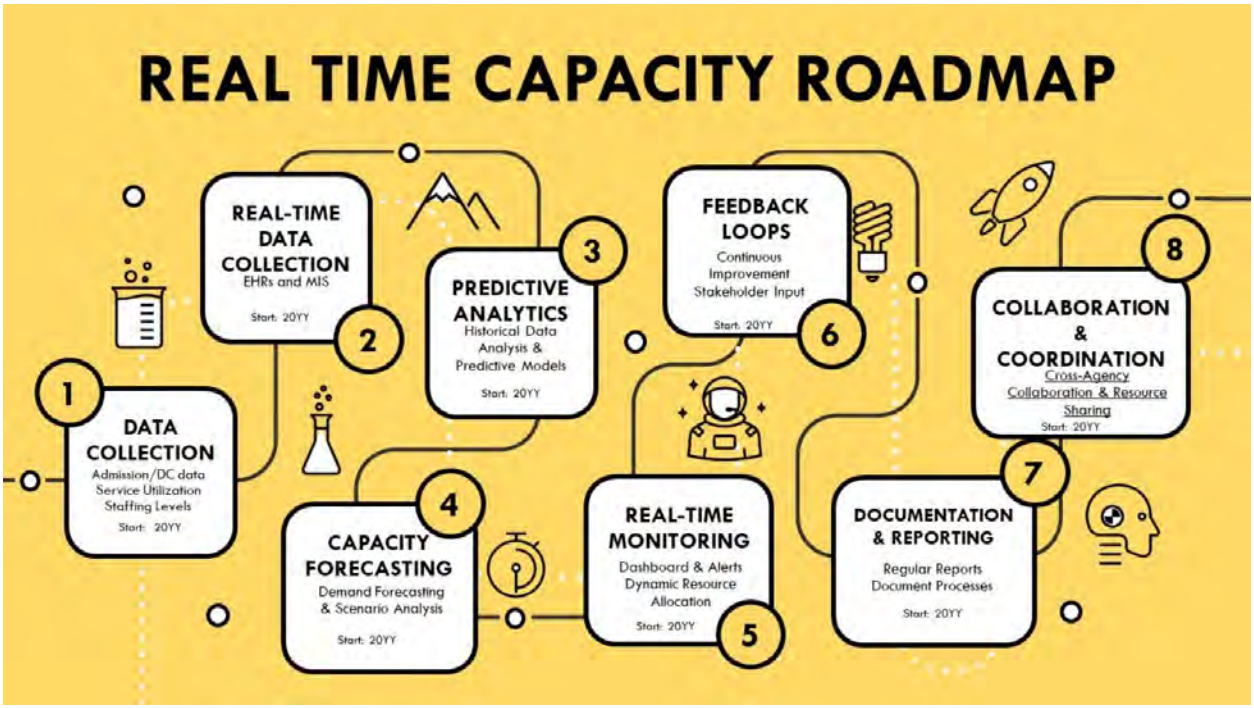
- *Continuous Improvement:* Establish mechanisms for regular review and adjustment of capacity management practices based on feedback from staff, patients, and data analysis.
- *Stakeholder Input:* Engage with stakeholders (e.g., clinicians, administrators) to understand practical challenges and opportunities for improving capacity management.

7. Documentation and Reporting

- *Regular Reports:* Generate regular reports on capacity utilization, trends, and predictive insights. Use these reports for strategic planning and to inform decision-making.
- *Documentation of Processes:* Document the processes and methodologies used for capacity determination to ensure consistency and facilitate future improvements.

8. Collaboration and Coordination

- *Cross-Agency Collaboration:* Collaborate with other service providers, community organizations, and government agencies to ensure a coordinated approach to capacity management.
- *Resource Sharing:* Explore opportunities for resource sharing or referrals to other services when capacity is reached.



Recommendation #2: Improve Service Integration and Coordination

Efforts to improve service integration and coordination of care between behavioral health providers in San Bernadino County could lead to better outcomes, reduced disparities, and lessen duplication of effort. Care integration and coordination leads to ensuring that service recipients receive the right care at the right time with fewer gaps and increased effectiveness. Reducing duplication of effort- like multiple assessments and treatment plans- can optimize existing resources which leads to more efficient service delivery, improving outcomes across the county. The recommendations are as follows:

- *Create a Resource Guide for Existing Services and Resources:* Upon completion of the county-wide asset mapping process, it is recommended that the County develop, and annually update, a resource guide that members of the community can use to locate services, develop partnerships, and coordinate care.

- *Improve Care Coordination and Transitions of Care to Support Service Continuity:* Best practices in behavioral health service delivery indicate that discharge planning should begin at the time of intake. All areas of need including mental health, substance use disorder, and social determinants of health should be included in discharge planning. This means, providers should ensure that high-quality service continuity occurs quickly upon a service recipient's transition from care.

  It is recommended that the County develop standard guidelines for transitions of care and care coordination to which providers will be held accountable. This would be done with the intent of

enhancing partnerships between providers and increasing the quality of care and outcomes for persons served.

- *Leverage Certified Peers to Guide Care Coordination:* Research supports the positive impact on behavioral health service recipients of incorporating certified peers into treatment. One area where peers can make a significant impact is in the realm of care coordination. A person with lived experience will be able to speak to the myriad of supports necessary to maintain one's own definition of recovery. By increasing the breadth of the peer role, the County has an opportunity to enhance care coordination and improve outcomes.

Recommendation #3: Enhance External Communication and Engagement

Enhancing external communication and engagement will help to build awareness of available services and support meaningful engagement with consumers and the community. These efforts should be targeted to historically marginalized communities and communities that are underrepresented in Department of Behavioral Health services.

- *Share Information About Available Services:* Once the Resource Guide developed above is finalized, it should be shared broadly and regularly. Both providers and community members felt that they did not have a clear understanding of what all was available to them, and the development and promotion of the guide could help this.

  The County should also review how it promotes County-operated and County-contracted services, with an eye to new strategies that could help to expand the universe of who is being reached. Sharing information through the established County-run forums can be effective, but also limits the reach of the message to individuals who are already actively engaged with behavioral health services.

- *Leverage Trusted Partners to Support Information Sharing:* In service of sharing information more broadly, the County should further leverage trusted partners within the community. While a message from the Department of Behavioral Health might be most effective for some, many community members – and in particular members of historically marginalized communities – are better reached and engaged by individuals/organizations they are connected to. This could include behavioral health providers but should also include schools and faith-based organizations that can reach individuals not already engaged with the behavioral health system. The County should also consider utilizing the peer workforce (e.g., certified peer support specialists, community health workers, etc.) to share information with clients and community members.

  To effectively leverage partners, the County should institute a process for how information and messages are distributed. It is not enough to email information to partner organizations with the hope that they share it. The County could develop and distribute posters, create videos that

could be shared, develop talking points, and do direct outreach to organizations to ensure that messages are being shared with key constituencies. County staff could also attend meetings convened by local organizations to share information.

- *Offer Engagement Opportunities in Community Settings:* As the County works to enhance its communication and community engagement, it is important to consider how to best connect with individuals in the community who may have more limited interaction with the behavioral health system. It is recommended that the County consider holding meetings and input-gathering sessions in more publicly accessible spaces, such as libraries, parks, or schools. This strategy dovetails with the recommendation about leveraging trusted partners. The County could work with said partners to convene meetings/groups, which could extend the County's reach to new individuals and communities. As the County pursues this strategy, it should also be mindful of geographic representation, and look to provide opportunities for engagement across the county.

Recommendation #4: Strengthen Administrative and Operational Processes

The analysis indicated a need to strengthen administrative and operational processes to create a more streamlined and efficient system. Improvement in these areas enhances care by ensuring that regulatory guidelines are clear and consistent which will reduce administrative burden and inconsistencies in implementation across providers. This work would lead to faster access to services, reduced provider burnout, and improved outcomes.

- *Improve Cross-Departmental and External Collaboration:* Respondents stated that gaps in coordination and communication between the Department of Behavioral Health, other County entities, and the State led to fragmentation in guidelines, communication, implementation, and oversight of new initiatives. It is recommended that the County adopt a project management structure that would seek provider feedback early in the design and implementation process, transparent communication between agencies, and synthesized guidance for rollouts and maintenance of projects.

  The County should also conduct an internal assessment to identify opportunities to improve department-to-department coordination and, more importantly, decision-making to reduce administrative delays and confusion that can impact service delivery.

- *Assess Provider Contract Requirements to Reduce Administrative Burden:* Over time, provider contracts have evolved, often adding additional requirements that can lead to duplication of effort and administrative burden that reduces time spent in meaningful client interventions. Reviewing and streamlining contractual requirements placed on providers can eliminate unnecessary paperwork, redundant reporting, and complex compliance requirements that

consume valuable time and resources. Given the substantial – and ever-evolving – changes resulting from behavioral health transformation initiatives such as CalAIM and Prop 1, a regular review of requirements with an eye to reduce provider burden is crucial.

- *Expedite Requests and Decisions to Support Contract Providers:* Interviewees reported experiencing long wait times for responses from the County regarding important decisions that ultimately would impact provider operations and compliance. These wait times have led to delays in service delivery, negatively impacting client care. It is recommended that the County consider implementing a streamlined inquiry process with published timelines regarding responses and inquiry status so that providers can better understand where things are in the process.

Recommendation #5: Address Workforce Challenges

The need for coordinated and intentional investment in behavioral health workforce improvements were identified repeatedly throughout the evaluation process as a critical need in San Bernadino County. The County and provider agencies have struggled with recruitment and retention of key team members who have the necessary skills to provide care. Investment in workforce improvements will lead to stronger outcomes and decreased disparities in the county.

- *Provide Workforce "Perks" to Improve Recruitment and Retention:* Interviewees – including both County and contracted providers – reported difficulties in offering salaries that are competitive with private practice and other fields of work. While underlying reimbursement rates that drive salaries may be difficult to change, the County should consider other, non-salary incentives to attract and retain critical workforce. Examples of meaningful incentives could include bonuses, childcare, loan forgiveness, amongst others. Incentives should be made available to contracted providers as well, to support the health of the behavioral health system as a whole.

- *Assess Workforce Requirements to Reduce Administrative Burden*: Interviewees reported feeling frustrated and demoralized by significant administrative burden taking away from time spent working with service recipients. Often, staff are working overtime in order to meet client needs due to the increasing volume of paperwork that is required. It is known that those in private practice often have far less administrative burden, and higher salaries which makes retention of behavioral health safety net staff progressively more difficult. It is recommended that the County collaborate with behavioral health providers to identify opportunities to streamline and reduce administrative burden overall.

- *Support Workforce Training and Professional Development:* One way the County could simultaneously enhance the behavioral health system while supporting recruitment and retention would be to expand access to specialized trainings and professional development opportunities. These trainings could be targeted to communities or populations that face disparities in care, thus expanding access to culturally-informed services. Many agencies and/or

individual providers cannot afford to pay for specialized training or lose the billable hours due to training time, however. It is recommended that the County explore priority trainings for the region and offer financial support for agencies that send attendees. As trainings and benefits are rolled out, these should be actively communicated to potential and current staff.

- *Increase Worker Flexibility, Where Possible:* Interviewees indicated that the limited flexibility of County positions has had negative impacts on hiring. During a time when staff across industries have seen increased flexibility, such as work-from-home options and more flexible hours, the County has mostly returned to traditional work settings and hours post-COVID. These policies should be reviewed and assessed for their impacts on recruitment, hiring, and retention of staff. Flexibility should also be offered to contracted agencies, as possible, to support the behavioral health system as a whole.

- *Improve Workforce Strategies Targeted to BIPOC Communities, and in Particular the Hispanic/Latino Community:* As outlined in the population and workforce assessment sections above, data shows that the County is underserving the Hispanic/Latino community and has too few Hispanic/Latino providers, especially Spanish-speaking providers. While the County must continue to monitor service engagement and workforce representation for other BIPOC communities, such as the Black/African American, Asian, and Native American, the data supports targeting the Hispanic/Latino community as an initial priority. Below are a sub-set of workforce recommendations for this community:
    - *Engage the Hispanic/Latino community in exploring career opportunities in behavioral health:* The County should conduct direct outreach to the community in an attempt to garner more interest in this field of study/work. The County could explore career fairs, job shadowing opportunities, paid internships, scholarships, and local forgiveness for Hispanic/Latino employees. The County could leverage trusted partners within the Hispanic/Latino community to support these outreach and engagement efforts. Similar strategies could be employed for other communities identified as priorities for hiring/retention.

    - *Established a Hispanic/Latino future leaders mentorship program:* The data reflects a substantial underrepresentation of Hispanic/Latino individuals in management roles within the County. Developing a mentorship program could help to expand the pool of future managers. We would recommend structuring it as a shared learning cohort, which would offer peer-to-peer support in addition to mentor-mentee relationship building. Similar strategies could be employees for other groups.

    - *Evaluate the success of hiring Asian nurses and Black nurse supervisors to leverage existing best practices:* The County should look to replicate successful strategies in hiring/retention. We would recommend evaluating the nurse and nurse supervisor job

categories to better understand what led to Asian and Black individuals being so well represented. The County should review other job categories that have seen similar successes.

- *Evaluate the hiring process:* HMA reviewed data on applicants and individuals hired, by race/ethnicity. While the County receives the most applicants by volume from Hispanic/Latino individuals, they are still underrepresented compared to the community as a whole. Further, the Hispanic/Latino hiring percentage is among the lowest by race/ethnicity. A deeper analysis of the hiring process should be conducted – keying in on service provision job categories – to better understand any barriers to hiring that may exist. This evaluation could also review the successes in attracting applicants from the Black/African American community, which receives approximately twice as many applicants as we might expect based on the community demographics.

CONCLUSION

It is abundantly clear from the assessment process that San Bernardino County has a strong behavioral health system and provider community that are committed to meeting the needs of county residents. While this report outlines recommendations for how the system can be further enhanced, they build on a solid foundation and history of success. Health Management Associates appreciates the partnership with the Department of Behavioral Health in completing this work, as well as the multitude of providers, partners, individuals with lived experience, and other members of the community who gave their voice to this process. We appreciate your time, wisdom, and commitment to building a better behavioral health system of tomorrow.

HEALTH MANAGEMENT ASSOCIATES

SAN BERNARDINO COUNTY

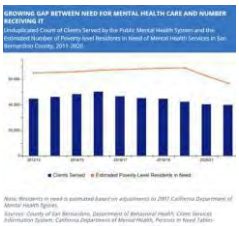
Behavioral Health and Community Planning Process Assessment

Summary of Stakeholder Engagement Findings

1

BEHAVIORAL HEALTH SERVICE OVERVIEW

- The estimated prevalence for severe mental illness or emotional disturbance in the Medi-Cal eligible population is 9%, according to the National Institute of Mental Health.
- Under this construct, approximately 73,909 persons from all age groups, who are Medi-Cal eligible, could be considered in need of some level of behavioral health services in San Bernardino
- In FY 2021/22, approximately 42,872 individuals received a mental health service from the mental health plan



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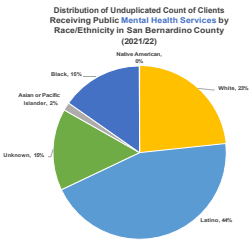
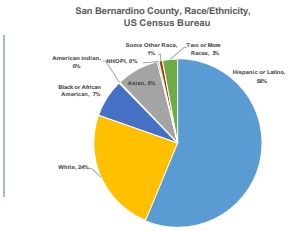
BEHAVIORAL HEALTH SERVICE OVERVIEW





Source: San Bernardino County Department of BH, Client Services Information System; 2021/22

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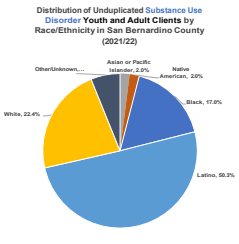
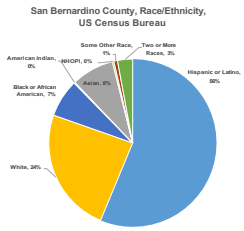
BEHAVIORAL HEALTH SERVICE OVERVIEW





Source: San Bernardino County Department of BH, Client Services Information System; 2021/22

4

COMMUNITY SURVEY RESULTS

5

COMMUNITY SURVEY OVERVIEW

The San Bernardino Department of Behavioral Health distributed a survey that asked questions about the strengths, needs, and barriers of the local behavioral health system, as well as opportunities for improvement. The survey was anonymous with the results analyzed by HMA.

A total of **232** individuals completed the survey.

Note: Based on our experience conducting similar surveys, we feel that 232 is a respectable number of responses. Recent surveys in the City of Minneapolis and Cabarrus County, North Carolina received 253 and 257 responses, respectively, but both surveys were open for 6+ weeks.

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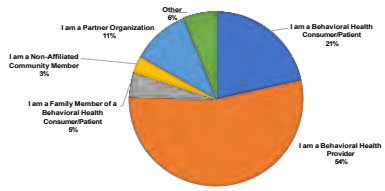
RELATIONSHIP TO BEHAVIORAL HEALTH SYSTEMS

Of the 232 individuals, 200 provided their connection to the behavioral health system…



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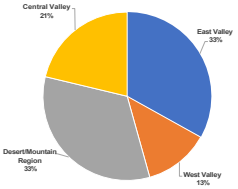
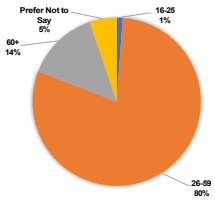
LOCATION & AGE

Of the 232 individuals, 127 provided their location....



Of the 232 individuals, 173 provided their age....



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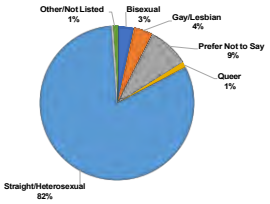
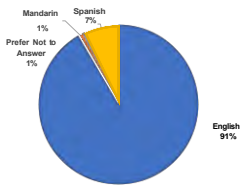
SEXUAL ORIENTATION

Of the 232 individuals, 173 provided their orientation....



Of the 232 individuals, 166 provided their primary language....



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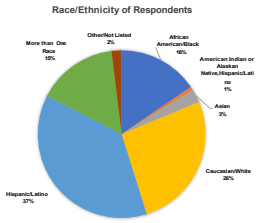
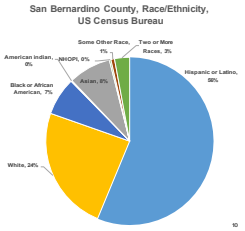
RACE/ETHNICITY

Of the 232 individuals, 171 provided their race/ethnicity....





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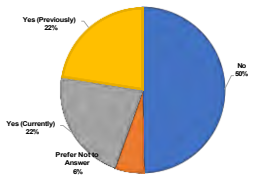
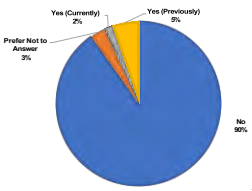
RECIPIENT OF SERVICES

Of the 232 individuals, 173 provided information if they are receiving mental health or SUD services....

Mental Health



Substance Use Services



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FINDINGS FROM THE COMMUNITY SURVEY

- The survey asked a set of questions about barriers to mental health and substance use services and the factors affecting client outcomes.
- The following slides show the top results and a comparison by respondent group.

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COMPARISON OF TOP BARRIERS AND FACTORS IMPACTING CARE

Consumers, Family Members, and Non-Affiliated Community Members	Providers and Partner Organizations
Mental Health Services	**Mental Health Services**
• Lack of access to housing and residential services (36%)	• Limited ability to hire and retain providers (69%)*
• Lack of access to food, transportation and other SDOH (36%)	• Lack of access to housing and residential services (45%)
• Stigma (28%)	• Lack of access to food, transportation and other SDOH (26%)
• Limited number of providers accepting patients (25%)	• Confusing/complex referral and intake process (17%)
• Confusing/complex referral and intake process (14%)	

**Only providers were offered the ability to hire/retain staff option*

13

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COMPARISON OF TOP BARRIERS AND FACTORS IMPACTING CARE

Consumers, Family Members, and Non-Affiliated Community Members	Providers and Partner Organizations
Substance Use Services	**Substance Use Services**
• Stigma (26%)	• Limited ability to hire and retain providers (48%)*
• Lack of access to housing and residential services (25%)	• Lack of access to housing and residential services (46%)
• Lack of access to food, transportation and other SDOH (22%)	• Confusing/complex referral and intake process (28%)
• Limited number of providers accepting patients (21%)	• Stigma (27%)
• Confusing/complex referral and intake process (14%)	• Lack of access to food, transportation and other SDOH (26%)

**Only providers were offered the ability to hire/retain staff option*

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COMPARISON OF TOP BARRIERS AND FACTORS IMPACTING CARE

Consumers, Family Members, and Non-Affiliated Community Members	Providers and Partner Organizations
Factors Negatively Impacting Outcomes	**Factors Negatively Impacting Outcomes**
• Poor access to stable housing (31%)	• Delays in care (51%)
• Lack of communication/coordination between providers (31%)	• Insufficient access to stable housing (48%)
• Confusing MH/SUD services system (30%)	• Insufficient access to MH/SUD residential services (43%)
• Poor access to MH/SUD inpatient services (26%)	• Insufficient access to MH/SUD inpatient services (41%)
• Poor access to MH/SUD residential services (26%)	• Difficulty with community/coordination between providers (41%)
• Delays in care due to difficulty accessing services (25%)	

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DISPARITIES IN ACCESS TO MENTAL HEALTH CARE

Provider and Partner Organization Respondents were asked to rank the cultural, ethnic, or identify groups that experience the highest disparities in access to mental health care. Below is the rank order.

1. African American/Black Americans
2. Undocumented Persons
3. Latino/a
4. Recent Immigrants
5. Native Americans / Tribal members
6. LGBTQIA+ Persons
7. Asian Americans
8. Justice-Involved Persons
9. Foster Youth
10. Pacific Islander Americans
11. Caucasian/White

1. Transitional Age Youth - 16 – 25
2. Older Adults/Seniors - 66+
3. Children and Adolescents - Birth – 15
4. Adults - 26 – 65

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DISPARITIES IN ACCESS TO SUBSTANCE USE CARE

Provider and Partner Organization Respondents were asked to rank the cultural, ethnic, or identify groups that experience the highest disparities in access to substance use care. Below is the rank order.

1. African American/Black Americans
2. Latino/a
3. Undocumented Persons
4. Native Americans / Tribal members
5. Recent Immigrants
6. Asian Americans
7. LGBTQIA+ Persons
8. Foster Youth
9. Justice-Involved Persons
10. Pacific Islander Americans
11. Caucasian/White

1. Children 0 – 12
2. Adolescents 12 – 15
3. Transitional Age Youth 16 – 25
4. Adults 26 – 65
5. Older Adults/Seniors 66+

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INTERVIEW FINDINGS

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STAKEHOLDER ENGAGEMENT – COMPLETED AND PLANNED

- As a part of this project, HMA interviewed individuals from the organizations below. In several instances, multiple individuals from an organization were interviewed.
- The following slides contain themes and takeaways from the interviews. The themes are presented as strengths and opportunities for improvement/unmet needs in the following areas:
  - The behavioral health landscape
  - County services and operations
  - The Community Planning Process

Organization
Asian American Resource Center
Boys Republic
Inland Empire Health Plan
Ontario-Montclair School District Counseling Center
Pacific Clinics
Reach Out
Riverside-San Bernardino County Indian Health
San Bernardino County Behavioral Health (Note: This included providers of BH services)
South Coast Counseling Services

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FINDINGS FROM INTERVIEWS – BEHAVIORAL HEALTH LANDSCAPE

Strengths

- Strong network of local provider organizations
- Organizations support one another and have forums for collaboration (e.g., Association of Community Based Organizations)
- Diverse set of services across the continuum available to the community
- Telehealth expansion has helped to address transportation issues
- Growing school-based behavioral health services and more openness to engage in services by youth
- Utilization of the CANS and Objective Arts System has been good and supports coordination

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FINDINGS FROM INTERVIEWS – BEHAVIORAL HEALTH LANDSCAPE

Opportunities For Improvement & Unmet Needs

Access/Service Availability

- Lack of awareness of available resources in the community which results in duplication of effort and/or gaps in care
- Long waitlists and delays in care – 6+ months in some cases
- Areas needing additional service capacity:
  - Substance use disorder treatment
    - In schools
    - Residential
    - Inpatient psych
  - Crisis
    - Walk-in center
  - Children/youth services
- Transportation is a barrier, especially for rural communities
- Limited hours restricts access to those who are working traditional hours
- Coordination around meeting SDOH is needed to improve access and outcomes
  - Transportation and housing mentioned frequently
  - Food insecurity and clothing mentioned as needs as well

Workforce

- Staffing shortages across the behavioral health system (psychiatrists in particular)
- Inability to pay competitive wages – providers are losing staff to Kaiser and private practice

Cultural Responsiveness/Disparity Reduction

- Need more specialized services for BIPOC and LGBTQIA+ communities
- Need to build more trust and efficacy with marginalized communities, especially the BIPOC community
- Need expanded language capacities

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FINDINGS FROM INTERVIEWS – COUNTY BHD SERVICES & OPERATIONS

Strengths

- Collaborative relationship between the County and providers
- There's a willingness to work with providers to address issues
- The County has helped to broker relationships between organizations
- The County seems to genuinely care and they try for their clients and providers
- The County is always looking for other funding streams to support work
- They're attempting to be more data-driven (although, it's a work in progress)

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FINDINGS FROM INTERVIEWS – COUNTY BHD SERVICES & OPERATIONS

Opportunities For Improvement & Unmet Needs

Implementation

- Implementation of new initiatives can be slow and are perceived as needing more intentional coordination
  - The lack of coordination and clarity of expectations puts an extra burden on providers that takes away from time dedicated to client care
- CalAIM and related initiatives were perceived to have slower and less clearly communicated rollouts in SB than in other counties which led to confusion and implementation challenges

Collaboration

- Better collaboration between county and state is needed – providers are negatively impacted by lack of alignment
- The County struggles to support contractors due to a lack of staffing – slow in getting responses, amending contracts, making decisions, etc. This can negatively impact providers' financial stability and service delivery.

Operations

- The fiscal review/audit process is punitive and occurs long after errors have occurred
  - "Clawing back" of funding occurs years after service delivery and is inflexible
- Accessing county services is complicated and results in clients not being able to connect with services
  - Interviewees reported: Too many calls, steps, and requirements
  - Need to consider linguistic, cultural, and educational barriers

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FINDINGS FROM INTERVIEWS – COMMUNITY PLANNING PROCESS

Strengths

- The County has tested multiple strategies for outreach, including partnering with organizations to host meetings, virtual forums, surveys, etc.
- The intent behind the process and sub-committees is good
- They promote the sessions to providers and the community
- The County is generally good about receiving programmatic feedback (not good at receiving feedback regarding fiscal procedures)

Opportunities & Unmet Needs

- Intentional design of meetings could help minimize meeting fatigue/burnout:
  - Goals of CPP need to be more clearly defined to audience
  - Sessions can be too technical and could benefit from focusing on application rather than statistics.
  - Meetings should result in more tangible action
- Need representation from those who have had difficulty engaging as those individuals may have important perspectives
- Consider providing other, lower-barrier methods to engage and share information – such as social media updates, apps, etc.
- Several individuals interviewed had never heard of the CPP process

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FOCUS GROUP FINDINGS

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FOCUS GROUP FINDINGS

- The following slides contain themes and takeaways from focus groups with individuals with lived experience.
- HMA conducted focus groups with a total of 220+ participants. Below is a list of the groups engaged:
  - Mental Health and SUD Service Recipients (4 focus groups)
  - Yucca Valley Clubhouse
  - Yucca Valley Family Resource Center
  - Rialto Clubhouse
- Participants were asked about their experiences, barriers to access, unmet needs, and strengths. They were also asked to score – on a scale from 1 to 5 – the county's ability to engage clients in developing programs/services and in communicating about programs/services.

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FOCUS GROUP FINDINGS

Summary of Themes: Yucca Valley Family Resource Center

Strengths

- **Information Sources:** Participants reported having supportive networks available to them introducing and informing them about available resources.
- **Available Programs and Services:** Clubhouses and crisis centers provide critical support in times of need.
- **Appreciated Services:** Participants reported high appreciation of available services such as mental health providers, clubhouses, and social security benefits.

On average, participants rated the county's ability to engage clients in developing programs and services as a **1 out of 5.**

On average, participants rated the county's communication around programs and services as a **1 out of 5.**

Opportunities & Unmet Needs

- **Communication:** Improve awareness and communication around available programs and services.
- **Engagement:** Enhance engagement with clients and patients in developing programs.
- **Service Availability:** Additional clubhouses, residential, and outpatient treatment centers with flexible hours.
- **Transportation:** Expand public transportation options, including more frequent buses and weekend services. Provide transportation assistance for individuals accessing mental health and SUD services.
- **Access Barriers**: Long waits, bureaucracy, high living costs, and housing access issues.
- **Mental Health**: Shortage of medication, providers, and experienced therapists.
- **Substance Use Services:** Insufficient treatment centers, inconsistent medication management, and lack of incentive programs.

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FOCUS GROUP FINDINGS

Summary of Themes: Yucca Valley Clubhouse

Strengths

- **Information Sources:** Word of mouth, referrals (outpatient, PCP, parole officer).
- **Appreciated Services:** Participants expressed having supportive counselors.
- **Clubhouse Programs:** Participants found significant value in clubhouse support groups (grief, mindfulness support, co-dependency, and substance use groups).
- **Personalized Care:** One-on-one therapy services are highly valued, with participants noting significant positive impacts on their mental health and well-being.

On average, participants rated the county's ability to engage clients in developing programs and services as a **1.5 out of 5.**

On average, participants rated the county's communication around programs and services as a **1 out of 5.**

Opportunities & Unmet Needs

- **Communication:** Enhance awareness of services (e.g., 988 hotline), better advertisement of available resources (billboards, flyers, etc.).
- **Service Availability:** Increase evening/weekend services, diversify support groups, and provide more psychiatric services and suicide prevention resources.
- **Transportation & Financial Support:** Address transportation and financial barriers and improve support for those ineligible for services.
- **Access Barriers**: Transportation, financial limitations, long waitlists, limited staffing, and lack of service availability in rural areas.
- **Mental Health Services:** Specific services for veterans, increased awareness and availability of psychiatric care, and more diverse support groups.
- **Substance Use Services**: Need for veteran centers, residential and outpatient sober living facilities, and youth services.

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FOCUS GROUP FINDINGS

Summary of Themes: Rialto Clubhouse

Strengths

- **Information Sources:** Participants learn about services through word of mouth, counselors, organizations (Caso Paseo), PCP, and psychiatrists.
- **Knowledge of Services:** Participants demonstrated a high level of awareness and appreciation for various services. These include clubhouse support. (socialization, meals), IEHP Car Ride, and the STAY housing program.
- **Effective Programs:** Participants highlighted effective programs including sober living facilities (Cedar House, River Community, Caso Paseo), supportive social workers, and coordinated primary care services.

On average, participants rated the county's ability to engage clients in developing programs and services as a **4 out of 5.**

On average, participants rated the county's communication around programs and services as a **3 out of 5.**

Opportunities & Unmet Needs

- **Improve Communication & Training:** Increase awareness and ads of services (988 hotline).
- **Service Availability:** Extend evening/weekend hours, broaden mental health management classes, and improve transportation options (e.g., bus passes like Riverside County).
- **Support for Unhoused Individuals:** Develop approaches to better serve individuals with mental health and substance use services.
- **Access Barriers:** Lack of medication management appointments, transportation, and accessible service hours.
- **Mental Health/SUD Services:** Need for more health education, culturally competent care, and diverse support groups.
- **Housing:** Long waits for housing programs and insufficient availability.
- **Cultural Responsiveness/Disparity Reduction:** Train healthcare professionals in cultural competence, and increase the availability of interpreters, including sign language.

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FOCUS GROUP FINDINGS

Summary of Themes: Individuals who have experience with substance use services

Strengths

- **Information Sources:** Participants learn about services through social media, other online research, their friends, and their PCP.
- **Effective Programs:** Participants highlighted the County's effective crisis intervention programs and successful utilization of community crisis response teams.
- **Access to Information:** Participants emphasized the volume of information and resources available to them and that accessing information is easy.

On average, participants rated the county's ability to engage clients in developing programs and services as a **3.5 out of 5.**

On average, participants rated the county's communication around programs and services as a **3.5 out of 5.**

Opportunities & Unmet Needs

- **Substance Use Disorder Services:** Need for more early prevention programs focused on substance use.
- **Stigma Reduction:** Address stigma and racial bias within the healthcare space. Increase education efforts to reduce stigma and promote help-seeking behaviors.
- **Financial Support:** Address economic and financial instability and improve financial aid supports for those ineligible for services.
- **Workforce Diversity:** Enhance cultural competency and linguistic diversity in services to better serve the county's diverse population.
- **Continuous Program Evaluation**: Improve data collection and evaluation to inform service development and understand the evolving needs of the community.
- **Partnership:** Foster collaboration between healthcare, criminal justice, and social services to provide comprehensive support.

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FOCUS GROUP FINDINGS

Summary of Themes: Individuals who have experience with substance use services

Strengths

- **Information Sources:** Participants learn about services through social media, other online research, their friends, and their PCP.
- **Appreciated Services:** Many of the participants expressed appreciation for the county's mental health, counseling, and therapeutic services.
- **Effective Outreach Programs:** Participants expressed positive experiences with various community outreach programs.
- **Peer Supports:** Participants acknowledged the access to and availability of a range of peer support groups.

On average, participants rated the county's ability to engage clients in developing programs and services as a **4 out of 5.**

On average, participants rated the county's communication around programs and services as a **4 out of 5.**

Opportunities & Unmet Needs

- **Access Barriers:** Continue to leverage technology, such as telehealth and online resources, to increase access to services.
- **Financial Support:** Increase accessibility by addressing financial barriers to affordable treatment options.
- **Substance Use Disorder Services:** Explore opportunities to increase recovery support services (e.g., Detoxification Services, Naloxone Distribution, and affordable Medication Assisted Treatment).
- **Long Wait Times:** Advocate and seek out opportunities for increased funding to expand substance use and treatment program services and reduce wait times.
- **Awareness:** Ensure all community members are aware of available resources through targeted outreach, educational sessions/workshops, and collaboration across departments.
- **Evaluate Services:** Continually assess and address both strengths and weaknesses of offered services to ensure they effectively meet the needs San Bernadino residents.

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FOCUS GROUP FINDINGS

Summary of Themes: Individuals who have experience with substance use services

Strengths

- **Information Sources:** Participants learn about services through their friends/family and online.
- **Appreciated Services:** Many of the participants expressed appreciation for the county's counseling and various support services.
- **Effective Programs:** Participants expressed community-based programs are working well.

On average, participants rated the county's ability to engage clients in developing programs and services as a **4 out of 5.**

On average, participants rated the county's communication around programs and services as a **4 out of 5.**

Opportunities & Unmet Needs

- **Transportation Barriers:** Continue to improve transportation options (e.g., bus passes like Riverside County).
- **Cultural Competency:** Increase mental health services that are culturally sensitive and tailored to diverse populations.
- **Access Barriers:** Continue to leverage technology, such as telehealth and online resources, to increase access to services
- **Aftercare and Support:** Expand ongoing support and aftercare services, such as sober living environments and support groups.
- **Continual Education:** Seek additional opportunities for culturally appropriate trainings and workshops for the personnels across departments.

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OBSERVATIONAL FINDINGS FROM CPP MEETINGS

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OBSERVATIONAL FINDINGS OF CPP

HMA consultants attended (virtually and in-person) several meetings that were a part of the Community Planning Process.

Below are several observational findings:

- Meetings were well attended
- A wide array of special population meetings have been held
- Information shared by the County with participants meets CLAS standards
- Participants were engaged and given opportunities to provide feedback
- The process of submitting written comments could be streamlined (requires submitting a form)
- The County is doing a better job at connecting the dots between the Mental Health Services Act and the Community Planning Process

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Assessment of MHSA Community Planning Process

PREPARED FOR
SAN BERNARDINO COUNTY

BY
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AUGUST 30, 2024

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EXECUTIVE SUMMARY

Health Management Associates (HMA) was contracted by the San Bernardino Department of Behavioral Health (DBH) to assess the DBH Community Planning Process (CPP), a stakeholder process for developing the MHSA Three-Year Integrated Plan and Plan Annual Updates.

HMA utilized a mixed-method approach to conduct the assessment. Strategies for qualitative and quantitative data collection are highlighted below:

- Conducted interviews with outpatient and residential behavioral health providers, culturally specific organizations, social service agencies, and school district representatives, amongst others to solicit their input on CPP.
- Facilitated focus groups where 220+ individuals with lived experience shared their stories and experiences, including awareness of and participation in the CPP.
- Administered a community survey that received 232 responses regarding system strengths, barriers, and unmet needs, as well as awareness of and participation in the CPP.
- Convened townhalls as a forum to hear additional input from community members.
- Observed several DBH-run meetings that are a part of the CPP.

The qualitative and quantitative data gathered was presented to a team of DBH staff – called the Core Team – that represented a cross-section of departments to review, discuss, and inform recommendation development. These same data were also presented to a Community Advisory Group (CAG) that was convened to support this process. The CAG included representatives from community-based organizations working in an around the behavioral health system. Findings from the data collection efforts are summarized in this document, with additional details provided in the addendum.

HMA used the collected data and insights from discussions with the Core Team and CAG to develop recommendations for addressing identified areas in need of improvement. The recommendations outlined in this report will build on the strong foundation in San Bernardino County and help to support further enhancements to the CPP.

INTRODUCTION

The San Bernardino Department of Behavioral Health (DBH) provides mental health and substance use disorder services to county residents who are experiencing serious mental illnesses (SMI) and/or substance use issues and are uninsured or insured through Medi-Cal, as well as individuals experiencing a behavioral health crisis. DBH serves all age groups and provides an array of prevention, early intervention, and treatment services for both mental health and substance use.

Nearly fifty DBH programs, services, and actions are supported through the Mental Health Services Act (MHSA), a state funded program designed to "reduce the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness". All MHSA programs are stakeholder informed and developed via a required Community Program Planning (CPP) process.

The Behavioral Health Continuum Infrastructure program (BHCIP), funded through the Department of Health Care Services (DHCS) provides investments in infrastructure funding alongside significant new state and federal resources to address homelessness, support healthcare delivery reform, and strengthen the social safety net. Together these commitments will address historic gaps in the behavioral health continuum to meet growing demand for services and supports. This funding opportunity allows DBH the ability to meet the needs of vulnerable populations with the greatest barriers to access, including people experiencing homelessness and justice involvement, utilizing direct stakeholder engagement and feedback.

Substance Use Disorder and Recovery Services (SUDRS) supports the recovery efforts of individuals by providing a drug and alcohol free sober social environment and other recovery resources by providing a full range of substance use disorder (SUD) treatment services and education. SUDRS services are offered through contracts with community-based organizations (CBOs) and county-operated clinics to promote prevention, intervention, recovery and resiliency for individuals (adolescents ages 12-17 and adults 18+) and families. SUD treatment services utilize the American Society of Addiction Medicine (ASAM) Criteria to determine appropriate level of care for covered SUD treatment services. SUDRS services are funded by multiple funding sources, which are informed by stakeholder engagement.

Health Management Associates (HMA) was contracted by DBH to assess the DBH Community Planning Process (CPP), a stakeholder process for developing the MHSA Three-Year Integrated Plan and Plan Annual Updates. The following analysis highlights program strengths, challenges, and provides recommendations for areas of opportunity.

METHODOLOGY

HMA utilized a mixed-method approach to conducting the assessment of the Community Planning Process (CPP) in San Bernardino County. HMA met early in the process with key members of the San Bernardino Department Behavioral Health (DBH) to build a thorough understanding of the behavioral health ecosystem and current CPP. San Bernadino County, with a diverse array of public, private, and non-profit partners, provides a dynamic portfolio of behavioral health services that is ever evolving to meet the needs of San Bernadino residents. The unique geographic nature, including the sheer size of the county, creates unique demands on the behavioral health system.

The County plays a critical role in identifying behavioral health needs, disparities, and inequities across the behavioral health service system. The County also distributes funds, develops partnerships, networks of services, identifies, and supports the creation of evidence-based practices, and provides services. Because of the heightened need for behavioral health services since the COVID-19 pandemic and the availability of increased state and federal funding San Bernadino has added new partners and new services with a strong focus on equity leveraging these funds, but they continue to experience service gaps and barriers.

HMA leveraged these early discussions and collaboratively designed the project approach outlined below.

Project Oversight

HMA and DBH created a project oversight structure to ensure the effective gathering of information and a collaborative approach to conducting the assessments. Three distinct groups were formed:

- A **Core Team** with representatives from a cross-section of DBH programs was convened to support data collection, review findings, and inform recommendation development. The Core Team met six times.
- A **Community Advisory Group (CAG)** with representatives from community-based organizations was convened to similarly review findings and inform recommendation development, but from an external perspective. The CAG met twice.
- Lastly, a **Project Management Team** with representatives from DBH leadership and various programs was established to support project management, coordination, and oversight. This group was tasked with supporting data collection and access to individuals and organizations to engage in the assessment effort. The Project Management Team met approximately bi-weekly from December 2023 to June 2024.

Data Collection Methods

Below is a brief overview of the primary quantitative and qualitative data collection efforts utilized in the assessment process. This is not meant to capture everything that was reviewed or incorporated into this effort, but instead offer an overview of primary sources and engagement efforts.

Document Review: Information and materials were collected and reviewed, such as the Mental Health Services Act Plan and Annual Updates, Cultural Competency Plan, applicable regulations, presentations to the Behavioral Health Commission and other bodies, and other previously developed reports and presentations.

Community Planning Process Observation: HMA consultants attended several meetings (both virtually and in-person) that were a part of the CPP. During these meetings, HMA consultants gathered and tracked several observational findings outlined in the section below.

Stakeholder Interviews: HMA interviewed individuals from nine separate organizations to build an understanding of the landscape and inform future data collection efforts.[1] Organizations engaged included outpatient and residential behavioral health providers, culturally specific organizations, social service agencies, and school district representatives, amongst others. In several instances, multiple individuals from an organization were interviewed. The interviews were broadly structured around an assessment of Strengths, Weaknesses, Opportunities, and Threats, as well as questions about the CPP. Interviewees were assured confidentiality to allow for candid responses. Their feedback was summarized and presented to the Core Team and CAG to review and reflect on.

Community Survey: HMA developed a web-based survey specifically designed to collect qualitative information in a person-centered, transparent, and culturally sensitive way. This survey was advertised through the distribution of flyers in both English and Spanish. DBH distributed the flyers which included links/QR codes to the survey. The survey asked questions about the respondent's relationship to behavioral health services and their perspectives on the strengths, unmet needs, and barriers of the local behavioral health system, as well as disparities in care and opportunities for improvement. The survey also asked about awareness of and participation in the CPP. The survey was anonymous with the results analyzed by HMA. Data was disaggregated by respondent type – i.e., consumers of behavioral health services vs. providers of services – to better analyze findings. Findings were presented to the Core Team and CAG to review and reflect on. The community survey received 232 responses, with the demographic profile of respondents aligning with the overall demographics of the community.

Focus Groups: HMA conducted a series of focus groups with individuals with lived experience with behavioral health conditions to gather their perspectives. These focus groups included individuals engaged in a variety of mental health and substance use services – including services funded by DBH. Focus groups were convened with the support of local behavioral health service providers, word-of-mouth information sharing, and the distribution of flyers in both English and Spanish.

Three focus groups were convened in person with another four convened virtually, and participants were compensated for their time and wisdom (30 gift cards of $50 value were provided to participants of the in-person focus groups and 90 gift cards of $25 value were provided electronically to participants of the virtual focus groups for a total of $3,750). In-person focus groups were attended by an HMA consultant who could interpret in Spanish, as needed. When registering for the virtual focus group(s)

[1] Asian American Resource Center, Boys Republic, Inland Empire Health Plan, Ontario-Montclair School District Counseling Center, Pacific Clinics, Reach Out, Riverside-San Bernardino County Indian Health, San Bernardino County Behavioral Health, South Coast Counseling Services

participants were asked to indicate if language interpretation was needed and if so, whether they preferred Zoom auto-translation or interpretation from an HMA team member. Auto-translation and/or interpretation services were then offered to those who requested them.

During the focus group(s), participants were asked about their experiences with the behavioral health system, barriers to access, unmet needs, and strengths. They were also asked to score – on a scale from 1 to 5 – the county's ability to engage clients in developing programs/services and in communicating about programs/services, to support the CPP assessment. In total, HMA conducted seven focus groups (3 in-person and 4 virtually) with 222 participants. Below is a list of the groups engaged:

- Yucca Valley Clubhouse – Monday, July 8th, *in person*
- Yucca Valley Family Resource Center – Monday, July 8th, *in person*
- Rialto Clubhouse – Tuesday, July 9th, *in person*
- Individuals who have experience with substance use and mental health services
    - Monday, August 12th, *virtual*
    - Monday, August 12th, *virtual*
    - Wednesday, August 14th, *virtual*
    - Monday, August 19th, *virtual*

Townhalls (2): HMA promoted and convened two virtual townhall meetings on August 19th and August 21st. The townhalls were intended to be opportunities to share findings from the assessment process as well as solicit additional feedback on the CPP. Flyers in English and Spanish were created by HMA and distributed by San Bernardino County to promote the event. A total of 6 individuals were in attendance between the two townhalls. As a result, limited additional data was collected from these efforts.

FINDINGS

HMA utilized a combination of data analysis, document review, and community engagement throughout the project to assess the Community Planning Process (CPP) in San Bernardino County. These engagements allowed HMA to gather diverse perspectives from individuals with lived experience, community members, service providers, and other key stakeholders. Key findings related to the CPP are outlined in the sections below. They are broken down by the strengths and opportunities for improvement that emerged from the data collection methods.

Qualitative Feedback- Strengths

Observations of the Community Planning Process

As noted above, HMA attended several in-person and virtual meetings that were a part of the CPP. Below are several strengths observed during those sessions.

- Meetings were well attended.

- Constituents were asked to introduce themselves and there were plenty of opportunities for constituent questions and feedback.
- Participants were engaged, with many offering thoughts and comments.
- Information shared by the County with participants meets CLAS (Culturally and Linguistically Appropriate Services) Standards.
- A wide array of special population meetings have been held.

Feedback on the Community Planning Process

HMA asked for feedback on the CPP through the survey, interviews, focus groups, and other engagement efforts. Below is a summary of key themes that emerged:

- The County has tested multiple strategies for outreach, including partnering with organizations to host meetings, virtual forums, surveys, etc.
- The intent behind the process and sub-committees is good, even if they are not always as effective and well-attended as participants would like.
- The County promotes the sessions to providers and the community.
- The County is generally good about receiving feedback.

Qualitative Feedback- Opportunities for Improvement

Observations of the Community Planning Process

As noted above, HMA attended several in-person and virtual meetings that are a part of the Community Planning Process. Below are several opportunities for improvement observed during those sessions.

- Initially there was a disconnect among constituents regarding the context and goal of the meetings and the connection between the Mental Health Services Act (MHSA) and the CPP. The County has started to provide more context about MHSA and CPP during meetings. This was an early verbal recommendation made to the Core Team and we recommend this effort continue.
- The process of submitting comments could be streamlined. It currently requires submitting a form which could be burdensome, particularly for virtual meetings.
- The County could leverage online tools to improve interactions and engagement during meetings.

Feedback on the Community Planning Process

HMA asked for feedback on the CPP through the survey, interviews, focus groups, and other engagement efforts. Below is a summary of key themes that emerged:

- Providers and members of the community report having many competing requirements for their time and resources. This is exacerbated by frequent meeting requirements from regulatory or

funding entities. Participants emphasized an intentional structuring of meetings, including the following, could improve this issue:

  - Clearly defined goals and objectives for each meeting
  - A stronger focus on technical assistance and operational application rather than statistics so that providers can leave with tools for programming
  - Clearly defined action items with follow-up so that progress is easily measured, tracked, and defined

- There is a desire to increase participation from individuals who have not traditionally been a part of the process, such as those who may have behavioral health needs but do not access services for one reason or another. Their participation would help to identify and address barriers to care that are not currently apart of the conversation(s). While interviewees noted that this is a challenge, they recommended holding more meetings "in the community" as one way to improve access.
- Participants described an expectation similar to the national trend of "nothing about us without us." In practice, this concept means that services are designed and progressively adjusted based on ongoing, meaningful engagement and feedback from the community.
- It was suggested that the County consider offering low-barrier engagement options, via social media posts, for example, to solicit additional feedback and perspectives.
- Several of the providers interviewed had not heard of the Community Planning Process. Most, however, had described engaging in meetings that are a part of the process, which speaks to the need for clearer communication on the objective of the CPP.

RECOMMENDATIONS

Through this evaluation, it was clear that San Bernadino County has a very successful Community Planning Process. As such, the County has a strong foundation from which focused enhancements could be implemented to improve planning and engagement efforts. Based on the findings from this assessment, HMA has developed several recommendations that could have a significant impact on community planning in San Bernadino County.

Recommendation: Enhance External Communication and Engagement

Enhancing external communication and engagement will help to build awareness of the CPP and support meaningful engagement with consumers and the community. These efforts should be targeted to historically marginalized communities and communities that are underrepresented in Department of Behavioral Health services.

- *Build Awareness of the Community Planning Process:* The County should be proud of its established Community Planning Process (CPP). Meetings are well attended, there are various forums and groups dedicated to special populations, and there is active engagement during sessions. That said, the County could serve to improve awareness of the process and its purpose. Many participants indicated limited to no awareness of the CPP – despite many attending sessions that are a part of the process. Even those who were aware of the CPP struggled to describe its purpose.

  The County should find ways to more clearly describe the CPP and consistently reinforce that messaging. However, this should be done in simple terms. Participants do not need to understand the nuances of Mental Health Service Act requirements but should understand how the meetings they attend are part of a larger process to hear from the community and improve services.

- *Improving CPP Progress and Outcomes Tracking:* A related recommendation is that the County should articulate more clearly how the information gathered is being used and report on progress made. This can help to build momentum and buy-in amongst CPP participants and community members.

- *Leverage Trusted Partners to Support Information Sharing:* In service of sharing information more broadly, including about the CPP, the County should further leverage trusted partners within the community. While a message from the Department of Behavioral Health might be most effective for some, many community members – and in particular members of historically marginalized communities – are better reached and engaged by individuals/organizations they are connected to. This could include behavioral health providers but should also include schools and faith-based organizations that can reach individuals not already engaged with the behavioral health system. The County should also consider utilizing the peer workforce (e.g., certified peer support specialists, community health workers, etc.) to share information with clients and community members.

  To effectively leverage partners, the County should institute a process for how information and messages are distributed. It is not enough to email information to partner organizations with the hope that they share it. The County could develop and distribute posters, create videos that could be shared, develop talking points, and do direct outreach to organizations to ensure that messages are being shared with key constituencies. County staff could also attend meetings convened by local organizations to share information.

- *Improve Connections with Marginalized Communities:* Aligned with to the previous recommendation, it is recommended that the County build intentional pathways to improve outreach, communication, and trust with marginalized communities – specifically the BIPOC

communities and the LGBTQIA+ community. So, as the County looks to identify partners in support of sharing information and engaging the community, special focus should be given to organizations/individuals serving these communities. These efforts will positively impact engagement and help to reduce disparities in the county.

- *Offer Engagement Opportunities in Community Settings:* As the County works to enhance its communication and community engagement, it is important to consider how to best connect with individuals in the community who may have more limited interaction with the behavioral health system. It is recommended that the County consider holding meetings and input-gathering sessions in more publicly accessible spaces, such as libraries, parks, or schools. This strategy also dovetails with the recommendation about leveraging trusted partners. The County could work with said partners to convene meetings/groups, which could extend the County's reach to new individuals and communities. As the County pursues this strategy, it should also be mindful of geographic representation, and look to provide opportunities for engagement across the county.

- *Leverage Technology to Support Engagement:* The County should explore how to better utilize technology to support engagement, especially during virtual meetings. The process to submit comment – via a form and/or survey – may serve as a barrier to engagement. It takes time to open, fill-out, and submit a comment/survey and, often, participants are asked to do so after a meeting has already ended which reduces response rates. HMA would recommend utilizing tools like Zoom polls, Mentimeter, and Miro as ways to garner real time feedback from participants. The tools are simple to use – especially Zoom polling, which is built directly into Zoom meeting functionality – and are great for capturing, displaying, and discussing feedback during the meeting itself.

CONCLUSION

It is abundantly clear from the assessment process that San Bernardino County has established a successful Community Planning Process and provides numerous avenues for community engagement. While this report outlines recommendations for how the CPP can be further enhanced, they build on a solid foundation and history of success. Health Management Associates appreciates the partnership with the Department of Behavioral Health in completing this work, as well as the multitude of providers, partners, individuals with lived experience, and other members of the community who gave their voice to this process. We appreciate your time, wisdom, and commitment to building a better behavioral health system of tomorrow.

HEALTH MANAGEMENT ASSOCIATES

SAN BERNARDINO COUNTY

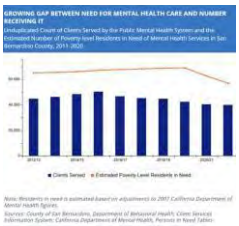
Behavioral Health and Community Planning Process Assessment

Summary of Stakeholder Engagement Findings

1

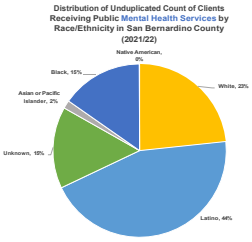
BEHAVIORAL HEALTH SERVICE OVERVIEW

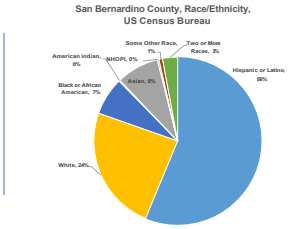
- The estimated prevalence for severe mental illness or emotional disturbance in the Medi-Cal eligible population is 9%, according to the National Institute of Mental Health.
- Under this construct, approximately 73,909 persons from all age groups, who are Medi-Cal eligible, could be considered in need of some level of behavioral health services in San Bernardino
- In FY 2021/22, approximately 42,872 individuals received a mental health service from the mental health plan



2

BEHAVIORAL HEALTH SERVICE OVERVIEW





Source: San Bernardino County Department of BH, Client Services Information System; 2021/22

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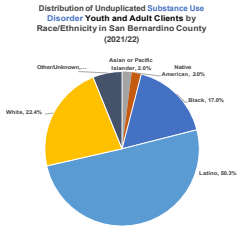
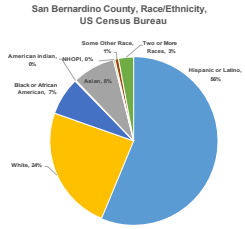
BEHAVIORAL HEALTH SERVICE OVERVIEW





Source: San Bernardino County Department of BH, Client Services Information System; 2021/22

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COMMUNITY SURVEY RESULTS

5

COMMUNITY SURVEY OVERVIEW

The San Bernardino Department of Behavioral Health distributed a survey that asked questions about the strengths, needs, and barriers of the local behavioral health system, as well as opportunities for improvement. The survey was anonymous with the results analyzed by HMA.

A total of **232** individuals completed the survey.

Note: Based on our experience conducting similar surveys, we feel that 232 is a respectable number of responses. Recent surveys in the City of Minneapolis and Cabarrus County, North Carolina received 253 and 257 responses, respectively, but both surveys were open for 6+ weeks.

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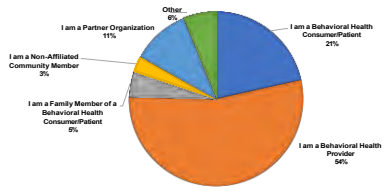
RELATIONSHIP TO BEHAVIORAL HEALTH SYSTEMS

Of the 232 individuals, 200 provided their connection to the behavioral health system…



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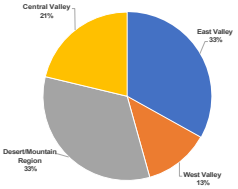
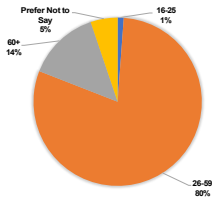
LOCATION & AGE

Of the 232 individuals, 127 provided their location....



Of the 232 individuals, 173 provided their age....



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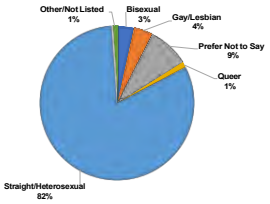
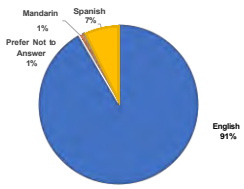
SEXUAL ORIENTATION

Of the 232 individuals, 173 provided their orientation....



Of the 232 individuals, 166 provided their primary language....



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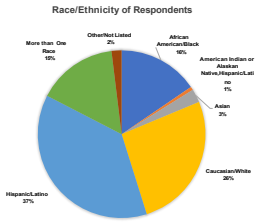
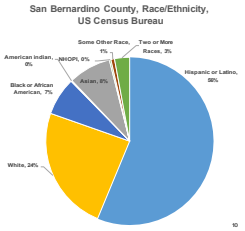
RACE/ETHNICITY

Of the 232 individuals, 171 provided their race/ethnicity....





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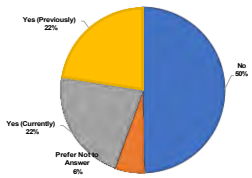
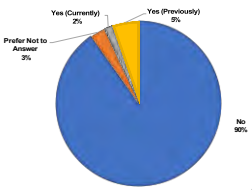
RECIPIENT OF SERVICES

Of the 232 individuals, 173 provided information if they are receiving mental health or SUD services....

Mental Health



Substance Use Services



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FINDINGS FROM THE COMMUNITY SURVEY

- The survey asked a set of questions about barriers to mental health and substance use services and the factors affecting client outcomes.
- The following slides show the top results and a comparison by respondent group.

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COMPARISON OF TOP BARRIERS AND FACTORS IMPACTING CARE

Consumers, Family Members, and Non-Affiliated Community Members

Mental Health Services

- Lack of access to housing and residential services (36%)
- Lack of access to food, transportation and other SDOH (36%)
- Stigma (28%)
- Limited number of providers accepting patients (25%)
- Confusing/complex referral and intake process (14%)

Providers and Partner Organizations

Mental Health Services

- Limited ability to hire and retain providers (69%)*
- Lack of access to housing and residential services (45%)
- Lack of access to food, transportation and other SDOH (26%)
- Confusing/complex referral and intake process (17%)

**Only providers were offered the ability to hire/retain staff option*

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COMPARISON OF TOP BARRIERS AND FACTORS IMPACTING CARE

Consumers, Family Members, and Non-Affiliated Community Members

Substance Use Services

- Stigma (26%)
- Lack of access to housing and residential services (25%)
- Lack of access to food, transportation and other SDOH (22%)
- Limited number of providers accepting patients (21%)
- Confusing/complex referral and intake process (14%)

Providers and Partner Organizations

Substance Use Services

- Limited ability to hire and retain providers (48%)*
- Lack of access to housing and residential services (46%)
- Confusing/complex referral and intake process (28%)
- Stigma (27%)
- Lack of access to food, transportation and other SDOH (26%)

**Only providers were offered the ability to hire/retain staff option*

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COMPARISON OF TOP BARRIERS AND FACTORS IMPACTING CARE

Consumers, Family Members, and Non-Affiliated Community Members

Factors Negatively Impacting Outcomes

- Poor access to stable housing (31%)
- Lack of communication/coordination between providers (31%)
- Confusing MH/SUD services system (30%)
- Poor access to MH/SUD inpatient services (26%)
- Poor access to MH/SUD residential services (26%)
- Delays in care due to difficulty accessing services (25%)

Providers and Partner Organizations

Factors Negatively Impacting Outcomes

- Delays in care (51%)
- Insufficient access to stable housing (48%)
- Insufficient access to MH/SUD residential services (43%)
- Insufficient access to MH/SUD inpatient services (41%)
- Difficulty with community/coordination between providers (41%)

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DISPARITIES IN ACCESS TO MENTAL HEALTH CARE

Provider and Partner Organization Respondents were asked to rank the cultural, ethnic, or identify groups that experience the highest disparities in access to mental health care. Below is the rank order.

1. African American/Black Americans
2. Undocumented Persons
3. Latino/a
4. Recent Immigrants
5. Native Americans / Tribal members
6. LGBTQIA+ Persons
7. Asian Americans
8. Justice-Involved Persons
9. Foster Youth
10. Pacific Islander Americans
11. Caucasian/White

1. Transitional Age Youth - 16 – 25
2. Older Adults/Seniors - 66+
3. Children and Adolescents - Birth – 15
4. Adults - 26 – 65

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DISPARITIES IN ACCESS TO SUBSTANCE USE CARE

Provider and Partner Organization Respondents were asked to rank the cultural, ethnic, or identify groups that experience the highest disparities in access to substance use care. Below is the rank order.

1. African American/Black Americans
2. Latino/a
3. Undocumented Persons
4. Native Americans / Tribal members
5. Recent Immigrants
6. Asian Americans
7. LGBTQIA+ Persons
8. Foster Youth
9. Justice-Involved Persons
10. Pacific Islander Americans
11. Caucasian/White

1. Children 0 – 12
2. Adolescents 12 – 15
3. Transitional Age Youth 16 – 25
4. Adults 26 – 65
5. Older Adults/Seniors 66+

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INTERVIEW FINDINGS

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STAKEHOLDER ENGAGEMENT – COMPLETED AND PLANNED

- As a part of this project, HMA interviewed individuals from the organizations below. In several instances, multiple individuals from an organization were interviewed.
- The following slides contain themes and takeaways from the interviews. The themes are presented as strengths and opportunities for improvement/unmet needs in the following areas:
  - The behavioral health landscape
  - County services and operations
  - The Community Planning Process

Organization
Asian American Resource Center
Boys Republic
Inland Empire Health Plan
Ontario-Montclair School District Counseling Center
Pacific Clinics
Reach Out
Riverside-San Bernardino County Indian Health
San Bernardino County Behavioral Health (Note: This included providers of BH services)
South Coast Counseling Services

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FINDINGS FROM INTERVIEWS – BEHAVIORAL HEALTH LANDSCAPE

Strengths

- Strong network of local provider organizations
- Organizations support one another and have forums for collaboration (e.g., Association of Community Based Organizations)
- Diverse set of services across the continuum available to the community
- Telehealth expansion has helped to address transportation issues
- Growing school-based behavioral health services and more openness to engage in services by youth
- Utilization of the CANS and Objective Arts System has been good and supports coordination

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FINDINGS FROM INTERVIEWS – BEHAVIORAL HEALTH LANDSCAPE

Opportunities For Improvement & Unmet Needs

Access/Service Availability

- Lack of awareness of available resources in the community which results in duplication of effort and/or gaps in care
- Long waitlists and delays in care – 6+ months in some cases
- Areas needing additional service capacity:
  - Substance use disorder treatment
    - In schools
    - Residential
    - Inpatient psych
  - Crisis
    - Walk-in center
  - Children/youth services
- Transportation is a barrier, especially for rural communities
- Limited hours restricts access to those who are working traditional hours
- Coordination around meeting SDOH is needed to improve access and outcomes
  - Transportation and housing mentioned frequently
  - Food insecurity and clothing mentioned as needs as well

Workforce

- Staffing shortages across the behavioral health system (psychiatrists in particular)
- Inability to pay competitive wages – providers are losing staff to Kaiser and private practice

Cultural Responsiveness/Disparity Reduction

- Need more specialized services for BIPOC and LGBTQIA+ communities
- Need to build more trust and efficacy with marginalized communities, especially the BIPOC community
- Need expanded language capacities

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FINDINGS FROM INTERVIEWS – COUNTY BHD SERVICES & OPERATIONS

Strengths

- Collaborative relationship between the County and providers
- There's a willingness to work with providers to address issues
- The County has helped to broker relationships between organizations
- The County seems to genuinely care and they try for their clients and providers
- The County is always looking for other funding streams to support work
- They're attempting to be more data-driven (although, it's a work in progress)

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FINDINGS FROM INTERVIEWS – COUNTY BHD SERVICES & OPERATIONS

Opportunities For Improvement & Unmet Needs

Implementation

- Implementation of new initiatives can be slow and are perceived as needing more intentional coordination
  - The lack of coordination and clarity of expectations puts an extra burden on providers that takes away from time dedicated to client care
- CalAIM and related initiatives were perceived to have slower and less clearly communicated rollouts in SB than in other counties which led to confusion and implementation challenges

Collaboration

- Better collaboration between county and state is needed – providers are negatively impacted by lack of alignment
- The County struggles to support contractors due to a lack of staffing – slow in getting responses, amending contracts, making decisions, etc. This can negatively impact providers' financial stability and service delivery.

Operations

- The fiscal review/audit process is punitive and occurs long after errors have occurred
  - "Clawing back" of funding occurs years after service delivery and is inflexible
- Accessing county services is complicated and results in clients not being able to connect with services
  - Interviewees reported: Too many calls, steps, and requirements
  - Need to consider linguistic, cultural, and educational barriers

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FINDINGS FROM INTERVIEWS – COMMUNITY PLANNING PROCESS

Strengths

- The County has tested multiple strategies for outreach, including partnering with organizations to host meetings, virtual forums, surveys, etc.
- The intent behind the process and sub-committees is good
- They promote the sessions to providers and the community
- The County is generally good about receiving programmatic feedback (not good at receiving feedback regarding fiscal procedures)

Opportunities & Unmet Needs

- Intentional design of meetings could help minimize meeting fatigue/burnout:
  - Goals of CPP need to be more clearly defined to audience
  - Sessions can be too technical and could benefit from focusing on application rather than statistics.
  - Meetings should result in more tangible action
- Need representation from those who have had difficulty engaging as those individuals may have important perspectives
- Consider providing other, lower-barrier methods to engage and share information – such as social media updates, apps, etc.
- Several individuals interviewed had never heard of the CPP process

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FOCUS GROUP FINDINGS

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FOCUS GROUP FINDINGS

- The following slides contain themes and takeaways from focus groups with individuals with lived experience.
- HMA conducted focus groups with a total of 220+ participants. Below is a list of the groups engaged:
  - Mental Health and SUD Service Recipients (4 focus groups)
  - Yucca Valley Clubhouse
  - Yucca Valley Family Resource Center
  - Rialto Clubhouse
- Participants were asked about their experiences, barriers to access, unmet needs, and strengths. They were also asked to score – on a scale from 1 to 5 – the county's ability to engage clients in developing programs/services and in communicating about programs/services.

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FOCUS GROUP FINDINGS

Summary of Themes: Yucca Valley Family Resource Center

Strengths

- **Information Sources:** Participants reported having supportive networks available to them introducing and informing them about available resources.
- **Available Programs and Services:** Clubhouses and crisis centers provide critical support in times of need.
- **Appreciated Services:** Participants reported high appreciation of available services such as mental health providers, clubhouses, and social security benefits.

On average, participants rated the county's ability to engage clients in developing programs and services as a **1 out of 5.**

On average, participants rated the county's communication around programs and services as a **1 out of 5.**

Opportunities & Unmet Needs

- **Communication:** Improve awareness and communication around available programs and services.
- **Engagement:** Enhance engagement with clients and patients in developing programs.
- **Service Availability:** Additional clubhouses, residential, and outpatient treatment centers with flexible hours.
- **Transportation:** Expand public transportation options, including more frequent buses and weekend services. Provide transportation assistance for individuals accessing mental health and SUD services.
- **Access Barriers**: Long waits, bureaucracy, high living costs, and housing access issues.
- **Mental Health**: Shortage of medication, providers, and experienced therapists.
- **Substance Use Services:** Insufficient treatment centers, inconsistent medication management, and lack of incentive programs.

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FOCUS GROUP FINDINGS

Summary of Themes: Yucca Valley Clubhouse

Strengths

- **Information Sources:** Word of mouth, referrals (outpatient, PCP, parole officer).
- **Appreciated Services:** Participants expressed having supportive counselors.
- **Clubhouse Programs:** Participants found significant value in clubhouse support groups (grief, mindfulness support, co-dependency, and substance use groups).
- **Personalized Care:** One-on-one therapy services are highly valued, with participants noting significant positive impacts on their mental health and well-being.

On average, participants rated the county's ability to engage clients in developing programs and services as a **1.5 out of 5.**

On average, participants rated the county's communication around programs and services as a **1 out of 5.**

Opportunities & Unmet Needs

- **Communication:** Enhance awareness of services (e.g., 988 hotline), better advertisement of available resources (billboards, flyers, etc.).
- **Service Availability:** Increase evening/weekend services, diversify support groups, and provide more psychiatric services and suicide prevention resources.
- **Transportation & Financial Support:** Address transportation and financial barriers and improve support for those ineligible for services.
- **Access Barriers**: Transportation, financial limitations, long waitlists, limited staffing, and lack of service availability in rural areas.
- **Mental Health Services:** Specific services for veterans, increased awareness and availability of psychiatric care, and more diverse support groups.
- **Substance Use Services**: Need for veteran centers, residential and outpatient sober living facilities, and youth services.

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FOCUS GROUP FINDINGS

Summary of Themes: Rialto Clubhouse

Strengths

- **Information Sources:** Participants learn about services through word of mouth, counselors, organizations (Caso Paseo), PCP, and psychiatrists.
- **Knowledge of Services:** Participants demonstrated a high level of awareness and appreciation for various services. These include clubhouse support. (socialization, meals), IEHP Car Ride, and the STAY housing program.
- **Effective Programs:** Participants highlighted effective programs including sober living facilities (Cedar House, River Community, Caso Paseo), supportive social workers, and coordinated primary care services.

On average, participants rated the county's ability to engage clients in developing programs and services as a **4 out of 5.**

On average, participants rated the county's communication around programs and services as a **3 out of 5.**

Opportunities & Unmet Needs

- **Improve Communication & Training:** Increase awareness and ads of services (988 hotline).
- **Service Availability:** Extend evening/weekend hours, broaden mental health management classes, and improve transportation options (e.g., bus passes like Riverside County).
- **Support for Unhoused Individuals:** Develop approaches to better serve individuals with mental health and substance use services.
- **Access Barriers:** Lack of medication management appointments, transportation, and accessible service hours.
- **Mental Health/SUD Services:** Need for more health education, culturally competent care, and diverse support groups.
- **Housing:** Long waits for housing programs and insufficient availability.
- **Cultural Responsiveness/Disparity Reduction:** Train healthcare professionals in cultural competence, and increase the availability of interpreters, including sign language.

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FOCUS GROUP FINDINGS

Summary of Themes: Individuals who have experience with substance use services

Strengths

- **Information Sources:** Participants learn about services through social media, other online research, their friends, and their PCP.
- **Effective Programs:** Participants highlighted the County's effective crisis intervention programs and successful utilization of community crisis response teams.
- **Access to Information:** Participants emphasized the volume of information and resources available to them and that accessing information is easy.

On average, participants rated the county's ability to engage clients in developing programs and services as a **3.5 out of 5.**

On average, participants rated the county's communication around programs and services as a **3.5 out of 5.**

Opportunities & Unmet Needs

- **Substance Use Disorder Services:** Need for more early prevention programs focused on substance use.
- **Stigma Reduction:** Address stigma and racial bias within the healthcare space. Increase education efforts to reduce stigma and promote help-seeking behaviors.
- **Financial Support:** Address economic and financial instability and improve financial aid supports for those ineligible for services.
- **Workforce Diversity:** Enhance cultural competency and linguistic diversity in services to better serve the county's diverse population.
- **Continuous Program Evaluation**: Improve data collection and evaluation to inform service development and understand the evolving needs of the community.
- **Partnership:** Foster collaboration between healthcare, criminal justice, and social services to provide comprehensive support.

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FOCUS GROUP FINDINGS

Summary of Themes: Individuals who have experience with substance use services

Strengths

- **Information Sources:** Participants learn about services through social media, other online research, their friends/family, and their PCP.
- **Appreciated Services:** Many of the participants expressed appreciation for the county's mental health, counseling, and therapeutic services.
- **Effective Outreach Programs:** Participants expressed positive experiences with various community outreach programs.
- **Peer Supports:** Participants acknowledged the access to and availability of a range of peer support groups.

On average, participants rated the county's ability to engage clients in developing programs and services as a **4 out of 5.**

On average, participants rated the county's communication around programs and services as a **4 out of 5.**

Opportunities & Unmet Needs

- **Access Barriers:** Continue to leverage technology, such as telehealth and online resources, to increase access to services.
- **Financial Support:** Increase accessibility by addressing financial barriers to affordable treatment options.
- **Substance Use Disorder Services:** Explore opportunities to increase recovery support services (e.g., Detoxification Services, Naloxone Distribution, and affordable Medication Assisted Treatment).
- **Long Wait Times:** Advocate and seek out opportunities for increased funding to expand substance use and treatment program services and reduce wait times.
- **Awareness:** Ensure all community members are aware of available resources through targeted outreach, educational sessions/workshops, and collaboration across departments.
- **Evaluate Services:** Continually assess and address both strengths and weaknesses of offered services to ensure they effectively meet the needs San Bernadino residents.

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FOCUS GROUP FINDINGS

Summary of Themes: Individuals who have experience with substance use services

Strengths

- **Information Sources:** Participants learn about services through their friends/family and online.
- **Appreciated Services:** Many of the participants expressed appreciation for the county's counseling and various support services.
- **Effective Programs:** Participants expressed community-based programs are working well.

On average, participants rated the county's ability to engage clients in developing programs and services as a **4 out of 5.**

On average, participants rated the county's communication around programs and services as a **4 out of 5.**

Opportunities & Unmet Needs

- **Transportation Barriers:** Continue to improve transportation options (e.g., bus passes like Riverside County).
- **Cultural Competency:** Increase mental health services that are culturally sensitive and tailored to diverse populations.
- **Access Barriers:** Continue to leverage technology, such as telehealth and online resources, to increase access to services
- **Aftercare and Support:** Expand ongoing support and aftercare services, such as sober living environments and support groups.
- **Continual Education:** Seek additional opportunities for culturally appropriate trainings and workshops for the personnels across departments.

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OBSERVATIONAL FINDINGS FROM CPP MEETINGS

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OBSERVATIONAL FINDINGS OF CPP

HMA consultants attended (virtually and in-person) several meetings that were a part of the Community Planning Process.

Below are several observational findings:

- Meetings were well attended
- A wide array of special population meetings have been held
- Information shared by the County with participants meets CLAS standards
- Participants were engaged and given opportunities to provide feedback
- The process of submitting written comments could be streamlined (requires submitting a form)
- The County is doing a better job at connecting the dots between the Mental Health Services Act and the Community Planning Process

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