



Artwork by Alfredo Davalos

Mental Health Services Act

Annual Update for Fiscal Year 2024/2025

Message from the Director

Welcome

On behalf of the Department of Behavioral Health (DBH) staff, community partners, providers, and stakeholders, we thank you for your interest in the Mental Health Services Act (MHSA) Annual Update for Fiscal Year (FY) 2024/25.

Since 2005, MHSA has allowed the Department to develop a robust system of community-informed behavioral health services in partnership with a diverse group of stakeholders. It is these stakeholders, partners, consumers, and community members that provide DBH with the understanding needed to make informed decisions concerning MHSA-funded programs. We look forward to continuing these collaborative efforts to promote wellness, recovery, and resilience throughout San Bernardino County.

In addition to the MHSA Three-Year Plan for FYs 2023/24-2025/26, the Annual Update provides the Department the opportunity to highlight the achievements of DBH and contracted partner programs during the previous fiscal year (FY 2022/23), demonstrate how community input has shaped DBH programming and implementation, and provide updates, or changes, to existing MHSA programs.

DBH engages in the continuous evaluation of programs and fiscal projections to ensure services are meeting the needs of the consumers and community. Program changes are made with the goal of building an integrated, seamless, and outcome-oriented behavioral health system that advances health equity and ensures critical services are available to those in need by eliminating health disparities across race, gender, sexual orientation, income, and geographic location. In support of this goal, the following program changes and enhancements highlight DBH's commitment to align its behavioral health programming to the needs identified by stakeholders, partners, consumers, and community members.

Highlights of the plan include expansion of programs to allow for service area expansion and serving additional regions and county populations; program expansion to create more places for people to connect with mental health and substance use disorder services; enhanced collaboration for the coordination of treatment; continued growth of peer support staff and enrichment of community education programs; heightened availability of crisis services; and implementation of successful innovative practices across our continuum of care.

Message from the Director

I hope you will find the MHSA Annual Update informative and a depiction of our efforts to remain focused on MHSA programming that supports a healthy county and is meeting the specific needs of our community with an emphasis on culturally appropriate and inclusive care.

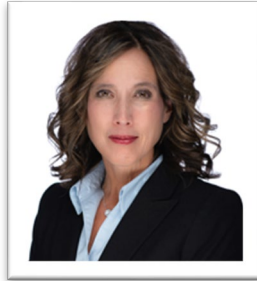
Thank you for taking the time to review and provide feedback on this plan. The DBH Mental Health Services Act Administration looks forward to receiving your input at MHSA@dbh.sbcounty.gov.

Sincerely,

A handwritten signature in black ink, appearing to read 'G. Yoshioka', with a long horizontal flourish extending to the right.

Georgina Yoshioka, DSW, LCSW, MBA
Director

San Bernardino County, Department of Behavioral Health



Mensaje de la Directora

Bienvenido

En nombre del personal del Departamento de Salud Mental (DBH por sus siglas en inglés), los aliados comunitarios, los proveedores y las partes interesadas, le agradecemos su interés en la Actualización Anual de la Ley de Servicios de Salud Mental (MHSA por sus siglas en inglés) para el año fiscal (FY) 2024/25.

Desde 2005, la MHSA ha permitido al Departamento desarrollar un sistema sólido de servicios de salud mental informados por la comunidad en asociación con un grupo diverso de partes interesadas. Son estas partes interesadas, aliados, consumidores y miembros de la comunidad quienes brindan a DBH la comprensión necesaria para tomar decisiones informadas sobre los programas financiados por la MHSA. Esperamos continuar con estos esfuerzos de colaboración para promover el bienestar, la recuperación y la resiliencia en todo el condado de San Bernardino.

Además del Plan Trienal de la MHSA para los años fiscales 2023/24-2025/26, la Actualización Anual brinda al Departamento la oportunidad de resaltar los logros de DBH y los programas de aliados contratados durante el año fiscal anterior (año fiscal 2022/23), demostrar cómo los aportes de la comunidad han dado forma a la programación e implementación de DBH, y proporcionar actualizaciones o cambios a los programas MHSA existentes.

DBH participa en la evaluación continua de programas y proyecciones fiscales para garantizar que los servicios satisfacen las necesidades de los consumidores y la comunidad. Los cambios en el programa se realizan con el objetivo de construir un sistema de salud mental integrado, fluido y orientado a resultados que promueva la equidad en salud y garantice que los servicios críticos estén disponibles para quienes los necesitan al eliminar las disparidades de salud por raza, género, orientación sexual, ingresos y ubicación geográfica.

En apoyo de este objetivo, los siguientes cambios y mejoras del programa resaltan el compromiso de DBH de alinear su programación de salud mental con las necesidades identificadas por las partes interesadas, aliados, consumidores y miembros de la comunidad.

Los aspectos más destacados del plan incluyen la expansión de programas para permitir expansión del área de servicio y servicio a regiones y poblaciones del condado adicionales; expansión del programa para crear más lugares para que las personas se conecten con servicios de salud mental y trastornos por uso de sustancias; colaboración mejorada para la coordinación del tratamiento; crecimiento continuo del personal de apoyo entre pares y enriquecimiento de los programas educativos comunitarios; mayor disponibilidad de servicios de crisis; e implementación de prácticas innovadoras exitosas en toda nuestra atención continua.

Mensaje de la Directora

Espero que la Actualización Anual de MHSA le resulte informativa y una descripción de nuestros esfuerzos para permanecer enfocados en la programación de MHSA que apoya un condado saludable y satisface las necesidades específicas de nuestra comunidad con énfasis en una atención inclusiva y culturalmente apropiada.

Gracias por tomarse el tiempo para revisar y brindar comentarios sobre este plan. La Administración de la Ley de Servicios de Salud Mental del DBH espera recibir sus comentarios en MHSA@dbh.sbcounty.gov.

Atentamente,



Georgina Yoshioka, DSW, LCSW, MBA
Directora

Condado de San Bernardino, Departamento de Salud Mental

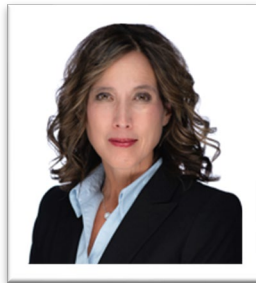


Table of Contents

<u>Title</u>	<u>Page</u>	<u>Title</u>	<u>Page</u>
Message from the Director	1	PEI CI-1: Promotores de Salud/Community Health Worker (PdS/CHW)	67
Message from the Director (Spanish)	3	PEI CI-4: Behavioral Health Ministries Pilot Project (BHMPP)	85
Table of Contents	5	PEI CI-5: Substance Use Prevention & Pathways to Outreach and Treatment (SUPPORt)	98
MHSA County Compliance Certification	9	Access and Linkage to Treatment	
MHSA Fiscal Accounting Certification	10	PEI SE-2: Child and Youth Connection (CYC)	106
MHSA Prudent Reserve Assessment/Reassessment Certification	11	Prevention	
Community Program Planning (CPP)	12	PEI SI-2: Preschool PEI Program (PPP)	121
Overview of San Bernardino County	13	PEI SI-3: Resilience Promotion in African American Children (RPIAAC)	135
Introduction	14	PEI SE-1: Older Adult Community Services (OACS)	146
MHSA Annual Update: CPP Process	19	PEI SE-5: Lift Program	164
Summary of Program Changes	33	PEI SE-6: Coalition Against Sexual Exploitation (CASE)	176
Overview of Public Posting and Comment Period	37	Prevention and Early Intervention	
Improvements in Progress	39	PEI CI-2: Family Resource Center (FRC)	187
Prevention and Early Intervention (PEI)	41	PEI SE-3: Community Wholeness and Enrichment (CWE)	200
Introduction	42	PEI SE-4: Military Services and Family Support (MSFS)	212
Stigma and Discrimination Reduction			
PEI CI-3: Native American Resource Center (NARC)	56		
Outreach for Increasing Recognition of Early Signs of Mental Illness			

Table of Contents

Title	Page	Title	Page
PEI SI-1: Student Assistance Program (SAP)	228	• Adult	281
PEI SE-7: Improving Detection and Early Access (IDEA)	240	• Transitional Age Youth (TAY)	286
Suicide Prevention		Peer Programs	
PEI SE-8 Office of Suicide Prevention (OSP)	243	A-1: Peer Programs	289
Community Services and Support (CSS)	245	Outreach, Access, and Engagement Programs	298
Introduction	246	A-9: Access, Coordination, and Enhancement (ACE) of Quality Behavioral Health Services	300
Crisis System of Care	252	A-15: Recovery Based Engagement Support Teams (RBEST)	304
A-5: Triage Transitional Services (TTS)	254	Full Service Partnerships	309
A-6: Community Crisis Services	257	C-1: Comprehensive Children and Family Support Services (CCFSS)	312
• Community Crisis Response Team (CCRT)		• Children's Residential Intensive Services (ChRIS)	
A-16: Crisis Intervention Collaborative Programs		• Wraparound	
• Crisis Intervention Training (CIT)	261	• Success First//Early Wrap	
• Community Education Program (CEP)	265	C-2: Integrated New Family Opportunities (INFO)	323
• Triage, Engagement, and Support Teams (TEST)	266	TAY-1: One Stop Transitional Age Youth (TAY) Centers	326
Crisis Stabilization System of Care	271	A-2: Forensic Services Continuum of Care	332
A-4: Crisis Stabilization Units (CSU)/Crisis Walk-In Centers (CWIC)	273	• Supervised Treatment After Release (STAR)	
A-10: Crisis Residential Treatment (CRT) Programs	281		

Table of Contents

<u>Title</u>	<u>Page</u>	<u>Title</u>	<u>Page</u>
A-2: Forensic Services Continuum of Care (cont.)		OA-1: Age Wise	361
- 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) - Choosing Healthy Options to Instill Change and Empowerment (CHOICE) - Re-Integrative Supportive Engagement Services (RISES)		Homeless Services, Long-Term Supports, and Transitional Care	
A-3: Assertive Community Treatment (ACT) Model FSP Services	342	A-7: Housing and Homeless Services Continuum of Care Programs (HHSCCP)	365
A-11: Regional Adult Full Service Partnership (RAFSP)	348	- Homeless Outreach Support Team (HOST) - Full Service Partnership (FSP) and Supportive Services Program	
A-20: Collaborative Adult Full Service Partnership Services	354	A-13: Adult Transitional Care Programs	374
- Community Reintegration Services (CRS) - Recovery Based Engagement Support Teams (RBEST) – Assisted Outpatient Treatment (AOT)	356 359	- Adult Residential Facilities (ARF) 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)	377 380 382 385
		Innovation (INN)	387
		Introduction	388
		INN-08: Innovative Remote Onsite Assistance Delivery (InnROADs)	391
		INN-09: Eating Disorder Collaborative (EDC)	396
		INN-10: Multi-County Full Service Partnership (FSP) Project	399

Table of Contents

<u>Title</u>	<u>Page</u>
INN-11: Cracked Eggs	404
INN-12: Progressive Integrated Care Collaborative (PICC)	407
Workforce Education and Training (WET)	411
Capital Facilities and Technological Needs (CFTN)	430
Fiscal	437
MHSA Budgets	439
Attachments	447



Artwork by Sondra Savage

MHSA COUNTY COMPLIANCE CERTIFICATION

County/City: San Bernardino

☐ Three-Year Program and Expenditure Plan

☒ Annual Update

Local Mental Health Director	Program Lead
Name: Georgina Yoshioka, DSW, MBA, LCSW	Name: Dr. Rebecca Scott Young
Telephone Number: (909) 252-5142	Telephone Number: (909) 252-4046
E-mail: Georgina.Yoshioka@dbh.sbcounty.gov	E-mail: MHSA@dbh.sbcounty.gov
Local Mental Health Mailing Address: Department of Behavioral Health 303 East Vanderbilt Way San Bernardino, CA 92415	

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

This Three-Year Program and Expenditure Plan or Annual Update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft Three-Year Program and Expenditure Plan or Annual Update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on June 11, 2024.

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

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

Dr. Georgina Yoshioka
Local Mental Health Director (PRINT)

Signature Date

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION¹

County/City: San Bernardino

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

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Georgina Yoshioka, DSW, MBA, LCSW	Name: Ensen Mason, CPA, CFA
Telephone Number: (909) 252-5142	Telephone Number: (909) 382-7000
E-mail: Georgina.Yoshioka@dbh.sbcounty.gov	E-mail: Ensen.Mason@sbcountyatc.gov
Local Mental Health Mailing Address:	
Department of Behavioral Health 303 East Vanderbilt Way San Bernardino, CA 92415	

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

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

Dr. Georgina Yoshioka

Local Mental Health Director (PRINT)SignatureDate

I hereby certify that for the fiscal year ended June 30, 2023, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated February 29, 2024 for the fiscal year ended June 30, 2023. I further certify that for the fiscal year ended June 30, 2023, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

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

Ensen Mason

County Auditor Controller / City Financial Officer (PRINT)SignatureDate

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

MENTAL HEALTH SERVICES ACT PRUDENT RESERVE ASSESSMENT/REASSESSMENT

County/City: San Bernardino County

Fiscal Year: FY 2024/2025

Local Behavioral Health Director

Name: Georgina Yoshioka, DSW, MBA, LCSW

Telephone: (909) 252-5142

Email: Georgina.Yoshioka@dbh.sbcounty.gov

I hereby certify¹ under penalty of perjury, under the laws of the State of California, that the Prudent Reserve assessment/reassessment is accurate to the best of my knowledge and was completed in accordance with California Code of Regulations, Title 9, section 3420.20 (b).

Dr. Georgina Yoshioka

Local Behavioral Health Director
(PRINT NAME)

Signature

Date

¹ Welfare and Institutions Code section 5892 (b)(2)
DHCS 1819 (Revised 11/2022)



MHSA Annual Update for FY 24/25: Community Program Planning

Overview of San Bernardino County

San Bernardino County is located in Southeastern California, approximately 60 miles inland from the Pacific Ocean. It is the largest county in the continental United States in terms of land mass, covering over 20,000 square miles. There are 24 cities in the County and multiple unincorporated and census-designated places.

Over 81% of the land is owned by federal agencies (Federal Bureau of Land Management and the Department of Defense). The County has four (4) active military bases, utilizing 13% of the land. These include Fort Irwin, Marine Corps Air Ground Combat Center Twentynine Palms, Marine Corps Logistics Base Barstow, and Twentynine Palms Strategic Expeditionary Landing Field.

According to the United States Census Bureau, the estimated population is 2,194,710 (*Source*: US Census Bureau). Approximately half of the County's population resides in the West Valley (29%) and East Valley (25.2%) region, accounting for only 2.5% of the land. The remaining population resides in the Central Valley (20.7%) and Desert or Mountain regions (24.5%). The remaining .2% of the population is unknown.

The residents of San Bernardino County fall into the following age groups: 44.9% are adults between the ages of 26 and 59 years old, 22.9% are children under the age of 15, 17.7% are older adults (age 60 and over), and the remaining 14.5% are between the ages of 16 and 25 years old.

San Bernardino County is the fifth largest county in California in terms of population and ethnic diversity. The largest ethnic population in the County is Latinx/Hispanic (55.8%), followed by Caucasian (24.8%), Asian/Pacific Islander (8.1%), African American/Black (7.6%), and Native American (0.2%). The remaining 3.5% is unknown.

The gender breakdown is even, with 50% male and 50% female.

Geographic Region

21% Central Valley	25% East Valley
25% Desert/Mountain	29% West Valley

Age

23% Children (0-15)	45% Adults (26-59)
14% TAY (16-25)	18% Older Adults (60+)

Race/Ethnicity

8% African American/Black	56% Latinx/Hispanic
8% Asian/Pacific Islander	<1% Native American
25% Caucasian/White	3% Other/Unknown

Gender Identity

50% Female	50% Male

N=2,194,710

Source: State of California Department of Finance and United States Census Bureau

Introduction

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

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

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

DBH ensures attendance by maintaining a published schedule of meetings and advertising these meetings using social media, press releases, other county departments, and an expansive network of community partners and contracted vendors. To ensure participation from diverse stakeholders, meetings include interpreter services, or as the occasion dictates, meetings held in languages other than English.

Community Program Planning

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

- Mental health policy
- Program planning
- Implementation
- Monitoring
- Quality improvement
- Evaluation
- Budget allocations

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

Many meeting locations are coordinated in all regions of San Bernardino County, virtual meetings are available for remote communities or for individuals who are unable to attend an in-person session or prefer the web format.

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

- Behavioral Health Commission (BHC): 12 annual meetings held monthly

- District Advisory Committee meetings: 5 quarterly meetings, one held in each of the five supervisorial districts within the county and led by the Behavioral Health Commissioners in each district
- Community Policy Advisory Committee (CPAC): 12 monthly meetings
- Cultural Competency Advisory Committee (CCAC), along with 14 separate cultural specific subcommittees: 15 monthly meetings
- Transitional Age Youth (TAY) Advisory Boards
- MHSA Executive Committee meetings

Note: A regularly scheduled meeting may be rescheduled or cancelled by the attendee's collective agreement.

Additional regular stakeholder engagement and education meetings include:

- Quarterly PEI Provider Network meetings
- Clubhouse Governing Board meetings
- DBH Peer and Family Advocate employee meetings
- Substance Abuse Provider Network (SAPN) meetings
- Association of Community Based Organizations (ACBO)

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

Cultural Competency

DBH has a commitment to cultural competency and ensuring this value is incorporated into all aspects of DBH policy, programming, and services, including planning, implementing, and evaluating programs. To ensure cultural competency in each of these areas, DBH has established the Office of Equity & Inclusion (OEI) which reports to the DBH Director, a Cultural Competency Advisory Committee, and 14 monthly cultural subcommittees and coalitions.

These elements are an essential part of the stakeholder process including the use of the regularly scheduled committee and subcommittee meetings to obtain feedback and input on services and programs. The Equity and Cultural Competency Officer (CCO) and the OEI work in conjunction with MHSA program leads to ensure compliance with cultural competency standards and to ensure that the services provided address cultural and linguistic needs. The CCO or OEI staff regularly sit on boards or committees to provide input or effect change regarding program planning or implementation. OEI also provides support by translating documents for the department, as well as coordinating interpretation services for stakeholder outreach, meeting, and training events.

Language regarding cultural competence is included in all department contracts with community-based organizations and individual providers to ensure contract services are provided in a culturally competent manner. Additionally,

cultural competence is assessed in each DBH employee's annual Work Performance Evaluation (WPE).

DBH is highly committed to including consumers, family members, and other stakeholders within all levels of our organizational structure. Our mission has been to include consumers and family members in an active system of stakeholders. Within DBH's organizational structure, the Office of Consumer and Family Affairs (OCFA) is elevated, reporting to the Equity and Cultural Competency Officer, with access to the Department Director. Outreach to consumers and family members is performed through the OCFA, the Department's Public Information Office, DBH's four TAY centers and DBH's nine consumer clubhouses, and by contracted provider agencies to encourage regular participation in MHSA activities.

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

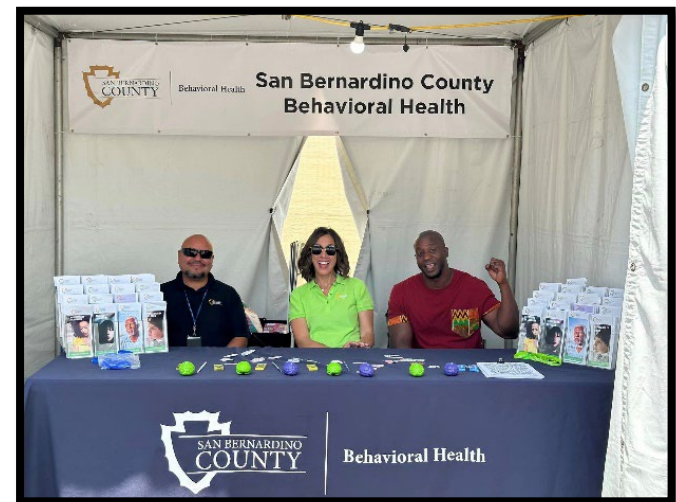
Public Relations and Outreach

The Public Relations and Outreach (PRO) division promotes services to people who have experienced mental illness or substance use disorders. PRO works to reduce stigma through education, awareness, and outreach. Utilizing strategic communication and community engagement, they advocate for all people to enjoy optimum wellness.

PRO participated in 214 (virtual and in-person) outreach events in FY 2022/2023. Outreach to targeted populations consisted of partnerships with committees and organizations. DBH participated in events focused on African American/Black, Latinx/Hispanic, and LGBTQ+ populations at community staple events such as San Bernardino Pride, CEEM Black Excellence Weekend, and the Mexican Consulate Annual Resource Fair. Targeted populations include African American/Black, Latinx/Hispanic, faith-based, youth, TAY, LGBTQ+, reentry, and unhoused populations.



DBH highlights Mental Health Awareness month in May. In FY 2022/2023, DBH participated in 34 outreach events in May, spanning the entire San Bernardino County service area. Some notable events include the The Behavioral Health Commission Mental Health Awareness Kick-Off Meeting, Directing Change Film and Awards Ceremony, The Resilient and Real Summit Live Podcast, and the Meet the Artist Art Exhibit. The San Bernardino County Board of Supervisors adopted the proclamation declaring September as National Recovery Month through the year 2028 throughout San Bernardino County and called upon its citizens, government agencies, public and private institutions, and faith-based organizations to reaffirm the countywide commitment to increase awareness and understanding of substance use disorders.



Community Program Planning

"Thank you so much for being here, and thanks for what you do. You all are making such an impact. Your resources and presence are so needed in this environment today. Continue the good work."

- Consumer

"I didn't know what self-care means. Today I do because of you. Thank you. I need to work on my self-care."

- Consumer

Success Story

My highlight of being a part of the outreach team is seeing the light go on in someone's eyes because you have given them a glimmer of hope that there is help there. There are programs to help them through whatever problems they may be facing, and they are qualified to receive that help. Help they didn't know existed.

- Outreach Taskforce Member

Success Story

At an outreach event with Children Support Services, a woman who was a foster parent of many children, including teenagers, came up to me. She said she was concerned about the behavior of one of her children. I suggested some pamphlets and pointed out the number on the brochure. I said if she called the access line and explained her needs in detail, they would assist in connecting her with the resources she needed. I also brought to her attention how she could obtain Narcan to have in her home just in case one of her foster family overdosed. I suggested she get some Fentanyl test strips to have on hand in case she ran across a substance she was concerned with and Detera pouches to dispose of any questionable substances she might come across. We talked for quite some time. I could tell she was overwhelmed and grateful to be given so much helpful information.

- Outreach Taskforce Member

MHSA Annual Update: Community Program Planning Process

DBH is fully committed to a year-round stakeholder engagement process. Preparation and development of this MHSA Annual Update included meetings hosted in multiple county and community venues in person and on virtual platforms. Meetings were available to each region of the County at Family Resource Centers and were also available in Spanish for monolingual Spanish-speaking county residents. A total of **39** scheduled meetings were held throughout San Bernardino County.

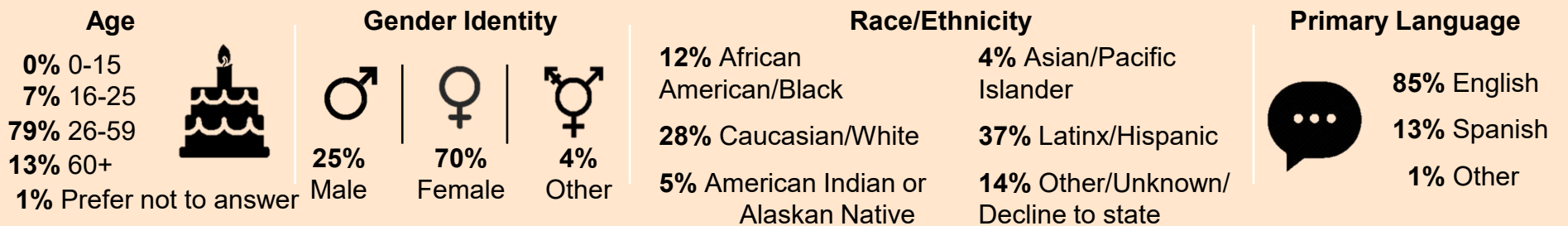
To meet the requirements of the MHSA, outreach was conducted to promote the MHSA Annual Update Community Program Planning (CPP) process. Various methods were used to allow all stakeholders, including consumers, family members, community members, and partner agencies to have their feedback included and their voice heard. This included distribution of emails and flyers to community partners, community and contracted organizations, other county agencies, cultural subcommittees, and regularly scheduled stakeholder meetings, such as the San Bernardino County

Behavioral Health Commission. These materials were distributed in both English and Spanish to representatives of our diverse population. Social media sites, such as Facebook, Twitter, Pinterest, YouTube, and Instagram, were also used to extend the department’s reach in connecting interested community members with the stakeholder process. DBH’s social media outlets can be accessed by clicking the icons below from the electronic version of this report.



The MHSA Administrative Manager and Component Leads, in conjunction with the OEI and Public Relations and Outreach (PRO), are responsible for coordinating and managing the CPP process. This process was built upon existing stakeholder engagement components, mechanisms, and collaborative networks within the behavioral health system and evolved out of the original CPP initiated in 2005.

MHSA Annual Update CPP Demographics



N= 286 **Note:** Not every participant responded to the survey. Not all numbers add to 100 due to rounding.

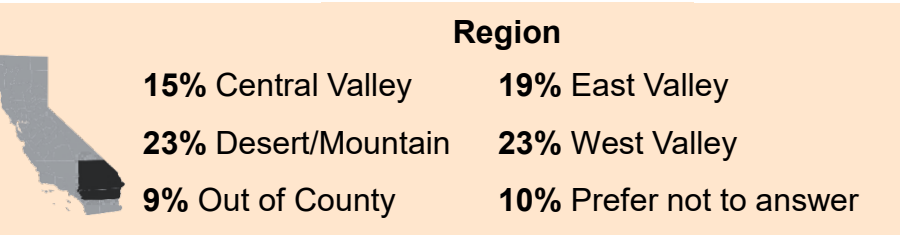
Community Program Planning

Participation by key groups of stakeholders included, but were not limited to:

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

As listed in the schedule, special sessions of the Behavioral Health Commission’s District Advisory Committee (DAC), along with other meetings, were conducted in each geographic region of the county.

MHSA Annual Update CPP Demographics



N=286 **Note:** Not every participant responded to the survey. Not all numbers add to 100 due to rounding.

This schedule ensured representation and participation in each region of San Bernardino County. To ensure the participation of unserved, underserved, or inappropriately served cultural groups, the OEI provided stakeholder engagement meetings for the MHSA Annual Update for each of their 14 Cultural Competency Advisory subcommittees. To further include community involvement, sessions were held in collaboration with Family Resource Centers, Clubhouses, and other community agencies such as the Department of Aging and Adult Services Senior Affairs Commission. Additionally, the PEI Provider meeting held sessions to include contract providers. DBH staff were able to host a discussion with diverse attendees about the background and intent of the MHSA, the MHSA Annual Update, and proposed program changes, as well as obtain feedback and recommendations for system improvement.

To ensure that stakeholders could fully benefit from the community meetings, OEI staff arranged for Spanish, American Sign Language, and Vietnamese interpretation, upon request, at each meeting. As an incentive for participation, Clubhouse members were delivered snacks to enjoy during stakeholder sessions.

Community Program Planning

To increase participation opportunities across the county, the department hosted additional online sessions on January 25, 2024, from 9 to 10 a.m. and February 8, 2024, from 5 to 6 p.m. These sessions provided additional opportunities for individuals unable to attend one of the regularly scheduled meetings to participate via computer, smartphone, and other technological devices.

At the end of the presentations, the facilitator opened the presentation to encourage discussion, allow stakeholders to have questions answered, and provide input. Once the question-and-answer session concluded, participants were advised about additional opportunities to provide feedback. The link to the survey was provided in the presentation, and participants were also provided information for alternative methods to provide input and feedback, including the email address, phone number for the MHSA Administration staff, and

a link to the MHSA Issue Resolution that can be accessed at: <http://wp.sbcounty.gov/dbh/wp-content/uploads/2021/08/COM0947.pdf>

The MHSA Annual Update was presented at the Cultural Competency Advisory Committee on Thursday, January 18, 2024, to ensure additional opportunities to stakeholders to interact with decision making staff.

To further support this Community Planning Process effort, a special Community Policy Advisory Committee (CPAC) session was hosted on Thursday, February 15, 2024.

Attendees at all stakeholder engagement meetings were allowed to provide feedback and input into the MHSA Annual Update via verbal comment and a post-meeting survey in which stakeholders could provide written comments.

MHSA Annual Update CPP Demographics

Groups Represented		
1% Law Enforcement	0% Veterans Organizations	1% Faith-Based Organization
13% Education/Students	49% Family Member or Loved One	11% Community-Based Organizations
6% Social or Human Service Program/Agency	8% Non-Profit Organization	51% Consumer of Mental Health Services
17% Healthcare – Behavioral/Mental Health and Physical Health	14% Federal, State, County, or City Government	9% Consumer of Substance Use Disorder Services
	3% Veterans	30% Self Employed/Not Employed/Other

N=286 **Note:** Not every participant responded to the survey. Respondents selected more than one response for some questions.

Community Program Planning

Surveys were available in both English and Spanish and accessible by a direct electronic survey link or QR code directly linked to the electronic survey.

A total of **774** stakeholders attended this year's Community Program Planning stakeholder sessions, and DBH received **286** completed stakeholder comment forms as a result of those who attended the CPP stakeholder sessions. Of the those who completed a survey, **85%** were either satisfied or very satisfied with the CPP meeting and its goals.

Stakeholder Comments

There are a lot of updates that are being done that I was not aware of, and this was very helpful to know what is being updated.

I am excited that the Crisis Response will now be available 24 hours a day.

Thank you for the updates and reminding us of the over all components of MHSA.

Thank you for providing a space with information and connection. This was really helpful, and I appreciate your effort, focus and dedication.

Good information, it's good to see where the funding is going and it's making a difference.

Community Program Planning Process Evaluation & Behavioral Health Needs Assessment

In an effort to improve the Community Program Planning (CPP) process, DBH staff facilitated a training through the Crisis and Recovery Enhancement (CARE) Technical Assistance (TA) Center, which is funded by the California Department of Health Care Services (DHCS) and administered by the Center for Applied Research Solutions (CARS). The CARE TA Center provides Training and Technical Assistance (TTA) services to California's Mental Health Services Act (MHSA)-funded stakeholders and partners to strategically plan, effectively implement, and continually evaluate and improve their behavioral health coordination and crisis response systems of care.

Staff at the training included DBH's MHSA Administration Unit, Office of Equity and Inclusion, Public Relations Office, and program staff. Topics included but were not limited to identifying strategies for ensuring proper support for a comprehensive CPP, exploring the role of local behavioral health boards and commissions, engaging in equity-centered work, designing approaches for meaningful and consistent engagement to build trust, partner engagement mapping, and fostering strategic and inclusive engagement.

DBH is committed to incorporating the strategies from the training to achieve its goals of providing information, consulting, involving, collaborating with, and empowering its community stakeholders. These principles are being used to inspire people to sign up to create change through focus groups, interviews, surveys, and town halls (see page 24 for more information).



Artwork by Gabriel Horne

Community Program Planning

In November 2023, DBH began partnering with an independent national research and consulting firm in the healthcare industry to complete assessments of the stakeholder process for developing the MHSA Three-Year Integrated Plan and Plan Annual Updates and behavioral health needs and capacity assessment. The project will extend from November 2023 to June 2024.

Administrative managers, program managers, program specialists, peer and family advocates, and an addiction medicine physician from the mental health and Substance Use Disorder and Recover Services divisions make up a project management team, core team, and community advisory group that work alongside the consultant to provide feedback on data collection, priorities, and recommendations.

Data will inform stakeholder engagement, and engagement with populations with disparities and barriers to services will be prioritized. The scope of work includes but is not limited to utilization data and other available data on access, outcomes, and health measures.

Behavioral health assessment activities include but are not limited to reviewing existing Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis data, service data, demographic information, capacity data such as staffing vs. need, and behavioral health system and workforce needs.

The consultant is conducting a population assessment of behavioral health needs to identify the cultural and linguistic needs of served and unserved county residents, in accordance with 9 CCR § 1810.410, and conducting a workforce needs assessment focusing on linguistic capability, provider diversity, and education and training needs in accordance with 9 CCR § 1810.410 and 9 CCR § 3830.

The community program planning process activities include, but are not limited to, leveraging the information gained from conducting key informant interviews and listening sessions, data from surveys, and information from key stakeholder interviews and public forums.

The next annual update will include a final summary assessment and community program planning report detailing the community planning and stakeholder engagement process.

Community Program Planning

The following pages provide the flyers distributed to the community to promote the MHSA Annual Update CPP process:



Behavioral Health

MHSA Annual Update FY 2024/2025 Planning Meetings

Please join us at a **Mental Health Services Act (MHSA) Annual Update FY 2024/25** 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 2024

08 10 a.m. Victor Community Support Services Call-in: 1-669-444-9171 Available in English and Spanish Zoom Meeting ID: 959 6126 4010 Passcode: 421362 Join Meeting	11 10 a.m. Disabilities Awareness Subcommittee Call-in: 1-415-655-0002 WebEx Meeting Number: 146 434 2208 Join Meeting
08 10 a.m. Suicide Prevention Awareness Subcommittee Call-in: 1-415-655-0002 WebEx Meeting Number: 146 264 6760 Join Meeting	11 1 p.m. PEI Quarterly Provider Meeting Call-in: 1-415-655-0002 WebEx Meeting Number: 2485 096 9219 Passcode: 68uGmpmdEF4 Join Meeting
09 1 p.m. Spirituality Awareness Subcommittee Call-in: 1-415-655-0002 WebEx Meeting Number: 961 357 009 Join Meeting	12 10 a.m. Asian Pacific Islander Awareness Subcommittee Call-in: 1-415-655-0002 WebEx Meeting Number: 968 187 539 Join Meeting
10 10 a.m. Co-Occurring and Substance Abuse Awareness Subcommittee (COSAC) Call-in: 1-415-655-0002 WebEx Meeting Number: 961 777 142 Join Meeting	12 11 a.m. Pacific Clinics Family Resource Center (Morongo Basin Healthcare District Yucca Valley) Call-in: 1-669-444-9171 Zoom Meeting ID: 827 7686 1866 Passcode: 669550 Join Meeting
10 11 a.m. Third District Advisory Committee Call-in: 1-415-655-0002 WebEx Meeting Number: 146 962 9460 Join Meeting	12 11 a.m. Amazing Place Clubhouse 2940 Inland Empire Blvd., Ontario
11 8 a.m. Sky Forest-Rim Family Services and Big Bear Community Healthcare District Call-in: 1-646-568-7788 Zoom Meeting ID: 869 3863 8902 Passcode: 646629 Join Meeting	16 10 a.m. Victor Community Support Services - San Bernardino and Inland Association for Continuity of Care (IACC) Call-in: 1-669-900-6833 Available in English and Spanish Zoom Meeting ID: 925 4265 6745 Passcode: 068201 Join Meeting

17 Noon Ontario Montclair School District - Family Solutions Collaborative Call-in: 1-877-853-5247 Zoom Meeting ID: 938 1487 6990 Passcode: 607520 Join Meeting	25 10 a.m. Older Adults Awareness Subcommittee Call-in: +1-415-655-0002 WebEx Meeting Number: 961 983 483 Join Meeting
17 1 p.m. Senior Affairs Commission 784 E. Hospitality Lane, San Bernardino	30 11 a.m. Central Valley Fun Clubhouse 1501 S. Riverside Ave. Rialto
17 6 p.m. Fourth District Advisory Committee Call-in: 1-415-655-0002 WebEx Meeting Number: 2495 776 5577 Passcode: fBwSHAvQH23 Join Meeting	31 11 a.m. A Place to Go Clubhouse 32770 Old Woman Springs Rd. Suite B, Lucerne Valley

February 2024

5 3 p.m. Veterans Awareness Subcommittee Call-in: +1-415-655-0002 WebEx Meeting Number: 2482 788 1413 Passcode: 2482 788 1413# Join Meeting	6 11 a.m. Desert Stars Clubhouse 1841 E. Main St., Barstow
8 3:30 p.m. Second District Advisory Committee Call-in: +1-415-655-0002 WebEx Meeting Number: 2483 823 7369 Passcode: pxYctfry353 Join Meeting	8 5 p.m. MHSA Administration (Evening) Call-in: +1-415-655-0002 WebEx Meeting Number: 2495 495 7647 Join Meeting
15 10 a.m. Community Policy Advisory Committee (CPAC) Meeting Call-in: +1-415-655-0002 WebEx Meeting Number: 2486 716 4468 Passcode: MnMKgByQ22 Join Meeting	27 5 p.m. Fifth District Advisory Committee Call-in: +1-415-655-0002 WebEx Meeting Number: 187 027 1608 Join Meeting

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/

Community Program Planning



Salud Mental

Actualización anual de la MHSA para el año fiscal 2024/2025

Reuniones de planificación

¡Únase a nosotros en una reunión de participación de las partes interesadas sobre la actualización anual de la Ley de Servicios de Salud Mental (MHSA) para el año fiscal 2024/25! Conozca los datos de servicio del último año fiscal y obtenga información sobre cambios y mejoras del programa.

El evento se llevará a cabo en persona.

Enero 2024

08
10 a.m.
Servicios de apoyo comunitario de Victor
Llamam: 1-669-444-9171 Disponible en inglés y español
ID de reunión Zoom: 959 6126 4010 | Código: 421362
[Unirse a la reunión](#)

08
10 a.m.
Subcomité de Conciliación de Prevención del Suicidio
Llamam: 1-415-655-0002
Número de reunión de WebEx: 146 264 6760
[Unirse a la reunión](#)

09
1 p.m.
Subcomité de Conciliación de Espiritualidad
Llamam: 1-415-655-0002
Número de reunión de WebEx: 961 357 009
[Unirse a la reunión](#)

10
10 a.m.
Subcomité de Conciliación de Diagnóstico Dual y Drogadicción (COSAC)
Llamam: 1-415-655-0002
Número de reunión de WebEx: 961 777 142
[Unirse a la reunión](#)

10
11 a.m.
Comité Asesor del Tercer Distrito
Llamam: 1-415-655-0002
Número de reunión de WebEx: 146 962 9460
[Unirse a la reunión](#)

11
8 a.m.
Servicios familiares Sky Forest-Rim y Big Bear Community Healthcare District
Llamam: 1-646-568-7788
ID de reunión Zoom: 889 3863 8902 | Código: 64629
[Unirse a la reunión](#)

11
10 a.m.
Subcomité de Conciliación de Discapacidades
Llamam: 1-415-655-0002
Número de reunión de WebEx: 146 434 2208
[Unirse a la reunión](#)

11
1 p.m.
Reunión trimestral de proveedores de PEI
Llamam: 1-415-655-0002
Número de reunión de WebEx: 2485 096 5219
Código: 68uGmpmDE4
[Unirse a la reunión](#)

12
10 a.m.
Subcomité de Conciliación de Asiáticos/Isleños del Pacífico
Llamam: 1-415-655-0002
Número de reunión de WebEx: 968 187 539
[Unirse a la reunión](#)

12
11 a.m.
Centro de recursos familiares de Pacific Clinics (Distrito de atención médica de Morongo Basin Yucca Valley)
Llamam: 1-669-444-9171
ID de reunión Zoom: 827 7686 1866 | Código: 669550
[Unirse a la reunión](#)

12
11 a.m.
Casa club Amazing Place
2940 Inland Empire Blvd., Ontario

16
10 a.m.
Servicios de apoyo comunitario de Victor - San Bernardino e Inland Association for Continuity of Care (IACC)
Llamam: 1-669-900-6893 Disponible en inglés y español ID de reunión Zoom: 925 4265 6745 | Código: 068201
[Unirse a la reunión](#)

16
11:30 a.m.
Casa club TEAM House
201 W. Mill St., San Bernardino

16
2 p.m.
Subcomité de Conciliación de Nativos Americanos
Llamam: 1-415-655-0002
Número de reunión de WebEx: 146 996 4635
[Unirse a la reunión](#)

17
11 a.m.
Comité Asesor del Primer Distrito
Llamam: 1-415-655-0002
Número de reunión de WebEx: 187 662 3366
[Unirse a la reunión](#)

17
2 p.m.
Subcomité de Conciliación de Jóvenes en Edad de Transición (TAY)
Llamam: 1-415-655-0002
Número de reunión de WebEx: 960 523 715
[Unirse a la reunión](#)

17
11:30 a.m.
Casa Club Pathways to Recovery
17053 E. Foothill Blvd. Suite B, Fontana

17
mediodía
Distrito Escolar Ontario Montclair - Colaboración de Soluciones Familiares
Llamam: 1-877-853-5247
ID de reunión Zoom: 958 1487 6990 | Código: 607520
[Unirse a la reunión](#)

17
1 p.m.
Comisión de asuntos para Adultos Mayores
784 E. Hospitality Lane, San Bernardino

17
6 p.m.
Comité Asesor del Cuarto Distrito
Llamam: 1-415-655-0002
Número de reunión de WebEx: 2495 776 5577
Código: f8wSHAvQH23
[Unirse a la reunión](#)

18
1 p.m.
Comité Consultivo de Competencia Cultural
Llamam: 1-415-655-0002
Número de reunión de WebEx: 969 101 891
[Unirse a la reunión](#)

22
11 a.m.
Subcomité de Conciliación de Consumidores y Miembros de Familias
Llamam: +1-669-900-9128
ID de reunión Zoom: 951 5082 7516 | Código: 682466
[Unirse a la reunión](#)

22
2 p.m.
Subcomité de Conciliación de Afroamericanos
Llamam: +1-415-655-0002
Número de reunión de WebEx: 146 893 8322
[Unirse a la reunión](#)

23
11 a.m.
Casa club del club de bienestar Santa Fe
56200 Santa Fe Trl. Suite M, Yucca Valley

23
12:30 p.m.
Subcomité de Conciliación de LGBTQ
Llamam: +1-415-655-0002
Número de reunión de WebEx: 960 570 704
[Unirse a la reunión](#)

24
11 a.m.
Casa club Serenity
12625 Hesperia Rd., Suite B, Victorville

24
1 p.m.
Subcomité de Conciliación de Mujeres
Llamam: +1-415-655-0002
Número de reunión de WebEx: 967 920 279
[Unirse a la reunión](#)

25
9 a.m.
Administración de MHSA (mañana)
Llamam: +1-415-655-0002
Número de reunión de WebEx: 2498 681 4350
[Unirse a la reunión](#)

25
10 a.m.
Subcomité de Conciliación de Latinos*
Llamam: +1-415-655-0002 *reunión en español
Número de reunión de WebEx: 966 009 041
[Unirse a la reunión](#)

25
10 a.m.
Subcomité de Conciliación de Adultos Mayores
Llamam: +1-415-655-0002
Número de reunión de WebEx: 961 983 483
[Unirse a la reunión](#)

30
11 a.m.
Casa club del Valle Central
1501 S. Riverside Ave. Rialto
31
11 a.m.
Casa club A Place to Go
32770 Old Woman Springs Rd. Suite B, Lucerne Valley

Febrero 2024

5
3 p.m.
Subcomité de Conciliación de Veteranos
Llamam: +1-415-655-0002
Número de reunión de WebEx: 2482 788 1413
Código: 2482 788 1413
[Unirse a la reunión](#)

6
11 a.m.
Casa club Desert Stars
1841 E. Main St., Barstow

8
3:30 p.m.
Comité Asesor del Segundo Distrito
Llamam: +1-415-655-0002
Número de reunión de WebEx: 2483 823 7369 Código: pxfYcfry353
[Unirse a la reunión](#)

8
5 p.m.
Administración de MHSA (tarde)
Llamam: +1-415-655-0002
Número de reunión de WebEx: 2495 495 7647
[Unirse a la reunión](#)

15
10 a.m.
Comité Comunitario Consultivo de Políticas
Llamam: +1-415-655-0002
Número de reunión de WebEx: 2486 716 4468 Código: MrMLKrbYQ22
[Unirse a la reunión](#)

27
5 p.m.
Comité Asesor del Quinto Distrito
Llamam: +1-415-655-0002
Número de reunión de WebEx: 187 027 1608
[Unirse a la reunión](#)

El evento se llevará a cabo en persona

Si habla otro idioma, los servicios de asistencia lingüística están disponibles sin costo llamando al (888) 743-1478. Los usuarios de TTY marcan 711. DBH cumple con las leyes federales 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 mas información por favor visite: sbcounty.gov/dbh/



Condado de San Bernardino Departamento de Salud Mental

Public Review

The MHSA Annual Update was posted on the department's website for stakeholder review and comment from February 20, 2024, through March 21, 2024, at <https://wp.sbcounty.gov/dbh/programs/mhsa/>. The Public Hearing to affirm the stakeholder process will take place at the regularly scheduled Behavioral Health Commission Meeting on April 4, 2024, which is held in person from Noon until 2 p.m. at County of San Bernardino Health Services Auditorium: 850 E. Foothill Blvd., Rialto, CA 92376.

Summary and Analysis of Substantive Comments

The Public Posting and Comment section of the final MHSA Annual Update will include an analysis of substantive recommendations. Comments/recommendations can be submitted via email to the DBH MHSA email box at MHSA@dbh.sbcounty.gov during the time the MHSA Annual Update draft is posted for public comment. Stakeholders are informed that comments can be received anytime through the year but will not be included in the final MHSA Annual Update unless provided during the 30-day comment period. The MHSA Annual Update was posted for 30 days, per Welfare and Institutions Code 5848, between February 20, 2024, and March 21, 2024, at <https://wp.sbcounty.gov/dbh/programs/mhsa/>.

If you would like to provide comments/recommendations after the close of the 30-day posting period, you may request a comment form be sent to you by contacting DBH at MHSA@dbh.sbcounty.gov or calling 1-800-722-9866 for

more information.

During stakeholder meetings, community members asked how to access additional information on available behavioral health services in the County, what services are available in their region, and where to find out more information on Substance Use Disorder and Recovery Services (SUDRS).

Services and programs by region

The DBH Services Guide is located at <https://wp.sbcounty.gov/dbh/resources/> and includes service providers in the East Valley, West Valley, Desert/Mountain, and Morongo Basin. The DBH Services Guide is a summary of DBH and DBH contract provider services and is not inclusive of all services and/or providers.

Organizations that provide services

DBH's Provider Directory, which includes each licensed, waived, or registered mental health provider and licensed substance use disorder services provider employed with or contracted by DBH to deliver Medi-Cal services may be viewed at www.sbcounty.gov/dbh/ProviderDirectory.

Substance Use Disorder and Recovery Services (SUDRS) Resources

The DBH SUDRS providers can be found in the DBH

Community Program Planning

Services Guide, and additional SUDRS resources can be found at <https://wp.sbcounty.gov/dbh/resources/#SUDRSresources>.

During stakeholder meetings, community members asked how they might participate in the CPP process and find additional information on upcoming meetings.

Community Program Planning Meetings

Throughout the year, regular stakeholder meetings include:

- Behavioral Health Commission (BHC)
- District Advisory Committee (DAC)
- Community Policy Advisory Committee (CPAC)
- Cultural Competency Advisory Committee (CCAC), along with 14 Culturally Specific Subcommittees
- Mental Health Services Act (MHSA) Executive Committee
- Association of Community Based Organizations (ACBO)
- PEI Provider Network
- Clubhouse Consumer Peer Support Groups

Feedback from regularly occurring stakeholder meetings is compiled throughout the year(s) and included with feedback from any special sessions that are held to review the Annual Plan Update.

The schedule of upcoming DBH meetings and events can be found at <https://wp.sbcounty.gov/dbh/events/>.

During stakeholder meetings, community members asked how they will be informed about upcoming legislation and how it could potentially affect their programs.

Community Program Planning Meetings

Throughout the year, as DBH is apprised on upcoming legislation that may affect their programs, they will share this information with stakeholders through the Community Program Planning meetings.

During stakeholder meetings, community members asked about programs for specific populations and early intervention.

Categories of programs for specific populations

The Community Services and Supports component comprises programs designed to support a continuum of services that support the mental health needs of diverse children, TAY, Adults, and Older Adults according to need.

The Prevention and Early Intervention component is comprised of culturally specific programs, children and youth programs, and specialty programs that are designed to prevent mental illness from becoming severe and disabling with an emphasis on improving timely access to services for underserved populations.

For a description of MHSA programs, please refer to the [MHSA Three-Year Integrated Plan for Fiscal Year 2023-24 through Fiscal Year 2025-26](#).

Community Program Planning

DBH encourages and supports community collaboration, particularly the involvement of stakeholders, in all aspects of the MHSA programs provided.

To address concerns related to DBH MHSA program issues in the areas of access to behavioral health services, violations of statutes or regulations relating the use of MHSA funds, non-compliance with MHSA general standards, inconsistency between the approved MHSA Annual Update and its implementation, the local MHSA community program planning process, and supplantation, please refer to the MHSA Issue Resolution process located at <http://wp.sbcounty.gov/dbh/wp-content/uploads/2016/08/COM0947.pdf>.

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

When the MHSA Annual Update is written and posted, feedback is regularly solicited on the content of plans/programs while plans are posted for public review.

Feedback/comments can be submitted via email at MHSA@dbh.sbcounty.gov or by phone at 1-800-722-9866. If feedback is received, it may be incorporated into the new MHSA Annual Update or, if not incorporated, addressed in the final MHSA Annual Update as to why it was not incorporated.

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

DBH clinics or organizational contract providers can provide new program proposals and/or program enhancement services. Programs are often implemented using DBH clinics and organizational contract providers working together to provide services in a system of care framework. A request for proposal (RFP)/procurement process is required for services provided by organizational providers. The RFP process can be accessed via the link here, which is as follows: <https://wp.sbcounty.gov/purchasing/>.

Community Program Planning

Additional information about past MHSA-approved plans can be accessed at the following link:

<https://wp.sbcounty.gov/dbh/programs/mhsa/>. If you have any questions about MHSA programs in general or programs as detailed in this MHSA Annual Update, please email or call the department at MHSA@dbh.sbcounty.gov or 1-800-722-9866.

During the stakeholder meetings, participants requested additional information regarding the following topics. In reviewing this feedback, DBH would like to respond to these areas already being addressed within our current system of care or by other community resources.

Assistance for Disabled Individuals

For individuals with developmental disabilities and intellectual disabilities, DBH collaborates and works with First 5 (<https://first5sanbernardino.org/initatives/early-learning/>) and the Inland Regional Center (<https://www.inlandrc.org/>). Both programs specifically work with this population (Developmental Disabilities and Intellectual Disabilities) and ensure that the individual and families are referred to the appropriate resources (i.e., Early Head Start/Head Start).

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

inlandsocaluw.org to find resources nearby.

Reduction of Discrimination and Stigma

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

Support for Parents and Caregivers

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

Crisis Services

Effective 12/31/2023, DBH Community Crisis Services began working alongside a community partner/contract provider to provide an expansion of mobile crisis response, previously available from 7 a.m. to 10 p.m. and now available 24/7/365.

The Crisis Walk-In Center (CWIC) programs are staffed with available nurses, and services remain available to the community 24/7. Further, the DBH Crisis Contact Center (CCC) now operates 24/7, offering text message, telephone, and telehealth support countywide to individuals in crisis. Additionally, the CCC is able to dispatch 24/7 mobile crisis response services, when safe and appropriate, to the West Valley, East Valley, and High Desert regions.

Community-based mobile crisis response teams are available 24/7/365 to provide services in all languages for individuals of any age experiencing a mental health crisis. Call 1-800-398-0018 or text 1-909-420-0560.

Shelter Beds and Homeless Assistance

The Office of Homeless Services (OHS) plays a vital role in the San Bernardino County Homeless Partnership as the administrative support unit for the organization. OHS ensures that the partnership's focus is to develop a countywide public-private partnership and to coordinate services and resources are carried into effect. Homeless services information and resources can be found at the San Bernardino County Homeless Partnership website: <https://sbchp.sbcounty.gov/>.

The 2-1-1 website offers a guide for homeless service providers and a list of homeless resource centers. For specific areas in need that may not be available on the website resources, dial 2-1-1 to access the most comprehensive database of free and low-cost health and human services available in the county. Call 2-1-1 or visit the website at inlandsocaluw.org to find resources nearby.

In addition to the available resources from the OHS regarding homeless services, DBH provides services from the Recovery-Based Engagement Support Teams (RBEST), Community Crisis Response Team (CCRT), the Crisis Walk-In Clinics (CWIC)/Crisis Stabilization Units (CSU), Innovative Remote Onsite Assistance Delivery (InnROADs), and Triage, Engagement, and Support Teams (TEST) programs throughout San Bernardino County.

These programs are intended to:

- Reduce incidents of acute involuntary psychiatric hospitalization
- Reduce the number of calls to law enforcement for psychiatric emergencies
- Reduce the number of psychiatric emergencies in hospital emergency departments

Shelter Beds and Homeless Assistance (cont.)

- Reduce the number of consumers seeking emergency psychiatric services from hospital emergency departments
- Reduce the amount of time a consumer with a psychiatric emergency spends in hospital emergency departments and increase consumer access to services

Additional information regarding Community Crisis Response Team (CCRT) and Crisis Walk-In Clinic (CWIC) can be obtained through the access unit hotline, which offers 24-hour crisis and referral information and can be reached at 1-888-743-1478.



Artwork by Catherine Sutton

Summary of Program Changes

DBH has made a practice of planning for sustainable growth in the development and implementation of MHSA and its system of care services. This MHSA Annual Update reflects program changes under Prevention and Early Intervention (PEI), Community Services and Supports (CSS), and Innovation (INN) components.

The following are proposed changes in programs and components:

Prevention and Early Intervention

Inland Empire Opioid Crisis Coalition (IEOCC) Program – Name Change

The IEOCC has been renamed SUPPOrT, which stands for Substance Use Prevention & Pathways to Outreach and Treatment.

The SUPPOrT Program – Program Expansion

The Program will grow to reach the mountain communities around Rim Forest, Arrowhead, and Big Bear. This expansion aims to offer education and outreach to the various communities nestled in the mountain regions. The pilot project is estimated at approximately \$100,000 and is scheduled to start in fiscal year 2023/24. The focus of the expansion will be on creating more places for people to connect with mental health and substance use disorder services.

Community Services and Supports

Adult Transitional Care Programs – Funding Reallocation

The Adult Transitional Care Programs are existing programs that will now be fully funded by General System Development funding instead of Full Service Partnership (FSP) funding.

This change results from of Community Reintegration Services moving from the Adult Transitional Care Programs to a newly created umbrella, titled Collaborative Adult Full Service Partnership Services, funded by FSP funding.

Centralized Hospital Aftercare Services – Placement and Coordination of Enhanced Services, a previous component of Community Reintegration Services, will remain as an Adult Transitional Care Program, funded by General System Development funding.

Collaborative Adult FSP Services – Program Transfer

The Community Reintegration Services Program and Recovery Based Engagement Support Team Assisted Outpatient Treatment Program are existing programs that will be relocated to a newly created umbrella titled Collaborative Adult Full Service Partnership Services.

Innovative Remote Onsite Assistance Delivery (InnROADs) Project – MHSA Funding Component Change

The Innovative Remote Onsite Assistance Delivery Project ends as an Innovation Project in March 2024. Starting April 2024, InnROADs will be funded via Community Services and Supports and continue under the Housing and Homeless Services Continuum of Care Programs.

Community Services and Supports (cont.)

Recovery Based Engagement Support Team (RBEST) Assisted Outpatient Treatment (AOT) – Program Expansion
Recovery Based Engagement Support Team Assisted Outpatient Treatment is court-ordered outpatient treatment for individuals who have a history of untreated mental illness and meet criteria as stipulated in the Welfare and Institutions Code.

In May 2023, three positions were approved for the Law Offices of the Public Defender (PD) San Bernardino County. A Memorandum of Understanding will be established for the coordination of court-ordered Assisted Outpatient Treatment per regulations defined in the Welfare and Institutions Code.

The Department of Behavioral Health will allocate \$1.7 million annually to fund positions carrying out responsibilities related to Assisted Outpatient Treatment.

California Mental Health Services Authority (CalMHSA) – Contract Renewal
San Bernardino County has renewed the agreement with the California Mental Health Services Authority (CalMHSA) as the County's Peer Support Specialist certifying entity.

Peer Provider Workforce – Program Transfer
The Peer Provider Workforce Support Program was developed to support DBH as it works to grow its peer

support staff. The program is being transferred from Workforce Education and Training and will be listed under Peer Programs.

Clubhouse and Community Connections – New Umbrella Name

To better reflect efforts to expand access to peer providers and peer run programs, a new umbrella, "Peer Programs" was created. This division will oversee the Clubhouse and Community Connections Programs and the Peer Provider Workforce Support Program.

Community Education Program (CEP) – New Program and Transfer

The Community Education Program is a new and distinct program that will be part of the Crisis Intervention Training budget. Existing Workforce Education and Training and Public Relations and Outreach staff and services forecasted and allocated in the three-year plan are being transferred to meet the needs of this new program.

The Community Education Program will provide general behavioral health training opportunities to the public, which includes the coordination and facilitation of certified curriculum such as:

- Mental Health First Aid
- Applied Suicide Intervention Skills Training
- SafeTALK
- Listen, Empathize, Agree, and Partner Training

Community Program Planning

Community Services and Supports (cont.)

Crisis Intervention Training (CIT) – Funding Transfer

The Crisis Intervention Training budget will require the transfer of existing funds for administrative costs related to the implementation of the Community Education Program.

Community Crisis Services – Program Expansion

The Community Crisis Response Teams (CCRT) will include contracted mobile crisis response services from 7 p.m. to 7 a.m. in compliance with Department of Health Care Services (DHCS) mandates by the required deadline of December 31, 2023.

The contract expansion is anticipated to be fully funded by Community Services and Supports funding to expand the current Community Crisis Services budget.

Expansion of mobile crisis response service hours through the contracted provider is anticipated to require a budget of \$1,067,934 from December 2023 to June 2024, and ongoing program costs will incur an estimated cost of \$2,003,532 annually.

Crisis Residential Treatment (CRT) and Crisis Walk-In Centers (CWIC) – Funding Increase

The Department of Behavioral Health will increase funding to the Crisis Residential Treatment and Crisis Walk-In Centers annual contract allocations. Budget increases total \$1,600,000 annually. The budget increases are anticipated to be fully funded by Community Services and Supports funding as expansions of the current Crisis Walk-In Center and Crisis Residential Treatment budgets.

The budget increase will maintain continued access to 24/7 crisis stabilization services in the rural High Desert and Eastern Desert areas, and ensure continued optimal bed capacity for Crisis Residential Treatment services delivered countywide.

Forensic Services Continuum of Care – Removal of Sub-Programs from the MHSA Three Year Plan

The Diversion Opportunity for Outpatient Recovery Services sub-program is removed from the Mental Health Services Act Plan. The Mental Health Services Act does not fund this program and has been included in error.

The Diversion Opportunity for Outpatient Recovery Services for Misdemeanor Incompetent to Stand Trial is no longer an existing program and is being removed from the Mental Health Services Act Plan. Positions were vacant in FY 22/23, and in FY 23/24, all position were transferred to Community Supervised Treatment After Release (CSTAR) or the Diversion Opportunity for Outpatient Recovery Services Department State Hospital program. This change does not impact services to this population.

Regional Adult Full Service Partnerships – Contract Consolidation

For FY 2023/24, the Regional Adult FSP program has been consolidated with a single contract provider, Valley Star. This consolidation is expected to increase consumer's access to FSP services throughout San Bernardino County.

Community Services and Supports (cont.)

Housing and Homeless Services Continuum of Care – Program Transfer

Homeless and Supportive Services will move the Community Supports service along with 15 positions to the Office of Homeless Services (OHS) to provide Community Supports. This will remove the Community Supports service from the HOST Mental Health Services Act (MHSA) funded HOST positions. This move is proposed to take place July 1, 2024.

Innovation

Progressive Integrated Care Collaborative (PICC) – New Project

The Progressive Integrated Care Collaborative Project was approved by the Mental Health Services Oversight and Accountability Commission in May 2023 and by the San Bernardino County Board of Supervisors in June 2023. Efforts to coordinate with collaborative agencies have begun, and project implementation is expected to start in FY 2023/2024.

The goals of this project are:

- Delivery of limited physical health care services within a behavioral health care setting.
- Delivery of integrated behavioral health, physical health, and substance use disorder services to Medi-Cal enrollees at pilot clinic sites.
- Financial integration of behavioral health, physical health, and substance use disorder services with a single entity.

The annual budgeted amount for this project for FY 2024/25 is \$2,937,654 and \$16,557,576 for five years. The project is estimated to serve 160 individuals per year.

The target population for this project is 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.

Vyvanse in Stimulant Addiction (VISA)

Vyvanse was not introduced for approval at this time. Due to stakeholder feedback and executive support, additional work will need to be done prior to this project being submitted for approval.

Fiscal

As part of the 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 be in-line with actual anticipated utilization values based on historical trends and anticipated growths. This revision helps ensure more accurate reporting of usages and availabilities of MHSA funds allotted to DBH consistent with the County of San Bernardino's continued goal of responsible use of our resources to ensure financial sustainability. It does not impact Board of Supervisors approved commitments.

Overview of Public Posting and Comment Period

Summary and Analysis of Comments

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

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

Comment: Thank you for the overview of program updates. It is helpful to be able to reference an easy to access summary.

Response: Thank you for your comment. Information for review related to the summary of program changes can be located in the Community Program Planning section of this Plan. All MHSA programs are developed as part of a community program planning process with diverse stakeholders and include consumer and family members. For additional plan information, the MHSA Three-Year Integrated Plan and Annual Updates can be found at [Mental Health Services Act \(MHSA\) – DBH Internet Website \(sbcounty.gov\)](https://www.sbcounty.gov/dbh/events/).

Question: Any additional comments or feedback?

Comment: Thank you for the transparency in reporting. Hoping future postings will include full data sets.

Response: Thank you for your feedback. Per Welfare and Institutions Code Section 5847 (a) and (b), counties must prepare and submit a Three-Year Program and Expenditure Plan and Annual Updates for MHSA programs and expenditures to Mental Health Services Oversight and Accountability Commission (MHSOAC) and Department of Health Care Services (DHCS). The Plan and Annual Updates provide required data on Performance Outcomes, including, but not limited to, linkages to ongoing services and success in meeting the program goals; MHSA funding expenditures and revenues; demographics of consumers served; and the Annual Prevention and Early Intervention report.

DBH is committed to improving and growing existing programs and welcomes comments and feedback. Your thoughts can be shared throughout the year at a stakeholder meeting, via email, phone call, or mail. For a calendar of stakeholder events, please visit <https://wp.sbcounty.gov/dbh/events/>. You may also contact MHSA Administration at 1-800-722-9866, or by emailing MHSA@dbh.sbcounty.gov.

Public Hearing

The Public Hearing hosted by the San Bernardino County Behavioral Health Commission was conducted on April 4, 2024, at County of San Bernardino Health Services Building Auditorium located at 850 E. Foothill Blvd., Rialto, CA 92376. Satellite location at Department of Behavioral Health Apple Valley Community Clinic located at 18818 Highway 18, Apple Valley, CA. The agenda, meeting regulations of MHSA public hearings, and a copy of the MHSA Public Hearing presentation were verbally and/or electronically accessible for all attendees during the meeting. As with all public meetings, interpretation services and materials in other languages were available upon request.

Commissioners' questions were addressed during the Public Hearing. No substantive recommendations were made during the public hearing.

The Behavioral Health Commission affirmed that the DBH adhered to the MHSA CPP process and supported the submission of the MHSA Annual Update for Fiscal Year 2024/25 to the San Bernardino County Board of Supervisors tentatively scheduled for approval in a May 2024 meeting and the subsequent submission to the Department of Health Care Services and Mental Health Services Oversight and Accountability Commission.

Improvements in Progress

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

- Information of bed availability to persons in need of residential treatment service, specifically for the CARE Court.
- Focus on specific populations for improvements.
- Information on programs, services, or specific outreach for people with disabilities that may lead to a mental health illness.
- Additional information on how the plan will meet the needs of Prop 1 and the financial implications of Prop 1.
- More meetings in person.

The following are examples of Department responses to stakeholder feedback:

Information of bed availability to persons in need of residential treatment service, specifically for the CARE Court

With the initiation of the CARE Act, DBH has diligently worked with community providers to increase the number of beds in our residential continuum of care including our contracted shelter beds, enhanced board and care, and social rehabilitation facilities.

Focus on Specific Populations for Improvements

In an effort to improve outreach to the African American/Black community, the Office of Prevention and Early Intervention (PEI) continues to assess current outreach programs to address concerns related to engagement with the African American/Black community. Enhanced data collection metrics are being implemented to ensure comprehensive representation of all populations, including the African American community. These updates are aimed at making it easier for providers to gather data across diverse demographics.

Programs, services, or specific outreach for people with disabilities that may lead to a mental health illness

DBH does not have programs for this specific population. The Prevention and Early Intervention Programs are available to people of all capacities who are struggling with early signs of mental illness or early psychosis.

Regarding resources specifically for this community in terms of Prevention and Early Intervention:

- There are no specific resources for individuals with a disability, however we continue to look for opportunities to expand our programming to additional unserved/underserved populations. For individuals with developmental disabilities and intellectual disabilities we collaborate and work with First 5 (<https://first5sanbernardino.org/initatives/early-learning/>) and the Inland Regional Center (<https://www.inlandrc.org/>). Both programs specifically work with this population (Developmental Disabilities and Intellectual Disabilities) and ensure that the individual and families are referred to the appropriate resources (i.e. Early Head Start/Head Start).
- Stakeholder feedback is a portion of the program planning process. We consider all feedback and examine if there are any funding opportunities to expand services to additional populations.

Additional information on how the plan will meet the needs of Prop 1 and the financial implications of Prop 1

The County and DBH will work together over the next couple of months to analyze the impact of Proposition 1 if passed by the voters and a mitigation plan.

More meetings in person

During Fiscal Year 2024/2025, DBH will begin assessing the feasibility of holding some of the Community Policy Advisory Committee (CPAC) meetings in person.



MHSA Annual Update for FY 24/25: PEI Component including Annual Prevention and Early Intervention Report

Introduction

Prevention and Early Intervention (PEI) program services are envisioned to develop and implement strategies that stop mental illness from becoming severe and disabling, giving emphasis to improvement in timely access to services for underserved populations.

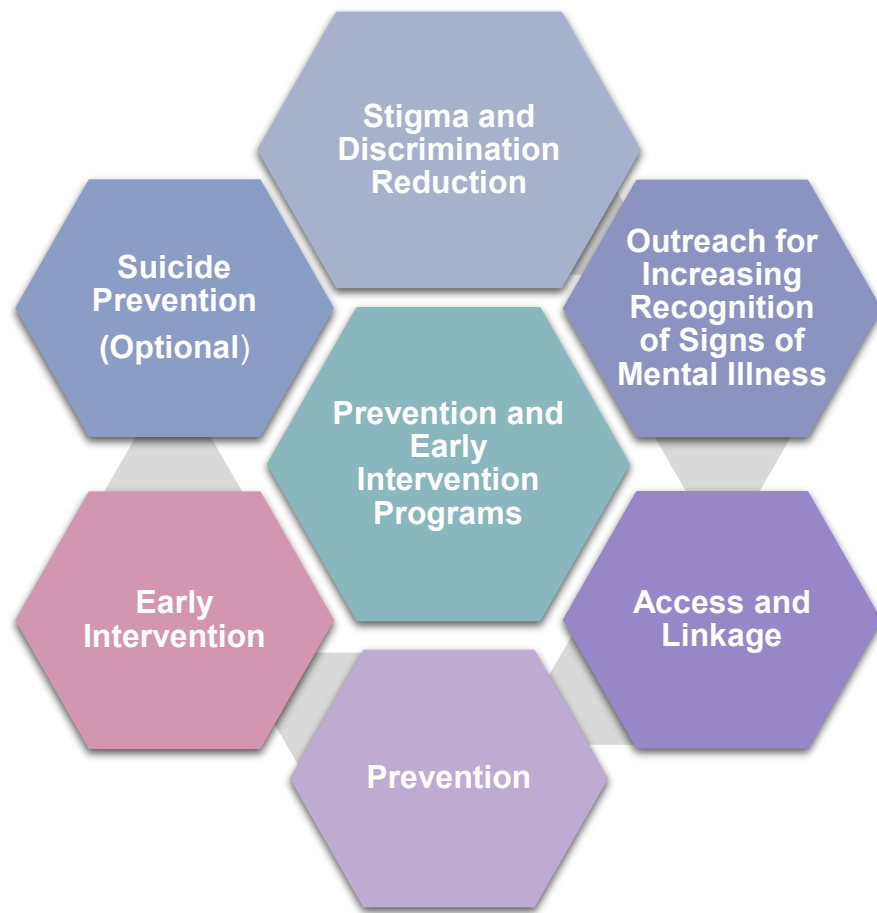
Strategies and activities are applied early on to avert the onset or relapse of mental health conditions among individuals. The component also seeks to change community conditions known to contribute to behavioral health concerns.

PEI programs incorporate the values of cultural competence, consumer and community empowerment, collaboration, and inclusion in providing services that emphasize recovery, wellness, and resilience.

PEI programs strive to meet the priority needs identified by local diverse community stakeholders, meet the critical community and priority population needs outlined in the Mental Health Services Act, and transform the public mental health system.

There are six (6) State-Defined Prevention and Early Intervention Programs. These State-Defined programs are Stigma and Discrimination Reduction, Outreach for Increasing Recognition of Signs of Mental Illness, Access and Linkage to Services, Prevention, Early Intervention, and Suicide Prevention, shown in the adjacent image.

State-Defined Prevention and Early Intervention Programs



Prevention and Early Intervention

Introduction, cont.

Local PEI Construct The county PEI programs operate under the State-Defined Prevention and Early Intervention reporting construct as illustrated in the following table

Stigma and Discrimination Reduction

- Native American Resource Center (NARC)

Outreach for Increasing Recognition of Signs of Mental Illness

- Promotores de Salud (PdS)
- Community Health Workers (CHW)
- Behavioral Health Ministries Project (BHMPP)
- Inland Empire Opioid Crisis Coalition (IEOCC)

Access and Linkage to Treatment

- Child and Youth Connection (CYC)

Prevention

- Preschool PEI Program (PPP)
- Resilience Promotion in African American Children (RPiAAC)
- Lift Program (LP)
- Coalition Against Sexual Exploitation (CASE)
- Older Adult Community Services (OACS)

Suicide Prevention (Optional)

- Office of Suicide Prevention (OSP)



Early Intervention

- Family Resource Center (FRC)
- Military Services and Family Support (MSFS)
- Community Wholeness and Enrichment (CWE)
- Student Assistance Program (SAP)
- Improving Detection and Early Access (IDEA)

Prevention and Early Intervention

Introduction, cont.

MHSA Legislative Goals and Key Outcomes		Local Program	
Increase early access and linkage to medically necessary care and treatment:			
	Connect children, adults, and seniors with severe mental illness, as early in the onset of these conditions as practicable, to medically necessary care and treatment, including, but not limited to, care provided by County mental health programs.	- CYC - SAP	-OACS - LP
Improve timely access to service:			
	Increase extent to which an individual or family from an underserved population who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in onset as practicable.	- OACS - MSFS - SAP	- PPP
Promote, design, and implement programs in ways that reduce and circumvent stigma:			
	- Reduce and circumvent stigma, including self-stigma. - Reduce discrimination related to being diagnosed with a mental illness, having a mental illness, or seeking mental health services. - Increase service accessibility.	- NARC	
Prevent suicide as consequence of mental illness:			
	Improve attitudes, knowledge, and/or behavior regarding suicide related to mental illness.	- MSFS - CWE - OACS	- OSP

Introduction, cont.

MHSA Legislative Goals and Key Outcomes	Local Program
Increase recognition of early signs of mental illness:	
• Increase identification of early signs of potentially severe and disabling mental illness for potential responders. • Increase support to individuals with mental illness. • Increase referrals for individuals who need treatment or other mental health services.	- CHW/PdS - OSP - BHMPP - IEOCC - OACS
Reduce prolonged suffering associate with mental illness:	
• Reduce risk factors. • Reduce indicators. • Increase protective factors that may lead to improved mental emotional and relational functioning. • Reduce symptoms. • Improve recovery, including mental, emotional and relational functioning.	- OACS - CYC - SAP - FRC - PPP - LP - CASE - MSFS - RPIAAC - IDEA
Reduce stigma and discrimination associated with mental illness:	
• Reduce negative feelings, attitudes, beliefs, perceptions, stereotypes, and/or discrimination related to having a mental illness, being diagnosed, or seeking services.	- RPIAAC - CWE - CHW/PDS

Prevention and Early Intervention

Introduction, cont.

SB 1004 PEI Program Priority Areas

All PEI programs are required to comply with WIC Section 5840.7 enacted by Senate Bill 1004, which requires counties to specify how they are incorporating the following six Commission-identified priorities in the FY 23-24 MHSA plan:

1. Childhood trauma prevention and early intervention to deal with the early origins of mental health needs.
2. Early psychosis and mood disorder detection and intervention; and mood disorder and suicide prevention programming that occurs across the lifespan.
3. Youth outreach and engagement strategies that target secondary school and transition-age youth, prioritizing partnership with college mental health programs.
4. Culturally competent and linguistically appropriate prevention and intervention;
5. Strategies targeting the mental health needs of older adults.
6. Early identification programming of mental health symptoms and disorders, including but not limited to anxiety, depression, and psychosis.

These priorities outlined in WIC Section 5840.7/SB 1004 are integrated into our plan and aligned with our previously outlined strategies, consistent with our community planning process (see subsequent totals for details).

Per WIC section 5840.7/SB 1004, counties are also required to provide an estimate of the share of PEI funding allocated to each priority. The following provides these estimates:

SB 1004 PEI Program Priority Categories:		Percentage of Funding Allocated to Priority:
1.	Childhood trauma prevention and early intervention to deal with the early origins of mental health needs	68%
2.	Early psychosis and mood disorder detection and intervention; and mood disorder and suicide prevention programming that occurs across the lifespan	2%
3.	Youth outreach and engagement strategies that target secondary school and transition age youth , with a priority on partnership with college mental health programs	13%
4.	Culturally competent and linguistically appropriate prevention and intervention	7%
5.	Strategies targeting the mental health needs of older adults	3%
6	Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis	7%

Prevention and Early Intervention

Introduction, cont.

PEI Component	Local Program Name	SB 1004 Priority Category					
		1 Child Trauma	2 Early Psychosis	3 Youth Outreach	4 Cultural Comp	5 Older Adults	6 Early ID
Stigma and Discrimination Reduction	PEI-CI-3: Native American Resource Center				x		
Outreach for Increasing recognition for early signs of Mental Illness	PEI CI-1: Promotores de Salud/Community Health Worker				x		
	PEI CI-4: Behavioral Health Ministries Pilot Project				x		
	PEI CI-5: Inland Empire Opioid Crisis Coalition (IEOCC)						x
Access and Linkage to treatment	PEI SE-2: Child and Youth Connection	x					

Prevention and Early Intervention

Introduction, cont.

PEI Component	Local Program Name	SB 1004 Priority Category					
		1 Child Trauma	2 Early Psychosis	3 Youth Outreach	4 Cultural Comp	5 Older Adults	6 Early ID
Prevention	PEI SI-2: Preschool PEI	x					x
	PEI SI-3: Resilience Promotion in African American Children			x	x		
	PEI SE-1: Older Adult Community Services					x	
	PEI SE-5: Lift						x
	PEI SE-6: Coalition Against Sexual Exploitation (CASE)	x		x			
Prevention and Early Intervention	PEI CI-2: Family Resource Center	x					x
	PEI SE-3: Community Wholeness and Enrichment		x	x			
	PEI SE-4: Military Services and Family Support				x		x
	PEI SI-1: Student Assistance Program	x		x			
	PEI SE-7: Early Psychosis Program / IDEA		x				

Introduction, cont.

PEI Community Program Planning

Description of PEI CPP Process: This includes explanation of how stakeholders contributed to PEI priorities and the allocation of funding for priorities.

A series of stakeholder engagement workshops covered PEI programs grouped by topic. Each engagement workshop was presented twice, with a lunchtime workshop and an afternoon workshop to reach a greater audience.

- Culturally Specific Programming – August 29, 2022
- Children & Youth Services – September 8, 2022
- Specialty Programs – September 13, 2022
- Prevention & Early Intervention – September 20, 2022

Two additional meetings were held at the following standing meetings.

- MHSA Exec – October 5, 2022
- PEI Provider Network Meeting – October 13, 2022

A total of 220 stakeholders attended the ten engagement meetings, including the MHSA Executive Committee and PEI Provider Network Meetings

Invites were sent to the general public, stakeholders, Community Policy Advisory Committee, Behavioral Health Commission, PEI providers, and Office of Equity and Inclusion.

Engagement meetings were advertised on all DBH social media platforms, including Facebook, Instagram, and Twitter.

Key findings as a result of the feedback from these stakeholder engagement meetings identified the following priorities:

- Review staffing patterns in programs to include more paraprofessionals
- Strengthen partnerships with faith-based communities to expand future access points to services
- Assess current data collection methods and identify areas of improvement
- Implement survey education before completion
- Improve marketing strategies to increase public awareness of available services
- Look for opportunities for leveraged funding (CalAIM/Medi-Cal)
- Increase program dollar amounts to improve staff retention (competitive salaries & benefits)

Prevention and Early Intervention

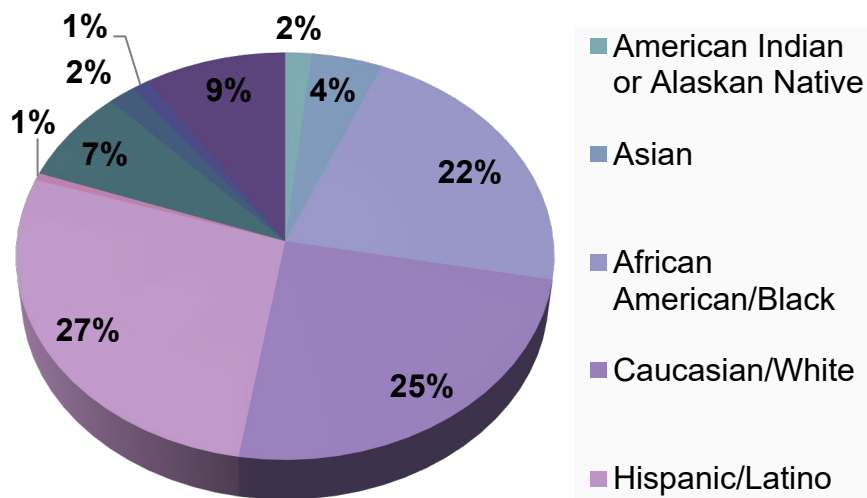
Introduction, cont.

PEI Community Program Planning (cont.)

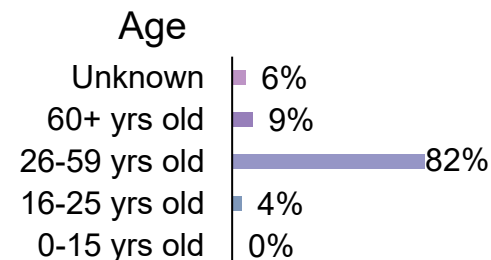
The following graphs show the community demographics of the stakeholders who attended the meetings.

The rich racial diversity of San Bernardino County was reflected in the demographic data of the participants, with 22% identifying as African American/Black, 25% Caucasian, 27% Latinx/Hispanic, and 4% Asian. In addition, 7% of participants indicated that they identify with more than one race.

Race

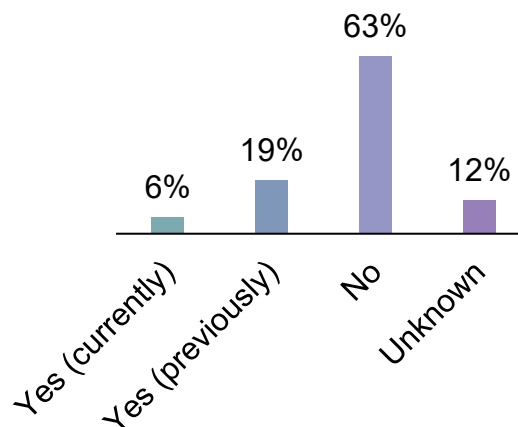


The majority of participants were adults, with 82% reporting that they were between 26-59 years old, 9% were older adults over 60, 4% TAY aged youth (16-25), and 6% who did not respond.

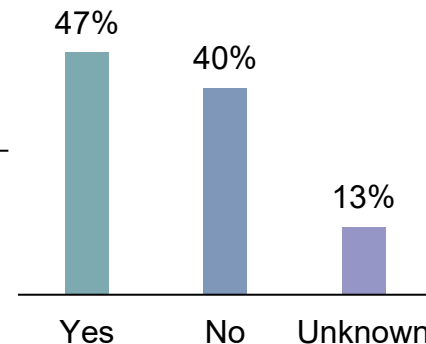


Participants comprised of a mix of individuals with 25% reporting that they are either a current or previous consumer of mental health services and 47% reporting that they are related to a consumer of either mental health or substance use disorder services.

Consumer of Mental Health Services



Related to Consumer of Mental Health and/or Substance Use Disorder Services



Introduction, cont.

PEI Data Collection

Data is collected for PEI Programming in various ways throughout the reporting cycle. Program providers enter data into the Data Collection System (DCS) 2.0 data collection portal for activities related to prevention, outreach for increasing recognition of early signs of mental illness, access & linkage, improving timely access, and stigma & discrimination reduction. DBH's Electronic Health Record and Billing System is myAvatar and will be presented as myAvatar throughout the document. PEI program providers use the myAvatar database to enter data associated with early intervention services.

In addition, PEI outcomes and successes related to increasing knowledge and changes in beliefs and perceptions are measured using tools such as the PEI Outreach Survey and the PEI Stigma and Discrimination Reduction Survey.

Other methods used to collect data include feedback from Community Program Planning meetings, PEI quarterly meetings, and bi-annual and annual reports submitted by the PEI program providers.

Additional information about the data collection methods is described in greater detail in the following sections.



Artwork by Gabriel Horne

Introduction, cont.

PEI Statewide Projects

PEI Statewide Projects are intended to build PEI capacity across the state and locally via the California Mental Health Services Authority (CalMHSA), a joint powers authority working on behalf of California Public Behavioral Health plans. The effort was jointly initiated with other California counties to make a statewide and local impact by expanding awareness of mental health needs and supports, reducing stigma, preventing suicides, and teaching individuals how to achieve mental wellness.

The three (3) statewide projects include:

1. Take Action for Mental Health (formerly Each Mind Matters)
 - **Goal:** Eliminating stigma and discrimination against individuals with mental illness
2. Directing Change (Student Mental Health Initiative)
 - **Goal:** Strengthening school (K-12) and higher education mental health programs
3. Know the Signs (Suicide Prevention)
 - **Goal:** Supporting and coordinating with counties on the implementation of the California Strategic Plan for Suicide Prevention

These projects are administered by CalMHSA and are represented under the Take Action for Mental Health project. Strategies for FY 22/23 included:

- Distribution of the Take Action for Mental Health campaign's materials and messages,
- Technical assistance and outreach to Members contributing to the PEI Program,

- Mental health and suicide prevention training to diverse audiences, and
- Engaging youth through the Directing Change program.

Technical Assistance (TA) is provided to San Bernardino County and local community organizations. The TA Team includes crisis support, capacity building, guidance, and resource navigation of stigma reduction, suicide prevention, and student mental health.



Introduction, cont.

San Bernardino County Local Impact

Directing Change is a statewide contest that engages students in creating 60-second public service announcements about suicide prevention and stigma and discrimination reduction.

One hundred and five participants submitted a total of 40 films. Entries were submitted by filmmakers from seven San Bernardino County schools: Apple Valley High School, Arroyo High School, Sage Oak Charter School, Silverado High School, Upland High School, Entrepreneur High School, Encore High School, and New Vision Middle School. San Bernardino County filmmakers whose entries competed in the categories of Mental Health Matters, Suicide Prevention, Animated Short, Walk in Our Shoes and Through the Lens of Culture.

San Bernardino County hosted a Directing Change Recognition Ceremony at the Cinemark Theater in Rialto on May 11, 2023, to honor the San Bernardino County filmmakers.

Directing Change Mini-Grant: New Vision Middle School received a Mini-Grant award. They submitted a compelling application detailing the school's students' needs and the trauma they have experienced. They used their award to leverage participation in the current Directing Change program into sustainable practices in the future by building out their peer helper program on campus.

Over the last four fiscal years more, than 3,000 individuals were reached through multiple trainings, presentations, and various outreach efforts with stigma reduction, suicide prevention, and student mental health messages, resources, tools and materials through the collective efforts of all programs implemented under the Statewide PEI Project. As shown on the following slide, these include:

Introduction, cont.

Training	Description
Directing Change Judges Training	Online trainings that provided an overview of best practices in suicide prevention and mental health messaging, giving volunteer judges criteria to apply in evaluating student-submitted Directing Change videos.
Each Mind Matters Insiders Newsletter	A monthly electronic newsletter created specifically for service providers that provides information about relevant resources, upcoming events and opportunities for providers to get involved in California's Mental Health Movement.
Suicide Prevention 101 for Parents: Recognizing Signs and What to Do	Webinar series providing information for parents including • Recognizing warning signs for suicide • How to have a conversation with your teen • Actions to take if your teen is having suicidal thoughts • Tips and resources to support emotional and mental health during COVID-19 • Information about raising resilient teens
Suicide Prevention Week: Share Hope Together for Suicide Prevention	Through sharing of experiences and stories we can connect with and inspire one another. Sharing can create a sense of belonging while also reducing the weight of our burdens – allowing us to take action for suicide prevention together.

Number of Consumers to be Served

The tables below demonstrate the number of consumers to be served by program name for Fiscal Year 2024/25

Program Name	Fiscal Year 2024/25 Total
Native American Resource Center	1,751
Promotores de Salud/Community Health Worker	30,665
Inland Empire Opioid Crisis Coalition (IEOCC)	3,400
Child and Youth Connection	5,235
Preschool PEI	1,508
Resilience Promotion in African American Children	4,190
Older Adult Community Services	3,166

Program Name	Fiscal Year 2024/25 Total
Lift	120
Coalition Against Sexual Exploitation (CASE)	1,500
Family Resource Center	26,945
Community Wholeness and Enrichment	2,956
Military Services and Family Support	3,878
Student Assistance Program	9,172
Early Psychosis Program/IDEA	26

Native American Resource Center (NARC)

Program Description and Target Population

The Native American Resource Center (NARC) is a Stigma and Discrimination Reduction program that functions as a one-stop center offering prevention and early intervention services designed to reduce stigma and discrimination surrounding behavioral health services for Native American community members of all ages. They use holistic approaches, recognizing that the mental, physical, spiritual, and emotional self are all interconnected.

The Native American Resource Center provides culturally-based behavioral health services and education through historical and cultural contexts. They use traditional and strength-based Native American practices in their service delivery model. The use of cultural methods in prevention activities such as beading, sewing, herbal medicines, and sharing a meal together helps to ease the discomfort of having conversations about mental illness, and reduces the stigma attached to mental illness and accessing mental health services.

The adjacent table provides an overview of the program’s target population, service locations, consumer numbers to be served each year, annual budget allocation, and the types of services offered. The Native American Resource Center program continually assesses the needs of its participants and updates the service type, as necessary.

Services Offered	- Talking Circles - Wellness Circles - Drumming Circles - Daughters of Tradition - Cultural education and awareness - Cultural arts therapy - Cognitive therapy groups	Program Serves	Children TAY (16-25) Adults Older Adults (60+)
		Location of Services	Counseling Centers
		Annual Budget FY 24/25	\$500,000
		Cost Per Client FY 24/25	\$285

Native American Resource Center (NARC), cont.

State Program Positive Results

The Native American Resource Center offers a mix of activities based on tradition. The program is reducing stigma surrounding mental illness and accessing behavioral health services by offering services that focus on culture as a preventative measure. For example, utilizing Talking Circles instead of group therapy reduces the stigma associated with participating in behavioral health activities. Incorporating traditional native practices such as beading, art, and storytelling are also examples of how cultural norms are integrated with therapeutic practices.

Stigma & Discrimination Reduction

Recognizing and acknowledging behaviors and actions that resulted in emotional harm for the Native American community are the first steps towards healing and change. Educating the community about historical and intergenerational trauma aids in understanding the specific needs of this underserved community.

A measurement indicator in reducing stigma and discrimination is measuring attitudes, knowledge, and behavior changes. These elements are measured using surveys to gauge how the participant's perception of mental illness has changed as a result of the activity or presentation the individual participated in.

The utilization of behavioral health services slightly increased from 5,200 to 5,972 between FY 2021/22 to FY 2022/23 and exceeded their annual projected services, as shown in the table below.

As a result of the culturally-based mental wellness activities offered by the Native American Resource Center, the total number of individuals participating in Native American Resource Center activities exceeded their projected targets for a third consecutive year. This demonstrates an increase in seeking and accepting assistance for behavioral health concerns.

Total participation increased in FY 2022/23 by 35% from FY 2021/22. The gradual reduction of COVID-19 restrictions allowed for the program to provide more in person mental health resources and education.

Number of Participants / Number of Services Projected vs Actual				
	Projected	Actual		
		FY 20/21	FY 21/22	FY 22/23
Unduplicated Participants	1,751	8,469	4,138	5,566
Number of Services	2,544	9,338	5,200	5,972

Native American Resource Center (NARC), cont.

State Program Positive Results, cont.

Access & Linkage to Services

The Native American Resource Center provides access and linkage to additional services and higher levels of care for participants who require treatment beyond early intervention. Participants needing higher levels of care receive referrals to providers who can provide the appropriate level of care. All referred participants engaged in treatment services with their selected providers.

The adjacent table shows the number of participants who linked to referrals during the previous three fiscal years. The number is relatively low in comparison to the total number served, which indicates that the program continues to be successful in reducing a potential illness from becoming disabling.

Access and Linkage to Services Referrals			
	FY 20/21	FY 21/22	FY 22/23
Number of Referrals Provided	6	5	4
Number of referrals to County-funded / administered programs	0	0	0
Number of referrals to other programs	6	5	4
Number of participants who followed through and engaged in services at a County-funded / administered program at least once	0*	0*	0
* All participants engaged in treatment with the non-County administered service providers to whom they were referred.			

Native American Resource Center (NARC), cont.

State Program Positive Results, cont.

Improving Timely Access

Native American Resource Centers improve timely access to behavioral health services for members of historically underserved populations. They provide referrals to appropriate prevention, early intervention, and/or higher-level care services. Members of traditionally underserved populations include individuals who are unserved, underserved, or inappropriately served in the system of care. These populations are at a higher risk of homelessness, institutionalization, incarceration, or out-of-home placement. This also includes members of ethnic/racial, cultural, and linguistic populations that do not have access to mental health programs. Barriers such as misidentification of their mental health needs, lack of engagement and outreach, limited language access, and lack of culturally competent services make it difficult to access services. Native American Resource Center actively identifies and engages individuals to determine their needs and provides referrals that meet their behavioral health care needs in a culturally relevant manner.

The data for measuring Improving Timely Access is gathered from referrals to prevention services, early intervention treatment, and higher levels of care. The table below represents those who were referred and identified as part of an unserved/underserved population.

Improving Timely Access Referrals			
	FY 20/21	FY 21/22	FY 22/23
Number of Referrals Provided	139	294	247

Native American Resource Center (NARC), cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-59	60+	UNK
FY 20/21	1%	1%	3%	0%	95%
FY 21/22	2%	2%	4%	1%	91%
FY 22/23	3%	6%	12%	3%	76%

Fiscal Year	Sexual Orientation
% of consumers who identified as LGBTQ+	
FY 20/21	<1%
FY 21/22	0%
FY 22/23	<1%

Fiscal Year	Gender Identity			
	♂	♀	⚧	UNK
FY 20/21	9%	18%	<1%	73%
FY 21/22	11%	26%	0%	64%
FY 22/23	8%	17%	<1%	75%

Fiscal Year	Veteran Status
% of consumers who identified as a veteran	
FY 20/21	0%
FY 21/22	0%
FY 22/23	1%

Fiscal Year	Disability
% of consumers who identified a physical disability	
FY 20/21	<1%
FY 21/22	1%
FY 22/23	3%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 20/21	100%	0%	0%	0%
FY 21/22	97%	0%	0%	3%
FY 22/23	14%	<1%	<1%	86%

Native American Resource Center (NARC), cont.

Demographics, cont.

Demographic Observations

- The Native American Resource Center continues to provide culturally appropriate services to the Native American community.
- The number of participants served has increased again in FY 2022/23. The reintegration of in-person activities, in addition to virtual activities and support groups, aided in the increase for the fiscal year.
- Due to the increased number of in-person activities, participants were again offered the opportunity to complete paper surveys instead of only electronic surveys.

	Race	%
FY 20/21	African American/Black	0%
	American-Indian/Alaska Native	4%
	Asian/Pacific-Islander	0%
	Caucasian/White	1%
	Latinx/Hispanic	10%
	Multiple Racial/Other	0%
FY 21/22	African American/Black	1%
	American-Indian/Alaska Native	6%
	Asian/Pacific-Islander	0%
	Caucasian/White	1%
	Latinx/Hispanic	1%
	Multiple Racial/Other	4%
FY 22/23	African American/Black	2%
	American-Indian/Alaska Native	10%
	Asian/Pacific-Islander	1%
	Caucasian/White	2%
	Latinx/Hispanic	7%
	Multiple Racial/Other	10%

Native American Resource Center (NARC), cont.

Demographics, cont.

	Ethnicity			
		FY 20/21	FY 21/22	FY 22/23
Ethnicity	African	0%	0%	0%
	Asian Indian/South Asian	0%	0%	0%
	Cambodian	0%	0%	0%
	Chinese	0%	0%	0%
	Eastern European	0%	0%	0%
	European	0%	0%	0%
	Latinx/Hispanic	10%	1%	7%
	Filipino	0%	0%	0%
	Japanese	0%	0%	0%
	Korean	0%	0%	0%
	Middle Eastern	0%	0%	0%
	Vietnamese	0%	0%	0%
	Other	0%	1%	0%
	More than one ethnicity	1%	0%	0%

Native American Resource Center (NARC), cont.

Program Goals

The goals of the Native American Resource Center are to:

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

The adjacent chart provides information on the metrics used to meet these goals. The Native American Resource Center utilizes two primary surveys to measure outcomes related to reducing stigma and discrimination.

By administering these surveys, they can measure changes in attitudes, knowledge, and behaviors related to behavioral health services. Challenges such as technology issues and cumbersome paper-based methods have been identified as barriers to effectively administering the surveys. Collaborative efforts between PEI and the provider are underway to design a more effective method of survey distribution.

Program Outcomes

Method use to collect outcome	Description of method	Frequency of use	Number Completed	
Historical Trauma Survey	Mixed-use survey designed to measure changes in attitudes, knowledge, and behavior through a combination of survey questions, storytelling, and artistic expression	Post-activity	FY 20/21:	74
			FY 21/22:	5
			FY 22/23:	0*
Stigma Reduction Questionnaire (SRQ) Surveys	Survey to measure changes in attitudes, knowledge and behavior related to mental health services	Post-activity	FY 20/21:	205
			FY 21/22:	8
			FY 22/23:	147*

*Reflects challenges in survey distribution.

Native American Resource Center (NARC), cont.

Outcome Discussion

Historical Trauma and Reduction of Stigma

The Native American Resource Center hosts several events designed to address historical trauma. Historical trauma presentations provide information to the community that increases understanding and awareness of Native American History. The information is delivered in many contexts and allows participants the opportunity for reflection and rich discussions in recognizing and acknowledging intergenerational trauma experienced by Native American communities. By increasing understanding, we can improve cultural competency and treatment strategies for the Native American community so that healing can begin.

Stigma caused by years of historical trauma is reduced by providing information on how it affects individual, family, and community functioning. Education leads to a greater understanding of validating and healing from unresolved grief and regaining cultural identity. The Native American Resource Center gives insight into the issues and obstacles that affect the willingness to access services. They provide culturally appropriate services and support to decrease the stigma and reduce traumatic effects.

By increasing understanding, we can improve cultural competency and treatment strategies for the Native American community, allowing healing to begin.

The Native American Resource Center continued to hold cultural education trainings focusing on historical trauma, historical trauma response, and the barriers to care because of intergenerational trauma. In November, during Native American Heritage Month, the Native American Resource Center facilitated an educational workshop and presentation on the impact of historical trauma with a focus on the impact of being removed from one's home as a child and placed in boarding schools.

Native American Resource Center (NARC), cont.

Outcome Discussion, cont.

Stigma Reduction Surveys

The Native American Resource Center utilized the Stigma Reduction Questionnaire (SRQ) as its primary tool for capturing stigma-related outcomes during FY 22/23. The SRQ is administered after events and activities to gauge shifting attitudes regarding discrimination towards mental health issues.

While a sample of questions and responses is provided in the accompanying table, some questions were omitted in FY 21/22 and FY 22/23 to refine data collection methods.

Challenges such as technology issues and cumbersome paper-based methods have been identified as barriers to effectively capturing data. Collaborative efforts between PEI and the provider are underway to design a more effective data collection method.

Percentage of participants who agreed that they would be more likely to engage or support someone living with a mental health challenge			
	FY 20/21 N=205	FY 21/22 N=8*	FY 22/23 N=147*
More likely to seek mental health support if needed	76%	100%	87%
More likely to talk to a friend or family member about mental health needs	77%	100%	84%
More likely to socialize with someone who has a mental illness	80%	Not Applicable	Not applicable
More likely to take action to prevent mental health discrimination	78%	88%	83%
More likely to actively and compassionately listen to someone in distress	83%	100%	89%

*Reflects difficulty in collecting data .

Native American Resource Center (NARC), cont.

Challenges/Solutions

The Native American Resource Center has consistently experienced challenges in collecting demographic data from program participants. The program collects qualitative and quantitative data well. However, when participants are asked to provide demographic data (age, gender, sex at birth, etc.) the response rate declines. In addition, the program experienced challenges with having consistent access to the necessary databases to provide its data.

As COVID-19 restrictions were relaxed, the Native American Resource Center resumed hosting in-person events and virtual meeting spaces. Informational kits were also created for participants to complete at home for those that did not prefer them virtually.

Success Story

A young woman of Mexican Indigenous descent participating in a Talking Circle facilitated by Native American Resource Center stated that even though she struggled with the English language, adapting to a different country's educational system, and carrying her family dynamics in the back of her mind as she learned more about historical trauma through her education, was triggering in her feelings of anxiety and was making it difficult for her to concentrate in her studies. She was encouraged to remain patient as she was on a waiting list to see a counselor on campus. She stated that meeting other native students on campus and expressing herself freely in a space specifically for Native/Indigenous students was very "healing" for her.

Program Updates

There are no planned program updates for Fiscal Year 2024/25.

Promotores de Salud/Community Health Worker (PdS/CHW)

Program Description and Target Population

The Promotores de Salud/Community Health Workers (PdS/CHW) program is categorized as a State Outreach for Increasing Recognition of Early Signs of Mental Illness program. The Pds/CHW program is designed to increase awareness of community-based prevention and mental health services in culturally diverse communities. The program promotes mental health awareness, education, and available resources for members of culturally-specific populations throughout the county. Services are designed to increase awareness of and access to the behavioral health system of care. The program targets five specific cultural populations identified by community stakeholders as having the highest need: Latinx/Hispanic, African American/Black, Asian/Pacific Islander, LGBTQ+, and Native American.

The program provides field-based outreach and education to all age groups in many areas of the County.

The chart below provides an overview of the program services.

Services Offered	• Mental Health and Substance Use Screenings and Assessments • Mental Health Educational Presentations • Case Management • Resource Referrals • Peer Counseling	Program Serves	Children TAY (16-25) Adults Older Adults (60+)
		Location of Services	Community based
		Annual Budget FY 24/25	\$1,264,429
		Cost Per Client FY 24/25	\$41

Promotores de Salud/Community Health Worker (PdS/CHW), cont.

State Program Positive Results

The Promotores de Salud/Community Health Worker (PdS/CHW) program provides community education on mental health and substance use disorder topics, promotes behavioral health prevention and wellness, and connects community members to local resources within San Bernardino County. The populations served include Latinx/Hispanic, African American/Black, Asian/Pacific Islander, Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ+), and Native American communities.

The PdS/CHW program utilizes evidence-based methods to engage the target populations. An effective strategy is recruiting PdS/CHW workers with many of the same social, cultural, and economic characteristics as the target population. This increases the probability that communities will engage with Promotores de Salud or Community Health Workers.

The program relies heavily on recruiting and training community members with lived experience or family members to become PdS and CHW workers and deliver services.

As an extension of Community Health Workers, Peer Providers draw upon their lived experience to help individuals access mental health services and navigate the mental health system. This peer perspective also helps to reduce stigma associated with accessing services.

Number of CHW Participants / Number of Services Projected vs Actual				
	Projected	Actual		
		FY 20/21	FY 21/22	FY 22/23
Unduplicated Participants	11,500*	15,904	12,820	24,083
Number of Services	15,520**	16,825	13,851	24,764

Number of PdS Participants / Number of Services Projected vs Actual				
	Projected	Actual		
		FY 20/21	FY 21/22	FY 22/23
Unduplicated Participants	23,885*	50,539	49,875	40,570
Number of Services	25,385**	50,777	58,519	47,925

Promotores de Salud/Community Health Worker (PdS/CHW), cont.

State Program Positive Results, cont.

Outreach

The PdS/CHW program uses a variety of culturally specific strategies to engage new participants and train potential responders about the signs and symptoms of mental illness. This information includes recognizing their symptoms and seeking help if necessary. These outreach activities build the capacity of entire communities to identify potential mental health concerns and increase help-seeking behaviors.

The PdS/CHW program's community outreach efforts reached 193,791 participants from FY 2020/21 through FY 2022/23. This figure includes potential responders in the community, who are people in the community who can identify early signs of mental illness and refer individuals to behavioral health services. In FY 2022/23, the PdS/CHW program expanded its services to the Morongo Basin.

There was an overall increase in unduplicated participants from FY 2021/22 to 2022/23. The PdS/CHW program was able to transition further into in-person outreach and events as COVID-19 restrictions were relaxed throughout the county. PdS/CHW's continue to use mostly virtual presentations in combination with field-based outreach strategies to reach potential responders. The program still collectively exceed the plan goals by exceeding the annual projected number to be served.



The PdS/CHW program captures information on the number of potential responders trained each year. This enables tracking the increase in mental health awareness in the community. Between FY 2020/21 and FY 2022/23, the program engaged an average of 61,912 potential responders per year, with a slight decrease in responders from FY 2021/22.

Potential Responders			
	Number of Potential Responders		
	<i>PdS</i>	<i>CHW</i>	<i>Total</i>
FY 2020/21	50,539	15,607	66,146
FY 2021/22	48,753	12,610	61,363
FY 2022/23	34,426	23,800	58,226

Promotores de Salud/Community Health Worker (PdS/CHW), cont.

State Program Positive Results, cont.

Outreach, cont.

Potential responders may include, but are not limited to, family members, employers, primary health care providers, school personnel, community service providers, peer providers, law enforcement personnel, and many others. Below are some of the specific potential responders who participated in the program.

- Consumer Family Members
- Families
- Employers
- Leaders of Faith-Based Organizations
- School Personnel
- Child Protective Services
- Peer Providers

Promotores de Salud and Community Health Workers organically become trusted and dependable members of their communities. These relationships allow them to become liaisons to their communities and aid in successfully delivering culturally appropriate services. As cultural brokers in the community, they may also fill the role of advocate, educator, mentor, and sometimes interpreter.

Community members with established relationships with PdS and CHWs in the program's target populations are more likely to engage and seek services. PdS/CHWs continue to engage participants in both traditional and non-traditional settings to build trust and reduce stigma in their targeted populations. The list below shows the types of settings used to engage potential responders:

Types of Settings	
• Residence • Church • Community-Based Organization • Family Resource Center • Community Event • Recreation Center • School	• Shelter • Primary Health Care • Library • Behavioral Health Clinic • Faith-Based Organizations • Senior Center

PdS/CHWs are beginning to engage with participants again for presentations and resources in residences as most COVID-19 restrictions are relaxed. There has been an increase in faith-based organizations making their churches available to PdS/CHWs to engage with potential responders to build trust and reduce stigma in spiritual communities.

Promotores de Salud/Community Health Worker (PdS/CHW), cont.

State Program Positive Results, cont.

Improving Timely Access to Underserved Populations

One of the PdS/CHW strategies is to improve timely access to services. This happens once participants begin engaging and seeking mental health services. PdS/CHWs are trained to identify participants during their outreach and/or presentations. They are equipped with the necessary resources to link them to services as soon as possible and provide support.

The program continues to find solutions to increase the data collection and outcomes after a referral. The PdS/CHW program has successfully connected underserved populations to timely services. PdS/CHW program providers have improved their efforts in increasing and tracking referrals to prevention, early intervention, and treatment beyond early onset. PdS/CHWs link participants to the necessary resources and services while providing peer support.

The PdS/CHW program made referrals for the following underserved populations:



- Trauma-exposed
- Co-occurring
- LGBTQ+
- African American/Black
- Latinx/Hispanic
- Asian and Pacific Islanders
- Native American

Improving Timely Access Referrals

	FY 2020/21	FY 2021/22	FY 2022/23
# of Referrals Provided	294	205	15,006
Referred To	• Prevention • Early Intervention • Treatment Beyond Early Onset		



Promotores de Salud/Community Health Worker (PdS/CHW), cont.

Demographics

Fiscal Year	CHW Age (yrs. old)				
	0-15	16-25	26-50	60+	UNK
FY 20/21	<1%	<1%	2%	2%	95%
FY 21/22	1%	2%	1%	2%	94%
FY 22/23	2%	3%	5%	2%	88%

Fiscal Year	CHW Sexual Orientation
% of consumers who identified as LGBTQ+	
FY 20/21	<1%
FY 21/22	<1%
FY 22/23	<1%

Fiscal Year	CHW Gender Identity			
	♂	♀	⚧	UNK
FY 20/21	3%	6%	<1%	91%
FY 21/22	4%	7%	<1%	90%
FY 22/23	3%	7%	<1%	90%

Fiscal Year	PdS Age (yrs. old)				
	0-15	16-25	26-50	60+	UNK
FY 20/21	13%	18%	52%	7%	10%
FY 21/22	12%	20%	56%	7%	6%
FY 22/23	8%	16%	63%	10%	3%

Fiscal Year	PdS Sexual Orientation
% of consumers who identified as LGBTQ+	
FY 20/21	<1%
FY 21/22	<1%
FY 22/23	<1%

Fiscal Year	PdS Gender Identity			
	♂	♀	⚧	UNK
FY 20/21	6%	88%	5%	1%
FY 21/22	5%	89%	0%	6%
FY 22/23	3%	93%	<1%	4%

Promotores de Salud/Community Health Worker (PdS/CHW), cont.

Demographics

Fiscal Year	CHW Veteran Status
% of consumers who identified as a veteran	
FY 20/21	<1%
FY 21/22	<1%
FY 22/23	<1%

Fiscal Year	CHW Disability
% of consumers who identified a physical disability	
FY 20/21	<1%
FY 21/22	<1%
FY 22/23	<1%

Fiscal Year	CHW Primary Language			
	ENG	SPAN	OTH	UNK
FY 20/21	86%	0%	2%	12%
FY 21/22	46%	0%	2%	52%
FY 22/23	6%	<1%	1%	92%

Fiscal Year	PdS Veteran Status
% of consumers who identified as a veteran	
FY 20/21	<1%
FY 21/22	<1%
FY 22/23	<1%

Fiscal Year	PdS Disability
% of consumers who identified a physical disability	
FY 20/21	<1%
FY 21/22	<1%
FY 22/23	<1%

Fiscal Year	PdS Primary Language			
	ENG	SPAN	OTH	UNK
FY 20/21	6%	88%	5%	1%
FY 21/22	5%	89%	0%	6%
FY 22/23	3%	93%	<1%	4%

Promotores de Salud/Community Health Worker (PdS/CHW), cont.

Demographics, cont.

	CHW Race	%
FY 20/21	African American/Black	1%
	American-Indian/Alaska Native	<1%
	Asian/Pacific-Islander	2%
	Caucasian/White	<1%
	Latinx/Hispanic	<1%
	Multiple Racial/Other	<1%
FY 21/22	African American/Black	<1%
	American-Indian/Alaska Native	2%
	Asian/Pacific-Islander	2%
	Caucasian/White	<1%
	Latinx/Hispanic	<1%
	Multiple Racial/Other	<1%
FY 22/23	African American/Black	27%
	American-Indian/Alaska Native	1%
	Asian/Pacific-Islander	<1%
	Caucasian/White	2%
	Latinx/Hispanic	3%
	Multiple Racial/Other	4%

	CHW Ethnicity			
		FY 20/21	FY 21/22	FY 22/23
Ethnicity	African	<1%	<1%	<1%
	Asian Indian/South Asian	<1%	<1%	<1%
	Cambodian	0%	0%	<1%
	Chinese	2%	2%	4%
	Eastern European	<1%	0%	0%
	European	0%	0%	<1%
	Latinx/Hispanic	<1%	<1%	3%
	Filipino	<1%	<1%	<1%
	Japanese	<1%	0%	<1%
	Korean	0%	<1%	<1%
	Middle Eastern	0%	0%	<1%
	Vietnamese	<1%	0%	2%
	Other	<1%	<1%	<1%
	More than one ethnicity	<1%	0%	<1%

Promotores de Salud/Community Health Worker (PdS/CHW), cont.

Demographics, cont.

	PdS Race	%
FY 20/21	African American/Black	<1%
	American-Indian/Alaska Native	0%
	Asian/Pacific-Islander	<1%
	Caucasian/White	61%
	Latinx/Hispanic	91%
	Multiple Racial/Other	17%
FY 21/22	African American/Black	<1%
	American-Indian/Alaska Native	<1%
	Asian/Pacific-Islander	<1%
	Caucasian/White	47%
	Latinx/Hispanic	92%
	Multiple Racial/Other	12%
FY 22/23	African American/Black	<1%
	American-Indian/Alaska Native	<1%
	Asian/Pacific-Islander	<1%
	Caucasian/White	36%
	Latinx/Hispanic	95%
	Multiple Racial/Other	9%

	PdS Ethnicity			
		FY 20/21	FY 21/22	FY 22/23
Ethnicity	African	<1%	<1%	0%
	Asian			
	Indian/South Asian	<1%	<1%	0%
	Cambodian	<1%	0%	0%
	Chinese	<1%	0%	0%
	Eastern European	0%	0%	0%
	European	<1%	<1%	0%
	Latinx/Hispanic	91%	92%	95%
	Filipino	0%	0%	0%
	Japanese	0%	0%	0%
	Korean	0%	0%	0%
	Middle Eastern	0%	<1%	0%
	Vietnamese	<1%	<1%	<1%
	Other	22%	21%	68%
	More than one ethnicity	2%	<1%	0%

Promotores de Salud/Community Health Worker (PdS/CHW), cont.

Demographics, cont.

CHW Demographic Observations

- Did we serve who we targeted?
 - CHW demographic data includes all target population programs for the African American/Black, Asian Pacific Islander, LGBTQ+, and Native American communities.
 - A significant effort made to reach additional members of the African American/Black community. There was a 27% increase in African American/Black participants between FY 21/22 and 22/23.
 - The number of adult participants aged 26-59 slightly increased over the last fiscal year.
 - While there has been an increase in the response rate in collecting data over the last year, there is also the opportunity for improvement when engaging with members of all the target communities served.

PdS Demographic Observations

- The PdS program was successful in serving its primary target population. Demographic data shows that 95% of participants identify as Latinx/Hispanic, and Spanish is the primary language for 93% of participants.
- FY 22/23 data also shows an increase in participants aged 26-59.



Promotores de Salud/Community Health Worker (PdS/CHW), cont.

Program Goals

The goals of the Promotores de Salud/Community Health Worker program are:

- Increase recognition of early signs of potentially severe and disabling mental illness,
- Provide support to individuals with mental illness,
- Refer individuals who need treatment to other mental health services, and
- Provide outreach to individuals to recognize and respond to their symptoms of potential mental illness.

The program achieves the above goals by deploying trained PdS/CHW into their targeted communities. They train community members to recognize and respond effectively to early signs of potentially severe and disabling mental illness and to provide health promotion, education services, alternative activities, or identify risk factors that can contribute to the development of a behavioral health condition. They promote positive mental health and wellness through educational services and culturally appropriate activities. Communities learn about the risk factors that contribute to developing a behavioral health condition.

The effectiveness of the program is evaluated through reflective surveys, which yield a sufficient measurement of improved learning. They are provided after the activity and allow participants to gauge their level of change in knowledge and comfort level.

The following table provides a summary of the tools used and a brief description.

Promotores de Salud/Community Health Worker (PdS/CHW), cont.

Program Outcomes

Method use to collect outcome	Description of method	Frequency of use	Number Completed
Stigma Discrimination Reduction Surveys	Refers to a compilation of surveys used by the Department of Behavioral Health – PEI programs designed to capture outcomes from Stigma and Discrimination Reduction activities. Examples of surveys used by PdS/CHW programs are the Modular presentation Survey, Measures, Outcomes, and Quality Assessment (MOQA) Survey, and the Stigma Reduction Questionnaire (SRQ).	Post – after each Stigma Reduction presentation	FY 20/21: 3,699 FY 21/22: 4,277 FY 22/23: 828
PEI Outreach Survey	PEI The Outreach Survey has 16 questions. The first 9 collect PEI demographic information, and the last 7 gather information on participants' confidence in recognizing potential mental health challenges and seeking services if needed.	Pre and Post each educational Outreach activity	FY 20/21: 72 FY 21/22: 430 FY 22/23: 1,571

Outcome Discussion

The Promotores de Salud/Community Health Worker program planning revolves around ensuring the community has access to linguistically and culturally competent mental health information. The program uses evidence-based strategies to reach out to community members and offers a variety of opportunities to learn more about behavioral health concerns surrounding their cultural communities.

Strategies for engagement vary between cultural groups. Some cultural groups are comfortable with utilizing technological tools, while others prefer traditional in-person strategies. An online, virtual approach was adopted due to the COVID-19 pandemic in communities where the target population may have been at high risk of transmission. Not all cultures experience the same level of comfort with the same approach. The program continues to explore the most effective methods for delivering culturally appropriate services in their communities.

Promotores de Salud/Community Health Worker (PdS/CHW), cont.

Outcome Discussion, cont.

An objective of this program is to train potential responders and other members of the community to recognize behaviors or symptoms that may indicate someone who is suffering from a mental health challenge. Furthermore, the program helps people become more comfortable supporting those individuals. That support can include informing individuals of the risks surrounding untreated mental illness and reducing the stigma surrounding accessing services.

The program evaluates success by administering surveys and questionnaires that capture changes in learning, perception and help seeking behaviors.

Fiscal Year 2022/23 was the first full year that the PdS/CHW program updated the stigma survey to measure stigma-related outcomes. The Stigma Reduction Questionnaire (SRQ) captures participant's changes in how they feel after participating in an event or activity. Sample questions include:

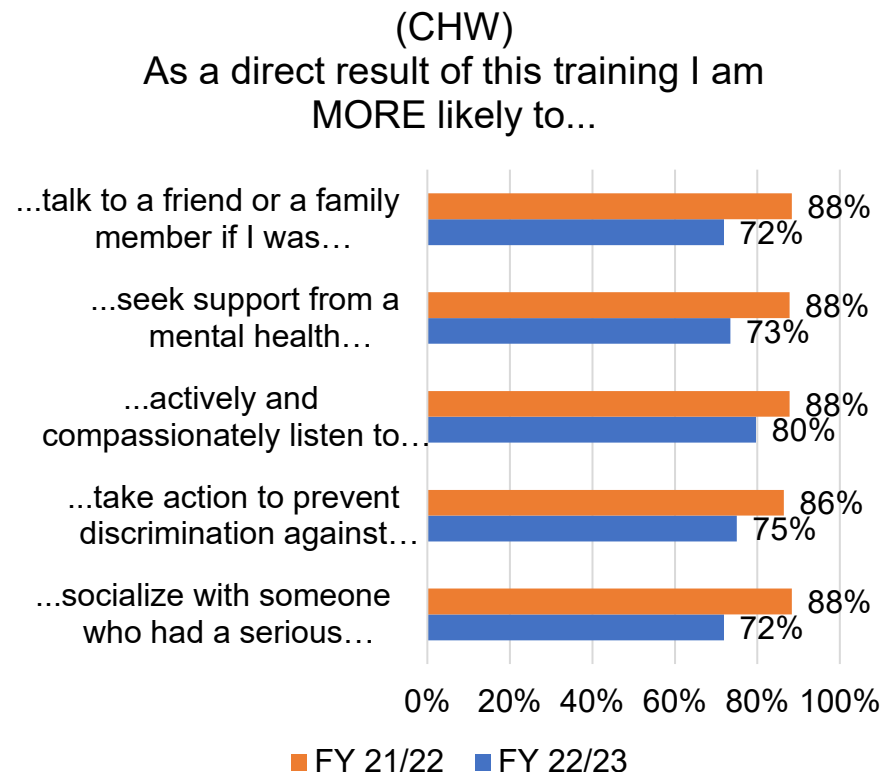
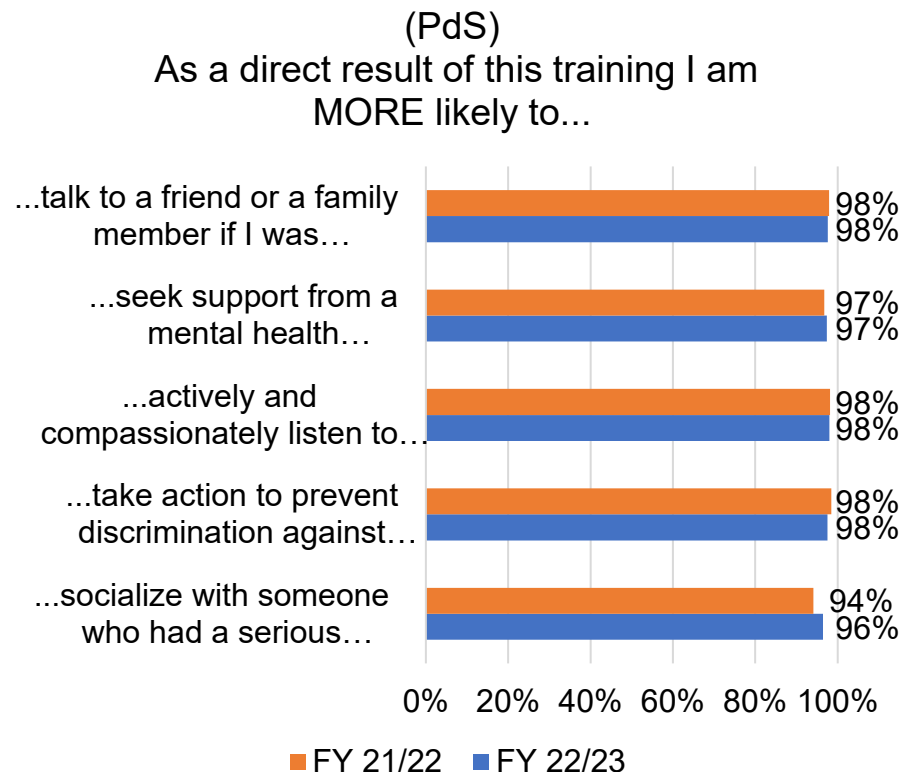
As a direct result of this program, I am MORE likely to...

- socialize with someone who had a serious mental health condition.
- take action to prevent discrimination against people with mental health conditions.
- actively and compassionately listen to someone in distress.
- seek support from a mental health professional if I thought I needed it.
- talk to a friend or a family member if I am experiencing emotional distress.

Promotores de Salud/Community Health Worker (PdS/CHW), cont.

Outcome Discussion, cont.

The survey results show that most participants agree or strongly agree with the statements below as a direct result of what they learned after participating in an event or activity. In FY 22/23, 86% of participants agree or strongly agree with the sample of the stigma survey questions after attending an event or activity, which is represented in the charts below. The data collected this fiscal year reflects that the efforts of PdS/CHWs continue to help reduce stigma in their target populations.

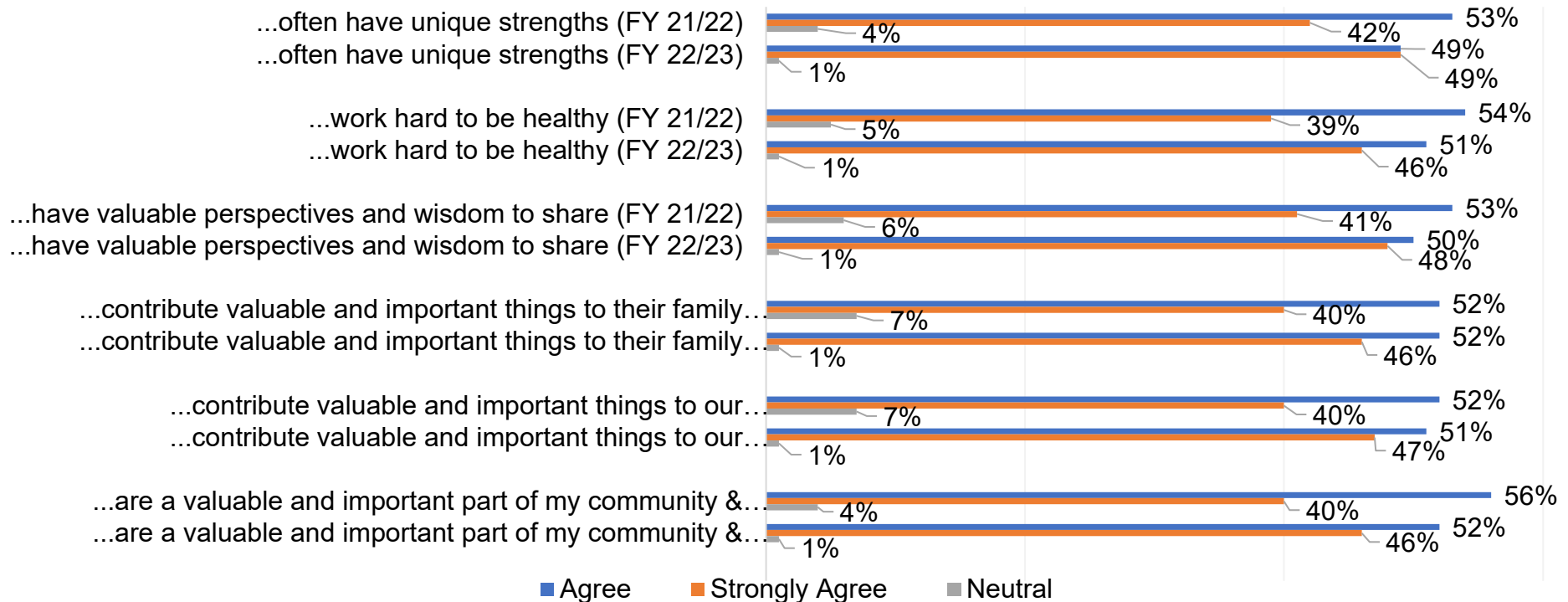


Promotores de Salud/Community Health Worker (PdS/CHW), cont.

Outcome Discussion, cont.

Additional stigma survey results below demonstrate a change in attitudes of the participants who received a stigma-reduction activity. FY 22/23 data shows that as a direct result of PdS trainings, 98% of participants agree or strongly agree that people experiencing mental health challenges are a valuable and important part of their community. In addition to this, 98% of participants agree or strongly agree that people experiencing mental health challenges often have unique strengths. Trainings have provided responders with the resources and the ability to assist friends, family, and community members facing mental health challenges.

Promotores de Salud: As a direct result of this training I am MORE likely to feel that people experiencing mental health challenges...

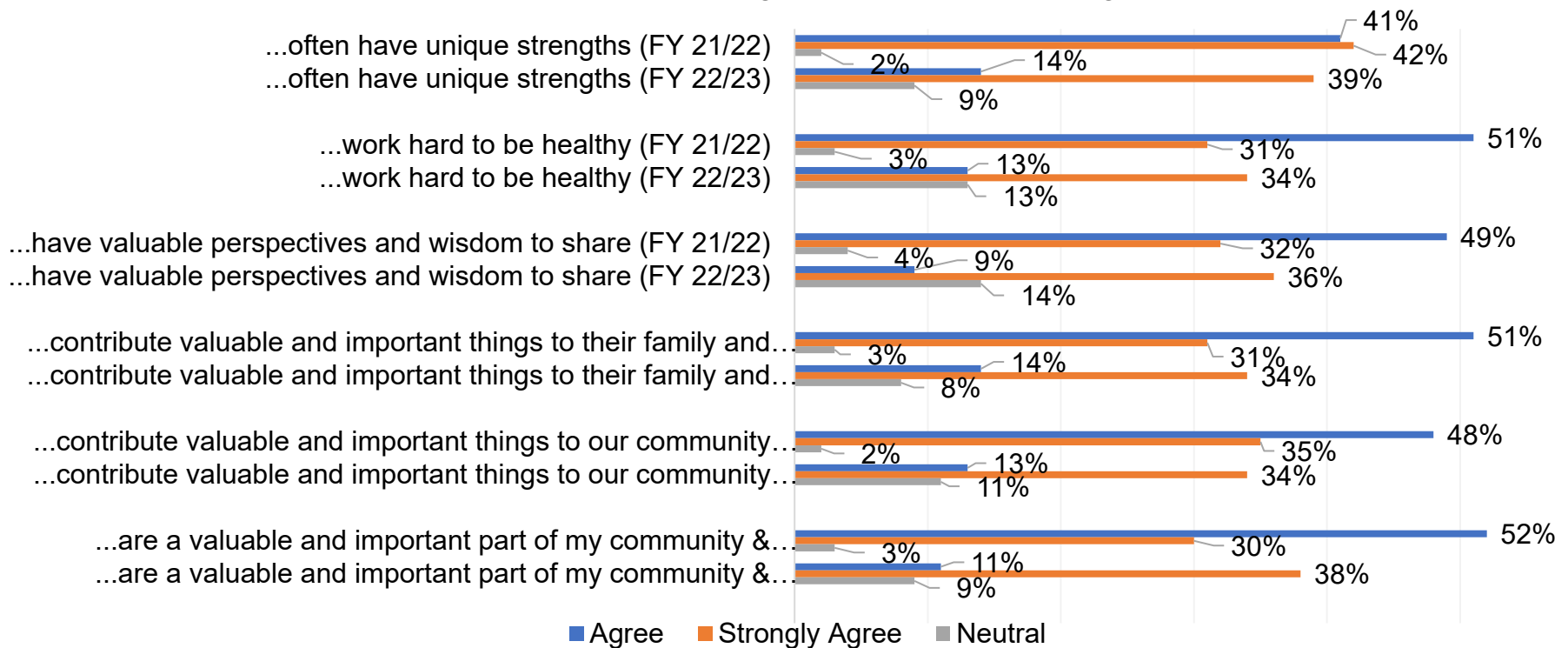


Promotores de Salud/Community Health Worker (PdS/CHW), cont.

Outcome Discussion, cont.

Similar findings indicate that the same conclusions were achieved for CHW target populations. Fiscal year 22/23 outcomes show that 48% of participants either agree or strongly agree that people experiencing mental health challenges contribute valuable and important things to their family and friends. Lastly, 53% of participants either agree or strongly agree that those experiencing mental health challenges often have unique strengths.

Community Health Worker: As a direct result of this training I am MORE likely to feel that those experiencing mental health challenges...



Promotores de Salud/Community Health Worker (PdS/CHW), cont.

Challenges/Solutions

In previous years, one of the primary challenges the PdS/CHW program faced was implementing innovative methods to provide in-person presentations and services to the community during the COVID-19 pandemic. Utilization of virtual meeting spaces through Zoom or Facebook Live continued as COVID-19 became commonplace. Virtual platforms have been permanently integrated into service models as in-person services returned.

The Asian and Pacific Islander (API) population has remained a difficult population for CHWs to reach despite the end of the COVID-19 pandemic. The stigma attached to mental health and illness in the API community remains one of the primary challenges faced. CHWs in the API community are continuing to build strong relationships and search for creative engagement efforts within the community so that they can reduce the stigma associated with mental health.

The San Bernardino County mountain communities faced heavy winter storms that provided barriers to service. Some of these barriers include road closures and power outages, limiting in-person and virtual services to community members.

PdS/CHW providers face challenges in collecting data, especially while tabling at outreach events. While PdS/CHWs were able to engage with participants, they found it challenging to build relationships and trust in those short engagement times. Due to this, participants aren't always yet comfortable with providing demographic data, especially in traditionally underserved populations. DBH collaborated with PdS/CHW providers to include their feedback to make surveys more user-friendly.

As a result, PdS/CHWs have been creative in providing solutions to some of these challenges. PdS/CHWs have put an emphasis on engaging with community members in as many activities as possible, so that they are familiar with the program and how they can assist in their needs.

An additional method that PdS/CHW program providers have utilized is providing incentives as motivation for participations, such as items and resources to help with unmet needs such as food, rental, and utility assistance.

Lastly, PdS/CHWs continues to engage with participants, agencies, and schools regarding the importance of collecting demographic data. It is critical that ongoing education is provided around surveys, their importance, and how they contribute to the program's current success and future.

Promotores de Salud/Community Health Worker (PdS/CHW), cont.

Lessons Learned

PdS/CHW providers continue to build themselves administratively by offering ongoing recruitment efforts to provide a greater presence to the target populations in their communities. They will also need to continue efforts to provide survey education and implement strategies to encourage completion, which could include incentives or prizes. PdS/CHW providers saw success in providing education about their surveys to their collaborative community partners and agencies. This helped to improve and provide access to participant demographic data.

Program Updates

There are no planned program updates for Fiscal Year 2024/25.

Success Story

“First of all, I like to thank you for your perseverance in approaching me at the local Market and letting me know the resources available for us, since we needed help, and for taking the time to explain and let us know the process. I also want to thank you for helping for my daughter enroll in mental health services, she is now receiving therapy. This help made a difference in me and in my family. Now I know that there are organizations that do work for the community. Once again, thank you and thanks to God for having put you on my way. Better said outside the market.”

“I love your presentation! It makes me understand so much more about myself.”

Behavioral Health Ministries Pilot Project (BHMPP)

Program Description and Target Population

The Behavioral Health Ministries Pilot Project was a collaboration between the Department of Behavioral Health (DBH) and the Inland Empire Concerned African American Churches (IECAAC). The project collaborated with a network of faith-based organizations and assisted in identifying the unmet behavioral health needs of the faith-based African American/Black Community. The project provided participants with education and resources to address the behavioral health needs of their congregations within church settings and provide appropriate and timely resources for members to access needed behavioral health resources. This pilot project was implemented over two years, from May 2021 through April 2023.

Services Offered	- Needs Assessment - Asset Mapping - Outreach - Engagement - Education - Training - Referrals to appropriate behavioral health services

Program Serves	Children TAY (16-25) Adults Older Adults (60+)
Location of Services	IECAAC member churches in the Central and West Valley regions
Annual Budget FY 24/25	N/A
Cost Per Consumer FY 24/25	N/A

Behavioral Health Ministries Pilot Project (BHMP), cont.

State Program Positive Results

Behavioral Health Ministries Pilot Project was introduced into PEI programming to strengthen the capacity of the faith-based community to respond to mental health challenges. The church is the pillar of the African American/Black community, and it has the capacity to provide support by utilizing resources and facilitating spiritual and technical expertise. Churches are in positions to identify needs and provide support and resources to their members and communities. This project increased the knowledge of signs and symptoms of mental illness, reduced the stigma of seeking mental health services, and increased the effectiveness of access and linkage to mental health services for African American/Black members of the faith-based community.

The BHMP began developing training and presentations based on feedback from a series of town halls and focus group meetings. Some training topics that were identified and categorized included mental health conditions, education and resources, trauma, and substance use. Following the analysis of town hall and focus group feedback, the BHMP either held or attended over a dozen community outreach events or trainings. In FY 2022/23, the project reached 361 unduplicated participants and provided 441 services to their target population. The project reached 67 church leaders and 294 IEAAC members, congregants, and community leaders.

The project equipped IECAAC members with tools to be mental health responders within not only their congregations but also in the broader scope of their community. A key instrument that has been realized through the development of the pilot is the strength and importance of spiritual testimonies. This use of prayer and scripture, in combination with mental health education and resources is what helps make the BHMP unique and engage the faith-based community.

In FY 2022/23, the project retained its 8 taskforce members, which provided presentations to IECAAC congregations and community responders. The taskforce members have a combination of lived experience and/or an educational background in mental health.

Number of Participants / Number of Services Projected vs Actual				
	Projected	Actual		
		FY 20/21	FY 21/22	FY 22/23
Unduplicated Participants	340	32*	288	361**
Number of Services	600	32*	551	441**

* Project began April 2021, data reflected from May and June of 2021 ** FY 2022-23 is from July 1, 2022, through April 30, 2023

Behavioral Health Ministries Pilot Project (BHMPP), cont.

State Program Positive Results, cont.

The pilot project was divided into four phases. During FY 2022/23, the BHMPP began implementing phases three and four, Community Engagement and Establishment of Behavioral Health Ministries and Reporting. BHMPP sought to serve forty (40) Church pastors and leaders and three-hundred (300) IECAAC members, congregants, and community members per fiscal year of this project. The FY 2022/23 saw the project meet its goal for unduplicated participants in only ten months after serving 361 unduplicated participants.

The ability to hold presentations and trainings at places of worship and incorporate faith-based approaches that may include scripture and prayer are relatable engagement methods with the BHMPP's target population. The project's members could engage participants in both traditional and non-traditional settings.

Types of Settings	Potential Responders
- Community-based organizations - Community events - Faith-based organizations - Virtual (Zoom and Webex)	Number of Potential Responders
	FY 2020-21
	FY 2021-22
	FY 2022-23
	N/A
	149
	257

Behavioral Health Ministries Pilot Project Phases	
Phase	Objective
1. Needs and Strength Assessment	- Development and delivery of needs and strength assessment tools to identify needs of IECAAC member churches - Develop evaluation/surveys that align with Prevention and Early Intervention regulations
2. Education and Awareness	- Development of training plan that includes educational presentations and trainings to IECAAC leaders and first responders - Creation of tools to measure and evaluate the effectiveness of trainings
3. Community Engagement and Establishment of Behavioral Health Ministries	- Conduct trainings to small and large faith-based and community groups - Administer and collect presentation surveys and evaluations
4. Reporting	Submitting monthly, bi-annual, and annual reports

Behavioral Health Ministries Pilot Project (BHMPP), cont.

State Program Positive Results, cont.

Stigma & Discrimination Reduction

Recognizing and acknowledging intergenerational negative attitudes and stereotypes associated with mental illness in the African American/Black community is a key step in moving toward change and healing. Participants have shared that those in the African American/Black community dealing with mental illness do not reach out for help for fear of not being heard or understood. The BHMPP's role in educating the faith-based African American/Black community about mental illness and understanding the importance of mental health is critical.

As part of the project's first phase, evaluations and surveys were developed to aid the project in measuring changes in behaviors, attitudes, and knowledge. The surveys measure these elements by gauging how the participant's perception of mental illness has transformed because of the attended activity. In the first full fiscal year of survey collection, results primarily revealed that participants experienced positive changes in attitudes toward mental health and illness after attending BHMPP-led activities. In FY 2022/23, 100% of participants who attended stigma reduction training and completed a survey strongly agreed that the training was relevant to them and other people of similar cultural backgrounds and experiences (race, ethnicity, gender, religion, etc.).

Increase Recognition of Early Signs of Mental Illness

The educational trainings and presentations developed by the BHMPP in the earlier phases of the project were given more frequently in FY 2022/23. They were developed to reduce stigma and discrimination and to educate and increase recognition of signs and symptoms of serious mental illness and emotional disturbance.

In FY 22/23, pre- and post-survey data show a 34% increase in knowledge regarding mental health and a 37% increase in knowledge regarding mental illness. With this knowledge, after responders completed their training, 16% would be able to better connect people with mental health challenges to appropriate county behavioral health programs, and 15% would be able to better connect people who are at risk of mental illness to the appropriate county behavioral health programs.

Behavioral Health Ministries Pilot Project (BHMP), cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-50	60+	UNK
FY 20/21	N/A	N/A	N/A	N/A	N/A
FY 21/22	0%	2%	19%	26%	53%
FY 22/23	<1%	3%	20%	10%	67%

Fiscal Year	Sexual Orientation
% of consumers who identified as LGBTQ+	
FY 20/21	N/A
FY 21/22	0%
FY 22/23	<1%

Fiscal Year	Gender Identity			
	♂	♀	⚧	UNK
FY 20/21	N/A	N/A	N/A	N/A
FY 21/22	7%	12%	0%	81%
FY 22/23	12%	27%	<1%	61%

Fiscal Year	Veteran Status
% of consumers who identified as a veteran	
FY 20/21	N/A
FY 21/22	2%
FY 22/23	3%

Fiscal Year	Disability
% of consumers who identified a physical disability	
FY 20/21	N/A
FY 21/22	4%
FY 22/23	4%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 20/21	N/A	N/A	N/A	N/A
FY 21/22	68%	1%	0%	31%
FY 22/23	28%	1%	0%	70%

Behavioral Health Ministries Pilot Project (BHMPP), cont.

Demographics, cont.

	Race	%
FY 20/21	African American/Black	N/A
	American-Indian/Alaska Native	N/A
	Asian/Pacific-Islander	N/A
	Caucasian/White	N/A
	Latinx/Hispanic	N/A
	Multiple Racial/Other	N/A
FY 21/22	African American/Black	66%
	American-Indian/Alaska Native	0%
	Asian/Pacific-Islander	0%
	Caucasian/White	1%
	Latinx/Hispanic	4%
	Multiple Racial/Other	2%
FY 22/23	African American/Black	12%
	American-Indian/Alaska Native	0%
	Asian/Pacific-Islander	<1%
	Caucasian/White	1%
	Latinx/Hispanic	8%
	Multiple Racial/Other	3%

	Ethnicity			
		FY 20/21	FY 21/22	FY 22/23
Ethnicity	African	N/A	9%	8%
	Asian Indian/South Asian	N/A	0%	0%
	Cambodian	N/A	0%	0%
	Chinese	N/A	0%	0%
	Eastern European	N/A	0%	0%
	European	N/A	0%	0%
	Latinx/Hispanic	N/A	4%	8%
	Filipino	N/A	0%	0%
	Japanese	N/A	0%	0%
	Korean	N/A	0%	0%
	Middle Eastern	N/A	0%	0%
	Vietnamese	N/A	0%	0%
	Other	N/A	45%	1%
	More than one ethnicity	N/A	8%	0%

Behavioral Health Ministries Pilot Project (BHMPP), cont.

Demographics, cont.

Demographic Observations

- Throughout the duration of the pilot project, demographic information indicated that it could meet its targeted audience of African American/Black adults.
- FY 22/23 saw a decrease in the participation of adults aged 60+. More participants declined to provide age demographic information during the FY 22/23 in comparison to the prior fiscal year.
- There was an improved response rate for the gender identity demographic in FY 22/23 compared to previous fiscal years. Improved survey education efforts may have improved the capturing of this specific demographic data. Overall, there was an increase in the number of unknown/declined-to-answer responses



Behavioral Health Ministries Pilot Project (BHMPP), cont.

Program Goals

The primary goal of BHMPP was to provide participants with education and resources to address the behavioral health needs of their congregations within church settings. The BHMPP was established and progressed through four phases to provide education and resources to the African American/Black faith-based community. BHMPP transitioned in to Phases III and IV during FY 22/23 as the project increased the number of trainings, presentations, and gathered data. The project set out to reach an estimated three-hundred and forty (340) unduplicated participants with these efforts.

Below were the project goals for the BHMPP.

Behavioral Health Education and Awareness:

- 90% Increase in knowledge about mental health, mental illness, and services/resources available
- 90% Increase in knowledge of Substance Use Disorders and services/resources available
- 80% Increase in the ability to connect children, adults and older adults with or at risk of mental illness to appropriate care and treatment, including, but not limited to, care provided by county mental health programs
- 80% Increase in the ability and comfort to address and present behavioral health topics to church members/congregants

Community Engagement:

- 80% Increase in knowledge of mental health, mental illness, and behavioral health services and resources
- 80% Increase in knowledge of substance use disorders and behavioral health services and resources
- 80% Increase in comfort seeking services in their church/community for mental health and substance use issues
- 80% Increase in comfort seeking services if needed
- 80% Increase in likelihood of utilizing information and resources to improve own mental health

Behavioral Health Ministries Pilot Project (BHMPP), cont.

Program Outcomes

Method use to collect outcome	Description of method	Frequency of use	Number Completed
Behavioral Health Ministries Pilot Project Pre and Post Surveys	A survey was developed in collaboration with DBH to measure participant education, awareness, and stigma reduction at each BHMPP outreach and engagement activity held.	Before and after each engagement and outreach event	FY 20/21: N/A FY 21/22: 137 FY 22/23: 144

Outcome Discussion

There continued to be an upward trend in religious communities encouraging the importance of mental health. Congregations are important spaces that help shape the lives of their members and perform an important role in developing positive narratives about behavioral health. Stigma remains an important factor in why members of the African American/Black faith-based community do not discuss or seek treatment or mental health resources.

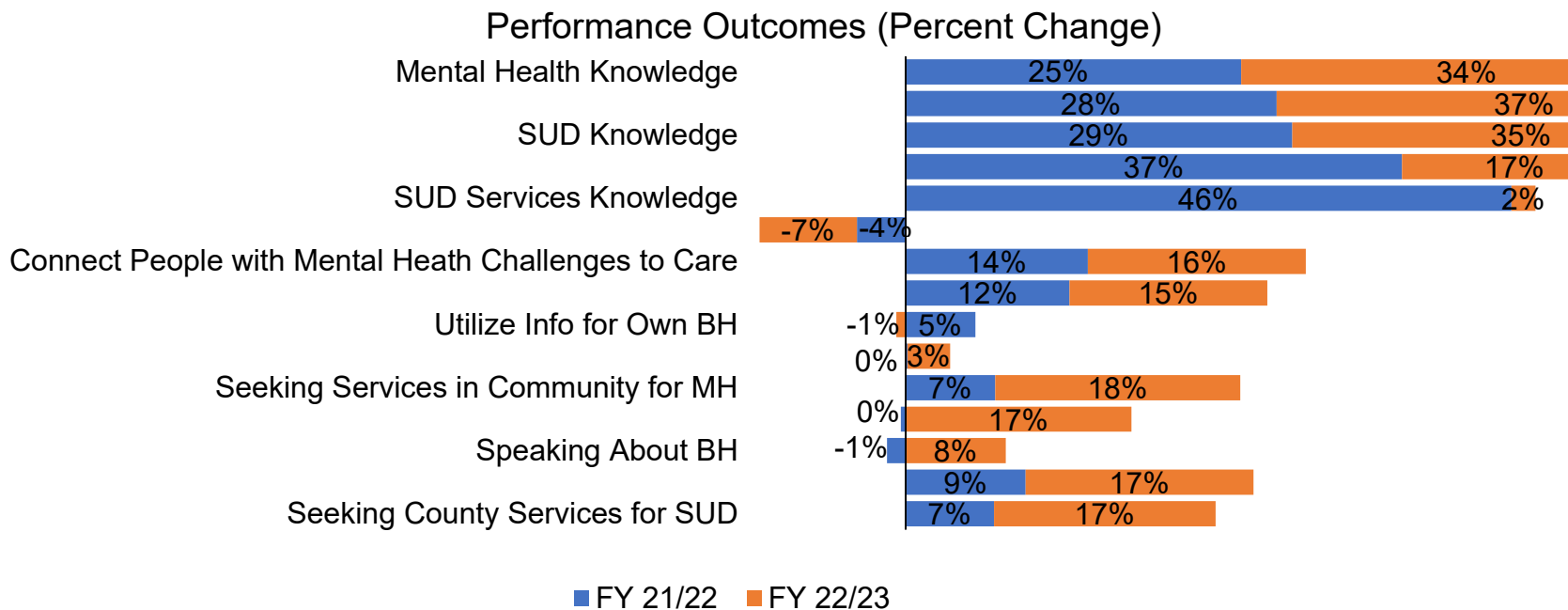
The project successfully trained Inland Empire Concerned African American Churches (IECAAC) members and other community members to be potential responders in virtual and in-person settings to identify behaviors or symptoms that may indicate someone who is suffering from a mental health challenge. Project data reveals that the BHMPP was successful in improving knowledge of mental health, mental illness, substance use disorder, mental health services, and substance use disorder services. In addition to improving understanding of behavioral health topics, the project made efforts to reduce mental health stigma.

IECAAC, with assistance from the San Bernardino County Department of Behavioral Health's Research and Evaluations team, developed surveys that aligned with the MHSA Prevention and Early Intervention regulations to capture measurable outcomes for the project goals. The project began collecting data from the participants of its presentations and activities. The BHMPP surveys gauge the change in participant's attitudes, knowledge, and stigma prior to and after events or activities. Over time, through experience and feedback, modifications were made to the surveys so that they were appropriate to the target population and yielded applicable data.

Behavioral Health Ministries Pilot Project (BHMPP), cont.

Outcome Discussion, cont.

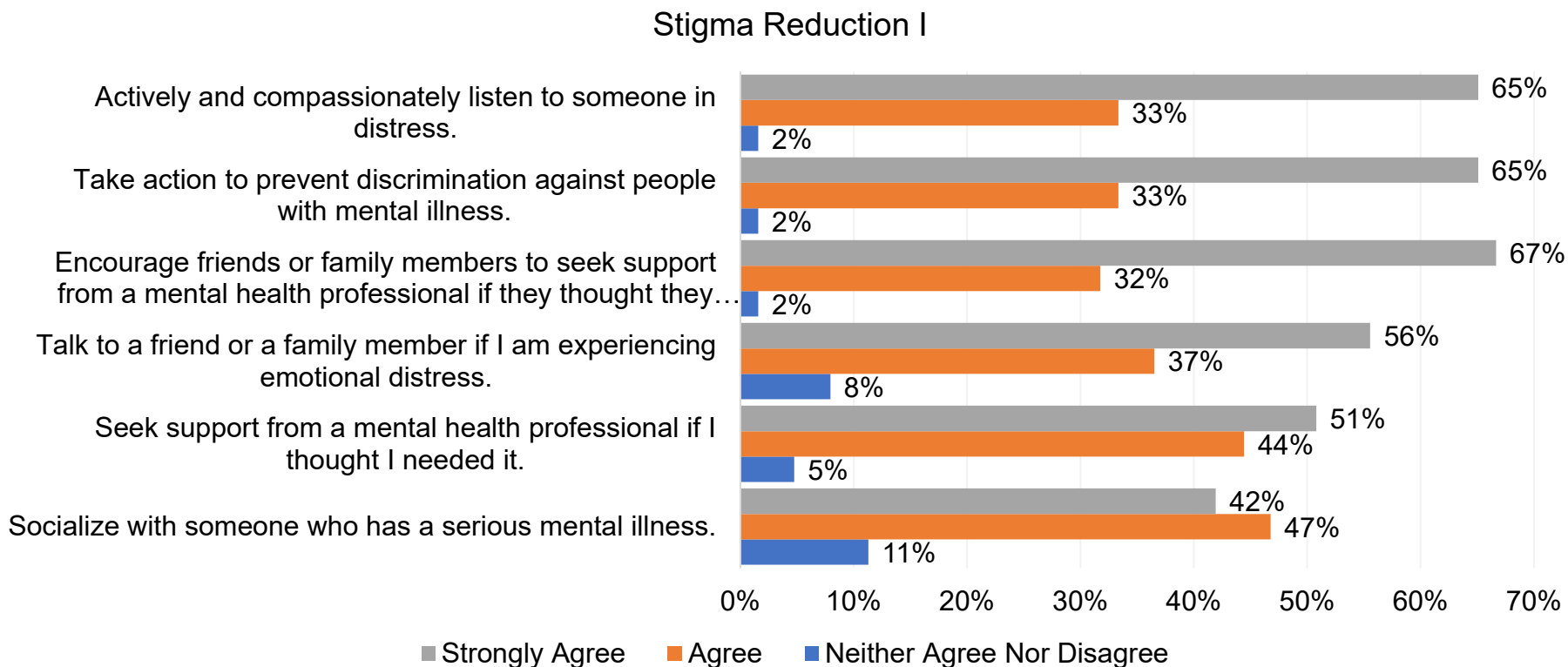
The San Bernardino County Department of Behavioral Health Office of Prevention and Early Intervention established ambitious goals at the commencement of the project. However, pre- and post-survey data shows that the target population already had a working knowledge of mental health, mental illness, and substance use disorders. Although the projected targets for each goal were not met, there was overall improvement in increasing knowledge and reducing mental health stigma. The survey questions inquiring about utilizing information to improve self-behavioral health received low improvement rates. This might imply that the questions were phrased so that participants misinterpreted their intent. There was also an opportunity to increase stigma reduction efforts so that participants were more likely to speak to others about behavioral health. The table below displays the percent change from the pre- and post-surveys provided during each training, presentation, or activity.



Behavioral Health Ministries Pilot Project (BHMP), cont.

Outcome Discussion, cont.

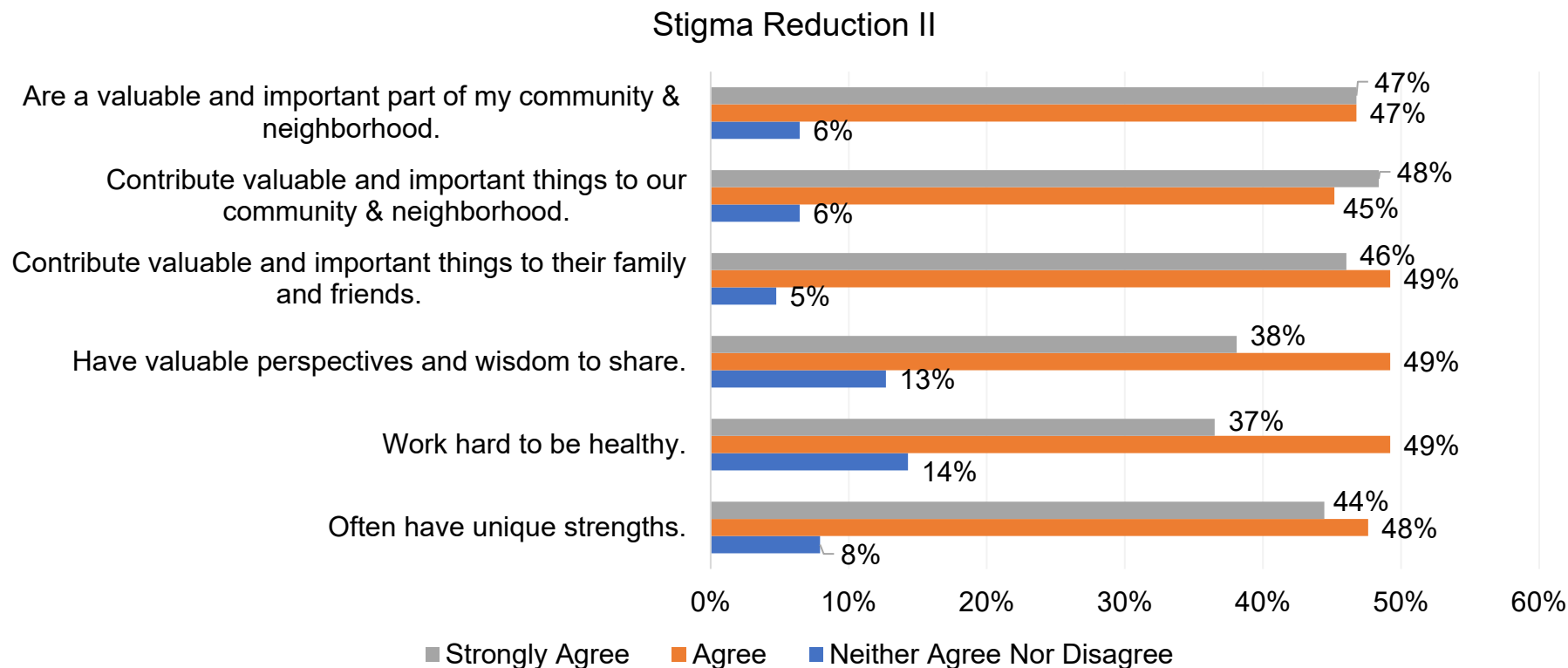
The survey developed for the BHMP also captured changes in the attitudes of the participants who received a stigma-reduction-related presentation. Throughout the duration of the project, over 93% of participants agreed or strongly agreed that they were more likely to talk to a friend or family member if they were experiencing emotional distress. Furthermore, 95% of participants agreed or strongly agreed that they would seek support from a mental health professional if they thought it was needed.



Behavioral Health Ministries Pilot Project (BHMPP), cont.

Outcome Discussion, cont.

The survey also finds that BHMPP participants' perceptions of persons in their community who are struggling with mental health concerns have shifted. These findings show the increased likelihood that participants are more understanding of community members encountering mental health crises and that they are valued contributors to their communities. As many as 94% of BHMPP participants agreed or strongly agreed that as a direct result of training, they now feel that people experiencing mental health challenges contribute valuable and important things to our community & neighborhood.



Behavioral Health Ministries Pilot Project (BHMPP), cont.

Challenges/Solutions

The need for administrative support arose throughout the year as the BHMPP attended more events and held additional trainings. While IECAAC staffed their administrative position, there were instances where additional assistance in administrative duties was needed. In addition, there were continuous challenges in staff gaining access to the PEI database collection system during fiscal year 22/23. DBH staff assisted in data entry and technical assistance through the course of the year.

Another challenge IECAAC faced was the cultural appropriateness of their surveys. At times, participants of the target population would find the phrasing of some questions inappropriate, particularly those referring to sexual orientation and gender identity. PEI, in collaboration with DBH Research and Evaluation staff, was able to continuously aid in the evolution of the project's survey to help address the issues of cultural appropriateness and collect improved data.

Lessons Learned

During the BHMPP planning phase, DBH aimed to offer flexibility in the duties and responsibilities of each staff role. Future iterations of a program providing the same services as the BHMPP would need to institute more definite staffing duties and minimum full-time staff to ensure adequate staff and administrative support. The BHMPP saw success in observing and providing the necessary outreach and supports to the African American/Black faith-based community.

"I thank the Lord for DBH. My youngest child went through some severe mental problems, and I didn't know what to do. Through the Inland Empire Concerned African American Churches (IECAAC) and Lady Cheville, I met Mr. Andre Bossieux who worked for the DBH. He was able to help me get him diagnosed and then placed in a rehabilitation center. The people there were very professional, helped him a lot, and supported him after completion of the program. He was transferred to a group home in which they taught him life skills that helped him become more independent. They helped him mentally, physically, spiritually, in all ways. Here we are several years later, and my son is on his own and still improving. He would not be where he is today had it not been for the assistance and nurturing we received from our BHMPP and DBH programs here in the Inland Empire. I am forever grateful. The Lord used BHMPP and DBH to help my son and I am thankful."

Program Updates

There are no planned program updates for Fiscal Year 2024/25.

The BHMPP sunset April 2023 of fiscal year 2022/23.

Substance Use Prevention & Pathways to Outreach and Treatment (SUPPOrT)

Program Description and Target Population

The Substance Use Prevention & Pathways to Outreach and Treatment Program (SUPPOrT), previously known as the Inland Empire Opioid Crisis Coalition (IEOCC), is a PEI program categorized as Outreach for Increasing the Recognition of Early Signs of Mental Illness. IEOCC comprises over forty (40) member organizations participating since 2017. It encompasses a multidisciplinary mix of partners working across sectors that include county agencies, community agencies and institutions, professional partners, and residents working together to educate one another support and develop strategies to combat the opioid crisis. IEOCC partners support to the Department of Behavioral Health's Substance Use Disorder Recovery Services (SUDRS) in providing outreach activities.

The SUPPOrT program aims to continue supporting the community by delivering outreach activities to provide access and linkages to prevention, early intervention, and substance use treatment. The SUPPOrT Program seeks to collaboratively work on bringing and maintaining community partners, agencies and professionals together to generate strategies to reduce opioid use and opioid related deaths. In addition, the SUPPOrT Program will conduct outreach to raise awareness, provide resources and support & educate individuals in the community.

Services Offered	- Medication Assisted Treatment (MAT) - Substance Use Disorder Services Referrals - Behavioral Health Services Referrals - Community Education and Awareness	Program Serves	Children TAY (16-25) Adults Older Adults (60+)
		Location of Services	School Campuses, Mental Health Clinics, In-home
		Annual Budget FY 24/25	\$417,500
		Cost Per Client FY 24/25	\$93

Substance Use Prevention & Pathways to Outreach and Treatment (SUPPOrT), cont.

State Program Positive Results

The SUPPOrT program delivers outreach activities to provide access and linkages to substance use prevention, early intervention, and treatment. In addition, the program raises awareness by educating individuals in the community and through dissemination and training in Naloxone/Narcan.

In May and June of FY 22/23, the program began its outreach efforts to raise awareness and provide substance use and mental health resources at community fairs, workshops, and conferences. The table on the right shows that SUPPOrT engaged 212 unduplicated participants at three community health fairs.

The SUPPOrT program outreach efforts reached out to 212 potential responders in the community. Potential responders are people in the community who can identify early signs of mental illness and refer individuals to behavioral health services. Examples of potential responders include community service providers and school personnel.

The SUPPOrT team provided substance use and mental health resources and trained and distributed Naloxone (Narcan) nasal spray to youth at the 2023 State of the Youth Conference held at San Bernardino Valley College.

This event was open to all youth ages 13 to 24 and their families living in the Inland Empire. Its objective was to empower and prepare the attendees for success. The event featured workshops and team-building activities.

Number of Participants / Number of Services Projected vs Actual				
	Projected	Actual		
		FY 20/21	FY 21/22	FY 22/23
Unduplicated Participants	3,400	N/A	N/A	212
Number of Services	3,400	N/A	N/A	216

Number of Potential Responders		
FY 20/21	FY 21/22	FY 22/23
N/A	N/A	212

Substance Use Prevention & Pathways to Outreach and Treatment (SUPPOrT), cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-59	60+	UNK
FY 20/21	N/A	N/A	N/A	N/A	N/A
FY 21/22	N/A	N/A	N/A	N/A	N/A
FY 22/23	0%	19%	10%	1%	70%

Fiscal Year	Sexual Orientation
% of consumers who identified as LGBTQ+	
FY 20/21	N/A
FY 21/22	N/A
FY 22/23	7%

Fiscal Year	Gender Identity			
	♂	♀	⚧	UNK
FY 20/21	N/A	N/A	N/A	N/A
FY 21/22	N/A	N/A	N/A	N/A
FY 22/23	7%	22%	1%	70%

Fiscal Year	Veteran Status
% of consumers who identified as a veteran	
FY 20/21	N/A
FY 21/22	N/A
FY 22/23	<1%

Fiscal Year	Disability
% of consumers who identified a physical disability	
FY 20/21	N/A
FY 21/22	N/A
FY 22/23	8%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 20/21	N/A	N/A	N/A	N/A
FY 21/22	N/A	N/A	N/A	N/A
FY 22/23	30%	<1%	0%	70%

Substance Use Prevention & Pathways to Outreach and Treatment (SUPPOrT), cont.

Demographics, cont.

	Race/Ethnicity	FY 20/21	FY 21/22	FY 22/23
Race	African American/Black	N/A	N/A	2%
	American-Indian/Alaska Native	N/A	N/A	0%
	Asian	N/A	N/A	1%
	Native Hawaiian or Pacific Islander	N/A	N/A	<1%
	Caucasian/White	N/A	N/A	3%
	More than One Race	N/A	N/A	1%
	Other Race	N/A	N/A	70%

	Race/Ethnicity	FY 20/21	FY 21/22	FY 22/23
Ethnicity	African	N/A	N/A	2%
	Asian Indian/South Asian	N/A	N/A	1%
	Cambodian	N/A	N/A	1%
	Chinese	N/A	N/A	0%
	Eastern European	N/A	N/A	1%
	European	N/A	N/A	2%
	Latinx/Hispanic	N/A	N/A	22%
	Filipino	N/A	N/A	1%
	Japanese	N/A	N/A	0%
	Korean	N/A	N/A	0%
	Middle Eastern	N/A	N/A	1%
	Vietnamese	N/A	N/A	0%
	Other	N/A	N/A	2%
	More than one ethnicity	N/A	N/A	89%

Substance Use Prevention & Pathways to Outreach and Treatment (SUPPOrT), cont.

Program Goals

- Reduce prolonged suffering associated with untreated mental illness:
 - Reduce risk factors
 - Reduce indicators
 - Increase protective factors that may improve mental, emotional, and relational functioning.
- Reduce stigma and discrimination associated with mental illness:

Reduce negative feelings, attitudes, beliefs, perceptions, stereotypes, and/or discrimination related to having a mental illness, being diagnosed, or seeking services.

Increase acceptance, dignity, inclusion, and equity for individuals with mental illness and members of families.
- Increase recognition of early signs of mental illness:
 - Potential Responders:
 - Identify early signs of potentially severe and disabling mental illness.
 - Provide support to individuals with mental illness.
 - Refer individuals who need treatment or other mental health services.
 - Individuals:
 - Recognize your own symptoms.
 - Respond to symptoms.

Substance Use Prevention & Pathways to Outreach and Treatment (SUPPOrT), cont.

Program Outcomes

Method use to collect outcome	Description of method	Frequency of use	Number Completed	
Outreach Survey	The Outreach Survey has 13 questions. The first 9 are used to collect PEI demographic information, and the last 4 are used to gather information on participants' confidence in recognizing potential mental health challenges and seeking services if needed.	After each outreach activity	FY 20/21: FY 21/22: FY 22/23:	N/A N/A 68

Outcome Discussion

The Department of Behavioral Health's Office of Prevention and Early Intervention, Substance Use Disorder Recovery Services, and Research and Evaluation teams collaborated in creating an outreach survey that gathers information on participant's knowledge of substance use disorders following an engagement activity. Sample outreach survey questions include:

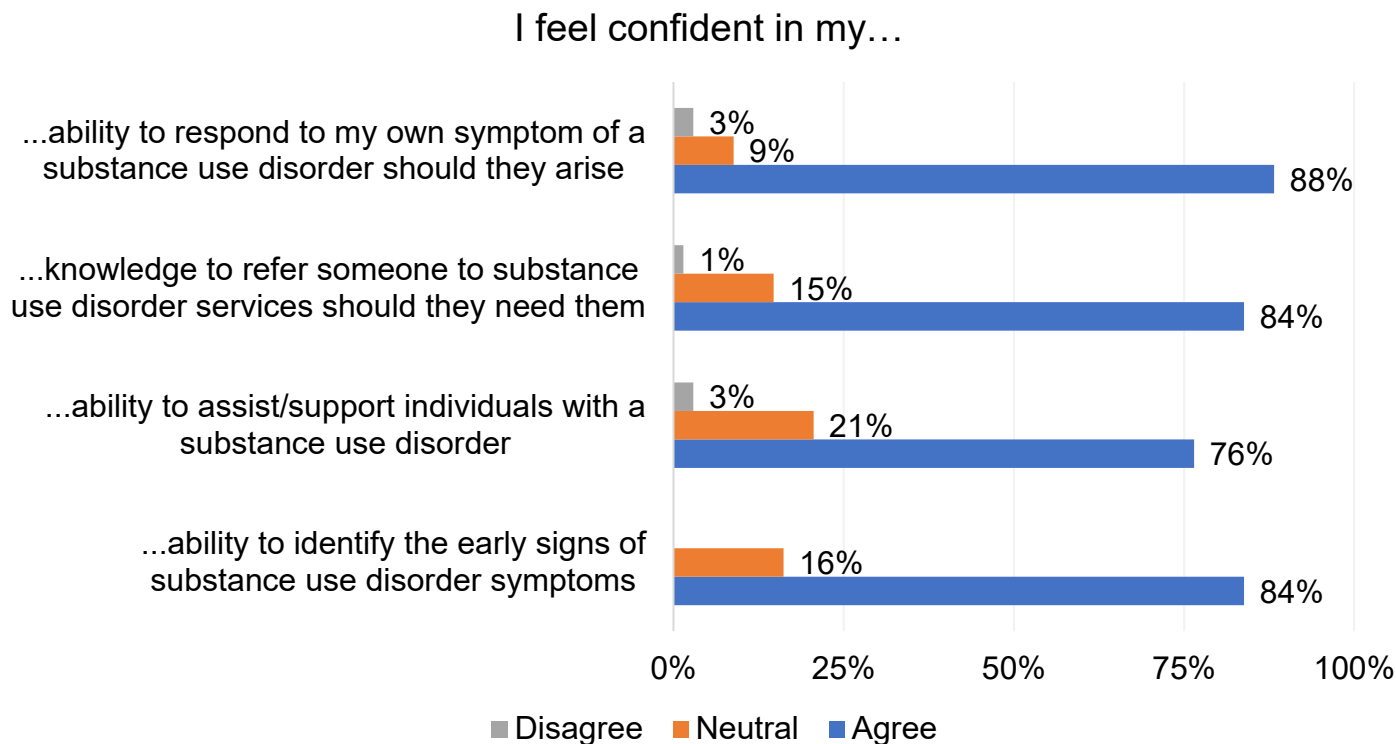
I feel confident in my...

- ability to identify the early signs of substance use disorder symptoms.
- ability to assist/support individuals with a substance use disorder.
- knowledge to refer someone to substance use disorder services should they need them.
- ability to respond to my symptoms of a substance use disorder should they arise.

Substance Use Prevention & Pathways to Outreach and Treatment (SUPPOrT), cont.

Outcome Discussion

Outreach survey data illustrates that 88% of participants who completed the survey agree that they successfully increased their ability to respond to their symptoms of a substance use disorder, should they arise. Also, following their activities, 84% of participants agreed that they were more confident in their ability to identify early signs of substance use disorder symptoms and, in their knowledge, to complete a referral for substance use disorder service. The overall outcomes demonstrate that SUPPOrT outreach and educational activities are successfully meeting the intended goals of the program.



Substance Use Prevention & Pathways to Outreach and Treatment (SUPPOrT), cont.

Challenges/Solutions

Staffing was one of the most significant issues for the SUPPOrT program in fiscal year 22/23. The program has received increased requests to provide outreach and educational activities, requiring more staff to assist with outreach events to provide information on substance use disorder to raise awareness.

As a result, the program will engage in efforts to recruit a Drug and Alcohol Counselor and Mental Health Consultant to assist with the outreach activities. In addition to this, SUPPOrT will collaborate with DBH's Public Relations and Outreach team for substance use disorder outreach efforts.

Lessons Learned

Program feedback has revealed a need to expand outreach to the mountain communities around Rim Forest, Arrowhead, and Big Bear. The focus will be on creating more places for people to connect with mental health and substance use disorder services.

Success Story

The SUPPORT team attended the 2023 State of the Youth Conference at San Bernardino Valley College, where they provided substance use and mental health resources to the youth and trained and distributed Naloxone (Narcan) nasal spray. One student expressed, "What a wonderful thing you guys are doing for the community."

Program Updates

The SUPPOrT program will be expanded to include Services to the mountain communities around Rim Forest, Arrowhead, and Big Bear.

Child and Youth Connection (CYC)

Program Description and Target Population

CYC is a State Access and Linkage to Treatment program that connects children suffering from severe emotional challenges to medically necessary care and treatment. CYC is comprised of several components:

- **Screening, Assessment, Referral, and Treatment (SART):** Offers complete treatment for children ages 0 to 6 suffering from social, physical, behavioral, developmental, and/or physiological problems. It's a comprehensive program for at-risk children, many of whom have been subjected to abuse, neglect, or prenatal exposure to hazardous substances.
- **Early Identification and Intervention Services (EIS):** EIS provides assistance to children aged 0 to 8 who have social, physical, behavioral, developmental, and/or psychiatric difficulties but do not require the intense therapies provided by SART. Children who participate in EIS do not always have a history of trauma, and they are usually referred from SART after being examined.
- **Children’s Assessment Center (CAC) Pre-Forensic Examination Counseling Services:** The Children’s Assessment Center (CAC) is a partnership between Loma Linda University Children’s Hospital (LLUCH) and the County to serve children and families who are in need services in a child-friendly environment. The CAC provides a safe location for the LLUCH physicians and nurse practitioners to perform the necessary forensic medical examinations on children who are victims of sexual and physical abuse. This contract allows the LLUCH medical staff to perform the pre-forensic examination counseling service prior to the exam to reduce the trauma to child victims and their families referred. It is in the best interest of the child to have the LLUCH medical staff provide the pre-forensic examination counseling service since they will be conducting the medical exam.

SART and EIS Services Offered	• Assessments • Comprehensive Treatment Services • Case Management Services • Mental Health Education

The SART and EIS Programs Serve	Children
Location of Services	Desert/Mountain, East Valley, Central Valley, West Valley
Annual Budget FY 24/25	\$20,907,180
Cost Per Consumer FY 24/25	\$3,216

Child and Youth Connection (CYC), cont.

Program Description and Target Population, cont.

- Juvenile Public Defender's Office: In-home screenings for adolescents involved in the juvenile justice system are provided by the Department of Behavioral Health in collaboration with the Public Defender's Office Juvenile Division.
- Mentoring Network: DBH collaborates with Children's Network to conduct mentoring needs assessments of at-risk youth through a collaborative effort of several County departments including the Public Defender's Office, Children's Network, and Children and Family Services. The Mentoring Network identifies new and existing mentoring organizations, links system-involved youth with appropriate agencies and collects and provides mentoring resources.

Program Highlights

The CYC program focuses on access and linkage to treatment where children are assessed and provided the appropriate level of care. In addition to these services, the program also offers prevention and outreach services to increase awareness and access to services.

CYC offers education, outreach, case management, resource referrals, and mentoring as part of the prevention services. These assist in reducing the stigma surrounding mental health services and connecting communities to appropriate resources.

The overall success of the program can be measured in the number of participants listed below. The number of unduplicated participants per year exceeded projections.

Number of Participants / Number of Services Projected vs Actual				
	Projected	Actual		
		FY 20/21	FY 21/22	FY 22/23
Unduplicated Participants	6,529	9,500	9,633	7,111
Number of Services	70,969	80,256	87,867	86,701

Prevention:

The risk factors for CYC program participants can include neglect and abuse, attachment difficulties, and exposure to substance use disorder.

Prevention activities within the program help to address these risk factors by boosting protective factors such as supportive parenting and education, healthy communication, and social support.

Some of the prevention activities offered include parenting support groups, substance use disorder workshops, multidisciplinary collaboration, and case management.

Child and Youth Connection (CYC), cont.



Artwork by Jian Lee

Program Highlights, cont.

An important indicator in prevention is the number of services provided to individual participants. When participants return more than once to a prevention activity, it shows that they are comfortable accessing services and willing to continue in a group or educational session. The table below illustrates the unduplicated number of participants who participated in a prevention service, and the number of total services provided.

Prevention	FY 20/21	FY 21/22	FY 22/23
Unduplicated Participants	2,405	3,231	2,349
Total Services	1,156	2,965	3,262

Early Intervention:

SART and EIIS are CYC programs that provide early intervention services, such as treatments and interventions, for children who have been exposed to trauma and/or have impaired functioning but do not require a wide range of ongoing services.

Parent-Child Interaction Therapy (PCIT) and Infant Massage are examples of the treatments administered by this program. The table below illustrates the total number of episodes opened, the number of episodes closed, and the proportion of participants who met their treatment goals for each fiscal year.

The participants are engaged in the program up to 6 years of age for SART and up to 9 years of age for EIIS. If the child still requires additional supports, they are transitioned to that appropriate level of care.

Treatment Success by Fiscal Year			
	Total Episodes	Closed Episodes	% Met Goals
FY 20/21	7,072	3,096	44%
FY 21/22	2,286	2,141	39%
FY 22/23	2,538	2,042	23%

Child and Youth Connection (CYC), cont.

Program Highlights, cont.

Outreach:

The outreach component of the CYC program provides services to participants to engage, encourage, educate, and/or train potential responders on how to recognize and respond effectively to early indicators of potentially severe and disabling mental illness. These services reach a variety of potential responders in an equally variable number of settings, as detailed below.

Potential Responders Reached			
	FY 20/21	FY 21/22	FY 22/23
Potential Responders	1,045	917	1,037

Outreach Types of Responders / Settings	
Types of Responders	Settings
- Community service providers - Child protective services personnel - Consumer family members - School personnel - Peer providers - Students and educators - Law enforcement	- Community-based organizations - Community events - Schools - Health centers - County offices - Behavioral health clinics - Hospitals - Various outreach events

Child and Youth Connection (CYC), cont.

Access and Linkage to Treatment:

Children needing mental health services are identified through either the Referral, Screening, Assessment, and Treatment (RSAT) assessment process or the full Clinic Day referral to the SART centers.

The RSAT process is a collaboration between the Department of Behavioral Health (DBH), Children and Family Services and the SART providers.

Those children age 0-5 are referred to SART while those age 6-17 are referred to DBH's Juvenile Court Behavioral Health Services (JCBHS) program. Both programs offer each referred child a full psycho-social assessment to determine eligibility and need for services.

Through a trans-disciplinary process known as "Clinic Day," each SART center has a public health nurse, pediatrician, occupational therapist, speech and language therapist and psychologists who can provide additional assessments for other needs. In many cases, the public health nurse functions as case manager by assisting families in reaching appropriate resources.

Children needing ongoing care are referred to appropriate resources provided either through the SART center directly or through partners such as the Inland Regional Center (IRC), medical services or educational services.

The Healthy Homes Program, a clinical unit with JCBHS, have clinicians who are co-located at the CFS offices throughout the County. The Healthy Homes clinicians conduct assessments for children who have recently become involved with CFS.

If these children and youth are in need of on-going services, they are referred out to local service providers and programs.

In some instances, these clinicians will provide short-term mental health services in an effort to prevent involvement in a more long-term program.



Artwork by Colleen Rowan

Child and Youth Connection (CYC), cont.

Program Highlights, cont.

Linkages to appropriate resources are part of each program's scope. In the last three fiscal years, SART and EIS providers in the CYC program did not make any referrals to entities outside of the County. Services were provided internally by DBH programs, demonstrating maximum utilization of MHSA funding.

Access and Linkage to Services Referrals			
	FY 20/21	FY 21/22	FY 22/23
Number of Referrals	2,390	2,053	1,919
County-funded	2,390	2,053	1,919
Non-County Funded	0	0	0
Participants Engaged	1,686	1,686	1,919

Improve Timely Access to Treatment:

The Improve Timely Access to Treatment strategy focuses on delivering appropriate services based on the community's assessed needs to promote access to mental health treatments for underserved populations. The CYC program identified the following as unserved or underserved populations in its referral processes.

Underserved Populations

- Trauma-exposed
- Co-occurring
- Children at risk of school failure, in stressed families, and risk of removal from home
- Foster children/former foster children
- Individuals experiencing the onset of serious psychiatric illness
- Victims of human trafficking
- Homeless
- African American/Black
- Latinx/Hispanic

The table below shows the number of referrals to prevention, early intervention, or treatment beyond early onset service over the last three fiscal years. There was a significant decrease in Fiscal Year 2020/21. This was primarily due to an identified need for improvement in data collection with the implementation of the new PEI data collection system. Most issues with the data have been identified, and we are actively working on a solution to address them.

Improving Timely Access Referrals			
	FY 20/21	FY 21/22	FY 22/23
Number of Referrals Provided	844	3,010	1,919

Child and Youth Connection (CYC), cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-50	60+	UNK
FY 20/21	82%	1%	7%	1%	3%
FY 21/22	27%	<1%	4%	<1%	68%
FY 22/23	36%	3%	26%	1%	34%

Fiscal Year	Sexual Orientation
% of consumers who identified as LGBTQ+	
FY 20/21	0%
FY 21/22	0%
FY 22/23	0%

Fiscal Year	Gender Identity			
	♂	♀	⚧	UNK
FY 20/21	52%	45%	0%	3%
FY 21/22	<1%	1%	0%	97%
FY 22/23	1%	8%	0%	90%

Fiscal Year	Veteran Status
% of consumers who identified as a veteran	
FY 20/21	0%
FY 21/22	0%
FY 22/23	0%

Fiscal Year	Disability
% of consumers who identified a physical disability	
FY 20/21	4%
FY 21/22	0%
FY 22/23	0%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 20/21	90%	6%	4%	0%
FY 21/22	38%	4%	<1%	57%
FY 22/23	78%	9%	<1%	12%

Child and Youth Connection (CYC), cont.

Demographics, cont.

Demographic Observations

The CYC program served the largest proportion of children, meeting its target participant age. In some categories, a large proportion of those declined to answer. Often, this is because it has been deemed inappropriate to ask this age group.

	Race	FY 20/21	FY 21/22	FY 22/23
Race	African American/Black	10%	14%	16%
	American-Indian/Alaska Native	<1%	1%	<1%
	Asian	<1%	1%	<1%
	Native Hawaiian/Pacific Islander	<1%	<1%	0%
	Caucasian/White	16%	15%	12%
	Latinx/Hispanic	21%	20%	39%
	More Than One Race	2%	2%	1%
	Other Race	5%	1%	3%
	Declined to Answer	66%	66%	28%

	Ethnicity	FY 20/21	FY 21/22	FY 22/23
Ethnicity	African	0%	1%	1%
	Asian Indian/South Asian	0%	0%	0%
	Cambodian	0%	0%	0%
	Chinese	0%	0%	0%
	Eastern European	0%	0%	0%
	European	0%	0%	0%
	Filipino	0%	0%	0%
	Japanese	0%	0%	0%
	Korean	0%	0%	0%
	Middle Eastern	0%	0%	0%
	Vietnamese	0%	0%	0%
	Other	14%	1%	4%
	More Than One Ethnicity	1%	1%	0%
	Declined to answer	26%	59%	9%

Child and Youth Connection (CYC), cont.

Program Goals

Increase early access and linkage to medically necessary care and treatment:

- Connect children, adults, and older adults with severe mental illness to care as early in the onset as practicable to medically necessary care and treatment, including, but not limited to, care provided by county mental health programs.

Improve timely access to services for underserved populations:

- Increased the extent to which individuals or families from underserved populations who need mental health services because of risk or presence of a mental illness receive appropriate services as early in onset as practicable.

Reduce prolonged suffering:

- Reduce risk factors,
- Increased protective factors that may lead to improved mental, emotional, and relational functioning,
- Reduced symptoms, and
- Improved recovery, including emotional and relational functioning.

Reduce stigma and discrimination associated with mental illness:

- Reduced negative feelings, attitudes, beliefs, perceptions, stereotypes, and/or discrimination related to having a mental illness, being diagnosed, or seeking services.

Child and Youth Connection (CYC), cont.

Program Outcomes

Method use to collect outcome	Description of method	Frequency of use	Number Completed
Children and Adolescent Needs and Strengths Assessment (CANS)	CANS is a multi-purpose tool developed for children's services to support decision making, including level of care and service planning.	Intake, 6 months, Discharge, Significant life events	FY 20/21: 750 FY 21/22: 1,020 FY 22/23: 1,045

Outcome Discussion

The CYC program uses the Child and Adolescent Needs and Strengths – San Bernardino (CANS-SB) assessment to measure outcomes of the early intervention treatments and develop treatment plans and goals. Children and TAY receive the initial CANS-SB assessment within the first 30 days of receiving assistance. Every three to six months, follow-up assessments are conducted. A final assessment is completed after services.

The focus of the early intervention treatment for the CYC program include:

- Life Functioning is described as the various areas of social interaction present in the lives of children, teenagers, and their families. This domain assesses their performance in the areas of self, family, peers, school, and community.
- The Behavioral/Emotional Needs domain identifies the child's behavioral health needs.
- The Ages 0-5 Early Childhood domain focuses on elements of a young child's functioning that are prominent during the first five years of development.

Each CANS-SB assessment domain includes sub-domains that measure more micro-level improvements.

Child and Youth Connection (CYC), cont.

Outcome Discussion, cont.

The Life Functioning domain consists of the following sub-domains utilized to measure a participant's needs in this area: school behaviors, family functioning, and living situation. Each sub-domain has the following explanation.

- School behaviors rate the child's behavior in a school or similar setting.
- Family functioning rates the child's relationships with those in their family. Family should be defined from the child's perspective and who they identify as family.
- Living situation refers to how the child functions in their current living arrangement, which could be with a relative, in a foster home, etc.

The Behavioral/Emotional Needs sub-domains include the following.

- Depression: This rates the symptoms of the child, such as irritable or depressed mood, social withdrawal, and loss of motivation.
- Anxiety: This rates the symptoms of the child, such as excessive fear and anxiety and related behavioral disturbances. Panic attacks can be a prominent type of fear response.
- Anger Control: This refers to the child's ability to identify and manage anger when frustrated.

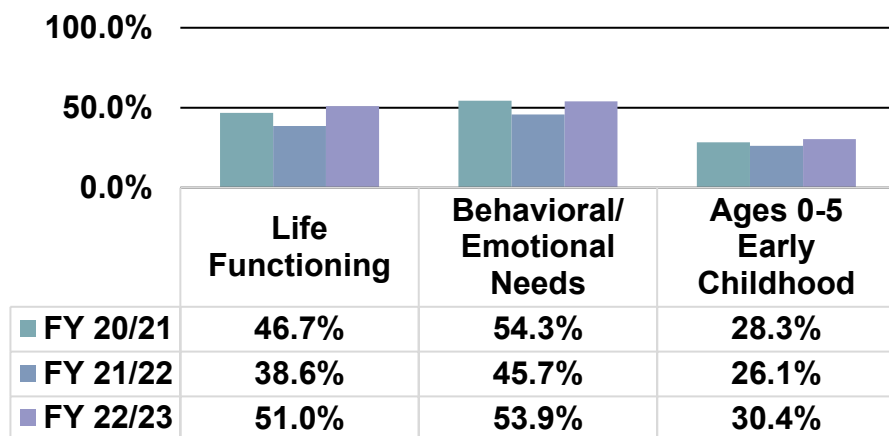
The Ages 0-5 Early Childhood module rates the same sub-domains as the Life Functioning Domain; however, these sub-domains are rated through a lens more focused on the stages of development from ages 0-5 rather than the participant's overall life functioning.

Child and Youth Connection (CYC), cont.

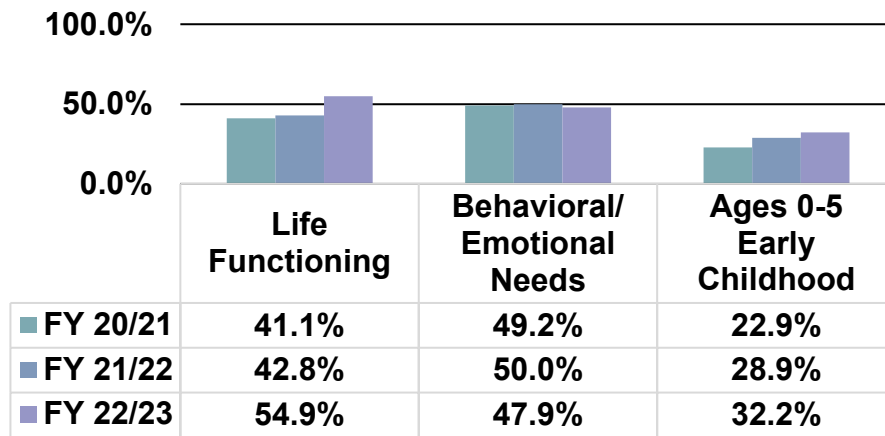
Outcome Discussion, cont.

These graphs demonstrate global improvement in Life Functioning, Behavioral/Emotional Needs, and Ages 0-5 Early Childhood for both EIIS and SART participants of the CYC program. Both programs have maintained an average of 46% improvement in the Life Functioning domain, 50% improvement in the Behavioral/Emotional Needs domain, and 28% in the Ages 0-5 Early Childhood domain.

CYC SART % Improved by Fiscal Year



CYC EIIS % Improved by Fiscal Year

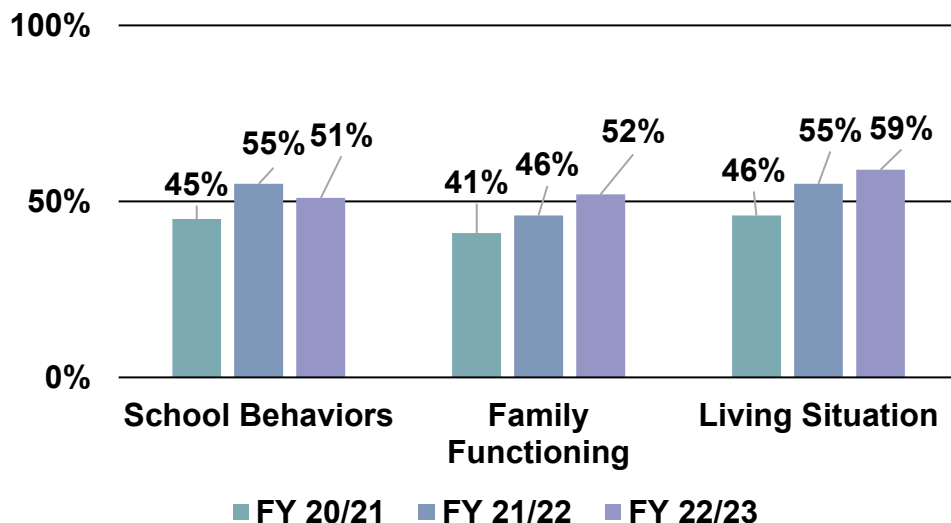


Child and Youth Connection (CYC), cont.

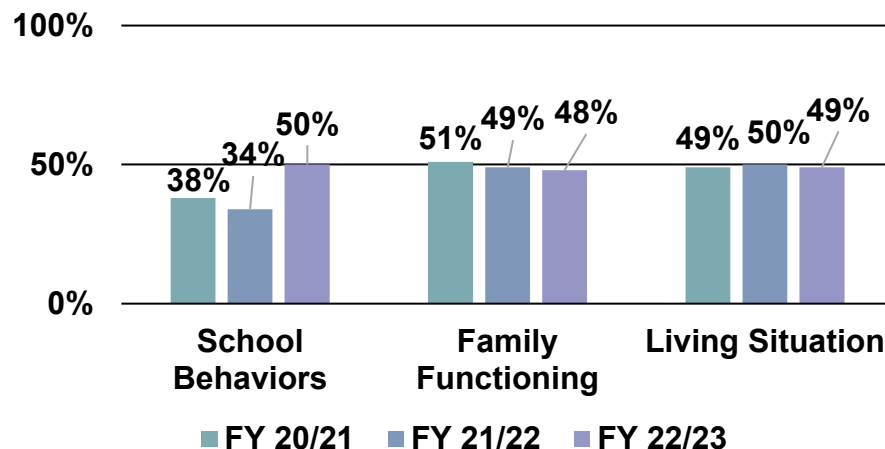
Outcome Discussion, cont.

The following graphs demonstrate the participants' improvement in these sub-domains over the last three fiscal years. The program steadily improved school behaviors, family functioning, and living situations. School functioning has continued to increase since the COVID-19 pandemic, indicating that children are steadily adjusting to life back in school. These increases also indicate that the children are improving relationships with their families because they engage with the program. Improving the family bonds serves to strengthen protective factors.

EIIS % Improvement Life Functioning and Early Childhood Module



SART % Improvement Life Domain Functioning and Early Childhood Module



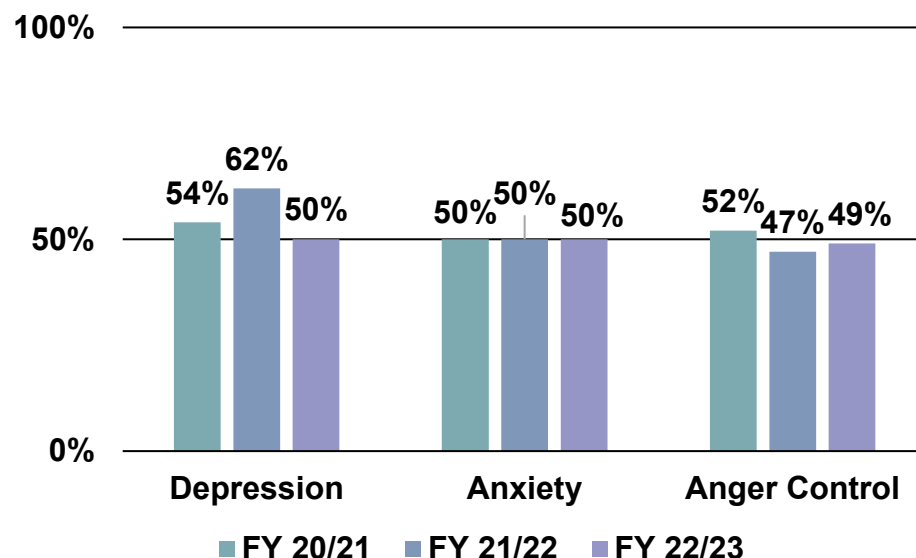
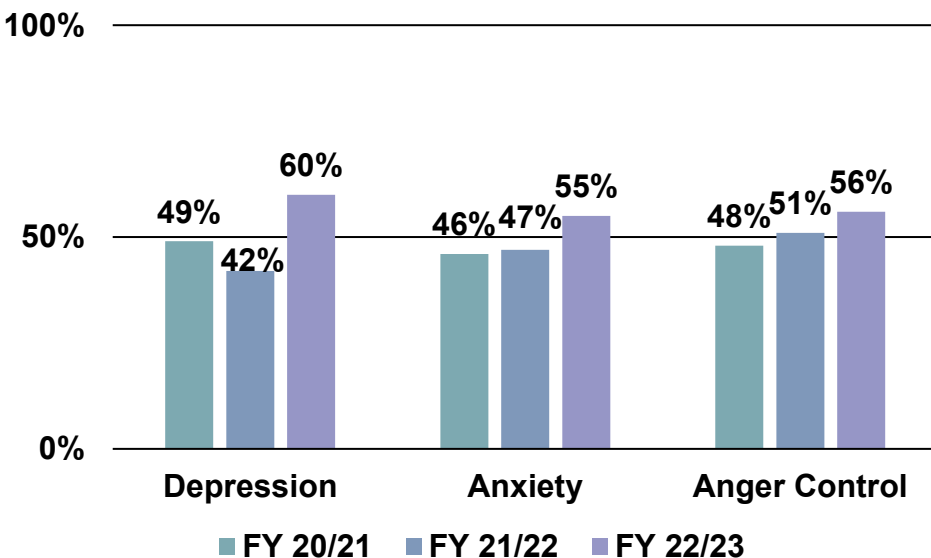
Child and Youth Connection (CYC), cont.

Outcome Discussion, cont.

Depression can be a significant barrier to child development. Both programs have been successful in maintaining an average of 53% improvement in depression. Children who were referred and presented difficulties with regulating anger showed an average improvement of 51%. Reducing anxiety leads to improved behavioral and emotional functioning. The program maintains an average improvement of 50% over the three-year review period.

**EIIS % Improvement
Behavioral/Emotional Needs**

**SART % Improvement
Behavioral/Emotional Needs**



Child and Youth Connection (CYC), cont.

Challenges/Solutions

The ongoing challenge for CYC providers is caregiver acknowledgment of the benefits of mental health services, especially for younger children and infants. It can be difficult for caregivers to understand the benefits of mental health treatment in infants and young children. Additionally, it can be difficult for caregivers to obtain transportation to and from appointments, as well as integrate treatment into already busy schedules.

The CYC programs work collaboratively with the caregivers to build rapport and provide education so that the caregiver has a full understanding of the benefits and value of mental health treatment. Providers are trained to educate caregivers on the benefits of infant mental health and the significant impact of addressing behavioral and emotional needs within the first few years of life.

Caregivers are provided referrals for resources and offered treatment via telehealth or other platforms to allow greater options for scheduling treatments for the children. Overall, this has helped to decrease missed appointments and increase the cooperation of caregivers.

Lessons Learned

With the implementation of a new data collection system, the CYC SART and EIIS providers were directed to discontinue entering some of their data as it would be collected utilizing the DBH Behavioral Health Management Information System (myAvatar). However, due to unforeseen challenges with myAvatar, a more efficient process has been identified for collecting SART and EIIS data from providers. This data collection method will be utilized moving forward.

Program Updates

There are no planned program updates for Fiscal Year 2024/25.

Success Story

“SART has helped me and my family by sending individuals who love their jobs and care about children. The therapist has been extremely helpful. Our girls have made amazing improvements during their treatment, and we could not believe it. We are grateful for SART because they came into our home to help and improve our lives. We will miss the therapist dearly and know her name will mean happiness in our home.”

Preschool PEI Program (PPP)

Program Description and Target Population

Preschool PEI Program (PPP) is a Prevention program that is a collaborative effort between the Department of Behavioral Health and the Preschool Services Department to serve students enrolled in the County’s Head Start program. The PPP supports preschool children (ages two through five) and educates their parents, caregivers, and teachers. The program is designed to help children learn to understand and manage their emotions. It also promotes and improves participants’ academic competence in areas such as language, reading, and social skills.

Program eligibility is based on an enrolled preschool child demonstrating self-regulation or social behavior that potentially affects the child’s ability to engage in educational or social experiences effectively.

Services Offered - Social-emotional development - Screenings & assessments - Trauma support - Resources & referrals - Behavioral health plan development - Family support	Program Serves Children, TAY (16-25), Adults, Older Adults (60+)
	Location of Services Preschool, In Home, and Counseling Centers
	Annual Budget FY 24/25 \$425,000
	Cost Per Client FY 24/25 \$281

Note: The Annual Budget shown is the amount of MHSA PEI funding which has been allocated to this program. It may differ from the amounts in the Fiscal section as those account for anticipated utilization values.

Preschool PEI Program (PPP), cont.

Program Highlights

The Preschool PEI Program provides services to preschool-aged children, their parents, and their caregivers. In addition, the PPP program provides education and classroom strategies to develop secure and consistent interactions between home and school settings.

As a prevention program, the PPP program seeks to provide activities and classroom instruction that promote protective factors such as:

- Supportive nurturing and attachment,
- Improving cognitive development,
- Developing social connections with peers, and
- Developing social and emotional competence.

Risk factors typically seen within the PPP program include ineffective parenting, which results in a lack of attachment, nurturing, and supportive relationships.

The PPP program seeks to reduce these risk factors by:

- Assisting parents in better understanding their children's needs and development,
- Fostering stable attachments with parents and caregivers, and
- Developing supportive connections with other significant adults.

Research shows that promoting protective factors and reducing risk factors increase children's and families' mental health and well-being and are associated with a lower likelihood of negative outcomes.

Number of Participants / Number of Services Projected vs Actual				
	Projected	Actual		
		FY 20/21	FY 21/22	FY 22/23
Unduplicated Participants	1,508	750	697	409
Number of Services	3,545	2,659	3,183	1,358

Preschool PEI Program (PPP), cont.

Program Highlights, cont.

Building social-emotional skills in preschool-aged children helps them learn to recognize, understand, and manage powerful feelings and helps them to develop empathy for others. These skills are important to developing their mental health and well-being. In addition, the family support component helps families create an environment where the children can develop a sense of predictability and safety through nurturing, stable, and consistent relationships with adults. This sense of predictability is further developed in the classroom with regular routines and consistent positive behavior management strategies.

The PPP program develops protective factors of emotional self-regulation, positive coping skills, effective problem-solving skills, peer engagement, supportive relationships with family members, and predictability in the home and school environment.

Teacher Training

Teachers within the Preschool PEI program receive training in using classroom management strategies to meet children's developmental milestones and teach emotional literacy, friendship skills, self-regulation, and problem-solving skills.

The teacher education component of the PPP program develops skills for teachers to promote children's social, emotional, and academic competence and to work with parents to support their school involvement and promote consistency between home and school.

Ongoing evaluations ensure that teachers are using classroom management strategies correctly. The effectiveness of these strategies is evidenced by the improvement in key areas within the Desired Results Development Profile (DRDP).

Specific to FY 2020/21, in preparation for returning to the classroom post-COVID-19, additional teacher training was conducted so that teachers would be able to recognize signs of trauma and to help acclimate the children to returning to school.

In the fiscal year 2022/23, an emerging trend indicated a decrease in self-regulation among preschoolers. In response, PSD Class Teacher Coaches are being utilized to address intervention strategies and provide Second Step curriculum training to teachers and staff.

Preschool PEI Program (PPP), cont.

Program Highlights, cont.

Trauma, Loss, and Compassion Group (TLC)

In addition to the social-emotional development strategies that are used within the classroom, this group assists children who have experienced trauma, loss, or separation from a parent or significant care provider in their lives.

This may include a parent, grandparent, or other person close to the child. The loss may be due to death, divorce, separation, foster care, military deployment, or parent incarceration. Groups meet for ten weeks and help children cope with loss and trauma. The group allows children to share feelings, thoughts, and stories during “circle time” with other children experiencing trauma or loss.

These activities help children self-regulate, practice social behavior in a safe space, and to develop healthy coping skills, which decrease aggressive, internalizing, self-isolation, and other self-harming behaviors. The effects of these activities are seen in the change of behavior exhibited in the classroom and at home, resulting in improved interactions with peers and adults, as shown in the DRDP assessment results.

To improve child/family outcomes, families of children participating in the TLC group receive referrals to the Family Support Partners home visiting program to provide additional family support in the home. The Life Skills Progression (LSP) survey measures growth in key areas.

Number of Children Participating in the TLC Group		
FY 2020-21	FY 2021-22	FY 2022-23
60	18	76

Preschool PEI Program (PPP), cont.

Program Highlights, cont.

Access & Linkage to Services

During the previous three years, twenty (20) participants were given referrals to the Screening, Assessment, Referral, and Treatment (SART) program. There were no referrals to independent service providers for higher-level services beyond the preventative services offered by the PPP program.

The program design is intended to engage with young children and their families at a very early age. The percentage of families who declined or did not engage in services is indicative of the stigma that still exists in accessing mental health services for young children.

PPP is exploring collaborations with partner agencies to provide additional support that will result in successful referrals. Easing the families' fear in the system of care is the first step in reducing the stigma and increasing the likelihood that they will engage in services.



Happy Place - artwork by Unknown

Preschool PEI Program (PPP), cont.

Program Highlights, cont.

Needs Assessment

Parents engaged within the TLC group component of the PPP program completed surveys indicating specific ways in which the families could benefit from the PPP program. The feedback that was received aligns with the program goals. Families indicated that their most significant need is ongoing support that is specific to them. This support would benefit the overall well-being of the children and families. For example, it was expressed that there was a need for bilingual support groups for those that are more comfortable speaking their native language. As a result of this feedback, bilingual Parent Wellness Groups were established for FY 2021-22 and added to the ongoing programming. Topics include parent fatigue, simple self-care, managing challenging behaviors, creating secure attachments, positive discipline, and parent-child relationships.

Additionally, a need was recognized for further teacher training in preparation for returning to the classroom post-COVID-19. The COVID-19 public health emergency impacted everyone. Children and teachers were transitioned to distance learning, which came with its own set of

challenges. Additional training was implemented so that teachers would be able to recognize signs of trauma in children and families. The training included information on acclimating children in returning to school sites post-COVID-19.



Artwork by José Luis Mendez

Preschool PEI Program (PPP), cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-59	60+	UNK
FY 20/21	61%	3%	26%	1%	9%
FY 21/22	53%	45%	30%	1%	4%
FY 22/23	51%	4%	26%	1%	18%

Fiscal Year	Sexual Orientation
% of consumers who identified as LGBTQ+	
FY 20/21	0%
FY 21/22	0%
FY 22/23	0%

Fiscal Year	Gender Identity			
	♂	♀	⚧	UNK
FY 20/21	20%	39%	1%	40%
FY 21/22	28%	44%	0%	26%
FY 22/23	32%	38%	0%	30%

Fiscal Year	Veteran Status
% of consumers who identified as a veteran	
FY 20/21	0%
FY 21/22	0%
FY 22/23	0%

Fiscal Year	Disability
% of consumers who identified a physical disability	
FY 20/21	1%
FY 21/22	3%
FY 22/23	5%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 20/21	79%	7%	10%	4%
FY 21/22	84%	7%	2%	0%
FY 22/23	79%	7%	1%	0%

Preschool PEI Program (PPP), cont.

Demographics, cont.

	Race	%
FY 20/21	African American/Black	11%
	American-Indian/Alaska Native	1%
	Asian/Pacific-Islander	0%
	Caucasian/White	28%
	Latinx/Hispanic	0%
	Multiple Racial/Other	3%
FY 21/22	African American/Black	20%
	American-Indian/Alaska Native	1%
	Asian/Pacific-Islander	2%
	Caucasian/White	28%
	Latinx/Hispanic	0%
	Multiple Racial/Other	6%
FY 22/23	African American/Black	21%
	American-Indian/Alaska Native	0%
	Asian/Pacific-Islander	3%
	Caucasian/White	31%
	Latinx/Hispanic	1%
	Multiple Racial/Other	7%

Ethnicity			
	FY 2020/21	FY 2021/22	FY 2022/23
African	0%	0%	0%
Asian Indian/South Asian	0%	0%	0%
Cambodian	0%	0%	0%
Chinese	2%	0%	3%
Eastern European	0%	0%	0%
European	0%	0%	0%
Latinx/Hispanic	34%	42%	88%
Filipino	0%	0%	0%
Japanese	0%	0%	0%
Korean	0%	0%	0%
Middle Eastern	5%	1%	0%
Vietnamese	0%	0%	0%
Other	0%	0%	3%
More than one ethnicity	0%	1%	3%

Preschool PEI Program (PPP), cont.

Demographics, cont.

Demographic Observations

The PPP program has consistently served the targeted demographics over the last three fiscal years.

- The majority of the population served is preschool-aged children.
- The program is designed to support parents and caregivers in providing a nurturing and supportive environment for the children's social-emotional development. As a result, the PPP program serves the adult population (TAY, adult, and older adult) and the children who receive services.

Questions related to gender and sexual orientation have a high rate of "Unknown" responses.

- Questions regarding sexual orientation are considered inappropriate to ask for the primary target population of preschool-aged children and contribute to lack of responses in this area.

The overall diversity of the participants within the PPP program reflects the diverse community of San Bernardino County.

Preschool PEI Program (PPP), cont.

Program Goals

The Preschool PEI Program aims to reduce risk factors and promote protective factors. Protective factors are associated with lower likelihoods of problem outcomes. Risk factors are associated with a higher likelihood of problem outcomes. Specific objectives of the PPP program are to reduce the occurrence of aggressive and oppositional behavior, increase social competency to support overall school functioning, increase overall family functioning, and increase mental and emotional health. Strategies used within the PPP program promote positive cognitive, social, and emotional development and encourages a state of well-being that allows the individual to function well in the face of ongoing changing and sometimes challenging circumstances.

Program Outcomes

The tools utilized to measure outcomes in the Preschool PEI Program include the Desired Results Developmental Profile (DRDP) and Life Skills Progression (LSP) assessments.

The Desired Results Development Profile

The Desired Results Developmental Profile (DRDP) is an assessment tool used to determine whether the preschool-aged child is at or above the California Foundations age expectations in social-emotional development. Building meaningful and rewarding relationships with others is a part of a child's social-emotional development. Children begin to manage their emotions and acquire a sense of predictability, safety, and responsiveness in their social contexts when they have nurturing, stable, and consistent relationships with adults.

Method use to collect outcome	Description of method	Frequency of use	Number Completed
The Desired Results Developmental Profile (DRDP)	Designed for teachers to observe, document, and reflect on the learning, development, and progress of children who are enrolled in early care and education programs and before-and after-school programs.	Fall, Winter, and Spring	FY 20/21: 750 FY 21/22: 2,451 FY 22/23: 1,290

Preschool PEI Program (PPP), cont.

Outcome Discussion

The DRDP assessment is completed in the fall, winter, and spring using observations of the children's work by the children's families and teachers.

Desired Results Developmental Profile									
Social-Emotional Development Domain	FY 2020/21			FY 2021/22			FY 2022/23		
	Pre	Post	Increase	Pre	Post	Increase	Pre	Post	Increase
Identity of Self in Relation to Others	47%	71%	24%	49%	65%	16%	48%	70%	76%
Social and Emotional Understanding	48%	71%	23%	46%	62%	16%	48%	67%	75%
Relationships and Social Interactions with Familiar Adults	48%	75%	27%	48%	68%	20%	52%	70%	80%
Relationships and Social Interactions with Peers	Not assessed*			53%	72%	19%	58%	76%	82%
Symbolic and Sociodramatic Play	25%	41%	16%	29%	44%	15%	33%	44%	59%
* Relationships and Social Interactions with Peers was not assessed during FY 2020-21 due to lack of in-person peer-to-peer interaction resulting from COVID-19 limitations.									

The results of the assessment shown in the table illustrate the increase in children's development in five key social-emotional development dimensions of Identity of Self in Relation to Others, Social and Emotional Understanding, Relationships and Social Interactions with Familiar Adults, Relationships and Social Interaction with Peers, and Symbolic and Sociodramatic Play across the previous three years.

Preschool PEI Program (PPP), cont.

Outcome Discussion, cont.

Life Skills Progression (LSP)

The LSP survey has been used in previous years to assess the strengths and needs of families participating in the PPP services' Trauma, Loss, Compassion (TLC) component. The LSP survey measures parental life skills in relationships, resources, medical health, mental health, and basic essentials.

Participating families demonstrated improvement in the following specific areas:

- Increased knowledge of child development,
- Improved nurturing relationships between participants and their children,
- Improved mental health and self-esteem,
- Improved knowledge of knowing who to contact in the community when help is needed,
- Improved use of age-appropriate discipline, and
- Improved relationships with spouse, partner, and peers.

Life Skills Progression Results				
Fiscal Year	Pre	Post	Increase	% Increase
FY 2020-21	103.54	109.99	6.45	6.2%
FY 2021-22	n/a	n/a	n/a	n/a
FY 2022-23	n/a	n/a	n/a	n/a

The LSP survey was used from FY 2012/13 through FY 2020-21 to capture data for evaluating the TLC component. While continuing to show an increase, the data reflected progressively smaller gains in outcomes. The TLC component represents approximately 3% of the total PPP program participation. In FY 2021/22, it was determined that the tool no longer met the program's needs. PPP is reviewing alternative methods to capture appropriate data for the TLC component.

Preschool PEI Program (PPP), cont.

Challenges/Solutions

One challenge has been supporting teachers in the classroom as we integrate children with low social-affective interaction. We have identified an escalation in behavior concerns with children in our program, and the number has increased on a yearly basis. The population of families we serve is at high risk for experiencing life-changing events, homelessness, foster care, etc.

As a result of these changing needs, PSD plans to continue to support staff well-being by offering one-on-one therapy services. Management is also working with Dr. Bergin, Clinical MFT Intern Supervisor, to develop strategies to support teachers as they process their trauma so that they can continue being present for children.

PSD continues to have difficulties keeping fully staffed. The PSD team will continue to work with other county departments to gain exposure to recruitment. PSD has created recruitment flyers, attended various job fairs, and encouraged Policy Council Parent Representatives to spread the word at their PSD sites. There is an increase in networking with local Community Colleges, Universities, and the local ROP program.

Program Updates

There are no planned program updates for Fiscal Year 2024/25.

Lessons Learned

The Life Skills Progression Tool was used in FY 2012-13 through FY 2020-21 to capture program data for evaluation. In FY 2021-22, it was determined that the tool no longer met the program's needs. While the DRDP is still being utilized to evaluate the program outcomes, PPP is reviewing alternate tools to capture appropriate data for this program better.

In addition, the PPP program adapted to providing virtual services during the COVID-19 pandemic, however, some of the key areas of social-emotional development involve age-appropriate interaction between the children and their peers. In-person interaction is necessary to develop and evaluate this aspect of development.

Preschool PEI Program (PPP), cont.

Collaborative Partners

- Fatherhood FIRE Program
- 211 Inland SoCal United Way – PSD 211 Specialist
- Cal Baptist University MFT Intern Program/Dr. Bergin
- Making a Difference Association (MADA)
- County Library & First 5 – PSD Online High School Diploma Program
- Transitional Assistance Department – Home Visiting Program
- Children’s Fund – Vouchers
- Screening, Assessment, Referral, Treatment (SART)
 - Victor Community Support Services/ Christian Counseling Services
- Desert Mountain SELPA/ Apple Valley
- Lutheran Social Services/ Barstow
- Foster & Kinship CARE Education/ Barstow College & San Bernardino Valley College
- Child Care Resource Center
- Inland Regional Center
- Dr. Kiti – Trauma, Loss, and Compassion Support Group
- Fontana Unified School District

Success Stories

“I have been working with a client for a month now due to her anxiety and fear that her relationship with her son’s dad may not work. I recall that in our first session the client was a bit quiet, had a sad tone on her voice, and stated that it was hard for her to open up to anyone. Now, a month in, she has a happier tone and has opened up so much to me about her feelings and past which has improved her anxiety and fear regarding her relationship. The client has mentioned that she appreciates the opportunity given to work with me because the tools, exercises, and homework assignments have helped her process. Client also stated that her son receives services through PSD as well and that he has improved so much.”

-MFT Intern #1

“After building some rapport with my client, during a session she was discussing how her birthday had recently passed and some events that took place that took her family’s attention away from her birthday. I’ve noticed in past sessions how selfless she is when it comes to her kids and husband, despite the relational challenges they have. I have decided to point out to her the selflessness I noticed in her and all she does for her family. She mentioned she never thought of it that way and after hearing me say that to her, she realized it to be true. This client lacks confidence and this really helped her see something positive in herself. Guiding her to this realization was a great feeling to know she finally realizes all that she does and is now giving herself the credit she deserves.”

-MFT Intern #2

Resilience Promotion in African American Children (RPiAAC)

Program Description and Target Population

The Resilience Promotion in African American Children (RPiAAC) program focuses on prevention and early intervention for African American/Black children and youth. The program embraces African American/Black values, beliefs, and traditions, incorporating them into educational and behavioral health services. The program's goal is to promote resilience in African American/Black children to reduce the risk factors that lead to the development of a mental illness and/or substance use disorder behaviors.

Services Offered	• Cultural awareness and empowerment workshops • Professional development presentations • Mental health / SUD screenings • Mental health / SUD education • Counseling services • Case management • Homework assistance • Parenting Workshops	Program Serves	Children TAY (16-25) Adults
		Location of Services	School campuses, Family Resource Centers, Community organizations
		Annual Budget FY 24/25	\$1,700,000
		Cost Per Client FY 24/25	\$358

Resilience Promotion in African American Children (RPIAAC), cont.

State Program Positive Results

RPIAAC works in collaboration with local schools to provide programming and activities at school sites that are convenient for students and their families. Participants are screened for potential risk factors that contribute to mental health symptoms and the possibility of an early onset mental illness. The issues of impairment and safety are further evaluated in order to determine the severity of the participant's need.

RPIAAC providers involve students and parents in planning culturally appropriate and engaging activities for the target audience. Suggestion boxes, polling, and trends from screening tools determine the offered activities.

The RPIAAC program is categorized as a State Prevention and Early Intervention program. The program aims to reduce risk factors such as school failure, dropout, and juvenile justice involvement. It increases protective factors such as positive coping skills, increased knowledge, access to services, and positive self-image. RPIAAC provides a variety of prevention activities and social skill groups through evidence-based curriculums, Peacemakers, and National Curriculum and Training Institute (NCTI) Youth Crossroads. Services are intended for children who are identified as struggling with behavior in class, maintaining passing grades, absenteeism, and tardiness.

Student participants are provided a variety of workshops to aid them with time management, conflict resolution, coping with challenges, and managing emotions. These services incorporate culturally specific strategies and approaches.

Number of Participants / Number of Services Projected vs Actual				
	Projected	Actual		
		FY 20/21	FY 21/22	FY 22/23
Unduplicated Participants	4,190	2,153	1,078	1,076
Number of Services	10,451	3,491	5,962	7,474



Resilience Promotion in African American Children (RPiAAC), cont.

State Program Positive Results

Prevention

The Resilience Promotion in African American Children program implements a variety of prevention services and social skill groups through evidence-based curriculums and activities, such as:

- Peacemakers,
- Meet A Pro,
- Effective Black Parenting Curriculum, and
- NCTI Youth© Crossroads Curriculum.

The Peacemakers and NCTI Youth Crossroads curricula are used for grade K-12 on school campuses and delivered during school hours and in after-school programs. The students participate in weekly training on varying topics throughout the school year. RPiAAC students that participate in these curriculums learn how to make better choices, resolve disputes through conflict resolution, and learn to have positive peer interactions.

Through the Meet A Pro activities, African American/Black professionals talk with students about their careers, personal experience of racism and discrimination, and how they overcame obstacles to succeed. These activities aim to influence

positive perceptions surrounding professional success for African American/Black children and TAY and inspire them to pursue their desired career paths.

The RPiAAC program also provides cultural awareness group sessions for children and TAY. In these session, participants are allowed to share their own background, which allows them to understand cultural differences and similarities in attitudes, beliefs, and values.



Resilience Promotion in African American Children (RPiAAC), cont.

State Program Positive Results, cont.

Early Intervention

RPiAAC utilizes various screening and assessment tools to ensure participants receive treatment services as soon as mental health concerns are identified.

The RPiAAC program utilizes the Child and Adolescent Needs and Strengths – San Bernardino (CANS-SB) to measure the outcomes of the early intervention treatments and assist in developing the mental health treatment plan.

The program also uses the Columbia Suicide Severity Rating Scale (C-SSRC) and Life Events Checklist (LEC-5) to assess to the severity of assistance required with special attention to suicide risk. Students who need services beyond prevention and early intervention are referred to higher levels of care. This allows for care to continue past the typical early interventions, which last approximately 18 months.

FY 2021/22 marked the first full year with only one provider rendering services for the RPiAAC program. The COVID-19 pandemic continued to restrict RPiAAC services in 2021 and 2022 as evidenced by the reduction in unduplicated participants and total services. Schools are slowly allowing the presence of outside organizations on their campuses. The current provider is servicing the contracted area and has also discovered a need for its services in the high desert region.

Early intervention services include mental health screenings and assessments, individual and group therapy, and case management. Successful treatment indicates that the participant has met all their treatment goals when the case has closed. Partially successful means that the participant did not meet all their goals but met most. It can also mean that the participant discontinued services early due to relocation. The information below illustrates the early intervention data for the last three fiscal years.

Early Intervention Participants / Services

	FY 2020/21	FY 2021/22	FY 2022/23
Unduplicated Participants	23	41	42
Number of Services	118	239	908

Treatment Success by Fiscal Year

	Total Episodes	Closed Episodes	% Met Goals
FY 2020/21	301	95	38%
FY 2021/22	335	122	38%
FY 2022/23	335	51	38%

Resilience Promotion in African American Children (RPiAAC), cont.

State Program Positive Results, cont.

Outreach

RPiAAC's outreach and education services are designed to incorporate cultural and historical education for African American/Black student populations. This promotes positive social identity and raises awareness among all students about the importance of mental health and wellness. RPiAAC providers build relationships that allow them to integrate themselves into the culture of schools. They engage with school leadership, teaching staff, and students to reduce the stigma associated with mental health services, which allows for services to begin rapidly. Examples of outreach activities include Principal's Meet and Greet, Meet a Pro, cultural awareness presentations and activities, and participation in school assemblies.

Collaborations with different agencies and stakeholders have allowed the program to identify and target the at-risk African American/Black population. One of the largest barriers faced was the decrease in in-person participation and change in engagement due to the virtual platform presented to students. The neighboring table illustrates the gradual increase in number of potential responders reached in FY 2022/23.

Outreach Settings



- Schools
- Community events
- Community based organization facility

Types of Potential Responders



- Families
- School Personnel
- Community Service providers
- Peer Providers
- Employees

Potential Responders Reached

	FY 2020/21	FY 2021/22	FY 2022/23
Potential Responders	1,835	977	992

Resilience Promotion in African American Children (RPIAAC), cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-50	60+	UNK
FY 20/21	3%	3%	35%	1%	58%
FY 21/22	13%	4%	0%	0%	83%
FY 22/23	12%	6%	0%	0%	83%

Fiscal Year	Veteran Status
% of consumers who identified as a veteran	
FY 20/21	0%
FY 21/22	0%
FY 22/23	0%

Fiscal Year	Sexual Orientation
% of consumers who identified as LGBTQ+	
FY 20/21	0%
FY 21/22	0%
FY 22/23	<1%

Fiscal Year	Disability
% of consumers who identified a physical disability	
FY 20/21	2%
FY 21/22	0%
FY 22/23	0%

Fiscal Year	Gender Identity			
	♂	♀	⚧	UNK
FY 20/21	1%	5%	0%	94%
FY 21/22	34%	51%	0%	15%
FY 22/23	30%	46%	0%	22%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 20/21	58%	2%	0%	40%
FY 21/22	88%	0%	12%	0%
FY 22/23	89%	1%	<1%	10%

Resilience Promotion in African American Children (RPiAAC), cont.

Demographics, cont.

Demographic Observations

- The RPiAAC program has consistently served the target population over the last three fiscal years.
- Some of the questions being asked are considered not applicable for this target population due to appropriateness for the age group they serve.
- Although the program focuses on African American/Black students, RPiAAC has also been successful with participants who identify as Latinx/Hispanic.
- The age demographics align with the program's target population in serving children and TAY.
- Of the participants that provided their age, 18% are between the ages of 0-25.

	Ethnicity/Race	%
FY 20/21	African American/Black	6%
	American-Indian/Alaska Native	0%
	Asian/Pacific-Islander	1%
	Caucasian/White	3%
	Latinx/Hispanic	12%
	Multiple Racial/Other	10%
FY 21/22	African American/Black	77%
	American-Indian/Alaska Native	0%
	Asian/Pacific-Islander	0%
	Caucasian/White	4%
	Latinx/Hispanic	18%
	Multiple Racial/Other	5%
FY 22/23	African American/Black	70%
	American-Indian/Alaska Native	<1%
	Asian/Pacific-Islander	<1%
	Caucasian/White	6%
	Latinx/Hispanic	25%
	Multiple Racial/Other	8%

Resilience Promotion in African American Children (RPIAAC), cont.

Demographics, cont.



		Ethnicity		
		FY 20/21	FY 21/22	FY 22/23
Ethnicity	African	5%	82%	74%
	Asian Indian/South Asian	1%	0%	<1%
	Cambodian	0%	0%	0%
	Chinese	0%	0%	0%
	Eastern European	0%	1%	7%
	European	0%	3%	0%
	Latinx/Hispanic	12%	18%	25%
	Filipino	0%	0%	1%
	Japanese	0%	0%	0%
	Korean	0%	0%	0%
	Middle Eastern	0%	0%	<1%
	Vietnamese	0%	0%	0%
	Other	1%	6%	4%
	More than one ethnicity	0%	4%	7%

Resilience Promotion in African American Children (RPIAAC), cont.

Program Goals

Reduce prolonged suffering associated with untreated mental illness by:

- Reducing risk factors,
- Reducing indicators,
- Increasing protective factors that may lead to improved mental, emotional, and relational functioning,
- Reducing symptoms, and
- Improving recovery, including mental, emotional, and relational functioning.

Reduce stigma and discrimination associated with mental illness by:

- Reducing negative feelings, attitudes, beliefs, perceptions, stereotypes, and/or discrimination related to having a mental illness, being diagnosed, or seeking services.

Program Outcomes

Method use to collect outcome	Description of method	Frequency of use	Number Completed	
Children and Adolescent Needs and Strengths Assessment (CANS)	CANS is a multi-purpose tool developed for children's services to support decision making, including level of care and service planning.	Intake, 3 - 6 months, Discharge, Significant life events	FY 20/21:	3
			FY 21/22:	31
			FY 22/23:	32
National Curriculum & Training Institute (NCTI)	A complete behavioral change system delivered in a group format, following a precise sequence that leads participants from a general level of discussion to a specific behavioral commitment.	2 times Initial & completion	FY 20/21:	49
			FY 21/22:	305
			FY 22/23:	377

Resilience Promotion in African American Children (RPIAAC), cont.

Outcome Discussion

RPIAAC intends to influence the following outcomes with its myriad of services by:

- Improving resilience and feelings of self-efficacy
- Reduction in truancy, drop-outs, suspensions, expulsions
- Increasing knowledge of risk and resilience/protective factors
- Reducing family stress/discord
- Reducing violence
- Improving school performance, and
- Reducing involvement with law enforcements and courts.

The adjacent chart shows the percent improvement by participants before and after participation in the NCTI curriculum.

The knowledge gained in the Cognitive Life Skills courses intends to establish positive, goal-directed behaviors that increases protective factors.

The knowledge gained in the Alcohol and Substance Use and Anger Management courses intends to provide identity skills and resources that help develop a healthy, positive lifestyle that can reduce involvement with law enforcement and courts.

On average, youth exhibited a percent improvement of 14% in their cognitive life skills and skills managing substance & alcohol use and anger management.

NCTI Youth Crossroads			
Curriculum	Average Pre-Test	Average Post-Test	Percent Improvement
Cognitive Life Skills	4.40	5.08	15%
Alcohol and Substance Use	4.01	4.15	4%
Anger Management	2.28	2.80	23%

Resilience Promotion in African American Children (RPiAAC), cont.

Challenges/Solutions

The RPiAAC's program faced challenges with data entry, compatibility challenges arose with the implementation and updates of new information management systems. DBH continues to work with RPiAAC to create streamlined access to all necessary databases.

Lessons Learned

In FY 2021/22, RPiAAC discovered the increasing need for services for at-risk African American/Black youth in the high desert region. In FY 2022/23, the RPiAAC has been successful in building relationships with schools in the high desert region, which has helped the program improve access and linkage to services for at-risk youth. RPiAAC also recruited and utilized student interns for assistance with the program and service delivery.

Success Stories

"It has given me time to think and express myself without being judged."

"It has impacted my life by me being more open on how to feel."

"This program has impacted my life by helping me connect with my people and create new bonds over the course of learning."

"The way the program impacted my life is by helping me understand problem solving and creating a safe environment for black students."

Program Updates

There are no planned program updates for Fiscal Year 2024/25.

Older Adult Community Services (OACS)

Program Description and Target Population

Older Adult Community Services (OACS) program is categorized as a State Prevention program that provides early intervention services. OACS program services target older adults (ages 60+) who are at risk for developing mental health concerns.

The program was created to address important indicators that can contribute to mental health issues such as depression, isolation, chronic physical health conditions, and lack of family support.

- The Mobile Resource Unit provides mental health and substance use screenings to seniors who live in rural or economically depressed areas.
- Older Adult Wellness Services provides various services to older persons, including transportation to and from medical appointments, basic life functioning requirements, and physical and mental health education programs tailored to their needs.
- The Older Adult Home Safety program assists older adults in maintaining the appropriate personal and home safety level. Older adults receive services and education in personal safety, home safety, preventing falls, and medication management.
- The Older Adult Suicide Prevention program provides suicide prevention education, screenings, and direct support services. These services are delivered to the program's target demographic in a culturally acceptable manner. Those who are experiencing the onset of a mental illness and/or relapse episodes related to a pre-existing psychiatric disorder can benefit from early intervention treatments.

Services Offered	• Mental Health Education • Mental Health/SUD Screenings • Case Management Services • Home Safety Screenings • Transportation Assistance for High Desert Residents • Counseling Services • Physical Fitness/Wellness Activities • Suicide Prevention	Program Serves	Older Adults (60+)
		Location of Services	In-home, Senior Centers, Mobile Services, Mental Health Care Facilities
		Annual Budget FY 24/25	\$663,818
		Cost Per Consumer FY 24/25	\$210

Older Adult Community Services (OACS), cont.

Program Highlights

The curriculum focuses on the causes and risk factors that can lead to suicide and/or suicidal ideation, as well as individuals who have been exposed to trauma or are grieving. Older Adult Peer Counselors, who have been trained in suicide prevention and have access to licensed suicide prevention resources, are also used in the program.

The OACS program is intended to promote healthy aging and assist in maintaining mental health wellness. OACS services must be delivered in a convenient and engaging manner for participants. It is classified as a Prevention program because it aims to strengthen protective factors and decrease risk factors associated with mental health challenges. On the following page, you'll find a list of prevention activities and the associated risk and protective factors.

OACS providers collaborate with service coordinators at local senior centers and apartment complexes. Presentations, workshops, and/or groups are developed to address community mental health symptom prevention needs.

Participants are screened for the presence of mental health symptoms and the possibility of an early onset mental health diagnoses. The impairment and safety issues are further evaluated to determine the severity of the participant's need.

OACS providers, their peer family advocates, and the participants use suggestion boxes, polling, and trends from screening tools to determine what activities will be offered.

The table below shows the projected service targets and the actual services provided by the OACS program during the past three fiscal years.

During the COVID-19 pandemic, providers had to learn to transition services from in-person to virtual. Virtual services have reduced several barriers related to transportation. The program continues to exceed the projected participation targets consistent with overall mental health services trends.

Number of Participants / Number of Services Projected vs Actual				
	Projected	Actual		
		FY 20/21	FY 21/22	FY 22/23
Unduplicated Participants	3,166	6,718	11,438	8,957
Number of Services	6,126	9,861	4,181	5,755

Older Adult Community Services (OACS), cont.

Program Highlights, cont.

Prevention Activity	Description	Risk Factors Addressed	Protective Factors Addressed
Wellness Activities • Socialization • Fitness • Nutrition • Craft/Art • Group Meals	• Senior social support groups, activities, and education designed to engage seniors in wellness activities to increase social engagement, decrease isolation/loneliness, and foster healthy personal and community interactions to prevent further escalation of mental health symptoms.	• Prolonged isolation • Ongoing stress • Chronic health conditions • Onset of mental illness	• Socialization • Education on mental wellness • Knowledge of physical health • Nutrition education • Improved flexibility and balance • Knowledge and access to services • Positive Coping Skills
Fall Prevention/Home Safety	• Older adults receive services and education in personal safety, home safety, disaster planning, preventing falls, and medication management.	• Prolonged isolation • Chronic health conditions • Ongoing stress • Lack of family support • Onset of mental illness	• Identification of potential household hazards • Increased safety in home • Knowledge and access to services
Step Down Groups	• Relapse prevention for consumers who have received or are receiving mental health services.	• Onset of mental illness • Depression • Severe trauma • On going stress	• Positive coping skills • Socialization • Knowledge and access to services

Older Adult Community Services (OACS), cont.

Program Highlights, cont.

Prevention Activity	Description	Risk Factors Addressed	Protective Factors Addressed
Telephone Support Groups/Wellness Calls	• Provided social support for residents most impacted by the repercussions of COVID-19 isolation/quarantine. Support was provided in the form of calls to identified residents.	• Prolonged isolation • Access to physical and mental health care • Depression • Chronic physical health conditions	• Screenings for mental health and substance use • Knowledge and access to services • Socialization • Positive coping skills
Transportation Reimbursement Escort Program (TREP)	• Transportation reimbursement program provided to seniors in the High Desert communities for their medical appts, medication pick up, and errands.	• Prolonged isolation • Access to physical and mental health care	• Transportation assistance • Socialization • Knowledge and access to services
Budget Workshops	• These workshop empowered people with a knowledge on how to develop and implement a simple home budget.	• Poverty - Insufficient food, shelter, healthcare • Ongoing stress	• Access to mental and physical health care • Knowledge and access to services

Older Adult Community Services (OACS), cont.

Program Highlights, cont.

Outreach

Outreach is a primary strategy in the OACS program for increasing recognition of early signs and symptoms of mental illness. As a result of successful outreach efforts, OACS has reached out to over 24,000 participants, also known as potential responders, between FY 20/21 through 22/23.

Potential Responders Reached

	FY 20/21	FY 21/22	FY 22/23
Potential Responders	5,801	9,911	8,988

Potential responders for this program are engaged in many ways. They take part in educational presentations about the signs and symptoms of mental illness and age-related difficulties. They are also part of multidisciplinary teams that bring together diverse responders/providers from other disciplines to build the capacity of the teams. By collaborating, they can better understand age-related difficulties, mental health issues, and other issues that affect older adults.

Responders are well equipped to engage with older adults personally and provide advice on age-related or mental health-related difficulties.

OACS provides education and outreach services in areas where potential responders for this population can be engaged. These include senior centers and primary healthcare facilities. Potential responders come from all types of roles. The table below provides a full list of outreach settings and types of potential responders.

Outreach Types of Responders / Settings	
Types of Responders	Settings
- Community Members - Community Service Providers - Healthcare Providers - Faith-Based Organization Leaders - Family Members - Government Service Staff - Primary Health Care Facilities - Law Enforcement Personnel	- Community Events - Community-Based Organizations - Government Service Offices - DBH Community Clubhouses - Faith-Based Organizations - Senior Centers - Primary Health Care Facilities

Older Adult Community Services (OACS), cont.

Program Highlights, cont.

Early Intervention Services

Early Intervention Services provided by the OACS program include mental health screenings and assessments, individual and group therapy, and case management. The information below illustrates the Early Intervention data for the last three fiscal years.

Number of Open Episodes by Fiscal Year			
	FY 20/21	FY 21/22	FY 22/23
Open Episodes at any time during FY	24	21	62

Early intervention services for homebound elders primarily shifted to virtual due to COVID-19. However, telehealth isn't favored among older adults due to limited resources and unfamiliarity with technology. Many lack access to computers or smartphones. Early intervention services are increasing as we transition back to in-person services and seniors adapt to technology.

Older Adult Community Services (OACS), cont.

Program Highlights, cont.

Early Intervention Services

Treatment Success by Fiscal Year			
	FY 20/21	FY 21/22	FY 22/23
Treatment Successful	36%	33%	15%
Treatment Partially Successful	27%	22%	33%
Treatment Not Successful	27%	38%	44%
Missing or Other	10%	14%	7%

The above table illustrates the discharge status at the conclusion of treatment. Many episodes opened results in participants meeting their treatment goals successfully. The OACS program assesses the success of the Early Intervention treatment by the following:

- Treatment Successful: The participant's treatment plan goals were met, and/or they received successful treatment.
- Treatment Partially Successful: Progress was made, but the participant did not meet all the requirements in their treatment plan.
- Treatment Not Successful: The individual did not make progress or did not complete the treatment.

The "treatment successful" data contains some episodes that may have been opened in a previous fiscal year.

Older Adult Community Services (OACS), cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-59	60+	UNK
FY 20/21	<1%	<1%	2%	95%	2%
FY 21/22	0%	0%	<1%	27%	72%
FY 22/23	0%	0%	<1%	29%	71%

Fiscal Year	Sexual Orientation
% of consumers who identified as LGBTQ+	
FY 20/21	<1%
FY 21/22	<1%
FY 22/23	<1%

Fiscal Year	Gender Identity			
	♂	♀	⚧	UNK
FY 20/21	14%	36%	0%	50%
FY 21/22	18%	51%	0%	31%
FY 22/23	13%	35%	0%	52%

Fiscal Year	Veteran Status
% of consumers who identified as a veteran	
FY 20/21	<1%
FY 21/22	<1%
FY 22/23	2%

Fiscal Year	Disability
% of consumers who identified a physical disability	
FY 20/21	9%
FY 21/22	3%
FY 22/23	3%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 20/21	16%	1%	<1%	83%
FY 21/22	10%	2%	0%	88%
FY 22/23	12%	3%	<1%	85%

Older Adult Community Services (OACS), cont.

Demographics, cont.

Demographic Observations

- It has become increasingly difficult for providers to capture demographic data for a skeptical population.
 - Older Adults historically are a difficult population to engage in services and provide demographic information because they grew up in eras where the government participated in harmful practices towards people who suffered from mental health challenges, LGBTQ+, and people from ethnic and minority groups.
- Previous years have also shown a reduction in participants identifying as male and an increase in people declining to answer the gender questions.
 - Studies show that older adult males, specifically White and Native American males, have higher rates of suicide attempts and death. This is a continued area of concern and focus for engagement that the OACS program will continue to monitor closely in the coming years.
- We are seeing a notable decrease in serving persons with a physical disability. This could be due to the increased telehealth service options available during the pandemic.
 - All current OACS providers have committed to continuing to offer telehealth options with support for participants needing technological assistance.

Older Adult Community Services (OACS), cont.

Demographics, cont.

	Ethnicity/Race	FY 20/21	FY 21/22	FY 22/23
Race	African American/Black	2%	1%	<1%
	American-Indian/Alaska Native	0%	<1%	<1%
	Asian	0%	<1%	<1%
	Native Hawaiian/Pacific Islander	0%	0%	0%
	Caucasian/White	8%	6%	8%
	Latinx/Hispanic	13%	3%	4%
	More than One Race	0%	<1%	<1%
	Other	2%	<1%	1%
	Declined to Answer	78%	67%	84%

Older Adult Community Services (OACS), cont.

Demographics, cont.

	Ethnicity/Race	FY 20/21	FY 21/22	FY 22/23
Ethnicity	African	0%	2%	<1%
	Asian Indian/South Asian	0%	1%	0%
	Cambodian	0%	0%	0%
	Chinese	0%	1%	<1%
	Eastern European	0%	0%	0%
	European	13%	30%	20%
	Filipino	0%	1%	<1%
	Japanese	0%	0%	0%
	Korean	0%	0%	0%
	Middle Eastern	0%	0%	0%
	Vietnamese	0%	0%	0%
	Other	1%	5%	2%
	More than One Ethnicity	38%	2%	1%
	Declined to answer	48%	57%	75%

Older Adult Community Services (OACS), cont.

Program Goals

The State Prevention Program's goal is to reduce prolonged suffering associated with untreated mental illness by reducing risk factors, reducing indicators, and increasing protective factors that may lead to improved mental, emotional, and relational functioning.

The OACS program promotes a healthy aging process for adults ages 60+ by:

- Providing access to activities that increase connections with other older adults.
- Providing education on mental and physical wellness and increasing participation in mental and physical wellness activities.
- Increasing personal safety, home safety, fall prevention, and assistance with medication management.
- Increasing the likelihood and willingness of older adults to engage in suicide and depression screenings.
- Increasing access, linkage, and engagement in therapy services as early in the onset of mental health conditions as practicable.



Artwork by Noraly Sainz

Older Adult Community Services (OACS), cont.

Program Outcomes

Method Used to Collect Outcomes	Description of Method	Frequency of Use	Number Completed
Adult Needs and Strengths Assessment (ANSA)	A comprehensive assessment of psychological and social factors used for treatment planning. This assessment measures functioning in several important life domains and helps to support decision-making and level of care and service planning, and ensure projected goals are being met.	• Intake • 3 Months • Discharge • Significant Life Events	FY 20/21: 29 FY 21/22: 65 FY 22/23: 35
Satisfaction Survey	Survey that reflects on the usefulness of the service/presentation and the speaker's ability to deliver information. An additional space was provided for narrative feedback.	• Post Service and/or Presentation	FY 20/21: 108 FY 21/22: 255 FY 22/23: 42
Outreach Questionnaires	A seven-item questionnaire that assesses a participant's improved knowledge of signs and symptoms that can lead to a potentially severe mental illness.	• Pre/Post Mental Health Education Presentation and/or Activity	FY 20/21: 49 FY 21/22: 52 FY 22/23: 73
PHQ-9	Nine-question instrument given to patients in a healthcare setting to screen for the presence and severity of depression.	• Intake • 6 Months	FY 20/21: 110 FY 21/22: 25 FY 22/23: 30

Older Adult Community Services (OACS), cont.

Outcome Discussion

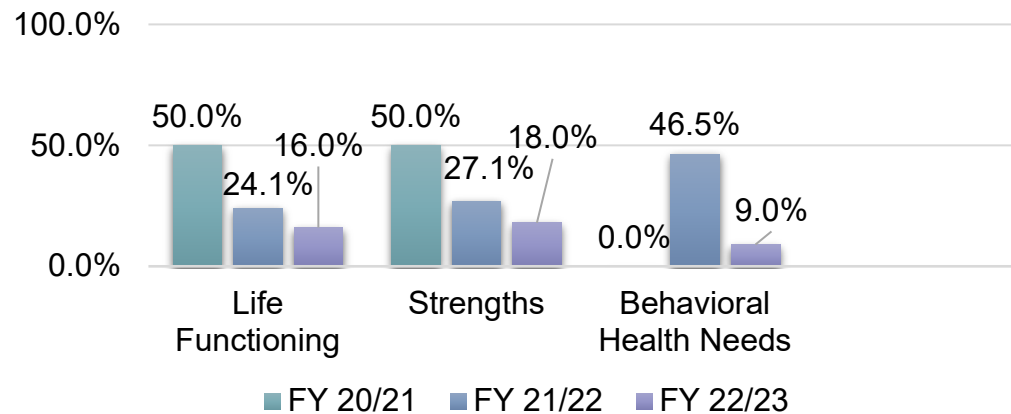
The OACS program uses the Adult Needs and Strengths Assessment – San Bernardino County (ANSA-SB) to measure the outcomes of the early intervention treatments. ANSA-SB is an information integration tool for adults with behavioral health challenges. The tool is used to support individual case planning and the planning and evaluation of service systems. Each dimension is rated on its four-point scale when the ANSA-SB is administered. The ANSA-SB is administered at intake and at three-month intervals until discharge.

The focuses of early intervention treatment for the OACS program are:

- Life Functioning domain evaluates factors like an individual's family relationships, social functioning, residential stability, self-care, and transportation.
- Strengths domain evaluates factors like family support, optimism, talents and interests, spirituality, relationship permanence, community connection, and resourcefulness.
- Behavioral Health Needs, which evaluate factors like thought disorders, depression, anxiety, antisocial behavior, adjustment to trauma, and substance use.

The chart below shows that all consumers who started services with a need to improve in Life Functioning, Strengths, and Behavioral Health Needs improved by the end of their treatment. An area of concern is shown in FY 22/23, where all three domains showed decreases. Many early intervention services are still feeling the impact of the COVID-19 pandemic. Transitioning out of stay-at-home isolation orders has left some residents leery of leaving their homes for services or socializing. The greatest decrease was in the Behavioral Health Needs domain, which includes factors like depression, anxiety, antisocial behavior, and adjustment to trauma. All OACS providers are exploring creative options to maintain older adults in early intervention services and improving outcomes.

OACS ANSA-SB % Improved by Fiscal Year



Older Adult Community Services (OACS), cont.

Outcome Discussion, cont.

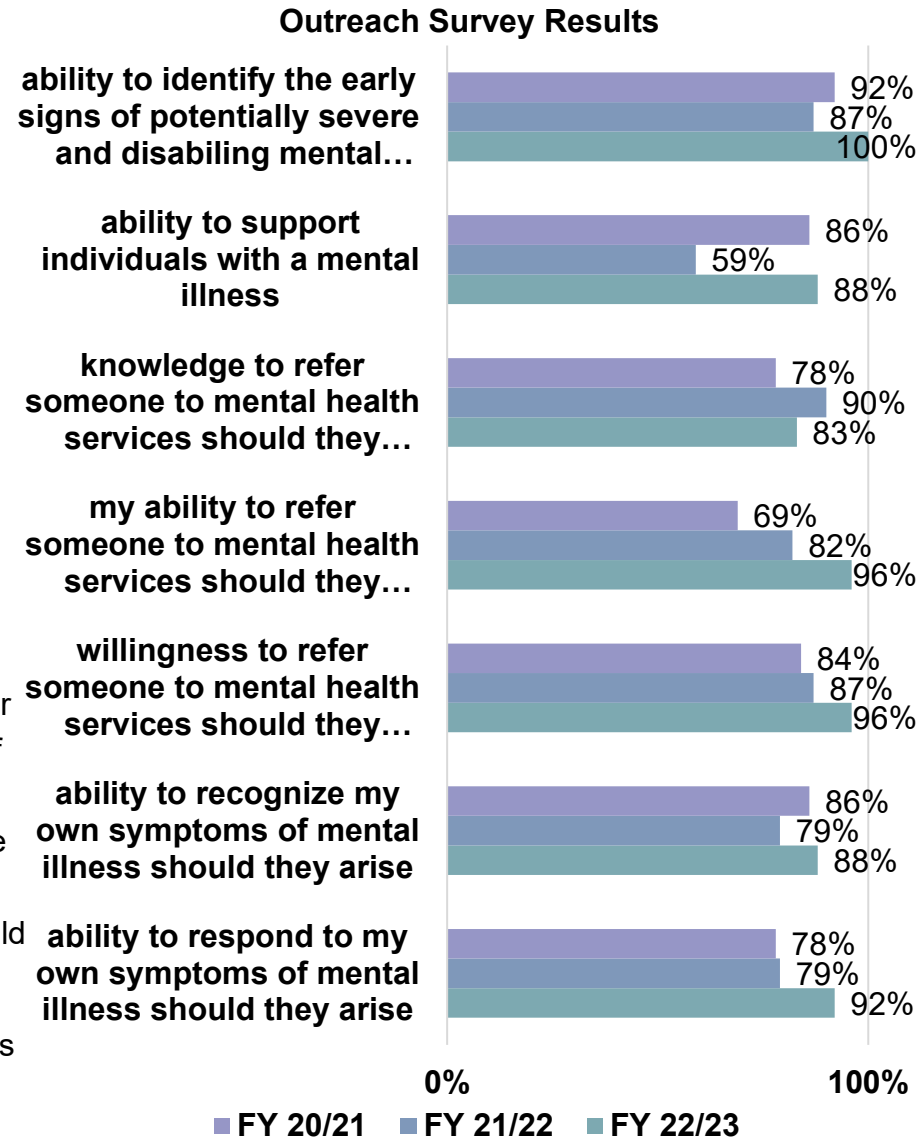
Outreach Survey Results

The OACS conducts a series of outreach activities. These activities include educational sessions for the community to learn more about mental health and wellness. It also includes events that disseminate information on signs and symptoms of mental illness and age-related difficulties. Participants are given a post-survey at the conclusion to gauge their level of understanding of the information received. It also measures the comfort level that the individuals have when assisting someone who may need assistance with mental health concerns.

Participants are asked to answer questions on how they feel after participating in the activity or event. The graph on this page includes the questions and responses over the last three years.

Almost all those surveyed agreed that they feel more confident in their ability to identify the early signs of mental illness. In FY 22/23, 88% of people feel that they can support individuals with mental illness and can recognize their symptoms of mental illness should they arise. The results also show an overall improvement in the referral process knowledge of referrals and intent to seek mental health services should they be needed.

Education and promotion of behavioral health prevention and wellness have shown to be a successful strategies for increasing community awareness of mental health and available resources.



Older Adult Community Services (OACS), cont.

Outcome Discussion, cont.

Consumer Satisfaction Surveys

OACS participant satisfaction is critical to the success of the OACS program. The participants are frequently surveyed on activities that they want to engage in and educational topics they want to learn. The programming is centered around the responses received to reduce stigma and increase engagement. Most, if not all, are satisfied with the program's services. The following represents the average results over the three-year review period.



Fitness Activity Results – Activities designed to improve physical/mental health, mobility, strength and decrease isolation

100% stated that program helped improve their mental health.

100% stated that they would continue walking due to the effects on their physical health.

33% stated improvements in quality time spent with friends and family.



OACS Wellness Services – Activities designed to increase knowledge on all aspects of wellness, increase socialization and decrease isolation.

83% of OACS participants agreed or totally agreed that participants improved knowledge on mental health and stigma reduction.

84% of OACS Wellness presentation participants agreed that the presentations were useful and the speaker delivered information.



OACS Mobile Outreach and Health Screenings – Designed to decrease transportation barriers and increase access to services by providing assessments and screenings at convenient locations for OACS participants.

98% of participants stated they learned something new at Mobile Outreach or Health screening event.

100% of participants found value in having services delivered in mobile settings.

Older Adult Community Services (OACS), cont.

Challenges/Solutions

The OACS providers continue to experience challenges with connecting participants with timely Early Intervention and Psychiatric services when they have private insurance and/or need a higher level of care. The mountain communities are especially impacted as insurance providers do not have sufficient mental health service providers in the mountain region. The lack of mental health service providers in the mountain regions leads to significant transportation challenges for the older adult population that must travel long distances to seek services.

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

The OACS providers use safety calls to handle isolation issues. During severe weather, they boost the number of calls they make to participants. They offer a variety of seminars and workshops on topics such as the benefits of socialization, stress reduction, and how to find local resources. The OACS program also intends to put a greater emphasis on activities that appeal to older adult men.

The OACS program is always looking for novel ways to address transportation issues. It has developed agreements with local health insurance providers to transport consumers to/from medical appointments. The program also assist older adults with information and training courses on how to access the public transit system.

Older Adult Community Services (OACS), cont.

Lessons Learned

The use of technology with the older adult population is not ideal. It has been found that many older adults do not have access to a computer or smartphone. Many others have no interest in learning to use platforms such as Zoom or Facebook to access mental health services. Increased technological use has been more beneficial for those with physical disabilities as they are more accustomed to embracing creative ways to stay connected.

Peer and Family Advocates have been the most successful component of the program. The advocates are trusted members of the program and were able to continue contact with participants during the pandemic. They were critical for information dissemination via telephone, and the participants felt more connected with their involvement.

Program Updates

There are no planned program updates for Fiscal Year 2024/25.

Success Story

“The [consumer] is an 80-year-old Latinx/Hispanic female that has been attending the Older Adult Community Services Program’s Color Away Your Stress coloring group for the last 3 months. At first, she appeared to be withdrawn and would isolate from others. She reported that she did not know if she should continue this group because she was not good with coloring. OACS’s Mental Health Specialist encouraged her to continue coming and would praise her for drawings. On many occasions [consumer] would seek attention and ask for approval on what colors she should use for the drawings. Other group members supported her and showed her how to use the pencils and how to combine colors. She continued to come to the class and started to feel more comfortable in the group. Gradually, she began to socialize more and now she engages in conversations with the other group members. [Consumer] has made lots of improvement and has improve herself esteem coming to this class. [Consumer’s] increased socialization also resulted in improved moods and decreased impairments of which [consumer] was able to utilize to self-determine her graduation of OACS EIS’s.”

Lift Program

Program Description and Target Population

The Lift Program is a Prevention program that is a collaborative effort between the Department of Behavioral Health and the Preschool Services Department. It is designed to improve the health, well-being, and self-sufficiency for pregnant and parenting mothers, their children, and their families. Nurses visit the individual in their own home and provide education to promote the physical and emotional care of the newborn child.

First-time pregnant mothers who meet income guidelines are given priority enrollment. Mothers with other risk factors are also eligible. These risk factors include homelessness, teenaged moms, child welfare involvement, at-risk for juvenile justice involvement, and pregnant mothers exhibiting signs of depression.

Pregnant mothers receive in-home visits from registered nurses who provide education about the connection between physical and mental health, as well as information about the developmental stages of their children. They provide supportive strategies to ensure that children and family thrive in their environment.

Referrals to the Lift program come from various sources, including community hospitals, local high schools, pregnancy resource centers, homeless shelters, faith-based organizations, the Black Infant Health program, and Women, Infant, and Children (WIC) centers.

Services Offered	• Parent education and support • Post-natal depression screenings • Nurturing activities to increase maternal attachment • Developmental milestones education • Life and employment skills development • Community referrals	Program Serves	Children, Youth, TAY, Older Adults
		Location of Services	In-home
		Annual Budget FY 24/25	\$396,000
		Cost Per Client FY 24/25	\$3,300

Lift Program, cont.

Program Positive Results

The Lift Program nurses use a variety of tools and assessments that identify potential risk factors and protective factors. These tools and assessments are designed to quickly identify indicators of areas of need, such as depression and nicotine dependency. The tools and assessments used are:

- Edinburgh Postnatal Depression Scale,
- Fagerstrom Test for Nicotine Dependency,
- Maternal Fetal Attachment Scale, and
- Life Skills Progression

Typically, these screenings take the form of a survey or a conversation. Lift nurses make referrals to partner agencies that specialize in these types of supportive services. These services contribute to the development of protective factors by providing tangible support during times of difficulty and by providing participants with information tailored to their specific needs.

Additionally, this strengthens feelings of social connection as Lift nurses provide support and reassurance. As a result of the early screening and identification process, participants better understand parenting and child development. They discuss the effects of smoking, attachment, and depression on the mother-child bond and the developing child.

The Lift program serves approximately 120 participants each year. As a result of ongoing education and trust-building efforts between the Lift nurses and prospective participants, overall participation exceeded program goals in FY 2019/20. There was a slight decline in participation in FY 2020/21 due to the COVID-19 pandemic and increased fears for in-home services. The participation rates in FY 2021/22 significantly increased exceeding program goals.

Number of Participants / Number of Services Projected vs Actual				
	Projected	Actual		
		FY 20/21	FY 21/22	FY 22/23
Unduplicated Participants	120	114	154	52
Number of Services	1,728	1,094	759	360

Lift Program, cont.

Program Positive Results, cont.

Edinburgh Postnatal Depression Scale

Lift nurses use the Edinburgh Postnatal Depression Scale as an assessment to recognize signs that might indicate a new mother may be experiencing postnatal depression. Scoring between 10 to 30 points on this 10-question scale signifies a high likelihood of participants experiencing clinical depression.

The Lift nurse administers the Edinburgh Postnatal Depression Scale within eight weeks after birth. Based on the assessment results, Nurses and Marriage and Family Therapists (MFTs) provide the appropriate interventions, services, and resources.

According to the Centers for Disease Control and Prevention (CDC), the national average of postnatal depression among new mothers in the United States is between 10% - 23% in the year after giving birth. However, the table below demonstrates a decline in the percentage of new mothers experiencing postnatal depression enrolled in the Lift program.

When a participating mother is identified as experiencing possible postnatal depression, nurses provide early support, education, and resources to help new mothers navigate through their symptoms. Nurses are trained at recognizing signs and continually assess during home visits.

Most new moms in the Lift program who exhibit symptoms improve through working with their Lift nurses, as observed in ongoing assessments conducted by the nurses. If a participating mother is identified as experiencing possible depression, a referral is generated and an MFT is assigned to work collaboratively with the participant and nurse to provide the necessary resources and services.

The chart below shows the data for the last three years. In the latest fiscal year, 52 mothers were screened for signs of depression. Only 6 received a score that indicated that they needed additional support to prevent the depression from becoming severe or disabling.

Identification of Depression Related Mental Health Needs			
	FY 2020-21 (N= 60)	FY 2021-22 (N= 46)	FY 2022-23 (N= 52)
Exhibited signs of depression	9	1	6
Received mental health supportive services	9	1	6
Required clinical intervention	1	1	4

Lift Program, cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-50	60+	UNK
FY 20/21	34%	19%	44%	0%	3%
FY 21/22	39%	18%	27%	0%	4%
FY 22/23	63%	0%	37%	0%	0%

Fiscal Year	Sexual Orientation
% of consumers who identified as LGBTQ+	
FY 20/21	12%
FY 21/22	1%
FY 22/23	2%

Fiscal Year	Gender Identity			
	♂	♀	⚧	UNK
FY 20/21	18%	79%	0%	3%
FY 21/22	21%	69%	0%	9%
FY 22/23	20%	69%	0%	11%

Fiscal Year	Veteran Status
% of consumers who identified as a veteran	
FY 20/21	2%
FY 21/22	0%
FY 22/23	0%

Fiscal Year	Disability
% of consumers who identified a physical disability	
FY 20/21	4%
FY 21/22	2%
FY 22/23	6%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 20/21	77%	6%	5%	12%
FY 21/22	74%	8%	7%	8%
FY 22/23	78%	9%	10%	4%

Lift Program, cont.

Demographics, cont.

Demographic Observations

The Lift program primarily targets first-time pregnant women, new mothers, and with their families.

The Lift program has consistently served the targeted demographics over the last three fiscal years.

Most participants are TAY and adult women. We also see a small percentage of male participants, which reflects services provided to fathers who are participating in the family services program.

The ethnic/racial diversity of the participants generally reflects the diversity of the population of San Bernardino County.

Notably, members of the Asian/Pacific Islander community are not currently participating in the Lift program.

Efforts will be made in the upcoming program years to engage this community.

	Ethnicity/Race	%
FY 20/21	African American/Black	19%
	American-Indian/Alaska Native	1%
	Asian/Pacific-Islander	0%
	Caucasian/White	32%
	Latinx/Hispanic	0%
	Multiple Racial/Other	20%
FY 21/22	African American/Black	22%
	American-Indian/Alaska Native	2%
	Asian/Pacific-Islander	0%
	Caucasian/White	27%
	Latinx/Hispanic	0%
	Multiple Racial/Other	38%
FY 22/23	African American/Black	27%
	American-Indian/Alaska Native	3%
	Asian/Pacific-Islander	0%
	Caucasian/White	10%
	Latinx/Hispanic	0%
	Multiple Racial/Other	26%

Lift Program, cont.

Demographics, cont.

	Ethnicity			
		FY 2020/21	FY 2021/22	FY 2022/23
Ethnicity	African	19%	5%	9%
	Asian Indian/South Asian	0%	0%	0%
	Cambodian	0%	0%	0%
	Chinese	0%	0%	0%
	Eastern European	0%	0%	0%
	European	0%	2%	0%
	Latinx/Hispanic	68%	38%	52%
	Filipino	0%	0%	0%
	Japanese	0%	0%	0%
	Korean	0%	0%	0%
	Middle Eastern	1%	1%	0%
	Vietnamese	0%	0%	0%
	Other	0%	0%	3%
	More than one ethnicity	10%	1%	11%

Lift Program, cont.

Program Goals

The goal of the Lift Program is to promote healthy outcomes for at risk mothers and their infants though providing home visitation services. Registered nurses provide education and resources to reduce risk factors and promote protective factors.

The goals of the Lift program are as follows:

- Improve pregnancy outcomes by helping participants obtain prenatal care from their physician and reduce cigarette, alcohol, and illegal drug use.
- Teach participants about healthy nutrition during pregnancy to improve overall mental health outcomes for mother and child.
- Improve child health and development by helping parents provide appropriate care of their children in the first two years of life.
- Guide parents on caring for and nurturing their children and provide safe and consistent child discipline practices.
- Improve maternal development by helping mothers to develop a vision and plan for their future, make reasoned choices about the partners, family, and friends involved with their child, plan future pregnancies, reach their educational goals, and find employment.

Program Outcomes

Method use to collect outcome	Description of method	Frequency of use	Number Completed	
Maternal Fetal Attachment Scale	The Maternal Fetal Attachment Scale is a tool used to determine the attachment between a mother and her unborn child.	1x at the beginning of services	FY 20/21:	60
			FY 21/22:	46
			FY 22/23:	52
Life Skills Progression Tool	The Life Skills Progression is a tool used to monitor participants' strengths and needs.	1x at the beginning of services	FY 20/21:	60
			FY 21/22:	40
			FY 22/23:	52

Lift Program, cont.

Outcome Discussion

Maternal Fetal Attachment Scale

The Maternal Fetal Attachment Scale is a questionnaire used to assess the bond between expectant mothers and their unborn child. Elevated scores indicate a greater degree of prenatal attachment. The Scale is administered to participants in the Lift program, and the results are analyzed to determine their unique needs.

Identifying and addressing early indicators of maternal-fetal attachment promotes protective factors in both mother and baby by increasing bonding, strengthening family support, and fostering a stable and healthy home environment, all of which contribute to the child's positive outcomes.

Lift nurses support mothers in the program by providing individualized support in key areas identified by the Maternal Fetal Attachment Scale. Key measures indicate whether pregnant mothers are willing to give up harmful activities for their child, their body image, their future hopefulness, and reading to their unborn child. Support may include education, positive nurturing activities, and family counseling, all of which contribute to developing more positive nurturing relationships.

The following tables illustrate the percentage of new mothers reporting the indicated attachment levels in the subdomains of nurturing and attachment, family supports, economic security, self-empowerment, and mastery and control over the future.

Lift Program, cont.

Outcome Discussion, cont.

Nurturing & Attachment

	FY 2020-21	FY 2021-22	FY 2022-23
I desire this baby / I'm not sorry I became pregnant	100%	100%	100%
I am willing to give up certain things to protect my baby	100%	67%	94%
I read to my baby / unborn child	80%	50%	53%

When evaluating nurturing and attachment, mothers responded positively to modifying their lifestyle to support a healthy environment for their child. They also agreed that reading to the child was important in strengthening the family bond.

These results are important for Lift nurses providing education and support about pregnancy and child development. They provide feedback on education and a healthy strategy for supporting emotional development.

Family support is a valuable protective factor. A new mother or expectant mother relies heavily on the support received from close family and friends during pregnancy and in the early years of the newborn's life. The Family Supports chart shows that over a three-year period, only a small percentage said that their mate did not want the pregnancy. There was also a small percentage that felt that their pregnancy interfered with their relationship with their mate. Those participants are offered family counseling to reconcile those feelings. Feelings about family supporting the pregnancy increased in the three-year review period. Including all family members in Lift program intervention reinforces the supports for the expectant mother during pregnancy.

Family Supports

	FY 2020-21	FY 2021-22	FY 2022-23
My mate wants this pregnancy	0% No	0% No	0% No
My pregnancy interferes with my relationship with my mate	0% Yes	33% Yes	22% Yes
My family supports my pregnancy	95% Yes	72% Yes	63% Yes
My family will help in caring for my baby	96% Yes	65% Yes	82% Yes

Lift Program, cont.

Outcome Discussion, cont.

Life Skills Progression (LSP) Tool

The Life Skill Progression tool captures a portrait of the behaviors, attitudes, and skills of mothers enrolled in the Lift program. It helps to establish a baseline of participant profile, identify strengths and needs, plan interventions, and monitors outcomes to show that interventions are working.

In the Lift program, the LSP is used to assess needs related to education and employment. As seen in the table below, during FY 2019/20 and 2021/22 there is a strong correlation between the education level and stable employment. There was a significant decrease in unemployment and an increase in stable employment for FY 2021-22. The percentage of participants with less than a high school education significantly decreased within the last three years.

Stable employment reduces risk factors related to poverty and unemployment and increases protective factors related to economic security. The Lift program includes support and referrals to high school diploma completion programs. Completing high school and earning a diploma also increases protective factors such as increasing future opportunities, improving feelings of mastery and control, and increasing self-esteem through accomplishment. The Lift program also provides referrals to the Preschool Services Department Apprenticeship program and other training programs for career options. Families obtaining stable employment reduces risk factors by helping with self-esteem, self-efficacy, and economic security.

Participant Education Level and Employment Stability			
	FY 2020-21	FY 2021-22	FY 2022-23
Less than high school education	10%	1%	2%
Unemployed / work occasionally	95%	61%	69%
Some college	18%	26%	46%
Stable employment	5%	26%	31%

Lift Program, cont.

Challenges/Solutions

Due to the ongoing COVID-19 pandemic and the rising number of cases throughout the year, the department has continued to face challenges. One Registered Nurse was out for an extensive period of time for a serious medical condition, which impacted recruitment efforts and put a strain on the remaining staff.

To address these challenges, the program continues to follow the procedures in response to the COVID-19 pandemic, such as telephonic or virtual visits to ensure the safety of both program participants and the staff. The department assessed the staffing issue by reviewing the caseloads and equally distributing the participants to the remaining staff, including but not limited to utilizing the Supervising Nurse Case Manager to conduct field visits to cover periods of time when staff were out on vacation or sick. Recruiting efforts were scaled back to ensure that the number of participants did not exceed established guidelines and impact the quality of service provided to participants of the program.

Lessons Learned

Education about the interrelation between the mental and physical developmental milestones of unborn and newborn infants is an important consideration of behavioral health; more emphasis can be placed on conducting follow-up screenings to measure the overall growth of participating mothers.

The Edinburgh Postnatal Depression Scale is a valuable tool to screen for early signs of postnatal depression and allows the nurse to develop a case plan. It would also be an effective tool to measure the success of the interventions if they were administered at appropriate intervals.

Program Updates

There are no planned program updates for Fiscal Year 2024/25.

Lift Program, cont.

Success Story

The LIFT nurse program is a crucial support for expectant mothers, addressing challenges in accessing prenatal care. Illustrated through Christina's story—a woman in a remote area with limited healthcare and financial constraints—the program played a vital role in her pregnancy journey, offering assessments, prenatal care, and emotional support. The nurse connected her with a labor doula and postpartum resources, addressing breastfeeding and postpartum depression. Beyond healthcare, the program linked Christina with housing, job leads, and childcare resources. The LIFT Program's commitment to supplying essential items to low-income families showcases its transformative impact, serving as a beacon of hope for healthier communities.

Coalition Against Sexual Exploitation (CASE)

Program Description and Target Population

The Coalition Against Sexual Exploitation (CASE) of San Bernardino County is a county-wide collaboration of public and private organizations with the common goal of combating the commercial sexual exploitation of children (CSEC). CASE partner organizations combine resources to educate the community and protect, intervene, and treat children and youth who are victims of commercial sexual exploitation.

The CASE program provides education and training to raise awareness of issues, recognize signs of exploitation, and provide direct services, resources, and treatment to CSEC youth.

The multidisciplinary team includes social workers from Children and Family Services, Public Defenders Office, and Behavioral Health; attorneys from the District Attorney's office and Public Defenders office; a probation officer, a public health nurse, an Alcohol and Drug Counselor, and advocates from Court Appointed Special Advocate (CASA), Open Door; and an educational consultant from San Bernardino County Superintendent of Schools, all working together to provide needed services to at-risk youth who have been identified as commercially sexually exploited.

CASE aims to reduce the number of those who are commercially sexually exploited or at risk of commercial sexual exploitation. The multi-agency collaboration model supports the State Prevention categorization through the services aimed at decreasing risk factors associated with children becoming commercially sexually exploited and increasing the protective factors.

Services Offered	• Mental health assessments • Crisis Intervention • Case Management including linkage and referrals • School enrollment assistance • Therapeutic interventions • Transportation assistance • Placement consultation • Outreach and community awareness training

Program Serves	Children, Youth, TAY
Location of Services	Foster care placements, hospitals, schools, community settings
Annual Budget FY 22/23	\$240,607
Cost Per Client FY 22/23	\$160

Coalition Against Sexual Exploitation (CASE) cont.

State Program Positive Results

The CASE program works to reduce prolonged suffering associated with untreated mental illness by recognizing signs of CSEC involvement and providing access to services early, thereby addressing risk factors and promoting protective factors. Their goals are as follows:

- Train agency staff on identifying and recognizing signs of commercial sexual exploitation of children (CSEC).
- Raise public awareness of CSEC issues.
- Raise knowledge of available community resources.
- Identify youth who are potential CSEC victims and provide access to needed resources and treatment.

Risk factors identified for CASE participants are running away, trauma exposure (e.g., history of sexual abuse and child welfare or probation system involvement), school failure/chronic absenteeism, poverty, substance use, and violence.

Protective factors for CASE participants include positive adult interactions, school/community involvement, resourcefulness, resiliency, peer relationships, optimism, leadership, and life skills. CASE prevention activities seek to address the risk factors and protective factors with the following services:

- Placement assistance, advocacy, safety planning, and CASE Youth Resource cards to help reduce the risk factors for homeless/runaway youth.
- Support, consultations, and advocacy from the San Bernardino Superintendent of Schools, Probation, and the District Attorney's office to help reduce risk factors for youth with a history of violations with truancy, curfew, and/or involvement with the juvenile justice system.
- Creation of safety plans, Child Family Services Social Worker assignment, Child Family Team (CFT) meetings, mentor assignment, Public Health, and therapeutic services are available to youth that face sexual abuse, physical abuse, and neglect risk factors.

Number of Participants / Number of Services Projected vs Actual				
	Projected	Actual		
		FY 20-21	FY 21-22	FY 22-23
Unduplicated Participants	1,500	1,229	1,398	1,661
Number of Services	1,500	1,652	1,920	2,044

Coalition Against Sexual Exploitation, cont.

State Program Positive Results, cont.

Prevention activities include ongoing, individualized engagement between the CSEC youth and the multidisciplinary team. There were thirty-five total CASE participants in FY 2022/23. The total number of participants is lower than previous years, as shown in the table below. This may be in part due to reduction in outreach during the 2020/21 and 2021/22 years while COVID restrictions were still in effect.

One of the indicators of successful engagement with CSEC youth is their ongoing participation in the CASE program. The percentage of youth who continue in the program from previous years increased from 61% in FY 2020/21 to 69% in FY 2021/22 and FY 2022/23. This indicates a building level of trust and receptiveness towards receiving services.

Number of Prevention Participants			
	FY 20-21	FY 21-22	FY 22-23
Unduplicated Participants	67	58	35
Number of participants continuing from previous year	41	40	24
Percentage of continuing participants	61%	69%	69%

Girls' Court

A prevention activity for CASE is Girls' Court, a program for at-risk females between the ages of 12 and 17 who are involved in the legal system. Girl's Court focuses on self-esteem-building and empowerment components for young women. If they complete the program successfully, their criminal records are sealed before turning 18 to alleviate further stigmatization of having prior juvenile justice involvement.

Graduation from Girls' Court requires participants to show progress in the program, meet benchmarks, and obtain supervision goals. The youth's changes demonstrate healthy lifestyle choices, self-empowerment, pro-social behavior, educational pursuits, and well being. Participation in Girls' Court reduces negative outcomes by encouraging participants to remain enrolled in school, fostering academic achievement, reducing school dropout rates and attempts to reduce recidivism and incarceration rates by the participants' commitment to healthy lifestyle choices and pro-social behavior.

Girls' Court Completion Rate			
	FY 20-21	FY 21-22	FY 22-23
Completion Rate	60%	20%	41%

Coalition Against Sexual Exploitation, cont.

State Program Positive Results, cont.

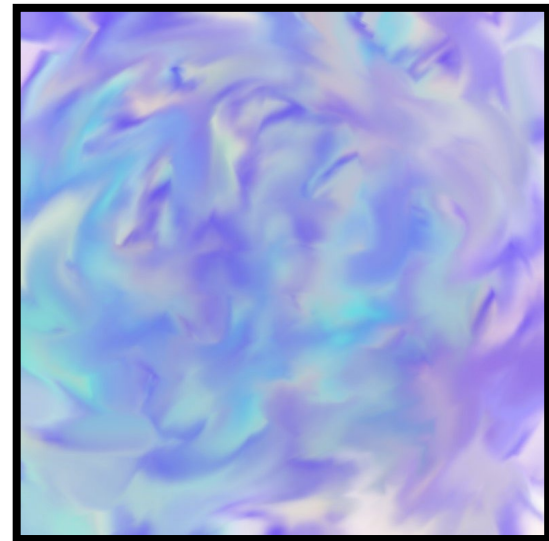
Outreach for Increasing Recognition of Early Signs and Symptoms of Mental Illness

CASE uses the State Strategy, Outreach for Increasing Recognition of Early Signs and Symptoms of Mental Illness, as a way to involve child-serving agencies and the community in identifying children who may be at risk of sexual exploitation and provide information and resources on how to keep children safe.

Outreach and education efforts focus on training agency staff on identifying and recognizing signs of CSE in youth, raising public awareness of CSEC issues, raising knowledge of available community resources, and increasing the ability to identify youth who are potential CSE victims and provide access to needed resources and treatment.

During FY 2022-23, the CASE program providing educational outreach to 1,626 potential responders, including staff from law enforcement agencies, probation department, attorneys, school personnel, health care providers, and local area community service providers.

Of the participants who completed program surveys, 99% increased their ability to define and describe human trafficking, 96% reported increasing their knowledge and awareness of recruiting tactics and locations, and 93% were more knowledgeable about available resources for CSEC youth.



Artwork by Rey French

Coalition Against Sexual Exploitation, cont.

State Program Positive Results, cont.

In terms of being able to identify youth who are potential CSEC victims, 97% reported that they can recognize key terms relating to CSEC victims and the subculture of trafficking, and 97% now have an understanding of trauma bonds and identifying signs of CSEC involvement, as shown in the table below:

Program Goals	
Goal: Raise awareness of CSEC issues	
Ability to define / describe human trafficking	99%
Increased knowledge and awareness of recruiting tactics and locations	96%
Goal: Raise knowledge of available community resources	
Knowledgeable about available resources for CSEC youth	93%
Goal: Identify youth who are potential CSEC victims	
Able to recognize key terms relating to CSEC victims and the subculture of trafficking	97%
Understanding trauma bonds / identifying signs of CSEC involvement	97%
N=335	

Early Intervention services are available to CASE participants. However, the CASE team members do not directly provide these services. The multidisciplinary team assesses, refers, and links children identified as needing early intervention support.

Coalition Against Sexual Exploitation, cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-59	60+	UNK
FY 20-21	3%	30%	32%	0%	35%
FY 21-22	0%	11%	20%	1%	68%
FY 22-23	4%	24%	56%	4%	12%

Fiscal Year	Veteran Status
% of consumers who identified as a veteran	
FY 20-21	0%
FY 21-22	0%
FY 22-23	3%

Fiscal Year	Sexual Orientation
% of consumers who identified as LGBTQ+	
FY 20-21	0%
FY 21-22	1%
FY 22-23	4%

Fiscal Year	Disability
% of consumers who identified a physical disability	
FY 20-21	0%
FY 21-22	0%
FY 22-23	4%

Fiscal Year	Gender Identity			
	♂	♀	⚧	UNK
FY 20-21	6%	31%	1%	62%
FY 21-22	10%	23%	0%	60%
FY 22-23	16%	33%	1%	50%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 20-21	100%	0%	0%	0%
FY 21-22	100%	0%	0%	0%
FY 22-23	100%	0%	0%	0%

Coalition Against Sexual Exploitation, cont.

Demographics, cont.

	Ethnicity/Race	%
FY 20-21	African American/Black	4%
	American-Indian/Alaska Native	0%
	Asian/Pacific-Islander	0%
	Caucasian/White	3%
	Latinx/Hispanic	1%
	Multiple Racial/Other	0%
FY 21-22	African American/Black	3%
	American-Indian/Alaska Native	0%
	Asian/Pacific-Islander	3%
	Caucasian/White	74%
	Latinx/Hispanic	11%
	Multiple Racial/Other	0%
FY 22-23	African American/Black	13%
	American-Indian/Alaska Native	1%
	Asian/Pacific-Islander	4%
	Caucasian/White	20%
	Latinx/Hispanic	10%
	Multiple Racial/Other	6%

Demographic Observations

- CASE has consistently served the targeted demographics over the last three fiscal years. Females between 16 - 50 are among the highest recipients of CASE services. The demographic totals represent both Prevention and Outreach service demographics.
- During FY 2020/21, the majority of the events and contacts were conducted virtually, and a higher than usual number of participants did not respond to demographic surveys. Data collection techniques to encourage responses were implemented, and subsequent years demonstrate this increased response rate.

Coalition Against Sexual Exploitation, cont.

Program Goals

Reduce prolonged suffering associated with untreated mental illness:

- Reduce risk factors,
- Reduce indicators, and
- Increase protective factors that may improve mental, emotional, and relational functioning.

Increase recognition of early signs and symptoms of mental illness:

- Raise public awareness of CSEC issues,
- Raise knowledge of available community resources, and
- Identify youth who are potential CSEC victims.

Program Outcomes

Method use to collect outcome	Description of method	Frequency of use	Number Completed	
Continuing Engagement	Determine percentage of CSEC youth remain active on the CASE MDT roster from one year to another, demonstrating continuing engagement in the program.	1x at beginning of new year	FY 20-21:	41
			FY 21-22:	40
			FY 22-23:	24
Girl's Court	Girls' Court completion requires meeting program requirements including demonstration of healthy lifestyle choices, self-empowerment, pro-social behavior, educational pursuit, and well being.	1x at completion of Girls' Court program	FY 20-21:	60%
			FY 21-22:	40%
			FY 22-23:	21%
Outreach Survey	Use survey to gauge effectiveness of educational outreach events designed to increase recognition of indicators of CSEC involvement, including understanding and awareness of trauma bonds and the effect on mental health	1x Completed at educational outreach events	FY 20-21:	n/a*
			FY 21-22:	214
			FY 22-23:	335
			* Survey developed and implemented in FY 21-22	

Coalition Against Sexual Exploitation, cont.

Outcome Discussion

Continuing Engagement

One of the challenges associated with CSEC youth is maintaining continuing engagement. A key indicator of success is building trust and rapport with the youth and allowing them to continue to engage in needed services. One measure of success is continued participation in the CASE program. During FY 2020/21, 41 of the 67 participants (61%) on the CASE MDT roster continued from previous years. The percentage of continuing participants in FY 2021/22 increased to 69% with 40 of the 58 active participants returning. In FY 2022/23, although the total number of participants declined, the percentage of those who continued stayed steady, with 24 of 35 participants (69%) continuing their CASE services.

Girls' Court

Girls' Court measures successful completion of program by successfully meeting goals, demonstrating healthy lifestyle choices, self-empowerment, pro-social behavior, educational pursuit, and well being. During FY 2020/21, 60% of the Girls' Court participants graduated from the program, 40% during FY 2021/22 and 21% in FY 2022/23.

Outreach Surveys

Outreach surveys designed to measure the effect of meeting the educational goals of the outreach presentations were implemented in FY 2021/22. These surveys measure whether participants gained knowledge and awareness about key topics discussed during the presentation, including increased awareness of CSEC issues, identifying and recognizing signs of CSE in youth, raising understanding of available community resources, and improving the ability to identify youth who are potential CSE victims and provide access to needed resources and treatment. Two hundred fourteen (214) surveys were completed during FY 2021/22 and three hundred thirty-five (335) surveys were completed following FY 2022/23 presentations.

Coalition Against Sexual Exploitation, cont.

Challenges/Solutions

Changes in staffing and staff turnover at partner agencies can lower awareness of signs of CSEC involvement in youth and a need for more knowledge of available resources. Training on CASE processes can only sometimes be completed immediately upon turnover, resulting in gaps. A solution that is underway is educating partner agencies on the importance of requesting training for new staff as soon as possible.

Solutions to previous data collection challenges have been implemented with the Outreach Survey and methods to encourage participation in surveys and other methods to collect data, resulting in increased responses.

Lessons Learned

The ability to effectively track and collect data that reflects the array of services each client receives continues to be a barrier with CASE. One aspect is that each agency is self-contained, and services may begin and terminate at different times with overlap. CASE participants receive intense case management services but there is currently no effective mechanism to track each service (e.g., hours, efforts, and services) that each team member provides to each participant. A database is needed that can track all of the participants and their encounters with each County and contract agency.

Multiple placement changes and chronic absent without leave (AWOL) status are expected for CASE participants. As a result, obtaining long-term or acceptable assignments remains difficult. Placement instability is a major factor contributing to the difficulty of using CANS consistently to appropriately monitor progress or regress of CASE participants.

Recognizing the importance of ongoing engagement with the CASE MDT team in a program where AWOL status among CASE participants is common, a new outcome measure of Continuing Engagement is being reported to demonstrate the success and importance this engagement.



Artwork by Lauri Luong

Coalition Against Sexual Exploitation, cont.

Success Story

Susann is a trafficked youth who has been actively involved in CSEC life and who has expressed her desire to one day be done and eventually be able to be just a kid. She had been placed in juvenile hall for being a victim of human trafficking. As a result of being involved in the CASE program she made the decision to get out of the life she was in. She was cooperative with law enforcement in identifying her trafficker and expressed how she wanted to get better. In her growth, she was able to verbally express her need for a break from the toxic relationship with her mother. Through efforts with the court, she was eventually released to her paternal family who greeted her with lots of love and support for her and is currently participating in an ongoing program. She has begun her healing process, and although she has felt like she has wanted to run, she has been able to process her feelings and frustrations and no longer feels the need to run away. She has worked on being able to express herself and communicate her feelings effectively. She is actively engaging in her rehabilitation process and continues to thrive.

Program Updates

There are no planned program updates for Fiscal Year 2024/25.

Family Resource Center (FRC)

Program Description and Target Population

Family Resource Centers (FRCs) offer a variety of Prevention and Early Intervention services supporting the health and wellness of individuals and families. FRC locations allow services to be tailored to individualized communities' specific needs and cultural requirements. Services and activities are offered at non-traditional locations, such as community centers, where other collateral services are also provided. This reduces the stigma associated with seeking mental health services, increasing the likelihood that community members will use the services.

The earlier people seek mental health intervention, the less intense treatment will be needed. People who receive early intervention learn to apply healthy coping skills and avoid reliance on unhealthy and sometimes dangerous coping mechanisms.

Family Resource Centers offer participants options to participate in activities that foster mental health, such as: raising self-awareness and practicing healthy coping skills in prevention activities; learning about signs and symptoms of mental illness to self-identify early signs; offering individual and family counseling sessions to work on problems and challenges; allowing recovery to be less difficult and time-consuming.

Services Offered	• After school youth projects and activities • Behavioral health education workshops • Maternal mental health • Personal development • Skills-based education for adults • Family counseling • Individual therapy	Program Serves	Children TAY (16-25) Adults Older Adults (60+)
		Location of Services	Community
		Annual Budget FY 24/25	\$3,350,000
		Cost Per Client FY 24/25	\$124

Family Resource Center (FRC), cont.

State Program Positive Results

Family Resource Centers offer a mix of Prevention and Early Intervention activities.

Prevention activities promote mental wellness by reducing risk factors and building protective factors.

The FRCs offer a variety of prevention activities, which include parenting classes, NCTI Crossroads© workshops, art programs, computer skills workshops, resume and job search workshops, and assistance in accessing basic needs through online applications. Prevention activities are often structured to focus on building strong relationships and reliable support systems with family and friends, participation in community activities, developing good coping skills, developing a healthy diet and exercise routine, building optimism and self-sufficiency, and providing access to support services. These activities help support mental wellness by developing protective factors in the participant, such as strengthening community involvement, nurturing family engagement, and building resilience and self-reliance.

Early Intervention activities are designed to address and promote recovery through therapeutic treatment services including individual counseling, family counseling, group therapy, and relapse prevention services.

The following table shows the total number of projected participants and the number of services to be provided per year along with the actual number of participants served and services provided per year.

Number of Participants / Number of Services Projected vs Actual				
	Projected	Actual		
		FY 20/21	FY 21/22	FY 22/23
Unduplicated Participants	26,945	22,434	28,355	36,383
Number of Services	51,011	37,881	39,861	47,207

Outreach services educate various community stakeholders, including service providers, families, law enforcement, peers, healthcare providers, and school staff, about identifying early signs of mental illness. Large-scale initiatives like community film screenings followed by expert Q&A sessions aim to raise awareness about mental health concerns.

Potential Responders Reached			
	FY 2020/21	FY 2021/22	FY 2022/23
Number of Potential Responders Reached	8,992	17,714	16,927

Family Resource Center (FRC), cont.**State Program Positive Results, cont.****Access & Linkage to Services**

Family Resource Centers provide access and linkage to services to higher levels of care for participants who need treatment beyond early intervention. Participants needing higher care services are given referrals to service providers that can meet their needs. Many Family Service Centers provide “warm hand-offs” to higher-level providers by calling in advance or making in-person introductions to ensure the participants can connect to their referral partners. The number of participants who received access and linkage referrals during the previous three fiscal years is shown in the table below:

Access and Linkage to Services Referrals			
	FY 2020-21	FY 2021-22	FY 2022-23
Number of Referrals Provided	91	52	182
Number of referrals to County-funded / administered programs	72	7	8
Number of referrals to other programs	19	45	38
Number of participants who followed through and engaged in services at a County-funded / administered program at least once	5	42	18

Family Resource Center (FRC), cont.

State Program Positive Results, cont.

Improving Timely Access

Family Resource Centers work to improve timely access to mental health services for members of historically underserved populations by providing referrals to appropriate prevention, early intervention, and/or higher-level care services as needed. Members of historically underserved populations include individuals who are so poorly served that they are at risk of homelessness, institutionalization, incarceration, out-of-home placement, as well as members of ethnic/racial, cultural, and linguistic populations that do not have access to mental health programs due to barriers such as poor identification of their mental health needs, poor engagement and outreach, limited language access, and lack of culturally competent services. Family Resource Centers actively work to identify and engage individuals in need and provide referrals that meet their mental health care needs in a culturally relevant manner.

In FY 22/23, a Family Resource Center service provider identified and implemented an alternate method for collecting information. This procedural adjustment significantly contributed to the upsurge in the number of referrals aimed at improving timely access. PEI is currently collaborating with other providers to explore avenues for integrating comparable modifications, with the objective of optimizing the capture of such referrals.

Improving Timely Access Referrals			
	FY 2020-21	FY 2021-22	FY 2022-23
Number of Referrals Provided	119	209	1,318

Family Resource Center (FRC), cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-59	60+	UNK
FY 20/21	22%	9%	51%	3%	15%
FY 21/22	9%	4%	19%	1%	67%
FY 22/23	21%	7%	35%	3%	35%

Fiscal Year	Veteran Status
% of consumers who identified as a veteran	
FY 20/21	1%
FY 21/22	<1%
FY 22/23	<1%

Fiscal Year	Sexual Orientation
% of consumers who identified as LGBTQ+	
FY 20/21	<1%
FY 21/22	<1%
FY 22/23	<1%

Fiscal Year	Disability
% of consumers who identified a physical disability	
FY 20/21	2%
FY 21/22	2%
FY 22/23	2%

Fiscal Year	Gender Identity			
	♂	♀	⚧	UNK
FY 20/21	11%	25%	<1%	63%
FY 21/22	12%	30%	<1%	57%
FY 22/23	17%	31%	<1%	52%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 20/21	74%	24%	2%	0%
FY 21/22	71%	16%	11%	2%
FY 22/23	65%	18%	<1%	17%

Family Resource Center (FRC), cont.

Demographics, cont.

	Race	%
FY 20/21	African American/Black	3%
	American-Indian/Alaska Native	0%
	Asian/Pacific-Islander	0%
	Caucasian/White	15%
	Latinx/Hispanic	22%
	Multiple Racial/Other	30%
FY 21/22	African American/Black	3%
	American-Indian/Alaska Native	3%
	Asian/Pacific-Islander	1%
	Caucasian/White	16%
	Latinx/Hispanic	39%
	Multiple Racial/Other	18%
FY 22/23	African American/Black	7%
	American-Indian/Alaska Native	2%
	Asian/Pacific-Islander	3%
	Caucasian/White	19%
	Latinx/Hispanic	31%
	Multiple Racial/Other	20%

Family Resource Center (FRC), cont.

Demographics, cont.

	Ethnicity			
		FY 2020/21	FY 2021/22	FY 2022/23
Ethnicity	African	0%	3%	3%
	Asian Indian/South Asian	0%	1%	1%
	Cambodian	0%	0%	0%
	Chinese	0%	0%	0%
	Eastern European	0%	0%	0%
	European	9%	5%	10%
	Latinx/Hispanic	22%	39%	31%
	Filipino	0%	0%	0%
	Japanese	0%	0%	0%
	Korean	0%	0%	0%
	Middle Eastern	0%	0%	0%
	Vietnamese	0%	0%	0%
	Other	5%	16%	41%
	More than one ethnicity	1%	2%	4%

Demographic Observations

The FRC program has consistently served the targeted demographics over the last three fiscal years.

Family Resource Center (FRC), cont.

Program Goals

The goal of the Family Resource Center program is to reduce prolonged suffering associated with untreated mental illness. Prevention activities achieve this by deducing risk factors, reducing indicators, and increasing protective factors that may lead to improved mental, emotional, and relational functioning.

Early intervention activities achieve this by providing counseling and treatment that leads to reduced symptoms and improved recovery, including mental, emotional, and relational functioning. Additional goals are to use strategies to reduce stigma associated with mental illness and improve early access to services by connecting participants with severe mental illness to medically necessary care and improving timely access for historically underserved populations.

Method use to collect outcome	Description of method	Frequency of use	Number Completed
Children and Adolescent Needs and Strengths Assessment (CANS)	CANS is a multi-purpose tool developed for children's services to support decision-making, including level of care and service planning.	Intake, 3 months, Discharge, Significant life events	FY 20/21: 56 FY 21/22: 211 FY 22/23: 312
Adult Needs and Strengths Assessment (ANSA)	A comprehensive assessment of psychological and social factors used for treatment planning. This assessment measures functioning in several important life domains and helps to support decision making and level of care and service planning, and ensure projected goals are being met.	Intake, 3 months, Discharge, Significant life events	FY 20/21: 209 FY 21/22: 130 FY 22/23: 237
NCTI Crossroads ©	A complete behavioral change system delivered in a group format, following a precise sequence that leads participants from a general level of discussion to a specific behavioral commitment.	2 times Initial & completion	FY 20/21: 91 FY 21/22: 98 FY 22/23: n/a*
Life Skills Progression (LSP)	Assesses the strengths and needs of families participating in the Family Support Program. The LSP measures 35 parental skills in areas such as relationships, resources, medical health, mental health, and basic essentials.	2 times Initial & completion	FY 20/21: 141 FY 21/22: 154 FY 22/23: 193

Family Resource Center (FRC), cont.

Outcome Discussion

Early Intervention activities such as individual and family counseling offer therapeutic services such as cognitive behavioral therapy and solution-focused therapy. Outcomes are measured using the Child and Adolescent Needs and Strengths – San Bernardino (CANS-SB) Assessments and Adult Needs and Strengths Assessments – San Bernardino County (ANSA-SB).

Child and Adolescent Needs and Strengths Assessment (CANS)

The Child and Adolescent Needs and Strengths assessment is a multi-purpose tool that helps develop the level of care and service planning and allows for the monitoring of outcomes of services. The table below shows that children and youth participating in Family Resource Centers' early intervention activities have made improvements in these domains.

Children and youth participating in the Family Resource Centers face a variety of challenges. The following tables show some of the most prevalent subdomains and the corresponding rates of improvement.

Suicide is a rising concern, as shown in the increasing numbers of participants presenting with suicidal risk and non-suicidal, self-injurious behaviors. These concerns were exacerbated in FY 20/21 with the COVID-19 pandemic; however, have continued to improve with the ease of pandemic regulations. Suicide awareness and prevention efforts are incorporated into FRC assessments and treatment plans when suicidal risk behaviors are presenting concerns.

Child and Adolescent Needs and Strengths Improvement in Primary Domains			
	FY 20/21	FY 21/22	FY 22/23
Life Functioning Domain	69.6%	45.5%	43.1%
Strengths Domain	69.6%	84%	79.1%
Behavioral Health Needs Domain	70.7%	42.3%	37.4%

Family Resource Center (FRC), cont.

Outcome Discussion, cont.

Child and Adolescent Needs and Strengths Assessment (CANS), cont.

Child and Adolescent Needs and Strengths Improvement in Subdomains			
	FY 20/21	FY 21/22	FY 22/23
Life Functioning Domain			
Family Functioning	80%	76%	61%
Social Functioning	80%	75%	80%
School Achievement	50%	61%	72%
Strengths Domain			
Family Strengths	81%	70%	59%
Interpersonal	63%	70%	69%
Resiliency	94%	70%	76%
Resourcefulness	86%	69%	61%
Behavioral Health Needs			
Depression	87%	83%	74%
Anxiety	84%	71%	68%
Anger Control	80%	71%	63%
Risk Behaviors			
Suicide Risk	100%	85%	71%
Non-Suicidal, Self-Injurious Behavior	50%	72%	72%

Adult Needs and Strengths Assessment (ANSA)

The Adult Needs and Strengths Assessment is a multi-purpose tool developed for adult behavioral health services to support decision-making, including the level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. The ANSA helps care providers decide which of an individual's needs are the most important to address in a treatment plan. The ANSA also helps to identify strengths.

Overall, adults participating in the Family Resource Centers' early intervention activities whose treatment sessions opened and closed within the same fiscal year made improvements in the following primary domains, as shown in the chart below:

Adult Needs and Strengths Improvement in Primary Domains			
	FY 20/21	FY 21/22	FY 22/23
Life Functioning Domain	83.9%	62.9%	76.8%
Strengths Domain	79.6%	59.3%	74.2%
Behavioral Health Needs Domain	77.4%	61.1%	73.2%

Family Resource Center (FRC), cont.

Outcome Discussion, cont.

Adult Needs and Strengths Assessment (ANSA), cont.

In FY 2022/23, anger management and trauma adjustment were common issues among adults. Out of 37 individuals with these concerns, 55% showed improvement in managing their anger, and the same percentage improved their trauma issues.

Adult Needs and Strengths Improvement in Subdomains

	FY 20/21	FY 21/22	FY 22/23
Life Functioning Domain			
Family Functioning	92%	59%	71%
Social Functioning	92%	64%	77%
Decision-Making/Judgment	93%	76%	89%
Parenting Roles	82%	63%	83%
Strengths Domain			
Family Strengths/Family Support	94%	55%	66%
Community Connection	78%	42%	76%
Natural Supports	89%	37%	73%
Resiliency	97%	70%	79%
Resourcefulness	97%	64%	77%
Behavioral Health Needs Domain			
Depression	95%	69%	84%
Anxiety	94%	60%	80%
Adjustment to Trauma	88%	58%	82%
Eating Disturbances	89%	68%	89%

National Curriculum and Training Institute (NCTI)

Participants engaged in a variety of NCTI courses with topics including anger management, cognitive life skills, substance use and alcohol, and parenting.

The knowledge gained in courses such as Cognitive Life Skills and Parenting intends to improve communication and family relationships, which results in increased protective factors.

The knowledge gained in the Alcohol and Substance use courses intends to reduce use and dependence on substances, resulting in a reduction of risk factors.

NCTI Percent Improvement All Courses

	Average Pre-Test	Average Post-Test	Percent Improvement
FY 20/21	8.61	9.48	10%
FY 21/22	5.73	9.46	65%
FY 22/23	n/a*	n/a*	n/a*

* Due to licensing issues, no data is available for FY 2022/23.

Family Resource Center (FRC), cont.

Outcome Discussion, cont.

Life Skills Progression (LSP)

The Life Skills Progression (LSP) surveys gather detailed family information through interviews and observations. They're completed at intake to assess family strengths and needs and again at the end of services to track progress. LSP measures growth in relationships, resources, medical and mental health, and essentials crucial for mental well-being. The outcomes, indicating average percent increases in these areas over the past three years, are detailed in the table below.

Life Skills Progression Percent Improvement			
	FY 20/21	FY 21/22	FY 22/23
Relationships	16.4%	13.8%	13.5%
Resources	27.3	29.0%	18.1%
Medical	9.6%	8.6%	8.5%
Mental Health	29.1%	37.9%	18.0%
Basic Essentials	13.7%	10.9%	12.8%

Challenges/Solutions

The Family Resource Center faces ongoing challenges in making mental health services accessible to communities. Collaborating with partners like the Mexican and Guatemalan Consulates, efforts are underway to expand mental health awareness and resources to nearby areas. Solutions include community education on available services, fostering prevention, and early intervention. Additionally, partnerships with local organizations facilitate mental health workshops and resource dissemination. However, a new challenge arises with community engagement due to post-pandemic adjustments and inconsistent school attendance. Despite increased referrals, provider shortages cause service delays. To address this, the FRC is hiring new mental health providers and offering emergency services to those awaiting intervention.

Lessons Learned

In the past three fiscal years, it was observed that providers' data filing and management processes posed challenges in data extraction and evaluation. To address this, providers will enhance their data storage system for improved accessibility by both providers and DBH. Additionally, adopting the new PEI database system in FY 2020/21 presented challenges for providers in data collection and aggregation. This has been resolved by transitioning to exclusive data entry into the PEI database system.

Family Resource Center (FRC), cont.

Success Story

The client signed into our services on April 2023 to receive PEI and EI VCSS-WSB programs as she was struggling to cope with anxiety symptoms and negative thoughts; client attended individual counseling, mental health workshops, and relapse prevention groups. The client reported after 3 months of participating in VCSS-WSB support groups and individual therapy, she started noticing a decreased in worries and enjoying “simple daily life activities”. Client reported practicing self-care activities and enjoying life and her family.

Program Updates

There are no planned program updates for Fiscal Year 2024/25.



Community Wholeness and Enrichment (CWE)

Program Description and Target Population

The Community Wholeness and Enrichment (CWE) program is categorized as a Prevention and Early Intervention program. CWE identifies and helps to manage the early onset of mental health symptoms in transitional age youth (TAY) ages 16-25 and adults ages 26-59 who are experiencing the initial onset of a mental or emotional illness and/or substance use disorder.

The primary goal of the CWE program is to address mental health disorders early in their onset, utilizing the prevention and early intervention services to prevent the onset or reduce the severity of a mental illness. Although prevention and early intervention can be implemented over the lifespan, the benefits are maximized when people are targeted at or around the time of onset of a mental disorder. Utilizing stakeholder feedback and community needs assessments, CWE providers work closely with their communities to understand their needs and ensure they are met. CWE services include screenings, assessments, therapeutic treatment, resources, and education.

TAY, adults, and/or their family members are considered eligible for CWE programs based on risk factors for developing a potentially serious mental illness. CWE providers can evaluate a participant's risk factors using various screenings, including the immediate needs screening tool. The screenings also address experience with mental health, including past services received, to determine the participant's current mental health needs.

Services Offered

- Screenings/Assessments
- Case Management, Linkage & Referrals
- Support Groups (includes suicide bereavement)
- Mental Health Education
- Early Intervention Counseling Services

Program Serves	TAY (16-25) Adults (26-59)
Location of Services	Central Valley, Desert/Mountain, East Valley, West Valley
Annual Budget FY 24/25	\$850,000
Cost Per Consumer FY 24/25	\$288

Community Wholeness and Enrichment (CWE), cont.

Program Highlights

CWE is a program that focuses on prevention and early intervention. In addition to these services, the program provides suicide prevention and outreach education. The program used strategies to increase and improve linkage and timely access to services to ensure participants are connected to appropriate services. These strategies include assessments and case management.

Number of Participants / Number of Services Projected vs Actual				
	Projected	Actual		
		FY 20/21	FY 21/22	FY 22/23
Unduplicated Participants	2,956	3,634	2,091	2,572
Number of Services	7,809	8,306	6,052	5,668

Prevention

The risk factors associated with those experiencing early onset of a mental illness can include the experience of trauma, stressful life events, and isolation. Building protective factors such as social connections, coping skills, and resilience helps to combat these risk factors. A large focus of the prevention component of the CWE program is supportive groups. The providers of the CWE program offer several support group topics, including relapse prevention, depression, anxiety, and suicide bereavement for those who have lost a loved one to suicide.

The table below illustrates the number of participants who received a prevention service over the last three fiscal years, and the number of services those participants received. CWE has struggled in the past two years to provide prevention services. Several factors have contributed to the struggle, including the effects of COVID-19, as well as staffing challenges and weather anomalies.

Prevention	Projected	FY 2020/21	FY 2021/22	FY 2022/23
Unduplicated Participants	1948	2,588	1,624	2,429
Total Services	3148	3,160	1,186	853

Early Intervention

The CWE program offers early intervention services such as evidence-based treatments and therapies and relapse prevention services. The program's objective is to address and promote early recovery and functional outcomes for a mental illness.

The table on the following slide shows the total number of episodes opened, the number of episodes closed, and the proportion of participants who met their treatment goals for each fiscal year.

Community Wholeness and Enrichment (CWE), cont.

Program Highlights, cont.

Treatment Success by Fiscal Year

	Total Episodes	Closed Episodes	% Met Goals
FY 2020/21	480	319	41%
FY 2021/22	399	264	53%
FY 2022/23	430	289	67%

Due to the availability of telehealth services during the COVID-19 pandemic, providers were able to continue with early intervention services. The CWE program is looking for ongoing solutions to increase the percentage of participants who meet treatment goals.

Outreach

The CWE engages new participants and educates potential responders about the signs and symptoms of mental illness, as well as to recognize their symptoms and seek services if needed. These outreach services provide participants an opportunity to identify signs and symptoms in their friends and family, as well as themselves, leading to a greater likelihood of seeking services for a mental health need.

The following table illustrates the number of potential responders reached and the types of settings where outreach occurred over the last three fiscal years. The number served decreased for FY 21/22 due to virtual outreach during the COVID-19 pandemic.

The community continues to adjust and show increased engagement as illustrated in the data for FY 2022/23

Potential Responders Reached

	FY 2020/21	FY 2021/22	FY 2022/23
Potential Responders	2,247	1,040	1,648

Outreach Types of Responders / Settings

Types of Responders	Settings
- Community service providers - Families - Employers - Primary health care providers - School personnel - Leaders of faith-based organizations - Peer providers - Consumer family members	- Community events - Community-based organizations - Social media outreach - County facilities - Family resource centers - Faith-based organizations - Schools - Virtual platforms

Community Wholeness and Enrichment (CWE), cont.

Program Highlights, cont.

Access & Linkage

The CWE program targets those with early-onset mental illness. However, the program is also designed to serve participants with severe mental illness. So, while the program does utilize the Access and Linkage to Treatment strategy, CWE providers need to link individuals to a higher level of care. The CWE program made 40 referrals to treatment beyond early onset over the last three fiscal years. These participants were engaged in the program

Improve Timely Access to Treatment

The CWE program occasionally provides referrals as part of the Improve Timely Access to Services strategy. In the last three years, CWE providers have made two referrals to either early intervention or treatment beyond early onset services. As with Access and Linkage, CWE providers do not make many referrals for Improve Timely Access. This is due to the provider agencies' capacity to provide these services within their program. The referrals made in FY 20/21 and 21/22 are due to the agencies adjusting to the COVID-19 pandemic protocols.

Improve Timely Access to Services			
	FY 2020/21	FY 2021/22	FY 2022/23
Number of Referrals	1	1	0
Participants Engaged	0	0	0
Average # of Days Participant Engaged	0	0	0

Within the Improve Timely Access strategy, CWE providers served the following underserved populations:

Underserved Populations	
- Trauma-exposed - Co-occurring - Justice-involved - TAY age foster children	- LGBTQ+ - Homeless - African American/Black - Latinx/Hispanic

Community Wholeness and Enrichment (CWE), cont.

Program Highlights, cont.

Suicide Prevention

One primary focus of the CWE program is to provide support for suicide. This includes providing services that are centered around the prevention of suicides. The program distributes information to the community on the signs and symptoms of someone who may be at risk of suicide.

In addition, the program organizes specific educational opportunities to learn more about suicide prevention. They provide access to gatekeeper trainings such as Applied Suicide Intervention Skills Training (ASIST), SafeTALK, and Question, Persuade, Refer (QPR) to build the communities' capacity to respond to a suicide-related crisis. They also customize suicide prevention trainings for the specific needs of the community. Community member organizations can reach out to the program and request individualized training for specific communities.

The COVID-19 pandemic created challenges in providing suicide prevention trainings. Providers began to implement virtual training and utilized curriculums that could be delivered in a virtual platform, such as QPR, to increase participation once again.

Providers of the CWE program have trained a total of 796 participants in suicide prevention over the last three fiscal years.

Suicide Prevention Trainings			
	FY 2020/21	FY 2021/22	FY 2022/23
Unduplicated Participants	342	150	304

Community Wholeness and Enrichment (CWE), cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-59	60+	UNK
FY 20/21	6%	30%	35%	0%	29%
FY 21/22	<1%	11%	28%	<1%	60%
FY 22/23	<1%	14%	40%	<1%	45%

Fiscal Year	Veteran Status	
	% of consumers who identified as a veteran	
FY 20/21	1%	
FY 21/22	<1%	
FY 22/23	<1%	

Fiscal Year	Sexual Orientation	
	% of consumers who identified as LGBTQ+	
FY 20/21	3%	
FY 21/22	0%	
FY 22/23	<1%	

Fiscal Year	Disability	
	% of consumers who identified a physical disability	
FY 20/21	9%	
FY 21/22	3%	
FY 22/23	<1%	

Fiscal Year	Gender Identity			
	♂	♀	⚧	UNK
FY 20/21	27%	53%	1%	19%
FY 21/22	7%	18%	0%	75%
FY 22/23	10%	23%	1%	66%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 20/21	90%	7%	0%	3%
FY 21/22	80%	17%	0%	3%
FY 22/23	76%	15%	0%	9%

Community Wholeness and Enrichment, cont.

Demographics, cont.

Demographic Observations

- The CWE primarily serves TAY and adults, consistent with its target population.
- Mental health concerns are prevalent in TAY and young adult populations. Young adulthood comes with numerous stressors, such as new and multiple responsibilities/roles, demands, and financial obligations. Early identification of mental health concerns and thorough assessments are critical in order to provide adequate services and to ensure better outcomes.
- Consistently, the program has served almost twice as many females as males over the last three fiscal years.
- This is consistent with research that demonstrates that mental illness in the past year has been more prevalent in females than males. As of 2020, roughly 25.8% of females had experienced mental illness in the previous year, compared to 15.8% of males. Depression, anxiety, and mood disorders are some of the most commonly diagnosed mental illnesses.



Artwork by Nadia Solis

Community Wholeness and Enrichment, cont.

Demographics, cont.

	Ethnicity/Race	FY 20/21	FY 21/22	FY 22/23
Race	African American/Black	5%	5%	2%
	American-Indian/Alaska Native	1%	<1%	<1%
	Asian	2%	<1%	<1%
	Native Hawaiian/Pacific Islander	1%	<1%	<1%
	Caucasian/White	24%	15%	12%
	Latinx/Hispanic	29%	29%	15%
	More than One Race	9%	4%	2%
	Other	21%	23%	3%
	Declined to Answer	37%	52%	65%

	Ethnicity/Race	FY 20/21	FY 21/22	FY 22/23
Ethnicity	African	2%	0%	<1%
	Asian Indian/South Asian	0%	<1%	0%
	Cambodian	0%	0%	0%
	Chinese	1%	<1%	0%
	Eastern European	0%	0%	<1%
	European	14%	3%	10%
	Filipino	0%	<1%	<1%
	Japanese	0%	0%	0%
	Korean	0%	0%	0%
	Middle Eastern	0%	<1%	0%
	Vietnamese	0%	0%	0%
	Other	3%	5%	3%
	More than One Ethnicity	7%	1%	7%
	Declined to answer	23%	61%	79%

Community Wholeness and Enrichment (CWE), cont.

Program Goals

The primary objective of the CWE program is to address mental health disorders early on in their development by utilizing prevention and early intervention services to avert or lessen the severity of a mental illness.

While prevention and early intervention can be implemented throughout a person's lifetime, the benefits are greatest when young people are targeted at or near the onset of mental health disorders.

To identify and help manage early mental health symptoms, the CWE program uses collaborative approaches and short-term interventions.

The CWE program services reduce and prevent crises by providing support early in the emergence of a mental health concern.

They also provide support and education to the families. These services include information on how to support their family member who is experiencing a mental health crisis.

Respite care is an important element of this program. Family members are provided with information on identifying their own signs and symptoms of a potential mental health concern. They have access to services that can help reduce the stressors associated with caring for a loved one suffering from a mental illness.

Program Outcomes

Method use to collect outcome	Description of method	Frequency of use	Number Completed
Adult Needs and Strengths Assessment (ANSA)	A comprehensive assessment of psychological and social factors is used for treatment planning. This assessment measures functioning in several important life domains and helps to support decision-making, level of care and service planning, and ensuring projected goals are being met.	• Intake • 3 months • Discharge • Significant life events	FY 20/21: 291 FY 21/22: 234 FY 22/23: 244

Community Wholeness and Enrichment, cont.

Outcome Discussion

The CWE program uses the Adult Needs and Strengths Assessment – San Bernardino County (ANSA-SB) to measure the outcomes of the early intervention treatments.

ANSA-SB is an information integration tool for adults with behavioral health challenges. It supports individual case planning and the planning and evaluation of service systems. When the ANSA-SB is administered, each dimension is rated on its own four-point scale. It is administered at intake and at three-month intervals until discharge.

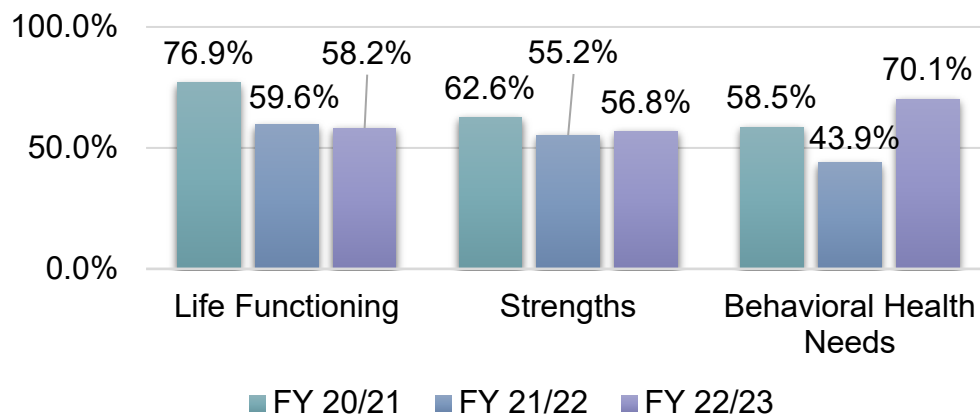
The ANSA-SB measures the readiness of early intervention participants to engage in services. CWE focuses on three primary domains:

- The Life Functioning domain evaluates factors like an individual's family relationships, social functioning, decision-making, self-care, and knowledge of illness.
- Strengths domain evaluates factors like family support, optimism, interpersonal, social connectedness, relationship permanence, vocational and resilience.
- Behavioral Health Needs, which evaluates factors like thought disorders, depression, anxiety, antisocial behavior, adjustment to trauma and substance use.

Over three fiscal years, CWE participants improved at varying rates. These variations may be the result of the COVID-19 pandemic delaying recovery. The pandemic also made it more difficult for people to develop their strengths and overcome challenges in life functioning and behavioral health needs. These factors were influenced by the strain and isolation caused by the COVID-19 pandemic restrictions.

These challenges contributed to the gradual decrease over the three years. This data will be compared with future data models to evaluate the impact of the COVID-19 pandemic on participants accessing services. The learning will be used to improve future programming.

CWE ANSA-SB % Improved by Fiscal Year



Community Wholeness and Enrichment (CWE), cont.

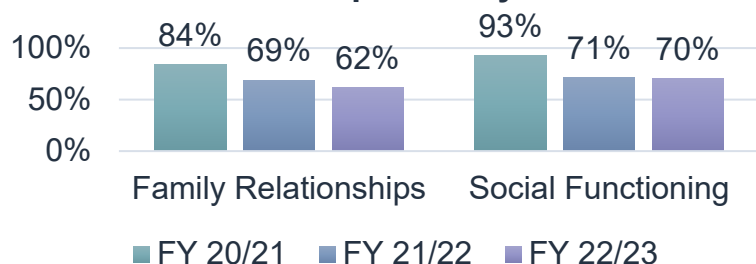
Outcome Discussion, cont.

Each domain contains sub-domains that measure:

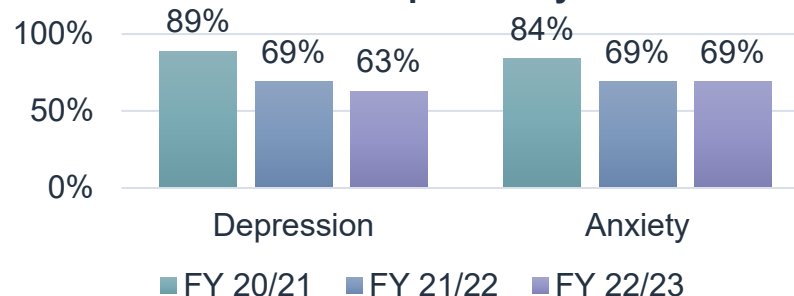
- Depression,
- Anxiety,
- Family Relationships,
- Social Functioning,
- Interpersonal/Social Connectedness, and
- Resilience.

These subdomains were found to align most closely with the goals of the CWE program. The charts on this page illustrate the percentage of improvement in each domain. The improvements are indicators that the interventions provided by the program helped to avert or lessen the severity of a mental illness.

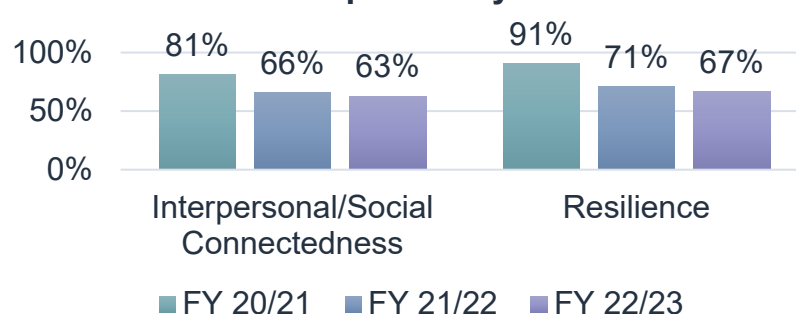
ANSA-SB Life Functioning Sub-Domains
% Improved by FY



ANSA-SB Behavioral Health Needs Sub-Domains
% Improved by FY



ANSA-SB Strengths Sub-Domains
% Improved by FY



Community Wholeness and Enrichment (CWE), cont.

Challenges/Solutions

The most persistent challenge CWE providers report is the stigma associated with seeking mental health services and providing the prevention service of support groups targeting loved ones of those with a mental health disorder. It has been difficult engaging family members, especially with the suicide bereavement groups that provide support to those who have lost a loved one to suicide. Through stakeholder feedback, CWE providers have discovered that the community found the group settings intimidating.

CWE providers continue to build community connections to ensure their communities know all the services CWE offers, including support groups. By continuing to partner with community organizations and providing education to the community, CWE providers continue to reduce the stigma associated with mental health, especially regarding the suicide of a loved one. The CWE program will continue to advocate for the importance of attending a suicide bereavement group for survivors of those who have died by suicide.

Lessons Learned

PEI has learned that over the last three fiscal years, managing CWE data within the agencies has made it challenging to retrieve and analyze. Providers will improve their methods for handling their data in the future to make it more easily accessible to them and DBH.

In FY 2020/21, the newest version of PEI database system was launched, making data collection and aggregation difficult. The providers are now entering their data into the PEI database system with increased success.

Success Story

There was a [consumer] who called the agency seeking therapy services. He was struggling with suicidal ideation with no plans, self-harm, stress from being told he was going to have a baby with his significant other as well as relationship stress. This [consumer] was concerned for his mental health and wanted to pass on “good habits” to his future baby. The [consumer] began individual therapy sessions virtually and met weekly for the next 5 months.

During his sessions, the clinician used CBT, solution-focused techniques, active listening, and other supportive techniques such as mindfulness. By his last session, the [consumer] had not engaged in self-harm for some time and reported no thoughts of suicidal ideation. The [consumer] stated, “I didn’t always weigh the risks/rewards of my choices, but now I do.” The [consumer] also reported being able to identify and avoid triggers for his mental health.

Program Updates

There are no planned program updates for Fiscal Year 2024/25.

Military Services and Family Support (MSFS)

Program Description and Target Population

The Military Services and Family Support program is a Prevention and Early Intervention program that targets active-duty military service members of all branches, veterans, and retired military personnel and their families.

This program addresses the challenges military members and their families face due to circumstances unique to military life. Due to the stigma of mental health discussion in the military community, it can be difficult for those experiencing a mental health concern to seek help as they fear retaliation, loss of job/status, or embarrassment.

Through mental health promotion activities and building relationships with the military communities, the MSFS program can offer and assure confidential services. Services are offered in any setting that makes the participant comfortable, including participant homes or nearby public places.

MSFS providers utilize stakeholder feedback and community needs assessments to work closely with their communities to understand their needs and ensure they are met.

MSFS services include screenings and assessments, therapeutic treatment, resources and education.

Services Offered	• Mental Health Education • Mental Health/Substance Use Disorder screenings • Case Management and Referrals • Psychoeducation • Counseling Services • Suicide Prevention	Program Serves	Children TAY (16-25) Adults Older Adults (60+)
		Location of Services	Central Valley, Desert/Mountain, East Valley
		Annual Budget FY 24/25	\$725,000
		Cost Per Client FY 24/25	\$259

Military Services and Family Support (MSFS), cont.

State Program Positive Results

The MSFS program is categorized as a Prevention and Early Intervention program. In addition to prevention and early intervention services, the program offers outreach education and suicide prevention. The MSFS program utilizes the Access and Linkage and Improve Timely Access strategies to ensure participants are linked to the necessary services to meet their needs. In the past 3 years, the program has consistently exceeded its goals. The most recent year reflects a slight decrease due to the onset of the staffing challenges that many of our providers are currently experiencing.

Number of Participants / Number of Services Projected vs Actual				
	Projected	Actual		
		FY 20/21	FY 21/22	FY 22/23
Unduplicated Participants	3,605	6,050	6,091	3,480
Number of Services	6,990	10,718	10,168	7,118

Prevention

The risk factors associated with military service include experience of trauma, isolation, moral injury, substance use, and stress.

To combat these risk factors, prevention services seek to build protective factors in participants, including supportive care, inclusion, and services relevant to military experience.

The table shows prevention participants and services by fiscal year. Prevention services have decreased. The program depends on local military bases for access to military families. Changes in leadership can disrupt progress made by previous leaders. Building rapport with new leadership takes time.

Prevention Participants / Services			
	FY 2020/21	FY 2021/22	FY 2022/23
Unduplicated Participants	3,329	292	414
Number of Services	5,138	1,100	1,344

Early Intervention

Early intervention services, treatments, and interventions are aimed at addressing and promoting recovery and related functional outcomes for a mental illness early in its emergence. Services are provided to individuals identified as experiencing the first onset of a serious mental illness. These treatment services include developing a treatment plan with goals that are meaningful to the individual participant.

Military Services and Family Support (MSFS), cont.

State Program Positive Results, cont.

The table below illustrates the total number of early intervention episodes opened in each fiscal year, the number of episodes closed in the fiscal year, and the percentage of participants who met their treatment goals. FY 2022/23 saw a decrease in overall episodes and the percentage of participants who met their goals.

The decrease is attributed to many participants not completing their early intervention treatment plan. Changes in the leadership at the military base limited access to military families engaged in services. There has been progress in reestablishing those relationships to gain access.

Treatment Success by Fiscal Year

	Total Episodes	Closed Episodes	% Met Goals
FY 2020/21	301	95	38%
FY 2021/22	335	122	40%
FY 2022/23	88	51	18%

Outreach

The MSFS program provides engaging outreach services that educate and train potential responders to recognize and respond to early signs of potentially severe and disabling mental illness.

Providing outreach services to this at-risk group helps responders recognize signs in themselves and others. Recent leadership changes at military installations restricted access to service areas, resulting in decreased services. Efforts are underway to address this issue.

Potential Responders Reached

	FY 2020/21	FY 2021/22	FY 2022/23
Potential Responders	2,453	5,786	2,533

**Outreach
Types of Responders / Settings**

Types of Responders	Settings
- Community service providers - Families - Military personnel/veterans - Peer providers - Consumer family members - Cultural brokers - Law enforcement personnel	- Community events - Cultural Organization - Family Resource Center - Social media outreach - Schools - Residences - Virtual platforms

Military Services and Family Support (MSFS), cont.

State Program Positive Results, cont.

Access & Linkage to Treatment

Access and Linkage to Treatment services are integrated into the MSFS program to connect participants and/or their family members with severe mental health concerns to care and treatment that will meet their needs as early as possible in the onset of these conditions.

The adjacent table illustrates the number of referrals made to a higher level of care each fiscal year. It also includes those referred to a County or non-county funded entity and those that were referred and engaged in treatment. MSFS providers can provide referrals to County-funded programs and occasionally to a non-county funded provider, such as a private physician. Regardless of where they are referred, 71% of participants engaged in the services to which they were referred for each fiscal year.

Access and Linkage to Services Referrals			
	FY 2020/21	FY 2021/22	FY 2022/23
Number of Referrals	9	15	21
County-Funded	8	15	7
Non-County Funded	1	0	8
Participants Engaged	9	15	15

Military Services and Family Support (MSFS), cont.

State Program Positive Results, cont.

Improve Timely Access to Treatment

The Improve Timely Access to Treatment strategy focuses on providing appropriate services based on accessibility, cultural and language appropriateness, transportation, family focus, available hours, and cost of services to increase access to appropriate mental health services for underserved populations.

The MSFS program services are available in whatever setting is most comfortable to a participant. For example, if the participant would prefer to receive services in-home, the MSFS program will accommodate that need. The Improve Timely Access to Services strategy aims to refer participants of underserved populations to prevention, early intervention, or higher level of care services.

Active military troops, Reserve and National Guard members, recently retired military/veterans, and their families are among the underserved populations supported by the MSFS program.

The Improve Timely Access to Services table illustrates the number of participants who were given a referral to a prevention, early intervention, or higher level of care service, the number of those referred who engaged in services, and the average number of days from date of referral to date been involved in services.

Over the last three fiscal years, participants were engaged, on average, no more than seven days after the date of referral. This illustrates that the MSFS program provides linkage and referrals in a timely manner to provide participants with needed services as soon as possible.

Improve Timely Access to Services			
	FY 2020/21	FY 2021/22	FY 2022/23
Number of Referrals	171	86	96
Participants Engaged	83	10	19
Average # of Days Participant Engaged	3.12	9.5	6.89

Underserved Populations	
•	Trauma-exposed
•	Co-occurring
•	At risk children and youth
•	Latinx/Hispanic
•	LGBTQ+

Military Services and Family Support (MSFS), cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-50	60+	UNK
FY 20/21	1%	2%	7%	1%	89%
FY 21/22	3%	3%	16%	3%	75%
FY 22/23	12%	8%	35%	6%	39%

Fiscal Year	Sexual Orientation
% of consumers who identified as LGBTQ+	
FY 20/21	1%
FY 21/22	1%
FY 22/23	2%

Fiscal Year	Gender Identity			
	♂	♀	⚧	UNK
FY 20/21	3%	8%	0%	89%
FY 21/22	13%	23%	0%	64%
FY 22/23	30%	46%	<1%	24%

Fiscal Year	Veteran Status
% of consumers who identified as a veteran	
FY 20/21	5%
FY 21/22	7%
FY 22/23	13%

Fiscal Year	Disability
% of consumers who identified a physical disability	
FY 20/21	1%
FY 21/22	0%
FY 22/23	0%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 20/21	74%	0%	0%	26%
FY 21/22	91%	1%	0%	8%
FY 22/23	98%	<1%	0%	2%

Military Services and Family Support (MSFS), cont.

Demographics, cont.

Demographic Observations

- There has been an overall reduction in decline to answer and/or unknown responses from participants in the MSFS program from FY 20/21 through 22/23.
- The largest age group consistently served was the adult population from ages 26-59. This aligns with the program's goal of serving those with military service.
- The number of veterans served doubled from FY 21/22 to FY 22/23.
- There also was a significant increase in the number of children aged 0-15 who were served, at 12%, and TAY aged 16-25, at 8%. Overall, children and TAY account for 20% of MSFS participants service, showing that the program plays a large role in providing services for families.

	Ethnicity/Race	%
FY 20/21	African American/Black	4%
	American-Indian/Alaska Native	0%
	Asian/Pacific-Islander	0%
	Caucasian/White	10%
	Latinx/Hispanic	4%
	Multiple Racial/Other	4%
FY 21/22	African American/Black	5%
	American-Indian/Alaska Native	0%
	Asian/Pacific-Islander	2%
	Caucasian/White	18%
	Latinx/Hispanic	10%
	Multiple Racial/Other	8%
FY 22/23	African American/Black	11%
	American-Indian/Alaska Native	1%
	Asian/Pacific-Islander	3%
	Caucasian/White	31%
	Latinx/Hispanic	10%
	Multiple Racial/Other	16%

Military Services and Family Support (MSFS), cont.

Demographics, cont.

		Ethnicity		
		FY 20/21	FY 21/22	FY 22/23
Ethnicity	African	0%	0%	2%
	Asian Indian/South Asian	0%	0%	4%
	Cambodian	0%	0%	0%
	Chinese	0%	0%	0%
	Eastern European	0%	0%	<1%
	European	0%	3%	3%
	Latinx/Hispanic	4%	10%	10%
	Filipino	0%	0%	<1%
	Japanese	0%	0%	<1%
	Korean	0%	0%	0%
	Middle Eastern	0%	0%	<1%
	Vietnamese	0%	0%	0%
	Other	1%	7%	34%
	More than one ethnicity	0%	9%	17%

Military Services and Family Support (MSFS), cont.

Program Goals

Increase early access and linkage to medically necessary care and treatment:

- Connect children, adults, and older adults with severe mental illness to care as early in the onset as practicable to medically necessary care and treatment, including, but not limited to, care provided by county mental health programs.

Improve timely access to services for underserved populations:

- Increase the extent to which individuals or families from underserved populations who need mental health services because of risk or presence of a mental illness receives appropriate services as early in onset as practicable.

Reduce prolonged suffering:

- Reduce risk factors.
- Increased protective factors that may lead to improved mental, emotional, and relational functioning.
- Reduced symptoms.
- Improved recovery, including emotional and relational functioning.

Reduce stigma and discrimination associated with mental illness:

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

Military Services and Family Support (MSFS), cont.

Program Outcomes

Method use to collect outcome	Description of method	Frequency of use	Number Completed	
Adult Needs and Strengths Assessment (ANSA)	A comprehensive assessment of psychological and social factors used for treatment planning. This assessment measures functioning in several important life domains and helps to support decision making and level of care and service planning, and ensure projected goals are being met.	Intake, 3 months, Discharge, Significant life events	FY 20/21: 42 FY 21/22: 42 FY 22/23: 36	
PTSD Checklist for Active and Veteran Military (PCL-M)	A comprehensive assessment of psychological and social factors used for treatment planning. This assessment measures functioning in several important life domains and helps to support decision-making and level of care and service planning, and ensure projected goals are being met.	Every three months for duration of treatment	FY 20/21: 5 FY 21/22: 6 FY 22/23: 7	

Outcome Discussion

The Adult Needs and Strengths Examination - San Bernardino County (ANSA-SB) is a comprehensive assessment of psychological and social aspects used for treatment planning by MSFS early intervention providers. This assessment assesses functioning in various essential life areas and aids in decision-making, level of care and service planning, and ensuring that planned goals are realized. Based on the individual's response, he/she receives a rating from 0 to 3, with 0 revealing there is no evidence of needs and 3 requiring immediate and/or intensive action.

The Life Functioning Domain focuses on the different areas of social interaction in a participant's life. This can include how they function individually, within family, peer, school, and community realms.

The Strengths Domain refers to the individual assets a participant can use to advance healthy development. Identifying areas where strengths can be built is a significant element of service planning.

Military Services and Family Support (MSFS), cont.

Outcome Discussion, cont.

The Behavioral Health Needs Domain identifies the behavioral health needs of a participant.

The following graph illustrates the percentage of participant improvement in global areas of Life Functioning, Strengths, and Behavioral Health Needs.

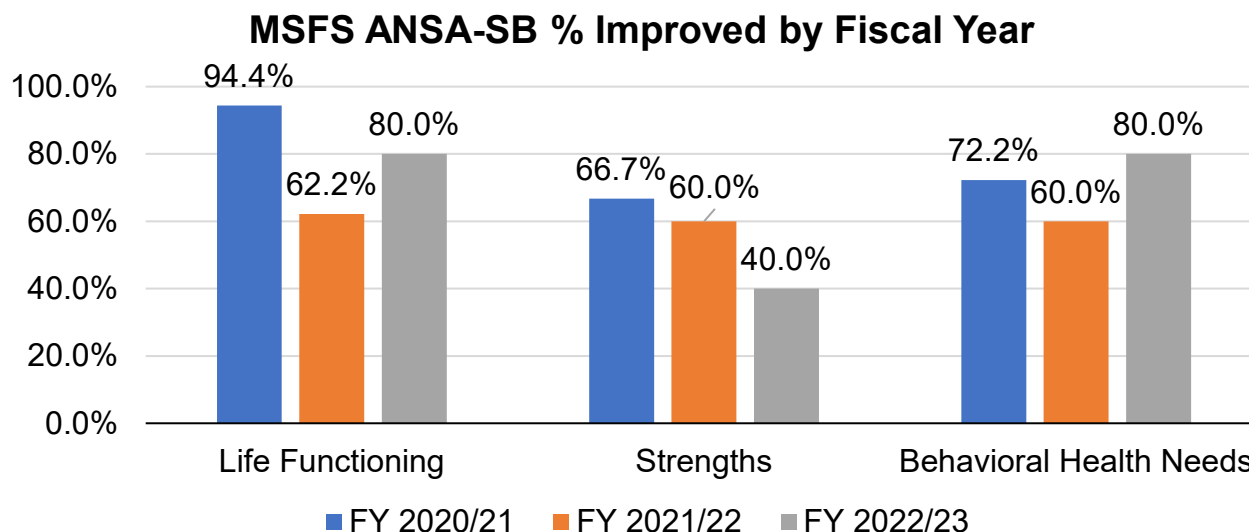
Domain improvement leads to improved recovery including emotional and relational functioning. These improvements reduce the prolonged suffering related to an untreated mental health concern.

These sub-domains are used to measure everyone's specific service needs. During FY 2022/23, individuals improved an average of 66% in the Life Functioning, Strengths, and Behavioral Health Needs domains.

The Life Functioning Domain saw an average improvement of 79% over the three-year period.

The Strengths remained steady, with an improvement of approximately 56% over the three years.

The percentage of improvement in Behavioral Health needs increased specifically in the depression, anxiety, and adjustment to trauma sub-domains.



Military Services and Family Support (MSFS), cont.

Outcome Discussion, cont.

Each domain includes sub-domains that help to evaluate the participant's readiness to participate in early intervention services.

In the domain of Life Functioning, the sub-domain of family relationships evaluates and rates the participant's relationships with their family members: spouse/partner, children, and other family members. Improvement in this sub-domain indicates that a significant need, such as problems with a spouse, that impacts the participant's ability to function has improved.

The sub-domain of social functioning rates social skills and relationships for a participant. An improvement in this area indicates the participant had a significant need, such as low quality of social relationships, which threatened the individual's safety, health, or development.

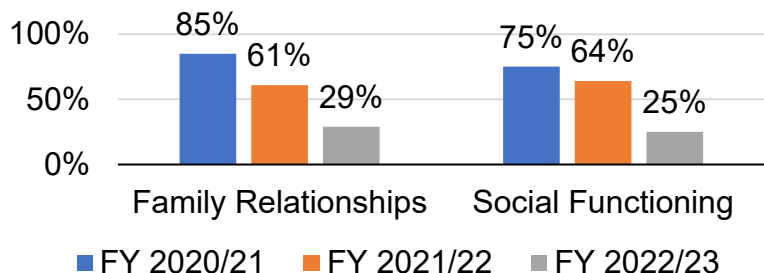
In Strengths, the interpersonal/social connectedness sub-domain measures a participant's social and relationship skills. An improvement in this domain indicates the participant needed to increase social functioning to avoid unhealthy isolation.

The resilience domain measures a participant's ability to recognize their internal strengths and use them to manage their daily life. Lower scores in this domain indicate the participant had the ability to identify their personal strengths and/or utilize them effectively.

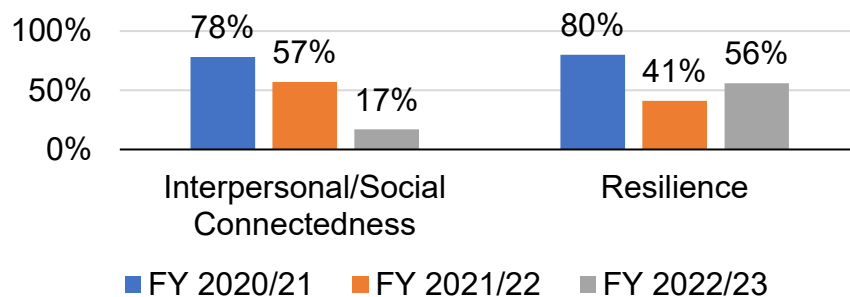
There was a decline in Interpersonal/Social Connectedness compared to the two previous fiscal years. This could be due to participants experiencing an increase in in-person interaction.

Individuals improved in the Resilience sub-domain on average by 59% over the last three years. These results demonstrate the effectiveness of early intervention services in improving MSFS participants' ability to recognize and capitalize on their personal strengths.

ANSA-SB Life Functioning Sub-Domains % Improved by FY



ANSA-SB Strengths Sub-Domains % Improved by FY



Military Services and Family Support (MSFS), cont.

Outcome Discussion, cont.

The Behavioral Health Needs sub-domain of adjustment to trauma is used to help the participant define their difficulties related to a traumatic experience. An improvement in an identified need indicates that a participant has improved a debilitating level of trauma symptoms.

The anxiety sub-domain rates the symptoms of anxiety as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). Improvement in this domain indicates a participant improved anxiety symptoms such as excessive fear and anxiety related to behavioral disturbances.

The sub-domain of depression rates symptoms of depression as defined by the DSM-5. Improvement in this domain may indicate a decrease in symptoms such as irritable or depressed mood, social withdrawal, and sleep disturbances.

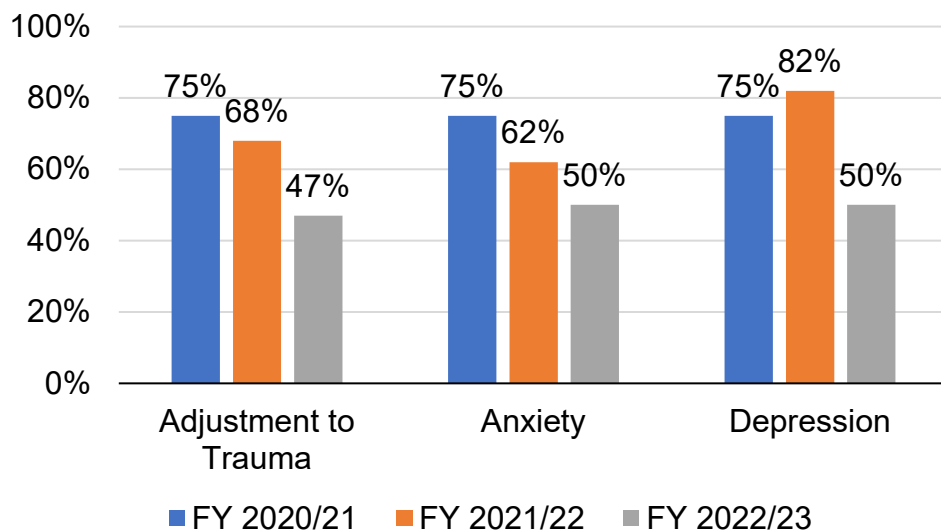
The following graph on the next slide illustrates the comparison of participant pre and post scores on the Post-Traumatic Stress Disorder (PTSD) Checklist for Active and Veteran Military members (PCL-M). The PCL-M uses 17 questions to assess the degree to which participants experience symptoms of PTSD, such as trouble falling or staying asleep, being “hyper alert” or watchful and on guard, or feeling jumpy and/or easily startled. Higher scores indicate a greater intensity of PTSD symptoms.

Total Symptom Severity Scores can range anywhere from 17 to 85. A cutoff score of 50 or more suggests the presence of a significant level of symptom severity. Results indicate that early intervention participants scored 63 points out of a total of 85 on the PCL-M before receiving treatment. At the end of treatment, participants scored 46 points on average, indicating a reduction in total symptom severity. MSFS participants reduced their total symptom severity score by an average of 17 points, which is above a 10-point reduction to indicate the clinical meaningfulness of PTSD symptom reduction.

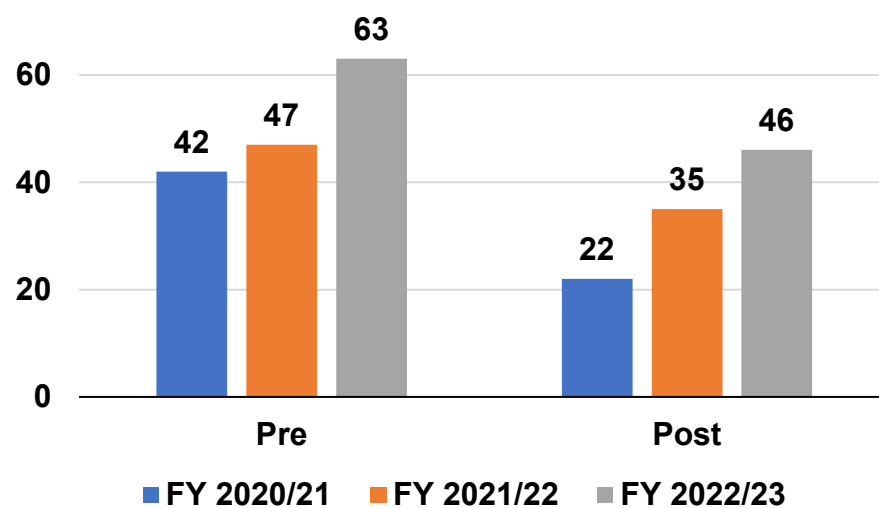
Military Services and Family Support (MSFS), cont.

Outcome Discussion, cont.

ANSA-SB Behavioral Health Needs Sub-Domains % Improved by FY



PTSD Average Scores Pre and Post by Fiscal Year



Military Services and Family Support (MSFS), cont.

Challenges/Solutions

Group participation also continues to be a challenge, as participants prefer individual meetings via videoconferencing or in person rather than group meetings. Participants have shared that they prefer virtual individual meetings because they help preserve anonymity within their communities and they face stigmas of being involved in mental health services. In more remote service regions, transportation and reliable internet service continue to challenge participants.

The MSFS program faced difficulties with one of the bases they partner with in Barstow. After a change in command, new limitations were placed on providing group services and access to the base from outside agencies. Even with the challenges presented, the MSFS program has continued to successfully serve the military community by meeting its clients where they are. The program seeks to create groups in a different settings, such as schools, to address the family members of servicemembers.

Lessons Learned

PEI continues to work with MSFS providers to ensure that the appropriate data is collected and to provide technical assistance for database navigation. MSFS providers can reach a larger population through telehealth services, including participants outside of their service regions. Program staff can train participants on how to use virtual meeting platforms, especially those poor internet service areas.

Staff recruitment efforts continue in the Central/East Valley regions to ensure that the program's target population is adequately served.



Artwork by: Rose Stout

Military Services and Family Support (MSFS), cont.

Success Story

“I just want to thank you for having been the perfect fit for my counseling needs. You were authentic and relatable. I felt safe opening up to you. You validated my pain and helped me to laugh again. I am forever grateful. I will continue to improve my use of the strategies you have taught me. I will hear your voice in my head reminding me to notice who is talking to me, helping me to reframe negative self-talk, and to continue to show love and compassion towards myself at every age and stage. I am writing a book I never thought I'd ever want to write and am enjoying it more than anything I've ever written. That is thanks to you. Be well and continue to do what you do so well! Anyone with the benefit of your counsel, input, and insight is better because of it! Thanks, again. I feel like I have come a long way.”

Program Updates

There are no planned program updates for Fiscal Year 2024/25.

Student Assistance Program (SAP)

Program Description and Target Population

The Student Assistance Program (SAP) employs a school-based approach to provide targeted services to students in kindergarten through 12th grade who require interventions for substance abuse, mental health, academic, emotional, and/or social issues. SAP links education, programs, and services within and across school and community systems to form a support network for students.

SAP's target population consists of K-12 students and their families who have the following characteristics: Trauma exposure, the onset of serious psychiatric illness for the first time, families in distress, at risk of dropping out of school, and/or becoming involved with the juvenile justice system.

The SAP program prioritizes schools and school districts with high rates of students from underserved ethnic/cultural groups, poverty, low academic achievement, suspension, expulsion, dropouts, children/youth in foster care, at risk of juvenile justice involvement, and/or community violence.

Services are not intended for those who have previously been diagnosed with a mental health condition, as well as students whose needs have been identified and should be met as part of an Individual Education Plan (IEP).

Services Offered	• Mental Health and Substance Use Screenings and Assessments
	• Mental Health Educational Presentations
	• Critical Incident Stress Debriefing
	• Individual and Group Counseling
	• Alcohol and Drug Education and Intervention

Program Serves	Children, Youth, TAY (16-25)
Location of Services	School Campuses, Mental Health Clinics, In-home
Annual Budget FY 24/25	\$5,237,676
Cost Per Consumer FY 24/25	\$370

Student Assistance Program (SAP), cont.

Program Highlights

SAP uses a school-based approach to provide focused services to students needing interventions for substance use, mental health, academic, emotional, and/or social issues. It is a process that connects students to a network of supports. SAP identifies students in need and links them to services that can fully assess their needs. Once assessed, students are connected with the appropriate level of services and ongoing support.

The SAP falls into the State Prevention and Early Intervention Program reporting structure. The program includes both prevention and early intervention activities to provide students with a comprehensive system of care.

Prevention

SAP prevention activities offer education, outreach, and support to help students and school staff understand mental wellness.

Prevention activities are readily available to all students and staff. Referrals can be made to additional services such as screening and assessments. These referrals can be made by school counselors, teachers, and/or parents.

SAP delivers presentations at school assemblies and offers after-school group activities. They are provided with useful information on the signs and symptoms of mental illness as well as substance use disorders.

The following includes some of the topics that are presented by the SAP program:

- Substance Use Education and Interventions,
- Conflict Resolution,
- Self-Control/Anger Management,
- Healthy Dating and Relationships,
- Psychoeducational/Social Skill Building,
- Grief Processing/Critical Incident Debriefing, and
- Suicide Prevention.

Number of Participants / Number of Services Projected vs Actual				
	Projected	Actual		
		FY 20/21	FY 21/22	FY 22/23
Unduplicated Participants	14,174	9,147	13,337	18,753
Number of Services	18,402	20,378	20,280	15,676

Student Assistance Program (SAP), cont.

Program Highlights, cont.

Early Intervention

The program’s core component consists of professionally trained teams. These teams comprise school personnel and staff from community behavioral health agencies.

SAP team members are trained to identify potential learning barriers and make recommendations that will benefit both the student and their families. They work collaboratively to meet the needs of the student in the most effective and practical manner.

The SAP team plans and implements services to improve student well-being. They include ongoing support to ensure the students are successful in their treatment program.

When a student’s needs exceed the scope of the program, the SAP team connects the student and their families to additional community resources and services. This would include referrals to a higher level of care.

The following chart includes data on the number of children and youth served by early intervention services.

Early Intervention Participants / Services			
	FY 20/21	FY 21/22	FY 22/23
Unduplicated Participants	805	836	570
Total Services	9,654	8,188	7,958

SAP early intervention services rely heavily on school site referrals originating from prevention services. When schools transitioned to distance learning, the prevention services were temporarily suspended. The result was a slight decline in the number of participants in the last few reporting years.

The chart below provides an overview of client successes. Data shows that their treatment plans dropped slightly over the last three fiscal years. Clients were displaced during the pandemic and moved out of their program service area causing interruptions in services. Some clients did not have adequate technology or space needed for a successful transition to telehealth services.

Treatment Success by Fiscal Year			
	FY 20/21	FY 21/22	FY 22/23
Treatment Successful	52%	38%	38%
Treatment Partially Successful	13%	22%	18%
Treatment Not Successful	26%	32%	36%
Missing or Other	9%	8%	7%

Student Assistance Program (SAP), cont.

Program Highlights, cont.

Outreach

The SAP program is intended to minimize barriers to learning, support students in developing academic and personal successes, and shorten the duration of untreated mental illness. To reach potential responders, the SAP program extends information and education in various settings. School staff meetings, community meetings, and schoolwide psychoeducation are used by all providers. The tables are shown to detail the settings in which Outreach is carried out and the types of potential responders who took part in the education activities.

San Bernardino County Superintendent of Schools, in collaboration with the Department of Behavioral Health, hosts a multi-day Student Wellness Conference that trains and supports all those who work closely with children and youth. In July 2023, over 900 people attended the conference to learn about positive behavior interventions for the classroom including identifying behavioral issues and referring to services. Through this partnership, schools also have access to year-round training and support for the implementation of the Positive Behavioral Intervention and Supports (PBIS) model on their school site campuses.

Outreach Settings



- Schools
- Community Events
- Health Fairs
- Family Resource Center
- Community Based Organization Facility
- Faith-Based Organizations
- Southern Region Student Wellness Conference
- Behavioral Health Clinics
- Student Attendance Review Board Meetings
- Shelters

Types of Potential Responders



- Families
- Parents
- Community Members
- School Officials/Staff
- Community Service Providers
- Law Enforcement
- Peer Providers
- Student Attendance Review Boards
- Mediators
- Prevention/Treatment Professionals
- Social Service Providers

Student Assistance Program (SAP), cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-59	60+	UNK
FY 20/21	34%	6%	28%	1%	31%
FY 21/22	51%	5%	26%	1%	17%
FY 22/23	55%	17%	14%	<1%	13%

Fiscal Year	Veteran Status
% of consumers who identified as a veteran	
FY 20/21	<1%
FY 21/22	<1%
FY 22/23	<1%

Fiscal Year	Sexual Orientation
% of consumers who identified as LGBTQ+	
FY 20/21	0%
FY 21/22	<1%
FY 22/23	<1%

Fiscal Year	Disability
% of consumers who identified a physical disability	
FY 20/21	<1%
FY 21/22	<1%
FY 22/23	<1%

Fiscal Year	Gender Identity			
	♂	♀	⚧	UNK
FY 20/21	16%	32%	0%	51%
FY 21/22	6%	10%	0%	83%
FY 22/23	5%	12%	0%	83%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 20/21	74%	3%	0%	22%
FY 21/22	61%	5%	0%	34%
FY 22/23	71%	5%	<1%	24%

Student Assistance Program (SAP), cont.

Demographics, cont.

Demographic Observations

- The SAP program has consistently served the targeted demographics over the last three fiscal years. Children and Youth are the significant participants.
- The SAP program serves high numbers of adults with the annual Southern Region Student Wellness Conference.
- Family support services also contribute to the number of adults served by the SAP program.
- There has been a significant increase in participants declining to answer demographic questions partly due to the age of participants and some of the questions being inappropriate to ask, as well as the difficulty with virtually capturing this information.
- The ethnic and racial participation is consistent with the demographic of the general population of San Bernardino County.

	Ethnicity/Race	FY 20/21	FY 21/22	FY 22/23
Race	African American/Black	13%	8%	9%
	American-Indian/Alaska Native	1%	0%	0%
	Asian	2%	2%	4%
	Native Hawaiian/Pacific Islander	1%	0%	1%
	Caucasian/White	28%	18%	19%
	Latinx/Hispanic	45%	16%	27%
	More than One Race	6%	3%	5%
	Other	9%	15%	11%
	Declined to Answer	41%	37%	24%

Student Assistance Program (SAP), cont.

Demographics, cont.

	Ethnicity/Race	FY 20/21	FY 21/22	FY 22/23
Ethnicity	African	3%	<1%	1%
	Asian Indian/South Asian	1%	0%	0%
	Cambodian	0%	0%	0%
	Chinese	0%	0%	0%
	Eastern European	0%	0%	0%
	European	2%	2%	1%
	Filipino	0%	0%	0%
	Japanese	0%	0%	0%
	Korean	0%	0%	0%
	Middle Eastern	1%	0%	0%
	Vietnamese	0%	0%	0%
	Other	4%	5%	3%
	More than One Ethnicity	8%	3%	1%
	Declined to answer	80%	87%	91%

Student Assistance Program (SAP), cont.

Program Goals

The State program's Prevention goal is to reduce prolonged suffering associated with untreated mental illness by reducing risk factors and increasing protective factors. The Early Intervention goal is to reduce symptoms and improve recovery, including mental and relational functioning. The SAP program is designed to meet the State's goals by reducing learning hurdles, assisting students in building academic and emotional achievement, and decreasing the period of untreated mental illness. The tools used to measure the effectiveness of the SAP program are listed in the table below.

Method use to collect outcome	Description of method	Frequency of use	Number Completed
Children and Adolescent Needs and Strengths Assessment (CANS)	CANS is a multi-purpose tool developed for children's services to support decision making, including level of care and service planning.	Intake, 6 months, Discharge, Significant life events	FY 20/21: 489 FY 21/22: 393 FY 22/23: 465
Pediatric Symptom Checklist (PSC 35)	PSC is a 35-item parent-completed questionnaire that assesses a broad range of emotional and behavioral problems in children. It is used as a screen for psychosocial problems in pediatric well-child visits, school enrollment, and entry into other systems of care for children from 4 to 18 years of age. With repeat administrations, it is also used to assess changes in functioning over time.	Initial, 6 months, discharge	FY 20/21: 444 FY 21/22: 485 FY 22/23: 737
Measurement Outcomes and Quality Assessment (MOQA_SPP/SDR)	The MOQA surveys are used to gather information regarding the stigma associated with mental health needs. Forms of MOQA used are Stigma and Discrimination Reduction (SDR), Suicide Prevention (SP), and Outreach.	Completion of SDR, SP, or Outreach activity	FY 20/21: 67 FY 21/22: 200 FY 22/23: 229
Client Satisfaction Survey	Client satisfaction surveys are used to determine whether the participants are gaining useful and valuable information from the program as well as a way to determine whether the participants are engaging in the program in a way that is satisfying and enjoyable.	Completion of Services	FY 20/21: 237 FY 21/22: 157 FY 22/23: 162

Student Assistance Program (SAP), cont.

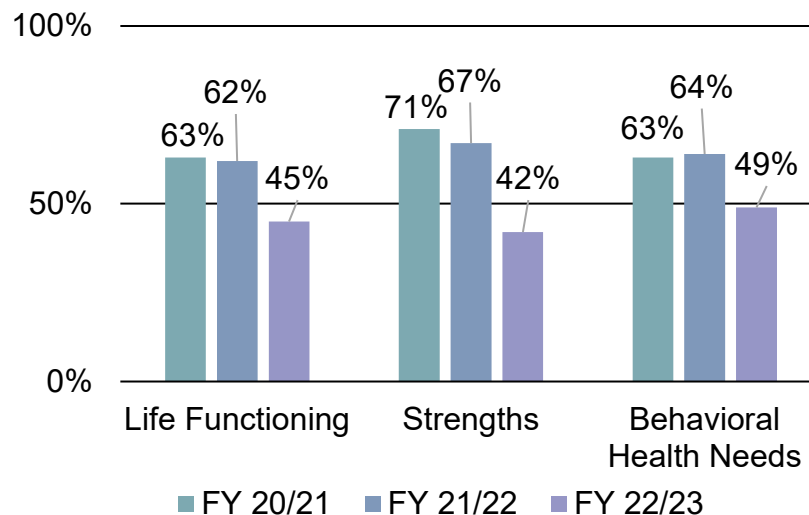
Outcome Discussion

The Student Assistance program uses the Children and Adolescent Needs and Strengths – San Bernardino (CANS-SB) assessment to measure outcomes of the early intervention treatments, as well as to develop treatment plans and goals. Within the first 30 days of receiving assistance, children and TAY receive the initial CANS-SB assessment. Every three to six months, follow-up assessments are conducted, and a final assessment is completed at the conclusion of services. The CANS-SB includes three primary domains used to evaluate early intervention needs. The domains utilized by the SAP program include:

- Life Functioning addresses various areas of social interaction present in the lives of children, teenagers, and their families. This domain assesses their performance in the areas of self, family, peers, school, and community.
- The Strengths domain describes the assets of the child/youth that can be used to advance healthy development. Addressing a child's strengths while also addressing their behavioral/emotional needs leads to better functioning and better outcomes.
- The Behavioral/Emotional Needs domain identifies the behavioral health needs of the child.

The following graph demonstrates overall improvement in the elements of Life Functioning, Strengths, and Behavioral/Emotional Needs, of participants of the SAP program. The results demonstrate consistent increases in approximately 54% of all three domains. The increase leads to an overall improvement in reducing symptoms and recovery, including mental and relational functioning.

SAP CANS-SB % Improved by Fiscal Year

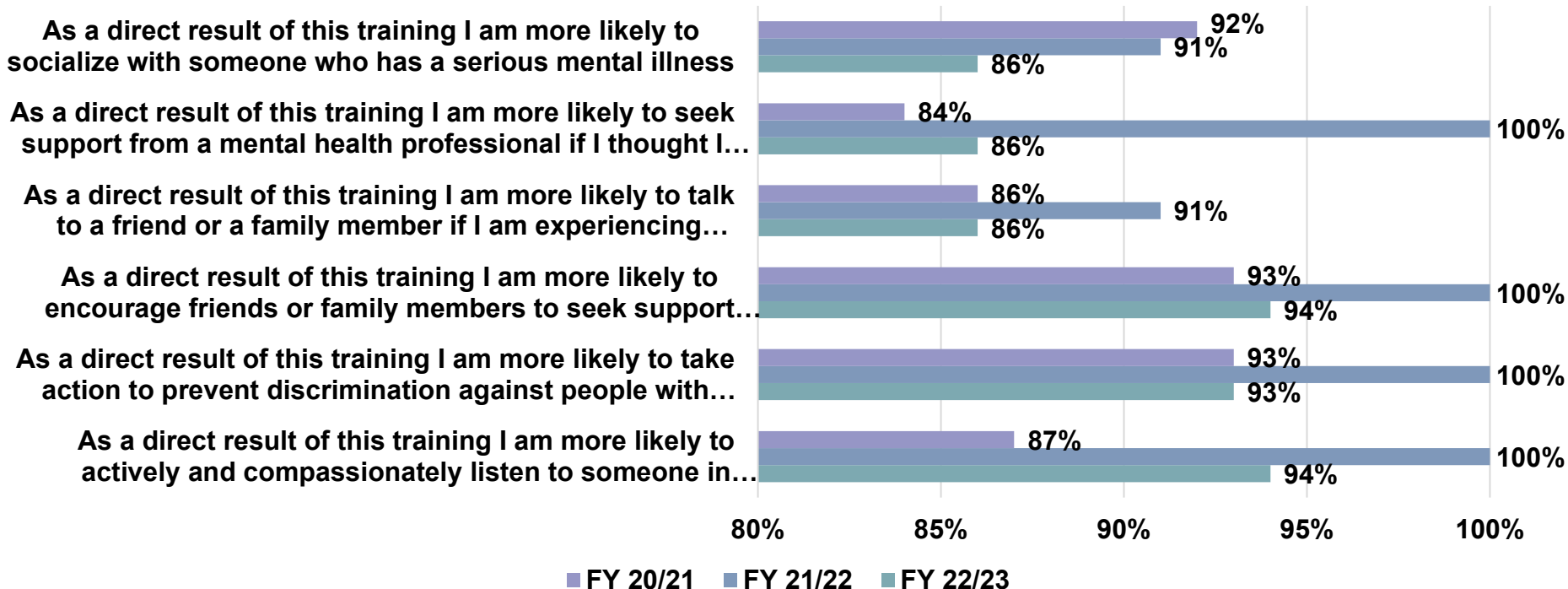


Student Assistance Program (SAP), cont.

SAP Stigma Surveys

The stigma surveys are used to examine whether stigma prevention efforts and/or curriculum aimed at youth affect their knowledge, attitudes, and behavior surrounding behavioral health. Stigma surveys are used after any direct activity whose purpose is to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes, and/or discrimination relating to being diagnosed with a mental illness, having a mental illness, or seeking mental health services. A Stigma and Discrimination Reduction activity also includes direct activities whose purpose is to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and members of their families.

SAP Stigma Survey



Student Assistance Program (SAP), cont.

Challenges/Solutions

An ongoing challenge for SAP is substance use among teens in the mountain communities. There are not many accessible treatment programs for children with substance use disorders.

The solution to this challenge is increased substance use education and prevention efforts for the providers serving the mountain communities. Additionally, providers will be collaborating with other agencies that can provide additional support to the families in identifying the potential signs of substance use.

Receiving appropriate referrals has been another program challenge. Incomplete referrals make it difficult for providers to coordinate services for students identified as having a need. Missing information causes students to miss out on beneficial group sessions or educational presentations. Furthermore, the lack of communication is leading to low parent engagement hindering the authorization and support for student participation.

It is critical for SAP providers to increase communication with key administrators to ensure that the referral process is implemented properly. SAP providers are working to streamline the referral and check-in process. They discovered that accuracy can be improved by aligning with schools' site Positive Behavioral Interventions and Supports (PBIS) teams in the coordination of referrals. Both programs share similar goals. By working collaboratively, they can avoid duplicating efforts or causing confusion among teachers and school staff.

Student Assistance Program (SAP), cont.

Lessons Learned

In FY 20/21, the SAP program providers had a hard time finding appropriate space on school campuses to provide confidential and non-stigmatizing services due to the COVID-19 shutdowns and social distancing requirements. Schools and providers had to learn to adapt to a new virtual service delivery model and navigate technology challenges and resources.

Success Story

The last 2 school years (post-pandemic) have been extra challenging for the students. Their biggest complaint is that they had no outlet for social interaction. The only connection to the outside world was social media. This past year, so many students have expressed in groups that integrating back into school has been tough for them because they lack the social skills they once had. The students have expressed being very grateful for the opportunity to learn and practice new social skills with others in the group. They have reported that it has made a huge difference in how they feel about coming to school and their outlook on the future.

Program Updates

There are no planned program updates for Fiscal Year 2024/25.

Improving Detection and Early Access (IDEA)

Program Description and Target Population

Psychosis is a serious mental health condition in which thought, and emotion are so disrupted that one loses contact with external reality. Early warning signs and symptoms, which can last from a few days to several weeks or years, typically predict the start of a serious and long-lasting mental condition accompanied by psychotic symptoms. This phase of forewarning is a powerful point at which intervention can help to reduce a worsening of mental symptoms, distress, and functional impairment. People at this early stage are at a Clinical High Risk (CHR) of developing a serious illness.

Most people who develop psychosis exhibit symptoms between the ages of 16 and 25. According to existing treatment model research, some people can escape a lifetime of impairment and find fulfillment in their everyday lives with proper and timely intervention.

The goal of the IDEA program, previously referred to as the Early Psychosis Care (EPC) program, is to identify youth at clinically high risk of psychosis as early as feasible in the warning phase and to begin treatment as soon as possible during the first episode of psychosis.

The IDEA program seeks to serve a total of 26 unduplicated participants annually through the TAY One-Stop Centers.

Services Offered	• Mental Health and Substance Use Screenings and Assessments	
	• Mental Health Educational Presentations	
	• Individual and Group Counseling	
	• Case Management	
	• Family Education and Support	
	• Supported Employment and Education	
Program Serves		TAY (16-25)
Location of Services		TAY Centers, Mental Health Clinics, Hospitals
Annual Budget FY 24/25		\$1,000,000
Cost Per Consumer FY 24/25		\$38,462

Improving Detection and Early Access (IDEA) Program, cont.

Existing Efforts

The Department of Behavioral Health continues to offer a continuum of services that includes prevention and early intervention, crisis assistance, and a variety of outpatient and short-term residential treatments that vary in intensity based on the needs of consumers. The continuum allows individuals to obtain care in a variety of ways and provides an existing infrastructure for identifying and treating early episodes of psychosis as well as the precursor signs and symptoms (e.g., Clinical High Risk or prodromal phase). The grant-funded Premier program is part of the continuum. Individuals who have been recognized as having their first episodes of psychosis are currently served through the Premier program. Individuals in the Premier program are often identified and referred from inpatient mental hospitals.

IDEA Updates

As stated in the previous annual update, the original structure and scope of the IDEA program (previously the Early Psychosis Program (EPC) introduced in the FY 20/21 Three-Year Integrated Plan) has been modified because of funding reductions resulting from COVID-19 restrictions. Program administrators plan to use the existing infrastructure within the continuum of services offered by the Department of Behavioral Health. Adjusted funding for the program will require a phased approach to program implementation.

A recap of the changes are as follows:

- The program's annual projected number of participants to be served was reduced from 105 participants per year to 26 participants per year.
- The IDEA program will redirect program planning and implementation from the development of several Coordinated Specialty Care (CSC) teams to the establishment of a small unit consisting of a Mental Health Clinic Supervisor, Clinical Therapist I, Program Specialist II, Social Worker II, Mental Health Specialist, Office Assistant III, Peer and Family Advocate, and part-time Adult and Child Psychiatrist.
- This unit will be responsible for the provision of mental health services including screening and assessments, individual and group counseling, case management, family education and support, as well as supported education and employment.

The process of implementing this program has been delayed due to the restrictions experienced due to the COVID-19 pandemic. Currently, the program is currently hiring and onboarding program staff.

Improving Detection and Early Access (IDEA) Program, cont.

The IDEA program will be developed through the following phases:

Phase I: Needs Assessment

- Complete needs assessments to identify training gaps.
- Map existing resources.
- Locate screening tool to be used to identify CHR.

Phase II: Recruitment of Program Support Staff

The program staff will coordinate program referrals and serve as a resource hub and centralized access point for mental health providers to facilitate participants' access to timely and appropriate services.

Phase II will consist of the following:

- Recruit and hire a program Clinical Therapist I. This position will be utilized to coordinate and provide the delivery of specialized services for Early Psychosis care in order to enhance the current mental health care system.
- Recruit and hire a Program Specialist II to assist with program development and outcome reporting.

- Recruit and hire a program Office Assistant III to support clinical staff and facilitate access and linkage services.
- Recruit and hire a Social Worker II. This position will provide outreach and education services to the department clinics, community partners, schools/colleges, and other community members as needed. This position will also conduct screenings for eligibility and fit for the program services offered.

Phase III: Clinical High-Risk Training and Education

The program coordinator will provide training and workshops to program staff within the DBH infrastructure, with community partners, school/college counselors, amongst others.

Training will be provided to:

- Prevention and Early Intervention program providers,
- TAY program administrators,
- DBH Outpatient Clinic staff, and
- Community partners.

Office of Suicide Prevention (OSP)

Program Description and Target Population

The Office of Suicide Prevention is a new PEI program categorized as a stand-alone Suicide Prevention Program.

As legislation changes and suicide prevention efforts increase across the state, DBH has considered how to meet the changing needs of the communities. Recent community planning supports the need to strengthen the infrastructure surrounding suicide prevention by enhancing our current programming to include staff that can direct their attention to implementing, coordinating, and evaluating suicide prevention efforts in San Bernardino County. There is an opportunity to be amongst one of the few counties in California to invest in the reduction of suicide by creating a local office that can lead the suicide prevention efforts in our county.

The Office of Suicide Prevention consists of full-time staff dedicated to guiding the continued implementation of a strategic plan for suicide prevention for San Bernardino County. The OSP is still in its infancy of implementation and will have more information to report in future updates.

Services Offered	• Suicide Prevention Outreach and Education • Critical Incident Stress Debriefing • Countywide Strategic Planning Coordination

Program Serves	Children, Youth, TAY, Adults, Older Adults
Location of Services	Countywide
Annual Budget FY 22/23	\$380,504
Cost Per Client FY 22/23	\$253

Office of Suicide Prevention, cont.

State Program Positive Results

In September 2023, DBH launched the Office of Suicide Prevention in San Bernardino County, offering a centralized website for current information on warning signs, upcoming trainings, conversation tips, and available resources. The site is regularly updated to provide the latest information for residents seeking support.

The OSP will consist of 3 primary positions to manage the daily tasks.

Program Specialist II- Leads a small support team in suicide prevention efforts, directing tasks, writing strategic plans, and implementing business processes.

Mental Health Specialist- Conducts community trainings and presentations, builds stakeholder networks for suicide prevention, and facilitates meetings within the suicide prevention network.

Office Assistant III- Provides administrative support for the Office of Suicide Prevention (OSP).

Recruitment for these positions began in July 2023 with the approval of the program. We anticipate to have a fully staffed office by June 30, 2024.



MHSA Annual Update for FY 24/25: Community Services and Supports

Introduction

Under the Mental Health Services Act (MHSA), 76% of MHSA funding is mandated to be directed toward the Community Services and Supports (CSS) component. The CSS component provides access to an expanded continuum of care for persons living with a serious mental illness (SMI) or serious emotional disturbance (SED).

Community Services and Supports Goals

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

The CSS section is organized according to programs that operate with similar service responsibilities but may serve different target populations. Programs intended to provide interventions or supports during a mental health crisis are described in the Crisis System of Care section of the CSS component. There are 9 Full Service Partnership programs.

The Peer Support Programs section highlights programs that are consumer driven and work from a lived experience perspective. The goal of all CSS programs is to provide the necessary services and supports that help consumers achieve mental health and wellness and recovery goals.



Artwork by Inje Delilah Bahamonde

Community Services and Supports

The table below lists the CSS programs:

Community Services and Supports Programs
Crisis System of Care • A-5: Triage Transitional Services • A-6: Community Crisis Services • A-16: Crisis Intervention Collaborative Programs
Crisis Stabilization Continuum of Care • A-4: Crisis Walk-In Centers (CWICs)/Crisis Stabilization Units (CSUs) • A-10: Crisis Residential Treatment (CRT)
Peer Programs • A-1: Peer Programs
Outreach, Access, and Engagement Programs • A-9: Access, Coordination, and Enhancement (ACE) • A-15: Recovery Based Engagement Support Teams (RBEST)
Full Service Partnerships • C-1: Comprehensive Children and Family Support Services (CCFSS) • C-2: Integrated New Family Opportunities (INFO) • TAY-1: One Stop Transitional Age Youth (TAY) Centers • A-2: Forensic Services Continuum of Care • A-3: Assertive Community Treatment Model Full Service Partnership Services • A-11: Regional Adult Full Service Partnership (RAFSP) • A-20: Collaborative Adult Full Service Partnership Services • OA-1: Age Wise
Homeless Services, Long-Term Supports, and Transitional Care • A-7: Housing and Homeless Services Continuum of Care Programs • A-13: Adult Transitional Care Programs

Community Services and Supports

CSS Demographics for FY 2022/23

Age Group	
Children (0-15)	22%
TAY (16-25)	22%
Adult (26-59)	48%
Older Adult (60+)	8%

Gender	
Female	49%
Male	51%
Other	<1%

Race/Ethnicity			
African American/Black	19%	Latinx/Hispanic	43%
Native American or Alaska Native	<1%	Caucasian/White	29%
Asian/Pacific Islander	2%	Other/Unknown	6%

Primary Language	
English	95%
Spanish	4%
Other/Unknown /Not Reported	1%

N = 17,053

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

Primary Diagnosis			
Anxiety disorders	12.8%	Psychosis	23.7%
Bipolar disorders	9.5%	Substance related	4.7%
Depressive disorders	25.3%	Neurodevelopmental/ cognitive disorders	4.1%
Disruptive disorders	3.6%	None/Deferred	2.0%
Other	14.4%		

Region	
Central Valley	20%
Desert/Mountain	35%
East Valley	25%
West Valley	13%
Out of County	6%

CSS Data Explanation

CSS provides data for the demographics of the consumers served as well as the number of consumers served for each program. The number of consumers served and demographics may differ depending on the level of services received. The number served is inclusive of all providers and includes data for all FSPs. The demographics represent the data for unduplicated consumers seen by the providers within the program.

CSS Capacity Assessment

The Community Services and Supports component comprises eighteen (18) programs designed to support a continuum of services that support the mental health needs of diverse children, TAY, Adults, and Older Adults according to need. In compliance with 9 CCR § 3650, each program was developed through the Community Program Planning process and includes a description of services, the targeted number of people to be served by age group, demographics of consumers, program outcomes, and includes a summary of challenges and solutions related to program implementation.

The Department of Behavioral Health (DBH) prepared an analysis of available San Bernardino County data to understand the scope of mental health needs among the four age-specific target populations. The data was reviewed and analyzed to determine estimates of the unserved, underserved, and inappropriately served individuals in the county. For additional information, please refer back to the [MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026](#), pages 212-218.

As part of program implementation, DBH is committed to an ongoing review of community behavioral health needs, the capacity of staff, the public behavioral health system, and the implementation of continuous improvement efforts based on qualitative and quantitative data and informatics.

DBH collects, prepares, and presents data and information to its stakeholders. Stakeholders review the information and provide feedback on identifying additional populations, program improvement and design, priorities, and unmet needs.

In December 2023, DBH began partnering with an independent national research and consulting firm in the healthcare industry to complete an assessment of the stakeholder process for developing the MHSA Three-Year Integrated Plan and Plan Annual Updates and behavioral health needs and capacity assessment (see page 24).



Artwork by Martin Rodriguez

CSS Capacity Assessment (cont.)

Populations for Full Service Partnerships

The CSS section of this Three-Year Plan contains detailed overviews of all Full Service Partnership (FSP) programs, including demographics, numbers projected to be served, goals, and key outcomes. Programs are designed to meet the needs of the specific populations. Below is a list of the prioritized populations to be served in FSP programs by age.

Children and Youth

- Those children and youth identified as living with serious emotional disturbances
- Those children and youth having problems at school or at risk of dropping out
- Those children and youth at risk of, or are involved in, the juvenile justice system
- Those children and youth in need of crisis intervention and/or at serious risk of psychiatric hospitalization
- Those children and youth at risk of residential treatment or are stepping down from residential treatment
- Those children and youth who are homeless or at risk of homelessness
- Those children and youth who are high users of service; multiple hospitalizations/institutions
- Those children and youth who are at risk due to lack of services because of cultural, linguistic, or economic barriers
- Those children and youth at risk due to exposure to domestic violence, physical, emotional, verbal, sexual abuse
- Those children and youth with co-occurring disorders
- Children and Youth at-risk of or experiencing sexual exploitation

Transitional Aged Youth

- Those transitional age youth who have serious mental illness or serious emotional disturbances
- Those transitional age youth who have repeated use of emergency mental health services
- Those transitional age youth who have co-occurring disorders
- Those transitional age youth who are homeless or at risk of homelessness
- Those transitional age youth who are at risk of involuntary hospitalization or institutionalization
- Those transitional age youth who are involved in the juvenile justice system
- Those transitional age youth who are in out-of-home placement
- Those transitional age youth aging out of or part of the child welfare system
- Those transitional age youth who are high utilizers of hospital services

CSS Capacity Assessment (cont.)

Populations for Full Service Partnerships (cont.)

Adults

- Those adults living with serious mental illness
- Those adults who are homeless or at risk of homelessness
- Those adults who have co-occurring substance use disorders
- Those adults who are involved in the criminal justice system or who are in transitioning/discharged from the criminal justice system
- Those adults who are recently discharged from psychiatric hospitals/higher levels of care
- Those adults who are frequently hospitalized or are frequent users of emergency room services for psychiatric problems

Older Adults

- Those older adults who have serious mental illness
- Those older adults who are homeless or at risk of homelessness
- Those older adults who are frequent users of emergency room services for psychiatric problems or are frequently hospitalized
- Those older adults who have reduced personal and/or community functioning due to physical and/or health problems
- Those older adults who have co-occurring substance use disorder
- Those older adults who are isolated and at risk for suicide due to stigma surrounding their mental health problems

Introduction

The primary goals of Crisis System of Care (CSOC) programs are to reduce hospital emergency room visits and unnecessary acute psychiatric hospitalization, improve consumer participation in outpatient services after a crisis, and reduce the percentage of consumers who return for additional crisis services within a short timeframe.

CSOC programs serve MHSA populations utilizing system development strategies that help enhance the capacity to provide value-driven, evidence-based services. Through system development, counties improve program services and supports for all consumers and families, enhance their service delivery systems, and build transformational programs and services. CSOC is comprised of a continuum of programming that provides education and support for community partners. In an effort to divert from unnecessary psychiatric hospitalization when a more appropriate level of care is available.

Programs under the CSOC are:

- A-5 Triage Transitional Services
 - Triage Transitional Services (TTS)
 - Placement After Stabilization (PAS)
- A-6 Community Crisis Services
 - Community Crisis Response Team (CCRT)
- A-16 Crisis Intervention Collaborative Programs
 - Crisis Intervention Training (CIT) Program
 - Community Education Program (CEP)
 - Triage, Engagement, and Support Teams (TEST)

Target Populations

The table below represents the target population of consumers to be served by programs within the Crisis System of Care.

Crisis Stabilization Continuum of Care Programs				
Program Name	Target Population			
	Children	TAY	Adults	Older Adult
Triage Transitional Services (TTS)		X	X	X
Community Crisis Response Team (CCRT)	X	X	X	X
Crisis Intervention Training (CIT)		X	X	X
Community Education Program (CEP)		X	X	X
Triage Engagement and Support Teams (TEST)	X	X	X	X

CSS: Crisis System of Care

Number of Consumers to be Served

The table below demonstrates the number of consumers to be served by age and service category for Fiscal Year 2024/25:

Program	Ages Served	Service Area*
Triage Transitional Services	400 TAY 1,300 Adult 100 Older Adult	1,800 GSD
	TOTAL = 1,800	TOTAL = 1,800
Triage, Engagement, and Support Teams	1,000 Children 1,447 TAY 2,730 Adult 900 Older Adult	3,077 GSD 3,000 O&E
	TOTAL = 6,077	TOTAL = 6,077
Community Crisis Response Team	2,514 Children 2,270 TAY 3,315 Adult 639 Older Adult	7,045 GSD 1,693 O&E
	TOTAL = 8,738	TOTAL = 8,738
Crisis Intervention Training	300 TAY 1,575 Adult 125 Older Adult	2,000 O&E
	TOTAL = 2,000	TOTAL = 2,000
Community Education Program	250 TAY 650 Adult 100 Older Adult	1,000 O&E
	TOTAL = 1,000	Total = 1,000

*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.

Triage Transitional Services (TTS)

Program Name	Actual Number Served FY 2022/23	Estimated Number to be Served FY 2024/25	Annual Budgeted Funds FY 2024/25	Estimated Annual Cost per Person FY 2024/25
Triage Transitional Services	2,454	1,800	\$3,279,588	\$1,822

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Ages 16+	SMI*	Clinic-based 	Experiencing a behavioral health crisis

*SMI = serious mental illness

Program Description and Target Population

Triage Transitional Services (TTS) were designed to assess consumers who voluntarily present to the Arrowhead Regional Medical Center – Behavioral Health Unit (ARMC-BHU). As part of a team, TTS works alongside ARMC-BHU staff to assist in determining if the consumer meets medical necessity for psychiatric inpatient treatment or if their needs can be met in other, less restrictive settings outside of an emergency department or psychiatric inpatient treatment unit.

The Placement After Stabilization (PAS) program, an

expansion of TTS, provides discharge planning and acts as a liaison to facilitate appropriate placement upon discharge for each of the five contracted Crisis Residential Treatment (CRT) facilities throughout San Bernardino County in the following areas: San Bernardino (2 sites), Joshua Tree, Victorville, and Fontana. The staff work collaboratively with CRT staff to provide services that are intended to divert and reduce psychiatric inpatient hospitalization, assist consumers to maintain self-sufficiency, increase housing stability, and assist consumers to successfully reintegrate into the community.

Demographics

Age

0% Children
21% TAY
76 Adult
3% Older Adult



Gender Identity



63% Male



37% Female

Race/Ethnicity

22% African American/Black
29% Caucasian/White
<1% American Indian/Alaska Native

2% Asian/Pacific Islander
43% Latinx/Hispanic
3% Other/Unknown

Primary Language



97% English
2% Spanish
<1% Other
<1% Unknown

N=1,679

Services Offered

TTS staff are co-located with ARMC-BHU to provide the following services:

- Crisis assessment and intervention
- Case management
- Collateral contacts
- Transportation assistance
- Linkage with housing assistance
- Linkage with outpatient resources and providers
- Referrals to medical and social services agencies
- Family and caretaker education
- Consumer advocacy

PAS Clinical Therapists are co-located at each CRT site to provide the following services:

- Screening for discharge services
- Assessments
- Discharge planning
- Placement assistance
- Transportation

Demographics

Primary Diagnosis

3.0% Anxiety disorders	43.7% Psychosis disorders
10.2% Bipolar disorders	5.6% Substance use disorders
25.1% Depressive disorders	11.0% Other
<1% Disruptive disorders	<1% None/deferred
<1% Neurodevelopmental/Cognitive	



N=1,679

Positive Results

In FY 2022/23, TTS staff served a total of 1,975 consumers from the ARMS-BHU Triage Unit. A total of 1,058 (54%) of those consumers were diverted from unnecessary hospitalization.

As part of the expanded TTS services, PAS services assisted a total of 479 consumers. Of these consumers, 285 remained in the CRT program long enough to receive linkage to aftercare services, and all (100%) were successfully placed in safe and sustainable community placements.

Success Story

TTS staff evaluated “Quanah” when he presented voluntarily to ARMC-BHU. Quanah was easily agitated and was only able to identify that he needed assistance with SUD treatment. Staff gathered additional information from him and helped his mother feel supported by answering her questions. Quanah avoided inpatient psychiatric treatment and was instead connected to SUD services and referred back to his treating psychiatrist to continue his medication management.

Challenges/Solutions

Program staff experienced challenges with limited resources for placement (homeless shelters/ housing services). Additionally, TTS staff had difficulty collaborating with Transitional Aged Young (TAY) programs and placement challenges for TAY consumers, especially Children and Family Services (CFS) system-involved and pregnant consumers.

To address this challenge, TTS staff worked with other TAY service providers in the community, particularly TAY- Victor Community Support Services, to assist with placements. Program staff established collaborative relationships within the community and other DBH programs to improve staff knowledge of resources.

The TTS program experienced staffing challenges which led to delays in accessing timely outpatient psychiatric appointments and clinic intakes, which could potentially impact access to needed medication. To ensure access to timely medication, TTS staff assisted consumers in educating themselves on obtaining medication refills at the Crisis Stabilization Units (CSUs) in the interim.

Another challenge for consumers was a lack of transportation options. Arrangements were made to assist clients via DBH staff, by providing bus passes or contacting Managed Care Plans for transportation services for medical appointments.

Outreach and Engagement

For FY 2022/23, a combined total of 71 participants attended three presentations where staff members from the TTS program were available to discuss their program and offer resources.

Program Updates

There are no planned updates for this program.

Success Story

PAS staff assisted a TAY consumer, “Faye” who was involved with the Children and Family Services (CFS) system in San Bernardino County. As she was an adult, the placing agency was not able to find appropriate placement. The PAS clinician worked with CRT staff and heavily advocated and coordinated with CFS for Faye to discharge to a Transitional Housing Program. Faye was successfully placed and now has access to appropriate follow up treatment. She has not returned to CRT or higher levels of care.

For additional information, please refer back to the [MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026](#), pages 222-225.

Community Crisis Response Team (CCRT)

Program Name	Actual Number Served FY 2022/23	Estimated Number to be Served FY 2024/25	Annual Budgeted Funds FY 2024/25	Estimated Annual Cost per Person FY 2024/25
Community Crisis Response Team	6,126	8,738	\$11,850,352	\$1,356

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
All ages	N/A	Field-based 	Experiencing a behavioral health crisis

Program Description and Target Population

Community Crisis Services is comprised of the Crisis Contact Center (CCC) and the Community Crisis Response Team (CCRT). The CCC is a centralized location where anyone can call or text for immediate access to specially trained crisis staff. When necessary, CCC dispatch CCRT staff who provide urgent mobile field-based behavioral health services to individuals in many cities throughout the County. CCRT teams are located in the East/Central Valley, West Valley, and

High Desert regions of the County. CCRT responds to crisis situations at community locations through collaborations that include, but are not limited to, law enforcement, hospitals, schools, Department of Behavioral Health (DBH) clinics and contract providers, specialty programs, group homes, Board and Care (B&C) facilities, family members, and self-referrals.

For additional information, please refer back to the [MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026](#), pages 226-229.

Demographics

Age

25% Children
22% TAY
33% Adult
6% Older Adult
14% Unknown

N=6,126



Gender Identity



48% Male



47% Female



<1% Transgender

5% Other/Unknown

Race/Ethnicity

12% African American/Black

15% Caucasian/White

1% American Indian/Alaska Native

2% Asian/Pacific Islander

38% Latinx/Hispanic

32% Other/Unknown

Program Description and Target Population (cont.)

CCRT is committed to assisting San Bernardino County residents in the least restrictive manner by providing behavioral health services on site where the individual is experiencing their crisis.

Services Offered

- Crisis assessment and intervention in the field, via text messaging, and/or virtual conferencing
- Follow-up services
- Linkage to community resources and providers
- Consultation for interruption of involuntary psychiatric hold (WIC 5150/5585)

Positive Results

In FY 2022/23, 1,186 consumers were diverted from hospitalization to alternative crisis interventions such as CWIC, CSU, and CRTs.

With COVID-19 restrictions lifted, CCRT was able to provide outreach to a wider audience in FY 2022/23 than in FY 2021/22. CCRT increased outreach activities by 15% since FY 2021/22. While law enforcement continues to be CCRT's most frequent contact (13 different agencies), out of 101 outreach events, CCRT reached 76 other collaborative partners such as schools, disaster relief stations, community groups, healthcare providers, and more.

In FY 2022/23, CCRT provided therapeutic support at culturally specific community events which included a health fair at the Mexican Consulate, Native American Heritage event, Women's Awareness subcommittee meeting, DBH's annual Black History month celebration, and the LA County Fair Black Excellence Weekend event.

Demographics

Primary Language



92% English
4% Spanish
4% Other

N=6,126



Primary Diagnosis

12.6% Anxiety disorders

4.9% Bipolar disorders

34.9% Depressive disorders

5.7% Disruptive disorders

1.1% None/Deferred

3.2% Neurodevelopmental/cognitive disorders

13.9% Psychosis disorders

1.7% Substance Use

22.1% Other

N=1,579

Challenges/Solutions

Due to promotional opportunities for current staff and increased competition from other healthcare providers in the county, recruitment and retention of qualified staff continues to be an ongoing challenge for CCRT.

CCRT is working closely with Human Resources to plan a crisis services specific hiring event to fill current vacancies. DBH is also planning a job fair targeting clinical therapists and social workers to entice applicants to apply.

Success Story

“Violet” was having some serious medical issues and reported feeling hopeless. She emailed the generic DBH email and was referred to CCRT for assistance. Through the combined efforts of two staff members, they listened, validated, and provided multiple resources to the consumer. Violet expressed gratitude for all the resources provided and appreciated the help received from CCRT.

Outreach and Engagement

For FY 2022/23, the CCRT program conducted the following outreach and engagement activities:

Activity Type	Number of Activities	Total Number of Participants
Law Enforcement Collaboration	24	455
School Collaboration	23	254
Disaster Relief Collaboration	14	160
Community Groups Collaboration	10	310
Health Care Clinic Collaboration	9	150
Other San Bernardino County Department Collaboration	9	255
Mental Health Provider/Clinics	8	19
Other DBH Program Collaboration	3	89
Community Partner Collaboration	1	1
Total	101	1,693

Program Updates

DBH will be allocating additional funding to A-6 to accommodate the implementation of 24/7 services and onboard a contract provider to deliver this service from 7 p.m. to 7 a.m. This does not affect current forecasted allocation for FY 23/24 and 24/25 due to cost savings in this component. Estimated additional funding is in the amount of \$1,067,934 from December 2023 to June 2024, and ongoing program costs will incur an estimated cost of \$2,003,532 annually.

Success Story

“Vincenzo” contacted CCRT feeling very upset. He had recently lost his long-time job, his home, and his vehicle. He had a history of mental health issues and felt like his job helped to keep him focused. He reported feeling like he had nowhere to go, as his family had not been supportive when he had experienced past trauma-related incidents. CCRT staff provided active listening with a compassionate demeanor and transported him to a crisis stabilization unit (CSU) where he was able to stabilize. Vincenzo was very grateful and thanked staff for their assistance. CCRT staff followed up with him some time later to ensure that he was receiving the 2-1-1 resources offered. Vincenzo eventually admitted into a Crisis Residential Treatment (CRT) program and was subsequently connected to appropriate living arrangements.

Crisis Intervention Training (CIT)

Program Name	Actual Number Served FY 2022/23	Estimated Number to be Served FY 2024/25	Annual Budgeted Funds FY 2024/25	Estimated Annual Cost per Person FY 2024/25
Crisis Intervention Training	2,585	2,000	\$5,995,985*	\$661*

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Ages 18+	N/A	Field-based 	First responders and community partners

*Annual budget and cost per consumer represent CIT, CEP, and TEST.

Program Description and Target Population

The Crisis Intervention Training (CIT) program provides behavioral health educational trainings to first responders and community partners. The goal of each training is to enhance participants' knowledge on behavioral health, ability to recognize signs of a behavioral health crisis, utilization of communication and de-escalation skills, stigma reduction,

and familiarity with behavioral health programs and other support services and how to access them.

For additional information, please refer back to the [MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026](#), pages 230-233.

Demographics

Age	Gender Identity	Race/Ethnicity
<1% Children 8% TAY 61% Adult 3% Older Adult 29% Unknown/ Declined to State 	 33% Male  39% Female  29% Other/Decline to State	11% African American/Black 16% Caucasian/White <1% American Indian/Alaska Native 3% Asian/Pacific Islander 34% Latinx/Hispanic 36% Multiple Races/Other
N=2,585	Note: not all numbers add to 100 due to rounding.	

Services Offered

- In collaboration with San Bernardino County Sheriff's Department:
 - 40-hour CIT course
 - 8-hour Senate Bill 29 (SB 29) Field Training Officer (FTO) CIT course
- In collaboration with Probation:
 - 8-hour Probation CIT course
- Multiple monthly collaborative partner trainings

Positive Results

In FY 2022/23, 2,585 law enforcement and community partners received training from the CIT program:

- 292 law enforcement personnel completed the 40 Hour CIT Course
- 142 Field Training Officers (FTO) completed the 8 Hour FTO CIT Course
- 694 Probation Officers and Probation Correctional Officers completed the 8 Hour CIT Course
- 1,457 community partners, including fire, public employees, and emergency departments received specialized training from the CIT program

Demographics

Primary Language



69% English

<1% Spanish

30% Unknown/Other

N=2,585

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

“CIT training has a lot of great information. Every presenter was very knowledgeable and gave personal advice, guidance, and feedback.”

-CIT Student

Challenges/Solutions

Staffing shortages were one of the main challenges during FY 2022/23. Two out of the three Staff Training Instructors promoted to different departments. Additionally, in January 2023, it was mandated that all sworn personnel complete the 40 Hour CIT class, thereby increasing the demand for this course amid personnel challenges.

To continue providing courses, including accommodating increased demand amid staffing shortages, CIT cross-trained staff on existing courses to ensure coverage. Cross-training enabled the team to reassign training as needed and complete additional training. CIT leadership has also been working diligently with Human Resources on recruiting and filling vacant positions.

Outreach and Engagement

Through community education and outreach, DBH cultivates an environment in which the public is more knowledgeable of crisis mitigation and de-escalation skills, self-care, and suicide prevention, in addition to the diverse resources available for San Bernardino County residents who may be experiencing mental health and/or substance use disorder concerns.

For FY 2022/23, the CIT program conducted the following outreach and engagement activities:

Activity Type	Number of Activities	Total Number of Participants
Outreach/Networking Event	4	410
Community Collaborative Meeting	7	201
Gang and Drug Taskforce	5	110
40 Hour CIT Course	7	292
8 Hour Field Training Officer (FTO) Course	6	142
8 Hour Probation Dept. CIT Course	17	694
Community Partner Trainings	56	1,457
Total	102	3,306

Program Updates

Community Education Program (CEP) is a new and distinct program that will be part of the Crisis Intervention Training (CIT) program budget, but with distinct staff and its own CEP-specific expenditure tracking.

Certain training and instruction blocks for CIT course require a clinical subject matter expert. The CIT program will be expanding to include one Clinical Therapist I to fulfill this requirement. This in turn improves accessibility to services and fosters a more supportive community.

The CIT budget will require transferred existing funds for administrative costs related the implementation of the CEP program along with a budget increase to accommodate additional positions for program implementation and expansion.

“The exercises we did in class were a good eye opener as to what it’s like to deal with someone having a mental crisis.”

-CIT Student

“Wonderful presenters and resources shared. Can’t wait to incorporate the strategies in my classroom.”

-CIT Student



Artwork by Kamelyta

Community Education Program (CEP)

Program Name	Actual Number Served FY 2022/23	Estimated Number to be Served FY 2024/25	Annual Budgeted Funds FY 2024/25	Estimated Annual Cost per Person FY 2024/25
Community Education Program (CEP)	New Program	1,000	\$5,995,985*	\$661*

*Annual budget and cost per consumer represent CIT, CEP, and TEST.

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Ages 16+	N/A	Field-based 	General public, including but not limited to community-based organizations, faith institutions, education institutions, and government agencies

Program Description and Target Population

Community Education Program (CEP) will provide general behavioral health training opportunities to the public, which includes the coordination and facilitation of certified curriculum such as Mental Health First Aid (MHFA), Applied Suicide Intervention Skills Training (ASIST), SafeTALK (Suicide Alertness Training), and Listen, Empathize, Agree, and Partner (LEAP) trainings.

The CEP is a new and distinct program that will be part of the Crisis Intervention Training Program budget. Existing Workforce Education and Training staff and Public Relations staff and services that were forecasted and allocated in the Three-Year Plan are being transferred to meet the needs of

this new program. Initial implementation planned within this fiscal year and continued steps to extend into FY 2024/25.

Services Offered

- Community Trainings:
 - Mental Health First Aid
 - Applied Suicide Intervention Skills Training (ASIST)
 - SafeTALK
 - Listen Empathize Agree and Partner (LEAP)
- Community Behavioral Health Presentations

Triage, Engagement, and Support Teams (TEST)

Program Name	Actual Number Served FY 2022/23	Estimated Number to be Served FY 2024/25	Annual Budgeted Funds FY 2024/25	Estimated Annual Cost per Person FY 2024/25
Triage, Engagement, and Support Teams	3,378	6,077	\$5,995,985*	\$661*

*Annual budget and cost per consumer represent CIT, CEP, and TEST.

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

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

Program Description and Target Population

The main objective for the TEST program is the mitigation of unnecessary expenditures for law enforcement by reducing the amount of time law enforcement spends with individuals needing a behavioral health crisis intervention, thus reducing the number of encounters between law enforcement and individuals in behavioral health crisis.

TEST staff are co-located within 31 internal and external County partner agencies, including, but not limited to, law enforcement agencies, hospital emergency departments, and college campuses.

For additional information, please refer back to the [MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026](#), pages 234-238.

Demographics

Age

18% Children
22% TAY
49% Adult
11% Older Adult



Gender Identity



45% Male



55% Female



<1% Other

Race/Ethnicity

14% African American/ Black

2% Asian/Pacific Islander

43% Caucasian/White

35% Latinx/Hispanic

<1% Native American

4% Other/Unknown

N=638 Note: not all numbers add to 100 due to rounding.

Program Description and Target Population (cont.)

The TEST program provides exclusive support to these partnering departments and agencies. Staff respond in the field with law enforcement personnel and/or assist other partnering agency staff in managing consumer behavioral health crises. TEST provides follow-up case management services for up to 59 days, after initial contact, to link consumers with resources for ongoing behavioral health stability.

Three of the co-located sites are part of a new collaborative initiative known as Community Outreach and Support Teams (COAST). COAST are co-response units comprised of a TEST social worker; a firefighter Emergency Medical Technician (EMT) with a therapy canine; and a plain-clothed, specially trained police officer. TEST's role as part of a COAST team is consistent with other co-located partnerships. The purpose of this model is to provide consumers with rapid access to crisis triage in a non-threatening manner.

Services Offered

- Crisis assessment and intervention in the field
- Case management
- Support to collateral contacts
- Referrals and linkages to community resources and providers
- Family and caretaker education
- Consumer advocacy
- Education and support to law enforcement and community partners regarding behavioral health concerns and resources

Demographics

Primary Language

97% English
2% Spanish
1% Other/Unknown



Primary Diagnosis

6.1% Anxiety disorders	1.1% None/deferred
7.1% Bipolar disorders	24.1% Psychosis disorders
34.2% Depressive disorders	4.9% Substance use disorders
1.7% Disruptive disorders	19.4% Other
1.4% Neurodevelopmental/cognitive disorders	

N=638 Note: not all numbers add to 100 due to rounding.

Positive Results

TEST program data is captured based on an “encounter,” which means an instance in which TEST staff engage an individual for services. In FY 2022/23, TEST

- Recorded 11,077 encounters and
- Provided 12,714 referrals to behavioral health and community resources.

In FY 2022/23, 92% of TEST Crisis Interventions were diverted from hospitalization, compared to 70% in FY 2021/22.

During FY 2022/23, TEST provided mental health awareness events to specifically target underserved age groups at senior centers and local schools.

Challenges/Solutions

There was a slight decrease in encounters and referrals from FY 2021/22 – a 10% decrease in total encounters and a 28% decrease in referrals. These decreases can be attributed to vacancies at various co-location sites. There continues to be a priority placed on filling TEST staff vacancies to help meet the staffing needs.

In 2023, TEST added an additional two co-location sites throughout San Bernardino County. Continued expansion requires the program to balance staffing needs and budgetary constraints, as each co-location site requires infrastructure to accommodate the stationed staff, including, but not limited to, added costs for space, equipment such as laptops and mobile phones, etc. In addition, there is a crucial need to maintain a robust collaborative relationship with the various agencies. This can be challenging at times due to changes in leadership, staff turnover, time constraints, and various background requirements.

Solutions in progress include continued efforts in building and maintaining relationships with law enforcement and community partners.

Outreach and Engagement

For FY 2022/23, the TEST program conducted the following outreach and engagement activities:

Activity Type	Number of Activities	Total Number of Participants
Community Groups Collaboration	26	1,832
Law Enforcement Briefing	1,494	21,428
Homeless Outreach	7	105
CIT Presentations	3	140
Law Enforcement Outreach	20	1,409
School Outreach	6	310
Totals	1,556	25,224

Program Updates

There are no planned updates for this program.

Success Story

"Raj" was recently released from prison and referred by a Probation Officer to be assessed for mental health services after reporting being homeless. He had limited medication remaining and was not connected to a medical or mental health care provider. His Medi-Cal benefits were inactive, and he had no resources with which to obtain housing, transportation, food, or personal care. TEST staff provided him with a hygiene kit, a gift card for food, and linkage with Probation housing in the area, which he would be able to secure the next day. TEST also transported him to the Transitional Assistance Department, where he was able to receive an emergency Cal-Fresh and a Medi-Cal card. TEST staff assisted him with scheduling doctor appointments to establish care and request a referral for behavioral health and dental services. On the way to his housing accommodations, Raj said, "Man, you're a miracle worker!" TEST staff continued to work closely with him for the next few weeks, checking in and inquiring of his progress and encouraging him to continue job searching. One month after his initial encounter, Raj visited the TEST office. He stood tall, his hair was pulled back, and he wore brand new clothes and shoes. He proudly informed staff that he had gotten a job and expressed gratitude for the staff who assisted him.

Success Story

COAST responded to a call involving a family's challenges with their autistic child "Riley." Riley was connected to services through Inland Regional Center (IRC) and had recently participated in partial hospitalization and residential treatment but was discharged early due to insurance issues. His mother did not feel like he benefited from the program due to his difficulties adjusting. She expressed concerns about Riley starting school, in addition to not knowing how to properly advocate for and support him in this transition. The COAST team provided the family with some suggestions to help ease Riley back into school, including contacting the school to request a walk-through of the campus so he could become reacquainted with the campus and locate his classes; discussing Riley's Individualized Education Plan (IEP) to communicate new needs; requesting advocates/coaches through IRC; and joining the Community Advisory Committee in their school district for support. The family was also encouraged to communicate with Riley about his needs and feelings. Riley stated that he felt his mother was too protective at times and did not allow him enough independence, indicating that he wanted to make mistakes so he can learn from them. The team encouraged the family to allow him to attempt tasks for himself, when safe, before helping him. Riley has now returned to school and is successfully adjusting, and his mother is meeting with the school to update his IEP to appropriately meet his needs.

Introduction

The Crisis Stabilization System of Care operates as part of the 24-Hour and Emergency Services Division of DBH. The services offered through these programs are centered on providing immediate intervention along with stabilization services to consumers who are experiencing a mental health crisis. These care options are accessible through various settings operated by contracted treatment providers with DBH including Fee-For-Service Lanterman-Petris-Short (LPS) hospitals, Crisis Stabilization Units (CSUs), Crisis Walk-In Centers (CWICs), and Crisis Residential Treatment Centers (CRTs).

Target Population

The table below demonstrates the target population of consumers to be served by programs within the Crisis Stabilization System of Care for Fiscal Year 2024/25. The target population is broken up into MHSA age categories: MHSA age categories are: Children, TAY, Adult, and Older Adult.

Crisis Stabilization System of Care Programs				
Program Name	Target Population			
	Children	TAY	Adults	Older Adult
Crisis Walk-In Center (CWIC)	X	X	X	X
Crisis Stabilization Unit (CSU)	X	X	X	X
Crisis Residential Treatment (CRT)		X	X	

CSS: Crisis Stabilization System of Care

Number of Consumers to be Served

The table below demonstrates the estimated number of consumers to be served by age and service categories for Fiscal Year 2024/25:

Program Name		Ages Served	Service Area*
Crisis Walk-In Center		212 Children 496 TAY 1,246 Adult 145 Older Adult	2,099 GSD
		TOTAL = 2,099	TOTAL = 2,099
Crisis Stabilization Unit		433 Children 1,110 TAY 3,138 Adult 259 Older Adult	4,940 GSD
		TOTAL = 4,940	TOTAL = 4,940
Crisis Resident Treatment	Adult CRT	50 TAY 416 Adult	466 GSD
		TOTAL = 466	TOTAL = 466
	TAY CRT	101 TAY	101 GSD
		TOTAL = 101	TOTAL = 101

*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.

Crisis Stabilization Unit (CSU)

Program Name	Actual Number Served FY 2022/23	Estimated Number to be Served FY 2024/25	Annual Budgeted Funds FY 2024/25	Estimated Annual Cost per Person FY 2024/25	Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Crisis Stabilization Unit (CSU)	5,665*	4,940	\$13,623,215**	\$1,935**	All Ages	All Levels	Clinic-based 	Experiencing a mental health crisis

*This number does not include O&E.
**Annual budget and cost per consumer represent both CWIC and CSU.

Program Description and Target Population

Crisis Stabilization Units (CSUs) provide voluntary mental health urgent care services in a community-based setting for consumers in need of immediate crisis stabilization as a result of a mental health crisis. Programs operate 24/7, and services last for less than 24 hours. Each facility has 20

spaces for crisis stabilization services which includes 16 for adults (aged 18 and older) and 4 for children and adolescents (aged 17 and under). CSU facilities are intended to serve as a home-like, community-based alternative to unnecessary psychiatric hospitalization or incarceration. Services are available to individuals of all ages experiencing a mental health crisis.

Demographics

Age

10% Children

22% TAY

62% Adult

6% Older Adult

N=5,244



Gender Identity



55%

Male



45%

Female



<1%

Other

Race/Ethnicity

20% African American/ Black

25% Caucasian/White

<1% American Indian/ Alaska Native

2% Asian/Pacific Islander

49% Latinx/Hispanic

3% Other/Unknown

Primary Language



96% English

4% Spanish

<1% Other

Services Offered

- Crisis intervention and stabilization
- Psychiatric evaluation and medication, if needed
- Voluntary peer-to-peer enriched engagement and support
- Substance use disorder screening, assessment, and referral/linkage
- Therapeutic interventions

Positive Results

The two CSU programs served a combined total of 5,665 unique consumers during FY 2022/23, a 24.7% increase from FY 2021/22. These programs provided a combined 8,728 crisis stabilization services to these consumers.

Of the 8,728 admissions, 95.9% were successfully diverted from psychiatric hospitalization at the time of receiving CSU services.

In FY 2022/23, the two CSUs received referrals from a total of 368 unique collaborative partners, including psychiatric hospitals, hospital emergency departments, outpatient clinics, substance use treatment providers, law enforcement agencies/officers, schools, faith-based organizations, shelters, and other community agencies.

- 247 referrals to these programs originated from law enforcement, who utilize the CSUs as an alternate destination to psychiatric hospitals or detention facilities when encountering a mental health crisis in the community.
- 111 referrals to these programs originated from local hospitals, representing a population whose crisis was appropriately manageable at the CSU rather than at the inpatient level of care.

Voluntary consumer satisfaction surveys were provided to consumers who received crisis stabilization services. Out of 4,030 surveys issued, the programs received a combined 90.4% consumer satisfaction rate with the services received.

Demographics



Primary Diagnosis

11.3% Anxiety disorders	1% Neurodevelopmental/Cognitive
10% Bipolar disorders	30.5% Psychosis disorders
22.1% Depressive disorders	4.6% Substance Related
3.1% None/deferred	<1% Disruptive disorders
16.5% Other	

N=5,244

For additional information, please refer back to the [MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026](#), pages 241-245.

Challenges/Solutions

Maintaining qualified personnel to deliver crisis stabilization services remains a challenge as remote work opportunities become more commonplace in the healthcare environment. As CSU regulations require on-site staff 24/7, remote work is not available to direct care staff, which impacts recruitment and retention.

To ensure ongoing availability of services and to combat workforce challenges, CSUs have a robust intern program, for clinical roles, that allows them to maintain a solid recruitment pipeline from internship to graduation.

For programs housed in county-owned buildings, standard facilities management procedures created delays in addressing building-related issues communicated by CSU staff.

Improvement in communication between the CSUs and DBH/County Facilities Management has facilitated smoother completions of work orders. The improved communication and new workflow have been valuable in expediting critical fixes as the needs arise.

CSUs serve a high volume of consumers experiencing co-occurring mental health and substance use disorders who are either currently connected or needed to be connected with Medication Assisted Treatment (MAT) services to assist them with their substance use disorder recovery.

The CSUs have not historically been authorized to provide these services per their contract.

As of October 2023, the CSU contracts will be modified to enable CSU psychiatrists to prescribe medications approved by the FDA for use in MAT services. This will increase the likelihood that they will continue with their medication support needs and reduce potential hospitalizations due to relapse or overdose. The service will be available to individuals who are admitted to the CSU with a primary mental health diagnosis who may also benefit from this treatment option. MAT services will be available in a phased integration approach:

Phase 1: CSUs will provide bridge MAT services to consumers discharged from Crisis Residential Treatment (CRT) who are already receiving this service and are at risk of service interruption due to limited DBH clinic availability.

Phase 2: CSUs will provide bridge MAT services to consumers admitted to the CSU from any referring source who are already receiving this service and are at risk of service interruption due to limited DBH clinic availability.

Phase 3: CSUs will initiate and/or provide bridge MAT services to consumers admitted to the CSU who may benefit from this treatment option.

Outreach and Engagement

CSU staff and DBH provide frequent outreach presentations to the community and to partnering agencies to increase awareness of the availability of this service, educate on program criteria and how to appropriately refer, and how CSU programs coordinate with the DBH continuum of care.

During FY 2022/23, the CSU program conducted the following outreach and engagement activities:

Activity Type	Number of Activities	Total Number of Participants
Telephone or Electronic Outreach Correspondence	113	267
Collaborative Meetings and Events	47	814
Presentations	35	1,292
Tours	2	10
Totals	197	2,383

Success Story

"Lester" visited the CSU multiple times in the first several months of the fiscal year. He was homeless and struggled with co-occurring mental health and substance use disorders. During initial visits, the severity of his mental health symptoms and substance use had prevented him from stabilizing long enough to see the psychiatrist and obtain much-needed medication. At a later date, he came in sober, stabilized overnight, and was able to complete a referral to a Full Service Partnership and obtain a medication refill. A result of the consistent efforts of the CSU team and Lester's willingness to commit to recovery, he later reported that he had successfully transitioned to a room and board and was regularly taking his medication.

Program Updates

There are no planned updates for this program.

Success Story

"Thanh" was brought to the CSU by law enforcement. She was homeless and had been living in an abandoned building after moving to California. She had a history of substance use, and she felt uncertain about receiving treatment and fearful about trusting the team. The team used extra sensitivity with her and worked on helping her feel safe so she could acclimate to the program. After being assessed by a nurse, clinician, and psychiatrist, Thanh was noted to have bruising around her wrists and ankles and was complaining of abdominal pain. She was transported to a hospital emergency room to ensure she received medical care. Staff remained with her in the ER as a source of support since she was fearful about trusting others. When she was admitted to the hospital, the receiving nurse informed the CSU staff that Thanh was a missing person, indicating a picture of her which was posted in the ER. The receiving nurse reported that the hospital would ensure law enforcement was contacted after she was medically stabilized to reunite Thanh with her family.

Crisis Walk-In Center (CWIC)

Program Name	Actual Number Served FY 2022/23	Estimated Number to be Served FY 2024/25	Annual Budgeted Funds FY 2024/25	Estimated Annual Cost per Person FY 2024/25
Crisis Walk-In Center (CWIC)	2,207*	2,099	\$13,623,215**	\$1,935**

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
All ages	All Levels	Clinic-based 	Experiencing a mental health crisis

*This number does not include O&E.
**Annual budget and cost per consumer represent both CWIC and CSU.

Program Description and Target Population

Crisis Walk-In Centers (CWIC) provide voluntary mental health urgent care services in a community-based setting for consumers in need of immediate crisis stabilization as a result of a mental health crisis. Programs operate 24/7, and services last for less than 24 hours. Each facility has 12 spaces for crisis stabilization services. CWIC facilities are

intended to serve as a community-based alternative to unnecessary psychiatric hospitalization or incarceration. Services are available to individuals of all ages experiencing a mental health crisis.

For additional information, please refer back to the [MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026](#), pages 246-250.

Demographics

Age



12% Children
23% TAY
58% Adult
7% Older Adult
N=2,207

Gender Identity



50% Male
49% Female
<1% Other

Race/Ethnicity

18% African-American/Black
45% Caucasian/White
1% American Indian/Alaska Native

1% Asian/Pacific Islander
20% Latinx/Hispanic
15% Other/Unknown

Primary Language



98% English
1% Spanish
1% Other/Unknown

Services Offered

- Crisis intervention and stabilization
- Psychiatric evaluation and medication, if needed
- Voluntary peer-to-peer enriched engagement and support
- Substance use disorder screening, assessment, and referral/linkage
- Therapeutic interventions

Positive Results

The two CWIC programs served a combined total of 2,207 unique consumers during FY 2022/23. These programs provided a combined 3,415 crisis stabilization services to these consumers.

Of the 3,415 admissions, 93% were successfully diverted from psychiatric hospitalization at the time of receiving CWIC services.

Demographics

Primary Diagnosis

13.3% Anxiety disorders	29.6% Psychosis disorders
15.4% Bipolar disorders	3% Substance use disorders
27% Depressive disorders	9% Other
1% Disruptive disorders	<1% None/Deferred
1% Neurodevelopmental/cognitive disorders	



N=2,207

Voluntary consumer satisfaction surveys were provided to consumers who received crisis stabilization services at the CWICs. Out of 1,454 surveys issued by the two CWICs, the programs received a combined 94% consumer satisfaction rate with the services received.

Success Story

"Marco" came into the CWIC exhibiting a variety of severe mental health symptoms, which he reported he had been struggling with for consecutive days. He was homeless and stated that [his] voices implored him to stay on the streets, which led to having thoughts of wanting to hurt himself. Throughout his time at the CWIC, Marco received counseling and support, and he was eventually connected to the local Crisis Residential Treatment (CRT) where he could continue his stabilization efforts in a residential environment to support his ongoing treatment and recovery. Before he left to go to the CRT, his mood had brightened, and he no longer had thoughts of self-harm. He reported feeling uplifted by CWIC staff, and he was able to hold onto hope for the future.

Challenges/Solutions

The CWICs experienced challenges with recruitment and hiring, especially amid increasing demand for remote work availability, which is not possible for CWICs due to the nature of the services provided by the program.

To address workforce challenges, CWICs completed market rate adjustments to remain competitive with other providers and implemented sign-on bonuses to boost recruiting and increase candidate pools.

Outreach and Engagement

CWIC staff and DBH provide frequent outreach presentations to the community and to partnering agencies to increase awareness of the availability of this service, educate on program criteria and how to appropriately refer, and how CWIC programs coordinate with the DBH continuum of care.

For FY 2022/23, the CWIC program conducted the following outreach and engagement activities:

Activity Type	Number of Activities	Total Number of Participants
Presentations and Collaborative Meetings	106	389
Totals	106	389

Program Updates

Effective for FY 2023/24, the annual allocation for the CWIC programs will be increasing to enable them to continue providing much-needed services to the High Desert and Eastern Desert areas of San Bernardino County. Additionally, this increase will allow these providers to remain in compliance with staffing and service requirements outlined by the Department of Health Care Services (DHCS).

Success Story

"Giselle" visited the CWIC multiple times over the course of several months. She was homeless and was struggling with symptoms of an acute mental illness for which she was resistant to accept a diagnosis. The CWIC provided resources and linkages for Giselle each time she visited; however, due to the severity of her symptoms, she was unable to maintain a connection with the linkages she received. CWIC staff continued to work with her and provide support despite her resistance to her diagnosis. Staff were able to alleviate some of the inherent internal stigma she carried about having a mental illness and seeking treatment for it. As a result, the CWIC was able to connect her with a Crisis Residential Treatment (CRT) program. Giselle was admitted to the CRT and was reported to be actively participating in the program and in her treatment.

Adult Crisis Residential Treatment (CRT)

Program Name	Actual Number Served FY 2022/23	Estimated Number to be Served FY 2024/25	Annual Budgeted Funds FY 2024/25	Estimated Annual Cost per Person FY 2024/25
Adult Crisis Residential Treatment	474*	466	\$16,119,345**	\$28,429**

*This number does not include O&E.
**Annual budget and cost per consumer represent both adult and TAY CRTs.

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Ages 18-59	SMI*	Facility-based 	Experiencing a behavioral health crisis

*SMI = serious mental illness

Program Description and Target Population

The Adult Crisis Residential Treatment (CRT) program offers short-term, voluntary crisis residential treatment options for San Bernardino County residents ages 18 to 59. Individuals may stay for up to 90 days to receive services in a home-like environment that supports and promotes the individual’s

recovery, wellness, and resiliency within the community. Services are for individuals who are experiencing an acute psychiatric episode or mental health crisis and are in need of short-term crisis residential treatment services to deter acute psychiatric hospitalization. CRT programs operate 24-hours a day, 7 days a week, 365 days a year.

Demographics

Age

0% Children
12% TAY
88% Adult
<1% Older Adult



Gender Identity



64% Male



36% Female

Race/Ethnicity

26% African American/Black
35% Caucasian/White
1% American Indian/
Alaska Native

3% Asian/Pacific Islander
31% Latinx/Hispanic
4% Other/Unknown

Primary Language



98% English
<1% Spanish
<1% Other

N=432

Services Offered

- Comprehensive clinical assessments and therapy
- Crisis intervention
- Psychiatric and medication support
- Life skills coaching
- Peer and family support networks
- Coping techniques
- Recovery education
- Substance use education
- Community resource linkages

Positive Results

During FY 2022/23, 474 unique consumers were served by the four adult CRT programs. Of consumers who were discharged from the program during the fiscal year, 93.8% were successfully diverted from psychiatric hospitalization at the time of receiving CRT services.

DBH contracts with two agencies for the delivery of CRT services. Each agency delivers a unique, voluntary consumer satisfaction survey after discharge from the facility.

The first contract agency operates three CRT programs and evaluates consumer agreement with twenty statements including, but not limited to:

- I felt safe and supported during my crisis.
- I am more resilient and am more likely to overcome challenges after participating in the program.
- Staff understood, respected, and sympathized with my unique abilities.

Out of 90 surveys, these three programs received a combined average 94.8% consumer satisfaction rating across all satisfaction questions, indicating that 94.8% of respondents agreed or strongly agreed with the given statements.

Demographics



Primary Diagnosis

4.1% Anxiety disorders	50% Psychosis disorders
12.3% Bipolar disorders	6.9% Substance use disorders
22% Depressive disorders	3% Other
<1% Disruptive disorders	1.4% None/Deferred

For additional information, please refer back to the [MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026](#), pages 251-255.

N=432

Positive Results (cont.)

The second contract agency operates one CRT program and evaluates consumer agreement with twelve statements including, but not limited to:

- As a direct result of the services I received, I am better able to deal with crisis.
- Staff here believed that I could grow, change, and recover.
- I was able to get all the services I thought I needed.

Out of 65 surveys, this program received an average 91.5% consumer satisfaction rating across all satisfaction questions, indicating that 91.5% of respondents agreed or strongly agreed with the given statements.

Challenges/Solutions

In FY 2022/23, the CRTs experienced challenges with recruitment and hiring, especially amid increasing demand for remote work availability, which is not possible for CRTs due to the nature of the services provided by the program. The CRTs completed market rate adjustments to remain competitive with other providers, implemented sign-on bonuses to boost recruiting and increase candidate pools, and hired a talent acquisition manager/team to engage in more targeted recruitment efforts such as hiring fairs and virtual recruitment projects to address the staffing shortage.

The CRTs reported that an increased number of consumers

admitted into the program with a history of trauma and Post-Traumatic Stress Disorder (PTSD), which necessitated amendments to programming and increased awareness training for care staff. To address the changing needs of the consumer population, the CRTs prioritized Adverse Childhood Experiences (ACE) screening tools, provided recovery-oriented and evidence-based interventions, emphasized the importance of trauma-informed care through hiring choices and workforce development, and worked to promote staff wellness.

The CRTs served a high volume of consumers experiencing co-occurring mental health and substance use disorders who are currently connected or need to be connected with Medication Assisted Treatment (MAT) services to assist them with their substance use disorder recovery. The CRTs have not historically been authorized to provide these services per their contract.

As of October 2023, the Wellspring CRT contract was modified to enable CRT psychiatrists to prescribe medications approved by the FDA for use in MAT services. This service increases the likelihood that CRT consumers will continue with their medication support plans and reduces potential hospitalizations due to relapse or overdose for this population. The service will be available to individuals who are admitted to the CRT with a primary mental health diagnosis, are currently connected with MAT services, and are at risk of service interruption due to limited DBH clinic availability.

Outreach and Engagement

For FY 2022/23, the CRT program conducted the following outreach and engagement activities:

Activity Type	Number of Activities	Total Number of Participants
Tours and presentations for Community- or Faith-Based Organizations	50	225
Tours and presentations for DBH programs, contracted programs, or clinics	10	34
Tours and presentations for healthcare providers and hospitals	18	64
Tours and presentations for other audiences, including law enforcement and schools	15	68
Totals	93	391

Program Updates

Effective for FY 2023/24, the annual allocation for all CRT programs will be increasing to enable them to remain in compliance with staffing and service requirements outlined by the Department of Health Care Services (DHCS) and the California Department of Social Services (CDSS), Community Care Licensing Division (CCLD).

Success Story

“Mateo” entered the CRT with a lengthy history of suicidal ideation and psychosis, both of which exacerbated his co-occurring substance use disorder. During his 70-day stay, Mateo was able to take advantage of the program’s weekly psychiatric visits, daily medication compliance, individual therapy with his clinician, and group therapy activities to build his coping skills and resiliency. When he left the program, he reported to the program team, “I’m so grateful for everything this program was able to provide me. I couldn’t have accomplished all of this without you.”

If all of these additional tasks with my care couldn’t have been accomplished, I know that on my discharge day, I would have chosen not to go to drug rehab. I would have gone back to living in homeless encampments, stopped taking meds or going to appointments, and been back on the streets using.”

Success Story

“Akin” was referred to the CRT from staff at the local psychiatric unit who felt he needed more support and treatment upon discharge from the facility. While in the program, he struggled with acclimating to the program, and was eventually able to change some of his behaviors that caused challenges with some of his peers. The consumer's symptoms led to him saying and doing inappropriate things at times, but he was able to adjust his behavior. He developed multiple coping skills while here and his overall mood was much more stable. He had come from out of state without a plan and just wanted to leave his family. During his time in the program, he improved his relationship with his family and returned to the city where they lived, maintaining separate living quarters to keep healthy boundaries.

TAY Crisis Residential Treatment (CRT)

Program Name	Actual Number Served FY 2022/23	Estimated Number to be Served FY 2024/25	Annual Budgeted Funds FY 2024/25	Estimated Annual Cost per Person FY 2024/25
TAY Crisis Residential Treatment	109	101	\$16,119,345*	\$28,429*

*Annual budget and cost per consumer represent both adult and TAY CRTs.

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Ages 18-25	SMI*	Facility-based 	Experiencing a behavioral health crisis

*SMI = serious mental illness

Program Description and Target Population

TAY CRT, a specialty CRT for Transitional-Age Youth (TAY) colloquially known as “The STAY”, is a short term, voluntary residential treatment center. The STAY accepts consumers ages 18-25 who are experiencing a mental health crisis. Individuals may stay for up to 90 days and receive services in a home-like environment that supports and promotes the consumer’s recovery, wellness, and resiliency within the community. The STAY increases access to appropriate

mental health services for TAY in crisis. Co-located with the DBH One-Stop TAY Center in San Bernardino, this unique program provides comprehensive and collaborative TAY-targeted services to support maximum recovery for young adults.

For additional information, please refer back to the [MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026](#), pages 256-259.

Demographics

Age

0% Children

97% TAY

3% Adult

0% Older Adult



N=109

Gender Identity



50% Male



50% Female

Race/Ethnicity

30% African American/Black

18% Caucasian/White

0% American Indian/ Alaska Native

2% Asian/Pacific Islander

48% Latinx/Hispanic

2% Other/Unknown

Primary Language



97% English

3% Spanish

San Bernardino County Department of Behavioral Health - MHSA 286

Services Offered

- Comprehensive clinical assessments and therapy
- Therapeutic and psycho-educational groups
- Activities and training that focus on daily living skills
- Behavioral intervention and modification training
- Individual and group counseling
- Crisis intervention
- Psychiatric and medication support
- Substance use disorder counseling and referrals
- Recreational therapy
- Educational assistance
- Pre-release and discharge preparation and planning

Positive Results

In FY 2022/23, 109 unique consumers were served by TAY CRT. Of consumers who were discharged from the program during the fiscal year, 95.7% were successfully diverted from psychiatric hospitalization at the time of receiving CRT services.

Demographics

Primary Diagnosis

8.3% Anxiety disorders	20.2% Depressive disorders
18.4% Bipolar disorders	39.5% Psychosis disorders
<1% None/deferred	6.4% Other
6.4% Substance Use disorder	

N=109

The TAY CRT received referrals from a total of 34 unique collaborative partners, including psychiatric hospitals and hospital emergency departments, Crisis Stabilization Units (CSU) and Crisis Walk-in Centers (CWIC), outpatient clinics, law enforcement agencies/officers, and community agencies.

Challenges/Solutions

During FY 2022/23, TAY CRT experienced challenges with recruitment and hiring, especially amid increasing demand for remote work availability, which is not possible for CRTs due to the nature of the services provided by the program.

To address workforce challenges, TAY CRT completed market rate adjustments to remain competitive with other providers and implemented sign-on bonuses to boost recruiting and increase candidate pools.

Additionally, an increasing number of TAY consumers are being routed to the adult-oriented CRT programs instead of being referred to TAY CRT first. While all CRT programs deliver quality services that support each individual's stabilization and recovery amid their mental health crisis, TAY CRT programming includes age-appropriate interventions, collaborations, and linkage/referral opportunities that target the TAY age group.

To address this concern, TAY CRT increased outreach to community partners, ensured they understood the benefits of connecting the consumer to the TAY, and worked with other CRTs to coordinate age-appropriate care.

Success Story

"Brigitte" was at TAY CRT for 78 days struggling with suicidal ideation and exhibiting severe mental health symptoms, which were exacerbated by homelessness. Following her stay at the CRT, she was successfully linked to a Full Service Partnership (FSP) program for housing and outpatient mental health services.

Outreach and Engagement

For FY 2022/23, the TAY CRT program conducted the following outreach and engagement activities:

Activity Type	Number of Activities	Total Number of Participants
Discharge Planning Collaboratives with DBH Programs	39	232
Totals	39	232

Program Updates

Effective for FY 2023/24, the annual allocation for the TAY CRT program will be increasing to enable the program to remain in compliance with staffing and service requirements outlined by the Department of Health Care Services (DHCS) and the California Department of Social Services (CDSS), Community Care Licensing Division (CCLD).

Success Story

"Natasha" presented at TAY CRT experiencing suicidal ideation in addition to co-occurring mental health and substance use disorders. She struggled to process past trauma and remain sober. During her 75-day stay, TAY CRT was able to successfully engage her and equip her with long-term skills for recovery and maintaining sobriety. Upon discharge, Natasha was successfully linked to the DBH Premier Program for housing and ongoing mental health services.

Introduction

Peer Support Programs is a newly identified division that coordinates service delivery efforts that offer stigma-free, peer support for consumers living with serious mental illness and/or seeking recovery from substance use and their family members. This person-centered, strengths-based approach embraces and incorporates each individual's lived experience into the recovery and support process. Peer Support Programs include Clubhouses, Community Connections, and Peer Provider Workforce Support.

Clubhouses are peer support centers that are recovery oriented for consumers 18 years or older. There are nine clubhouses located throughout the county that are dedicated

to assisting consumers living with a serious mental illness or seeking recovery from substance use. Clubhouses are primarily consumer-driven and operate with minimal support from department staff. Clubhouse members drive all operations decisions such as support groups, community engagement, staffing, and activity choices.

The **Community Connections Program** focuses on connecting consumers ages 16 and over with opportunities such as improving pre-employment skills, volunteering, paid employment, and engaging in peer support. Participants partner with Employment Specialists to maximize their existing skills, while also considering their individual wellness goals in relation to potential community commitments.

Peer Provider Workforce Support Program, formerly titled Peer Workforce, the Peer Provider Workforce Support Initiative continues DBH's commitment to growing, supporting, and improving the inclusion of a fully integrated peer workforce. In FY 2023/2024 these efforts were shifted under the newly formed Peer Programs division. Current efforts include ongoing support of Peer Certification, identification of department wide training needs, regularly scheduled engagement meetings with peer providers, and targeted training efforts for supervisors of peer providers.



Artwork by Stacy McLemore

For additional information, please refer back to the [MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026](#), pages 260-266.

Program Name	Actual Number Served FY 2022/23	Estimated Number to be Served FY 2024/25	Annual Budgeted Funds FY 2024/25	Estimated Annual Cost per Person FY 2024/25
Clubhouse and Community Connections	28,694	22,500	\$5,945,850	\$264

Number of Consumers to be Served

The table below demonstrates the estimated number of consumers to be served for the upcoming fiscal year.

Program	Service Area*	Total Served
Clubhouse and Community Connections	• 2,500 GSD • 20,000 O&E	22,500

*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.

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
18+	BHC*	Facility-based 	Seeking recovery-based support services

*BHC = Behavioral Health Challenges

Target Populations

The table below identifies the target population of consumers to be served by the Clubhouse and Community Connections program for the upcoming fiscal year.

Program Name	Target Population			
	Children	TAY	Adult	Older Adult
Clubhouse		X	X	X
Community Connections		X	X	X
Peer Provider Workforce Support Program	X	X	X	X

Program Description and Target Population

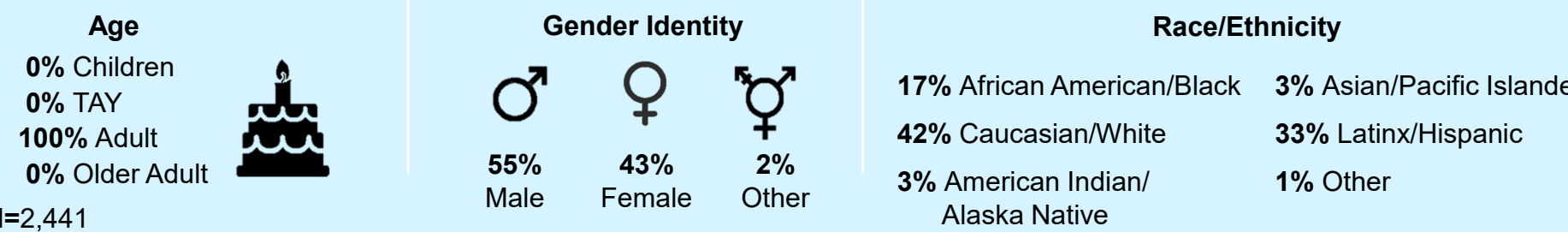
Clubhouses are peer-driven support centers for adults aged 18 and over in recovery. Clubhouses provide peer-run programs using a Recovery, Wellness, and Resilience model in a stigma free environment for adults, referred to as members, managing their behavioral health. Members do not need to be receiving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



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.

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

Program Description and Target Population (cont.)

Members plan and facilitate daily activities and determine workshop topics. Clubhouses also sponsor social and recreation 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, in order to ensure the consumer’s feedback is being captured in the stakeholder process.

The Community Connections 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



98% English
1% Spanish
<1% Other

Region

10% Central Valley
11% Desert/Mountain
29% East Valley
50% West Valley

N=2,441

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

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 of certification are currently in the design and implementation phase. Currently 18 of the 36 filled PFA positions have received certification and an additional 16 are in process.

This unit will also coordinate 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.

“Thank you for allowing me to be part of the family at the Clubhouse. I got a job that I love and am renting a room on my own. Things have turned around for me and part of that is because of you encouraging me to do and be.”

– Former Clubhouse Member

Services Offered

- 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 2022/23, Clubhouses averaged over 100 groups per month per site with an average attendance of at least 8 consumers per group. Clubhouses averaged over 220 unhoused members per month for a 22% increase from the past fiscal year and provided over 1,130 service deliveries per month for a 41% increase compared to the past fiscal year.

Community Connections served 151 participants with 37 successful connections to sustained paid employment. Of the consumers served, 12 individuals were resourced to other opportunities, such as volunteer positions, and 73 remain actively working with the Employment Support Specialists.

Clubhouse and Community Connections utilize the “Consumer Empowerment Evaluation” consumer created outcomes metrics tool created in FY 2021/2022. This tool was created in partnership with the Consumer Evaluation Council (CEC) and DBH Research and Evaluation. After researching validated 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 in order to preserve the integrity of measuring subjective suffering. There were 206 consumers that took the evaluation with the following outcomes resulting from clubhouse participation:

- 85% of consumers reported being satisfied with themselves.
- 97% of consumers reported having respect for themselves and others.
- 96% of consumers reported being hopeful about their future.
- 97% reported having goals they want to reach.
- 86% reported being able to understand themselves better.
- 82% reported being able to develop positive relationships with other people.
- 87% reported being able to keep themselves and their space clean.
- 89% reported a sense of belonging.
- 97% reported believing it is possible to change.
- 85% reported being able to maintain peace of mind and tranquility.
- 94% reported being able to forgive themselves and others.
- 92% reported being able to speak openly in a group.

Positive Results (cont.)

As the number of consumers who attend the program identify as unhoused continues to rise, these supports have also increased. Clubhouses have increasingly tried to meet members where they are at. In addition to weekly community meals, all locations now offer daily meal support. Clubhouses have access to mobile jump starters for consumers who are living in their vehicle and encounter battery issues. Increased hygiene support including laundry soap, dryer sheets, shampoo, conditioner, oral hygiene, deodorant, emergency clothing, condoms, etc. are available at all locations. Specifically, shampoo and conditioners have been added for all hair textures. Clubhouses also offer tarps, ponchos, sunscreen, and other weather-related supports for those exposed to the elements.

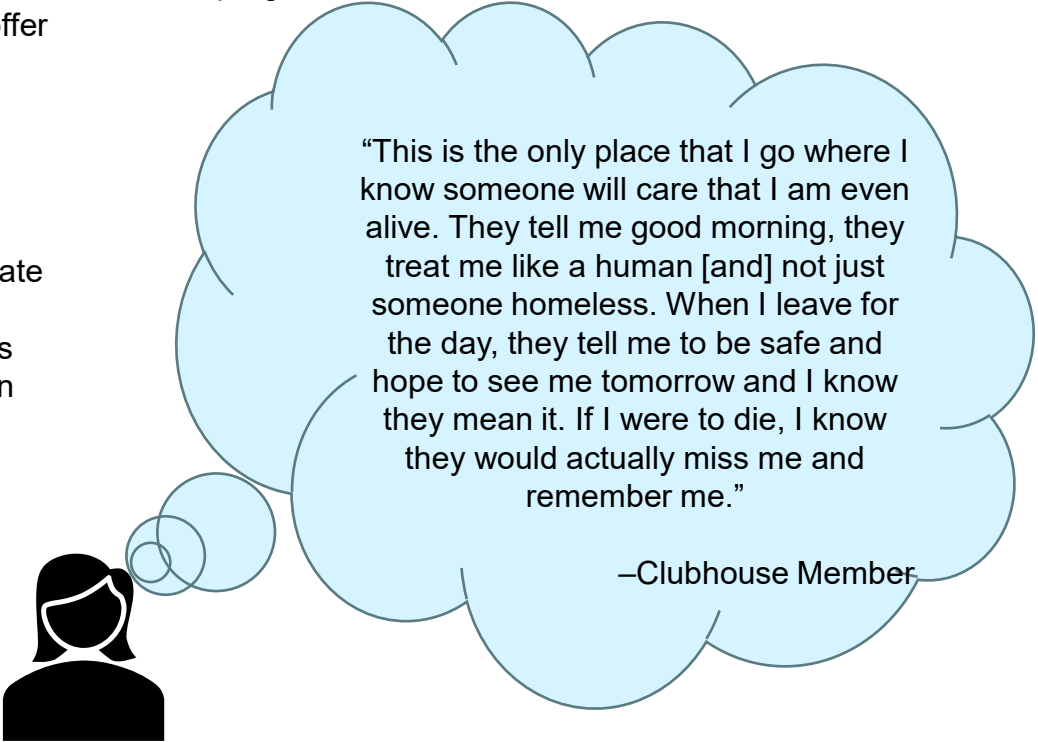
Challenges/Solutions

Expanding facilities, to appropriate levels, to accommodate the increased population continues to be delayed. As a result, some sites continue to be without shower facilities and have inadequate space for programming. Relocation of the Victorville, Barstow, and San Bernardino sites are still not complete.

Clubhouses continue to work towards addressing the expressed need for more space at several of the sites. Facilities and Project Management staff are continuing

efforts to complete negotiations for pending relocations. Prior stalls during and post Covid resulted in cost increases as a result of inflation. Adjustments have been made to project budgets, and all sites are actively moving towards contract completion and the start of construction.

In response to uncertainty regarding who is eligible for services, statements and standardized rules were added to the brochure and DBH website to clarify that members do not need to be currently receiving clinical services to participate in the program.



“This is the only place that I go where I know someone will care that I am even alive. They tell me good morning, they treat me like a human [and] not just someone homeless. When I leave for the day, they tell me to be safe and hope to see me tomorrow and I know they mean it. If I were to die, I know they would actually miss me and remember me.”

—Clubhouse Member

Outreach and Engagement

Clubhouses continue to outreach to and engage unserved and underserved populations through resource support and cultural education opportunities. Clubhouses celebrated and learned about a variety of cultural moments in FY 2022/23 such as Lunar New Year, Juneteenth, Pride, and Cinco de Mayo. The Clubhouse and Community Connections conducted the following outreach and engagement activities:

Activity Type	Number of Activities	Total Number of Participants
Community Integration Excursions	25	373
Crisis Intervention Training	12	900
Cultural Celebrations	24	1,300
Behavioral Health Wellness Triathlon	3	375
Community Food Distribution	36	20,500
Consumer Evaluation Council	24	240
Unhoused Outreach	12	2,414
Community Connections	12	151
Totals	148	26,253

Program Updates

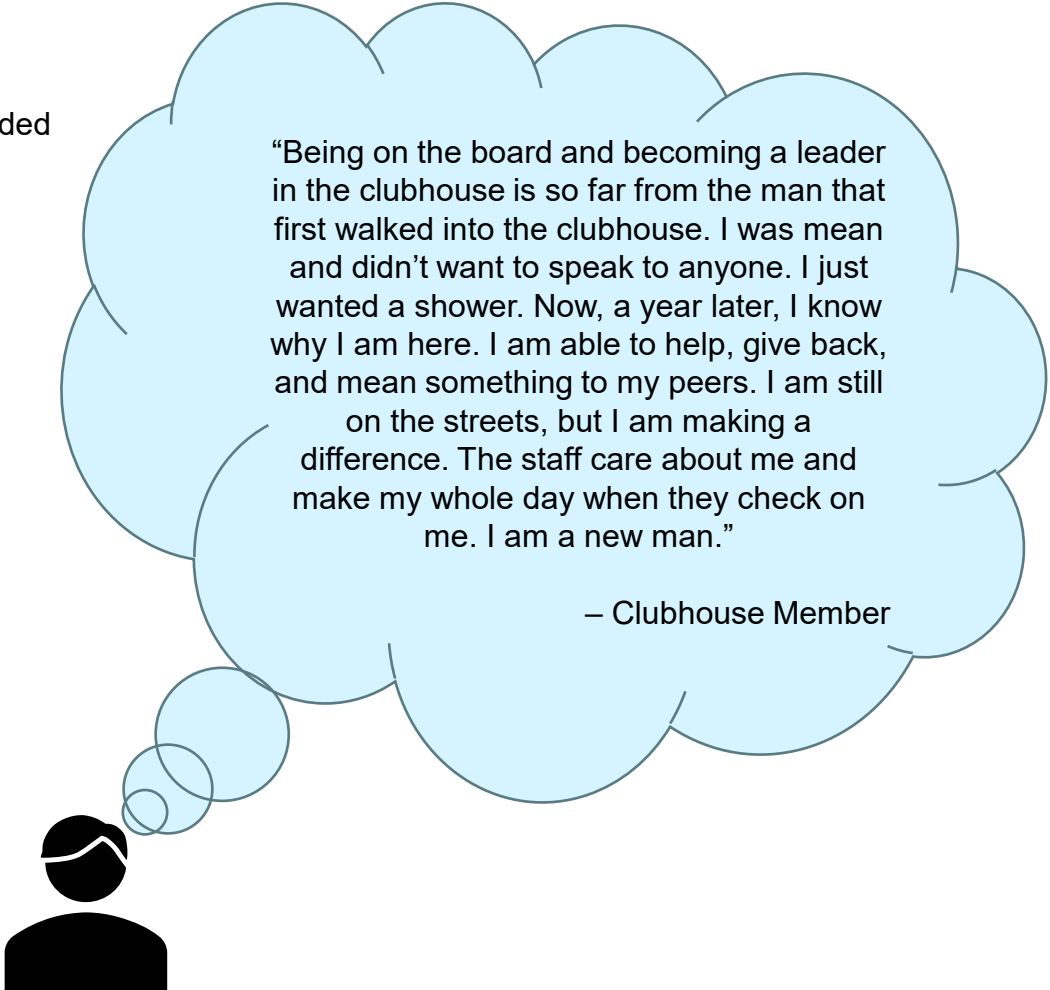
In FY 2022/23, DBH continued the work to recognize the benefit of peer support providers, paving the way for Department of Healthcare Services (DHCS) to establish “Peer Support Specialists” as a provider type for both mental health and substance use support services. The Peer Provider Workforce Support Program was developed to support DBH as it works to grow its peer support staff. Plans to receive additional staffing dedicated to Peer Workforce, as outlined in the MHSA Three-Year Integrated Plan, shifted to include administrative leadership staff instead of Workforce Education and Training (WET) staff in order to better begin long term planning and integration supports. WET will continue to develop trainings geared towards helping peers meet their new Continuing Education Unit (CEU) requirement.

In order to better reflect the efforts to expand access to peer providers and peer run programs, this component has been renamed to “Peer Programs.” The Division will oversee Clubhouse and Community Connections programs as well as Peer Provider Workforce Support, including ongoing efforts towards Medi-Cal Peer Support Specialist Certification for all providers. The proposed name change is to enhance communication and understanding of this division to stakeholders.

Program Updates (cont.)

San Bernardino County has renewed the agreement with California Mental Health Services Authority (CalMHSA) as the county's Peer Support Specialist certifying entity, including a commitment to fund training and exams for current and future county employed peer providers.

In the next fiscal year, additional Clubhouses will be added in Apple Valley and Yucaipa.



“Being on the board and becoming a leader in the clubhouse is so far from the man that first walked into the clubhouse. I was mean and didn’t want to speak to anyone. I just wanted a shower. Now, a year later, I know why I am here. I am able to help, give back, and mean something to my peers. I am still on the streets, but I am making a difference. The staff care about me and make my whole day when they check on me. I am a new man.”

– Clubhouse Member

CSS: Outreach, Access, and Engagement Programs

Introduction

Outreach, Access, and Engagement programs provide linkage to needed mental health and other necessary services, advocacy, case management services, care navigation, family education, and support. Outreach, Access, and Engagement 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 7 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 2024/25.

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	



Artwork by Victoria Johnson

Number of Consumers to be Served

The table below indicates the number of individuals projected to be served by ACE and RBEST for FY 2024/25.

Program Name	Service Area*	Total to be Served
Access, Coordination, and Enhancement (ACE) of Quality Behavioral Health Services	• 36 FSP • 2,566 GSD • 670 O&E	3,272
Recovery Based Engagement Support Teams (RBEST)	• 275 GSD • 700 O&E	975

*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.

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

Program Name	Actual Number Served FY 2022/23	Estimated Number to be Served FY 2024/25	Annual Budgeted Funds FY 2024/25	Estimated Annual Cost per Person FY 2024/25
ACE	2,934	3,272	\$2,961,782	\$905

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 right services to meet their needs.

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

Demographics

Age

20% Children
20% TAY
53% Adult
7% Older Adult



Gender Identity



49% Male



51% Female



<1% Other

Race/Ethnicity

17% African American/Black

32% Caucasian/ White

1% American Indian/ Alaska Native

2% Asian/ Pacific Islander

44% Latinx/Hispanic

4% Other/unknown

Primary Language



95% English
4% Spanish
1% Other

N=2,597

Program Description and Target Population (cont.)

ACE program staff perform initial screenings, intake assessments, and evaluate the best level of care for the consumer. ACE provides evaluations within 7 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 that can help make connections to:

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



Artwork by Elise Dagostin

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.

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



Artwork by Vanessa M. Gomez

Positive Results

During FY 2022/23, the ACE program diverted 3 individuals from hospitalization, and sixteen staff members delivered 8,163 services, including 795 assessments.

The ACE program was successful in linking hospital discharges with appointments during FY 2022/23, as shown below:

2,047 Referrals from Acute Psychiatric Hospitals to ACE	
1,762	Scheduled appointments within 7 days of discharge
145	Scheduled appointments within 14 days of discharge

Demographics



N=2,597

Primary Diagnosis

9.7% Anxiety

11.9% Bipolar

23.8% Depression

2.4% Disruptive/Impulse control and conduct

9.4% Neurodevelopmental/neurocognitive

2.3% None/deferred diagnosis

22.2% Psychosis

11.7% Substance related

6.6% Other

Challenges/Solutions

Staffing challenges at the end of the COVID pandemic were a significant issue in FY 2022/23. The difficulty in hiring staff put pressure on the ability to adequately provide services.

Additionally, the implementation of the California Advancing and Innovating Medi-Cal (CalAIM) initiative has presented challenges to the system of care. Implementation is complex and continues to require significant resources.

Staff will continue to seek solutions for these challenges.

Outreach and Engagement

For FY 2022/23, the ACE program staff participated in various outreach and engagement activities organized by the Department of Behavioral Health Public Relations Office. Activities included community presentations, health fairs, and attendance at the Recovery Happens community fair, where staff celebrated National Recovery Month and supported individuals in recovery.

Program Updates

There are no planned updates for this program.



Artwork by Michael R. Cabrera

Recovery Based Engagement Support Teams (RBEST)

Program Name	Actual Number Served FY 2022/23	Estimated Number to be Served FY 2024/25	Annual Budgeted Funds FY 2024/25	Estimated Annual Cost per Person FY 2024/25
RBEST	458	975	\$2,338,604	\$2,399

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

Program Description and Target Population

Recovery Based Engagement Support Team (RBEST) is a voluntary, consumer-centered program providing community (field-based) services to individuals (adults 18 and over) living with untreated or inappropriately treated mental illness. The program is “non-clinical” in its orientation with a primary focus on meeting the needs and supporting the goals of the consumer and helping them eliminate obstacles to recovery.

RBEST strives to connect and activate consumers into appropriate ongoing treatment and services. Multidisciplinary engagement teams provide 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.

Demographics

Age	Gender Identity	Race/Ethnicity	Primary Language
0% Children 15% TAY 71% Adult 14% Older Adult  N=366	 58% Male  42% Female	16% African American/ Black 27% Caucasian/ White <1% American Indian/ Alaska Native 5% Asian/ Pacific Islander 48% Latinx/Hispanic 4% Other/Unknown	 94% English 5% Spanish 1% Other

Recovery Based Engagement Support Teams (RBEST)

Program Description and Target Population (cont.)

Connecting Families is an expansion project under the RBEST program. The Connecting Families component is an educational/support group for families and caretakers of individuals living with a 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.

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.

Demographics

Primary Diagnosis



5.2% Anxiety disorders	2.5% None/deferred
7.1% Bipolar disorders	49.5% Psychosis disorders
7.1% Depressive disorders	3.8% Substance use disorders
<1% Disruptive disorders	24.3% Other
N=366	<1% Neurodevelopmental/cognitive disorders

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

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.

Positive Results

During FY 2022/23, 112 RBEST consumers surveyed during the 30 days post RBEST engagement in comparison to the 30 days pre RBEST engagement showed:

- 32% decrease in psychiatric hospital admissions
- 28% decrease in psychiatric hospital bed days
- 39% increase in routing outpatient services, including individual therapy, medication services, rehabilitation, activities of daily living, and residential services

Many of the group's participants (families of clients, community members) are Spanish speaking. The Connecting Families support group continues to make a notable impact on the community. Connecting Families is offered in English and Spanish. The Connecting Families component of RBEST has assisted many clients and their families by eliminating language barriers, increasing delivery of psychoeducation, and decreasing the negative stigma that surrounds mental health and those who experience mental health illness.

Success Story

“Jakob’s” father attended Connecting Families for a full 8-week session. Both of Jakob’s parents were having a difficult time understanding mental illness, the progression of illness, and setting healthy boundaries to promote partnership with their son, who has history of substance use. Jakob was living with his parents for 10 years and, as time progressed, became withdrawn, was not socializing with family, spent his days in his bedroom, and only came out of his bedroom to eat. He experienced hallucinations and delusions which resulted in physical aggression towards his parents, who were elderly. Jakob refused all mental health services and refused any visits from RBEST and other county programs. It wasn’t until his father attended Connecting Families sessions that Jakob began to receive the help he needed.

Prior to participating in Connecting Families, his family had endured years of social isolation and, in the last months, physical aggression from their son. After participating in Connecting Families, Jakob’s father began to develop healthy boundaries with Jakob. Ultimately, Jakob was placed in long term hospitalization and is now in a state hospital awaiting to receive ongoing treatment in a structured setting that can manage his behaviors, and safety concerns have been eliminated for the family.

Challenges/Solutions

During FY 2022/23, COVID restrictions remained in place at certain facilities which led to limited ability to conduct engagements in-person. To prevent RBEST staff from losing contact and relationships with consumers, the program increased telehealth services. Despite some restrictions still remaining in place, RBEST continues all field operations. RBEST utilizes Personal Protective Equipment (PPE) and safety precautions to ensure the safety of all staff and consumers.

RBEST experienced collaboration challenges in the System of Care with various agencies. Without effective and thorough collaboration, consumers continued to cycle through crisis and emergency services. In addition, overall misunderstanding of anosognosia and LEAP communication techniques from partnering agencies proved to be a detriment when attempting to link consumers to appropriate resources.

To address these challenges, RBEST continues to make efforts to increase participation and presence in the various meetings. Additionally, staff are conducting in-service presentations on the program to collaborative partners. By increasing participation, education, and collaboration in the community, the program hopes to improve the requisite level of flexibility that this population requires. In addition, an increasing demand remains for supportive services from family members and caretakers; therefore, Connecting Families continues to be conducted via telehealth, with the

hope of moving towards in-person once all COVID restrictions have been lifted.

RBEST also experienced training challenges during FY 2022/23. RBEST leadership is addressing the training challenges by continuing to seek and request potential training opportunities in the future.

Outreach and Engagement

In FY 2022/23, the RBEST program organized and/or participated in the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
CIT 40 Hour Training	7	292
Connecting Families Group	48	236
Clinic Presentations	9	120
Total	64	648

Program Updates

The RBEST-AOT program will be moved out of the Recovery Based Engagement Support Teams section and will be placed into a new program section (A-20), with other programs, to provide Full Service Partnership services under the 24-Hour Emergency Services Division-CHAS Unit, to begin services in FY 2023/24.

Success Story

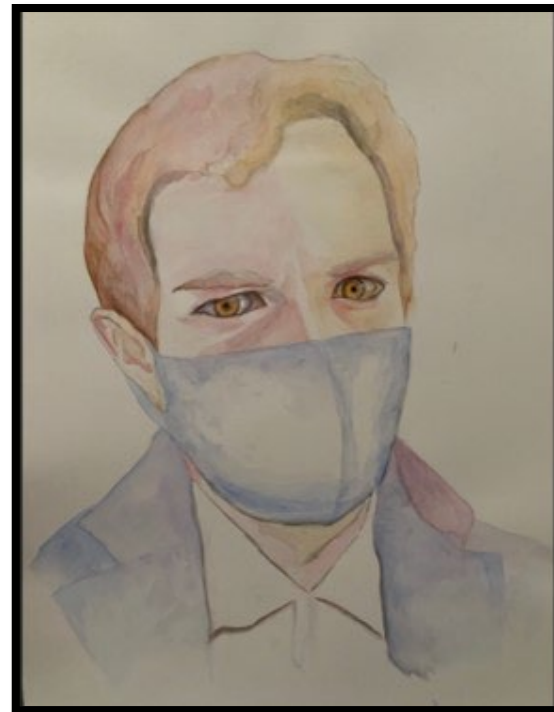
The mother of "Ulysses" is a regular Connecting Families attendee and has attended every session for the past four quarters. This mother has expressed her gratitude to RBEST Clinician for being able to educate her on various mental health topics, coping methods, and community resources. As a result of participating in Connecting Families, she has been able to better communicate with her daughter and understand more of her behavior that results from her diagnosis of Schizophrenia. She continues to help her daughter during this difficult journey. Her daughter is now accepting of mental health services.

Success Story

RBEST staff received a referral and attempted to engage with "Blessing" more than fifteen times. Despite their attempts, most of their encounters consisted of talking to her from the outside of her apartment door. Blessing was extremely resistant to any mental health services and refused to open the door to speak to the team. RBEST staff managed to speak to the mother of the consumer, during which they explained Connecting Families. Blessing's mother was able to obtain tools to assist her in communicating effectively with her daughter. Blessing's mother was able to convince her to seek out medical treatment after she reported severe physical pain. Blessing was eventually diagnosed with stage 4 cervical cancer, lung cancer, and an inoperable tumor. She started chemotherapy and external radiation. Due to RBEST assistance, education, and engagement, Blessing now lives with her mother, is receiving ongoing medical care, and has started receiving psychiatric treatment. She is compliant with all medical and psychiatric treatment, and she has started rebuilding her relationship with her children and mother. Her quality of life has greatly improved, and she is receiving the care that she so greatly needed.

Introduction

Full Service Partnership (FSP) programs provide intensive case management and treatment services for consumers living with serious mental illness (SMI) or severe emotional disturbance (SED). The full service partnership 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 goals of FSP programs are to improve 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.



Artwork by Gabriel Quiroz Duarte

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.

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 2024/25:

Program Name	Ages to be Served	Service Area*	Total
Comprehensive Children and Family Support Services (CCFSS)	11,466 Children 4,913 TAY	2,741 FSP 13,638 O&E	16,379
Integrated New Family Opportunities (INFO)	63 Children 86 TAY	55 FSP 94 GSD	149
One Stop Transitional Age Youth (TAY) Centers	10,403 TAY	494 FSP 1,494 GSD 8,415 O&E	10,403
Forensic Services Continuum of Care	10 TAY 330 Adults 10 Older Adults	350 FSP	350
Assertive Community Treatment (ACT) Model Full Service Partnership (FSP) Services	135 Adults	135 FSP	135
Regional Adult Full Service Partnership (RAFSP)	21 TAY 285 Adults 20 Older Adults	326 FSP	326
Age Wise	1,320 Older Adults	120 FSP 1,200 O&E	1,320
Collaborative Adult Full Service Partnership Services	150 Adults 5 Older Adults	155 FSP	155

*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.

Services Offered

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

- 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
- 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)
- Food assistance
- Clothing assistance
- 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
- Respite care

Comprehensive Children and Family Support Services (CCFSS)

Program Name	Actual Number Served FY 2022/23	Estimated Number to be Served FY 2024/25	Annual Budgeted Funds FY 2024/25	Estimated Annual Cost per Person FY 2024/25
CCFSS	2,946*	16,379	\$49,755,221	\$3,038

*This number does not include O&E.

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

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

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 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

75% Children
25% TAY
0% Adult
0% Older Adult



Gender Identity



52%
Male



48%
Female



<1%
Other

Race/Ethnicity

<1% American Indian/Alaskan Native
19% African American/Black
50% Latinx/Hispanic

1% Asian/ Pacific Islander
19% Caucasian/White
9% Other

N=2,532

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 Adolescent Needs and Strengths (CANS) assessment is utilized within all C-1 programs. CANS data in FY 2022/23 was used by all C-1 FSP programs and is 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 the planned discharge. The Specific Area Construct 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 showed an improvement of the need 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.

Global Measurement of Life:

Item/Issue	Presented with a Need	Improvement of the Need
Having at least one area of impaired life functioning	98.8%	65.3%

Specific Areas of Life Functioning (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
Family Difficulties	82%	57%
Social Functioning	76%	60%
Recreational	50%	53%
Sleep	52%	66%
School Behavior	54%	64%
School Achievement	59%	57%
School Attendance	34%	62%
Decision Making	81%	59%



Artwork by Tova Dean Reyes

Positive Results (cont.)

Global Measurement of Behavioral and Emotional Needs:

Item/Issue	Presented with a Need	Improvement of the Need
Having at least one significant behavioral or emotional need	99.5%	66.7%



Artwork by Lisbeth Corona

Demographics

Primary Language



93% English
5% Spanish
2% Other

N=2,532



Primary Diagnosis

1.3% Psychosis
1.7% Bipolar Disorders
24.9% Depressive Disorders
1.3% Substance Related
15.2 % Other

24.1% Anxiety Disorders
15.6% Disruptive Disorders
13.1% Neurodevelopmental/ Cognitive
<1% Childhood/Adolescent Onset
2.7% None/Deferred Diagnosis

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

Of the children and youth who started a C-1 FSP program, 67% 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	56%	60%
Depression	64%	67%
Anxiety	57%	62%
Anger Control	68%	65%
Adjustment to Trauma	61%	53%
Emotional and/or Physical Dysregulation	74%	61%

Positive Results (cont.)

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

The concept of residential stability is quite different for children than it is for adults. Children coming to the CCFSS programs are in a variety of situations regarding their residence. Some children residing with biological families have Child Welfare involvement while others do not. Child Welfare places some children into a family and others into group homes. In addition to the basic question of residential stability for the caregiver, the Key Outcomes likely to increase residential stability for a child are (1) being with a caregiver likely to be involved once the child has grown, (2) how well the child is functioning within the family home, and (3) how involved and knowledgeable the caregiver is regarding 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%	61%
Children needing help improving their functioning within their living situation	57%	50%
Caregivers significantly uninvolved with the mental health needs of their children at time of admission	13%	61%
Caregivers showing a detrimentally low level of knowledge regarding the child's mental health needs at the start of services	41%	65%

Positive Results (cont.)**Specific indicators likely to increase juvenile justice involvement:**

A significant number of children seen in a CCFSS program, 62.2%, needed help with issues that could easily lead to criminal or juvenile justice involvement; however, only 9% had specific difficulties related to formal legal charges.

The effectiveness of CCFSS to reduce the likelihood of juvenile justice involvement focuses on how the program reduces the impact of specific issues (e.g., delinquency, danger to others) which could lead to involvement with the juvenile justice system.

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	12%	43%
Danger to Others	24%	61%
Runaway	17%	51%
Conduct Disorder Behaviors	20%	58%
Oppositional Behaviors	47%	47%

In an effort to provide services to identified unserved and underserved populations, the Children's Residential Intensive Services (ChRIS) established a specialized program tailored to meet the unique needs of LGBTQ+ youth. The program focuses on natal male trans youth and has 6 beds which are usually full. DBH began regular bi-weekly consultation sessions for clinicians working with trans youth. Steps towards establishing a weekly Web-based therapy group have been made, but identifying youth that will participate regularly has been a challenge.

Challenges/Solutions

Wraparound Clinical Staffing Shortages

In FY 2022/23, the wraparound programs funded by the Mental Health Services Act (MHSA) experienced a significant staffing shortage that had a cascading impact on the number of services provided and the overall program's effectiveness. Due to the shortage, the program had to limit new admissions, reducing the number of children and families that it could serve. Existing cases also faced challenges as overburdened staff struggled to maintain growing caseloads, leading to a decreased frequency of one-on-one counselling sessions and home visits. Essential services like case management, crisis intervention, and multidisciplinary team meetings were likewise strained, often leading to delays in service delivery. This situation also impeded timely reviews and updates of individualized care plans, a cornerstone of the wraparound approach, thus affecting the program's ability to adapt to changing needs and circumstances of the participating families. The staff shortage also meant fewer family engagement sessions, which are critical for holistic recovery and resilience building.

CYCS is problem-solving the staffing shortage by increasing the communication with providers about staffing status and referral numbers and centralizing the referral process for the wraparound programs. CYCS will redistribute referrals to

programs with openings or the more immediate first appointment available. CYCS met with providers to explore the minimum necessary job requirements for positions to possibly increase the number of candidates. The Success First/Early Wrap and Wraparound providers found this solution to be helpful in increasing the number of candidates.

Administrative Oversight Shortages

The MHSA-funded residential treatment program for foster youth faced an administrative staffing shortage over the past year, presenting challenges for program oversight and monitoring. This shortage led to fewer routine program reviews. Communication with external agencies like Child Welfare Services, schools, and health care providers regarding particular youth was prioritized, and the existing administrative team adopted a more targeted approach to data collection, reporting, and compliance. This allowed for the continued evaluation of the program's effectiveness and alignment with MHSA guidelines, although at a reduced scale. The staff reallocated their focus to the most urgent of provider issues, ensuring that critical needs were met and concerns for cases were monitored in a timely manner. Overall, the staffing challenges highlighted areas for improvement to maintain long-term effectiveness and compliance with the MHSA standards.

Challenges/Solutions (cont.)

CYCS will continue to use clerical staff, when possible, to input tracking data from providers and alert administrative staff when data meets established criteria for a concern to be noted.

Increased Acuity of Youth

Over the past year, the wraparound program faced an unprecedented increase in the acuity of mental health needs among the children and families it serves, along with an elevated demand for services. This surge required a greater allocation of specialized resources and expertise to manage more complex cases, putting additional pressure on already strained staff and financial resources. Consequently, the program struggled to maintain its typical caseload, leading to longer wait times for new enrollments. The increased acuity of needs also meant that treatment plans required frequent updates and adjustments, straining the multidisciplinary teams responsible for designing and monitoring these plans. Despite these challenges, the program has adapted using additional service providers to layer services to better meet the growing and increasingly complex needs of the community.

The elevated acuity and service demand have underscored the importance of scalability and flexibility within the program to meet adherence to MHSA guidelines.

CYCS and providers are in the process of accommodating the increased acuity of its clients through additional staff training, increased assessment monitoring, and new ways to track client progress. Staff, who are oftentimes at the beginning of their careers, will be provided intensive training focused on the treatment of youth with the highest levels of risk and need. Ensuring that trainings are provided and that the goals of the trainings are met will be a shared task of providers and CYCS. Increased monitoring of youth will be through the use of monitoring of CANS scores of Risks and Behavioral and Emotional Needs Items. CYCS is developing dashboards with data to improve the ease with which these items can be reviewed.

AB 1051 Legislation

The uncertainty surrounding the passage of legislation AB 1051, which proposes changes to funding mechanisms and requirements for mental health services, hindered long-term planning and made it challenging to develop contracts, policies, and procedures that could be affected by the legislative outcomes. This also led providers to adopt a wait and see approach, which resulted in a delay in establishing future strategic plans. While the program remains committed to serving foster youth in alignment with the mission of MHSA guidelines, the pending legislation necessitated a more cautious and flexible approach to program management and service delivery.

Challenges/Solutions (cont.)

CYCS is working on accommodating the new legislation with changes to policies, procedures, and practices. The new legislation will necessitate the development of funding relationships with new providers, many of whom will be located significantly far away from San Bernardino County. CYCS will create a detailed business processes for monitoring the youth, services, and program to ensure compliance with new legislation. Additionally, training the new providers and their staff on San Bernardino County Standards, policies, and procedures will be a focus in the upcoming fiscal years.

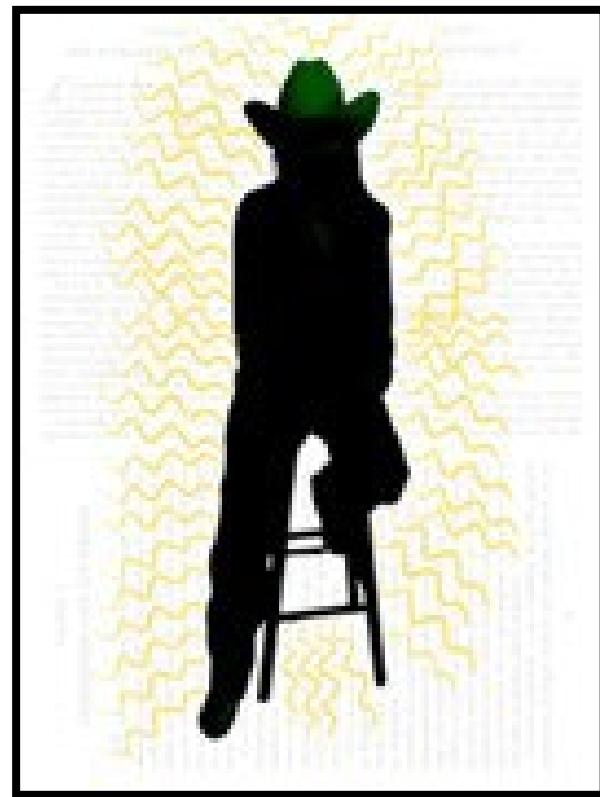
Outreach and Engagement

For FY 2022/23, 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, ASC, Healthy Homes Rescreens, IPC, QI)	13,638	28,093
Total	13,638	28,093

Program Updates

There are no planned updates for this program.



Artwork by Jesse Ramirez

Success Story

“Justin” started the program with a lack of trust and self-worth but made a tremendous amount of progress while here at our Children’s Residential Intensive Services (ChRIS) Short Term Residential Therapeutic Program (STRTP). He presented with an intense amount of physical aggression due to his anger and pain, which led to his use of drugs to numb the pain. This consumer was placed at our ChRIS STRTP for about 6 months and received 8 months of mental health services. During his time here, we worked on targeting those presenting behaviors and were able to increase his communication, trust, views of self, and his ability to make and maintain healthy relationships.

A moment of change that demonstrated progress was an incident during our Children Family Treatment Meeting (CFTM) where the consumer became highly escalated. During that time, the consumer left the meeting highly aggressive, yelling, cursing, and had a sense of hopelessness. His team here at ChRIS STRTP did what we do best: assisted in de-escalation, practiced grounding with him to help calm his anger, and helped him address feelings of hopelessness by having him remind himself of his strengths while looking into a mirror. In that moment, our mental health team knew he would continue to thrive and so he did. He graduated from our ChRIS STRTP by entering a lower level of care, finishing an anger management curriculum, and obtaining his own apartment. He continues to thrive by attending college and is currently a 3.9 GPA student.

Success Story

“Maya” had been in the foster care system for most of her life and had been in many foster homes and Short-Term Residential Therapeutic Program (STRTP) but did not always have successful placements. Therefore, when she came to our ChRIS program at 14, she figured the outcome would be the same as every other placement. Maya once said that she was mean and aggressive because it wouldn’t hurt as badly when she had to leave the placement.

After 8 months, she was recommended for a lower level of care. She was not happy about that and began sabotaging her placement in the STRTP by refusing to attend school, smoking, being argumentative and aggressive with staff, and refusing all services. After a few weeks, she found herself in Juvenile Hall.

Two years later, a request was sent to our ChRIS STRTP for Maya’s placement, and we took her back knowing she was capable of success. We discovered a brand-new person in Maya. She had made a commitment to us (manager and therapist) that she was going to do her best this time around. Her best is what we received. She loved going to school and was on track to graduate early, she participated in all services, therapy, mental health rehabilitation, substance abuse, independent living, and THRIVE – therapeutic, healing, resilience, inclusivity, values, and empowerment. She became a model resident, graduated high school three months early, is attending community college as a full-time student, and is eagerly awaiting her 18th birthday so she can move into her transitional housing program. Maya lives by the saying “Your true success in life begins only when you make the commitment to become excellent at what you do.”

Integrated New Family Opportunities (INFO)

Program Name	Actual Number Served FY 2022/23	Estimated Number to be Served FY 2024/25	Annual Budgeted Funds FY 2024/25	Estimated Annual Cost per Person FY 2024/25
INFO	228*	149	\$1,894,103	\$12,712

*This number includes FSP services only

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

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

*SED = Serious emotional disturbance

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	Gender Identity	Race/Ethnicity	Primary Language
36% Children 64% TAY 0% Adult 0% Older Adult  N=197	 89% Male  11% Female	<1% American Indian/ Alaskan Native 22% African American/ Black 64% Latinx/Hispanic 1% Asian/ Pacific Islander 8% Caucasian/White 4% Other/Unknown	 85% English 12% Spanish 3% Other/ Unknown

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 2022/23, the program expanded screenings and increased services to youth by 70%.

During FY 2022/23, youth who completed the program served significantly fewer days (mean 13.77 days) in detention after the program (relative to before the program) compared to youth who terminated (mean 50.82 days) from the program or declined (mean 34.53) to participate in the program. Recidivism rates for youth who completed the INFO program were also significantly lower than youth who were terminated from the program.

“The program helped make everything better for us and helped us work through all our [problems] with our mom.”

-INFO Consumer

“Moral Reconciliation Therapy (MRT) helped me learn I don’t need [substances], I can do it without that. Family therapy helped my family with communication and learn so much about each other.”

-INFO Consumer

Demographics



N=197

Primary Diagnosis

10.7% Anxiety disorders

1% Bipolar disorders

12.7% Depressive disorders

23.9% Disruptive disorders

7.1% Neurodevelopmental/cognitive disorders

8.1% None/deferred

<1% Psychosis disorders

3.6% Substance use disorders

32.5% Other

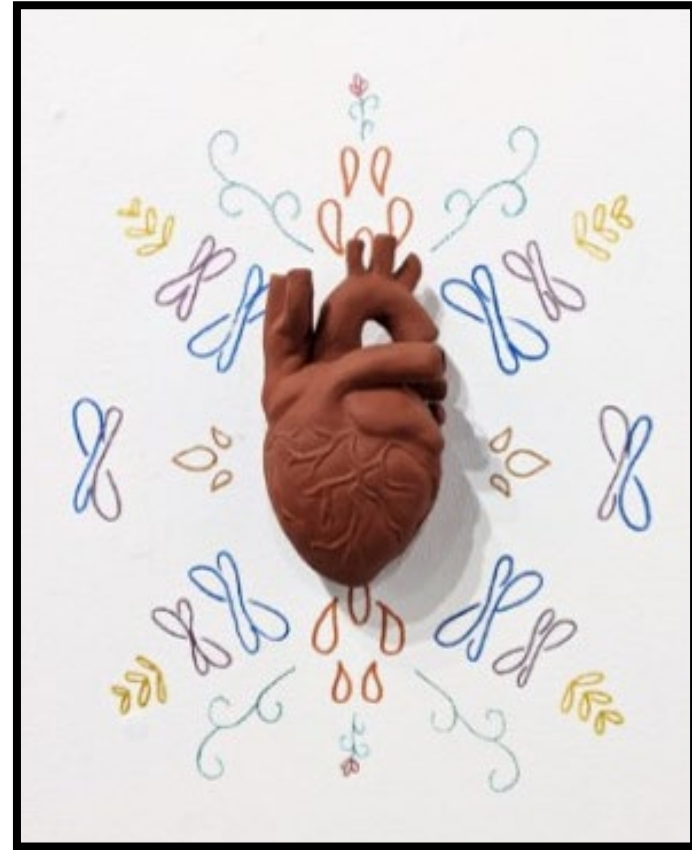
Challenges/Solutions

In FY 2022/23, the INFO program experienced a shift in the criminogenic needs and mental health acuity in the population served. To address these issues, INFO is adding the Functional Family Therapy (FFT) - Gangs modality to address population specific needs, including at risk of gang involvement and gang affiliated youth. This model includes stakeholder engagement and community support to address youth and family needs.

Additionally, the INFO program experienced a staffing shortage during FY 2022/23. To address the staffing shortage, recruitment efforts were made a priority by both the Department of Behavioral Health and Probation leadership.

Program Updates

There are no planned updates for this program.



Artwork by Alcira Isabel Mendoza

One Stop Transitional Age Youth (TAY) Centers

Program Name	Actual Number Served FY 2022/23	Estimated Number to be Served FY 2024/25	Annual Budgeted Funds FY 2024/25	Estimated Annual Cost per Person FY 2024/25
TAY	440*	494	\$6,679,071	\$13,520

*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 the County of San Bernardino. 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 (caused

by 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 to maximize their individual potentials through the Recovery, Wellness, and

Demographics

Age	Gender Identity	Race/Ethnicity	Primary Language
0% Children 97% TAY 3% Adult 0% Older Adult 	 43% Male  57% Female	14% African American/ Black 2% Asian/Pacific Islander 24% Caucasian/White 55% Latinx/Hispanic <1% American Indian or Alaskan Native 5% Other/Unknown	 96% English 3% Spanish <1% Other/ Unknown

N=437

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 Departments 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) under 200% of the federal poverty level 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).

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.

Demographics

Primary Diagnosis

21.3% Anxiety disorders	<1% None/deferred
10.3% Bipolar disorders	10.8% Psychosis disorders
46% Depressive disorders	2.1% Substance use disorders
2.5% Disruptive disorders	5.7% Other
1.1% Neurodevelopmental/cognitive disorders	



N=437

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, 2023*, 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	179	54%
Social Functioning	189	59%
Recreational	166	63%
Legal	11	18%
Physical/Medical	32	41%
Sleep	120	60%
Living Skills	136	57%
Residential Stability	86	55%
Self-Care	129	58%
Medication Compliance	19	32%
Decision-Making/Judgement	145	54%
Involvement in Recovery/ Motivation for treatment	30	50%
Transportation	62	24%

Item/Issue	Presented with a Need	Improvement of the Need
Parenting Roles	14	50%
Intimate Relationships	113	54%
Educational Attainment	98	58%
Family/Family Strengths/ Support	161	50%
Interpersonal/Social Connectedness	181	57%
Optimism	124	67%
Educational Setting	84	58%
Vocational	94	47%
Community Connection	162	53%
Natural Supports	133	50%
Resilience	89	52%
Resourcefulness	91	53%

*Due to the length of time most TAY consumers spend in the program, data was pulled for July 1, 2021, through June 30, 2023, (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 27 new collaborative partners in FY 2022/23.

Challenges/Solutions

During FY 2022/23, the One Stop TAY Centers program continued to experience staffing challenges:

The San Bernardino TAY Center was down two clinical therapists for most of the fiscal year due to staff leaving or being assigned to other duties. Additionally, the center lost one Case Manager position and one General Service Worker who provided consumer transportation duties. To address the issue of being down two therapists, the San Bernardino TAY Center increased the number of DBH interns supervised in the program to provide services to consumers. By the end of the fiscal year, two full-time Clinical Therapist I positions were filled and the consumer caseload was able to be distributed among three therapists.

The Ontario TAY Center was challenged with filling multiple positions and experienced a staffing shortage due to an increase in Covid cases and other illnesses. To address the staffing shortage, staff filled in where possible; additionally, the center followed standard Covid protocol to address the rise in Covid cases. Staff out due to Covid teleworked if well enough and provided telehealth services when appropriate.

The Victorville TAY Center also experienced a staffing shortage due to increased Covid cases. They addressed this shortage by having staff telework if well enough and provided telehealth services when appropriate; additionally, the center followed standard Covid protocol to address the rise in Covid cases. The center struggled with getting consumers to attend services on site.

To get consumers to attend more services, the program provided more social activities to reengage consumers. The program also experienced issues with high school consumers making it to sessions. To address this issue, the staff collaborated with the Family Resource Center program to set up a parenting and kid's group to engage parents and get more high school TAY involved.

The Yucca Valley TAY Center had a few months of staffing shortage that brought challenges with staff workload. The center addressed their challenges with the staff workload by hiring two new Peer and Family Advocates, a new Quality Assurance Specialist, a new Billing Clerk, and a new Drug and Alcohol Counselor. This brought the center to full staff regarding consumer services. Additionally, the center had a challenge with consumers who were receiving DBH emergency shelter services (ESS) not attending many groups.

Challenges/Solutions (cont.)

To address their challenge in getting ESS consumers to attend more groups, the Yucca Valley TAY Center implemented a requirement that all TAY who receive an ESS housing voucher must attend eight groups per week.

Outreach and Engagement

For FY 2022/23, 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	1	4
Collaborative Meetings	141	3,694
Community Outreach	311	1,177
Conference Resource Booth	9	1,975
Health/Resource Fair	24	453
Mental Health Events Attended	6	326
Online Media	11	52
Orientation	54	54
Other (e.g., Community Client Contact)	480	638
Presentations	2	142
Total	1,039	8,515

Program Updates

There are no planned updates for this program.

Success Story

Below are just a few of the many consumers' highlights noted throughout the fiscal year by each TAY center.

The San Bernardino TAY Center had one consumer who was hired on full-time with Caltrans; four consumers graduated from high school and one consumer graduated from university with a double bachelor's degree. Several consumers met goals such as securing permanent housing, obtaining and maintaining full time employment, and re-establishing positive familial connections.

The Ontario TAY Center had one consumer reunite with biological family; one consumer hired at an internship site; and one consumer working at the college as an ambassador. Additionally, several consumers graduated from high school and enrolled in college (community/university), and several consumers graduated with AA degrees.

Success Story (cont.)

The Victorville TAY Center had five consumers who were recognized with the "Helping Hand" award for their volunteering and assistance with events throughout the month; three consumers who were recognized with the "Beautiful Addition" award for challenging their comfort zones and joining groups, activities, and events more often; and one consumer who started a new peer-led group. Additionally, the center celebrated a staff member for finishing her master's program.

The Yucca Valley TAY Center had a consumer obtain an art commission, a consumer set financial boundaries with family, and a consumer attain their state ID. Additionally, several consumers found employment at the local grocery store, Boys and Girls Club, on the 29 Palms Marine Corp base, and with other businesses. Several consumers are learning to advocate for themselves.

Adult Forensic Services (AFS)

Program Name	Actual Number Served FY 2022/23	Estimated Number to be Served FY 2024/25	Annual Budgeted Funds FY 2024/25	Estimated Annual Cost per Person FY 2024/25
AFS	448	350	\$7,025,010	\$20,071

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 severe mental illness (SMI) who are involved in the justice system. The program consists of 8 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 Health Options to Instill Change and Empowerment (CHOICE)

Demographics

Age	Gender Identity	Race/Ethnicity	Primary Language
0% Children 9% TAY 84% Adult 7% Older Adult N=448 	 66% Male  34% Female	<1% American Indian/Alaskan Native 25% African American/Black 30% Latinx/Hispanic 2% Asian/Pacific Islander 35% Caucasian/White 7% Other/Unknown	 97% English <1% Spanish 3% Other

Program Description and Target Population (cont.)

As of July 1, 2023, Adult Forensics Programs refers consumers to be housed at an Enhanced Board and Care facility. The facility provides 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; 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



44% Psychosis	8% Anxiety disorders
16% Bipolar disorder	14% Substance related
15% Depressive disorder	<1% None/Deferred Diagnosis
<1% Neurodevelopmental/ Cognitive disorders	3% Other

N=448

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 as well as Mental Health Diversion (MHD) Court. The program also serves Mental Health Diversion individuals determined to be appropriate by Diversion Courts under PC 1001.36 who live with Severe Mental Illnesses. CFACT consumers transition from either MHD Court, other Forensic Services programs, or general community but must be referred through Department of Behavioral Health (DBH) Forensic Services (FS).

The Corrections Outpatient Recovery Enhancement (CORE) 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 that are often not admitted to other community-based services as they have complex and unique treatment needs that 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



Artwork by Rick Cummings

services provided by DBH FS. 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 offices 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.

Program Description and Target Population (cont.)

The Re-Integrative Supportive Engagement Services (RISES) program serves as a key entry point/linkage to all FS 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.



Artwork by Arturo Martinez

Success Story

Ms. G was referred to DBH STAR by the Mental Health Court system of care. Her services included outpatient treatment, intensive case management, individual therapy, residential placement, and periodic court reviews. Per Ms. G she had a difficult time adjusting in the beginning of her program and had had many challenges she had to overcome. Ms. G maintained her mental stability and worked towards self-sufficiency throughout her programming. She obtained employment July 2021, started a second job January 2022, enrolled in college August 2022.

She re-established relationships with her grandparents and children which ultimately transitioned her from shared housing to living with her family.

Ms. G learned coping skills, medication management, relapse prevention techniques that addressed her severe and persistent mental illness to prevent her from returning to the criminal justice system and to become a productive member of society. Upon completion of the STAR program Ms. G reported she was going to continue to focus on her treatment and recovery, with a plan to obtain psychiatric services with insurance from her employer.

Positive Results

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

The tables to the right show the number of consumers who were housed through emergency shelter placement and/or received interim housing assistance during FY 2022/23.

Through participation in the program (typically 18 months), the number of participants experiencing homelessness decreased by 5%.



Artwork by Jackie Joice

In comparison to pre-enrollment levels, participants enrolled in the Forensic Services programs have shown high rates of diversion from incarceration. The following table represents the reduction in jail days for consumers who completed their first full year of the program during FY 2022/23 compared to the year prior to program admittance.

Program	Percentage Reduction in Jail Days
MHC	98%

In comparison to pre-enrollment levels, participants enrolled in the FSP programs have shown rates of diversion from psychiatric hospitalization. The following data represents the reduction in psychiatric hospital days for consumers in FY 2022/23 compared to the year prior to program enrollment.

Program	Percentage Reduction
STAR	50%
FACT/CFACT	50%
JTMHC	38%

Positive Results (cont.)

From FY 2021/22 to FY 2022/23, there was a 15% increase in the total number of consumers, resulting in an additional 8 consumers. The overall number of unique consumers, rose 28% with an additional 12 consumers and there was a 7% reduction in total hospital visits (40 consumers).

Reductions were also observed in consumer hospitalizations. Programs observed a 33% decrease in consumer hospitalizations for individuals aged 60 and older in the FACT/CFACT program, and a 38% reduction in hospitalizations for individuals aged 25 to 59 in Valley Star.

Consumers have avoided overusing medical providers by developing skills to better handle urgent situations and reaching out to their provider for help and support.

Consumers experienced less distress and reported increased satisfaction with life, as evidenced by self-report and changes in scores. As a result, consumers experienced success in other areas of their lives such as housing, employment, and family. Program staff has seen members gain employment, go back to school, get their charges expunged, and reconnect with family.

“This program saved me”

– FACT/CFACT Consumer



Artwork by Traci Butts

Challenges/Solutions

The Forensic Services Continuum of Care programs are engaged in ongoing dialogue with the mental health collaborative team to explore strategies for boosting referrals to the mental health program. The team is actively collaborating with contract monitors to streamline referrals and expand service to “after care” support. The programs are working closely with Treatment Courts and Probation to deliver psychoeducation, clarify enrollment criteria, and review services to enhance acceptance rates.

Programs continue to actively engaged in several collaborative efforts to enhance Mental Health Court services. These efforts include working closely with Probation to increase the number of referrals that are suitable for Mental Health Court and 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.

Staff is also 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 consumers with another opportunity for treatment under formal probation with FSP level services.

Many consumers lack their own transportation and rely on public modes of transportation, which can be a barrier to accessing services. To ensure continued success for consumers, the programs will remain partnering with local providers for public assistance and transportation to meet consumers' needs. In conjunction with the Probation Officer and the Sheriff's liaison, DBH is coordinating transportation to the Joshua Tree jail for pre-court date screenings.

Programs experienced limited housing options for justice-involved consumers. The programs are researching additional housing vendors to expand the list of options and facilitating access to housing vouchers when necessary. Staff are collaborating with DBH's Homeless and Supportive Services and in the process of soliciting proposals from potential vendors interested in partnering with DBH to tackle housing-related challenges.

Recognizing staffing needs, the programs are exploring avenues to expand staff capacity, including specialized forensic recruitments. Staff have intensified hiring efforts and introduced additional retention strategies to support current staff.

Outreach and Engagement

In FY 2022/23, the Forensic Services Continuum of Care programs conducted the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
FACT/CFACT		
Annual member picnic	1	12
Member graduation party	2	48
Halloween member event	1	20
Member holiday Party	1	31
Total	5	111
JTMHC		
Community member outreach	20	30
Resource fair	6	636
Community coalitions	4	89
Community partner collaborations	113	260
Total	143	1,015

Success Story

One notable instance involved STAR assisting a consumer referred to MHC after failing Veteran's Court due to significant mental health issues that couldn't be addressed within the Veteran's Court system. The client's treatment program was customized to incorporate Veteran-specific concerns, allowing them to attend the Veteran's Brotherhood Bridge Foundation instead of a traditional 12-Step Program. This marked the STAR program's first involvement with a Veteran client, and the client now feels more comfortable around the Veteran population.

Program Updates

The Diversion Opportunities for Outpatient Recovery Services (DOORS) General Diversion program also known as DOORS M-IST was intended to service Mental Health Diversion individuals determined to be appropriate by Diversion Courts under PC 1001.36 who live with Severe Mental Illnesses, but who do not meet the specific requirements of the current Department of State Hospitals (DSH) grant funded DOORS program under WIC 4361.

The Diversion Opportunity for Outpatient Recovery Services sub-program is being removed from the Mental Health Services Act Plan. This program is not funded by the Mental Health Services Act, and it has been included in error.

The Diversion Opportunity for Outpatient Recovery Services for Misdemeanor Incompetent to Stand Trial is no longer an existing program and is being removed from the Mental Health Services Act Plan. Positions were vacant in FY 22/23 and in FY 23/24 all position were transferred to Community Supervised Treatment After Release (CSTAR) or the Diversion Opportunity for Outpatient Recovery Services Department State Hospital program.

This change does not impact services to this population.



Artwork by The Ultra Violet Mermaid

Success Story

“Ms. R” came into the STAR program in April of 2022. Prior to this she had been homeless, sleeping in vehicles, committing petty thefts and self-medicating with hard drugs. Before the program, Ms. R was in custody for six months. By this point, her mental health had deteriorated. She was struggling with suicidal and homicidal ideation, severe depression, and high levels of anxiety and hallucinations. Regardless, she made the choice to seek help in jail and began taking medications and attending groups.

Ms. R chose the STAR program and Mental Health Court with the understanding that it would be a large commitment. She would be held accountable for her choices. She would be expected to fully commit to taking care of herself by attending treatment groups, weekly therapy, case management, and medication support. She would stand in front of the judge and her peers on a bi-monthly basis and be held accountable for her progress and choices.

At the beginning of treatment, Ms. R struggled with poor boundaries, high levels of anxiety, and difficulties regulating her emotions. Throughout treatment, Ms. R developed coping strategies such as gardening, preparing meals, and utilizing grounding techniques, among other forms of self-care. She identified past maladaptive coping, developed healthier relationships, and learned how to set boundaries with others. Although she displayed clear improvements in these struggles, she learned that managing them will require life-long vigilance.

Ms. R. reconnected with her children and obtained employment. Her initial employment was through a probation program, which lead to regular community employment where she was promoted to a shift leader. During this period Ms. R saved enough money to purchase her own vehicle, was paying her own rent, and paid off her restitution.

After showing up for treatment consistently, abstaining from substances, and being a positive example for her peers, Ms. R's felony charges were dismissed, and she graduated from Mental Health Court. Her depression and anxiety were reported as under control, and she reported no longer experiencing hallucinations. Ms. R's medication dosages were lowered, some medications were discontinued entirely. Through her employment, she was able to move to South Dakota with two of her children after graduation. She had attained close to two years of sobriety when she last checked in with staff.

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

Program Name	Actual Number Served FY 2022/23	Estimated Number to be Served FY 2024/25	Annual Budgeted Funds FY 2024/25	Estimated Annual Cost per Person FY 2024/25
ACT Model FSP Services	165	135	\$2,779,852	\$20,591

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 difference between the two programs is that the ACT program serves consumers transitioning from institutional settings, such as State Hospitals, Institutions for Mental Disease (IMDs), or locked psychiatric facilities; whereas the MAPS program serves consumers who are historically high users of acute psychiatric inpatient and crisis services. These consumers

Demographics

Age

0% Children
4% TAY
82% Adult
14% Older Adult
N=165



Gender Identity



61% Male



39% Female

Race/Ethnicity

0% American Indian/
Alaskan Native

15% African- American/Black

38% Latinx/Hispanic

6% Asian/Pacific Islander

35% Caucasian/White

6% Other

Program Description and Target Population (cont.)

may also have a history of a co-occurring substance use disorder (SUD) or a history of identifying as homeless.

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

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



96% English
1% Spanish
3% Other

N=165



Primary Diagnosis

1.2% Anxiety	5.5% Bipolar disorder
3.6% Depressive disorder	<1% Substance related
84.2% Psychosis	4.2% Other
<1% Neurodevelopmental/Cognitive disorders	

Positive Results

In FY 2022/23, ACT served 80 consumers and MAPS served 85 consumers. Out of the consumers served by the program, 90% of the ACT consumers and 89% of the MAPS consumers avoided acute psychiatric hospitalization through the provision of Full Service Partnership services provided by the program.

A total of thirteen consumers were homeless upon entry into the program and obtained safe and stable housing. All (100%) ACT/MAPS consumers maintained safe and stable housing while in the program.

All consumers who identify a substance abuse concern are referred for substance use treatment. Substance Use Disorder groups, which focus on managing and coping with symptoms, are held at the program's administration office weekly. Additionally, consumers are linked to medical providers for their medical needs. Those in need are connected to psychiatry within 7 days of referral for medication.

More than 39% of the ACT consumers' services and 15% of the MAPS consumers' services focused on working in collaboration with family, the Office of the Public Guardians, and support systems.



Artwork by Andrea Austin

Positive Results (cont.)

The Mental Health Statistics Improvement Program (MHSIP) Survey is a nationally used survey that includes measures on concerns that are important to consumers of publicly-funded mental health services. This survey is a valuable tool that provides an assessment of how the public mental health system is perceived and what changes may be needed.

In FY 2022/23, 31 consumers completed the Community MHSIP Survey with over 90% satisfaction rate. 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	94%
I, not staff, decided my treatment goals	94%
Staff encouraged me to take responsibility for how I live my life	92%
I'm getting along better with my family	92%
I do better in social situations	91%
I am better able to deal with crisis	92%
I deal more effectively with daily problems	84%

Survey Question	Percent Agree
I am better able to control my life	90%
My symptoms are not bothering me as much	92%
I do things that are meaningful to me	87%
I am better able to take care of my needs	96%
I am better able to handle things when they go wrong	96%
I am better able to do things that I want to do	92%
I like the services that I receive here	92%
I would recommend this agency to a friend or family member	96%

Challenges/Solutions

During FY 2022/23, transportation was an ongoing challenge, particularly in the High Desert region. Consumers who are on Lanterman Petris-Short (LPS) conservatorships are unable to utilize any public transportation such as Uber/Lyft, IEHP transport, and buses to their appointments out in the community, which limits their transportation options.

The program will continue to educate consumers on how to utilize public transportation, including how to obtain reduced cost bus passes, to ensure that consumers who can utilize public transportation may continue attending their visits with the Psychiatrist and nurses at the office. For consumers unable to use public transportation, the program will provide advanced notice to assist the consumer with transportation to the office for their scheduled Psychiatrist appointments. 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 (OPG), and contracted vendors are considering alternative transportation options that ACT/MAPS programs have presented to help improve consumers' quality of life and increase independence as they prepare to graduate to a lower level of care.

Consumers experienced ongoing housing challenges as some have been unsuccessful in prior attempts to remain housed, unable to access housing due to medical conditions, or unable to access housing due to payment concerns. In addition, obtaining SSI benefits has also been difficult due to occasional denials for consumers.

The ACT/MAPS team continues to support 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 who have no financial resources with housing and linkage to SSI benefits. Staff also worked to connect consumers to other financial resources to help support their living situations while they work toward collecting benefits as needed.

"I was a mess when I started this program and now, I'm the most stable I've ever been."

-ACT Consumer

Outreach and Engagement

For FY 2022/23, the ACT Model FSP Services program conducted the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Program Referrals	2	49
Clinic Visits	40	360
Total	42	409

Program Updates

There are no planned updates for this program.

Success Story

“Asher” entered the program with an extensive history of drug usage, incarcerations, and homelessness. He was evicted from several room and boards because of his behavioral health symptoms. He was non-medication compliant and lacked motivation to increase his independence.

When case managers first started meeting with Asher, he was guarded and minimally engaged. However, as interactions continued, he became more sociable and open about his life’s struggles. He shared with case managers his history of addiction and that he has been separated from his family for several years.

Today, Asher is working hard to reach the goals he has set for himself. He is medication compliant, no longer exhibits some of his more severe behavioral health symptoms, and has been living in the same room and board for over one year. The house manager has complimented him for having a positive attitude. He has learned to budget his finances, obtained a driver’s license, and purchased a car.

Regional Adult Full Service Partnerships (RAFSP)

Program Name	Actual Number Served FY 2022/23	Estimated Number to be Served FY 2024/25	Annual Budgeted Funds FY 2024/25	Estimated Annual Cost per Person FY 2024/25
RAFSP	621	326	\$16,367,247	\$50,206

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 the 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.

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.

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

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. The ratio of staff to consumers is typically one to ten to allow for intense support for consumers 24 hours a day/7 days per 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



Artwork by Pauline Velarde

Success Story

“Adam” came to us resisting all medications. He used to intimidate people and had cut himself off from all family members. Since joining the FSP program, he consented to an injectable medication, attends groups faithfully, and now accepts assistance from an aunt. We offered him shelter bed placement, and he has been there for 9 months without incident. He is working to repair some family relationships and was approved by the court to have fewer sessions. He has not had a single psychiatric hospitalization since joining our program.

Demographics

Age



4% Children
11% TAY
72% Adult
13% Older Adult

N=532

Gender Identity



45%
Male



55%
Female

Race/Ethnicity

<1% American Indian/
Alaskan Native

20% African American/Black

35% Latinx/Hispanic

3% Asian/Pacific
Islander

34% Caucasian/White

7% Other

Primary Language



94% English
4% Spanish
2% Other

N=532

Primary Diagnosis



11.4% Anxiety disorders

14.8% Bipolar disorders

24.4% Depressive disorders

6.2% Other

<1% None/deferred

37.5% Psychosis disorders

4.2% Substance related

1.5% Neurodevelopmental/cognitive disorders

Success Story

“Valentine’s” severe mental health symptoms that prevented him from leaving the house reduced significantly to the point where he is now able to run his own errands, use public transportation, and be self-employed. Valentine has remained stable for the past 6 months and graduated from the FSP program. He said, “I appreciate you guys. You were there when I needed [support].”

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 2022/23 are reported by provider.

Provider Name	Unduplicated Consumers Served	% of Consumers Who Avoided Hospitalization Completely in FY 22/23
Barstow Counseling	36	92%
Mesa Counseling Services	75	80%
Victor Valley Counseling Center	97	82%
Phoenix FSP (Clinic Based)	165	81%
Step Up On Second FSP*	510	97%
Valley Star FSP and Valley Star Behavioral Health	204	94%
MHS*	184	90%
Mariposa Counseling Center	44	80%

* 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.

In FY 2022/23, the Victor Valley FSP program increased engagement with monolingual Spanish-speaking consumers, largely helped by bilingual case managers.

Additionally, Barstow Counseling implemented a LGBTQ resiliency group to provide inclusive services to this diverse population and remain up to date with LGBTQ trainings.

Challenges/Solutions

The major challenges for the RAFSP program were limited staffing, staff turn-over, and competing priorities, which resulted in a minimal number of consumers served. To address these challenges, staff have decreased competing priorities and adjusted FSP team to consumer ratio. Despite limited staffing, the FSP program has bilingual staff who provide case management and Rehab/ADL services in Spanish to monolingual Spanish speaking consumers. Interpretation services are available for monolingual staff members. To address disparities in services to unserved and underserved populations, the program is hiring more bilingual staff to provide services to monolingual speaking consumers and continually training staff on the use of available interpretation services for monolingual speaking consumers.

One example of a competing priority is the mandated treatment of the area's eating disordered individuals. A lack of resources has resulted in a lack of sufficient training for eating disorders, particularly the most high-risk disorder, Anorexia Nervosa. Staffing shortages have necessitated the need to share staff or have RAFSP staff assist with Outpatient duties. These additional functions detract from how many FSP consumers each Therapist can have on his or her caseload and the amount of time spent with each FSP consumer. Until staffing issues improve, the program will continue to assist the clinic in meeting the current consumer needs.

Another challenge was the continuous lack of available housing including shelters, room & boards, board & care, or permanent housing for those with low income. Furthermore, consumers in shelters are not able to receive food stamps which causes difficulty for consumers with food allergies or medical conditions that require a special diet. FSPs will continue to advocate for their consumer's needs.

Staff continue to work to find housing solutions for FSP participants. At-risk consumers have been able to obtain permanent supportive housing through collaboration with the Homeless and Supportive Services programs.

Reliable transportation continues to be a pronounced challenge. With the addition of new transportation requirements, for contracted providers, consumers have found it difficult to obtain daily needs (e.g., groceries, medication pick up) and secure transportation to and from their appointments. The program provides bus passes as well as assists consumers in setting up transportation with collaborative partners.

Program Updates

For FY 2023/24, the Regional Adult FSP program has been consolidated with a single contract provider Valley Star. This consolidation is expected to result in increased access to FSP services for consumers throughout San Bernardino County.



Artwork by T. Faye Griffin

Success Story

“Colin” had not had a California ID since coming to the U.S. in 1980. His case manager was able to assist him in obtaining his ID which enabled him to receive legal Temporary Permanent Status (TPS). After receiving his TPS, Colin said “You are a Saint, and you need to be the boss.”

The case manager was able to assist Colin to move from a cockroach-infested trailer to a 1-bedroom apartment and helped him obtain vouchers from a local church to buy clothes and furniture for his new apartment. After receiving help, Colin said, “I am very blessed” and stated that if it were not for the Mariposa clinic staff, he would probably be dead now.

Success Story

“Amy” came to us with multiple medical issues and an eating disorder. After working with her, the eating disorder moved into remission, and she has not had anymore psychiatric hospitalizations. Amy had been homeless and ‘couch surfing’ but now lives independently. She manages her own income and recently won a settlement dating back 20 years. She graduated the program in August 2023.

Introduction

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

DBH has moved CRS and RBEST-AOT from their current locations, A-13 and A-15, respectively, and combined them under a newly developed CSS component FSP subtitle of MHSA, A-20, titled Collaborative Adult FSP Services.

Full Service Partnership programs provide intensive case management for adult consumers living with serious mental illness. The program's framework is built upon a "whatever it takes" format to meet the needs of consumers. Services are field based and meet consumers where they are at or wherever they are comfortable. The goal of these FSP programs is to improve quality of life by implementing practices which consistently promote good outcomes, including linkage and connection to appropriate treatment and resources.

The Collaborative Adult FSP Services 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.



Artwork by Taliyah Danielle Bradberry

Target Population

The table below identifies the target population of consumers to be served by the Collaborative Adult FSP Services programs for FY 2024/25.

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 2024/25.

Program Name	Ages to be Served	Service Area*
Community Reintegration Services (CRS) program	70 Adult 5 Older Adult TOTAL = 75	75 FSP TOTAL = 75
The Recovery Based Engagement Support Teams (RBEST) – Assisted Outpatient Treatment (AOT) program	80 Adult TOTAL = 80	80 FSP TOTAL = 80

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

Community Reintegration Services (CRS)

Program Description and Target Population

The Community Reintegration Services (CRS) program is a Full Service Partnership designed to serve adults who are living with severe mental illness or untreated co-occurring disorders who, in many cases, have recently been discharged from State Hospitals and/or higher levels of locked psychiatric facilities. These adults are at imminent risk of homelessness, incarceration, hospitalization, 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 2022/23	Estimated Number to be Served FY 2024/25	Annual Budgeted Funds FY 2024/25	Estimated Annual Cost per Person FY 2024/25
Community Reintegration Services	80	75	\$4,033,119*	\$26,020*

*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
1% TAY
74% Adult
25% Older Adult



Gender Identity

75% Male
25% Female



Race/Ethnicity

18% African American/Black
46% Caucasian/White
1% American Indian/Alaska Native

3% Asian/Pacific Islander
30% Latinx/Hispanic
3% Other/Unknown

Primary Language



100% English

N=80

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

Community Reintegration Services (CRS)

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 2022/23, 80 consumers received services from the CRS program.

Of the consumers served:

- 90% did not require psychiatric hospitalizations
 - 20% were able to utilize alternative crisis services
 - 80% did not require any crisis intervention services

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.

Challenges/Solutions

There was an increase in the number of referrals from other programs due to limited resources available for housing for clients with severe and persistent symptoms.

To assist with this challenge, CRS staff explored resources for housing and support for consumers outside of DBH programs. Additionally, DBH has expanded treatment placement options for enhanced board and care.

Outreach and Engagement

For FY 2022/23, a combined total of 65 participants attended two presentations where staff members from the CRS program were available to discuss their program and offer resources.

Demographics



N=80

Primary Diagnosis

5% Bipolar disorders	12.5% Substance Use disorders
10% Depressive disorders	2.5% None/Deferred
67.5% Psychosis disorders	2.5% Other

Community Reintegration Services (CRS)

Program Updates

The newly expanded Program for Assisting and Coordinating Enhanced Services (PACES) will not be providing FSP level of service. PACES will now be categorized under the A-13 Adult Transitional Care Programs and will no longer be included under CRS. The PACES program will transition from the MHSA CSS FSP to the MHSA CSS GSD funding component.

Success Story

“Theo” entered the program with significant health challenges requiring repeated medical hospitalizations. The medical problems also contributed to an increase in his psychiatric symptoms. Program staff collaborated and referred him to Enhanced Care Management (ECM) and, along with ECM’s support, were ultimately able to move him into a less restrictive setting in an assisted living. Theo has since stabilized, and his physical symptoms continue to be closely monitored. With the added support and assistance, his psychiatric condition has stabilized, and he is successfully maintaining his placement.



Artwork by Kathy Miller Stewart

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 Team – 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 was approved as an expansion of the current RBEST program (A-15), designed to provide voluntary engagement services. RBEST does not provide FSP

Program Name	Actual Number Served FY 2022/23	Estimated Number to be Served FY 2024/25	Annual Budgeted Funds FY 2024/25	Estimated Annual Cost per Person FY 2024/25
RBEST-AOT	N/A	80	\$4,033,119*	\$26,020*

*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 	Severe Mental Illness

*SMI = serious mental illness

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

Program Description and Target Population (cont.)

services; however, the 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 is new and in the development phase, with a plan to be implemented by early 2024.

RBEST-AOT provides intensive, client-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. The RBEST-AOT team will monitor those receiving services to ensure follow-through with treatment services.

Services Offered

- Outreach and engagement
- Access and Linkage
- Advocacy
- Case management services
- Care navigation
- Family/caretaker education and support
- Listen, Empathize, Agree, Partner (LEAP) communication technique

RBEST-AOT will provide services to individuals who are severely and persistently mentally ill, and who are non-compliant with psychiatric treatment. If RBEST-AOT is successful in engaging these individuals, the program works to identify appropriate resources such as mental health services in an outpatient clinic, housing (Room and Boards, Board and Cares, Assisted Livings, Skilled Nursing Facilities), DBH Clubhouses, and Full Service Partnerships.

Program Updates

A Memorandum of Understanding (MOU) will be established for a partnership between DBH and Law Offices of the Public Defender San Bernardino County (PD) for coordination of court-ordered AOT per regulations defined in Welfare and Institutions Code (WIC) Sections 5345-5349.5. Staff will provide services for individuals who have a history of untreated mental illness and meet all nine categories stipulated in the Code. Additionally, DBH will be funding three PD positions (Deputy Public Defender, Paralegal, and Social Service Practitioner) with MHSA funding to assist in carrying out responsibilities related to AOT and a Clinical Therapist I position that will be working with the Sheriff HOPE team to assist in carrying out responsibilities related to AOT.

Age Wise

Program Name	Actual Number Served FY 2022/23	Estimated Number to be Served FY 2024/25	Annual Budgeted Funds FY 2024/25	Estimated Annual Cost per Person FY 2024/25
Age Wise	1,367*	1,320	\$2,248,491	\$1,703

*This number includes FSP (114), GSD (236), and O&E (1,017) services.

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

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

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
2% Adult
98% Older Adult



Gender Identity



25% Male



75% Female

Race/Ethnicity

1% American Indian/Alaskan Native
17% African American/Black
34% Latinx/Hispanic

1% Asian/Pacific Islander
42% Caucasian/White
5% Other

N=102

Positive Results

The following table reports the measured Age Wise outcome domains and the percentage of consumers served in FY 2022/23 who met the criteria in each category:

Outcome Domain	Percentage of consumers
Maintained low or reduced risk of subjective suffering	71%
Maintained safe and stable housing	97%
Are stable and able to seek outside assistance to locate their own resources	80%
Consumers linked to a Primary Care Physician	98%
Diverted from hospitalizations related to a behavioral health diagnosis	100%

Additionally, the Age Wise program added 27 new collaborative partners in FY 2022/23.

The Age Wise team has grown in terms of diversity of staff in an effort to ensure behavioral health staff represent the population being served. During FY 2022/23, Age Wise increased the number of males on staff by two (5 out of 20 staff members are males), added three additional Spanish speaking staff (7 out of 20), and hired two African American/Black clinicians and one Asian clinician.

The Age Wise program is a six-time NACo award and one-time USAging award winning program. In FY 2022/23, the Age Wise 24/7 Senior Hotline's clinical staff responded to 105 calls and more than 700 calls since its inception. To date, the award winning 24/7 Senior Hotline remains a unique service that provides urgent support to older adults struggling with social isolation, food insecurities, and transportation and links them to a diverse array of resources and services. Additionally, should the individual calling have mental health concerns or self-harming ideations, the clinicians are trained to manage the situation until first responders can arrive on-site to assist.

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



78% English
19% Spanish
3% Other

N=102



Primary Diagnosis

12.7% Psychosis 8.8% Anxiety disorders
15.7% Bipolar disorder 56.9% Depressive disorder
5.9% Other

Challenges/Solutions

Throughout FY 2022/23, persistent challenges for older adults included access to affordable housing, reliable transportation, and food insecurities. Additionally, older adults were significantly impacted by a substantial rise in inflation as well as the reduction or elimination of many pandemic-related services and available financial aid. These issues have heightened distress among older adults. More so, affording basic food essentials, securing affordable rent, and the constant financial scams and fraudulent practices that target older adults continue to be of great concern with this population.

Age Wise staff will continue to educate its consumers on fraudulent and scam activities targeting the older adult population. The staff will provide regular communication on Social Security Administration updates and public information announcements regarding scam alerts; these practices will continue with a heightened focus in FY 2023/24. To achieve this, Age Wise consumers will continue to be contacted, informed, and educated on how to avoid and/or manage these situations, and they will be guided to the appropriate services should they become a victim of fraud. Additionally, the 24/7 Senior Hotline provides urgent support for older adults struggling with issues such as social isolation and food insecurities and links consumers to resources and services.

Age Wise continues to see an increasing number of requests for transportation services and/or assistance. Age Wise staff spend a significant amount of time coordinating or providing transportation to medical appointments, utility service appointments, and shopping for basic needs (e.g., pharmacy, grocery, clothing). Reliable transportation remains a pronounced challenge, especially as many older adults still desire to practice social distancing and isolation.

Age Wise continues to promote and provide Telehealth Home-Based Behavioral Health Care for Older Adults, in addition to ensuring all clinical staff are trained and certified to provide telehealth services. The program provides the iPad and internet service to those clients who do not have the equipment for telehealth services. A growing number of Age Wise consumers have elected to use telehealth this past year primarily due to worsening chronic medical conditions such as cancer, dialysis, and diabetes. The usage of telehealth services by older adults living in remote and rural areas remains consistent, with approximately one in five Age Wise consumers participating in this flexible service delivery option. Age Wise telehealth services continues its progress toward closing the digital divide among older adults.

Outreach and Engagement

For FY 2022/23, the Age Wise program conducted the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
In-Service Presentation	1	3
Displacement Event	1	17
Health Fair	2	297
LGBTQ+ Resource Fair	1	20
Veteran/Homeless Event	1	50
Park Opening Senior Meals	1	2
Senior Function	5	128
Behavioral Health Inland Empire Roundtable	1	60
35th Annual DAAS – PG Multi-Disciplinary Conference	1	400
Total	14	977

Program Updates

There are no planned updates for this program.

Success Story

Due to committed efforts of the staff, the Age Wise program received national recognition for the third consecutive year and was awarded the following four 2023 National Association of Counties (NACo) awards for Human Services Achievement Awards: *Age Wise Fall Prevention Program; Age Wise Learning Collaborative with Lifestyle Medical; Robotic Pet Initiative; and Telehealth Home-Based Behavioral Health Care for Older Adults.*

In addition to this recognition, Age Wise Leadership presented an overview of the program at the 2023 California Association of Area Agencies on Aging conference in Glendale, California.

Age Wise has been recognized by USAging, formally known as the National Association of Area Agencies on Aging, for its fully comprehensive service approach in addressing the complex and specialized needs of older adults. As the recipient of the 2021 *Aging Innovations Award in the Home and Community Based Services Category*, Age Wise leadership had the honor of presenting at the USAging 'Answers on Aging' 2023 National Conference in Salt Lake City, Utah, in a workshop titled '*Behavioral Health and Wellness in 2023: A Roadmap for Success!*'.

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 HHSCCP has adapted and changed to meet the expanding needs of the homeless population and incorporate new and changing funding options.

Staff partner with consumers to problem solve and build on existing strengths and skills needed for daily living in permanent supportive housing.

Services are driven by consumer self-determination, and every effort is made to meet consumers where they are in the community. Field-based services allow consumers that are experiencing homelessness to stay with their belongings and pets while participating in the program. These services are provided for individuals that may not be able to access services at traditional office locations.



Artwork by Stacey McDaniel

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 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 clients 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 MHSa Innovation project that consists of Regional Engagement Teams, Rapid Response Teams, and a Mobile Medical Team that provide field-based services to consumers.

The Regional Engagement Teams (RET) provide mental health treatment to residents experiencing severe mental illness and homelessness. Services are provided in the streets, where the individual lives. Services are provided numerous times a week in an effort to improve the consumer's wellness and to help them obtain the appropriate level of housing. RET are regionally-based and comprised of Clinical Therapist and Peer and Family Advocate teams.

The Rapid Response Teams (RRTs) are regionally-based teams 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. RRTs provide outreach, engagement, services, and linkages to other resources for our county's homeless residents.

The Mobile Medical Team (MMT) consists of a Nurse Practitioner and Psychiatric Technician from DBH. They provide psychiatric evaluation and medication support services.

Number of Consumers to be Served

The table below demonstrates the number of consumers to be served for FY 2024/25:

Program Name	Ages to be Served	Service Area*	Total to be Served
Housing and Homeless Services Continuum of Care Programs (HHSCCP)	• 138 TAY • 2,561 Adult • 745 Older Adult	• 92 TAY O&E • 29 TAY GSD • 17 TAY FSP • 1,458 Adult O&E • 542 Adult GSD • 561 Adult FSP • 295 Older Adult O&E • 165 Older Adult GSD • 285 Older Adult FSP	3,444

*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.

Target Population

The table below identifies the target population of consumers to be served for FY 2024/25.

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



Artwork by Cristy Wiley

Program Name	Actual Number Served FY 2022/23	Estimated Number to be Served FY 2024/25	Annual Budgeted Funds FY 2024/25	Estimated Annual Cost per Person FY 2024/25
HHSCCP	1,203	3,444	\$19,233,860	\$5,585

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 Program:

- 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	Gender Identity	Race/Ethnicity	Primary Language
0% Children 2% TAY 65% Adult 33% Older Adult 	 38% Male  62% Female	26% African American/Black 39% Caucasian/White 1% American Indian/Alaska Native	1% Asian/Pacific Islander 29% Latinx/Hispanic 4% Other/Unknown 

94% English
4% Spanish
2% Other

N=862

Services Offered (cont.)

InnROADs:

- Outreach and Engagement
- Nursing interventions
- Case Management
- SUD Assessment and Linkage
- MH treatment
- Psychiatric Evaluation
- Medication Management

Positive Results

A total of 79 consumers were housed in FY 2022/23. DBH and DBH contractors currently support 807 consumers in Permanent Supportive Housing.

To meet the needs of the unserved/underserved older adult population identified in the current [Cultural Competency Plan](#), the Housing and Homeless Services Continuum of Care continued to partner with Age Wise. In FY 2022/23, older adults made up 33% of FSP and 28% of GSD consumers served by the Housing and Homeless Services Continuum of Care Program.

Storm Relief Homeless community members are particularly vulnerable to danger in times of extreme weather. Flood channels and other embankments can seem like attractive shelter when dry, but flood waters can come quickly. As a partner with DBH Disaster and Safety, staff connected with displaced community members, some of whom were homeless when there has been flooding in the past year. HOST and Supportive Services staff participated in the DBH and County emergency response coordinated efforts to address the needs of community members impacted by extreme weather events.

New Housing Projects Las Terrazas Apartments opened in this past year. Las Terrazas is a 112 unit affordable housing complex in Colton. There are 12 No Place Like Home units that are available for consumers that are experiencing chronic homelessness and a severe mental illness. These units are accessed through CES and Housing Navigation is provided by HOST.

Primary Diagnosis

13.5% Anxiety disorders	<1% None/deferred
17.5% Bipolar disorders	22.6% Psychosis disorders
37% Depressive disorders	4.1% Substance use disorders
<1% Disruptive disorders	4.4% Other
<1% Neurodevelopmental/cognitive disorders	

N=862



Success Story

HOST staff began working with “Michael,” a 68-year-old gentleman, in Feb of 2022. He was living in a camper shell, heavily infested with roaches and rodents without access to running water or electricity. He was naturalized; however, he had lost his documents in the course of 6 years on the street. Extensive efforts were made in working with United States Citizenship and Immigration Services (USCIS) to apply for renewal of expired documents. In early 2023, HOST staff were able to secure an ID and a social security card necessary for housing. While working to remedy his homelessness, additional case management needs were also being tended to by the HOST team. Michael was assisted in connecting to and receiving medical care, which resulted in a cancer diagnosis and treatment. He received a referral for a Housing Authority subsidy and was moved into bridge housing. This interim housing allowed for a necessary surgical procedure to be completed as having a sanitary place to recover was a prerequisite. Michael moved into a one-bedroom unit in the summer of 2023. He is continuing with his medical treatments, is very thankful for the services, and now takes great pride in his home and appearance.

Success Story

The pandemic left the whole family of one of our consumers, “Matty” homeless. In early 2023, she was living in her vehicle with her partner and three kids (ranging from 5 to 8 years) when HOST received the referral to assist them with a No Child Left Unsheltered (NCLU) rental subsidy. After 2 years of homelessness, Matty had become sober and was focused on creating better circumstances for herself and her family. Through her resilience and support from the HOST program, she was able to keep the children in school with little disruption. HOST staff worked diligently to assist with housing navigation. Matty was tearful when receiving her keys to her unit. She expressed plans to rejoin the workforce and aspires to pursue higher education. The children continue to thrive and Matty reports being able to reconnect with her own mother since being housed.

Challenges/Solutions

A primary goal of the HHSCCP is to reduce homelessness and increase safe and permanent housing. Housing rental inventory continues to be low, and the costs of rent continues to increase. 63% of the county residents that have been homeless for more than a year have no income. An additional 14% have an income of \$500 or less.

DBH Homeless and Supportive Services has hired two psychologists to assist the homeless community in obtaining Supplemental Security Income (SSI).

Those with SSI are able to afford room and board or other shared housing options. The hope is that assisting homeless consumers in obtaining SSI may assist them in ending their homelessness.

Outreach and Engagement

Housing and Homeless Services Continuum of Care staff participated in table events sponsored or endorsed by DBH Public Relations and Outreach (PRO) throughout the year.

Program Updates

DBH developed the Innovative Remote Onsite Assistance Delivery (InnROADs) project to assist underserved individuals and groups experiencing mental illness and homelessness in remote, rural, and unincorporated areas of San Bernardino County. The project has focused on targeting individuals experiencing homelessness by engaging and linking them into the appropriate system of care with the goal of providing the needed mental health care and housing.

InnROADs ends as an Innovation Project in March 2024. Starting April 2024, InnROADs will be funded via MHSA CSS. Since this project's inception, an estimated 5,368 total individuals have been served, 7,787 treatment activities in the field have been provided, and 17,684 records of engagement have been completed (data through March 20, 2023). For more information about InnROADs, please refer to pages 391-395. A final innovation program report will be completed and posted. Updates to the program will be provided in future plans under MHSA CSS.

Homeless and Supportive Services will be moving the Community Supports service along with 15 positions to the Office of Homeless Services (OHS) to provide the Community Supports. This will remove the Community Supports service from the HOST Mental Health Services Act (MHSA) funded HOST positions. This move is proposed to take place July 1, 2024, and allows for additional oversight and accountability of services. This change does not negatively impact services to this population.

Success Story

“Daniel” was in his late 50s and had been involved with various County departments since he was a child. More recently, he had been homeless for approximately 8 years; his housing insecurity began when his wife passed away. While living on the street, he was facing various medical issues that would frequently require hospitalization. Daniel did not have a social support system and was constantly stressed about his property being stolen while he was receiving medical care. He also expressed facing challenges with others’ aggression toward him and others trying to pressure him into drug use. InnROADs was the first DBH team to have contact with him. An application was submitted to the MHSA Housing Waitlist that resulted in his being housed. HOST staff assisted Daniel in the housing navigation process. He was inspired on his first visit to his future apartment and began making a list of goals, including to find a church to attend in his new area. He takes great pride in his new apartment, and when HOST case managers brought him a welcome home kit after he moved in, he asked them to take off their shoes before coming in because he wanted to keep his home clean. When giving a tour of his kitchen, he showed his cupboards full of food, and HOST case managers noticed a dish towel in his kitchen with the word ‘Blessed’. At the end of their visit, Daniel invited them to join him for a meal that he was making in his crockpot later.



Artwork by Revolutionary Dreamer

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.

Program Name	Actual Number Served FY 2022/23	Estimated Number to be Served FY 2024/25	Annual Budgeted Funds FY 2024/25	Estimated Annual Cost per Person FY 2024/25
Adult Transitional Care Programs	207*	538	\$30,291,992	\$56,305

*This number does not include CHAS-PACES.

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 Updates

The Adult Transitional Care Programs will no longer receive MHSA CSS FSP funding, as Community Reintegration Services (CRS) was moved to a new MHSA CSS FSP Program (A-20). Moving forward, the Adult Transitional Care Programs will be funded entirely by the MHSA CSS GSD funding component.

- CHAS-PACES, which was planned and presented as a component of CRS, will remain as an Adult Transitional Care Program.

The Adult Transitional Care Programs expanded significantly in FY 2022/23. However, one planned expansion to these programs did not come to fruition due to:

- The vendor's inability to secure site(s) in Southern California
- Insufficient need for additional sites in Northern California
- Potential concerns with the vendor's ability to appropriately manage this level of care

Therefore, after extensive analysis, the 24-Hour and Emergency Services Division - Centralized Hospital Aftercare Services (CHAS) Unit proposed and received approval from the DBH Director to repurpose the MHSA funding initially intended for this expansion. This funding has been returned to MHSA for appropriate reallocation, and positions planned in support of this expansion have transitioned to support the other expansions under the Adult Transitional Care Programs umbrella.

Target Population

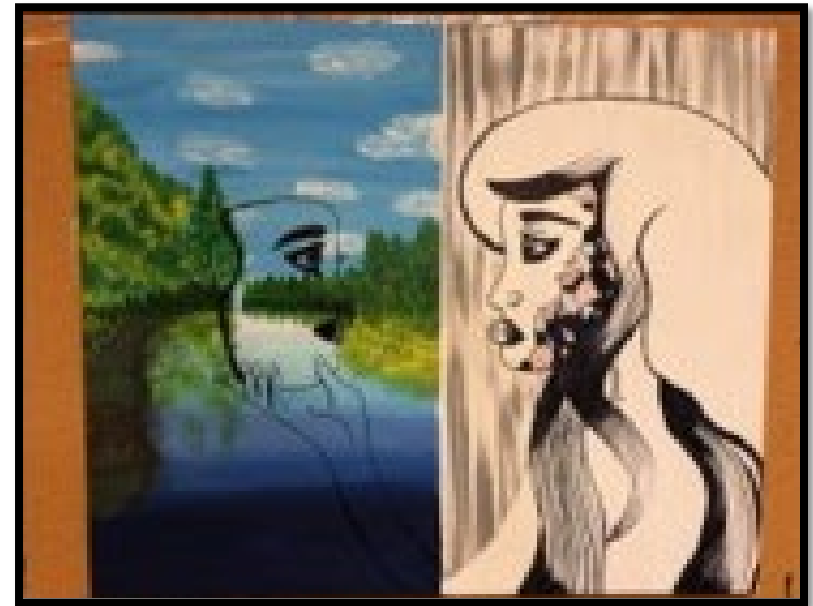
The table below identifies the target population of consumers to be served by the Adult Transitional Care Programs for FY 2024/25.

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	
Centralized Hospital Aftercare Services (CHAS) - Placement and Coordination of Enhanced Services (PACES)			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 2024/25.

Program Name		Ages to be Served	Service Area*
Adult Transitional Care Programs	Adult Residential Facilities Certified In Social Rehabilitation Services	108 Adult TOTAL = 108	108 GSD TOTAL = 108
	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)	125 Adult Total=125	125 GSD Total = 125



Artwork by Blanca Sandoval

*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.

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.

Services Offered

- Residential treatment
- Rehabilitative services

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

Success Story

“Moe” started attending adult school to receive their high school diploma while working the treatment program. They were able to successfully manage their behavioral health condition while attending classes. They have passed all classes and received their diploma. They have come so far, and it is incredible to see them achieve this objective while still participating in the program.

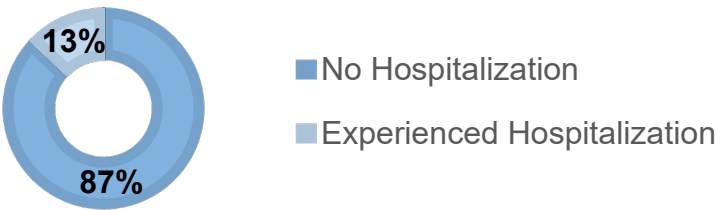
Adult Residential Facilities Certified in Social Rehabilitation Services

Positive Results

Through the provision of Adult Residential Facilities Certified in Social Rehabilitation Services, 87% of facility residents were diverted from hospitalization due to the stability and interventions provided by this program.

The program also improved timely access to appropriate level of care necessary to treat both mental health and medical conditions. Providing more timely access reduced the amount of time a consumer spent in a locked psychiatric facility.

ARF CONSUMERS IN FY 2022/23



In FY 2022/23, staff increased bed capacity by adding fourteen additional beds to provide additional resources for the community.

Challenges/Solutions

As a result of multiple board and care closures throughout the county in addition to barriers posed by some consumers' criminal histories, the program experienced difficulties in locating available lower-level of care placements, such as room and board or board and care. In response, staff has collaborated with various county departments to identify new and appropriate lower-level care placements and resources.

Demographics

Age	Gender Identity	Race/Ethnicity		Primary Language
0% Children 6% TAY 91% Adult 3% Older Adult	♂ 51% Male ♀ 49% Female	21% African- American/ Black	4% Asian/Pacific Islander	... 99% English 1% Other/Not reported
		39% Caucasian/White	33% Latinx/Hispanic	
		0% American Indian/ Alaska Native	2% Other/Unknown	

N=90

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

Adult Residential Facilities Certified in Social Rehabilitation Services

Outreach and Engagement

For FY 2022/23, 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
Community Outreach with Neighbors	3	5
Program Presentation-Behavioral Health Commission Meeting	1	50
Social Community Services	48	270
Total	52	325

Program Updates

There are no planned updates for this program.

Success Story

Through the use of residential and behavioral supports provided by the program, in addition to the learned activities of daily living, “Sergio” was able to complete the program and his conservatorship was discontinued.

Demographics



Primary Diagnosis

3.3% Bipolar disorders

84.4% Psychosis disorders

3.3% Other

1.1% Disruptive disorders

7.8% Schizoaffective disorders

N=90

Enhanced Assisted Living Program

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

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

Success Story

"Adrian" entered the program with significant mental health and medical health needs. Since entering the program, he has made significant progress and was released from Lanterman-Petris-Short (LPS) conservatorship. Adrian continues to actively participate in development activities. He is learning to remain in control of his feelings by using coping skills learned in rehab sessions.

Demographics

Age

0% Children
5% TAY
25% Adult
70% Older Adult



Gender Identity



70% Male



30% Female

Race/Ethnicity

25% African American/Black
65% Caucasian/ White
0% American Indian/ Alaska Native
5% Asian/Pacific Islander
5% Latinx/Hispanic
0% Other/Unknown

Primary Language



95% English
5% Other/Not reported

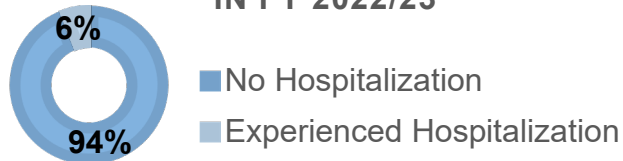
N=20

Enhanced Assisted Living Program

Positive Results

Of the 17 consumers served during this fiscal year, 100% of these consumers did not require use of Alternative Crisis Intervention Services. Additionally, 16 out of 17 (94%) were able to avoid psychiatric hospitalization through use of alternative crisis interventions and support by program staff.

**ENHANCED ASSISTED LIVING
PROGRAM CONSUMERS
IN FY 2022/23**



In FY 2022/23, staff increased bed capacity by adding five additional beds to provide additional resources for the community.

The program also improved timely access to appropriate level of care necessary to treat both mental health and medical conditions. Providing more timely access reduced the amount of time a consumer spends in a locked psychiatric facility.

Challenges/Solutions

In FY 2022/23, the program experienced an increase in referrals from other programs due to limited resources available for housing for consumers with severe and persistent symptoms.

To address these challenges, DBH has worked with vendors to add enhanced board and care beds. These vendors provide medical care on site to manage the co-occurring medical needs.

Outreach and Engagement

For FY 2022/23, the Enhanced Assisted Living Program conducted one program presentation at the Behavioral Health Commission meeting for 50 participants.

Program Updates

There are no planned updates for this program.

Demographics



Primary Diagnosis

20% Bipolar disorders

10% Depressive disorders

70% Psychosis disorders

N=20

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 behavioral 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

Demographics

Age

0% Children
5% TAY
83% Adult
12% Older Adult



Gender Identity



57% Male



42% Female



1% Other

Race/Ethnicity

26% African American/Black

30% Caucasian/White

0% American Indian/Alaska Native

5% Asian/Pacific Islander

33% Latinx/Hispanic

5% Other/Unknown

Primary Language



91% English

4% Spanish

5% Other/Not reported

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

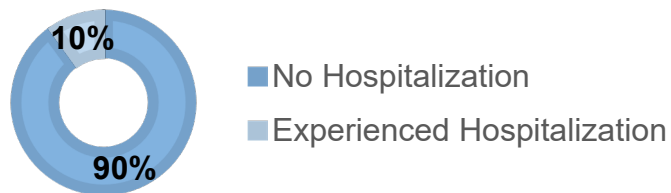
N=76

Enhanced Board and Care Program

Positive Results

The Program served a total of 70 consumers throughout FY 2022/23. Of the consumers served, 90% 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 2022/23**



Demographics



N=76

Primary Diagnosis

1.3% Bipolar disorders	6.6% Depressive disorders
82.9% Psychosis disorders	6.6% Other
2.6% Substance use disorders	

In FY 2022/23, staff increased bed capacity by adding ten additional beds to provide additional resources for the community. In FY2023/24, bed capacity will increase by another 150 beds.

Success Story

“Marisol” came into the program with significant impairment, including lack of funds, no motivation to work, and poor compliance with medications and completion of activities of daily living. Her family was unwilling to consider having her live with them due to these challenges.

Through consistent support and advocacy, Marisol was able to improve her medication compliance and tasks of daily living. She became motivated and started attending a day program, which sparked an interest in working. With the improvement she showed, her family became willing to have her come home for weekend visits. Marisol demonstrated a commitment to taking her medications and, ultimately, the family agreed to have her return home. Her case manager helped her establish medication support services and additional in-home support services. Marisol was able to find a part-time job and is now even helping contribute a small amount to the family household income. She has a new sense of pride and accomplishment in being a contributing member of society. With her immigrant status under the Deferred Action for Childhood Arrivals (DACA) act, she is now in the process of applying for citizenship.

Enhanced Board and Care Program

Challenges/Solutions

In FY 2022/23, a lack of available housing geared towards consumers with higher level of acuity created barriers for consumers stepping down from this level of care. DBH has expanded contracts to allow for increased housing programs.

Staff also experienced challenges in getting consumers on LPS conservatorship into SUD treatment programs. The Program collaborated with the Office of the Public Guardian (OPG) and local SUD treatment programs to eliminate barriers for consumers on LPS conservatorships.

One placement option is outside of the county. Due to this, Medi-Cal benefits must be switched to the new county of residence in order to make auxiliary medical services accessible to the consumers. The DBH Long-Term Care (LTC) team is working closely with OPG to improve the timeliness of the Medi-Cal benefit transfer between counties, thereby avoiding adverse situations such as missed medications or additional costs to the placement facility. 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

For FY 2022/23, the Enhanced Board and Care program conducted one program presentation at the Behavioral Health Commission meeting for 50 participants.

Program Updates

A previously planned expansion to the Enhanced Board and Care program is no longer moving forward. However, in its place, DBH successfully contracted with a new vendor in San Bernardino County with 150 beds. Funding and positions previously dedicated to the initial expansion have been reallocated to the CHAS-PACES program, which will provide ongoing support and services for these new beds.

Success Story

“Gregori” was able to safely transition from the State Hospital level of care into a structured, supportive community-based enhanced board and care facility. Gregori is deaf and, due to the services and supports provided by the enhanced board and care, he has been able to connect to other deaf or hearing-impaired residents and maintain stability within the community.

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

Program Description and Target Population

As of July 1, 2023, the CHAS-PACES team provides on-site services to consumers who are housed at a contracted Enhanced Board and Care facility. The facility provides a stable, structured treatment program in a community setting. The Enhanced Board and Care facility accepts referrals from DBH's Centralized Hospital Aftercare Services, as well as Adult Forensics Programs.

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.

Services Offered

The CHAS-PACES team provides coordinated ongoing case management and therapeutic services to clients in the program, including referral and linkage to community resources and providers, enrollment in benefits, psychoeducational groups, individual therapy, and assistance to step down and transition to lower levels of care when appropriate.

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



Artwork by Julioux Gordilloux

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

Program Updates

The Centralized Hospital Aftercare Services (CHAS) – Placement and Coordination of Enhanced Services (PACES) program is a newly approved program in the MHSA Plan for FY 2023/24. This program will provide coordinated services to those consumers placed at a newly established Enhanced Board and Care site. CHAS-PACES will provide community-based care for consumers exiting from higher levels of locked psychiatric care into this enhanced board and care facility.

Two positions have been transferred from supporting the Enhanced Board and Care contracts to CHAS-PACES where they are most needed in order to ensure ongoing support and services.



Artwork by Rachel Miller



MHSA Annual Update for FY 24/25: 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 a primary focus on providing services.

Innovation projects create an environment for the development of new and effective practices and/or approaches in the field of behavioral health. Innovation projects are time-limited, must contribute to learning, and be developed through a process that is inclusive and representative, especially of unserved, underserved, and inappropriately served populations.

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

- Introduce a behavioral health practice or approach that is new to the overall behavioral health system, including, but not limited to, prevention and early intervention.
- Make a change to an existing practice in the field of behavioral health, including, but not limited to application to a different population.
- Apply to the behavioral health system a promising community-driven practice or an approach that has been successful in a non-behavioral health context or setting.

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



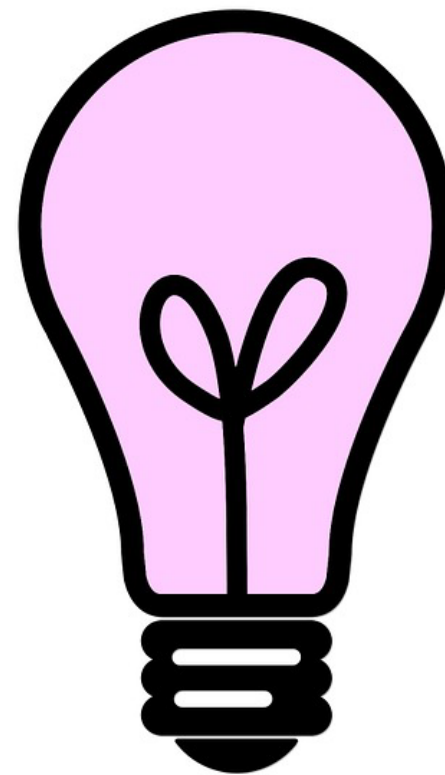
MHSA Legislative Goals

The overall MHSA goal of the Innovation component is to implement and test novel, creative, time-limited, or ingenious mental health approaches that are expected to contribute to learning, transformation, and integration of the mental health system.

Every Innovation project must identify one of the following primary purposes as part of the project's design:

- Increase access to mental health services to underserved groups.
- Increase the quality of mental health services, including measurable outcomes.
- Increase access to mental health services.
- Promote interagency and community collaboration related to mental health services, supports, or outcomes.

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, with the local Behavioral Health Commission being responsible for confirming that the stakeholder process was complete.



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

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.

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.

2023

Progressive Integrated Care Collaborative:

July 2023 – June 2028

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 2022/23	Estimated Number Served FY 2024/25	Annual Budgeted Funds FY 2024/25	Estimated Annual Cost per Person FY 2024/25
InnROADs INN Project	2,148	2,000	\$4,148,595	\$2,074

Target Population and Project Description

InnROADs is a voluntary, consumer-centered project which 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 with 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 2022/23

Age	Sexual Orientation	Gender Identity	Race/Ethnicity
1% Children 4% TAY 75% Adult 17% Older Adult 4% Unknown	 1% of consumers identified as LGBTQ+	 46% Male  29% Female UNK 24% Other *Note: <1% of total Declined to State	14% African American/ Black 46% Caucasian/White 1% American Indian/ Alaska Native 1% Asian/Pacific Islander 18% Latinx/Hispanic 2% 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 2022/23?

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

Culturally Responsive Engagement

Understanding cultural diversity and the ways in which it impacts decision making is a key requirement for effective and responsive outreach and engagement. Over the course of the last fiscal year, the homeless engagement teams have been restructured to allow the engagement team members flexibility to be responsive to cultural needs of those that they are engaging with. This flexibility has allowed members to address language needs and other cultural needs that may present as barriers to engagement if handled by someone unfamiliar with the culture. This learning has resulted in the merging of two engagement teams making a larger culturally diverse team that is centrally located with team members available to be deployed to where the cultural expertise is needed.



An encampment visited by the InnROADs team.

What have we learned during FY 2022/23? (cont.)

Homeless Point in Time Count: The 2023 Homeless Point in Time Count was completed in January 2023 and revealed a sharp increase of 25% more homeless individuals than the year prior. Of these 4,195 total individuals, 77% 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.

Rapid Response Team(s) implemented: Shortly after the InnROADs project fully launched, the COVID-19 pandemic began which required the regional field-based engagement teams to adapt and respond to new needs in the homeless community such as addressing food insecurity, and later providing vaccinations to this population. The service delivery model shifted from being a high frequency/high intensity street-medicine team approach to a “rapid response” model where services and resources were provided through short-term engagements with a higher number of individuals. InnROADs teams were able to adapt to the needs within the community.

In Fiscal Year 2022/23, InnROADs implemented dedicated “Rapid Response Teams” addressing immediate community needs. Targeted response includes addressing immediate needs of individuals in the community as well as short-term interventions specific to the individuals care needs, linkage to appropriate community resources, and/or referral to Engagement Teams. Engagement Teams continue to provide intensive engagement services. Staffing has been added to these teams without affecting the InnROADs approved funding.

Consumer Demographics Highlights FY 2022/23

Veterans



4% of consumers identified as veterans

Language



90% English
2% Spanish
8% Unknown

*Note: >1% listed primary language as Other

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

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?

InnROADs Positive Project Outcomes FY 2022/23



6,967
Records of
Engagement for FY
2022/23



162
Medical
Assessments
documented



88
Crisis
Activities



1,714
No. of total
Referral/Linkage
Activities



609
Counseling and/or
Therapy Activities



2,148
unduplicated consumers
received services during
FY 2022/23

Note: A consumer may have more than one linkage.

Program Updates

Implementation of Rapid Response Teams: Rapid Response teams were implemented in March 2023. The purpose of the Rapid Response Teams is to respond to calls from law enforcement and other community stakeholders on individuals who are homeless and are presenting with an immediate need. Service delivery consists of short-term interventions specific to the individuals care needs, Public Health communicable disease services, linkage to appropriate community resources, referral to a Street Medicine Team, and/or referral to Regional Engagement Teams to provide intensive engagement and behavioral health treatment.

In May 2023, InnROADs was the topic of the Community Policy Advisory Committee meeting. As part of the stakeholder process an update on InnROADs was presented. Eighty-one percent of participants agreed that InnROADs is effectively serving the unhoused population as a multi-agency, multidisciplinary team and 90% of participants were supportive of InnROADs continuing as a program under Homeless and Supportive Services. InnROADs is slated to end as an Innovation Project in Fiscal Year 2023/2024. Planning for sustainability is underway and will continue into Fiscal Year 2023/2024. In the next fiscal year, a final report with a comprehensive evaluation and outcomes, in compliance with the regulations set forth for Innovation Reporting by the MHSOAC, will be completed.

Eating Disorder Collaborative (EDC)

Innovation Projects	Actual Number Served FY 2022/23	Estimated Number Served FY 2024/25	Annual Budgeted Funds FY 2024/25	Estimated Annual Cost per Person FY 2024/25
EDC INN Project	43	134	\$2,624,564	\$19,586

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

Target Population and Project Description

The Eating Disorder Collaborative will focus 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. This project will improve our system of care to better meet the physical and mental health needs of people with EDOs by achieving the following:

- The development and distribution of trainings and informational materials;
- Establishing a more robust initial eating disorder assessment tool;
- The creation and activation of specialized, multidisciplinary eating disorder treatment teams.

Consumer Demographics Highlights FY 2022/23

Age

24% Children
51% TAY
25% Adult
0% Older Adult



Sexual Orientation


8% of consumers identified as LGBTQ+

Gender Identity

 9% Male
 91% Female

Language

 91% English
8% Spanish
1% Unknown

Race/Ethnicity

8% African-American/Black	2% Asian/Pacific Islander
13% Caucasian/White	49% Latinx/Hispanic
0% American Indian/Alaska Native	27% Multiple Races/Other

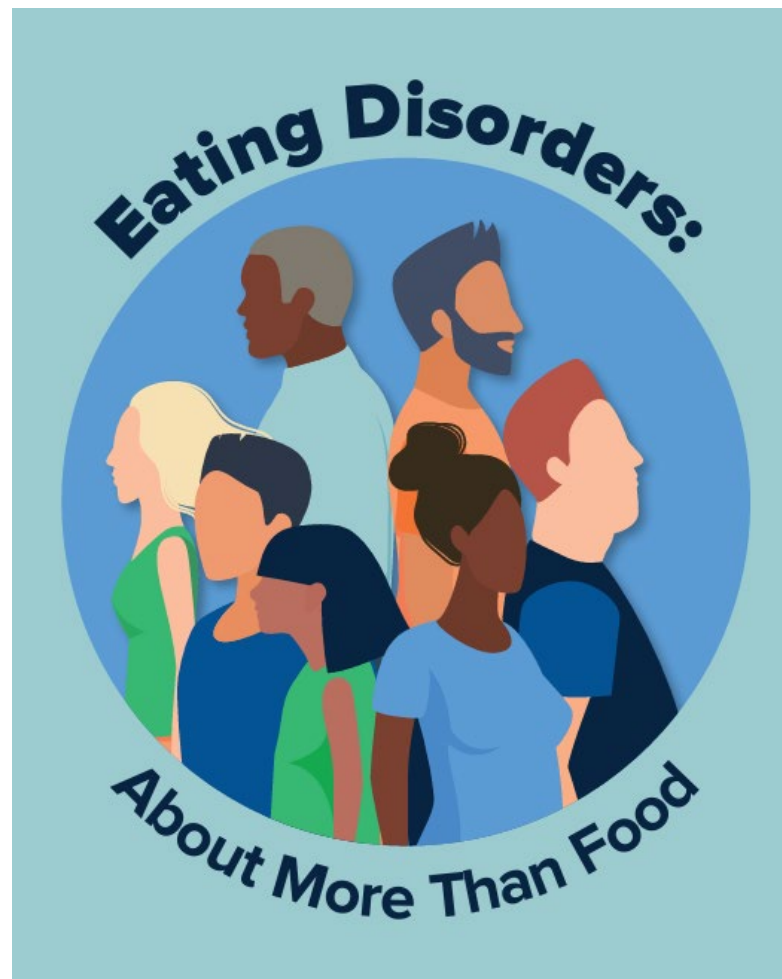
Information represented is based on data collected and may not represent of the number of unique consumers served.

Positive Results

- In FY 2022/23 EDC staff participated in the International Association of Eating Disorder Professionals Symposium held in Palm Desert. Topics of the training included foundational core courses. The topics included: Overview of Eating Disorders, Psychological Treatment of Eating Disorders, Nutrition Therapy for Eating Disorders and Medical Treatment of Eating Disorders. Training included EDC staff and was extended to select DBH staff.
- EDC hosted a two-part training series for DBH staff and contracted providers specifically on Dialectical Behavioral Therapy and the skills needed for working with consumers with disordered eating.

Challenges/Solutions

- Staff hiring and retention remained a challenge during FY 2022/23. EDC management continues to work with Human Resources to recruit and onboard necessary staff. See the Workforce Education and Training Component for additional information on Departmentwide efforts that address staffing issues.



Program Updates

- EDC will continue to work with managed care plans to provide service authorizations for eating disorder clients, referral to appropriate care, care coordination, linkage to outpatient services, and case management for individuals served by the Eating Disorder Collaborative program.
- DBH staff is working on completing the integration of an EDC authorization form into a web-based form, in which collection and tracking of data will ensure a more effective and efficient way of processing payment on EDC invoice claims.
- Additional coordination with Human Resources staff on recruiting and onboarding necessary staff will occur during the upcoming fiscal year.
- Efforts continue in gaining access to a registered dietitian to assist with complex care cases and multidisciplinary treatment.
- EDC staff will work to identify additional trainings regarding eating disorders and treatment options that can be provided to all staff and contracted providers.

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) Project

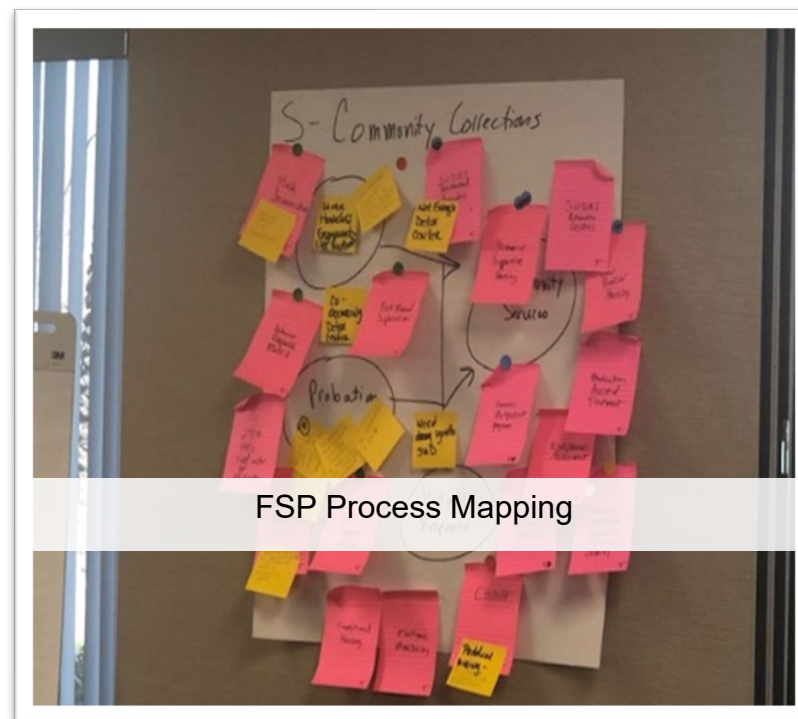
Innovation Projects	Actual Number Served FY 2022/23	Estimated Number Served FY 2024/25	Annual Budgeted Funds FY 2024/25	Estimated Annual Cost per Person FY 2024/25
Multi-County FSP Project	N/A	N/A	\$0	N/A

Target Population and Project Description

The Multi-County Full-Service Partnership (FSP) Project 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), and RAND Corporation, are participating in a 4.5-year Multi-County FSP Innovation Project that will leverage counties' collective resources and experiences to improve FSP service delivery across California.

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



Milestones in FY 2022/23

During the last fiscal year, SBC-DBH accomplished the following:

- Standardization of Graduation Guidelines that balance individual services and supports plans and system-wide outcomes in making individual graduation decisions.
- Ongoing process of developing an electronic referral process and protocols to ensure consistent data collection across FSP programs.
- Improved data reporting by updating existing and/or developing new data reports so that DBH and providers can more effectively, collect, access and utilize FSP Data to inform care decision and understand outcomes.

As part of the larger FSP cohort San Bernardino County and the other five cohort counties built, and finalized, the development of shared population definitions, outcomes, process measures, and statewide data recommendations. As a result, San Bernardino will have more comparable and actionable FSP data that can be used to identify and disseminate FSP best practices. The following activities were developed by the cohort:

- *Population definitions:* Standardized definitions for the following priority FSP populations: “homeless”, “at risk of homelessness”, “justice-involved”, “at-risk of justice involvement”, “high-utilizers of psychiatric emergency facilities”, “at-risk high utilizers of using psychiatric emergency facilities.”
- *Outcomes & process metrics:* Identified 3-5 outcomes, 3-5 process measures, and associated metrics to track what services individuals enrolled in FSP receive and how successful those services are. In January 2022, San Bernardino, and the other five counties, will began sharing data with RAND for the evaluation portion of the project and to compare outcomes across counties.
- *State reporting recommendations:* Finalized recommendations for revising the statewide Data Collection & Reporting (DCR) system.

Challenges/Solutions

- Staffing became a major challenge during FY 2022/23. Due to unforeseen vacancies progress on this project has been slowed. Staffing and onboarding for this project is in progress.

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.



Post-Implementation and Sustainability Phase Summary

In the beginning of 2020, counties began the Landscape Assessment phase of the project to learn how each county's FSP programs are structured and identifying program assets and opportunities in service design, populations served, data collection, and eligibility/graduation practices. During this phase, the cohort was able to identify the foundational components necessary to begin creating consistency across programs and counties.

These learnings included setting the project goals that could be implemented at the cohort level including:

- Defining population characteristics for the six main populations served (homeless, frequent utilizer of psychiatric or crisis services, justice involved, and the corresponding at-risk populations).
- Creating standardized outcomes and process measures to track progress (increased stable housing, reduced justice involvement, reduced utilization of psychiatric facilities, increased social connectedness, and service utilization and location of services).
- Develop state reporting recommendations to address challenges with the Data Collection and Reporting (DCR) system in order to make outcomes data more readily accessible for monitoring program and consumer success.

Additionally, the cohort learned that some challenges may be better addressed at the local level with each of the six counties determining what areas could be improved for their specific populations. With the input from stakeholders, San Bernardino County used this opportunity to focus on developing a streamlined referral process and guidelines, stepdown guidelines, and new data reports to share with providers on a regular basis.

Stakeholder feedback played an important role in not only determining which activities to pursue but also throughout the implementation process as feedback was solicited throughout in the form of workgroups, surveys, and interviews with staff, providers, peer advocates, and consumers.

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 Projects	Actual Number Served FY 2022/23	Estimated Number Served FY 2024/25	Annual Budgeted Funds FY 2024/25	Estimated Annual Cost per Person FY 2024/25
Cracked Eggs INN Project	31	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 see 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% ran by a peer-owned and operated production company Bezerk Productions. The owner Linda Sibio, 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 that are individuals over the age of 16.

Consumer Demographics Highlights FY 2022/23

Age	Sexual Orientation	Gender Identity	Language	Race/Ethnicity	
0% Children 52% TAY 26% Adult 10% Older Adult 13% Unknown 	 6% of consumers identified as LGBTQ+	 29% Male  71% Female	 100% English 0% Spanish	11% African American/Black 39% Caucasian/White 7% American Indian/Alaska Native	16% Asian/Pacific Islander 22% Latinx/Hispanic 5% 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

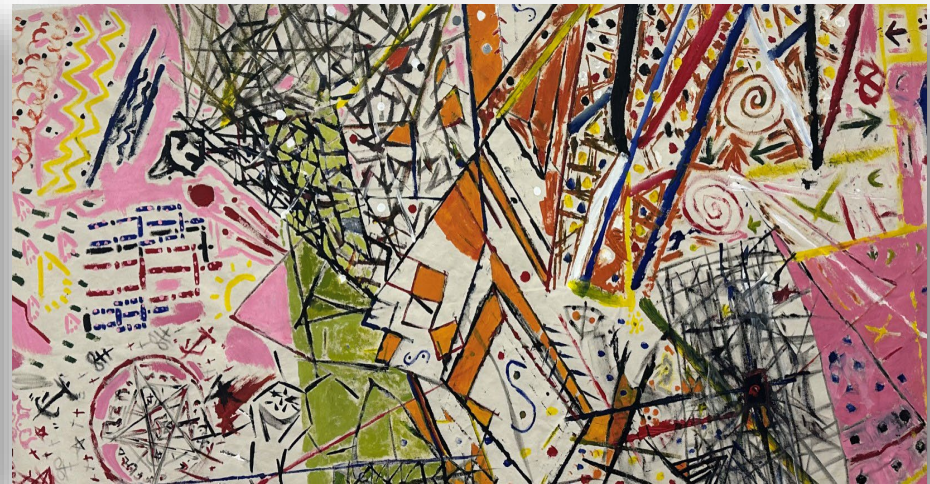
Positive Results

In FY 22/23 there were three successful cohorts, all held in person. These cohorts had consistent attendance with positive feedback.

- Cohort 2 was held from 09/12/2022 to 11/14/2022 and was hosted by Amazing Place Clubhouse in Ontario. Participants from Amazing Place, Serenity and Pathways to Recovery clubhouses were included in this cohort.
- Cohort 3 was held from 01/23/2023 to 04/05/2023 and was hosted at the DBH Training Institute. Clubhouse members from Our Place and Central Valley Fun clubhouses participated.
- Cohort 4 was held from 05/15/2023 to 07/19/2023 and was hosted by Valley Star Transitional Aged Youth (TAY) One Stop Center in Yucca Valley.



Artwork from Cohort 2



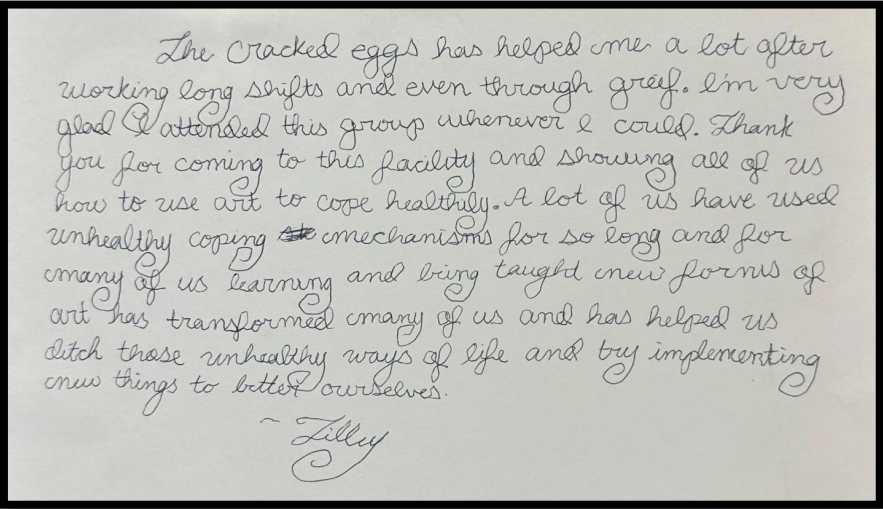
Collaborative piece by Cohort 4

Challenges/Solutions

- Virtual workshops were a challenge in the first cohort, however this fiscal year, in-person workshops have received positive feedback from Clubhouses and the One Stop TAY centers. Participation and attendance have improved significantly this fiscal year due to in-person and hands-on instruction.

Program Updates

- Movement, breathing and visual art have been incorporated throughout the program's curriculum. Participants have expressed that Cracked Eggs provides a safe space.
- Below is a letter a Cracked Eggs participant from Cohort 4 wrote about the Cracked Eggs program and how it has helped her.

A handwritten letter on a piece of lined paper, written in cursive. The text expresses gratitude for the Cracked Eggs program, mentioning how it helped the writer cope with grief and learn healthy coping mechanisms through art. The letter is signed "Lilly".

The Cracked eggs has helped me a lot after working long shifts and even through grief. I'm very glad I attended this group whenever I could. Thank you for coming to this facility and showing all of us how to use art to cope healthily. A lot of us have used unhealthy coping ~~to~~ mechanisms for so long and for many of us learning and being taught new forms of art has transformed many of us and has helped us ditch those unhealthy ways of life and try implementing new things to better ourselves.

- Lilly

Project Learning Goals

These project goals are currently in progress as the program continues into its 6th 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 2022/23	Estimated Number Served FY 2024/25	Annual Budgeted Funds FY 2024/25	Estimated Annual Cost per Person FY 2024/25
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 disproportionately 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 (MHOAC) on 05/25/2023 and the San Bernardino County Board of Supervisors on 06/13/2023. 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 approved project will incorporate a full range of outpatient mental health and substance use disorder services alongside primary care services with the goal of:

- Sharing access to medical information (with appropriate permissions);
- Streamline the patient experience;
- Meeting and conferring about individual cases; and
- Developing procedures and practices to ensure the delivery of all needed care.



The Apple Valley Clinic where PICC will be located

Project Overview

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

- **Laboratory Studies:** Physical health, mental health and substance use treatment rely upon 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 and Medical Imaging:** 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. Radiographic studies which include ultrasound studies, X-Ray studies, Computed Tomography and Magnetic Resonance Imaging provide detailed and objective evidence in support of accurate diagnosis of physical health conditions which frequently have implications for both mental health and substance use recovery. In office ultrasound can provide rapid diagnostic information while more advanced imaging studies require a referral system to be established along with a contract for interpretation by skilled physician radiologists.
- **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.

Project Overview (cont.)

- **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.
- **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.



MHSA Annual Update for FY 24/25: 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 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 utilization of various strategies to recruit and retain qualified behavioral health employees.



Artwork by Jessica Darling

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.

“I enjoyed talking to patients and learning different interviewing styles. I also enjoyed learning about different medications and seeing how patients responded to therapy and medications. After completing this rotation, I am more interested in psychiatry, I now want to do another psychiatry rotation to gain more experience and decide if I would like to do residency in psychiatry.”

-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.

Positive Results

To meet the goal of addressing workforce shortages, a needs assessment was 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 2022/23, including Clinic Supervisor, Mental Health Specialist, Pre-Licensed Clinical Therapist (Psychology), Nurse Supervisor, Program Manager II, and Psychiatric Technician I. There was also a dramatic increase in applications for the Alcohol and Drug Counselor position in FY 2022/23.

"It has been a privilege and an honor to have been selected as an employee intern. This program is essential in promoting growth and professional development. I am very appreciative of all my experiences and know that I have gained competencies and skills necessary to promote wellness to the [consumers] and our community."

– Master of Social Work 20/20 Employee Intern

Workforce Education and Training

Positive Results (cont.)

The table below shows the number of qualified applications received for specific job positions in FY 2022/23:

Job Title	Number of Qualified Applications Received in FY 2022/23	Job Title	Number of Qualified Applications Received in FY 2022/23
Alcohol and Drug Counselor	103	Nurse Supervisor	11
Child Psychiatrist	5	Peer and Family Advocate I	N/A
Clinic Assistant	N/A	Peer and Family Advocate II	N/A
Clinic Supervisor	55	Peer and Family Advocate III	170
Clinical Therapist, LCSW	6	Pre-Licensed Clinical Therapist, LCSW	464*
Clinical Therapist, MFT	1	Pre-Licensed Clinical Therapist, MFT	464*
Clinical Therapist, Psychology	2	Pre-Licensed Clinical Therapist, Psychology	42
Clinical Therapist II	33	Pre-Licensed Clinical Therapist, LPCC	464*
Licensed Vocational Nurse	63	Program Manager I	34
Mental Health Education Consultant	N/A	Program Manager II	26
Mental Health Nurse II	22	Psychiatric Technician I	71
Mental Health Specialist	133	Psychiatrist	27
Nurse Manager	11	Research and Planning Psychologist	N/A

* Pre-Licensed Clinical Therapists Recruited Together

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 1-13, there has been, on average, an approximately **78%** 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	16	89%
LEPP 5	2014/15	41	38	93%
LEPP 6	2015/16	59	54	92%
LEPP 7	2016/17	65	58	89%
LEPP 8	2017/18	49	39	80%
LEPP 9	2018/19	41	31	76%
LEPP 10	2019/20	35	29	83%
LEPP 11	2020/21	26	22	85%
LEPP 12	2021/22	31	20	65%
LEPP 13	2022/23	15	8	53%
Grand Total		510	399	78%

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 13 Cohorts of LEPP, Prior to Implementation of Revised LEPP*

	Clinical Therapist I	Clinical Therapist I Psychologist	Total
Licensed	45	3	48
Pre-Licensed	87	7	94
Total	132	10	142
Percentage Licensed	34.1%	30.0%	33.8%

*DBH has seen a decrease of 1.5% in the percentage of licensed staff in FY 2022/23.

“Personally, I always wanted to work with underserved population, but this rotation made that desire stronger.”

-Western University Medical Student

With the passage of the MHSA and the creation of WET, DBH was able to consolidate and expand the Internship Program. WET coordinates all aspects of the internships and practicums placed within DBH. Currently, the Internship Program trains students who are enrolled in the following bachelor and graduate programs:

- Social Work
- Marriage and Family Therapy (MFT)
- Psychology

Depending on their discipline, interns participate in the Internship Program for 12 to 18 months. During that time, they learn to provide clinical services in a public community behavioral health setting. In FY 2022/23, there was a total of 41 interns in the Internship Program across the three disciplines.

The program continues to grow and receive positive feedback from participants who report that they received comprehensive training and a valuable experience during their time at DBH. It is hoped that integrating psychiatric residents into the clinical staff and supporting their understanding of the therapeutic process, as well as increasing their clinical skills, will lead to an increase in the retention and hiring of psychiatrists who complete their residency at DBH.

Workforce Education and Training

Positive Results (cont.)

DBH is committed to hiring applicants who were previous DBH interns. As seen in the following table, 30% of clinical hires in FY 2022/23 were DBH interns; fifteen DBH interns were hired as pre-licensed Clinicians with the department in FY 2022/23.

Pre-Licensed Clinicians Hired	FY 2022/23
Total Number of Interns Hired	15
Total Number of Non-Interns Hired	35
% of Interns Hired	30%

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 80 NP students with four of those in FY 2022/23.

To meet the goal of educating the workforce by incorporating 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 2022/23, the following are examples of trainings that incorporate MHSA standards:

- Law and Ethics for County Healthcare Providers
- Motivational Interviewing
- Objective Arts
- Transformational Collaborative Outcomes Management (TCOM)

Workforce Education and Training

Positive Results (cont.)

The training information table below indicates that the evaluation average of the trainings in FY 2022/23 was 4.67 out of 5. This rating reflects higher than average trainee satisfaction for the previous nine years. There was a 13% increase in attendance in FY 2022/23 largely due to WET being able to resume a more traditional training practice following the COVID-19 restrictions of previous fiscal years.

In FY 2022/23, WET was pleased to again offer New Employee Orientation in person, which allowed new staff to network with each other and meet department leadership personally. Additionally, CPR training was resumed after a long-term hold due to COVID, and staff are now able to certify and re-certify in CPR through the department. Several important trainings were provided for staff in the fiscal year, including Personal Safety in the Field, which trained 113 field-based staff to keep them safe in their work, and 183 clinical staff completed AB 1759: Telehealth in Mental Health training, which is a new training requirement for clinical licensure. Finally, 25 staff members were provided with Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) training in 3 formats to complete most of the requirements toward pursuit of national TF-CBT certification.

The table below provides additional information regarding trainings provided by WET in FY 2022/23.

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

Workforce Education and Training

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 seen 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 the public's knowledge of the Peer and Family Advocate position, as well as increases the number of qualified applicants applying for these vacancies each year.

Total Peer and Family Advocates with DBH			
Fiscal Year	Positions	Fiscal Year	Positions
FY 2005/2006	4	FY 2014/2015	29
FY 2006/2007	19	FY 2015/2016	28
FY 2007/2008	24	FY 2016/2017	26
FY 2008/2009	24	FY 2017/2018	36
FY 2009/2010	21	FY 2018/2019	28 (Plus 7 Vacancies)
FY 2010/2011	20	FY 2019/2020	35 (Plus 7 Vacancies)
FY 2011/2012	24	FY 2020/2021	35 (Plus 7 vacancies)
FY 2012/2013	25	FY 2021/2022	29 (Plus 20 vacancies)
FY 2013/2014	23	FY 2022/2023	34 (Plus 21 vacancies)
Total			464

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		

“Previously, I wasn’t considering psychiatry as a possible career choice, but I am now. Getting to interact with many diverse patients every day increased my interest in psychiatry.”

-California University of Science & Medicine Medical Student

The contract agencies that work with DBH are required to employ PFAs as well, although they may be given different working titles. The number of PFAs employed with DBH contract agencies continues to increase as more programs are choosing to utilize the benefits presented by incorporating peer support and advocacy into their practices.

Not all contract agencies use the PFA title. A few other titles they use are:

- Family Partner
- Youth Partner
- Peer Partner
- Parent Partner
- Family Support Partner
- Parent Family Advocate

To meet the 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 following table, 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

Workforce Education and Training

Positive Results (cont.)

caused the Volunteer Services Coordinator to attend fewer outreach events than in previous years.

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
Total	492	51,405

To help reach the Spanish speaking community, the 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 the employment of individuals in the public mental health system who are culturally and linguistically competent or, at a minimum, are educated and trained in cultural competence, DBH strives to have staff that provide culturally and linguistically competent services to consumers. To ensure that 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.

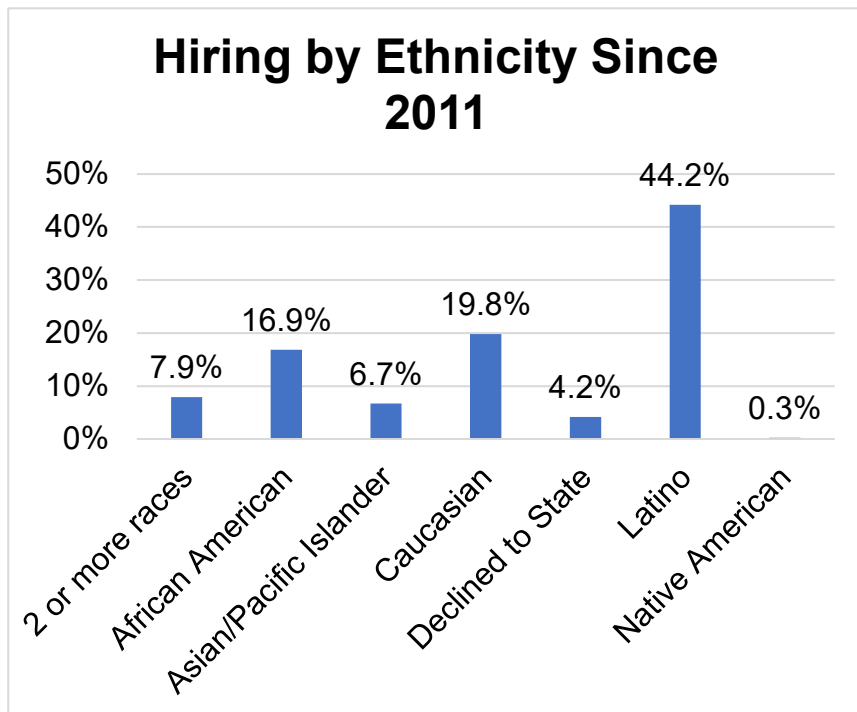
"Thank you for this opportunity. I have really grown and become more confident in my clinical skills. Great Program!!"

– Master of Social Work Intern

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 help provide culturally and linguistically competent services to consumers, DBH actively recruits applicants who are bilingual and bicultural. As can be seen below, DBH continued to maintain the number of bilingual staff employed in FY 2022/23. However, 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

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 2022/23, **27%** of interns were bilingual. Of the bilingual interns, **73%** 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%
Total	215	610	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	Doctorate	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
Total	3	3	37	33	2	78

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		

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

Success Points

- MFT interns successfully completed internship.
- All 3rd year Psychiatric residents promoted to 4th year maintaining service needs with their psychotherapy consumers.
- All 4th year Psychiatric Residents successfully terminated with their psychotherapy consumers prior to graduation and transitioned the consumers to another provider.

WET was able to renew the following DBH sites as approved National Health Service Corps (NHSC) designated sites in FY 2022/23, enabling DBH employees working at those sites to continue to be eligible for NHSC Financial Incentive Programs including the Loan Repayment Programs:

- Barstow Counseling Center
- CCRT High Desert/Age Wise
- Needles Counseling Center
- Victorville Day Reporting Center
- Victor Valley

To meet the goal of incorporating the input of consumers and family members, and when possible, utilize them as trainers and consultants in public mental health WET programs and/or activities, the Office of Consumer and Family Affairs (OCFA) is invited to the Workforce Development Discussion (WDD) meeting to provide input on the implementation of the MHSA WET Plan component. OCFA is a Peer and Family Advocate office that provides advocacy and support to consumers and family members.

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 the diverse racial/ethnic populations of San Bernardino County are being met.

To meet the goal of establishing regional partnerships, the Southern Counties Regional Partnership (SCRCP) was created in 2009. SCRCP is a collaborative effort between ten Southern California counties. The Partnership's goals are to coordinate regional education programs, disseminate information and strategies throughout the region, develop common training opportunities, and share programs that increase diversity of the public behavioral health system workforce when those programs are more easily coordinated at a regional level. The ten member counties include:

- Kern
- Imperial
- Orange
- Riverside
- San Bernardino
- San Diego
- San Luis Obispo
- Santa Barbara
- Tri Cities
- Ventura

San Bernardino County was the fiscal agent of SCRCP until June 30, 2014. Santa Barbara County assumed responsibility as the fiscal agent since FY 2014/15. San Bernardino County continues to participate in SCRCP as a member county.

Workforce Education and Training

Challenges/Solutions

The WET program experienced a staffing shortage in FY 2022/23, which made it challenging to provide trainings to meet the needs of a growing and diverse workforce, including Continuing Education Units (CEUs) and certification requirements. Difficulties continue with recruitment and retention efforts, such as high turn-over rates and increased vacancies. To address these difficulties, DBH held hiring fairs and utilized targeted recruitment efforts with County HR. Additionally, there was an increase in requests for in-person training for DBH staff. To meet these requests, WET continues to transition into offering more in-person training opportunities.

WET experienced a decreased use of the employee scholarship program during the last fiscal year. To increase use of this program, a discussion was held to expand the employee scholarship program to include previous ineligible participants to increase employee participation. This led to concentrated advertising efforts, and the program is in the preliminary stages of expanding services.

Insufficient numbers of site supervisors and the need to adjust the current internship programs to meet the needs of nontraditional degree programs presented challenges for the WET team. To address these challenges, WET adjusted the intern program dates to align one cohort per year with the schedules of nontraditional schools.

An increased need for Nurse Practitioners (NPs) and specialized psychiatrists such as Child and Adolescent Psychiatrists revealed challenges for placement opportunities and creation of career of MOUs have been updated to include Nurse Practitioner as a pipeline for nursing staff. To address these challenges, a number internship option, which expands the nursing pipeline. There are also plans to expand the number of psych residents in the program.

Lack of placement sites for the Volunteer Services Program, Internship Program, NP students, and psychiatric residents/fellows is an on-going issue as is the lack of multiple entry points needed for various internship programs. Discussions continue on how to address these challenges.

The addition of interactive online modules to our catalog brought to light the high completion rates of online training in the department. While online training via our 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.

Workforce Education and Training

Challenges/Solutions (cont.)

Since online modules of all types are available on demand and self-paced, the data is best represented by the total number of completions by fiscal year instead of by month. It is also important that we gather evaluation data for these trainings, just as we do for live sessions. To accomplish this, new evaluation forms were implemented for all online courses and added to the LMS modules to be used to track staff completion within the fiscal year. As well, the feedback collected will help to improve our online courses and their effectiveness.

“This program helped me to feel prepared to step into my professional social work career. I have appreciated the support from WET, as well as the staff at my site that contributed to my learning experience.”

-Bachelor of Social Work Intern

Outreach and Engagement

In FY 2022/23, WET organized and/or participated in the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
School College and Career Fairs (Elementary, Middle, High Schools)	0	0
College Career Fairs	24	2,993
Classroom Presentations	10	1,090
Mock Interviews	5	139
Total	39	4,222

Success Points

Two medical students who completed their clinical rotations in DBH started the ARMC Psychiatry Program in FY 2022/23.

Program Updates

In FY 2022/23, DBH continued the work to recognize the benefit of peer support providers, paving the way for Department of Healthcare Services (DHCS) to establish “Peer Support Specialists” as a provider type for both mental health and substance use support services. WET will work to develop trainings geared towards helping peers meet their new CEU requirement.

WET received three new Clinical Therapist II positions to enable the expansion of the MSW, BSW, MFT, and Psychology internship programs.

In FY 2022/23, San Bernardino County retained the services of Reality Based Leadership, LLC, for leadership training and employee development. Reality Based Leadership, LLC, will provide 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 will include interactive learning sessions, books and support materials, and group coaching sessions (Leadership component). The trainings will be conducted in-person and/or virtually to begin in FY 2023/24 through March 2026 and will include 100 individuals from the management and leadership teams with an additional 2,000 slots for line staff.

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
- Brandman 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)



MHSA Annual Update for FY 24/25: 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 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 a variety of 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 will reduce the need for incarceration or institutionalization, and
- The development of technological infrastructure for the public behavioral health system to facilitate high quality, cost-effective services and supports for consumers and their families.

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 which increases the San Bernardino County Department of Behavioral Health's infrastructure on a permanent basis. Simply stated, a building or space where MHSA services can be provided.

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.

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 provides the necessary framework for meeting the requirements of CalAIM 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) and the delivery modes
- Maintain and utilize the Data Warehouse to generate reports
- Respond to various aspects related to the 1115 Waiver Medi-Cal Program (Medi-Cal 2020)
- Enhancing and maintaining the telehealth and data communications network that is strictly used to support telehealth services
- 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

Capital Facilities

The DBH Call Center is the centralized phone system for all calls for the ACCESS Unit, Substance Use Disorder and Recovery Services (SUDRS), and Community Crisis Response Teams (CCRT). The phone system utilizes the CISCO Unified Contact Center and is designed to allow DBH staff to answer calls remotely and connect to the phone system. The phone system provides features including call queuing, comprehensive reporting, call volume monitoring, and dashboards for real-time view of calls.

Technological Needs

To address the goal of increasing access to services, DBH's Research and Evaluation (R&E) created interactive clinical maps for the Adult's and Foster Youth System of Care to assist with informed decision making and ensure access to care. R&E also specifically monitors and reports on access to services for consumers shared by each Managed Care Plan, including special populations like Foster Youth or unsheltered individuals. Data from the Data Warehouse supports grant requests and contract negotiations which are instrumental in maintaining and expanding the DBH network of care.

Budgetary allocation and the renewal of SAS software licensing and maintenance agreement to support and expand the Data Warehouse, with text mining/text analytics for data extraction from clinical notes, will continue to improve data collection, monitoring, reporting of new and

Technological Needs (cont.)

existing requirements (MHSA, SB1291, Final Rule, CalAIM, HEDIS, and CARES Act, etc.), and data modeling designed for use in clinical support tools.

The Data Warehouse also supports the monitoring and implementation of:

- Data quality improvement initiatives
- Additional data reporting for MHSA annual reports, audits, and reviews
- Data collection and reporting for Innovations programs
- Data and reporting for DBH housing programs
- Expanded reporting to meet Network Adequacy requirements including monthly electronic submissions of the provider directory to the Department of Healthcare Services (DHCS).

In order to maintain and utilize the Data Warehouse, DBH began submitting finder files to DHCS for the Plan Data Feed, allowing DBH to receive data files containing Medi-Cal service and pharmacy data for DBH consumers from external providers. This data will provide a more comprehensive view of DBH consumers for clinical and medical staff when incorporated with DBH EHR data.

R&E's ability to report out data for the InnROADs program showing its positive impacts on its target population provided information necessary for program continuation funding and incorporation of this key program into DBH's homeless initiatives.

Positive Results (cont.)

Innovative Health Information Technology (iHIT)

To support the complex requirements associated with reimbursements, a dedicated Revenue Cycle Unit has been established, and responsibilities for claiming and billing have been transferred from IT to the Revenue Cycle Unit. This transfer of duties provided the IT staff needed to update the EHR to support the Department of Healthcare Services (DHCS) California Advancing and Innovating Medi-Cal (CalAIM) program. Payment reform was implemented on 7/1/2023 and Medi-Cal claims have been submitted and approved.

To enhance data security, eliminate the need to use a Virtual Private Network (VPN) to connect to the EHR, and streamline access to the EHR for County & Community Based Organizations, the EHR was migrated to the Netsmart Cloud and the Multifactor Authentication (MFA) was implemented to verify user identities before granting access to the EHR.

Challenges/Solutions

Technological Needs

The Data Warehouse challenges continue to be the integration of the wide range of data, including new clinical data, into the Data Warehouse, the development and use of data mining in clinical support, and text analytics for use with clinical notes.

Innovative Health Information Technology (iHIT)

Complying with the CalAIM requirements continues to be a challenge for the EHR. CalAIM requires 1. improving data sharing capabilities with Medi-Cal Managed Care Plans, 2. mapping EHR data elements to the United States Core Data for Interoperability (USCDI) standard set, and 3. implementing an active Fast Healthcare Interoperability Resources (FHIR) application programming interface (API) to demonstrate compliance with CMS-mandated interoperability rules.

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

- The budgetary increase has allowed our Information Technology (IT) department to add staffing roles within SOaS.
- These newly established positions are set to play a pivotal role in supporting our capacity to meet DBH's new and highly specialized technological demands, particularly in the context of healthcare systems and their associated requirements.

Behavioral Health Management Information Systems Expansion

- The budgetary increase has allowed our Information Technology (IT) department to add staffing roles within iHit.
- This expansion is necessary to support claiming and billing functions that allow DBH to receive revenue and increase access and system availability for providers and consumers and to support security of data in compliance with evolving requirements (CalAIM, Final Rule, CMS Interoperability Rule, and CalHHS Data Exchange Framework (DxF)).

Data Warehouse Maintenance and Support

Budgetary allocation and the renewal of SAS software licensing and maintenance agreement to support and expand the Data Warehouse, with text mining/text analytics for data extraction from clinical notes, will continue to improve data collection, monitoring, reporting of new and existing requirements (MHSA, SB1291, Final Rule, CalAIM, HEDIS, and CARES Act, etc.), and data modeling designed for use in clinical support tools.

Capital Facilities and Technological Needs-Grant Funding

- DBH was awarded the Community Care Expansion (CCE) Preservation Grant by DHCS in the amount of \$10,093,171 on June 23, 2023. MHSA funds from the Capital Facilities and Technological Needs component to fund capital facilities projects was utilized as matching funds. Acceptance of a CCE Grant required the accepting agency to provide matching funds in the amount of 10%.

Capital Facilities and Technological Needs

Program Updates (cont.)

Capital Facilities and Technological Needs-Grant Funding (cont.)

- DBH was awarded the Behavioral Health Continuum Infrastructure Program (BHCIP) Round 5. MHSA funds from the Capital Facilities and Technological Needs component to fund capital facilities projects was utilized as matching funds. Acceptance of the BHCIP Grant, required the accepting agency to provide matching funds in the amount of 29% of the award.
- Together, these two grants focus on addressing the housing and treatment needs of unsheltered persons, adolescents and adults with serious mental health and substance use disorder (SUD) and increase bed capacity with mental health and SUD facilities.



Artwork by Estefania Galvez



MHSA Annual Update for FY 24/25: 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 be in-line with actual anticipated utilization values based on historical trends and anticipated growths. This revision helps ensure more accurate reporting of usages and availabilities of MHSA funds allotted to DBH consistent with County of San Bernardino's continued goal of responsible use of our resources to ensure financial sustainability and does not impact Board of Supervisors approved commitments.



Artwork by Jesus Aleman

Funding Summary FY 2024/25
County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Annual Update Fiscal Year 2024/25

	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 2024/2025 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	\$ 162,031,572	\$ 51,423,391	\$ 18,606,484	\$ -	\$ -	\$
2. Estimated New FY 2024/2025 Funding	\$ 136,934,403	\$ 34,825,724	\$ 9,262,942			\$
3. Transfer in FY 2024/2025	\$ (14,270,777)	\$	\$	\$ 6,045,605	\$ 8,225,172	\$
4. Access Local Prudent Reserve in FY 2024/2025	\$	\$	\$	\$	\$	\$
5. Estimated Available Funding for FY 2024/2025	\$ 284,695,198	\$ 86,249,115	\$ 27,869,426	\$ 6,045,605	\$ 8,225,172	\$
Estimated FY 2024/2025 MHSA Expenditures	\$ 134,525,029	\$ 32,059,056	\$ 3,537,126	\$ 6,045,605	\$ 8,225,172	\$
FY 2024/2025 Unspent Fund Balance	\$ 150,170,169	\$ 54,190,060	\$ 24,332,300	\$ -	\$ -	\$
Estimated Local Prudent Reserve Balance						
1. Estimated Local Prudent Reserve Balance on June 30, 2024	\$ 21,655,429.00					
2. Contributions to the Local Prudent Reserve in FY 2024/2025	\$					
3. Distributions from the Local Prudent Reserve in FY 2024/2025	\$					
4. Estimated Local Prudent Reserve Balance on June 30, 2025	\$ 21,655,429.00					

PREVENTION AND EARLY INTERVENTION FY 2024/25

County of San Bernardino

Department of Behavioral Health

Mental Health Services Act (MHSA)

MHSA Annual Update Fiscal Year 2024/25

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	\$ 27,599,548	\$ 13,255,235	\$ 12,386,150			\$ 1,958,163
Outreach for Recognition of Early Signs of Mental Illness						
1. PEI CI-1 Promotores de Salud/Community Health Worker	\$ 1,260,000	\$ 1,260,000				
2. PEI CI-4 Behavioral Health Ministries Pilot Project	\$ -	\$ -				
3. PEI CI-5 Substance Use Prevention & Pathways to Outreach and Treatment (SUPPOrT)	\$ 317,500	\$ 158,750	\$ 158,750			
Suicide Prevention						
1. PEI SE-8 Office of Suicide Prevention	\$ 380,504	\$ 380,504				
Stigma and Discrimination Reduction						
1. PEI CI-3 Native American Resource Center	\$ 456,851	\$ 456,851				
Prevention						
1. PEI SI-2 Preschool PEI Program	\$ 451,969	\$ 451,969				
2. PEI SI-3 Resilience Promotion in African American Children	\$ 1,700,000	\$ 1,700,000				
3. PEI SE-1 Older Adult Community Services	\$ 805,710	\$ 805,710				
4. PEI SE-5 Lift Program	\$ 811,341	\$ 811,341				
5. PEI SE-6 Coalition Against Sexual Exploitation (CASE)	\$ 318,403	\$ 318,403				

PREVENTION AND EARLY INTERVENTION FY 2024/25 (cont.)

County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Annual Update Fiscal Year 2024/25

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 and Early Intervention						
1. PEI CI-2 Family Resource Center	\$ 4,603,915	\$ 4,603,915				
2. PEI SE-3 Community Wholeness and Enrichment	\$ 778,151	\$ 778,151				
3. PEI SE-4 Military Services and Family Support	\$ 535,521	\$ 535,521				
4. PEI SI-1 Student Assistance Program (SAP)	\$ 7,212,144	\$ 2,439,472	\$ 3,236,672			\$ 1,536,000
5. PEI SE-7 Improving Detection and Early Access (IDEA)	\$ 1,000,000	\$ 1,000,000				
PEI Programs	\$ 48,231,557	\$ 28,955,822	\$ 15,781,572	\$ -	\$ -	\$ 3,494,163
PEI Administration	\$ 2,541,340	\$ 2,541,340				\$ -
PEI Assigned Funds	\$ 561,894	\$ 561,894				\$ -
Total PEI Program Estimated Expenditures	\$ 51,334,791	\$ 32,059,056	\$ 15,781,572	\$ -	\$ -	\$ 3,494,163

COMMUNITY SERVICES AND SUPPORTS FY 2024/25

County of San Bernardino

Department of Behavioral Health

Mental Health Services Act (MHSA)

MHSA Annual Update Fiscal Year 2024/25

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)	\$ 49,755,221	\$ 31,976,142	\$ 17,762,644			\$ 16,435
2. C-2 Integrated New Family Opportunities Program (INFO)	\$ 1,894,103	\$ 1,217,907	\$ 676,196			
3. TAY-1 One Stop TAY Centers	\$ 6,679,071	\$ 4,294,638	\$ 2,384,433			
4. A-2 Forensic Services Continuum of Care	\$ 7,025,010	\$ 3,021,001	\$ 2,507,933		\$ 968,703	\$ 527,373
5. A-3 Assertive Community Treatment Model FSP	\$ 2,779,852	\$ 1,787,443	\$ 992,409			
6. A-7 Homeless Services, Long-Term Supports, and Transitional Care Programs	\$ 19,233,860	\$ 11,927,881	\$ 6,389,134			\$ 916,845
7. OA-1 Age Wise	\$ 2,248,491	\$ 1,445,778	\$ 802,713			
8. A-11 Regional Adult Full Service Partnership (RAFSP)	\$ 16,367,247	\$ 6,359,215	\$ 7,422,941			\$ 2,585,091
10. A-20 Collaborative Adult Full Service Partnership Services	\$ 4,033,119	\$ 2,593,293	\$ 1,439,826			
FSP Programs Total	\$ 110,015,974	\$ 64,623,298	\$ 40,378,229	\$ -	\$ 968,703	\$ 4,045,744

COMMUNITY SERVICES AND SUPPORTS FY 2024/25 (cont.)

County of San Bernardino

Department of Behavioral Health

Mental Health Services Act (MHSA)

MHSA Annual Update Fiscal Year 2024/25

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	\$ 5,945,850	\$ 5,945,850				
2. A-4 Crisis Stabilization Units (CSU)/Crisis Walk-In Centers (CWIC)	\$ 13,623,215	\$ 8,455,435	\$ 4,649,296			\$ 518,484
3. A-5 Triage Transitional Services (TTS)	\$ 3,279,588	\$ 2,108,773	\$ 1,170,815			
4. A-6 Community Crisis Services	\$ 11,850,352	\$ 6,999,001	\$ 3,515,321			\$ 1,336,030
5. A-9 Access, Coordination, and Enhancement (ACE) of Quality Behavioral Health Services	\$ 2,961,782	\$ 1,904,424	\$ 1,057,358			
6. A-10 Crisis Residential Treatment Program (CRT)	\$ 16,119,345	\$ 9,588,990	\$ 5,397,615			\$ 1,132,740
7. A-13 Adult Transitional Care Programs	\$ 30,291,992	\$ 18,072,482	\$ 12,219,510			
9. A-15 Recovery Based Engagement Support Teams (RBEST)	\$ 2,338,604	\$ 1,503,721	\$ 834,883			
8. A-16 Crisis Intervention Collaborative Programs	\$ 5,995,985	\$ 3,262,827	\$ 2,140,570			\$ 592,588
Non-FSP Programs Total	\$ 92,406,713	\$ 57,841,503	\$ 30,985,368	\$ -	\$ -	\$ 3,579,842
CSS Programs	\$ 202,422,687	\$122,464,801	\$ 71,363,597	\$ -	\$ 968,703	\$ 7,625,586
CSS Administration	\$ 16,588,325	\$ 12,060,228	\$ 4,500,920			\$ 27,177
Total CSS Program Estimated Expenditures	\$ 219,011,012	\$134,525,029	\$ 75,864,517	\$ -	\$ 968,703	\$ 7,652,763
FSP Programs as Percent of Total	50%					

INNOVATION FY 2024/25
County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Annual Update Fiscal Year 2024/25

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	\$ 2,624,564	\$ 2,624,564				
3. INN-10 Multi County Full Service Partnership (FSP)	\$ -					
4. INN-11 Cracked Eggs	\$ 185,241	\$ 185,241				
5. INN-12 Progressive Integrated Care Collaborative (PICC)	\$ 2,816,114	\$ 2,816,114				
6. INN-13 Vyvanse in Stimulate Addiction (VISA)	\$ -	\$ -				
INN Programs	\$ 5,625,919	\$ 2,809,805	\$ -	\$ -	\$ -	\$ -
INN Administration	\$ 727,321	\$ 727,321	\$ -			\$ -
Total INN Program Estimated Expenditures	\$ 6,353,240	\$ 3,537,126	\$ -	\$ -	\$ -	\$ -
*Transitioned to CSS A-7- effective April 2024						

WORKFORCE EDUCATION AND TRAINING FY 2024/25

County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Annual Update Fiscal Year 2024/25

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	\$ 487,479	\$ 487,479				
2. Internship Program	\$ 1,958,975	\$ 1,958,975				
3. Psychiatric Residency Program	\$ 1,268,742	\$ 1,268,742				
4. Financial Incentive Program	\$ -					
WET Programs	\$ 3,715,196	\$ 3,715,196				
WET Administration	\$ 2,133,956	\$ 2,133,956				
WET Contribution	\$ 196,453	\$ 196,453				
Total WET Program Estimated Expenditures	\$ 6,045,605	\$ 6,045,605	\$ -	\$ -	\$ -	\$ -

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS FY 2024/25

County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Annual Update Fiscal Year 2024/25

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	\$ 348,182	\$ 348,182				
2. Behavioral Health Management Information Systems (BHMIS), Electronic Health Record (EHR), Telemedicine Project	\$ 5,114,827	\$5,114,827				
CFTN Projects	\$ 5,463,009	\$5,463,009	\$ -	\$ -	\$ -	\$ -
CFTN Administration	\$ 2,762,163	\$2,762,163				
Total CFTN Program Estimated Expenditures	\$ 8,225,172	\$8,225,172	\$ -	\$ -	\$ -	\$ -



MHSA Annual Update for FY 24/25: Attachments

Attachments Table of Contents

Attachment A – CPP Meeting Flyer English

Attachment B – CPP Meeting Flyer Spanish

Attachment C – CPP Meeting Web Blast

Attachment D – CPP Meeting Presentation English

Attachment E – CPP Meeting Presentation Spanish

Attachment F – CPP Meeting Stakeholder Comment Form English

Attachment G – CPP Meeting Stakeholder Comment Form Spanish

Attachment H – 30 Day Posting Press Release

Attachment I – IOM Notification of 30 Day Posting to BOS, CAO

Attachment J – 30 Day Posting Web Blast

Attachment K – 30 Day Posting Stakeholder Comment Form English

Attachment L – 30 Day Posting Stakeholder Comment Form Spanish

Attachment M – Public Hearing Agenda

Attachment N – Public Hearing Press Release

Attachment O – List of Media Outlets that Published Press Release



Behavioral Health

MHSA Annual Update FY 2024/2025

Planning Meetings

Please join us at a **Mental Health Services Act (MHSA) Annual Update FY 2024/25** 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 2024

- 08**
10 a.m. **Victor Community Support Services**
Call-in: 1-669-444-9171 Available in English and Spanish
Zoom Meeting ID: 959 6126 4010 | Passcode: 421362
[Join Meeting](#)
- 08**
10 a.m. **Suicide Prevention Awareness Subcommittee**
Call-in: 1-415-655-0002
WebEx Meeting Number: 146 264 6760
[Join Meeting](#)
- 09**
1 p.m. **Spirituality Awareness Subcommittee**
Call-in: 1-415-655-0002
WebEx Meeting Number: 961 357 009
[Join Meeting](#)
- 10**
10 a.m. **Co-Occurring and Substance Abuse Awareness Subcommittee (COSAC)**
Call-in: 1-415-655-0002
WebEx Meeting Number: 961 777 142
[Join Meeting](#)
- 10**
11 a.m. **Third District Advisory Committee**
Call-in: 1-415-655-0002
WebEx Meeting Number: 146 962 9460
[Join Meeting](#)
- 11**
8 a.m. **Sky Forest-Rim Family Services and Big Bear Community Healthcare District**
Call-in: 1-646-568-7788
Zoom Meeting ID: 869 3863 8902 | Passcode: 646629
[Join Meeting](#)

- 11**
10 a.m. **Disabilities Awareness Subcommittee**
Call-in: 1-415-655-0002
WebEx Meeting Number: 146 434 2208
[Join Meeting](#)

- 11**
1 p.m. **PEI Quarterly Provider Meeting**
Call-in: 1-415-655-0002
WebEx Meeting Number: 2485 096 9219
Passcode: 68uGmpmdEF4
[Join Meeting](#)

- 12**
10 a.m. **Asian Pacific Islander Awareness Subcommittee**
Call-in: 1-415-655-0002
WebEx Meeting Number: 968 187 539
[Join Meeting](#)

- 12**
11 a.m. **Pacific Clinics Family Resource Center (Morongo Basin Healthcare District Yucca Valley)**
Call-in: 1-669-444-9171
Zoom Meeting ID: 827 7686 1866 | Passcode: 669550
[Join Meeting](#)

- 12**
11 a.m. **Amazing Place Clubhouse**
2940 Inland Empire Blvd., Ontario

- 16**
10 a.m. **Victor Community Support Services - San Bernardino and Inland Association for Continuity of Care (IACC)**
Call-in: 1-669-900-6833 Available in English and Spanish
Zoom Meeting ID: 925 4265 6745 | Passcode: 068201
[Join Meeting](#)

- 16**
11:30 a.m. **TEAM House Clubhouse**
201 W. Mill St., San Bernardino

- 16**
2 p.m. **Native American Awareness Subcommittee**
Call-in: 1-415-655-0002
WebEx Meeting Number: 146 996 4635
[Join Meeting](#)

- 17**
11 a.m. **First District Advisory Committee**
Call-in: 1-415-655-0002
WebEx Meeting Number: 187 662 3366
[Join Meeting](#)

- 17**
2 p.m. **Transitional Age Youth (TAY) Awareness Subcommittee**
Call-in: 1-415-655-0002
WebEx Meeting Number: 960 523 715
[Join Meeting](#)

- 17**
11:30 a.m. **Pathways to Recovery Clubhouse**
17053 E. Foothill Blvd. Suite B, Fontana

17
Noon

Ontario Montclair School District - Family Solutions Collaborative

Call-in: 1-877-853-5247
Zoom Meeting ID: 938 1487 6990 | Passcode: 607520

[Join Meeting](#)

17
1 p.m.

Senior Affairs Commission

784 E. Hospitality Lane, San Bernardino

17
6 p.m.

Fourth District Advisory Committee

Call-in: 1-415-655-0002
WebEx Meeting Number: 2495 776 5577
Passcode: fBw5HAvQH23

[Join Meeting](#)

18
1 p.m.

Cultural Competency Advisory Committee (CCAC) Meeting

Call-in: +1-415-655-0002
WebEx Meeting Number: 969 101 891

[Join Meeting](#)

22
11 a.m.

Consumer and Family Members Awareness Subcommittee

Call-in: +1-669-900-9128
Zoom Meeting ID: 951 5082 7516 | Passcode: 682466

[Join Meeting](#)

22
2 p.m.

African American Awareness Subcommittee

Call-in: +1-415-655-0002
WebEx Meeting Number: 146 893 8322

[Join Meeting](#)

23
11 a.m.

Santa Fe Wellness Club Clubhouse

56020 Santa Fe Trl. Suite M, Yucca Valley

23
12:30 p.m.

LGBTQ Awareness Subcommittee

Call-in: +1-415-655-0002
WebEx Meeting Number: 960 570 704

[Join Meeting](#)

24
11 a.m.

Serenity Clubhouse

12625 Hesperia Rd., Suite B, Victorville

24
1 p.m.

Women's Awareness Subcommittee

Call-in: +1-415-655-0002
WebEx Meeting Number: 967 920 279

[Join Meeting](#)

25
9 a.m.

MHSA Administration (Morning)

Call-in: +1-415-655-0002
WebEx Meeting Number: 2498 681 4350

[Join Meeting](#)

25
10 a.m.

Latino Awareness Subcommittee*

Call-in: +1-415-655-0002 *Spanish only
WebEx Meeting Number: 966 009 041

[Join Meeting](#)

25
10 a.m.

Older Adults Awareness Subcommittee

Call-in: +1-415-655-0002
WebEx Meeting Number: 961 983 483

[Join Meeting](#)

30
11 a.m.

Central Valley Fun Clubhouse

1501 S. Riverside Ave. Rialto

31
11 a.m.

A Place to Go Clubhouse

32770 Old Woman Springs Rd. Suite B, Lucerne Valley

February 2024

5
3 p.m.

Veterans Awareness Subcommittee

Call-in: +1-415-655-0002
WebEx Meeting Number: 2482 788 1413
Passcode: 2482 788 1413#

[Join Meeting](#)

6
11 a.m.

Desert Stars Clubhouse

1841 E. Main St., Barstow

8
3:30 p.m.

Second District Advisory Committee

Call-in: +1-415-655-0002
WebEx Meeting Number: 2483 823 7369
Passcode: pxYctfry353

[Join Meeting](#)

8
5 p.m.

MHSA Administration (Evening)

Call-in: +1-415-655-0002
WebEx Meeting Number: 2495 495 7647

[Join Meeting](#)

15
10 a.m.

Community Policy Advisory Committee (CPAC) Meeting

Call-in: +1-415-655-0002
WebEx Meeting Number: 2486 716 4468
Passcode: MnMJKr8yQ22

[Join Meeting](#)

27
5 p.m.

Fifth District Advisory Committee

Call-in: +1-415-655-0002
WebEx Meeting Number: 187 027 1608

[Join Meeting](#)

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/





Salud Mental

Actualización anual de la MHSA para el año fiscal 2024/2025

Reuniones de planificación

¡Únase a nosotros en una reunión de participación de las partes interesadas sobre la actualización anual de la **Ley de Servicios de Salud Mental (MHSA) para el año fiscal 2024/25**! Conozca los datos de servicio del último año fiscal y obtenga información sobre cambios y mejoras del programa.

El evento se llevará a cabo en persona.

Enero 2024

08
10 a.m.

Servicios de apoyo comunitario de Víctor

llamar: 1-669-444-9171 Disponible en inglés y español
ID de reunión Zoom: 959 6126 4010 | Código: 421362

[Unirse a la reunión](#)

08
10 a.m.

Subcomité de Concientización de Prevención del Suicidio

llamar: 1-415-655-0002
Número de reunión de WebEx: 146 264 6760

[Unirse a la reunión](#)

09
1 p.m.

Subcomité de Concientización de Espiritualidad

llamar: 1-415-655-0002
Número de reunión de WebEx: 961 357 009

[Unirse a la reunión](#)

10
10 a.m.

Subcomité de Concientización de Diagnóstico Dual y Drogadicción (COSAC)

llamar: 1-415-655-0002
Número de reunión de WebEx: 961 777 142

[Unirse a la reunión](#)

10
11 a.m.

Comité Asesor del Tercer Distrito

llamar: 1-415-655-0002
Número de reunión de WebEx: 146 962 9460

[Unirse a la reunión](#)

11
8 a.m.

Servicios familiares Sky Forest-Rim y Big Bear Community Healthcare District

llamar: 1-646-568-7788
ID de reunión Zoom: 869 3863 8902 | Código: 646629

[Unirse a la reunión](#)

11
10 a.m.

Subcomité de Concientización de Discapacidades

llamar: 1-415-655-0002
Número de reunión de WebEx: 146 434 2208

[Unirse a la reunión](#)

11
1 p.m.

Reunión trimestral de proveedores de PEI

llamar: 1-415-655-0002
Número de reunión de WebEx: 2485 096 9219
Código: 68uGmpmdEF4

[Unirse a la reunión](#)

12
10 a.m.

Subcomité de Concientización de Asiáticos/ Isleños del Pacífico

llamar: 1-415-655-0002
Número de reunión de WebEx: 968 187 539

[Unirse a la reunión](#)

12
11 a.m.

Centro de recursos familiares de Pacific Clinics (Distrito de atención médica de Morongo Basin Yucca Valley)

llamar: 1-669-444-9171
ID de reunión Zoom: 827 7686 1866 | Código: 669550

[Unirse a la reunión](#)

12
11 a.m.

Casa club Amazing Place

2940 Inland Empire Blvd., Ontario

16
10 a.m.

Servicios de apoyo comunitario de Victor - San Bernardino e Inland Association for Continuity of Care (IACC)

llamar: 1-669-900-6833 Disponible en inglés y español ID de reunión Zoom: 925 4265 6745 | Código: 068201

[Unirse a la reunión](#)

16
11:30 a.m.

Casa club TEAM House

201 W. Mill St., San Bernardino

16
2 p.m.

Subcomité de Concientización de Nativos Americanos

llamar: 1-415-655-0002
Número de reunión de WebEx: 146 996 4635

[Unirse a la reunión](#)

17
11 a.m.

Comité Asesor del Primer Distrito

llamar: 1-415-655-0002
Número de reunión de WebEx: 187 662 3366

[Unirse a la reunión](#)

17
2 p.m.

Subcomité de Concientización de Jóvenes en Edad de Transición (TAY)

llamar: 1-415-655-0002
Número de reunión de WebEx: 960 523 715

[Unirse a la reunión](#)

17
11:30 a.m.

Casa Club Pathways to Recovery

17053 E. Foothill Blvd. Suite B, Fontana

17
mediodía

Distrito Escolar Ontario Montclair - Colaboración de Soluciones Familiares

Llamar: 1-877-853-5247
ID de reunión Zoom: 938 1487 6990 | Código: 607520

[Unirse a la reunión](#)

17
1 p.m.

Comisión de asuntos para Adultos Mayores

784 E. Hospitality Lane, San Bernardino

17
6 p.m.

Comité Asesor del Cuarto Distrito

Llamar: 1-415-655-0002
Número de reunión de WebEx: 2495 776 5577
Código: fBw5HAvQH23

[Unirse a la reunión](#)

18
1 p.m.

Comité Consultivo de Competencia Cultural

Llamar: 1-415-655-0002
Número de reunión de WebEx: 969 101 891

[Unirse a la reunión](#)

22
11 a.m.

Subcomité de Concientización de Consumidores y Miembros de Familias

Llamar: +1-669-900-9128
ID de reunión Zoom: 951 5082 7516 | Código: 682466

[Unirse a la reunión](#)

22
2 p.m.

Subcomité de Concientización de Afroamericanos

Llamar: +1-415-655-0002
Número de reunión de WebEx: 146 893 8322

[Unirse a la reunión](#)

23
11 a.m.

Casa club del club de bienestar Santa Fe

56020 Santa Fe Trl. Suite M, Yucca Valley

23
12:30 p.m.

Subcomité de Concientización de LGBTQ

Llamar: +1-415-655-0002
Número de reunión de WebEx: 960 570 704

[Unirse a la reunión](#)

24
11 a.m.

Casa club Serenity

12625 Hesperia Rd., Suite B, Victorville

24
1 p.m.

Subcomité de Concientización de Mujeres

Llamar: +1-415-655-0002
Número de reunión de WebEx: 967 920 279

[Unirse a la reunión](#)

25
9 a.m.

Administración de MHSA (mañana)

Llamar: +1-415-655-0002
Número de reunión de WebEx: 2498 681 4350

[Unirse a la reunión](#)

25
10 a.m.

Subcomité de Concientización de Latinos*

Llamar: +1-415-655-0002 *reunión en español
Número de reunión de WebEx: 966 009 041

[Unirse a la reunión](#)

25
10 a.m.

Subcomité de Concientización de Adultos Mayores

Llamar: +1-415-655-0002
Número de reunión de WebEx: 961 983 483

[Unirse a la reunión](#)

30
11 a.m.

Casa club del Valle Central

1501 S. Riverside Ave. Rialto

31
11 a.m.

Casa club A Place to Go

32770 Old Woman Springs Rd. Suite B, Lucerne Valley

Febrero 2024

5
3 p.m.

Subcomité de Concientización de Veteranos

Llamar: +1-415-655-0002
Número de reunión de WebEx: 2482 788 1413
Código: 2482 788 1413#

[Unirse a la reunión](#)

6
11 a.m.

Casa club Desert Stars

1841 E. Main St., Barstow

8
3:30 p.m.

Comité Asesor del Segundo Distrito

Llamar: +1-415-655-0002
Número de reunión de WebEx: 2483 823 7369 Código: pxYctfry353

[Unirse a la reunión](#)

8
5 p.m.

Administración de MHSA (tarde)

Llamar: +1-415-655-0002
Número de reunión de WebEx: 2495 495 7647

[Unirse a la reunión](#)

15
10 a.m.

Comité Comunitario Consultivo de Políticas

Llamar: +1-415-655-0002
Número de reunión de WebEx: 2486 716 4468 Código: MnMJKr8yQ22

[Unirse a la reunión](#)

27
5 p.m.

Comité Asesor del Quinto Distrito

Llamar: +1-415-655-0002
Número de reunión de WebEx: 187 027 1608

[Unirse a la reunión](#)

El evento se llevará a cabo en persona

Si habla otro idioma, los servicios de asistencia lingüística están disponibles sin costo llamando al (888) 743-1478. Los usuarios de TTY marcan 711. DBH cumple con las leyes federales 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 más información por favor visite: sbcounty.gov/dbh/



Behavioral Health

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Q

Announcements

How to Provide Stakeholder Feedback



Draft MHSA Annual Update FY 24/25 will be posted on the MHSA page of the DBH Website from February 20, 2024, through March 21, 2024, for a 30 Day Public Comment Period

[How to Provide Stakeholder Feedback – English >](#) | [How to Provide Stakeholder Feedback – Spanish >](#)

MHSA Annual Update FY 24/25 Community Program Planning Meetings



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 2024 meeting have been scheduled and are posted at the link below!

[View Meetings](#)



MHSA Annual Update FY 2024/25 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 2024/25 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 38 meetings.

MHSA Meeting Schedule Flyer (English)

MHSA Meeting Schedule Flyer (Spanish)

Behavioral Health

Mental Health Services Act Annual Update

Fiscal Year 2024/25

Community Program Planning Stakeholder Meeting



1

Behavioral Health MHSA Annual Update FY 2024/25

Meeting Objectives



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

2

Behavioral Health MHSA Annual Update FY 2024/25

We Want to Know More!

- At the end of 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

Behavioral Health MHSA Annual Update FY 2024/25

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

Behavioral Health MHSA Annual Update FY 2024/25

Mental Health Services Act Three Year Plan

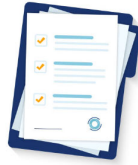
- It is required by Mental Health Services Act regulations (Welfare Institution Code § 5847).
- Highlights trends, program goals, and outcomes of the Department of Behavioral Health programs and provides a roadmap to a unified system of care.
- Current plan covers the time period of Fiscal Years (FYs)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



5

Behavioral Health MHSA Annual Update FY 2024/25

Annual Plan Update Overview



6

Behavioral Health MHSA Annual Update FY 2024/25

7

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 2022/23.
- Information on program planning for the upcoming fiscal year to our stakeholders.
- Updates to the [Mental Health Services Act 3 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 2024/25.

7

Behavioral Health MHSA Annual Update FY 2024/25

8

The Mental Health Services Act Plan and Annual Updates is constructed out of six 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

Behavioral Health MHSA Annual Update FY 2024/25

9

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

Behavioral Health MHSA Annual Update FY 2024/25

10

Community Program Planning



10

Behavioral Health MHSA Annual Update FY 2024/25

11

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

Behavioral Health MHSA Annual Update FY 2024/25

12

Who are DBH's Stakeholders?

WIC §5848 identifies the following as stakeholders:

- Adults and seniors with severe mental illness,
- Families of children, adults, and seniors with severe mental illness,
- Providers of services,
- Law Enforcement agencies,
- Education, social services agencies,
- Veterans and representatives from Veteran's organizations,
- Providers of alcohol and drug services,
- Health care organizations, and
- Other important interests.

12

Behavioral Health MHSA Annual Update FY 2024/25 13

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

Behavioral Health MHSA Annual Update FY 2024/25 14

Program Changes and Updates FY 2024/25



Artwork by The Ultra Violet Memorial

14

Behavioral Health MHSA Annual Update FY 2024/25 15

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

Behavioral Health MHSA Annual Update FY 2024/25 16

Prevention and Early Intervention (PEI) Updates

Inland Empire Opioid Crisis Coalition (IEOCC) Program – Name Change

- IEOCC has been renamed to SUPPORt, which stands for Substance Use Prevention & Pathways to Outreach and Treatment.

The SUPPORt Program – Program Expansion

- The Program will grow to reach the mountain communities around Rim Forest, Arrowhead, and Big Bear.
- This expansion aims to offer education and outreach to the various communities nestled in the mountain regions.
- The focus will be on creating more places for people to connect with mental health and substance use disorder services.
- The project has an estimated cost of approximately \$100,000 and is scheduled to start in fiscal year 2023/24.

16

Behavioral Health MHSA Annual Update FY 2024/25 17

Community Services and Supports (CSS) Updates

Adult Transitional Care Programs – Funding Reallocation

- The Adult Transitional Care Programs are existing programs that will now be fully funded by General System Development funding instead of Full Service Partnership funding.

Collaborative Adult Full Service Partnership Services – Program Transfer

- The Community Reintegration Services Program and Recovery Based Engagement Support Team Assisted Outpatient Treatment Program are existing programs that will be relocated to a newly created umbrella, titled Collaborative Adult Full Service Partnership Services.

17

Behavioral Health MHSA Annual Update FY 2024/25 18

Community Services and Supports (CSS) Updates

Recovery Based Engagement Support Team Assisted Outpatient Treatment – Program Expansion

- Recovery Based Engagement Support Team Assisted Outpatient Treatment is court-ordered outpatient treatment for individuals who have a history of untreated mental illness and meet criteria as stipulated in the Welfare and Institutions Code.
- In May 2023, three positions were approved for the Law Offices of the Public Defender (PD) San Bernardino County. A Memorandum of Understanding will be established for coordination of court-ordered Assisted Outpatient Treatment per regulations defined in the Welfare and Institutions Code.
 - The Department of Behavioral Health will allocate \$1.7 million annually to fund positions that will be carrying out responsibilities related to Assisted Outpatient Treatment.

18

Behavioral Health MHSA Annual Update FY 2024/25 19

Community Services and Supports (CSS) Updates

California Mental Health Services Authority (CalMHSA) – Contract Renewal

- San Bernardino County has renewed the agreement with California Mental Health Services Authority (CalMHSA) as the County's Peer Support Specialist certifying entity.

Peer Provider Workforce – Program Transfer

- The Peer Provider Workforce Support Program was developed to support DBH as it works to grow its peer support staff. The program is being transferred from Workforce Education and Training and will be listed under Peer Programs.

Clubhouse and Community Connections – New Umbrella Name

- To better reflect efforts to expand access to peer providers and peer run programs, a new umbrella, titled "Peer Programs" was created. This division will oversee the Clubhouse and Community Connections Programs, as well as the Peer Provider Workforce Support Program.

19

Behavioral Health MHSA Annual Update FY 2024/25 20

Community Services and Supports (CSS) Updates

Community Education Program – New Program and Transfer

The Community Education Program is a new and distinct program that will be part of the Crisis Intervention Training Program budget. Existing Workforce Education and Training and Public Relations and Outreach staff and services that were forecasted and allocated in the three-year plan are being transferred to meet the needs of this new program.

The Community Education Program will provide general behavioral health training opportunities to the public, which includes the coordination and facilitation of certified curriculum such as:

- Mental Health First Aid
- Applied Suicide Intervention Skills Training
- SafeTALK
- Listen, Empathize, Agree, and Partner Training

20

Behavioral Health MHSA Annual Update FY 2024/25 21

Community Services and Supports (CSS) Updates

Crisis Intervention Training Program – Funding Transfer

- The Crisis Intervention Training Program budget will require transferred existing funds for administrative costs related to the implementation of the Community Education Program.

Community Crisis Services – Program Expansion

- The Community Crisis Response Teams (CCRT) will include contracted mobile crisis response services from 7 p.m. to 7 a.m. in compliance with Department of Health Care Services (DHCS) mandates.
 - Services will begin implementation by the required deadline of December 31, 2023.
- The contract expansion is anticipated to be fully funded by CSS funding, as an expansion of the current Community Crisis Services budget.

21

Behavioral Health MHSA Annual Update FY 2024/25 22

Community Services and Supports (CSS) Updates

Crisis Residential Treatment and Crisis Walk-in Centers – Funding Increase

- The Department of Behavioral Health will increase funding to the Crisis Residential Treatment and Crisis Walk-In Center annual contract allocations.
 - The budget increases are anticipated to be fully funded by Community Services and Supports funding, as expansions of the current Crisis Walk-In Center and Crisis Residential Treatment budgets.
 - The budget increase will serve to maintain continued access to 24/7 crisis stabilization services in the rural High Desert and Eastern Desert areas, in addition to ensuring continued optimal bed capacity for Crisis Residential Treatment services delivered countywide.

22

Behavioral Health MHSA Annual Update FY 2024/25 23

Community Services and Supports (CSS) Updates

Innovative Remote Onsite Assistance Delivery Project – Funding Component Change

- The Innovative Remote Onsite Assistance Delivery Project ends as an Innovation Project in March 2024. Starting April 2024, this project will be funded via Community Services and Supports and continue under the Housing and Homeless Services Continuum of Care Programs.



An encampment visited by the InROADS team in FY 2023.

23

Behavioral Health MHSA Annual Update FY 2024/25 24

Community Services and Supports (CSS) Updates

Forensic Services Continuum of Care – Removal of Sub-Programs from the Mental Health Services Act Three Year Plan

- The Diversion Opportunity for Outpatient Recovery Services sub-program is being removed from the Mental Health Services Act Plan. This program is not funded by the Mental Health Services Act, and it has been included in error.
- The Diversion Opportunity for Outpatient Recovery Services for Misdemeanor Incompetent to Stand Trial is no longer an existing program and is also being removed from the Mental Health Services Act Plan. Positions were vacant in FY 22/23 and in FY 23/24 all positions were transferred to Community Supervised Treatment After Release (CSTAR) or the Diversion Opportunity for Outpatient Recovery Services Department State Hospital program.
- This change does not impact services to this population.

24

Behavioral Health MHSA Annual Update FY 2024/25 25

Innovation (INN) Updates

Progressive Integrated Care Collaborative (PICC) – New Project

The Progressive Integrated Care Collaborative Project was approved by the Mental Health Services Oversight & Accountability Commission in May 2023 and by the San Bernardino County Board of Supervisors in June 2023. Efforts to coordinate with collaborative agencies have begun and project implementation is expected to begin in fiscal year 2023/2024.

- The goals of this project are:
 - Delivery of limited physical health care services within a behavioral health care setting.
 - Delivery of integrated behavioral health, physical health, and substance use disorder services to Medi-Cal enrollees at pilot clinic sites.
 - Financial integration of behavioral health, physical health, and substance use disorder services with a single entity.

25

Behavioral Health MHSA Annual Update FY 2024/25 26

Innovation (INN) Updates

Progressive Integrated Care Collaborative – New Project (cont.)

- The annual budgeted amount for this project for fiscal year 2024/25 is \$2,937,654 and \$16,557,576 for five years.
- The target population for this project is individuals 18 years and older experiencing serious mental illness, who are Medi-Cal beneficiaries enrolled with the Inland Empire Health Plan as the managed care provider.
- The project is estimated to serve 160 individuals per year.

26

Behavioral Health MHSA Annual Update FY 2024/25 27

Innovation (INN) Updates

Vyvanse in Stimulant Addiction (VISA)

- Vyvanse was not introduced for approval at this time. Due to stakeholder feedback and executive support, additional work will need to be done prior to this project being submitted for approval.



27

Behavioral Health MHSA Annual Update FY 2024/25 28

2024-Mental Health Services Act Annual Update Community Program Planning Schedule



28

Behavioral Health MHSA Annual Update FY 2024/25 29

Community Program Planning Schedule 2024

JANUARY - FEBRUARY	FEBRUARY - MARCH	APRIL	MAY
The CPP process is scheduled for January through February 2024.	The Mental Health Services Act Annual Update is tentatively scheduled to be posted for public review and comment from February 19 - March 20, 2024.	Public Hearing is tentatively set to be conducted at the regular Behavioral Health Commission Meeting on April 4, 2024.	The Annual Update is tentatively scheduled to be presented to the Board of Supervisors for approval in May 2024.

- 38 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.

29

Behavioral Health MHSA Annual Update FY 2024/25 30

Upcoming Community Planning Meetings

Please use the link below for upcoming MHSA Community Program Planning Meetings:

English: <https://bit.ly/MHSA MeetingsEnglish>

Spanish: <https://bit.ly/3NW1QUT>

30

Behavioral Health MHSA Annual Update FY 2024/25 31

Questions?



31

Behavioral Health MHSA Annual Update FY 2024/25 32

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://bit.ly/MHSASurvey>



32

Behavioral Health MHSA Annual Update FY 2024/25 33

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 **March 5, 2024**.
- Items mailed in must be postmarked no later than **March 5, 2024**.

33

Behavioral Health MHSA Annual Update FY 2024/25 34

Concerns

To report any concerns related to MHSA Community Program Planning, please refer to the MHSA Issue Resolution Process located at:
<http://wp.sbcounty.gov/dbh/wp-content/uploads/2021/08/COM0947.pdf>

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.

34

Behavioral Health MHSA Annual Update FY 2024/25

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

35

Actualización anual a la Ley de Servicios de Salud Mental

Año Fiscal 2024/25

Reunión de las partes interesadas en la planificación de programas comunitarios

Salud Mental



1

Actualización anual a la Ley de Servicios de Salud Mental (MHSA) para el Año Fiscal 2024/25

Objetivos de la Reunión



- Presentar un resumen general de la Ley de Servicios de Salud Mental
- Presentar un resumen general de la actualización del Plan de la Ley de Servicios de Salud Mental
- Presentar el Calendario de planificación de programas comunitarios
- Aprender sobre los cambios y actualizaciones al programa
- Presentar la encuesta de planificación de programas comunitarios

2

Actualización anual a la Ley de Servicios de Salud Mental (MHSA) para el Año Fiscal 2024/25

¡Queremos saber más!

- Al final de la presentación de hoy le agradeceremos que responda una breve encuesta. Esta encuesta nos permite saber "quién" está presente en el público.
- Esta información también se utilizará para identificar necesidades en la comunidad, determinar prioridades de financiamiento de la Ley de Servicios de Salud Mental, y servirá como guía para crear, implementar y evaluar programas.

3

Actualización anual a la Ley de Servicios de Salud Mental (MHSA) para el Año Fiscal 2024/25

¿Qué es la Ley de Servicios de Salud Mental?

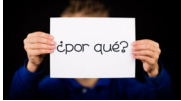
- La Ley de Servicios de Salud Mental (Mental Health Services Act), Prop. 63, fue aprobada por los votantes de California en noviembre de 2004 y entró en vigor en enero de 2005.
 - La Ley proporciona mayor financiamiento a los programas de salud mental en todo el estado.
 - La Ley está financiada mediante un recargo fiscal del 1 % sobre los ingresos personales que superan un millón de dólares al año.
- Las fluctuaciones en los pagos de impuestos afectan las proyecciones fiscales y la disponibilidad de fondos.

4

Actualización anual a la Ley de Servicios de Salud Mental (MHSA) para el Año Fiscal 2024/25

Plan de tres años para la Ley de Servicios de Salud Mental

- Es requerido por los reglamentos de la Ley de Servicios de Salud Mental (Welfare Institution Code § 5847).
- Destaca las tendencias, metas de programas y resultados de los programas del Departamento de Salud Mental y ofrece una guía para un sistema unificado de atención de la salud.
- El Plan actual abarca el período de los años fiscales 2023/24 hasta 2025/26.
- Aprobado el 13 de junio de 2023 por la Junta de Supervisores del Condado.



5

Actualización anual a la Ley de Servicios de Salud Mental (MHSA) para el Año Fiscal 2024/25

Resumen general de la Actualización Anual del Plan



6

Actualización anual a la Ley de Servicios de Salud Mental (MHSA) para el Año Fiscal 2024/25

¿Qué es una actualización anual del Plan?

Una actualización anual del Plan proporciona:

- Datos de los servicios del año fiscal anterior.
 - Los datos del informe pertenecen al Año Fiscal 2022/23.
- Información a las partes interesadas sobre la planificación del programa para el año fiscal siguiente.
- Actualizaciones para el [Plan integrado de tres años de la Ley de Servicios de Salud Mental para los años fiscales del 2023/2024 hasta 2025/2026](#).

El propósito de la actualización anual del plan es:

- Evaluar el impacto a corto y largo plazo de los programas financiados por la Ley de Servicios de Salud Mental.
- Utilizar el documento como prueba fehaciente de que cumplimos con los requisitos reglamentarios.

Este año haremos una actualización anual del plan del Año Fiscal 2024/25.

7

Actualización anual a la Ley de Servicios de Salud Mental (MHSA) para el Año Fiscal 2024/25

El Plan de la Ley de Servicios de Salud Mental y las actualizaciones anuales se basan en seis componentes, además de un resumen del presupuesto y detalles de los componentes:

Servicios y Apoyo Comunitarios Programas y servicios para personas que sufren de enfermedades mentales graves (SMI), enfocados en personas que corren el riesgo de hospitalización psiquiátrica y/o de quedar sin hogar debido a la gravedad de la enfermedad que padecen.	76% ● ● ● Fondos de la Ley de Servicios de Salud Mental
Prevención e Intervención Temprana Servicios que tienen como fin evitar que una enfermedad mental se convierta en grave e incluso, de ser posible, evitar que ésta se desarrolle. Las poblaciones objetivo son las personas que experimentan señales de síntomas o factores de riesgo.	19% ● ● ● Fondos de la Ley de Servicios de Salud Mental

8

Actualización anual a la Ley de Servicios de Salud Mental (MHSA) para el Año Fiscal 2024/25

Innovación Proyectos de tiempo limitado cuyo fin es llevar a cabo investigaciones a corto plazo que ayuden a mejorar el sistema público de salud mental. Estos programas realizan pruebas con diferentes estrategias y nos permiten incorporar aquellas que tienen éxito, a los servicios públicos de salud mental.	5% ● ● ● Fondos de la Ley de Servicios de Salud Mental
Educación y Capacitación para la Fuerza Laboral Nos permite capacitar y reclutar personal en todos los niveles para proveer servicios ininterrumpidos.	Asignación única, sostenida a través de transferencia de fondos de CSS.
Infraestructura capital y necesidades tecnológicas Espacio para proveer servicios y tecnología para asistir en la recopilación y almacenamiento de la información de los usuarios y asistir en la planificación de tratamientos.	Asignación única, sostenida a través de la transferencia de fondos de CSS.

9

Actualización anual a la Ley de Servicios de Salud Mental (MHSA) para el Año Fiscal 2024/25

Planificación de Programas comunitarios



10

Actualización anual a la Ley de Servicios de Salud Mental (MHSA) para el Año Fiscal 2024/25

Planificación de Programas comunitarios

Como parte del proceso constante de retroalimentación y mejoras, nos reunimos con los interesados cada mes de diversas formas.

- Las reuniones se llevan a cabo por medio de plataformas virtuales como WebEx y Zoom, además de reuniones presenciales.
- Esto permite la comunicación continua entre el Departamento y los interesados con respecto a nuestros servicios, informar resultados y otra información relacionada con el sistema público de salud mental.

11

Actualización anual a la Ley de Servicios de Salud Mental (MHSA) para el Año Fiscal 2024/25

¿Quiénes son los Interesados en el DBH?

WIC §5848 identifica a los siguientes interesados:

- Adultos y adultos mayores con enfermedades mentales graves
- Familias de niños, adultos y adultos mayores con enfermedades mentales graves
- Proveedores de servicios
- Entidades del orden público
- Entidades educativas y de servicios sociales
- Veteranos de las fuerzas armadas y representantes de sus organizaciones
- Proveedores de servicios por consumo de alcohol y drogas
- Organizaciones de atención de la salud y
- Otros grupos importantes

12

Ejemplos de las reuniones de interesados

- Comité de Asesoría de Competencia Cultural (CCAC)
- Subcomités de concientización de Competencia Cultural
- Comité de Asesoría de Políticas Comunitarias (CPAC)
- Reunión de la Comisión de Salud Mental
- Reuniones del Comité de Asesoría del Distrito (DAC)
- Juntas Directivas de Asesoría de Casas Club para usuarios
- Asociación de Organizaciones basadas en la comunidad (ACBO)

13

Cambios y actualizaciones del Programa Año Fiscal 2024/25



14

Actualizaciones anuales a los programas de la Ley de Servicios de Salud Mental

- El Departamento de Salud Mental evalúa continuamente los gastos actuales, la utilización y la disponibilidad de fondos para actualizaciones y desarrollo de los programas respaldados por los interesados.
- La evaluación de la retroalimentación y participación de los interesados es un proceso continuo que nos permite estar informados acerca de qué programas y servicios satisfacen mejor las necesidades de nuestra comunidad.
- El Departamento de Salud Mental continuará utilizando los fondos existentes de la Ley de Servicios de Salud Mental para respaldar los programas existentes.

15

Actualizaciones a Prevención e Intervención Temprana (PEI)

Programa de la Coalición por Crisis de opioides de Inland Empire (IEOCC) - Cambio de nombre

- El IEOCC recibió el nuevo nombre de SUPPORt, que son las siglas de *Substance Use Prevention & Pathways to Outreach and Treatment* (Prevención de uso de sustancias y rutas para la proyección y tratamiento).

Programa SUPPORt – Expansión del programa

- El programa se expandirá para cubrir las comunidades aledañas al área montañosa de Rim Forest, Arrowhead y Big Bear.
- Esta expansión tiene por objeto ofrecer educación y proyección a varias comunidades situadas en las regiones montañosas.
- Su enfoque consiste en crear más lugares para que las personas se conecten con los servicios de salud mental y trastornos por uso de sustancias.
- Se considera que el costo aproximado del proyecto es de \$100,000 y está programado para iniciar en el año fiscal 2023/24.

16

Actualizaciones a Servicios y Apoyo Comunitarios (CSS)

Programas de atención de transición para adultos - Reasignación de fondos

- Los programas de Atención de transición para adultos son programas existentes cuyo financiamiento total ahora estará a cargo del Desarrollo General de Sistemas en lugar de ser financiados por Full Service Partnerships (Alianzas de servicio completo).

Alianzas colaborativas de servicio completo para adultos - Traslado de programas

- El Programa de Servicios de reintegración a la comunidad y el Programa de tratamiento ambulatorio asistido por equipos de apoyo participativo basados en la recuperación, son programas existentes que se reasignarán a un programa general llamado Alianzas colaborativas de servicio completo para adultos

17

Actualizaciones a Servicios y Apoyo Comunitarios (CSS)

Tratamiento ambulatorio asistido por equipos de apoyo participativo basados en la recuperación – Expansión del programa

- La participación en el Tratamiento ambulatorio asistido por equipos de apoyo participativo basados en la recuperación es por mandato judicial para personas con historial de salud mental sin tratamiento y que cumplen los criterios estipulados en el Código de Bienestar Público e Instituciones (Welfare and Institutions Code).
- En mayo de 2023 se autorizó la creación de tres plazas dentro de la Oficina Legal de Defensa Pública (PD) del Condado de San Bernardino. Se establecerá un memorando de entendimiento para coordinar el tratamiento ambulatorio asistido ordenado por mandato judicial de conformidad con los reglamentos definidos en el Código de Bienestar Público e Instituciones.
 - El Departamento de Salud Mental asignará \$1.7 millones anuales para financiar las plazas que cumplan con las responsabilidades relacionadas con el tratamiento ambulatorio asistido.

18

Actualizaciones a Servicios y Apoyo Comunitarios (CSS)

Autoridad de Servicios de Salud Mental de California (CalMHSA) – Renovación de contrato.

- El condado de San Bernardino ha renovado el contrato con la Autoridad de Servicios de Salud Mental de California (CalMHS) como entidad certificadora especialista de soporte entre pares.

Fuerza laboral de proveedores de pares – Traslado del programa

- El Programa Fuerza laboral de proveedores de pares fue desarrollado para apoyar al DBH a medida que expande su personal de proveedores entre pares. Este programa se está trasladando de Educación y capacitación para la fuerza laboral y figurará en los listados de Programas entre pares.

Casa Club y Conexiones Comunitarias – Bajo nuevo nombre general

- Para reflejar mejor los esfuerzos de expansión al acceso de proveedores entre pares y los programas ejecutados por pares, se creó un nuevo nombre general titulado “Programas entre pares”. Esta división supervisará el Programa de Casa Club y conexiones comunitarias, así como el Programa de apoyo de la fuerza laboral de proveedores entre pares.

19

Actualizaciones a Servicios y Apoyo Comunitarios (CSS)

Programa de educación comunitaria – Nuevo programa y traslado

El programa de educación comunitaria es un programa nuevo y distinto que formará parte del presupuesto de capacitación en intervención en crisis. El personal y los servicios existentes de educación y capacitación de la fuerza laboral y oficina de relaciones públicas que se pronosticaron y asignaron en el plan de tres años se están transfiriendo para satisfacer las necesidades de este nuevo programa.

El Programa de educación comunitaria brindará oportunidades de capacitación general de salud mental para el público, lo que incluye coordinar y facilitar programas de formación certificada, como:

- Primeros auxilios para la salud mental
- Capacitación en aptitudes aplicadas para la intervención por suicidio
- SafeTALK (Conversación segura)
- Capacitación para escuchar, empatizar, concordar y ser aliado (Listen, Empathize, Agree, and Partner Training)

20

Actualizaciones a Servicios y Apoyo Comunitarios (CSS)

Capacitación para intervención ante crisis –Traslado de financiamiento

- El presupuesto de Capacitación para intervención ante crisis requerirá la transferencia de financiamiento existente de costos administrativos relacionados con la implementación del Programa de educación comunitaria.

Servicios comunitarios ante crisis – Expansión del programa

- Los equipos comunitarios de respuesta ante crisis (CCRT) incluirán servicios móviles contratados de respuesta ante crisis de las 7 p.m. a las 7 a.m. de conformidad con los mandatos del Departamento de Servicios de Salud Mental (DHCS).
- La implementación de los servicios dará inicio cerca de la fecha límite requerida del 31 de diciembre de 2023.
- Se anticipa que la expansión del contrato esté totalmente financiada con fondos de Servicios y Apoyo Comunitarios (CSS), como una expansión del presupuesto actual de Servicios comunitarios ante crisis.

21

Actualizaciones a Servicios y Apoyo Comunitarios (CSS)

Tratamiento residencial de crisis y Centros de atención por crisis sin cita previa – Incremento al financiamiento

- El Departamento de Salud Mental aumentará el financiamiento a las asignaciones anuales bajo contrato de Tratamiento residencial de crisis y Centros de atención por crisis sin cita previa
- Se anticipa que el aumento en el presupuesto sea totalmente financiado por Servicios y Apoyo Comunitarios como expansiones a los presupuestos actuales de los Centros de atención por crisis sin cita previa y de Tratamiento residencial de crisis.
- El incremento en el presupuesto tiene por objeto mantener el acceso continuo a los servicios de estabilización por crisis con atención las 24 horas, 7 días de la semana, en las áreas rurales de High Desert y Eastern Desert, además de garantizar la capacidad de camas óptima para los servicios de Tratamiento residencial de crisis de todo el condado.

22

Actualizaciones a Servicios y Apoyo Comunitarios (CSS)

Proyecto innovador remoto de asistencia in situ – Cambio en el componente de financiamiento

- El Proyecto innovador remoto de asistencia in situ finalizará como proyecto innovador en marzo de 2024. A partir de abril de 2024, el financiamiento de este proyecto dependerá de Servicios y Apoyo Comunitarios y continuará bajo los programas de Atención ininterrumpida para personas sin hogar y de vivienda.



El equipo de InnROAD visitó un campamento durante el Año Fiscal 22/23

23

Actualizaciones a Servicios y Apoyo Comunitarios (CSS)

Atención ininterrumpida de los servicios forenses – Eliminación de subprogramas del Plan de tres años de la Ley de Servicios de Salud Mental

- El subprograma Oportunidad de reencauzamiento de los servicios de recuperación de pacientes ambulatorios está siendo eliminado del plan de la Ley de Servicios de Salud Mental. Este programa no recibe financiamiento de la Ley de Servicios de Salud Mental y ha sido incluido por error.
- El programa Oportunidad de reencauzamiento de Servicios de recuperación de pacientes ambulatorios por el delito menor de incompetencia para asistir a juicio, ya no es un programa existente, también está siendo eliminado del Plan de la Ley de Servicios de Salud Mental. Hubo plazas vacantes durante el Año Fiscal 22/23, y para el Año Fiscal 23/24 todas las plazas fueron transferidas al Programa Comunitario de Tratamiento Supervisado después de la Liberación (CSTAR), o bien a los programas de Servicios de oportunidad de reencauzamiento para la recuperación de pacientes ambulatorios del Departamento de hospitales estatales.
- Este cambio no impactará los servicios que recibe esta población.

24

Actualización anual a la Ley de Servicios de Salud Mental (MHSA) para el Año Fiscal 2024/25 25

Actualizaciones a Proyectos de Innovación (INN)

Colaboración de la atención integrada progresiva (PICC) – Nuevo proyecto

El Proyecto de Colaboración de la atención integrada progresiva fue aprobado por la Comisión de Responsabilidad y Supervisión de Servicios de Salud Mental en mayo de 2023 y por la Junta de Supervisores del Condado de San Bernardino en junio de 2023. Se han iniciado los esfuerzos para coordinar con agencias colaborativas y la implementación del proyecto se espera que comience durante el Año Fiscal 2023/2024.

- Las metas de este proyecto son:
 - Proveer servicios de salud física limitados dentro de un entorno de salud mental.
 - Proveer servicios integrados de salud mental, salud física y servicios por trastornos por uso de sustancias a los usuarios inscritos de Medi-Cal en clínicas piloto.
 - La integración financiera de salud mental, salud física y servicios por trastornos por uso de sustancias en una entidad única.

25

Actualización anual a la Ley de Servicios de Salud Mental (MHSA) para el Año Fiscal 2024/25 26

Actualizaciones a Proyectos de Innovación (INN)

Colaboración de la atención integrada progresiva – Nuevo proyecto (continuación)

- La cantidad anual presupuestada para este proyecto para el Año Fiscal 2024/25 es de \$2,937,654 y de \$16,557,576 para cinco años.
- La población objetivo para este proyecto está compuesta por personas de 18 años y más que sufren problemas de salud mental graves, y son beneficiarios de Medi-Cal inscritos en el Plan de salud Inland Empire como proveedor de atención administrada.
- Se calcula que este proyecto atenderá 160 personas al año.

26

Actualización anual a la Ley de Servicios de Salud Mental (MHSA) para el Año Fiscal 2024/25 27

Actualizaciones a Proyectos de Innovación (INN)

Vyvanse en la adicción estimulante, (VISA)

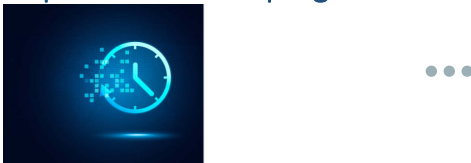
- Vyvanse no fue presentado para la aprobación en esta oportunidad. Debido a la retroalimentación de los interesados y al apoyo ejecutivo, se necesitará trabajo adicional antes de que este proyecto sea presentado para aprobación.



27

Actualización anual a la Ley de Servicios de Salud Mental (MHSA) para el Año Fiscal 2024/25 28

Actualización anual a la Ley de Servicios de Salud Mental **Calendario de** planificación de programas comunitarios



28

Actualización anual a la Ley de Servicios de Salud Mental (MHSA) para el Año Fiscal 2024/25 29

Calendario de planificación de programas comunitarios 2024

ENERO A FEBRERO	FEBRERO A MARZO	ABRIL	MAYO
Este año se estableció el proceso CPP de enero a febrero de 2024.	La Actualización anual a la Ley de Servicios de Salud Mental está calendarizada tentativamente para su publicación para revisión pública y comentarios del 19 de febrero al 20 de marzo de 2024.	Se ha programado tentativamente que la Audiencia Pública se lleve a cabo durante la Reunión ordinaria de la Comisión de Salud Mental el 4 de abril de 2024.	La Actualización Anual está programada tentativamente para ser presentada a la Junta de Supervisores para su aprobación en mayo de 2024.

- Se llevarán a cabo 38 reuniones en todas las regiones geográficas del condado.
- El calendario incluirá todas las reuniones ordinarias de interesados de CPP del DBH (CPAC, DAC, subcomités de CCAC, etc.).
- El calendario incluye las casas club de todas las regiones.

29

Actualización anual a la Ley de Servicios de Salud Mental (MHSA) para el Año Fiscal 2024/25 30

Próximas reuniones de Planificación Comunitaria

Por favor utilice el enlace a continuación para las próximas reuniones de planificación de programas comunitarios de la MHSA:

English: <https://bit.ly/MHSA MeetingsEnglish>

Español: <https://bit.ly/3NWtQUT>

30

Actualización anual a la Ley de Servicios de Salud Mental (MHSA) para el Año Fiscal 2024/25

¿Preguntas?



31

Actualización anual a la Ley de Servicios de Salud Mental (MHSA) para el Año Fiscal 2024/25

¡Queremos saber más!

Esta información también se utilizará para identificar necesidades en la comunidad, determinar prioridades de financiamiento de la Ley de Servicios de Salud Mental, y servirá como guía para crear, implementar y evaluar programas financiados por ley de Servicios de Salud Mental.

Enlace para la encuesta: <https://bit.ly/MHSASurvey>



32

Actualización anual a la Ley de Servicios de Salud Mental (MHSA) para el Año Fiscal 2024/25

Encuestas impresas

Puede escanear las encuestas impresas y mandarnos por correo electrónico a MHSA@dbh.sbcounty.gov.

Los asistentes también pueden mandarnos una copia impresa de la encuesta respondida a:

- Mental Health Services Act Administration
1950 S. Sunwest Lane, Suite 200
San Bernardino, CA 92415

O pueden enviarla por medio del correo interno de las oficinas:

- Mental Health Services Act Administration
WET/Training Institute
Attn: Mental Health Services Act Admin
#0019

- Si no recibí la encuesta impresa, envíenos un correo electrónico a MHSA@dbh.sbcounty.gov o puede agregar su dirección de correo electrónico en la sección de chat.
- La fecha límite para recibir los formularios llenos es al final del día hábil el **5 de marzo de 2024**.
- Cualquier correo postal deberá llevar la marca de recepción de correos con fecha límite el **5 de marzo de 2024**.

33

Actualización anual a la Ley de Servicios de Salud Mental (MHSA) para el Año Fiscal 2024/25

Inquietudes

Para reportar inquietudes relacionadas con la Planificación de Programas Comunitarios de la MHSA, consulte el Proceso de Resolución de Problemas de la MHSA en:

<https://wp.sbcounty.gov/dbh/wp-content/uploads/2021/08/COM0947.pdf>

Para reportar sus inquietudes relacionadas con la recepción de servicios de salud mental, comuníquese con la Unidad de Acceso del DBH al:

(909) 386-8256
Teléfono sin cargos: 1 (888) 743-1478
o 7-1-1 para usuarios de TTY.

34

Actualización anual a la Ley de Servicios de Salud Mental (MHSA) para el Año Fiscal 2024/25

¡Gracias!

Para preguntas o comentarios, por favor comuníquese con:

Dr. Rebecca Scott Young, MBA, PHR
Mental Health Services Act
Administrative Manager
MHSA@dbh.sbcounty.gov
909-252-4021

www.SBCounty.gov/DBH

35



Behavioral Health

Stakeholder Survey Form

MHSA Annual Update

Fiscal Year 2024/2025

Community Program Planning Meeting

1. What is your age?

- ☐ 0-15 years ☐ 26-59 years
☐ 16-25 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 or Alaskan Native
☐ Asian
☐ African American/Black
☐ Caucasian/White
☐ Hispanic/Latino
☐ Native Hawaiian or other Pacific Islander
☐ More than One Race
☐ Other/Not Listed: _____
☐ Prefer not to answer

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.



Behavioral Health

Stakeholder Survey Form

MHSA Annual Update

Fiscal Year 2024/2025

Community Program Planning Meeting

12. Do you work in any of the following areas/fields? (Check all that apply)

- ☐ Alcohol and Drug Service Program
- ☐ Education
- ☐ Faith Based Organization
- ☐ Healthcare – Behavioral/Mental Health
- ☐ Healthcare – Physical Health
- ☐ Law Enforcement
- ☐ Social or Human Service Program/Agency
- ☐ Veterans Organization
- ☐ 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, 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, Rancho Cucamonga
- ☐ I live and work in a neighboring California County
Zip Code: _____
- ☐ Prefer not to answer

15. Are you satisfied that the MHSA Annual Update presentation met its goals and/or objectives?

- ☐ Very Satisfied
- ☐ Satisfied
- ☐ Neutral
- ☐ Unsatisfied
- ☐ Very Unsatisfied

16. In the future how would you like to receive MHSA updates? (Check all the apply)

- ☐ Community Policy Advisory Committee Meetings
- ☐ Webinar (virtual meeting)
- ☐ In person meeting
- ☐ Email (Provide email address below)
Name: _____
Email: _____
- ☐ Social Media
- ☐ Special meeting in your community (provide contact information below)
Name: _____
Email: _____
Phone Number: _____
- ☐ 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.



Stakeholder Comment Form

Community Policy Advisory Committee

Meeting Name:

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 other concerns not addressed in this discussion?

4. Any additional comments or feedback?

Thank you again for taking the time to review and provide feedback.



**Departamento
de Salud
Mental**

Encuesta para las partes interesadas

Actualización anual de la MHSA

Año fiscal 2024/2025

Reunión de planificación de programas comunitarios

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.



Encuesta para las partes interesadas

Actualización anual de la MHSA

Año fiscal 2024/2025

Reunión de planificación de programas comunitarios

12. ¿Trabaja en alguna de las siguientes áreas/campos?

(Marque todas las opciones que correspondan):

- ☐ Programa de servicios para consumidores de alcohol y drogas
- ☐ Educación
- ☐ Organización de fe
- ☐ Atención médica – Salud mental/del comportamiento
- ☐ Atención médica – Salud física
- ☐ Fuerzas policiales
- ☐ Programa/agencia de servicios sociales o humanos
- ☐ Organización de veteranos
- ☐ 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. ¿Qué tan satisfecho está con el hecho de que la presentación de actualizaciones anuales de la Ley de Servicios de Salud Mental (MHSA) haya cumplido sus metas u objetivos?

- ☐ Muy satisfecho
- ☐ Satisfecho
- ☐ Ni satisfecho ni insatisfecho
- ☐ Insatisfecho
- ☐ Muy insatisfecho

16. 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)
- ☐ En una reunión presencial
- ☐ Por correo electrónico (escriba su dirección de 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

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

LEY DE SERVICIOS DE SALUD MENTAL (MHSA)

Formulario de comentarios para las partes interesadas

Comité Asesor de Políticas Comunitarias

Nombre de la reunión:

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.

From: [Canseco, Miranda DBH](#)
To: [Gutierrez, Maribel DBH](#); [Scott Young, Rebecca DBH](#); [Yoshioka, Georgina DBH](#)
Cc: [McAdam, Cheryl DBH](#); [Caldwell, Alia DBH](#); [Espinosa, Marina DBH](#); [Alsina, Jennifer DBH](#)
Subject: FW: Courtesy Copy: Behavioral Health Seeks Public Input on MHSA Annual Update
Date: Thursday, February 22, 2024 1:03:51 PM
Attachments: [image002.png](#)

Good Afternoon,

Providing an update that the following press release has been sent to our media partners. Thank you!

This is a courtesy copy of an email bulletin sent by Miranda Canseco.

This bulletin was sent to the following groups of people:

Subscribers of County Press Releases (7388 recipients)

Having trouble viewing this email? [View it as a Web page.](#)

County of San Bernardino



News Release

Contact

For Immediate Release

February 22, 2024

Miranda Canseco-Ochoa
Public Relations Supervisor
Department of Behavioral Health

miranda.canseco@dbh.sbcounty.gov
(909) 386-8202

Behavioral Health Seeks Public Input on MHSA Annual Update

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 2024/25.

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 years. View and comment on the draft plan by visiting <https://wp.sbcounty.gov/dbh/programs/mhsa/> now until March 21, 2024. 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.

“Community input is essential in our planning process,” said DBH Director Dr. Georgina Yoshioka. “Community is at the center of what we do. Therefore, it is important that you share feedback for DBH to plan on further developing our services.”

The MHSA was passed by California voters in November 2004 and is funded by a one percent tax surcharge on personal income over \$1 million per year. DBH, through the MHSA, is supporting the Countywide Vision by providing behavioral health services and ensuring residents have the resources they need to promote wellness, recovery, and resilience in the community. Information on the Countywide Vision and on DBH can be found at <https://main.sbcounty.gov/>.

MHSA



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Interoffice Memo

DATE: February 21, 2024

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 2024-2025

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 2024/25. 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-eight special stakeholder engagement meetings in all regions (i.e., supervisory districts) to review proposed programmatic changes and new programs.
- 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 2024/25 will be available for a minimum 30-day public review and comment period on the DBH website from February 20, 2024, through March 21, 2024. 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 4, 2024, 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 2024. 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
Christopher Lange, 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, Senior Program Manager, MHSA Administration
Dr. Rebecca Scott Young, Department of Behavioral Health, MHSA Administrative Manager


Behavioral Health

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How to Provide Stakeholder Feedback



Draft MHSA Annual Update FY 24/25 will be posted on the MHSA page of the DBH Website from February 20, 2024, through March 21, 2024, for a 30 Day Public Comment Period

[How to Provide Stakeholder Feedback - English >](#) |
 [How to Provide Stakeholder Feedback - Spanish >](#)

MHSA Annual Update FY 24/25 Community Program Planning Meetings



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 2024 meeting have been scheduled and are posted at the link below!

[View Meetings](#)



MHSA Annual Update Fiscal Year 2024/25 30 Day Public Posting for Comment

The MHSA Annual Update Fiscal Year 2024/25 will be posted for 30 days to receive public comment from stakeholders. This will give the opportunity for stakeholders to review the Annual Update Draft and provide comments.

February 20, 2024 through March 21, 2024

[MHSA Website](#)



Order Deterra Now

As part of the departments plan, Deterra will be available for order by all Department programs and clinics. Deterra Drug Deactivation and Disposal System is used by government agencies, healthcare providers, pharmacies, employers, and individuals nationwide to control the misuse of prescription drugs and other harmful substances and dispose of them properly.

[Click to Order Deterra Pouches](#)



Behavioral Health

Stakeholder Survey Form

MHSA Annual Update

Fiscal Year 2024/2025

30-Day Public Comment

1. What is your age?

- ☐ 0-15 years ☐ 26-59 years
☐ 16-25 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 or Alaskan Native
☐ Asian
☐ African American/Black
☐ Caucasian/White
☐ Hispanic/Latino
☐ Native Hawaiian or other Pacific Islander
☐ More than One Race
☐ Other/Not Listed: _____
☐ Prefer not to answer

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.



Behavioral Health

Stakeholder Survey Form

MHSA Annual Update

Fiscal Year 2024/2025

30-Day Public Comment

12. Do you work in any of the following areas/fields? (Check all that apply)

- ☐ Alcohol and Drug Service Program
- ☐ Education
- ☐ Faith Based Organization
- ☐ Healthcare – Behavioral/Mental Health
- ☐ Healthcare – Physical Health
- ☐ Law Enforcement
- ☐ Social or Human Service Program/Agency
- ☐ Veterans Organization
- ☐ 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, 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, Rancho Cucamonga
- ☐ I live and work in a neighboring California County
Zip Code: _____
- ☐ Prefer not to answer

15. Are you satisfied that the MHSA Annual Update presentation met its goals and/or objectives? (if applicable)

- ☐ Very Satisfied
- ☐ Satisfied
- ☐ Neutral
- ☐ Unsatisfied
- ☐ Very Unsatisfied

16. In the future how would you like to receive MHSA updates? (Check all the apply)

- ☐ Community Policy Advisory Committee Meetings
- ☐ Webinar (virtual meeting)
- ☐ In person meeting
- ☐ Email (Provide email address below)
Name: _____
Email: _____
- ☐ Social Media
- ☐ Special meeting in your community (provide contact information below)
Name: _____
Email: _____
Phone Number: _____
- ☐ 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.



Behavioral Health

MENTAL HEALTH SERVICES ACT (MHSA)

Stakeholder Comment Form

MHSA Annual Update

Fiscal Year 2024/2025

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.



**Departamento
de Salud
Mental**

Encuesta para las partes interesadas

Actualización anual de la MHSA

Año fiscal 2024/2025

Periodo de Comentario Público de 30 días

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?

- ☐ Si (actualmente) ☐ No
☐ Si (en el pasado) ☐ Prefiero no responder

7. ¿Usa los servicios para consumidores de alcohol o drogas?

- ☐ Si (actualmente) ☐ No
☐ Si (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?

- ☐ Si ☐ No
☐ Prefiero no responder

9. ¿Alguna vez estuvo en el ejército?

- ☐ Si (actualmente) ☐ No
☐ Si (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.



Encuesta para las partes interesadas

Actualización anual de la MHSA

Año fiscal 2024/2025

Periodo de Comentario Público de 30 días

12. ¿Trabaja en alguna de las siguientes áreas/campos?

(Marque todas las opciones que correspondan):

- ☐ Programa de servicios para consumidores de alcohol y drogas
- ☐ Educación
- ☐ Organización de fe
- ☐ Atención médica – Salud mental/del comportamiento
- ☐ Atención médica – Salud física
- ☐ Fuerzas policiales
- ☐ Programa/agencia de servicios sociales o humanos
- ☐ Organización de veteranos
- ☐ 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 una actividad de la vida diaria como resultado de una enfermedad mental grave?

- ☐ Si ☐ No
- ☐ Prefiero no responder

14. ¿Vive o trabaja en el condado de San Bernardino? Si vive o 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 o trabajo en otro condado en California
Código postal: _____
- ☐ Prefiero no responder

15. ¿Qué tan satisfecho está con el hecho de que la presentación de actualizaciones anuales de la Ley de Servicios de Salud Mental (MHSA) haya cumplido sus metas u objetivos? (si es aplicable)

- ☐ Muy satisfecho
- ☐ Satisfecho
- ☐ Ni satisfecho ni insatisfecho
- ☐ Insatisfecho
- ☐ Muy insatisfecho

16. 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)
- ☐ En una reunión presencial
- ☐ Por correo electrónico (escriba su dirección de 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

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**

LEY DE SERVICIOS DE SALUD MENTAL (MHSA)

Encuesta para las partes interesadas

Actualización anual de la MHSA

Año fiscal 2024/2025

Periodo de 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 preocupación que no se haya discutido?

4. ¿Tiene algún otro comentario?

Gracias de nuevo por tomarse el tiempo para revisar la encuesta y hacer comentarios.



Behavioral Health Administration

Dr. Georgina Yoshioka,
DSW, MBA, LCSW
Director

Jennifer Alsina, MBA
Assistant Director

Marina Espinosa, MPA
Assistant Director

GENERAL SESSION AGENDA

THURSDAY, APRIL 4, 2024, 12:00 P.M. – 2:00 P.M.

County of San Bernardino Health Services Auditorium

850 E. Foothill Blvd. Rialto, CA 92376 – Conference Room F120

Satellite Locations:

Apple Valley Clinic 18818 Highway 18 Apple Valley, CA 92307

Yucca Valley/Morongo PENDING

*If you require ADA accommodations (ASL Interpreter, other communication devices, or other interpreter services), please contact Fabiola Yanez at (909) 252-5150 prior to the meeting.

ALL MEETINGS OPEN TO THE PUBLIC

District 1

Lorrie Denson
Michael Grabhorn, *Vice Chair*
Mark Graham

District 2

Dr. Valerie Samuel
Jennifer Oglesby, *Secretary*
VACANT

District 3

Troy Mondragon
Allie Mink, *Treasurer*
Timothy A. Brown

District 4

Dr. Monica Caffey, *Chair*
Dr. Akin Merino
Jennifer Spence

District 5

Veatrice Jews
Gil Navarro
Lynn Summers

Board of Supervisors

Col. Paul Cook

Clerk of the Commission

Marybel Valadez

12:00pm - 12:05pm

CALL TO ORDER/PLEDGE OF ALLEGIANCE
ROLL CALL/INTRODUCTIONS

12:05pm - 12:10pm

MINUTES

Tab 5: Review and approve minutes from March 7, 2024

12:10pm - 12:20pm

PUBLIC COMMENTS (3-minute time limit)

County Performance Contract Amendment Review

12:20pm - 12:25pm

CHAIRPERSON'S REPORT

12:25pm – 1:00pm

COMMISSIONER REPORTS

1:00pm – 1:40pm

SUBJECT MATTER PRESENTATION

- Care Court/Laura's Law – Presenter: Christina Entz
- Public Hearing – MHSA Annual Update FY 24-25 – Presenter: Maribel Gutierrez

1:40pm - 1:45pm

NEW BUSINESS – ACTION ITEM(S)

1:45pm - 1:55pm

DIRECTOR'S REPORT

1:55pm – 2:00pm

OUTSIDE AGENCIES ANNOUNCEMENTS

2:00pm

ADJOURNMENT

POST IN PUBLIC VIEW

Dr. Monica Caffey, Chair

Members of the Commission

Dr. Monica Caffey, Chair

Members of the Commission

Members of the Commission

Dr. Georgina Yoshioka, Director

Dr. Monica Caffey, Chair

Dr. Monica Caffey, 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>

BOARD OF SUPERVISORS

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Fifth District

Luther Snoke
Chief Executive Officer

Public Hearing for Mental Health Services Act (MHSA) Annual Update



The San Bernardino County Department of Behavioral Health (DBH) is inviting community members to participate in a public hearing that will be held on Thursday, April 4, 2024, 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 Fiscal Year 2024/2025.

The public hearing will be conducted at the Behavioral Health Commission General Session Meeting on Thursday, April 4, 2024, 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.

The Annual Update is a report highlighting the achievements and progress of MHSA programs and the plan for using the funds in the upcoming 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 wellness, recovery, and resiliency in the community. Information on the Countywide Vision and DBH can be found at www.sbcounty.gov



Public Hearing for Mental Health Services Act Annual Update



The San Bernardino County Department of Behavioral Health (DBH) is inviting community members to participate in a public hearing that will be held on Thursday, April 4, 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 Fiscal Year 2024/2025.

The public hearing will occur during the Behavioral Health Commission General Session meeting at the County of San Bernardino Health Services Building Auditorium, 850 E. Foothill Blvd. in Rialto. A satellite location will also be available at the Department of Behavioral Health Apple Valley Community Clinic, 18818 Highway 18 in Apple Valley.

The Annual Update is a report highlighting the achievements and progress of MHSA programs and the plan for using the funds in the upcoming year.

For more information about 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.

DBH supports the [Countywide Vision](#) by providing behavioral health and substance use disorder services that promote wellness, recovery and resiliency in the community. For more information about DBH, please visit <https://www.sbcounty.gov/dbh/>.



Behavioral Health Administration

Dr. Georgina Yoshioka,
DSW, MBA, LCSW
Director

Jennifer Alsina, MBA
Assistant Director

Marina Espinosa, MPA
Assistant Director

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