Artwork by Gary Bustin

Mental Health Services Act Three Year Integrated Plan for Fiscal Years 2020/2023

DRAFT for Public Review and Comment

SAN BERNARDINO COUNTY

Behavioral Health

DIRECTOR'S MESSAGE

Thank you for your interest in San Bernardino County, Department of Behavioral Health's (DBH) Mental Health Services Act (MHSA) Three-Year Integrated Plan for Fiscal Years 2020/21 through 2022/23. Since the inception in 2005, MHSA funded programs have provided enhancements to the public behavioral health system of care that promote wellness, recovery, and resilience and include the values of cultural competency, community-based collaboration, and meaningful inclusion of clients and family members in all aspects of behavioral health planning and services.

The MHSA Three-Year Integrated Plan is the opportunity for the Department to highlight the accomplishments of the previous fiscal year and share program updates along with announcing new programs for the next three fiscal years. The Plan also allows for the department to demonstrate continued engagement with community partners to implement stakeholder-informed decisions.

Within the past decade, approximately $900 million MHSA dollars have been invested in the community to support the behavioral health needs of San Bernardino County residents. As a result, there has been a significant increase in a number of people being served across the County. For example, when MHSA initially began, just under 9,000 individuals per fiscal year were served. In the most recent fiscal year, MHSA programs were able to serve over 200,000 across the entire continuum of care.

Through the participation of full service partnership services, adult programs yielded a 53% reduction in homelessness after one year and a 68% reduction after two years, 93% reduction in arrests after one year with a 100% reduction after two years, and 71% reduction in psychiatric hospitalizations after one year with an increase to 82% reduction after two years. Children and youth programs also benefited from these intensive services as demonstrated by a 51% increase in academics for children, 96% reduction in arrests for children and youth and 100% reduction for TAY after one year, and respectively, 100% and 99% reduction in mental health emergencies for children and TAY.

The implementation of MHSA has increased the presence of DBH in the community. The very first MHSA Plan referenced 10 community partners to support implementation of MHSA programs and services. The latest MHSA Plan identified 562 collaborative partners that DBH works with the implementation of MHSA programs.

In addition, MHSA has allowed the implementation of prevention and early intervention services within the County, including suicide prevention. Since Fiscal Year 2011/12, 1,604 individuals have been trained in Applied Suicide Intervention Skills Training, an evidence-based suicide prevention approach. This training is a two-day event that teaches skills necessary for individuals to identify individuals displaying suicide risks, how to intervene, and link those to services and safety.

Without MHSA, DBH would not have been able to build and expand our continuum of crisis services that allows DBH to respond in partnership with law enforcement to mental health crisis in the community. For instance, an average of 14,000 individuals receive crisis services each year (average from Fiscal Year 2011/12 through 2018/19). Of the 114,378 served in the eight year period, 81% (92,565) were diverted from unnecessary hospitalization.

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

Sincerely,

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

DIRECTOR'S MESSAGE

MENSAJE DE PARTE DE LA DIRECTORA

Gracias por su interés en el Plan Integrado de Tres Años de la Ley de Servicios de Salud Mental (MHSA, por sus siglas en inglés) del Departamento de Salud Mental (DBH, por sus siglas en inglés) del Condado de San Bernardino, que cubre los años fiscales 2020/21 a 2022/23. Desde su incepción en el 2005, programas financiados por la Ley de Servicios de Salud Mental han ayudado a mejorar programas del sistema público de salud mental que promueven el bienestar, la recuperación, y la resiliencia e incluyen los valores de la competencia cultural, colaboración basada en la comunidad, e inclusión valida de clientes y miembros de sus familias en todos aspectos de planificación para servicios de salud mental.

El Plan Integrado de Tres Años de la Ley de Servicios de Salud Mental es una oportunidad para que el departamento pueda compartir los resultados del año fiscal previo y compartir los resultados de programas y anunciar programas nuevos que se van a realizar en los siguientes tres años. El plan también se utiliza para demonstrar como el departamento solicita la opinión de clientes, sus familias, y la comunidad para hacer decisiones informadas.

Durante la última década, aproximadamente $900 millones de dólares de la Ley de Servicios de Salud Mental han sido invertidos en la comunidad para apoyar las necesidades de salud mental de residentes del Condado de San Bernardino. Como resultado, ha habido incrementación significa en el número de gente que ha sido servida en el Condado. Por ejemplo, cuando la Ley de Servicios de Salud Mental empezó aproximadamente 9,000 personas fueron servidas. En el año fiscal más reciente, programas fundados por la Ley de Servicios de Salud Mental sirvieron a más de 200,000 personas a través del continuo.

A través de la participación en programas de colaboración para servicios completos (FSP, por sus siglas en inglés), programas para adultos resultaron en una reducción de 53% en falta de vivienda y una reducción de 68% después de dos años, una reducción de arrestos de 93% después de un año, una reducción de 100% en arrestos después de dos años, una reducción de 71% en hospitalizaciones psiquiátricas después de un año y una incrementación al 82% después de dos años. Programas para niños y jóvenes (TAY, por sus siglas en inglés) también beneficiaron de estos servicios intensos, demostrado por una incrementación de 51% en las académicas de los niños, e una reducción en arrestos para niños y jóvenes y una reducción de 100% para jóvenes después de un año, e respectivamente, una reducción de 100% de emergencias de salud mental para niños y una reducción de 99% para jóvenes.

La implementación de la Ley de Servicios de Salud Mental ha incrementado la presencia del Departamento en la comunidad. El primer Plan de la Ley de Servicios de Salud Mental menciono diez socios comunitarios que apoyaron la implementación de programas y servicios de la Ley de Servicios de Salud Mental. El último Plan Anual de

MENSAJE DE PARTE DE LA DIRECTORA

la Ley de Servicios de Salud Mental identifico a 562 socios colaborativos que trabajan con el Departamento para implementar programas del MHSA.

Adicionalmente, la Ley de Servicios de Salud Mental ha permitido la implementación de servicios de prevención e intervención temprana (PEI, por sus siglas en inglés) en el Condado, incluyendo prevención del suicidio. Desde el año fiscal del 2011/12, 1,604 individuales han participado en un entrenamiento de intervenciones aplicadas para el suicidio, una intervención basada en evidencia. Este entrenamiento es un evento que dura dos días y enseña a los participantes las habilidades necesarias para identificar a individuos mostrando riesgos suicidios y como se puede intervenir y referir a estas personas a servicios y seguridad.

Sin la Ley de Servicios de Salud Mental, el Departamento no pudiera haber construido e expandido nuestro continuo de servicios de crisis que permiten que el Departamento pueda responder en asociación con cumplimientos de la ley a crisis de salud mental en la comunidad. Por ejemplo, un promedio de 14,000 individuos reciben servicios de crisis cada año (promedio de los años fiscales de 2011/12 hasta el 2018/19). De los 114,378 que fueron servidos en este período, un 81% (92,565) fueron desviados de hospitalización innecesaria.

Gracias por haber tomado el tiempo para revisar y proporcionar retroalimentación sobre este plan. El Departamento de Salud Mental espera sus sugerencias al DBH-MHSA@dbh.sbcounty.gov

Sinceramente,

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

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MHSA COUNTY COMPLIANCE CERTIFICATION

County/City: San Bernardino

☒ Three-Year Program and Expenditure Plan

☐ Annual Update

Local Mental Health Director	Program Lead
Name: Veronica Kelley, DSW,LCSW	Name: Michelle Dusick
Telephone Number: (909) 388-0820	Telephone Number: 909-252-4046
E-mail: vkelley@dbh.sbcounty.gov	E-mail: 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 _____.

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

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

_____ _____

Local Mental Health Director (PRINT) Signature Date

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: San Bernardino

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

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Veronica Kelley, LCSW Telephone	Name: Michelle Dusick
Number: (909) 388-0820	Telephone Number: 909-252-4046
E-mail: vkelley@dbh.sbcounty.gov	E-mail: MHSA@dbh.sbcounty.gov
Local Mental Health Mailing Address: Department of Behavioral Health 303 E. Vanderbilt Way San Bernardino, CA 92415	

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

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

_____ _____
Local Mental Health Director (PRINT) Signature Date

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

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

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

Community Program Planning

Community Policy and Advisory Committee

Community Program Planning

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

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

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

DBH ensures attendance by maintaining a published schedule of meetings and advertising these meetings using social media, press releases, other county departments, and an expansive network of 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.

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.

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

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

- Behavioral Health Commission (BHC): 12 annual meetings held monthly
- District Advisory Committee meetings: Five monthly meetings, one held in each of the five supervisorial districts within the county and led by the Behavioral Health Commissioners in each district
- Community Policy Advisory Committee (CPAC): 12 annual meetings held monthly
- Cultural Competency Advisory Committee (CCAC), along with 13 separate cultural subcommittee/coalitions: 14 monthly meetings
- Transitional Age Youth (TAY) Center Advisory Boards
- MHSA Executive Committee meetings
- Association of Community Based Organizations (ACBO): 12 monthly meetings
- Room and Board Advisory Coalition
- Screening, Assessment, Referral and Treatment (SART) Collaborative
- System-wide Program Outcomes Committee (SPOC)

Note: A regularly scheduled meeting may be rescheduled or cancelled by the collective agreement of the attendees.

Additional regular stakeholder engagement and education meetings include:

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

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

DBH is highly committed to including consumers, family members, and other stakeholders within all levels of our organizational structure. It has been our mission to include consumers and family members into an active system of stakeholders. Within DBH's organizational structure, the Office of Consumer and Family Affairs (OCFA) is elevated, reporting to the Cultural Competency Officer, with access to the Department Director. Outreach to consumers and family members is performed through the OCFA, as well as the Department's Public Information Office, Community Outreach and

Education division, DBH's four TAY centers and DBH's nine consumer clubhouses, and by contracted provider agencies to encourage regular participation in MHSA activities.

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

Improvements in Progress

During this last fiscal year, stakeholder feedback received during prior Community Program Planning (CPP) indicated that stakeholders would like:

- Comprehensive materials and reports to communicate and share information to our stakeholders.
- Multi-media and technological approaches to education and information sharing, including the use of short videos, social media platforms, and adaptive technology.
- Focus on ensuring that each region of the County can participate in meaningful stakeholder opportunities.
- Additional opportunities for consumers to participate in all aspects of program planning and evaluation.
- Focus on specific populations for improvements.

The following are examples of Department responses to stakeholder feedback:

Sharing Information with Our Stakeholders

Comprehensive Materials and Reports

In an effort to better educate and communicate information to our stakeholders, comprehensive materials and reports have been created to better communicate the information that is being presented on or discussed. Additionally, in response to stakeholder feedback and to highlight the stakeholder comments the department receives from functions such as trainings and stakeholder meetings, reports that summarize stakeholder feedback and demographics are created and shared at subsequent meetings. These snapshot reports include stakeholder demographics, a summary of the feedback in the form of text, charts, and infographics to communicate this information. At the beginning of each subsequent meeting, an overview of the analysis is presented that allows for additional conversation or feedback. This change

has allowed the department to better communicate information and its services to the community and has allowed stakeholders to see how their involvement and suggestions shape and influence program planning and the services the department provides.

Approaches to Education and Information Sharing

To better advertise, communicate, and educate our diverse stakeholders and staff to the departments' activities, events, goals, resources, and programs, the department has incorporated multi-media approaches to information sharing which have included the use of short videos and social media platforms. These strategies include the development of an internal platform, DBH NOW, that serves to inform DBH staff and stakeholders of changes, updates, and happenings across the department. Included as part of the strategy is a video communication platform, the Directors Minute. The Directors minute provides an opportunity for the DBH Director to discuss department happenings, communicate with and educate staff about changes, and acknowledge the achievements of staff and the department.

Additional examples of how the department is incorporating technology and varied media approaches to support education and events are highlighted below:

- Use of web-based platforms to host meetings that enable participation opportunities for individuals unable to attend a meeting in-person.
- Use of web-based survey tools that are linked via Quick Response (QR) codes. A QR code is the trademark for a type of matrix barcode that quickly links the user to a website or application.
- Ensuring posted documents, such as this MHSA Three Year Integrated Plan, are enabled to be compatible with text to speech (TTS) software applications.
- Participation in radio and televised educational segments to inform the public of available mental health services, such as the video linked below. https://www.youtube.com/watch?v=eV9cX68jFgo
- Development of educational videos to communicate outcomes of MHSA and mental health programming such as https://youtu.be/ayBXo1Jm64Q.

In addition to community education, DBH makes certain staff are aware of MHSA requirements and programming. As an example, at the February 10, 2020 Administrative Staff Meeting, the MHSA Manager provided a comprehensive training concerning the Mental Health Services Act regulations and Community Program Planning requirements.

County-Wide Regional Representation at Stakeholder Meetings

To increase stakeholder participation and to better accommodate the needs of our stakeholders, DBH has been flexible in altering meeting times for stakeholder meetings and has also changed or alternated some the meeting locations to allow for easier accessibility. For example, the location of some of the Commission's District Advisory

Committee meetings varies to allow participation in geographically isolated communities. This strategy and others ensure that stakeholder input is received from each region of the county. The department has also made concentrated efforts to ensure that information regarding departmental events, conferences, and trainings are shared with our stakeholders in the Central, Desert/Mountain, East Valley, and West Valley regions. This information has been shared via social media and e-mail with our stakeholders, contract providers, and county partners and also through departmental events, presentations, and trainings that are facilitated by DBH throughout the county.

Technological Solutions for the County's Geographic Challenges

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

During the Community Program Planning meeting for the MHSA Three Year Integrated Plan, an Adobe® Connect™ session was provided. Also, call-in options for other DBH facilitated meetings such as System-wide Program Outcomes Committee (SPOC), Association of Community Based Organizations (ACBO), etc. are also available.

Consumer Empowered Evaluation

As an enhancement to the existing Community Program Planning process, this year DBH started the Consumer Evaluation Council. The Consumer Evaluation Council (CEC) is a group of consumer representatives from Department of Behavioral Health (DBH) Clubhouses. Council members of the CEC provide ongoing direction on all matters related to research, evaluation, and quality improvement, as well as ongoing consumer representation and advocacy at key DBH meetings. Council members from the CEC also are leading the DBH clubhouse empowerment evaluation, and are responsible for designing and implementing this evaluation, as well as analyzing, reporting, and presenting on the findings. This evaluation project is being conducted in an effort to determine clubhouse impact on members and the community it serves. Key staff from Research & Evaluation are supporting the council members throughout the evaluation, as needed.

The vision of the CEC is to be a voice of influence throughout the system, addressing stigma by educating DBH, the county, and the public about consumer experience, culture, humanity, and success stories, while bringing to light the healing benefits of the Clubhouse Community. The Council ensures that consumer voice and representation is present throughout research, evaluation, and quality improvement efforts. To support these efforts, the department is determining a method of compensation for the community planning work performed by this Council.

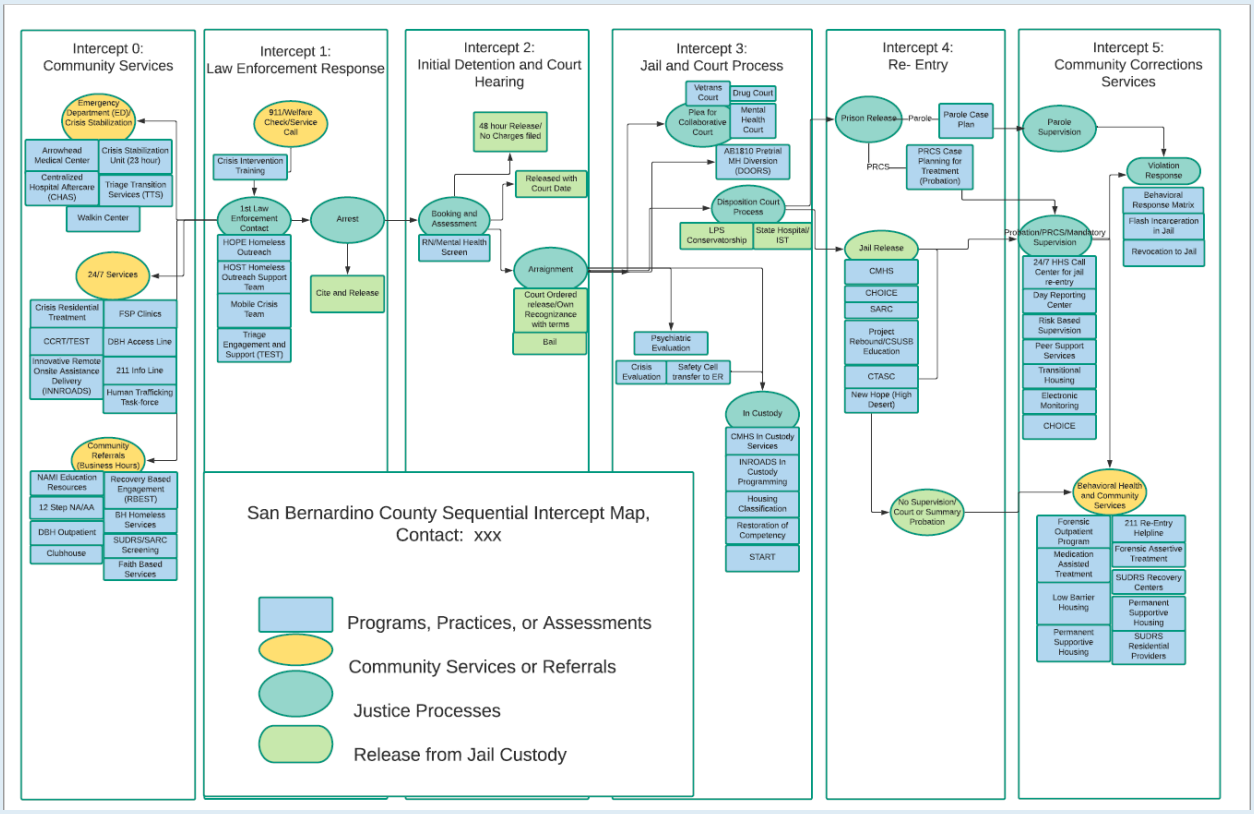
Focus on Criminal Justice Collaborative

In an effort to improve outcomes for individuals living with a behavioral health condition and also involved in the criminal justice system, DBH is participating in a Data Driven Recovery Project (DDRP) with four other California counties, Yolo, Nevada, Plumas, and Sacramento (MHSA/MHSOAC funded via Innovation Incubator project). The DDRP is an initiative to improve sustained outcomes for adult behavioral health consumers in the criminal justice system. The goal is to identify strategies for reducing incidence, duration, and recurrence of arrests and incarcerations of people with behavioral health conditions. As part of the project, DBH and criminal justice partners are developing a set of analytic tools to assist in identifying programmatic and systemic improvements in the county system.

On February 5, 2020, DBH hosted a focused planning meeting in collaboration with criminal justice stakeholders to engage in a Sequential Intercept Model (SIM) Mapping process, a method designed to identify system resources, gaps, and priorities. A total of 41 individuals representing DBH systems of care, the Public Defender, District Attorney, Courts, law enforcement, hospitals, and community providers convened to participate in the process of identifying existing programming across the various agencies, identifying the gaps across the county, and determining priority areas to focus system improvement.

The results of this process is the development of a Sequential Intercept Map and list of gaps and opportunities to be prioritized for cross system improvement. The next steps will include analysis of the data to support the development of a local action plan for incremental cross-system improvements.

Below is the Sequential Intercept Map:



MHSA Three Year Integrated Plan: Community Program Planning Process

DBH is fully committed to a year-round stakeholder engagement process. Preparation and development of this MHSA Three Year Integrated Plan included meetings hosted in multiple venues in each region of the County, an interactive countywide webinar, monolingual Spanish sessions hosted in collaboration with the Consulate of Mexico in San Bernardino and Family Resource Centers, and an MHSA Summit (postponed to end of Fiscal Year 2019/20 or beginning of the following fiscal year due to California Governor's Executive Order in response to the COVID-19 emergency).

A total of 34 scheduled meetings were held throughout San Bernardino County.

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

The MHSA Administrative Manager and Component Leads, in conjunction with the Office of Cultural Competency and Ethnic Services (OCCES), and Public Relations and Outreach (PRO), have responsibility for coordination and management of the Community Program Planning (CPP) process. This process was built upon existing stakeholder engagement components, mechanisms and collaborative networks within the behavioral health system, and evolved out of the original CPP initiated in 2005. In many cases, meetings were held in the community at sites where consumers were already comfortable attending services, events, and meetings.

Participation 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 a 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. This schedule ensured representation and participation in each region of San Bernardino County. To ensure participation of unserved, underserved, or inappropriately served cultural groups, the OCCES provided stakeholder engagement meetings for the MHSA Three Year Integrated Plan for each of their 13 Cultural Competency Advisory subcommittees. To further include community involvement, sessions were held in collaboration with Family Resource Centers, Clubhouses, and Senior Centers across the County. DBH staff were able to host a discussion with diverse attendees about the background and intent of the MHSA, the MHSA Three Year Integrated Plan and proposed updates, as well as obtain feedback and recommendations for system improvement. To ensure that stakeholders could fully benefit from the community meetings, OCCES staff arranged for Spanish, American Sign Language, and Vietnamese interpretation, upon request, at each meeting.
In order to increase opportunities for participation across the county, the department hosted an online session using Adobe® Connect™ software on January 30, 2020, from 10:00 a.m. to 12:00 p.m. This session allowed individuals living in remote areas of the county to participate via computed, smart phones, and other technological devices.

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

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

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

To further support this Community Planning Process (CPP) effort, a special session of the Community Policy Advisory Committee (CPAC) was hosted by MHSA Administration on February 20, 2020. The session followed the format that had been established as a standard practice for all CPAC meetings. Attendees were seated in small groups, to allow for comfortable discussion opportunities. In preparation for future departmental program planning and to further inform the MHSA Three Year Integrated Plan, a comprehensive community needs assessment was distributed at the CPAC and at all of the Community Program Planning (CPP) meetings to allow our stakeholders to provide written and verbal input after the information was presented.

9 CCR § 3300 further includes:

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

A special session of the Cultural Competency Advisory Committee was hosted by the MHSA Administrative Manager to ensure additional opportunities to stakeholders to interact with decision making staff. Attendees at all stakeholder engagement meetings were afforded the opportunity to provide feedback and input into the MHSA Three Year Integrated Plan via verbal comment and a post meeting survey in which stakeholders could provide written comments. Surveys were available in both English and Spanish, in hard copy, as well as provided a QR code that directly linked to the electronic link of the survey. Participants were also provided a handout that provided instruction for multiple ways to submit comments.

During the Community Program Planning (CPP) process meetings for the MHSA Three Year Integrated Plan, highlights of community support included support and interest in all of the new proposed programs: Early Psychosis Care, Behavioral Health Ministries Pilot Program, and the Family Support Program. All three of these programs are contained in the New Programs Section of this MHSA Three Year Integrated Plan. A continued conversational focus was also for improved housing for consumers. Attendees were educated about some of the new housing developments the department has planned through No Place Like Home (NPLH) and the Special Needs Housing Program (SNHP).

Additional feedback included recommendations for workforce development and education. Attendees were informed of upcoming opportunities to participate in update of the Workforce Education and Training plan development that will be occurring over this next fiscal year.

The following pages provide the flyers distributed to the community to promote the MHSA Three Year Integrated Plan planning process:

SAN BERNARDINO COUNTY | Behavioral Health

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

Cultural Competency Advisory Committee Sub-Committee Meetings

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

Veteran's Awareness Subcommittee **Monday, Jan. 6, 2020** Department of Behavioral Health Administration 303 E. Vanderbilt Wy., San Bernardino 3 - 4:30 p.m.	**Asian Pacific Islander Awareness Subcommittee** **Friday, Jan. 10, 2020** Asian American Resource Center 1133 S. E St., San Bernardino 10 - 11:30 a.m.	**African American Awareness Subcommittee** **Monday, Jan. 13, 2020** Valley Star Community Services 1585 S. D St., Ste. 101, San Bernardino 2 - 3:30 p.m.
Spirituality Awareness Subcommittee **Tuesday, Jan. 14, 2020** Department of Behavioral Health Administration 303 E. Vanderbilt Wy., San Bernardino 1 - 2:30 p.m.	**Transitional Age Youth Awareness Subcommittee** **Wednesday, Jan. 15, 2020** One Stop TAY Center 780 Gilbert St., San Bernardino 11 a.m. - noon	**Native American Awareness Subcommittee** **Tuesday, Jan. 21, 2020** Native American Resource Center 11980 Mt. Vernon Ave., Grand Terrace 2 - 3:30 p.m.
Women's Awareness Subcommittee **Wednesday, Jan. 22, 2020** Department of Behavioral Health Administration 303 E. Vanderbilt Wy., San Bernardino 1 - 2:30 p.m.	**Latino Health Awareness Subcommittee** **Thursday, Jan. 23, 2020** Consulate of Mexico in San Bernardino — Lobby 293 N. D St., San Bernardino 10 - 11:30 a.m.	**Older Adult Awareness Subcommittee** **Thursday, Jan. 23, 2020** Victor Community Support Services 15400 Cholame Rd., Victorville 2 - 3:30 p.m.
Consumer & Family Member Awareness Subcommittee **Monday, Jan. 27, 2020** Pathways to Recovery Clubhouse 17053 E. Foothill Blvd., Fontana 10 - 11:30 a.m.	**Co-Occurring and Substance Abuse Subcommittee** **Thursday, Feb. 20, 2020** Uplift Family Services 572 N. Arrowhead Ave., San Bernardino 3 - 4:30 p.m.	**LGBTQ Awareness Subcommittee** **Tuesday, Feb. 25, 2020** Department of Behavioral Health Administration 303 E. Vanderbilt Wy., San Bernardino 12:30 - 2 p.m.

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

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

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

Coaliciones y Subcomités del Comité Consultivo de Competencia Cultural

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

Subcomité de Concientización de Veteranos **lunes, 6 de enero, 2020** Administración de DBH 303 E. Vanderbilt Wy., San Bernardino 3 - 4:30 p.m.	**Subcomité de Concientización de Asiáticos/Isleños delPacifico** **viernes, 10 de enero, 2020** Asian American Resource Center 1133 S. E St., San Bernardino 10 - 11:30 a.m.	**Subcomité de Concientización de Afroamericanos** **lunes, 13 de enero, 2020** Valley Star Community Services 1585 S. D St., Ste. 101, San Bernardino 2 - 3:30 p.m.
Subcomité de Concientización de Espiritualidad **martes, 14 de enero, 2020** Administración de DBH 303 E. Vanderbilt Wy., San Bernardino 1 - 2:30 p.m.	**Subcomité de Concientización de Jóvenes en Edad de Transición** **miércoles, 15 de enero, 2020** One Stop TAY Center 780 Gilbert St., San Bernardino 11 a.m. - noon.	**Subcomité de Concientizacion de Nativos Americanos** **martes, 21 de enero, 2020** Native American Resource Center 11980 Mt. Vernon Ave., Grand Terrace 2 - 3:30 p.m.
Subcomité de Concientización de Mujeres **miércoles, 22 de enero, 2020** Administración de DBH 303 E. Vanderbilt Wy., San Bernardino 1 - 2:30 p.m.	**Subcomité de Concientización de Latinos** **jueves, 23 de enero, 2020** Consulado de México en San Bernardino—Sala de Espera 293 N. D St., San Bernardino 10 - 11:30 a.m.	**Subcomité de Concientización de Adultos Mayores** **jueves, 23 de enero, 2020** Victor Community Support Services 15400 Cholame Rd., Victorville 2 - 3:30 p.m.
Subcomité de Concientización de Consumidores y Miembros de Familias **lunes, 27 de enero, 2020** Pathways to Recovery Clubhouse 17053 E. Foothill Blvd., Fontana 10 - 11:30 a.m.	**Subcomité de Concientización de Diagnostico Dual y Drogadicción** **jueves, 20 de febrero, 2020** Uplift Family Services 572 N. Arrowhead Ave., San Bernardino 3 - 4:30 p.m.	**Subcomité de Concientización de LGBTQ** **martes, 25 de febrero, 2020** Administración de DBH 303 E. Vanderbilt Wy., San Bernardino 12:30 - 2 p.m.

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

Revised 1/2020

SAN BERNARDINO COUNTY Behavioral Health

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

Family Resource Centers

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

Wednesday, Jan. 8, 2020
9 - 10 a.m.
Rim Family Services
28545 Hwy. 18
Skyforest

Friday, Jan. 10, 2020
10 - 11 a.m.
Pacific Clinics
58945 Business Center Dr., Ste. D
Yucca Valley

Wednesday, Jan. 22, 2020
9 - 10 a.m.
Victor Community Support Services
1053 N. D St.
San Bernardino

Friday, Jan. 24, 2020
3 - 4 p.m.
Victor Community Support Services
15400 Cholame Rd.
Victorville

Wednesday, Jan. 29, 2020
1 - 2 p.m.
Ontario Montclair School District
1556 S. Sultana Ave.
Ontario

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

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

Revised 1/2020

SAN BERNARDINO COUNTY

Behavioral Health

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

Centro de Recursos de Familia

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

miércoles, 9 de enero, 2020
9 - 10 a.m.
Rim Family Services
28545 Hwy 18
Skyforest

viernes, 11 de enero, 2020
10 - 11 a.m.
Pacific Clinics
58945 Business Center Dr., Ste. D
Yucca Valley

jueves, 10 de enero, 2020
9 - 10 a.m.
Victor Community Support Services
1053 N. D St.
San Bernardino

miércoles, 23 de enero, 2020
3 - 4 p.m.
Victor Community Support Services
15400 Cholame Rd
Victorville

viernes, 18 de enero, 2020
1 - 2 p.m.
Ontario Montclair School District
1556 S. Sultana Ave.
Ontario

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

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

Revised 1/2020

SAN BERNARDINO COUNTY

Behavioral Health

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

Clubhouses

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

Tuesday, Jan. 7, 2020
10 - 11 a.m.
Serenity Clubhouse
12625 Hesperia Rd., Ste. B
Victorville

Wednesday, Jan. 15, 2020
9:30 - 10:30 a.m.
Pathways to Recovery
17053 E. Foothill Blvd.
Fontana

Friday, Jan. 17, 2020
10 - 11 a.m.
Amazing Place
2940 Inland Empire Blvd.
Ontario

Friday, Jan. 24, 2020
10:30 - 11:30 a.m.
"Our Place" Clubhouse
24950 Redlands Blvd., Ste. 1
Loma Linda

Monday, Jan. 27, 2020
11 a.m. - noon
Santa Fe Social Club
56020 Santa Fe Trl., Ste. M
Yucca Valley

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

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Revised 1/2020

SAN BERNARDINO COUNTY | Behavioral Health

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

Clubhouses (por sus siglas en ingles)

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

martes, 7 de enero, 2020
10 - 11 a.m.
Serenity Clubhouse
12625 Hesperia Rd., Ste B
Victorville

miércoles, 15 de enero, 2020
9:30 - 10:30 a.m.
Pathways to Recovery
17053 E. Foothill Blvd.
Fontana

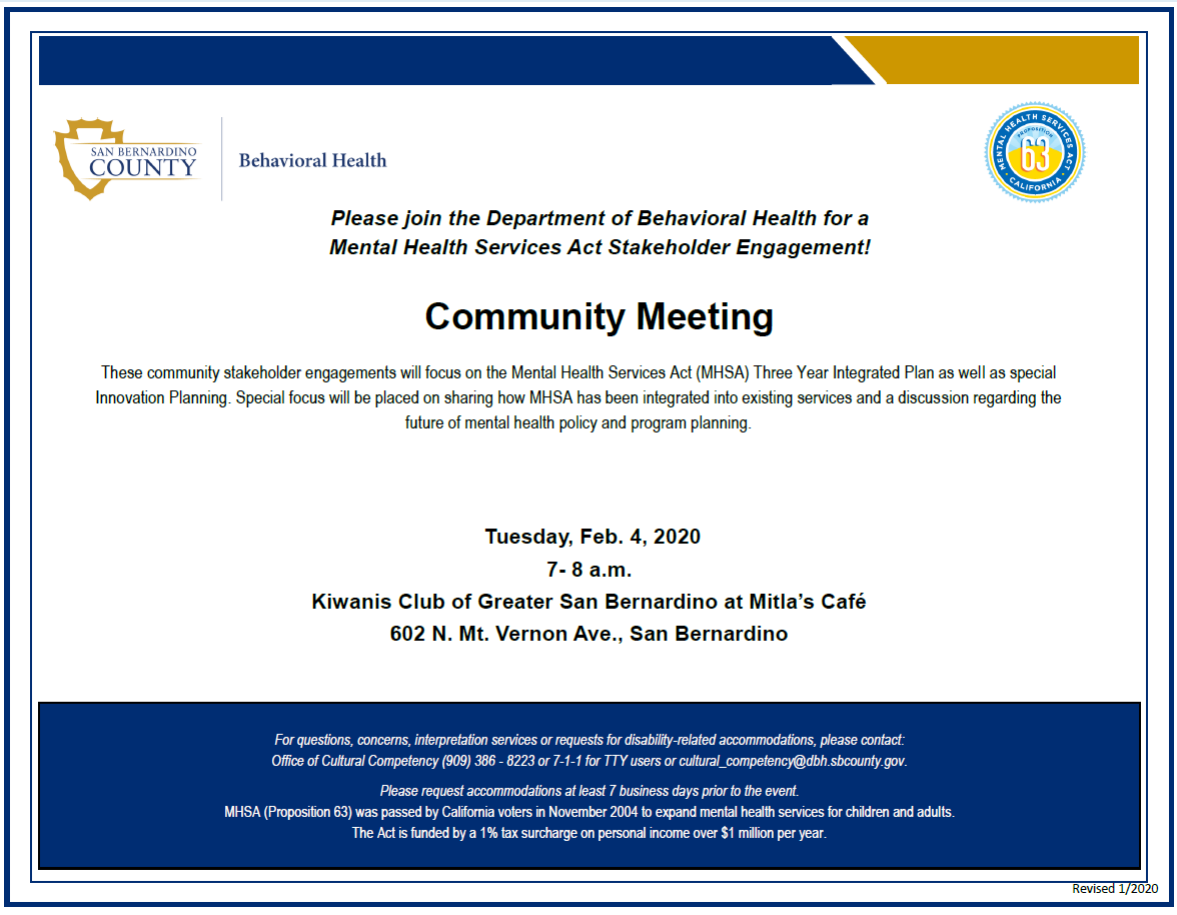
viernes, 17 de enero, 2020
10 - 11 a.m.
Amazing Place
2940 Inland Empire Blvd.
Ontario

viernes, 24 de enero, 2020
10:30 - 11:30 a.m.
"Our Place" Clubhouse
24950 Redlands Blvd., Ste. 1
Loma Linda

lunes, 27 de enero, 2020
11 a.m. - mediodía
Santa Fe Social Club
56020 Santa Fe Trl., Ste. M
Yucca Valley

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

Revised 1/2020



SAN BERNARDINO COUNTY | Behavioral Health

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

Community Meeting

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

Tuesday, Feb. 4, 2020
7- 8 a.m.
Kiwanis Club of Greater San Bernardino at Mitla's Café
602 N. Mt. Vernon Ave., San Bernardino

For questions, concerns, interpretation services or requests for disability-related accommodations, please contact: Office of Cultural Competency (909) 386 - 8223 or 7-1-1 for TTY users or cultural_competency@dbh.sbcounty.gov.

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

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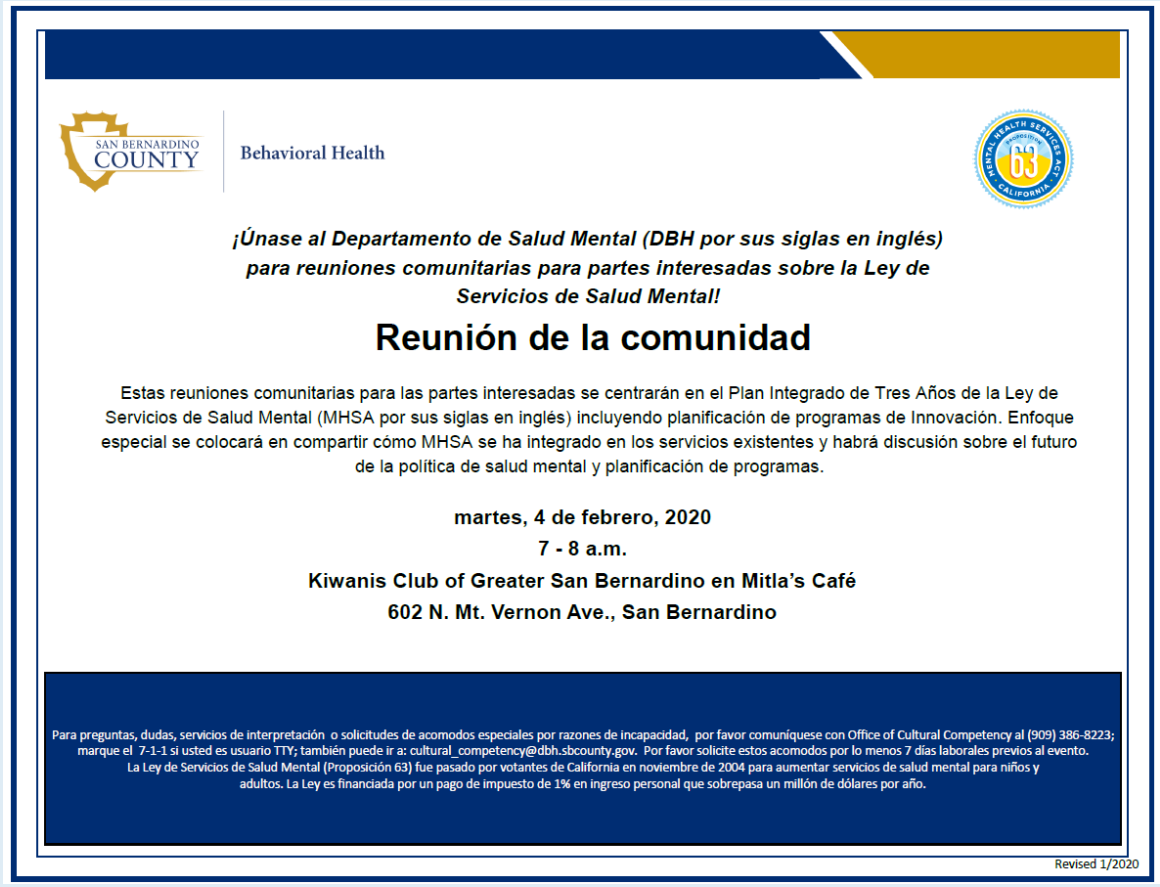
Revised 1/2020



SAN BERNARDINO COUNTY

Behavioral Health

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

Reunión de la comunidad

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

martes, 4 de febrero, 2020
7 - 8 a.m.
Kiwanis Club of Greater San Bernardino en Mitla's Café
602 N. Mt. Vernon Ave., San Bernardino

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

Revised 1/2020

SAN BERNARDINO COUNTY

Behavioral Health

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

Senior Centers

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

Tuesday, Jan. 7, 2020 **Noon - 1 p.m.** **Perris Hill Senior Center** **780 E. 21st St.** **San Bernardino**	**Tuesday, Jan. 14, 2020** **Noon - 1 p.m.** **San Bernardino Senior Center** **600 W. 5th St.** **San Bernardino**	**Monday, Jan. 27, 2020** **10:30 - 11:30 a.m.** **Fontana Senior Center** **16710 Ceres Ave.** **Fontana**

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

Revised 1/2020

SAN BERNARDINO COUNTY | Behavioral Health

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

Centro para personas mayores

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

martes, 7 de enero, 2020 **12 - 1 p.m.** **Perris Hill Senior Center** **780 E. 21st St.** **San Bernardino**	**martes, 14 de enero, 2020** **12 - 1 p.m.** **San Bernardino Senior Center** **600 W. 5th St.** **San Bernardino**	**lunes, 27 de enero, 2020** **10:30 - 11:30 a.m.** **Fontana Senior Center** **16710 Ceres Ave.** **Fontana**

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

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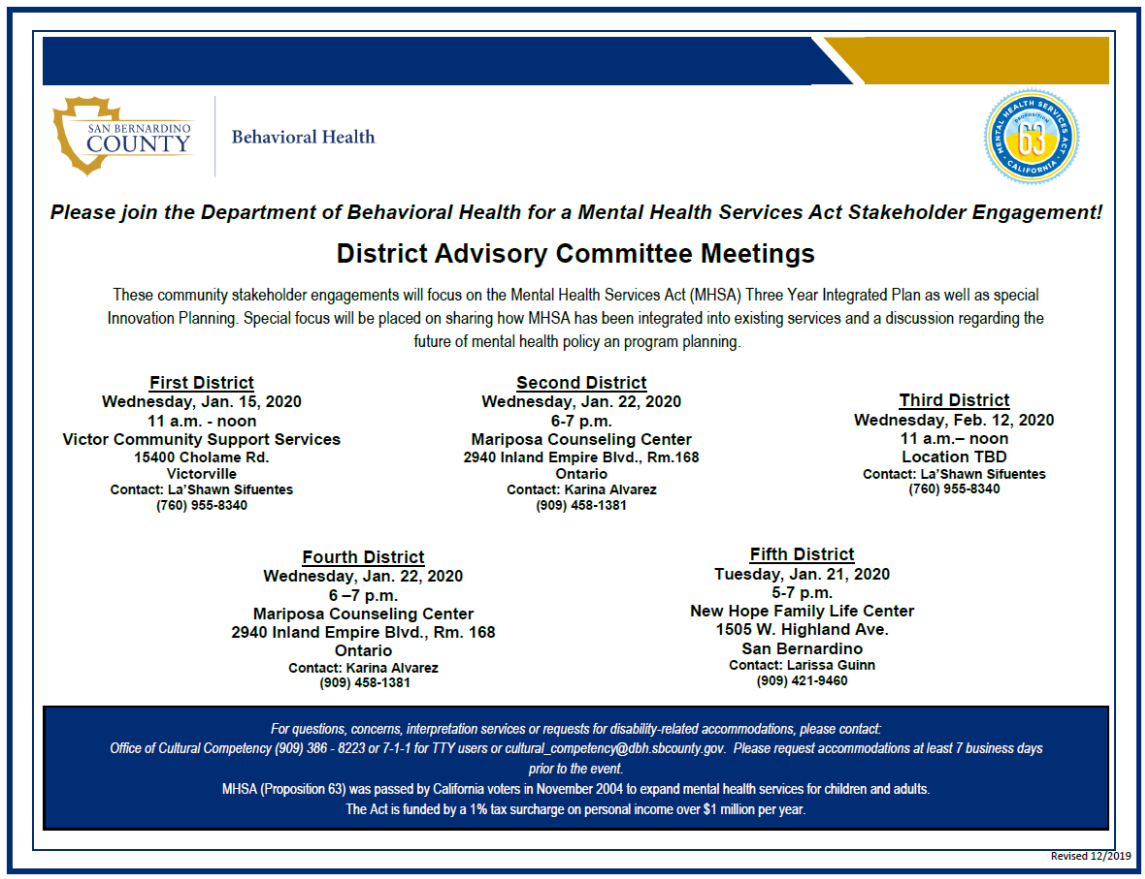
Revised 1/2020



SAN BERNARDINO COUNTY | Behavioral Health

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

District Advisory Committee Meetings

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

First District
Wednesday, Jan. 15, 2020
11 a.m. - noon
Victor Community Support Services
15400 Cholame Rd.
Victorville
Contact: La'Shawn Sifuentes
(760) 955-8340

Second District
Wednesday, Jan. 22, 2020
6-7 p.m.
Mariposa Counseling Center
2940 Inland Empire Blvd., Rm.168
Ontario
Contact: Karina Alvarez
(909) 458-1381

Third District
Wednesday, Feb. 12, 2020
11 a.m.– noon
Location TBD
Contact: La'Shawn Sifuentes
(760) 955-8340

Fourth District
Wednesday, Jan. 22, 2020
6 –7 p.m.
Mariposa Counseling Center
2940 Inland Empire Blvd., Rm. 168
Ontario
Contact: Karina Alvarez
(909) 458-1381

Fifth District
Tuesday, Jan. 21, 2020
5-7 p.m.
New Hope Family Life Center
1505 W. Highland Ave.
San Bernardino
Contact: Larissa Guinn
(909) 421-9460

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

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

Revised 12/2019

SAN BERNARDINO COUNTY | Behavioral Health

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

Reunión de Comité Consultiva de Distrito

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

Primer Distrito
miércoles, 15 de enero, 2020
11 a.m. - mediodia p.m.
Victor Community Support Services
15400 Cholame Rd.
Victorville
Contacto: La'Shawn Sifuentes
(760) 955-8340

Segundo Distrito
miércoles, 22 de enero, 2020
6 - 7 p.m.
Mariposa Counseling Center
2940 Inland Empire Blvd., Cuarto 168
Ontario
Contacto: Karina Alvarez
909-758-1381

Tercer Distrito
miercoles, 12 de febrero, 2020
11 a.m. - mediodia p.m.
El lugar y será determinado
Contacto: La'Shawn Sifuentes
(760) 955-8340

Cuarto Distrito
jueves, 10 de enero, 2019
2 - 3 p.m.
Mariposa Community Counseling
2940 Inland Empire Blvd., Cuarto 168
Ontario
Contacto: Karina Alvarez 909-758-1381

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

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

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

Revised 12/2019

SAN BERNARDINO COUNTY

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

Online Adobe Connect

Evening Session
Wednesday, Jan. 9, 2020
5:00 - 7:00 p.m.

Morning Session
Thursday, Jan. 30, 2020
10:00 a.m. - 12:00 p.m.

Facilitated by Michelle Dusick, MHSA Administrative Manager
US/CAN Toll Free: 1-877-820-7831 Passcode: 603377

To join the meeting on Jan. 9, 2020:
https://sbcdbh.adobeconnect.com/rh56sbf3zofy/

To join the meeting on Jan. 30, 2020:
https://sbcdbh.adobeconnect.com/r5ekrlnmhesf/

Both sessions: Behavioral Health Training Institute, 1950 S. Sunwest Lane, Suite 200
San Bernardino, CA 92415

If you have never attended an Adobe Connect meeting before:
Test your connection: https://sbcdbh.adobeconnect.com/common/help/en/support/meeting_test.htm

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

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

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

Revised 12/2019

Below is the press release notifying the public of the Community Program Planning

(CPP) process for the MHSA Three Year Integrated Plan for Fiscal Years 2020/21 through 2022/23:

For Immediate Release

www.SBCounty.gov

SAN BERNARDINO COUNTY

NEWS RELEASE
Behavioral Health

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February 12, 2020

Behavioral health seeks public review and input on three year plan

San Bernardino County Department of Behavioral Health (DBH) invites members of the public to review and comment on the draft Mental Health Services Act (MHSA, Prop. 63) Three Year Integrated Plan, Fiscal Years 2020/21 – 2022/23. The draft plan is a comprehensive report that illustrates the progress made by DBH and its contracted partners in addressing the behavioral health needs of the community and addresses proposed changes in MHSA components in the upcoming three fiscal years.

The draft MHSA Plan will be posted online from February 27, 2020 through March 27, 2020 on http://wp.sbcounty.gov/dbh/admin/mhsa/ Comment forms will be posted in English and Spanish.

"The draft MHSA Three Year Plan explains how DBH intends to provide services to the unserved, underserved, and inappropriately served members of our community," said DBH Director Veronica Kelley. "DBH is dedicated to including diverse consumers, family members, stakeholders, and community members throughout the county."

For additional information on the update or to request interpretation services or disability-related accommodations, call (800) 722-9866 (dial 7-1-1 for TTY users) or email mhsa@dbh.sbcounty.gov.

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 www.sbcounty.gov.

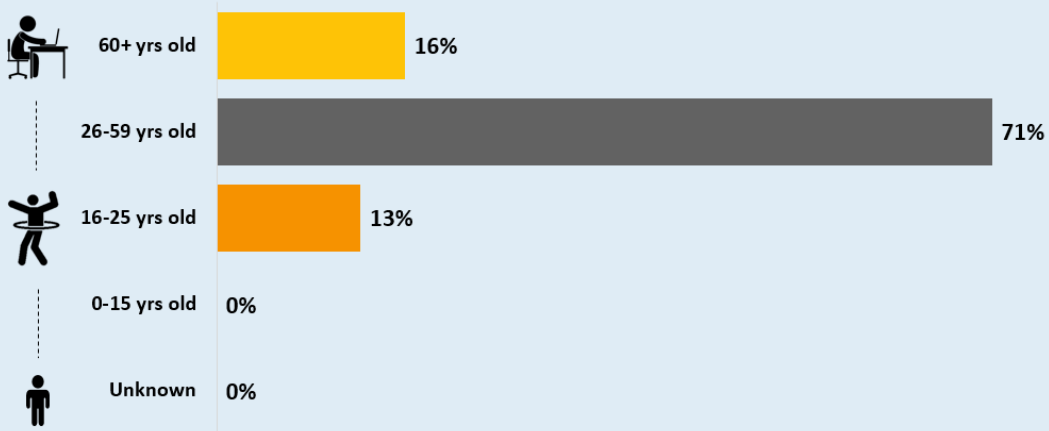
A total of **487** stakeholders attended this year's Community Program Planning (CPP) stakeholder sessions and DBH received **339** completed stakeholder comment forms as a result of those who attended the CPP stakeholder sessions. This year the department created a comprehensive needs assessment survey that was distributed at each of the CPP stakeholder sessions and also available online. A similar survey was provided during last years' process which assisted the department to enhance, streamline, and restructure programming in this MHSA Three Year Integrated Plan.

The demographic breakdown of **339** participants who completed a stakeholder comment form is illustrated on the following pages. Not every respondent answered every question.

MHSA Three-Year Integrated Plan CPP Demographics

Age:

The graph below illustrates the ages of CPP participants. The majority of participants served, 71%, were between the ages of 26-59 years old. The second largest group were the ages of 60+ years old at 16%, followed by ages 16-25 at 13%. There were no participants who identified as ages 0-15, or as unknown or declined to state.



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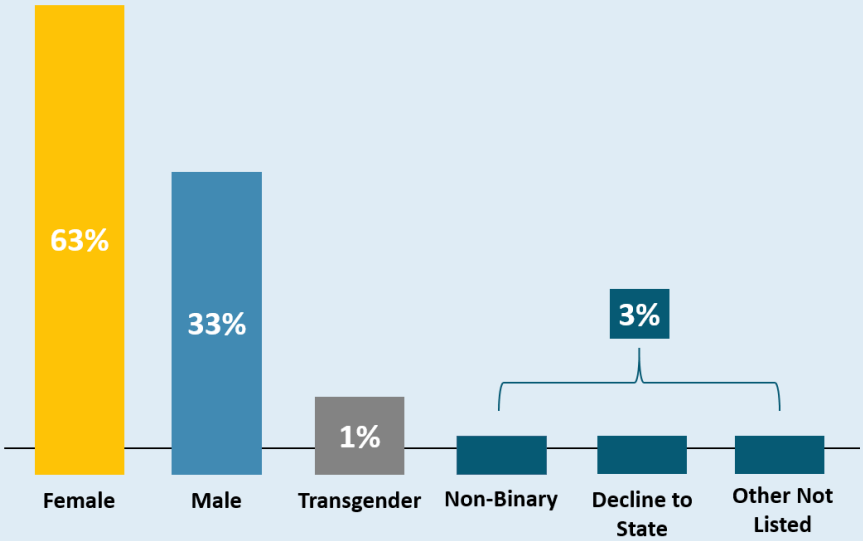
Gender:

The graph below demonstrates that 63% of CPP participants identified as female, 33% identified as male, and 1% identified as transgender. Another 3% identified as non-binary, other or not listed, or declined to state.



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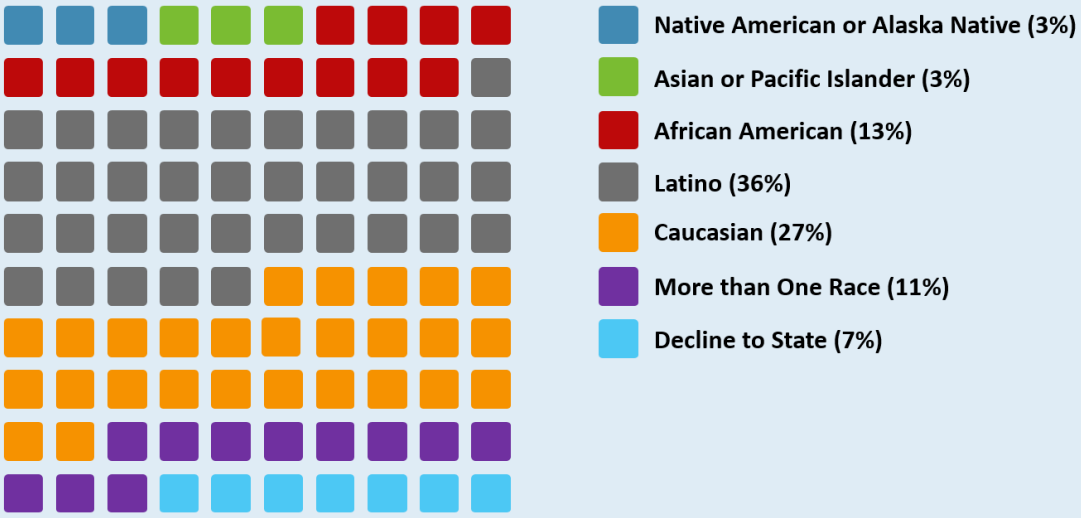
Ethnicity and Ancestry:

The graph below illustrates the various ethnicities of participants of the CPP process. The largest group of participants was 42% in the category of Caucasian. The second largest category was African American at 20%. Following that, 17% identified as more than one race, 5% identified as American Indian or Alaska Native, and an additional 4% identified as Asian or Pacific Islander. Finally, 12% declined to answer.



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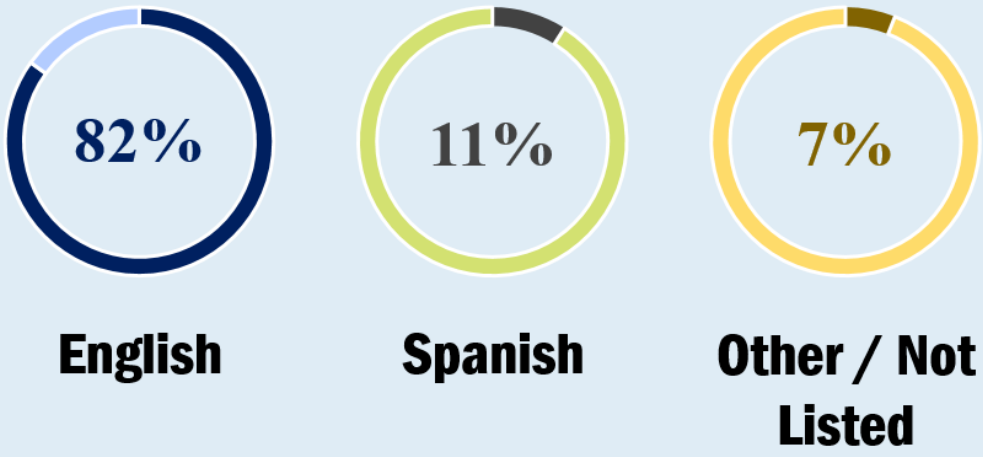
Primary Language:

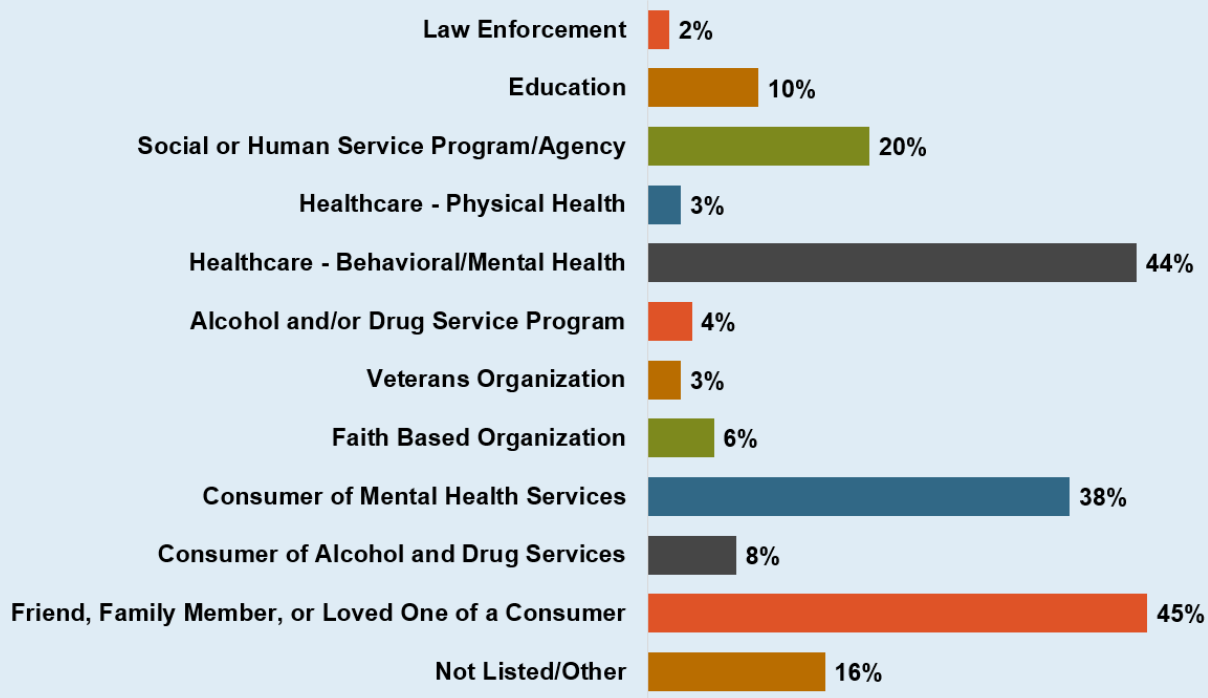
The graph below demonstrates that 82% of CPP participants identified English as their primary language. Additionally, 11% identified Spanish as the primary language, and 7% identified their primary language as something other than English or Spanish.



*While most CPP participants selected one answer, some CPP participants selected multiple answers.

Groups Represented:

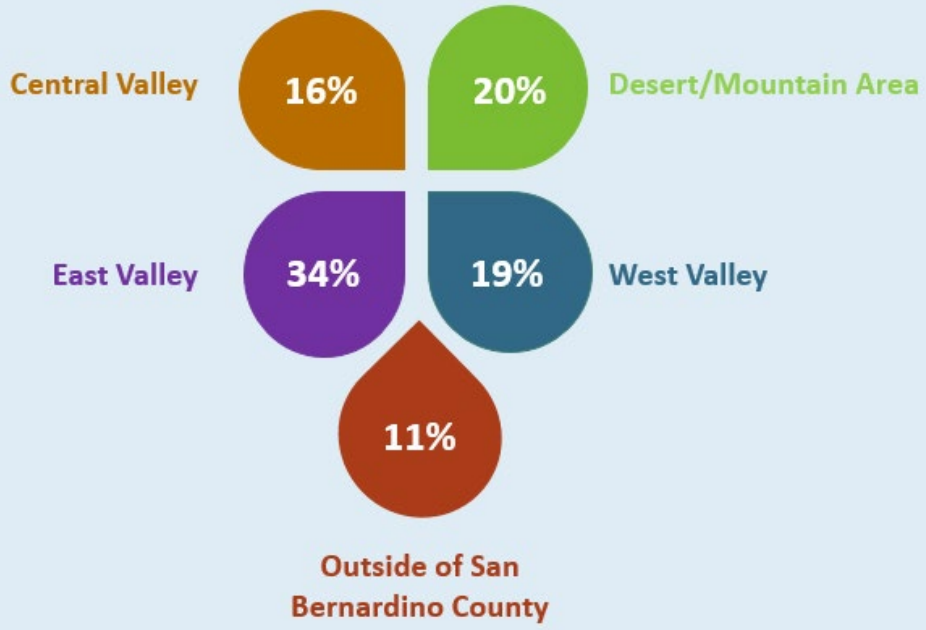
The graph below depicts the groups represented by the CPP participants, who attended the CPP meetings. The largest group represented was the category of friend, family member, or loved one of a consumer of mental health or alcohol and drug services at 45%, closely followed by the category of Healthcare – Behavioral/Mental Health at 44%. Additionally, 38% identified as a consumer of mental health services and 8% identified as a consumer of alcohol and drug services. Further CPP participants identified as belonging to the category of Social or Human Service Program/Agency at 20%, category of education at 10%, category of faith based organization at 6%, and category of not listed or other group at 16%. Healthcare – Physical Health and Veterans Organization categories were represented with 3% each. Lastly, 2% identified belonging to the law enforcement category



*CPP participants selected all that apply.

Regions:

The graph below shows the representation of CPP participants who either work of live in different regions of the County. The largest group represented were those in in the East Valley region at 34% followed by the Desert or Mountain Regions at 20%. Additionally 19% represented the West Valley region and lastly, 16% represented the Central Valley region. 11% of CPP participants stated they work and live outside of San Bernardino County.



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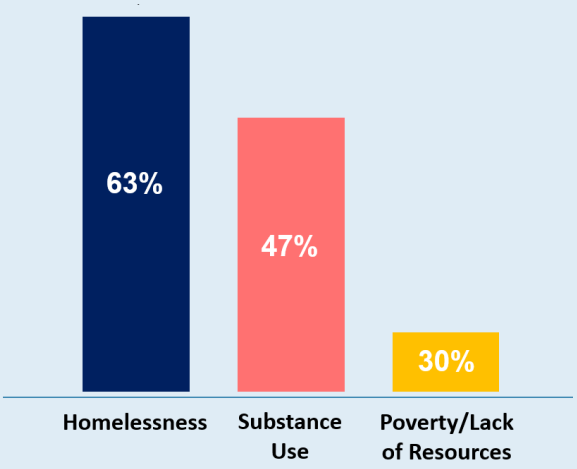
Artwork by Mariah Jamie

Additional Questions

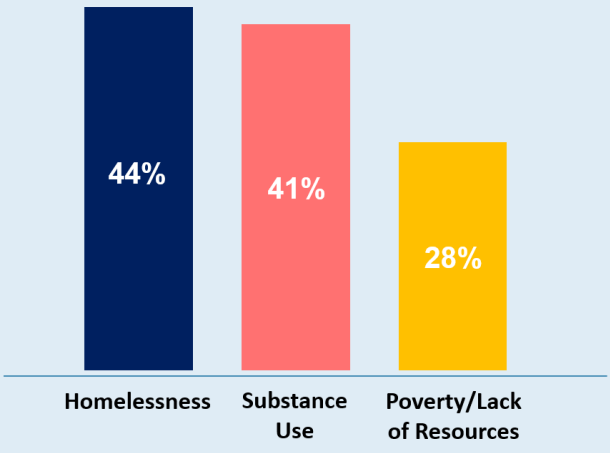
During the Community Program Planning (CPP) process meetings for the MHSA Three Year Integrated Plan, several community members voiced their support and approval of the MHSA Three Year Integrated Plan, as well as the enhanced CPP that has occurred over the last year. Statements from the meetings are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

In your perspective, in San Bernardino County, what are the main issues resulting from untreated mental illness? (Top three answers)



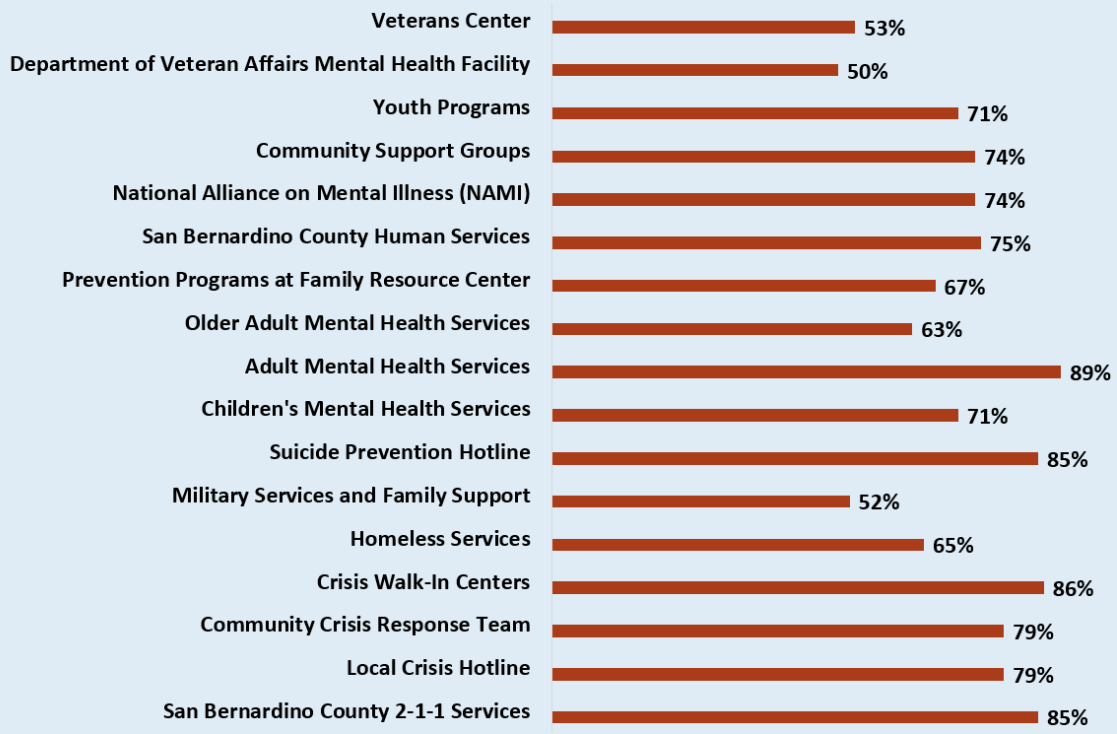
*CPP participants selected multiple answers.

In your perspective, in the community/culture you identify with, what are the perceived main issues resulting from untreated mental illness? (Top three answers)



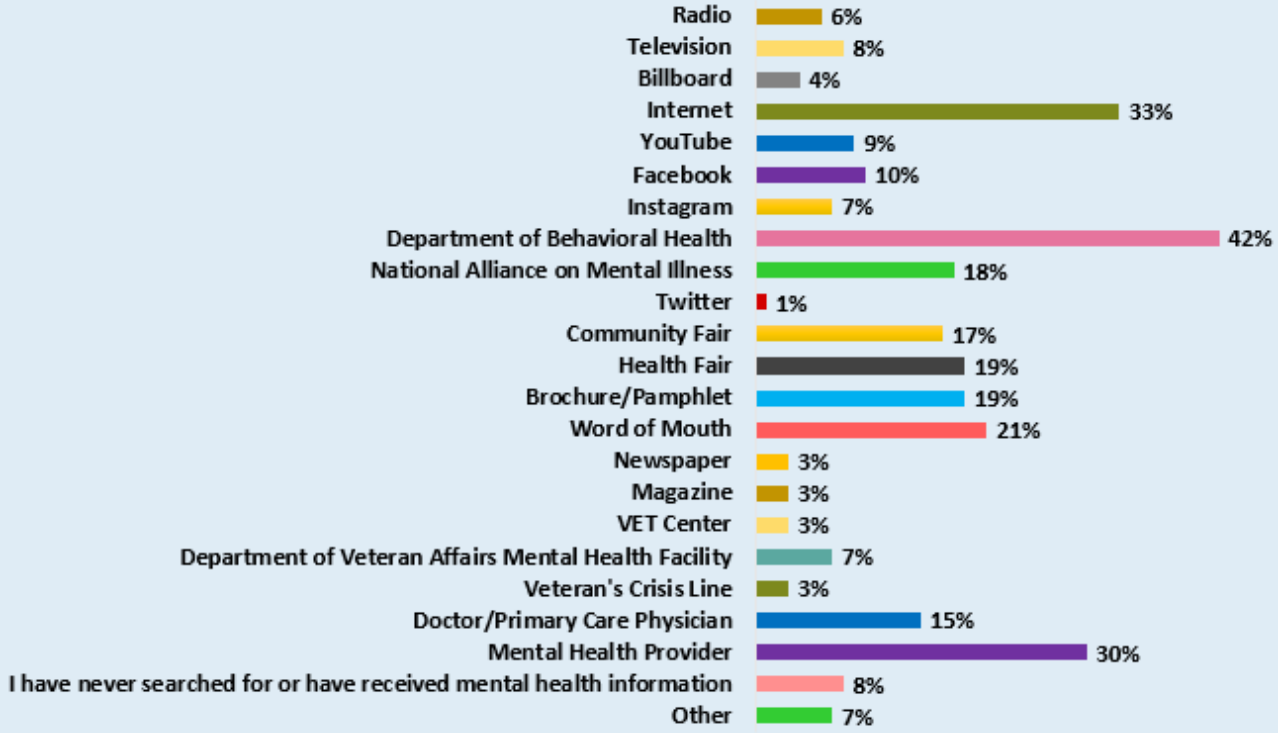
*CPP participants selected multiple answers.

I am aware of the following programs and services:



*CPP participants selected multiple answers.

I have looked for or received mental health information through:



*CPP participants selected multiple answers.

Stakeholder Comments

"I learned about how many people receive mental health services in our county."

"I was most interested to learn about the new programs that are coming down the road!"

"Excellent presentation! Let's keep opening space for ideas to be shared!"

"I appreciated everyone's time in attending and in contributing! A very worthwhile meeting!"

"It was nice to hear about DBH's expansion of programming to serve young adults!"

"Very good information about behavioral health services in the MHSA presentation. I learned about programs I didn't know existed!"

"Aprendí que ofrecen muchos servicios y programas para ayudar a la comunidad y a la gente con problemas mentales."

MHSA Summit

The final event of Community Program Planning (CPP) process is the Mental Health Services Act (MHSA) Summit. The overarching goal of the MHSA Summit is to strategically advance MHSA communication and future planning with collaborative partners, County residents, and key stakeholders. Department of Behavioral (DBH) has hosted the MHSA Summit for the previous five years.

In light of the 2020 COVID-19 emergency, DBH postponed the 6th Annual MHSA Summit to the end of Fiscal Year 2019/2020 or the beginning of the next fiscal year to remain in compliance with California Governor's Executive Order restricting large gatherings and suspending certain requirements of the Ralph M. Brown Act.

More information regarding the date, time, location, and topic of the MHSA Summit will be available at a later date. Additionally, the event may be cancelled or modified to a web-based platform.

Summary of Program Changes

DBH has made a practice of planning for sustainable growth in the development and implementation of MHSA and system of care services. This MHSA Three Year Integrated Plan reflects stakeholder informed changes, expansion of existing programs, and includes new programs under the Prevention and Early Intervention, Community Services and Supports, and Innovation components.

Many stakeholder supported expansion efforts have occurred over the last fiscal year, which were posted in an Amendment to the Fiscal Year 2019-2020 MHSA Annual Update from August 30, 2019 to September 30, 2019. This Amendment will be reflected and affirmed in this MHSA Three Year Integrated Plan. The updates included in the amendment are outlined in the table:

Program Name	Update and Estimated Allocation Amount (if applicable)	
Community Program Planning: Peer Evaluation Workgroup	$96,934	This funding will be used to provide evaluation training for a workgroup of peers and consumers of SBC-DBH services. This training will allow peers and consumers to be more fully integrated in the establishment of outcome measures and system evaluations within SBC-DBH's system of care.
Program Name (cont.)	**Update and Estimated Allocation Amount (if applicable) (cont.)**	
Expansion of Comprehensive Children and Family Support Services, Early Wrap/Success First	$900,000.00	DBH has seen an increase in demand and increase in length of time in treatment for this Full Service Partnership program. Because of this, the cost per client has increased from $10,000 to $12,000 over the last two fiscal years. In order to account for this increase, an additional $9,000,000 will be allocated to this program from the CSS component to allow for more interaction with probationary youth prior to placement, as well as increase the amount of interaction with Children and Family Services youth.
Reallocation of Funds from Prudent Reserve	$496,934	The Mental Health Services Act allows for a county to transfer funds from the CSS component in order to create and/or maintain a prudent reserve to be able to continue to provide mental health services during years in which revenues are lower than previous years. A county must fund its prudent reserve solely from funds allocated to the CSS component, not to exceed 33% of the average CSS revenue received in the proceeding five years (IN 19-017). SBC-DBH exceeds this 33% maximum by $496,934. In order to remain in compliance with the Information Letter 19-017, $496,934 will be reallocated from the prudent reserve.

InnROADs	N/A	Update the start date of the program from July 1, 2019 to reflect approval from the MHSAOC and the San Bernardino County Board of Supervisors. The new start date is reflected as 03/12/2019.

A full copy of the amendment can be located at www.sbcounty.gov/dbh.

Expansion of existing and development of new programs, which are contingent on MHSA funding, will focus on increasing access to and improve the quality of needed prevention and early intervention programming and family support services.

Cost per consumer and consumers served estimates are included in the cost per consumer grids included with this report. The cost per consumer information includes both MHSA and other funding utilized to serve the participants and consumers in MHSA Integrated programs.

The following programs will continue to operate as currently approved:

Prevention and Early Intervention

- PEI SI-1: Student Assistance Program (SAP)
- PEI SI-2: Preschool Prevention and Early Intervention Program
- PEI SI-3: Resilience Promotion in African American Children (RPiAAC)
- PEI CI-1: Promotores de Salud/Community Health Worker (Pds/CHW)
- PEI CI-2: Family Resource Centers (FRC)
- PEI CI-3: Native American Resource Center (NARC)
- PEI SE-1: Older Adult Community Services (OACS)
- PEI SE-2: Child and Youth Connection (CYC)
- PEI SE-4: Military Services and Family Support (MSFS)
- PEI SE-5: Lift Program
- PEI SE-6: Coalition Against Sexual Exploitation (CASE)

Community Services and Supports

- A-1: Clubhouse Expansion
- A-2: Adult Criminal Justice Continuum of Care
- A-3: Assertive Community Treatment Programs
- A-4: Crisis Walk-In Centers (CWICs)/Crisis Stabilization Units (CSUs)
- A-5: Diversion Programs
- A-6: Community Crisis Response Team (CCRT)
- A-7: Housing and Homeless Services Continuum of Care Program
- A-9: Access, Coordination, and Enhancement (ACE) of Quality Behavioral Health Services

- A-10: Crisis Residential Treatment (CRT) Program
  - ◊ Adult
  - ◊ Transitional Age Youth
- A-11: Regional Adult Full Service Partnership (RAFSP)
- A-13: Adult Transitional Programs
- A-15: Recovery Based Engagement Support Team (RBEST)
- C-1: Comprehensive Children and Family Support Services (CCFSS)
- C-2: Integrated New Family Opportunities (INFO)
- OA-1: Age Wise
- TAY-1: Transitional Age Youth (TAY) One Stop Centers

Innovation

- INN-08: Innovative Remote Assistance Delivery (InnROADs)

The following are proposed changes in programs and components:

Prevention and Early Intervention (PEI)

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

These priorities include:

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

Per the statute, the MHSOAC will establish new PEI assessment tools and establish priorities by January 1, 2020. A letter dated January 30, 2020 was received by the MHSOAC indicating that “the Commission has not at this time established priorities additional to those specifically enumerated in WIC Section 5840.7(a). Further, the letter indicated that Counties are responsible for identifying program reporting measures. To remain in compliance with the updated statute, the PEI Component introduction includes a table demonstrating how each PEI program fits within the construct of the requirements. To date, no process for how Counties are to obtain approval for locally approved programs that do not fit within the construct has been received. Should the PEI Component require updates, they will be contained in a future amendment to this MHSA Three Year Integrated Plan.

Expansion of existing and development of new programs, which are contingent on MHSA funding, will focus on increasing access to and improving the quality of needed prevention and early intervention programming.

- The Prevention and Early Intervention (PEI) Community Wholeness and Enrichment Program is being expanded to pilot the co-location of behavioral health services on community college campuses with a primary goal of identifying, assessing, and connecting individuals experiencing signs of the onset of a behavioral health condition to appropriate care.
- A new PEI program, the Early Psychosis Care Program, is included in this MHSA Three Year Integrated Plan. The goal of the program will be to implement and provide evidence-based care for an individual's first experiencing symptoms of serious mental illness with psychotic features.

- A new PEI Behavioral Health Ministries Pilot Program allows the department to partner with faith-based organizations to assist in identifying unmet behavioral health needs, specifically in African-American churches and communities, providing targeted education to potential first responders, and connecting individuals to culturally appropriate services.

Community Services and Supports (CSS)

Expansion of existing and development of new programs, which are contingent on MHSA funding, will focus on increasing family supports and enhancing complex care.

- The Recovery Based Engagement Teams (RBEST) program ended as an Innovation project in October 2019 and has transferred to CSS. A learning from that program included the need to expand family supports. RBEST, under CSS, will be expanded to ensure regional supports are offered in English and Spanish to family members with a loved one living with a mental health condition. The expanded program increases natural supports, provides education, and increases coping strategies for RBEST families.

Several administrative changes are reflected in the CSS component section of the MHSA Three Year Integrated Plan. Programs designed to meet the needs of specific populations have been "combined" under descriptive titles in an effort to allow readers easier identification of programming.

Innovation

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

- The proposed Innovation (INN), Integrated Care Project, intends to create an integrated model where the delivery coordination and payment for care related to

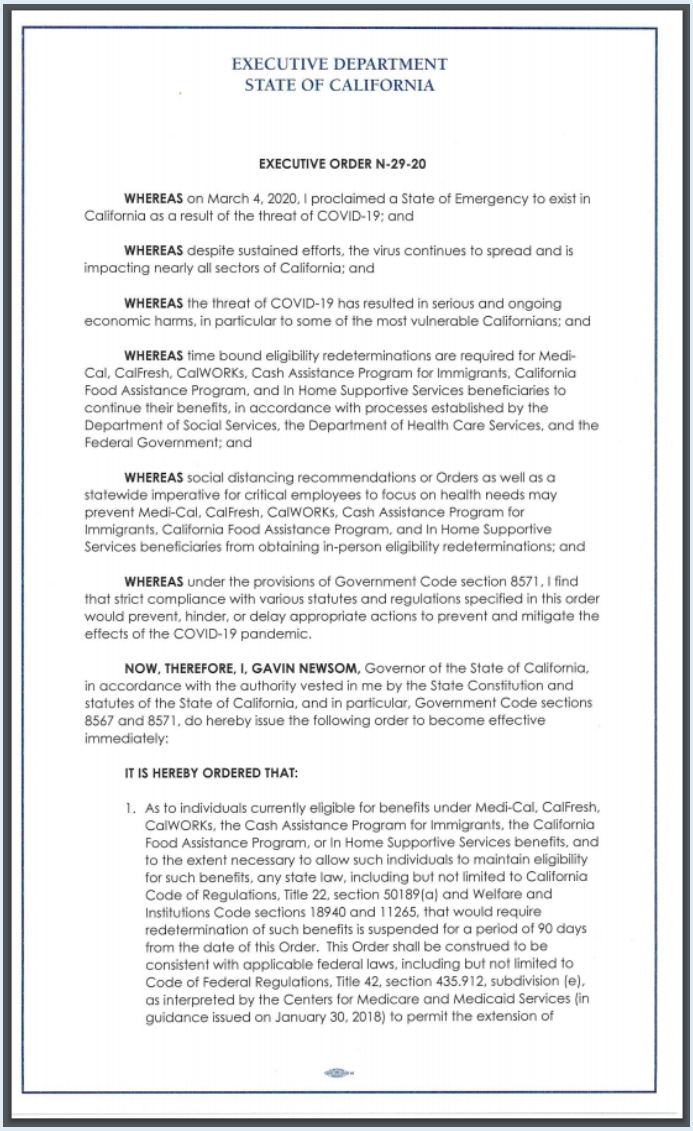
an individual's physical and behavioral health needs is managed by a single entity. The Community Program Planning portion of this program is concurrent with that of the MHSA Three Year Integrated Plan. MHSOAC approval will be sought before the approval of this MHSA Three Year Integrated Plan by the San Bernardino County Board of Supervisors. Those approvals will be reflected in the final and posted version of the INN plan.

- Three new Innovation programs, Eating Disorder Collaborative (EDC), Cracked Eggs, and the Multi-County Full Service Partnership (FSP) Program, are in the process of approval.
    - ◊ It is anticipated that the EDC and Cracked Eggs programs will be reviewed for consideration as part of the March 26, 2020 Commission meeting. The Multi-County FSP program is anticipated for consideration on April 23, 2020. The final version of this MHSA Three Year Integrated Plan will reflect the final decision of the MHSOAC.

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

Public Review

The MHSA Three Year Integrated Plan was posted on the department's website for stakeholder review and comment from **February 27, 2020 through March 27, 2020** at http://wp.sbcounty.gov/dbh/admin/mhsa/. The Public Hearing to affirm the stakeholder process took place at the regularly scheduled Behavioral Health Commission Meeting on **April 2, 2020**, which is held from **12:00 p.m. until 1:00 p.m.**



EXECUTIVE DEPARTMENT
STATE OF CALIFORNIA

EXECUTIVE ORDER N-29-20

WHEREAS on March 4, 2020, I proclaimed a State of Emergency to exist in California as a result of the threat of COVID-19; and

WHEREAS despite sustained efforts, the virus continues to spread and is impacting nearly all sectors of California; and

WHEREAS the threat of COVID-19 has resulted in serious and ongoing economic harms, in particular to some of the most vulnerable Californians; and

WHEREAS time bound eligibility redeterminations are required for Medi-Cal, CalFresh, CalWORKs, Cash Assistance Program for Immigrants, California Food Assistance Program, and In Home Supportive Services beneficiaries to continue their benefits, in accordance with processes established by the Department of Social Services, the Department of Health Care Services, and the Federal Government; and

WHEREAS social distancing recommendations or Orders as well as a statewide imperative for critical employees to focus on health needs may prevent Medi-Cal, CalFresh, CalWORKs, Cash Assistance Program for Immigrants, California Food Assistance Program, and In Home Supportive Services beneficiaries from obtaining in-person eligibility redeterminations; and

WHEREAS under the provisions of Government Code section 8571, I find that strict compliance with various statutes and regulations specified in this order would prevent, hinder, or delay appropriate actions to prevent and mitigate the effects of the COVID-19 pandemic.

NOW, THEREFORE, I, GAVIN NEWSOM, Governor of the State of California, in accordance with the authority vested in me by the State Constitution and statutes of the State of California, and in particular, Government Code sections 8567 and 8571, do hereby issue the following order to become effective immediately:

IT IS HEREBY ORDERED THAT:

1. As to individuals currently eligible for benefits under Medi-Cal, CalFresh, CalWORKs, the Cash Assistance Program for Immigrants, the California Food Assistance Program, or In Home Supportive Services benefits, and to the extent necessary to allow such individuals to maintain eligibility for such benefits, any state law, including but not limited to California Code of Regulations, Title 22, section 50189(a) and Welfare and Institutions Code sections 18940 and 11265, that would require redetermination of such benefits is suspended for a period of 90 days from the date of this Order. This Order shall be construed to be consistent with applicable federal laws, including but not limited to Code of Federal Regulations, Title 42, section 435.912, subdivision (e), as interpreted by the Centers for Medicare and Medicaid Services (in guidance issued on January 30, 2018) to permit the extension of

Snapshot of Executive Order

Substantive Comments/Recommendations

An analysis of substantive recommendations is included in the Public Posting and Comment section of the final MHSA Three Year Integrated Plan. Comments/recommendations can be submitted via email to the DBH MHSA email box at MHSA@dbh.sbcounty.gov during the time the MHSA Three Year Integrated Plan draft is posted for public comment. Stakeholders are informed that comments can be received anytime through the year, but will not be included in the final MHSA Three Year Integrated Plan unless provided during the 30-day comment period. The MHSA Three Year Integrated Plan was posted for 30-days, per Welfare and Institutions Code 5848, between **February 27, 2020 and March 27, 2020** at http://wp.sbcounty.gov/dbh/admin/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 **1-888-743-1478** for more information.

During stakeholder meetings, community members asked how they might get additional information on what behavioral health services are available in the County. The County has an Access Unit that can be called for assistance in locating services and can be reached at **1-888-743-1478**. Service directories are also available online at http://wp.sbcounty.gov/dbh/wp-content/uploads/2016/06/Directory_Service_Eng.pdf.

During stakeholder meetings, it was noted that community members would like information about how to access funds related with MHSA programs for their areas. The Department releases several Requests for Proposals (RFPs) every year through a procurement process. MHSA funds can be accessed by successful applicants who participate in the procurement process and are determined to meet criteria for RFPs. RFPs may be accessed at the County website per the following link: http://www.sbcounty.gov/main/Pages/rfp.aspx. More information on the Department's RFP process will be provided over the course of the next year at the Regional District Advisory Committee meetings.

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

DBH encourages and supports community collaboration, particularly the involvement of stakeholders, in all aspects of the MHSA programs provided. To address concerns related to DBH MHSA program issues in the areas of access to behavioral health services, violations of statutes or regulations relating the use of MHSA funds, non-compliance with MHSA general standards, inconsistency between the approved MHSA Three Year Integrated Plan and its implementation, the local MHSA community program planning process, and supplantation, please refer to the MHSA Issue Resolution process located at http://wp.sbcounty.gov/dbh/wp-content/uploads/2016/08/COM0947.pdf.

Community members do not have to wait for a meeting to provide feedback to the Department. Feedback can be provided at any time via email at MHSA@dbh.sbcounty.gov or phone by calling **1-800-722-9866**. As program data, outcomes, statistics, and ongoing operations are discussed on a regular basis, regular attendance at one or more of the meetings listed above is encouraged. The Community

Policy and Advisory Committee (CPAC) specifically addresses MHSA programs and occurs monthly. If you would like to be added to the invite list for CPAC's meetings, please email MHSA@dbh.sbcounty.gov.

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

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

Depending on the program proposal, services can be provided by DBH clinics or organizational contract providers. In many cases, programs are implemented using both DBH clinics and organizational contract providers working together to provide services in a system of care framework. For services provided by organizational providers, an RFP/procurement process is required. The RFP process can be accessed via the link above and is as follows http://www.sbcounty.gov/main/Pages/rfp.aspx.
Additional information about past MHSA approved plans can be accessed at the following link http://wp.sbcounty.gov/dbh/admin/mhsa/. If you have any questions about MHSA programs in general or programs as detailed in this MHSA Three Year Integrated Plan, please email or call the department at MHSA@dbh.sbcounty.gov or **1-800-722-9866**.

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

Assistance for Disabled Individuals:
A good resource for finding services to support developmentally and physically disabled adults would be the utilization of the **2-1-1** service. The **2-1-1** service is a free and confidential service, available 24-hours a day, providing information and resources for

health and social services in San Bernardino County. Call **2-1-1** or visit the website at www.211sb.com to find resources nearby.

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

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

Innovation Projects:
There is currently one active Innovation Project and three newly proposed projects that still require final approval from the Mental Health Services Oversight Accountability Commission (MHSOAC) and the San Bernardino County Board of Supervisors, and one newly proposed project currently included in this MHSA Three Year Integrated Plan. The current Innovation project is the Innovative Remote Onsite Assistance Delivery (InnROADS) program. The Eating Disorder Collaborative, Cracked Eggs, Multi-County FSP project, and Integrated Health Projects are all in varied stages of review and approval. Information regarding Innovation and the Community Program Planning process can be obtained at **1-800-722-9866**.

Shelter Beds and Homeless Assistance:
The Office of Homeless Services (OHS) plays a vital role in the San Bernardino County Homeless Partnership as the administrative support unit to the organization. OHS insures that the vision, mission, and goals of the Partnership are carried into effect.

Homeless services information and resources can be found at the San Bernardino County Homeless Partnership website: http://wp.sbcounty.gov/dbh/sbchp/. The focus of the partnership is to develop a countywide public and private partnership and to coordinate services and resources to end homelessness in San Bernardino County.

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

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

Overview of Public Posting and Comment Period

The Department of Behavioral Health (DBH) would like to thank those who participated in the public review and comment portion of the stakeholder comment process. During the 30 day public posting of the MHSA Three Year Integrated Plan for Fiscal Years 2020/21 – 2022/23, that occurred from February 27, 2020 through March 27, 2020, DBH continued to promote the 30 day posting and provided overviews and information related to the MHSA Three Year Integrated Plan. All 30 public libraries in San Bernardino County, as well as DBH's community, government, and law enforcement stakeholders received a copy of the plan's Executive Summary including instructions for submitting feedback. A total of 86 hard copies of the Executive Summary were distributed to these stakeholders. A press release, in English and Spanish, notifying the public of the posting was sent to 44 media outlets. A series of web blasts were released to all DBH clinics, contracted provider agencies, the Community Policy Advisory Committee, the Cultural Competency Advisory Committee, and all associated cultural

sub-committees, the Association of Community Based Organizations, and the Behavioral Health Commission. This information was also advertised on all DBH sponsored social media sites, including Facebook, Instagram, and Twitter and it was posted on the DBH website.

As a result, 8 completed surveys were received during the 30 day public posting and comment period, which provided general comments to the plan as well as comments specifically related to the creation and implementation of the Early Psychosis Care Program.

Summary and Analysis of Substantive Comments

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

Questions: Do you have other concerns not addressed in this document.

Comment:
Greetings, I have a concern related to the Early Psychosis Care Program. I am sure a great time and thought went into its development. However, I am concerned the program lacks cultural relevance and will stagnate K-12 education from the integration of social and emotional learning programs essential to youth development. In November 2019, California's Surgeon General called trauma as a public health crisis. County DBH has been successful at serving an estimated 10% of the county's total population of 2 million residents; therefore, 90% of the population remains in jeopardy. Current DBH school-based services are not benefiting all children and youth in a timely manner as required by policy as service access is through teacher referral upon their reaction to students demonstrating a range of disruptive behaviors or appearing physically in crisis. The new PEI regulations acknowledge childhood trauma prevention and early intervention to target children exposed to or who are risk of exposure, to adverse traumatic childhood events and prolonged toxic stress. I am concerned the Early Psychosis Care Program does not reduce the risk associated with childhood trauma and will sustain non-clinical mental health stigma among distrusting children and parents similar to current school-based services. While the program is warranted similar to current school-based services will inappropriately diagnose students with mental disorders who are attempting to manage toxic stress. The Early Psychosis Care Program doesn't appear to be scalable to impact the current population health crisis and neglects to highlight focused prevention and early intervention. Local Education Agencies will be better served with proactive service delivery to prevent problem behaviors and intervene early in socio-economically disadvantaged communities of

color where children are trauma-exposed. As co-chair of the San Bernardino County Department of Behavioral Health Cultural Competence Advisory Committee, I strongly recommend before launching the Early Psychosis Care Program, the county adopts and implements a unified and comprehensive prevention and early intervention practice. The program method should simultaneously serve children and youth proactively and intervene early to effectively identify students demonstrating the first signs of the onset of mental illness for an appropriate referral into the Early Psychosis Care Program. The program should incorporate the new PEI strategies and have the ability to scale to impact population health. The application should adhere to new guidelines that include youth outreach and engagement collaboratively with post-secondary education to embrace a whole-community approach to wellness. Thank you for your time and consideration.

Response:
Thank you for your response and feedback. San Bernardino County Department of Behavioral recognizes that prevention and early intervention services are essential to our youth. For the initial intent of the Early Psychosis Care Program, DBH will target services to those considered Clinical High Risk (CHR) for developing a serious illness. Research has shown that majority of individuals who experience the onset of symptoms occur between the ages of 16 and 25. As in any new program, the program will focus on a specific population. After implementation, DBH will evaluate the program's effectiveness and determine if the program is successfully meeting its goals. After thorough evaluation, the program can be reassessed to determine if the lessons learned can benefit additional vulnerable populations.

In response to the recently passed PEI regulations through Senate Bill 1004, DBH has identified each program and its corresponding targeted priorities (i.e., childhood trauma prevention and early intervention, early psychosis, youth outreach, cultural competency, and strategies targeting older adults). Further information can be accessed via the Prevention and Early Intervention component of this MHSA Three-Year Integrated Plan. We encourage continuous feedback through the Community Program Planning process. You may contact MHSA Administration at 1-800-722-9866 or emailing MHSA@dbh.sbcounty.gov.

Questions: What did you learn about the MHSA Three Year Integrated Plan Fiscal Year 2020/21 through 2022/23?

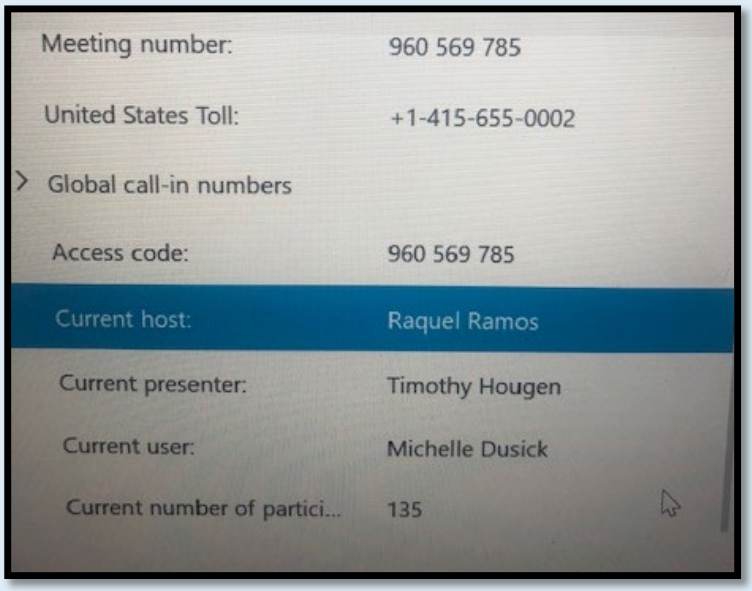
Comment:
As much as things change, they remain the same. Mental Health Services is making an impact due to the significant tax revenue generated annually, yet, the system has not transformed to drastically increase access, reduce cost, or improve the delivery of services in underrepresented ethnic populations.

Response:
Thank you for your response and comment. San Bernardino County Department of Behavioral Health is committed to providing services within the entire continuum of care to its residents who are unserved, underserved, and inappropriately served. DBH engages in a continuous effort to improve and grow existing programs and investing in innovative ideas to ensure access and improved delivery of services to underrepresented populations. While DBH recognizes progress has occurred since the inception of the MHSA in 2005, areas of need evolve and continue to exist. Your suggestions are appreciated and welcomed and can be provided throughout the year at a stakeholder meeting, via email, phone call, or mail. For a calendar of stakeholder events, please visit: http://wpcl.sbcounty.gov/dbh/. You may also contact MHSA Administration at 1-800-722-9866 or emailing MHSA@dbh.sbcounty.gov.

Public Hearing

The Public Hearing was hosted by the San Bernardino County Behavioral Health Commission was conducted April 2, 2020 via a web-based forum pursuant to the provisions in the California Governor's Executive Order N-29-20, regarding the gathering of large groups and suspending certain requirements of the Ralph M. Brown Act. Handouts, which included an agenda, meeting regulations of MHSA public hearings, and a copy of the MHSA public hearing PowerPoint presentation, were verbally and/or electronically accessible for all attendees during the meeting. As with all public meetings, interpretive services and materials were available upon request.

Approximately 135 community members attended the Public Hearing via calling in or video conferencing.



Screenshot of number of Public Hearing attendees

There was one public comment received during the Public Hearing:

Comment:
The stakeholder acknowledged Department of Behavioral Health's efforts to increase access of services to underrepresented ethnic and cultural communities. Then, further addressed the abundance of county residents living below the poverty level, adverse childhood experiences and its impacts occurring concurrently with the current COVID-19 emergency. Stakeholder proposed the expansion and linkages of Prevention and Early Intervention to appropriately and effectively identify children, youth, and transitional-aged youth requiring services through Early Psychosis Care Program and Community Wholeness Enrichment Programs as a remedy to this public health concern. In order to comply with Senate Bill (SB) 1004, stakeholder proposed the following for the Early Psychosis Care Program and Community Wholeness and Enrichment Program: to allocate MHSA funds to support a comprehensive and collaborative program to simultaneously reduce stigma and target the children, youth, and transitional aged youth populations countywide. These programs will serve to prevent adverse behaviors and intervene early to appropriately identify the targeted populations.

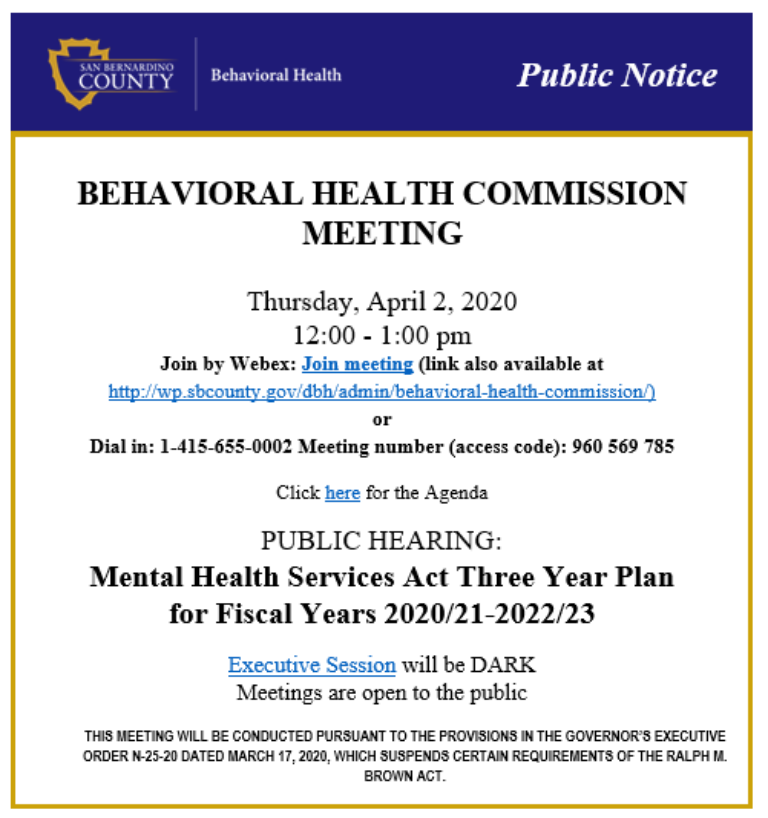
Response:
Thank you for your response and feedback. Through the implementation of the Mental Health Services Act, Prevention and Early Intervention (PEI) program services implement programs and strategies that prevent mental illness from becoming severe and disabling, emphasizing improvement in timely access to services for underserved populations. Strategies and activities are implemented early on to deter the onset of mental health conditions, reduce risk factors, and address relapse among individuals and are integrated into systems of care to create broadened access points for all DBH programming, regardless of funding.

We encourage continuous feedback through the Community Program Planning process. You may contact MHSA Administration at 1-800-722-9866 or emailing MHSA@dbh.sbcounty.gov.

The Behavioral Health Commission affirmed that the Department adhered to the MHSA CPP process and supported the submission of the MHSA Three-Year Integrated Plan for Fiscal Years 2020/21-2022/2023 to the San Bernardino County Board of Supervisors tentatively for approval at the May 18, 2020 meeting and the subsequent submission to the Mental Health Services Oversight and Accountability Commission.

One comment was also received from the Behavioral Health Commissioners. The comment and question focused on the use and impact of the public comments received during the 30-Day posting. A summary of the results was provided along with an emphasis that the feedback resulted in no substantive changes to the Plan.

Below is a copy of the flyer distributed to the community to promote the MHSA Three-Year Integrated Plan Public Hearing at the Behavioral Health Commission Meeting.



SAN BERNARDINO COUNTY | Behavioral Health — *Public Notice*

BEHAVIORAL HEALTH COMMISSION MEETING

Thursday, April 2, 2020
12:00 - 1:00 pm
Join by Webex: Join meeting (link also available at
http://wp.sbcounty.gov/dbh/admin/behavioral-health-commission/)
or
Dial in: 1-415-655-0002 Meeting number (access code): 960 569 785

Click here for the Agenda

PUBLIC HEARING:
Mental Health Services Act Three Year Plan for Fiscal Years 2020/21-2022/23

Executive Session will be DARK
Meetings are open to the public

THIS MEETING WILL BE CONDUCTED PURSUANT TO THE PROVISIONS IN THE GOVERNOR'S EXECUTIVE ORDER N-25-20 DATED MARCH 17, 2020, WHICH SUSPENDS CERTAIN REQUIREMENTS OF THE RALPH M. BROWN ACT.

New Programs

Following are descriptions of new programs planned to be introduced and implemented during this reporting period.

COMMUNITY PROGRAM PLANNING

Behavioral Health Ministries Pilot Project

The Behavioral Health Ministries Pilot project is a short term pilot project that seeks to partner with a network of faith based organizations to assist in identifying the unmet behavioral health needs for the faith-based, African American Community. This pilot project is intended to be a collaboration between the Department of Behavioral Health (DBH) and the Inland Empire Concerned African American Churches (IECAAC) to address the behavioral health needs of IECAAC member churches. The goal is to provide participants with education and resources to address the behavioral health needs of their congregations within the church settings and provide appropriate and timely resources for members to access needed behavioral health resources. The pilot project will also inform and explore the development of a future comprehensive early intervention programs within faith-based entities that will increase behavioral health access for church members that may show signs of mental health issues and substance use disorder symptoms. This pilot project will provide the opportunity for African American families at risk of or living with behavioral health issues to receive supportive services in the safe environment of their church and access help without fear of stigma or discrimination.

> The IECAAC was formed over 20 years ago to unify the African-American churches and become a voice for the people they serve.

The church is the pillar of the African American community with the capacity to provide support through utilizing resources, facilitating spiritual as well as technical expertise. Churches are in positions to identify needs and provide support and resources to their members and communities. IECAAC is the body that organizes the efforts of over 20 churches in addressing various community needs through six committees. The committees are 1) Community Development, 2) Education, 3) Health, 4) Prayer, 5) Economic Development, and 6) Church Unity.

This pilot will be part of IECAAC's Health Committee. The goal of the committee is to promote comprehensive wellness within its churches and communities. The efforts of the committee are centered on promoting Behavioral Health awareness in order to reduce mental health disparities, stigma, and increase access to appropriate behavioral health care for African Americans. The committee is responding to its members' needs, as there is an increasing need in their communities for behavioral health services and resources. Additionally, church leaders are in need of behavioral health training and resources. This pilot supports a united effort to meet the growing need for behavioral health services, awareness, and acceptance through development and implementation of a comprehensive, targeted community outreach and stigma/discrimination reduction

program implemented in collaboration with partnering faith based organizations serving African Americans and San Bernardino County Department of Behavioral Health (DBH). The result will be Behavioral Health Ministries in each of the member churches/faith based organizations that elect to participate.

Projected Number to be…	
Trained	**Trained**
40 Church Pastors and Leadership	40 Church Pastors and Leadership

The pilot project will be developed thorough the following phases:

Phase I: Needs Assessment

- Recruitment of individuals interested in participating in the pilot project.
- Creation of a needs assessment survey to identify community needs.
- Collection of community needs data by community members via needs assessment surveys, town hall meetings, and key informant interviews.
- Mapping of existing resources.
- Analysis of needs assessment data and resources to determine training and resource needs.
- Development of training responsive to participants identified needs. Possible training topics may include: Mental Health First Aid, Suicide Prevention, Reducing Stigma, Substance Use Disorders and Recovery Services for all age groups: Children, TAY, Adults, Older Adults.
- Development Pre and Post Training Surveys to measure training effectiveness.
- Needs Assessment report and recommendations.

Phase II: Behavioral Health Education and Awareness

- Training of individuals included in the pilot project.
- Training survey collection and reporting.

Phase III: Community Engagement

- Regularly scheduled outreach presentations to faith-based and community groups.
- Targeted presentations to smaller groups, families, couples or individuals to address specific behavioral health topics.
- Regularly scheduled ongoing trainings for pilot project participants.
- Regularly scheduled meetings and focus groups to support pilot project participants and identify community unmet needs.
- Community engagement data collection and surveys.

Phase IV: Reporting

- Monthly Progress Reports
- Annual Report detailing deliverables and lessons learned.
- Final Pilot Project Report and recommendations to inform the San Bernardino County Mental Health Plan.

Expected Outcomes:

- An organized and established collaboration between the DBH and IECAAC to ensure IECAAC members and members of the faith based community are informed and able to connect individuals experiencing the onset of a behavioral health issue to the appropriate level of care.
- An increase in awareness within the IECAAC membership to reduce negative stigmas and biases about mental health and substance abuse disorders.
- Identification of strengths and limitations in DBH and IECAAC's collaboration.
- Identification of IECAAC's and other faith based organizations' capacity to provide or link to mental health services.
- Recommendations for policy or systems change to inform DBH's future collaboration with other faith based organizations interested in developing behavioral health ministries.
-

Targeted Audiences:

- All IECAAC members, congregants and church leadership.

MHSA Legislative Goals and Related Key Outcomes

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

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

Improve timely access to services for underserved populations:

- Increase extent to which individual or family from underserved population who need mental health services because of risk or presence of a mental illness receives appropriate services as early in onset as practicable.

Reduce prolonged suffering:

- Improve life satisfaction

- Decrease hopelessness/increase hope
- Increased resiliency
- Decreased impairment in general areas of life functioning

Reduce stigma and discrimination associated with mental illness:

- Increase accurate knowledge about mental illness
- Increase extent to seek services, if needed

Project Quantifiable Outcomes

Behavioral Health Education and Awareness:

- 90% Increased knowledge about mental health, mental illness and services/resources available
- 90% Increased knowledge of Substance Use Disorders and services/resources available
- 80% Increased ability to connect children, adults, and seniors 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% Increased ability and comfort to address and present behavioral health topics to church members/congregates

Community Engagement:

- 80% Increased knowledge of mental health, mental illness and behavioral health services, and resources
- 80% Increased knowledge of substance use disorders and behavioral health services, and resources
- 80% Increased awareness of behavioral health services and resources in their church and community
- 80% increased comfort in seeking services in their church/community for mental health and substance use issues
- 80% increased comfort in speaking with family and/or friends about mental health
- 80% increased comfort in seeking services, if needed.
- 80% likelihood of utilizing information and resources to improve own mental health

Early Psychosis Care Program

Psychosis is a severe disturbance in mental health in which thought and emotions are so impaired that contact is lost with external reality. Early warning signs and symptoms, lasting from days to several years, often foreshadow the onset of a serious and persistent mental illness with psychotic features. This early warning phase is a powerful point of intervention for curbing escalating psychiatric symptoms, distress, and functional disability. People experiencing this early phase are considered to be at a Clinical High Risk (CHR) for developing a serious illness.

Artwork by Carmela Gonzalez

For the majority of individuals who experience psychosis, the onset of symptoms occurs between the ages of 16 and 25. Research of existing treatment models indicate that some individuals can avoid a lifetime of disability and find fulfillment in daily life with appropriate and timely intervention.

The intent of the Early Psychosis Care program is to identify individuals with a clinical high risk as early as possible in the warning phase of psychosis and/or intervene as soon as possible during the first episode of psychosis.

The Challenge

A brief review of research indicates that three out of 100 people experience psychosis at some time in their lives, with approximately 100,000 adolescents and young adults in the U.S. experiencing a first episode psychosis each year. People presenting with early psychosis usually present with multiple problems such as suicidal ideation, aggressive behavior, legal difficulties, school challenges, and are often diverted to other systems such as the criminal justice system. Additionally, treatment delays are common throughout the U.S. Research suggests that 68% of patients in the U.S. who experience a psychotic episode for the first time present a Duration of Untreated Psychosis (DUP) greater than 6 months. Additional information published by the National Council for Behavioral Health suggests that of persons experiencing psychosis, the average person does not engage with treatment until an average of 74 weeks (approximately 18 months) after the onset of the illness.

Longer durations of untreated psychosis are associated with:

- Increases in severity of symptoms,
- Increased numbers of psychiatric hospitalizations and relapse rates,
- Reduced social and cognitive functioning, and
- Poor responses to treatment.

Psychosis can be treated and early treatment increases the chance of a successful recovery. Recent studies conducted show that early intervention services, which include anti-psychotic medication, yield high rates of remission, ranging from 75% to 85% over a period of 1 to 2 years. Overall, studies consistently suggest that compared with standard care, an early intervention approach to treatment of early psychosis results in modestly superior benefits for a wide range patients through high rates of remission, better symptom management, and greater adherence to and retention in treatment. Similarly, an early intervention approach results in better social and vocational outcomes.

Existing Efforts

Currently, the Department of Behavioral Health provides a continuum of services ranging from prevention and early intervention, crisis services, and include an array of outpatient and short term residential services that vary in intensity according to the needs of individuals. The continuum allows individuals to access care through multiple avenues and provides an existing infrastructure to identify and address first episodes of psychosis and the precursor signs and symptoms (i.e., Clinical High Risk or prodromal phase). Included in the continuum is the grant funded Premier program. The Premier program currently serves individuals who are identified as experiencing their first episodes of psychosis. Typically, individuals participating in the Premier program are identified and referred from inpatient psychiatric facilities. The Premier program is limited to the requirements identified in the funding and serves 10-15 consumers per year. Several Department of Behavioral Health programs serve this population. Currently, a more systematic and evidence-based response could lead to improved outcomes.

Program Overview

The Early Psychosis Care (EPC) program will build on the existing infrastructure within the continuum of services offered by the Department of Behavioral Health through development of several Coordinated Specialty Care (CSC) teams focused on first episodes of psychosis and identification of individuals at high clinical risk. The CSC teams will enhance programming and be based in existing programs such as the Transitional Aged Youth (TAY) Full Service Partnership (FSP) and the Premier Program. Additionally, a centralized team of expert consultants will utilize evidence-based models to work with enhanced programs to wrap services and supports around the individual experiencing psychosis and consumer identified friends and family members. This includes utilization of standardized measures of clinical characteristics,

interventions, and early psychosis outcomes to create a unified informatics approach to study variations in treatment, quality, clinical impact, and value.

The support and consultation team will be comprised of a Clinical Supervisor, Clinical Therapists, Social Worker IIs, a Peer and Family Advocate, a Program Specialist II, a Office Assistant, and include a portion of time of a Psychiatrist.

The program will support and measure delivery of services in detail utilizing the First Episode Psychosis Services Fidelity Scale (FEPS-FS). Components of the CSC could include but are not limited to the following:

- **Team Meetings:** A range of healthcare workers who are members of different disciplines (e.g. Psychiatrists, Social Workers, Peer and Family Advocates, etc.), that provide specific services to the consumer and come together to improve care planning and coordination.
- **Case Management**: Assistance by case manager who helps clients and family members navigate their treatment options.
- **Psychiatry Services with close monitoring of medication**: Communication about the importance of medication even after symptom improvement.
- **Psychotherapy**: Use of evidence-based interventions for psychosis provided for individuals, groups, and family.
- **Family Education and Support**: Consumers chose who they want involved in their recovery, and families/supports receive information to play an active role in recovery.
- **Supported employment and education**: Fostering autonomy and setting goals to live to the fullest.
- **Advocacy**: Delivering peer support that reduces barriers consumers and families face in accessing mental health care.
- **Outreach**: Assertively outreaching to individuals, at-risk populations and their families, which could include home visitation.

In addition to the direct services provided to individuals, the Early Psychosis Care program centralized team of expert consultants will provide support and assistance to the CSC teams and coordinate the delivery of specialized workshops that build the capacity and expertise of the entire care system. Examples of workshop topics include Prodromal Assessment, Family Focused Treatment, Cognitive Behavioral Therapy for Psychosis, and utilization of the FEPS-FS in the delivery of care.

Target numbers served and age group(s)

Recipients of mental health services, will be included in the MHSA or grant funded program in which they are being served. The numbers represented below in TAY and Premier are provided for reference to demonstrate the expanded number of individuals anticipated to be served for fiscal years (FY) 2020-21 through 2022-23. The counts for the TAY program will be included in the TAY One Stop in future years.

The Premier program will be enhanced to serve an additional five individuals through MHSA funded services and supports. The table below illustrates the anticipated number of participants to be served over the next three fiscal years.

Fiscal Year	Service/Activity	TAY FSP Program	Premier Program	Total
2020-2021	**Mental Health Service Recipients**	100	5	105
2021-2022	**Mental Health Service Recipients**	100	5	105
2021-2022	**Mental Health Service Recipients**	100	5	105

MHSA Legislative Goals and Related Key Outcomes

- Increase Early Access and Linkage to Medically Necessary Care and Treatment:
  - ◊ Connect children and transitional aged youth with severe mental illness to care as early as possible. This will include, but is not limited to, care provided by county mental health programs.
- Reduce prolonged suffering associated with untreated mental illness:
  - ◊ Reduce risk factors
  - ◊ Reduce indicators
  - ◊ Increase protective factors that may lead to improved mental emotional, and relational functioning
  - ◊ Reduce symptoms, and
  - ◊ Improve recovery including emotional and relational functioning.
- 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.

Measures of Effectiveness

The Early Psychosis Care program will utilize the First Episode Psychosis Services Fidelity Scale (FEPS-FS 1.0) © to monitor the fidelity of services. The tool monitors broad implementation across 32 individual evidence-based practice domains with each domain containing critical items that must be met to meet fidelity for the domain.

Items evaluate client and program level data and address team functioning and outcomes over a one year period. Data will be collected quarterly. The data collected will be used to assess and monitor fidelity and support ongoing quality improvement.

Additional items will be collected by fidelity monitors through conducting site evaluations. Site visits will consist of interviews with consumers and family members, observations of team meetings, and review of client charts and programs. These observations are useful in reviewing domains related to care processes, such as shared decision making.

DBH intends to build on existing data collection and reporting systems to incorporate the FEPS-FS tool data collection and monitoring activities. Output information will be reported annually and included in MHSA Plans.

Examples of variables to be evaluated and rated via the FEPS-FS 1.0© include the following:

- Timeliness of contact with referred individuals
- Assessment of psychosocial needs for care plan
- Patient and family involvement in assessments and care planning
- Medication Management
- Implementation of Evidence-based therapies
- Community Living Skills

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).

Integrated Behavioral Health Care Innovation Project (INN-*)

The Integrated Care Innovation project is currently in development. It is anticipated that this project will be presented to the Mental Health Services Oversight and Accountability Commission (MHSOAC) and San Bernardino County 's Board of Supervisors (BOS) during Summer 2020.

Proposed Project Concept

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 death decades earlier than necessary, often from easily treatable health 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 this challenge by partnering with the Inland Empire Health Plan (IEHP) to create and deliver integrated behavioral and physical health services to Medi-Cal enrollees at two pilot clinic sites. The integration model that SBC-DBH seeks to create is one where the delivery, coordination, and payment for care related to the full continuum of an individual's physical and behavioral health needs is managed by a single accountable entity. This integration will be more than the common practice of "co-locating" either physical or behavioral health staff in the same location. The pilot clinics will incorporate a full range of outpatient mental health and substance use disorder services alongside primary care services that will:

- Share access to medical information (with appropriate permissions),
- Meet and confer about individual cases, and
- Develop procedures and practices to ensure the delivery of all needed care.

To minimize the dislocation caused when an individual steps down to mild-to-moderate behavioral health services, mental health providers at the two clinic sites will be credentialed with IEHP and authorized not only to provide specialty mental health services, but mild-moderate mental health services as well. This is an option available nowhere else in the county. Traditional services for Medi-Cal enrollees offered through

SBC-DBH or IEHP do not have the option for a single provider to deliver both specialty mental health services and mild-to-moderate mental health services.

Other important components of this Innovation project will include:

- Care management teams built upon the infrastructure and practices, established by the Department of Health Care Services, for the Health Homes Program designed to serve eligible Medi-Cal enrollees with complex medical needs.
- The creation of a shared financial model where IEHP, while under contract with SBC-DBH, will have financial responsibility for needed inpatient and outpatient medical and behavioral health services for the pilot population.

Artwork by Betsy Pruitt

Prevention and Early Intervention

Introduction

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

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

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

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

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

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

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

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

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

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

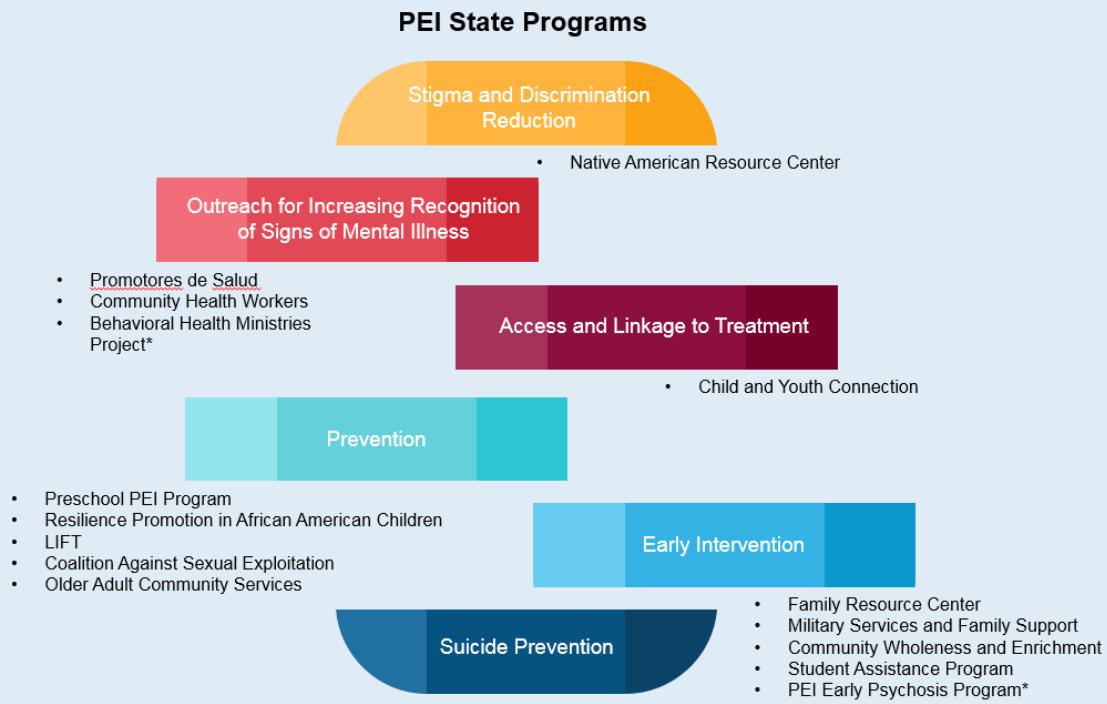
- Childhood trauma prevention and early intervention to deal with the early origins of mental health needs.
- Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programming that occurs across the lifespan.
- Youth outreach and engagement strategies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

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

Local PEI Construct

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

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



*New program to be implemented in Fiscal Year 2020/21.

County Program Target Populations

The following table list each PEI County program and the age groups they serve.

Prevention and Early Intervention Programs				
Program Name	**Age Groups Served**			
	Children	**TAY**	**Adults**	**Older Adult**
Native American Resource Center	X	X	X	X
Promotores de Salud/Community Health Workers	X	X	X	X
Child and Youth Connections	X	X	X	
Student Assistance Program	X	X	X	
Preschool PEI Program	X	X	X	
Resilience Promotion in African American Children	X	X	X	
Older Adult Community Services				X
LIFT	X	X	X	
Coalition Against Sexual Exploitation (CASE)	X	X	X	
Family Resource Center	X	X	X	X
Community Wholeness and Enrichment	X	X		
Military Services and Family Support	X	X	X	X
PEI Early Psychosis Program*		X	X	
Behavioral Health Ministries Project*	X	X	X	X

*New program to be implemented in Fiscal Year 2020/21.

Artwork by Carmela Gonzalez

MHSA Legislative Goals and Key Outcomes

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

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

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

Improve timely access to services:

- Increase extent to which an individual or family from an underserved population who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in onset as practicable.

Promote, design, and implement programs in ways that reduce and circumvent stigma:

- Reduce and circumvent stigma, including self-stigma.
- Reduce discrimination related to being diagnosed with a mental illness, having a mental illness, or seeking mental health services.
- Increase service accessibility.

Prevent suicide as a consequence of mental illness:

- Improve attitudes, knowledge, and/or behavior regarding suicide related to mental illness.

Increase recognition of early signs of mental illness

- Increase identification of early signs of potentially severe and disabling mental illness for potential responders.
- Increase support to individuals with mental illness.
- Increase referrals for individuals who need treatment or other mental health services.

Reduce prolonged suffering associate with mental illness:

- Reduce risk factors.
- Reduce indicators.
- Increase protective factors that may lead to improved mental emotional and relational functioning.
- Reduce symptoms.
- Improve recovery, including mental, emotional and relational functioning

Reduce stigma and discrimination associated with mental illness:

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

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

In accordance with the regulations passed with Senate Bill (SB) 1004 in September 2018, the following table reflects each County PEI program and the priorities they outlined in SB-1004:

Prevention and Early Intervention Programs					
Program Name	Targeted Priorities				
	Childhood Trauma PEI	Early Psychosis	Youth Outreach	Culturally Competency	Strategies Targeting Older Adults
Native American Resource Center				X	
Promotores de Salud/Community Health Workers			X	X	
Child and Youth Connections	X			X	
Student Assistance Program	X		X		
Preschool PEI Program	X				
Resilience Promotion in African American Children	X		X	X	
Older Adult Community Services					X
LIFT	X				
Coalition Against Sexual Exploitation (CASE)	X		X		
Family Resource Center			X	X	X
Community Wholeness and Enrichment	X	X	X		
Military Services and Family Support				X	X
PEI Early Psychosis Program*		X			
Behavioral Health Ministries Project*				X	

*New program to be implemented in Fiscal Year 2020/21.

PEI Data Collection

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

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

Providers are required to submit the monthly reports to the Department no later than the tenth day following the last day of the month of services. In FY 2020/21, DBH anticipates launching a Prevention and Early Intervention Data Collection System (PEI-DCS) to streamline the electronic data collection process. This database will replace the current process of submitting monthly reports and will offer the County the ability to access real time data entered by the providers.

Providers who deliver early intervention services are required to enter all Early Intervention services into the San Bernardino Department of Behavioral Health's billing system, SIMON. They are required to input their service information and data in SIMON no later than seven days from the date of services. Starting in FY 2020/21, the Department's goal is to replace the SIMON system by a Behavioral Health Information Management System (BHMIS). The BHMIS provides a more comprehensive method of capturing client information and service data.

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

Projected Number of Consumers Served

The table below reports the projected number of consumers the County anticipates serving annually for fiscal years 2020-21 through 2022-23 for each State program.

	Fiscal Year	Annual Projected No. of Consumers			
		Children	TAY	Adult	Older Adult
Stigma Reduction	2020 – 21 2021 – 22 2022 – 23	542	509	538	162
Outreach for Increasing Recognition	2020 – 21 2021 – 22 2022 – 23	657	2,327	25,965	1,921
Access and Linkage to Treatment	2020 – 21 2021 – 22 2022 – 23	6,992	552	1,656	
Prevention	2020 – 21 2021 – 22 2022 – 23	3,394	647	4527	6,339
Early Intervention	2020 – 21 2021 – 22 2022 – 23	28,334	9,958	18,570	2,773

PEI Statewide Projects

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

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

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

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

As part of the community planning process, the Department and its stakeholders in the development of the Three Year Plan reaffirmed the commitment to statewide PEI projects and contributed resources to support these continued efforts through next three fiscal years (July 2020 through June 2023). The following provides an overview of the goals and activities related to each statewide project.

Stigma and Discrimination Reduction

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

ACTIVITIES:

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

Student Mental Health Initiative

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

ACTIVITIES:

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

Suicide Prevention

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

ACTIVITIES:

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

San Bernardino County Local Impact

Directing Change is a statewide contest that engages students in creating 60 second public services announcements about suicide prevention as well as stigma and discrimination reduction. San Bernardino County, in collaboration with Riverside County, hosted its fifth annual local screening and award ceremony on May 2, 2019, at the California Theatre of the Performing Arts where local student winners were announced and recognized for their films.

139 films were submitted from the following schools and youth organizations in San Bernardino County: A.B Miller High School, Apple Valley High School, Ayala High School, Cajon High School, City of Rancho Cucamonga, Don Lugo High School, Encore High School, Grand Terrace High School, Redlands East Valley High School, Rim of the World High School, San Bernardino Valley College, Summit High School, and Upland High School. This represents a **56%** increase in participation from the prior year.

The films are used locally in outreach efforts and at various stakeholder meetings to bring awareness to the importance of suicide prevention. Community partners are also encouraged to use them as part of their suicide prevention engagement strategies. To view the winning films from San Bernardino County students, follow this link and select San Bernardino: http://www.directingchangeca.org/ .

In San Bernardino County, 11 organizations received **Each Mind Matters** community engagement mini-grants to combat stigma and discrimination related to mental illness: San Bernardino Valley College, Crafton Hills College, Chino High School, Mil Mujeres, Hearts & Lives, Arrowview Middle School, Mariana Academy, Sierra High School, Inland Empire Health Plan- UC Riverside, Healthy RC- City of Rancho Cucamonga Youth Leaders, and Chino High School Club. Through these grants, selected agencies support the development, local integration, and dissemination of resource materials for

local faith based organizations, health providers, and diverse communities that include but are not limited to Native American, African American, LGBTQ (Lesbian/Gay/Bisexual/Transgender/Questioning), Asian and Pacific Islander, and other populations. In FY 2018/19, $9,600 in funding was distributed to these local organizations to distribute training and materials.

Trainings, presentations and other forms of in-person outreach provide additional skills and knowledge to communities about stigma reduction and suicide prevention. Over the last three fiscal years), 3,131 individuals were reached through trainings, presentations and various outreach efforts with stigma reduction, suicide prevention and student mental health messages, resources, tools and materials through the collective efforts of all programs implemented under the Statewide PEI Project. These include:

- **Kognito Suicide Prevention and Mental Health trainings:** Online avatar-based suicide prevention and mental health trainings for college students, faculty and staff. All California Community Colleges staff and students were provided with the opportunity to utilize the Kognito training.
- **Directing Change Judges Training:** Online trainings that provided an overview of best practices in suicide prevention and mental health messaging, as a platform for judging submitted Directing Change videos.
- **Community College Outreach Events:** The Foundation for California Community Colleges and their local campuses conduct mental health outreach to campuses utilizing Each Mind Matters materials and messaging.
- **Each Mind Matters Tabling:** The Each Mind Matters Outreach & Engagement Team and Resource Navigators tabled at various conferences to engage conference attendees with Each Mind Matters materials and messages.
- **Each Mind Matters Insiders Newsletter:** A monthly electronic newsletter created specifically for service providers that provides information about relevant resources, upcoming events and opportunities for providers to get involved in California's Mental Health Movement.

Technical assistance (TA) is provided to San Bernardino County and local community organizations by Statewide PEI Project contractors. Technical assistance includes providing crisis support, capacity building, guidance, and resource navigation on stigma reduction, suicide prevention and student mental health. It also includes building and maintaining a statewide network of providers and organizations who collaborate and learn from each other to implement more effective efforts and reach broader audiences. Between FY 2017/18 and FY 2018/19, 43 TA sessions were provided to San Bernardino County covering topics such as Suicide Prevention and Mental Health Awareness Month Toolkits, Self-Care and Coping with Crisis, Means Restrictions, Strategies to collaborate with Native Communities and others.

Between July 1, 2016 and June 30, 2019, a total of 71,941 physical, hardcopy materials across Each Mind Matters programs and initiatives were disseminated throughout San

Bernardino County. In addition, county contacts received numerous emails to access and share resources electronically via the Each Mind Matters Resource Center (www.emmresourcecenter.org).

Applied Suicide intervention Skills Training (ASIST) is a training for individuals who want to feel more confident and competent in helping to prevent the immediate risk of suicide of those at risk. In San Bernardino County, starting July 2011 through June of 2019, **1,604** individuals have been trained in ASIST as part of an early investment that allowed local individuals to become certified trainers. The County continues to capitalize on the investment by continuing to provide trainings for stakeholders throughout the county.

safeTALK is a suicide alertness training that prepares caregivers, students, teachers, community volunteers, first responders, military personnel, police, public and private employees, and athletes to become suicide-alert helpers. Beginning July 2011 through June 2019, San Bernardino County in partnership with local providers has trained 2,287 community members on how to identify early signs of suicidal ideation for someone who may be at risk of suicide, how to start a discussion about suicide, and how to access resources available to connect someone in need of a suicide intervention to appropriate supports.

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

Looking Forward

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

Projected 10 year outcomes:

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

Projected 20 year outcomes:

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

Artwork by Carmela Gonzalez

Native American Resource Center (PEI CI-3)

The Native American Resource Center (NARC) is a Stigma and Discrimination Reduction program. This program functions as a one-stop center offering prevention and early intervention services designed to reduce stigma and discrimination surrounding mental health services for Native American community members of all ages. The center provides culturally-based services using traditional and strength-based Native-American practices.

Services offered include:

- Cultural parenting programs and education
- Healthy choices prevention activities
- Talking Circles
- Drumming Circles
- Cultural education and awareness
- Youth Empowerment
- Workforce development
- Education Assistance

Artwork by Hope Platt

MHSA Legislative Goals and Related Key Outcomes

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 their families.

Increase Early Access and Linkage to Medically Necessary Care and Treatment:

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

Improve Timely Access to Services for Underserved Populations:

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

Artwork by Gary Bustin

Positive Results

The annual goal of the Native American Resource Center is to provide services to a minimum of 1,750 unduplicated participants each year. During Fiscal Year 2018/19, the Native American Resource Center provided services to 3,025 unduplicated participants in the service categories shown in the table below.

Total Unduplicated Count and Total Number of Services by Service Type for Fiscal Year 2018/19		
	Unduplicated Participants Served	**Total Number of Services**
Early Intervention	184	235
Stigma and Discrimination Reduction	2,651	3,435
Access and Linkage to Treatment	6	6
Improve Timely Access to Services for Underserved Populations	184	235
Total	3,025	3,911

Early Intervention Services

Treatment of an early onset mental illness is available to all community members. Each participant receives a thorough clinical interview at which time screening tools such as Patient Health Questionnaire-9 (PHQ-9), Outcomes Questionnaire, Adverse Childhood Experience (ACE), and CAGE Alcohol Screening Test are administered. The screening tools are used as a method to identify participants at risk of developing a serious mental illness. Mental health treatment providers determine the level of care needed and proceed with low-intensity early intervention treatment if appropriate. Treatment plans are developed collaboratively with the participant and the mental health provider to identify and define treatment goals and objectives.

The assessment and screening tools are as follows:

- **Patient Health Questionnaire-9 (PHQ-9)**
  The Patient Health Questionnaire-9 is a nine-question screening tool used to detect the presence and severity of depression.

- **Outcomes Questionnaire**
  The Outcomes Questionnaire provides clinicians with a snapshot of the participant's current functioning across a wide variety of disorders.

- **Adverse Childhood Experience (ACE)**
  The Adverse Childhood Experience survey is a tool used to identify whether a participant was exposed to stressful or traumatic events, including abuse or neglect.

- **CAGE**
  The CAGE Alcohol Screening Test is a short, four-question test that is used to diagnose alcohol problems over a lifetime. The questions asked are:

  1. Have you ever been asked to **c**ut down on your drinking?
  2. Have people **a**nnoyed you by criticizing your drinking?
  3. Have you ever felt **g**uilty about your drinking?
  4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? (**E**ye-opener)

The Native American Resource Center is a mental health program that provides service to participants in various stages of mental health. Although it is categorized as a Stigma and Discrimination Reduction Program, the program continues to increase its early intervention services each year. The table below shows the total number of participants utilizing early intervention services and the total number of services received.

Early Intervention unduplicated participants and total services for Fiscal Years 2016/17, 2017/18, and 2018/19

	2018/19	2017/18	2016/17
Unduplicated Participants	184	173	N/A*
Total Services	235	252	N/A*

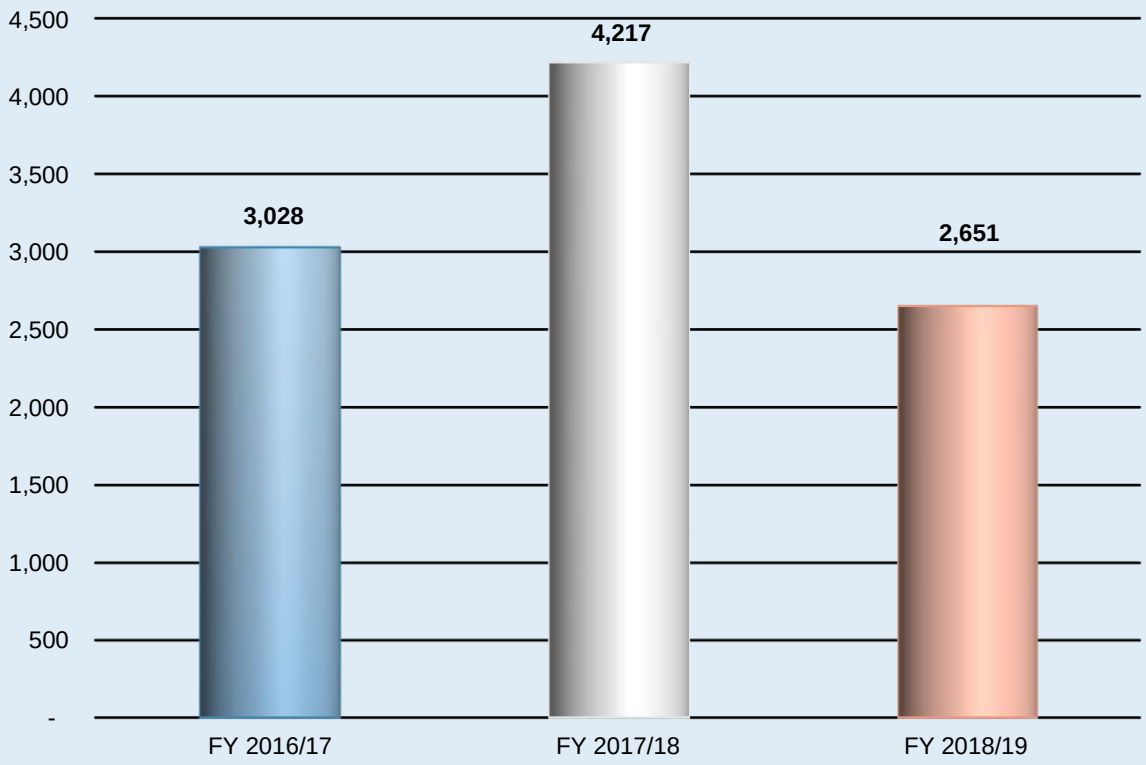
* The Native American Resource Center did not provide early intervention services in Fiscal Year 2016/17.

Stigma and Discrimination Reduction

The Native American Resource Center addresses the reduction of stigma and discrimination associated with mental illness through education and activities that focus on historical trauma, domestic violence, alcohol and other drug use, mental health awareness, suicide and bullying, cultural sensitivity, and community resiliency.

Some of the methods and activities used to change attitudes and beliefs about being diagnosed with mental illness and seeking mental health services is to provide services in non-stigmatizing ways. For example, using traditional Native American practices such as Talking Circles, Sons & Daughters of Tradition, and Pathways to Wellness offer group support and address mental health concerns within the community. Other activities such as cultural storytelling and song and dance are some of the ways that the Native American community copes with trauma. These traditions display the strength and resiliency of the Native American community and represent effective strategies for engaging the Native American population.

TOTAL PARTICIPANTS WHO PARTICIPATED IN STIGMA AND DISCRIMINATION REDUCTION ACTIVITIES FISCAL YEARS 2016/17, 2017/18, AND 2018/19

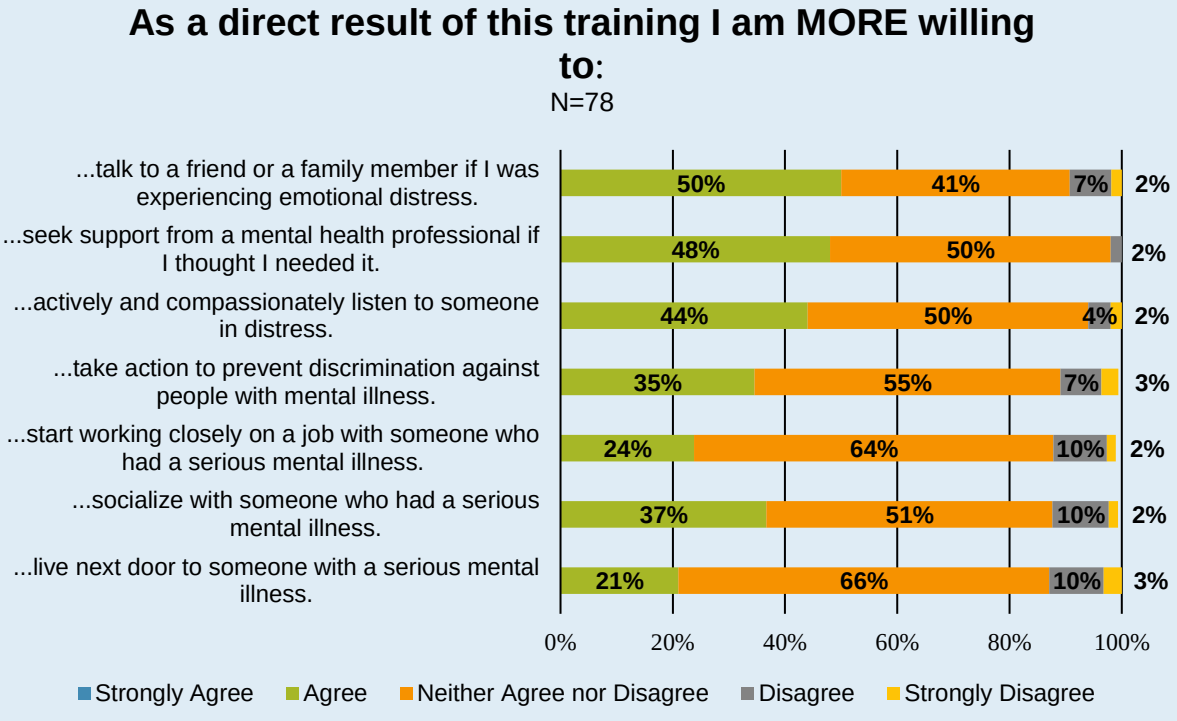


California Institute for Behavioral Health Solutions Measurements, Outcomes, and Quality Assessment (MOQA) Survey Results

During the period of January 1, 2019 through June 30, 2019, the Native American Resource Center implemented the collection of Stigma Reduction data using the Measurements, Outcomes, and Quality Assessment (MOQA) questionnaire as part of a pilot program in a county-driven, DHCS-supported effort to improve statewide reporting on outcomes resulting from program supported through Mental Health Services Act (MHSA, Prop 63) funds.

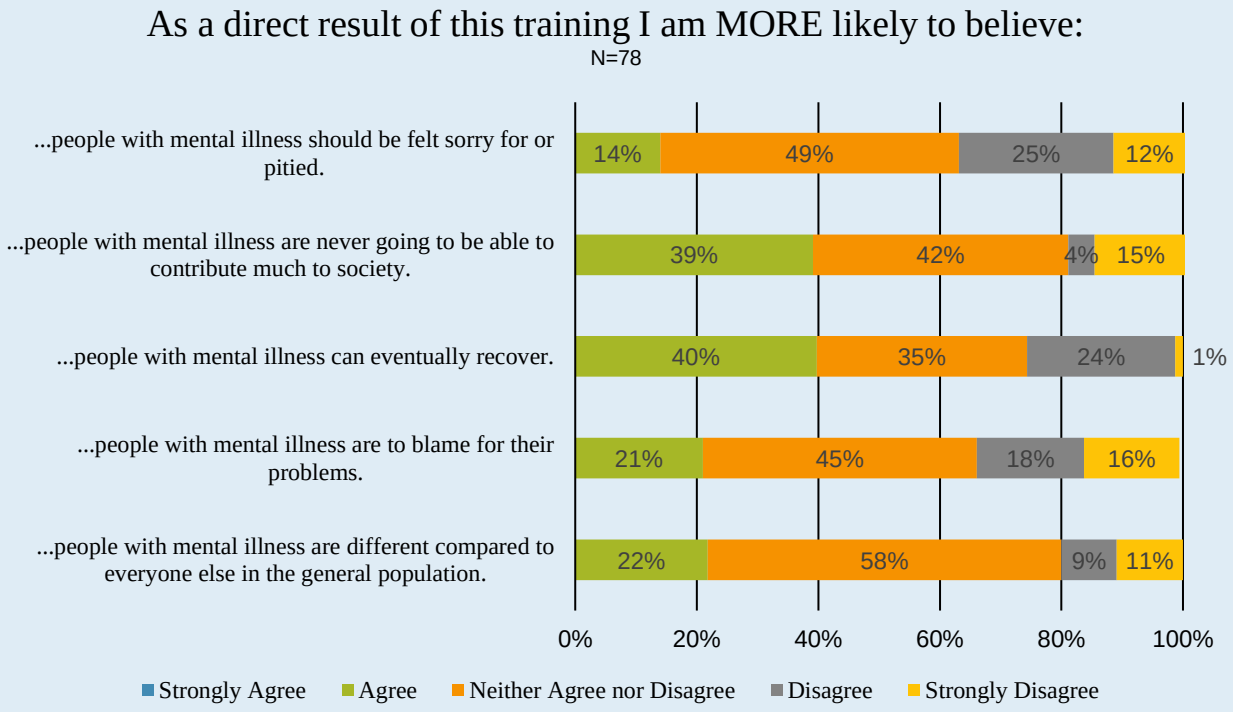
The chart below shows the responses gathered from Native American Resource Center participants. As a direct result of the training offered, 50% of participants indicated that they would be more willing to talk to a friend or family member if they were experiencing emotional distress and 48% said that they would seek support from a mental health professional if they thought they needed it. In addition, 35% of the participants said that they would take action to prevent discrimination against people with mental illness, 24% said that they would be willing to work closely with someone with a mental illness, and 37% said they would be willing to socialize with someone who had a mental illness.

PARTICIPANT RESPONSES TO MOQA QUESTIONNAIRE



As shown in the chart below, following the trainings offered by the Native American Resource Center, 86% of the participants disagreed with the statement that they were more likely to believe that people with mental illness should be felt sorry for or pitied, 61% of participants disagreed that people with mental illness were never going to be able to contribute much to society, and 78% said that they disagreed with the statement that people with mental illness are different compared to everyone else in the general population.

PARTICIPANT RESPONSES TO MOQA QUESTIONNAIRE



Historical Trauma Conference

The Native American Resource Center program hosted a Historical Trauma Conference on November 29, 2018. The goal of the conference was to provide a greater understanding of how historic trauma affects the attitudes and beliefs about mental health services and to provide a different way to look at treating mental health by recognizing and embracing the cultural aspect of other cultural values.

Attendees of the Historical Trauma Conference submitted 118 perception survey responses following the presentation. The surveys used a mixed-methods approach with both qualitative and quantitative methodologies being used to allow participants to express themselves.

Ninety-seven percent of the participants agreed that it was “quite or very important” to learn and utilize culturally appropriate approaches to treatment, recovery, and

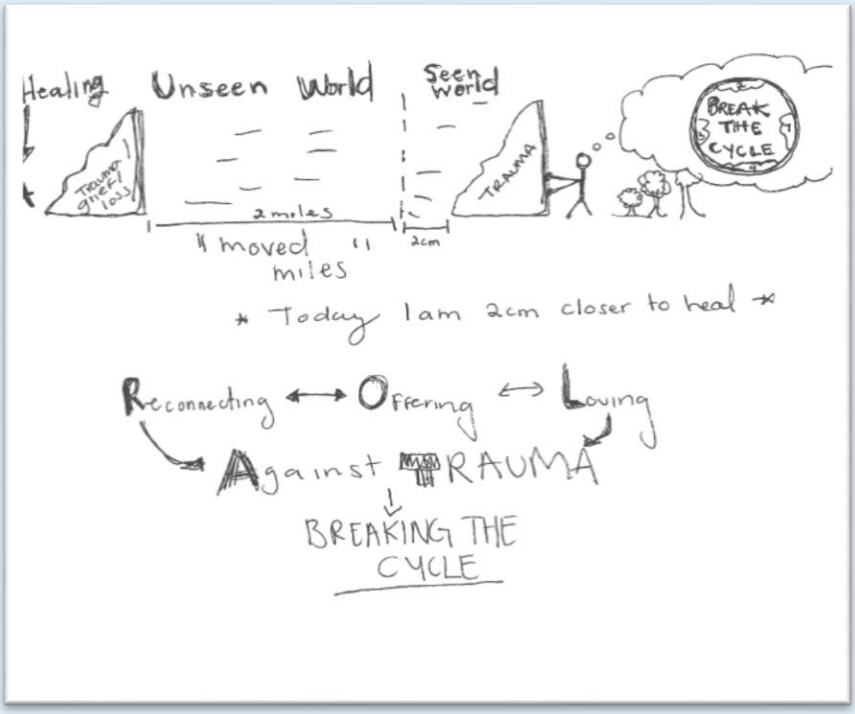
prevention while 3% of the participants believed that it was “a little or somewhat important.” Ninety-three percent of participants agreed that they have a deeper understanding of indigenous approaches to healing vs. western concepts of treatment and 7% said “no” they did not have a greater understanding of the difference between approaches or were unsure. 92% of the participants agreed that they gained a greater understanding of both Traditional / Archetypal (Jungian) psychology and Native American psychology and 8% of the attendees stated that they either did not or they were unsure whether they gained a greater understanding.

> *“This training was beautiful and so full of meaning for me. I felt that I have a connection to what was discussed, regarding healing, the importance of understanding the past to heal the future.”*
>
> *– Historical Trauma Conference Attendee*

The final question of the survey asked respondents to share an image or series of words that captured their experience during the event. Of the 118 surveys collected, 57 participants chose to create an image or series of words of some sort.

Some of the common themes expressed in these images included:

- Intergenerational healing
- Healing
- Knowledge
- Freedom, power, and resilience
- Personal transformation
- Other worlds
- Animist relational approach to spirit



Artwork by Historical Trauma Conference participant

The mixed use approach to data gathering, including qualitative responses such as the creation of an image or a series of words to describe their experiences, reduces stigma surrounding mental health services by the Native American community. Including the spiritual aspect of mental health and valuing the interrelationship of physical, mental, emotional, and spiritual perspective of recovery and wellness supports a culturally responsive approach to evaluation. Some of the survey responses included, “Healing through stories and the stories of elders, I agree first and foremost that we are all humans and herein lies our similarities and uniqueness,” and, “I felt that I have a connection to what was discussed regarding healing and the importance of understanding the past to heal the future.”

Access and Linkage to Treatment

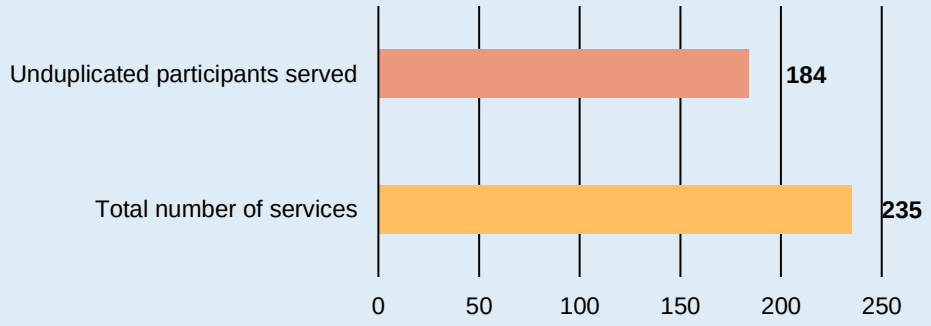
The Native American Resource Center is co-located at the San Manuel Indian Health Clinic in Grand Terrace, California. When initial screening and assessment reveals that a participant requires medically necessary treatment beyond early intervention, a referral is made to the psychiatry department at the San Manuel Indian Health Clinic or to other local providers. During Fiscal Year 2018/19, six participants where referred for individual outpatient services.

Staff at the Native American Resource Center link participants to further treatment by making individual appointments before the participant leaves the Native American Resource Center. All six of the referred participants followed through and engaged in treatment. Due to the linkage services provided by Native American Resource Center staff, the average number of days from referral until the participants engaged in treatment is 26 days and the average duration of untreated mental illness is 38 days.

Improve Timely Access to Treatment

The Native American Resource Center provides behavioral health services in a manner that is designed to reduce stigma and discrimination surrounding mental health services. Because of this, 184 members of historically underserved populations referred to mental health services through the Native American Resource Center participated in early intervention programs during Fiscal Year 2018/19.

IMPROVING TIMELY ACCESS TO TREATMENT FISCAL YEAR 2018/19



The Native American Resource Center offers a variety of screening and tools to assess risk of developing mental illness when someone comes in for either behavioral health services through the Native American Resource Center, or for medical services through the San Manuel Indian Health Clinic. Individuals provide information using the electronic health system (EHS) that screens for domestic violence, substance abuse and mental health risk factors. Both a holistic and clinical approach to health care is taken involving sensitivity towards values of the Native American community.

When a participant comes into the Native American Resource Center for their appointment, a screening and assessment is completed. When early intervention services are appropriate, the participant is referred to a licensed clinician the same day. As a result, there is no interval between the referral and engagement in services.

Number of participants of an underserved population referred to prevention, early intervention and or treatment beyond early onset		
Service Type	**Number of Participants Referred**	**Number of Participants Who Followed Through**
Early Intervention Services	184	184

Suicide Prevention

The Native American Resource Center is raising awareness about suicide through use of a video featuring community members and board delegates that is played on the television monitors throughout the clinic systems and waiting rooms. This video has reached over 10,000 individuals.

A one-day Family Conference at the Double Tree Inn in San Bernardino was held in December 2018 to raise awareness to parents about suicide and the impact that bullying can have on their children. This conference had 225 participants who attended. In addition, the Native American Resource Center also hosted a workshop in December 2018 to raise suicide awareness among students with 89 students attending. These programs were promoted through the Native American Resource Center, San Manuel Indian Health Clinic, Morongo TANF partners, and local schools that have high Native American populations.

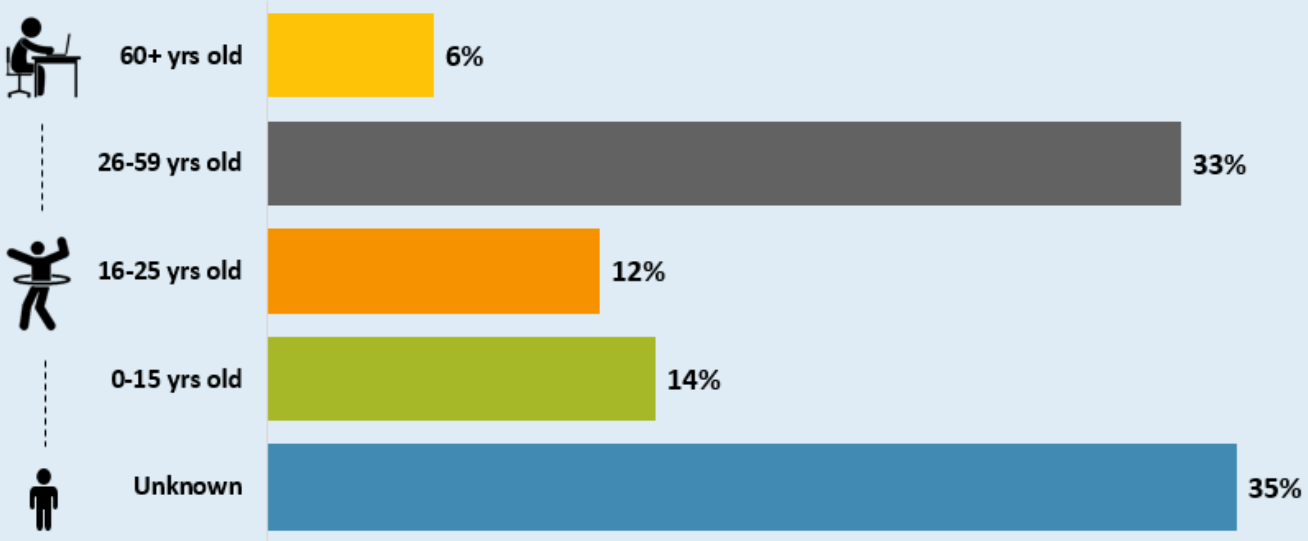
The Native American Resource Center has developed a touch screen questionnaire administered through the EHS located in the behavioral health clinic as well as the medical health clinic. This questionnaire is used to identify individuals at risk for suicide and suicide ideation as well as potential responders. Native American Resource Center staff provide appropriate resources based upon the information provided in the questionnaire.

Fiscal Year 2018/19 Program Demographics

The following graphs illustrate the demographics in various categories of the Native American Resource Center participants.

Age:

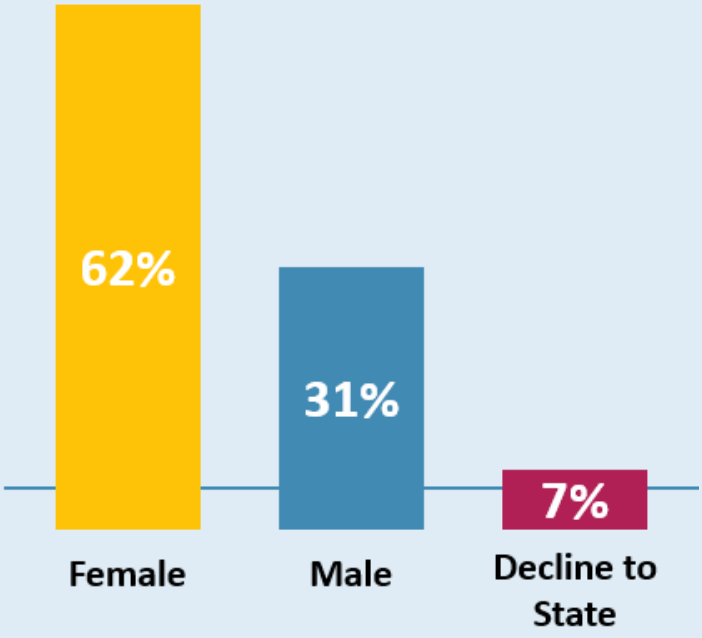
The graph below illustrates the ages of the Native American Resource Center participants. The majority of participants served,33%, were between the ages of 26-59 years old. 14% of participants were between the ages of 0-15 years old. The TAY group, 16-25 years old, made up 12% of the Native American Resource Center participants, and 6% identified as 60+ years old. The remaining 35% of the population age groups is unknown or the participant declined to state.



N = 3,025

Gender:

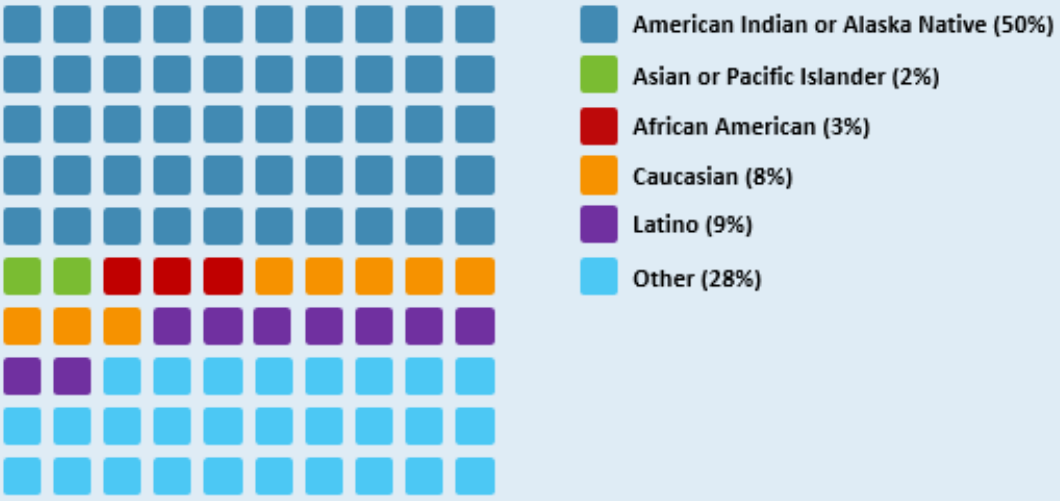
The graph below indicates that 62% of the Native American Resource Center participants identified as female, 31% identified as male, and 7% declined to state.



N = 3,025

Ethnicity and Ancestry:

The graph below illustrates the various ethnicities of participants of the Native American Resource Center program. The largest group was in the American Indian or Alaska Native representing 50% of the program participants. The second largest category was Other at 28%. This category includes those who identified as other, more than one race, or declined to answer. In addition, 9% of participants identified as Latino, 8% Caucasian, 3% African American and 2% Asian or Pacific Islander.



N = 3,341

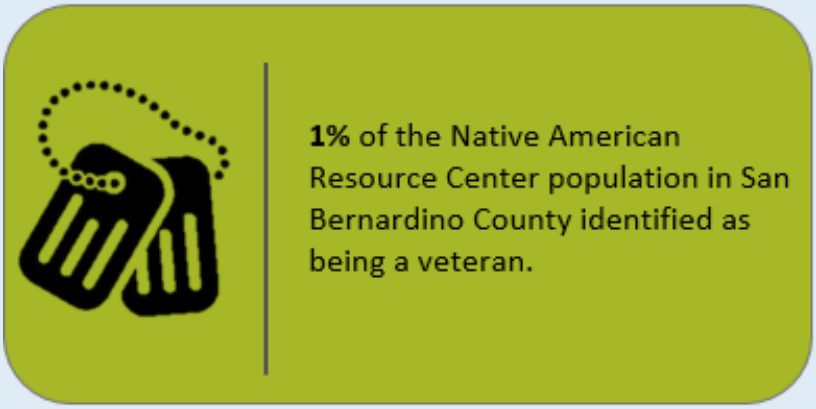
Primary Language:

The graph below demonstrates that 100% of the Native American Resource Center participants identified English as their primary language.

N = 3,025

Veterans Status:

Of the Native American Resource Center participants, 1% identified as being veterans.



N = 3,025

Success Story

The Historical Trauma conference created a positive impact on participants. One attendee wrote, “This ceremony is very eye-opening on how trauma from different cultures can be found collectively in each and every one. Being able to use all resources and ideals to better help those around us, opening the door to every perspective, I will do my best to spread and share my knowledge with others of different cultures and to learn from them.”

Program Challenges

The Native American Resource Center faced challenges with collecting meaningful data to measure the effect of services on the reduction of stigma and discrimination.

Another challenge experienced by the Native American Resource Center this year is the ability to effectively communicate about the impact of historic trauma on the mental health of the Native American community.

Program Solutions

To meet the data collection challenge, the Native American Resource Center began administering the California Institute for Behavioral Health Solutions Measurements, Outcomes, and Quality Assessment (MOQA) questionnaire to collect survey data from the program’s participants. Due to the anonymous nature of this questionnaire, program participants were more receptive to complete the surveys. In addition, the Native American Resource Center worked with the Department of Behavioral Health’s Research and Evaluation department to design qualitative methods to collect data through storytelling and imagery.

To address the challenge with communicating the impact of historic trauma, the Native American Resource Center collaborated with the Department of Behavioral Health to hold a one-day training about the impact of historical trauma on the Native American

community. The training program facilitated a discussion between Indian Child Family Services, a San Manuel Tribal judge, the Department of Social Services, and the community. The discussion centered around the connection between historic trauma, mental health, and substance abuse.

Program Updates

There are no planned program updates for FY 2020/21.

Collaborative Partners

- California Diversity Project
- California State University, San Bernardino
- Childrens Network
- Crime Survivors Redlands
- First 5 San Bernardino
- Inland Empire Health Plan (IEHP)
- Inland Regional Center
- Morongo TANF
- One Stop TAY Center, San Bernardino
- Option House
- San Bernardino County Child Support Services
- San Bernardino County Department Behavioral Health
- San Bernardino County District Attorney
- San Bernardino County Public Social Services
- San Bernardino County Victim Services
- San Bernardino Sexual Assault
- San Bernardino Unified School District
- San Manuel Band of Mission Indians
- University of California, Riverside
- University of Redlands
- Valley College

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

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

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

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

MHSA Legislative Goals and Related Key Outcomes

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

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

Improve timely access to services for underserved populations:

- Increase extent to which individual or family from underserved population who need mental health services because of risk or presence of a mental illness receives appropriate services as early in onset as practicable.

Reduce prolonged suffering:

- Improve life satisfaction.
- Decrease hopelessness/increase hope.
- Increased resiliency.
- Decreased impairment in general areas of life functioning.

Reduce stigma and discrimination associated with mental illness:

- Increase accurate knowledge about mental illness.
- Increase extent to seek services, if needed.

Positive Results

In San Bernardino County, the PdS/CHW program provides culturally specific services to five underserved target populations. These underserved populations include:

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

The Department of Behavioral Health has explored the most effective methods for delivering these culturally specific services, including providers most able to deliver these services.

The table below illustrates the current providers of PdS/CHW services.

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

Collectively, all PdS/CHW providers reached 89,902 unduplicated participants. This is a 61% increase in participation from Fiscal Year 2017/18.

Latino

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

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

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

- Faith based organizations
- Community centers
- Schools
- Health care providers

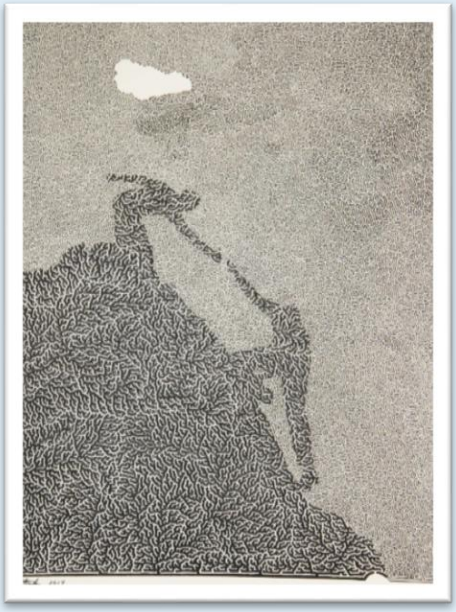
These partnerships have been instrumental in building rapport with the communities they serve in order to facilitate the dissemination of information and services throughout the community and increase community awareness about the importance of mental health and wellness.

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

In Fiscal Year 2018/19, the target number of participants to be reached by the Promotores de Salud Program was 23,885. PdS providers served a reported 64,089 community members, exceeding their target number.

Asian and Pacific Islander

The Community Health Workers serving the Asian and Pacific Islander populations have made great progress in penetrating this target population. Historical data shows that a large quantity of this population immigrated to the United States because of economic or political oppression from their country of origin. This has led to a lack of trust of organizations that offer unfamiliar services.



Artwork by Marcy Grebus

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

Community Health Worker Resource Table

These culturally specific strategies have helped the provider exceed their targeted goal of 2,400 participants by 53%.

The CHWs provided outreach services to the Asian and Pacific Islander population and engaged potential responders in the following settings:

- Churches
- Community Based Organization facilities
- Community events
- Libraries
- Primary health care
- Recreation centers
- Residences
- Schools
- Senior centers
- Parks

Over half of the people reached were at community events and schools.

The types of potential responders reached were as follows:

- Children and Family Services
- Community service providers
- Consumer Family Members
- Emergency medical service providers
- Employers
- Families

- Family law practitioners
- Law enforcement personnel
- Military personnel or veterans
- Peer providers
- Visiting nurses
- Others in a position to identify early signs of potentially severe and disabling mental illness, provide support & or refer individuals who need treatment or other mental health services.

The majority of potential responders identified as families or others in a position to identify early signs of potentially severe and disabling mental illness.

African American

Community Health Workers for the African American population use traditional engagement strategies that have proven to be effective. Establishing strong community bonds and creating long lasting relationships with local community resources has helped to increase participation in the CHW program. The program has partnered with various faith-based organizations, as well as African American groups and organizations, to establish a consistent presence in the community. They work collaboratively with partners to identify and address the needs of the African American community. They attend large cultural events to promote the outreach and education available through the program. They attend smaller meetings to deliver educational materials on reducing the stigma surrounding seeking mental health services. They have been successful as establishing themselves as an access point for individuals seeking information on services for behavioral health concerns. The Community Health Worker program was able to reach a total of 2,704 people that identified as Black or African and African American heritage.

LGBTQ+

There are specific challenges when engaging the LGBTQ+ community. Overall, there is still a great deal of stigma and discrimination surrounding sexuality and gender identity. In addition, there is also stigma surrounding seeking mental health services as a member of the LGBTQ+ community. The program has made significant progress in reaching out to this target population. They are quickly establishing a reputation in the community for understanding the needs of a vastly underserved population. The outreach and education modules used in presentations have been tailored to address the behavioral health needs of the LGBTQ+ community in a manner that is relevant and easily understood. The Community Health Worker Program was able to reach 189 people that reported identifying with the LGBTQ+ community.

Native American

The Outreach and Education service delivery model for the Native American population

also uses strong community engagement and cultural understanding as underlying theme. A primary strategy that is of paramount importance in a successful CHW program is recruiting Community Health Workers who are part of the community and understand the cultural norms. This strategy creates greater confidence in the program and the services they provide. The historical trauma associated with this target population, challenges the provider to develop strategies that are highly appropriate culturally. Large cultural events draw the greatest amount of attention to the program. Incorporating Native American traditions to events and gatherings has increased the probability that participants will engage in the outreach and education opportunities that exists as part of this program. The provider has established spaces in the community where the Native American population can gather and learn about their culture and the impact that historical trauma as on mental health and wellness. The Community Health Worker program was able to reach 1,582 people that reported identifying as American Indian or Alaskan Native.

Improve Timely Access to Services

The PdS/CHW program provided referrals to 341 unduplicated participants in FY 2018/19. These are referrals to Prevention, Early Intervention, or Treatment Beyond services for those from identified underserved populations. The following lists the underserved populations served by the PdS/CHW program.

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

Outreach for Increasing Recognition of Early Signs of Mental Illness

The PdS/CHW program served 89,902 potential responders. These responders included the following:

- School personnel
- Community service providers
- Peer providers
- Consumer family members
- Leaders of faith based organizations
- Families
- Employers
- Cultural brokers
- Primary health care providers

These responders were reached in the following settings:

- Schools
- Community based organizations
- Community events
- Health centers
- County offices
- Churches
- Residences
- Cultural organizations
- Primary Health Care

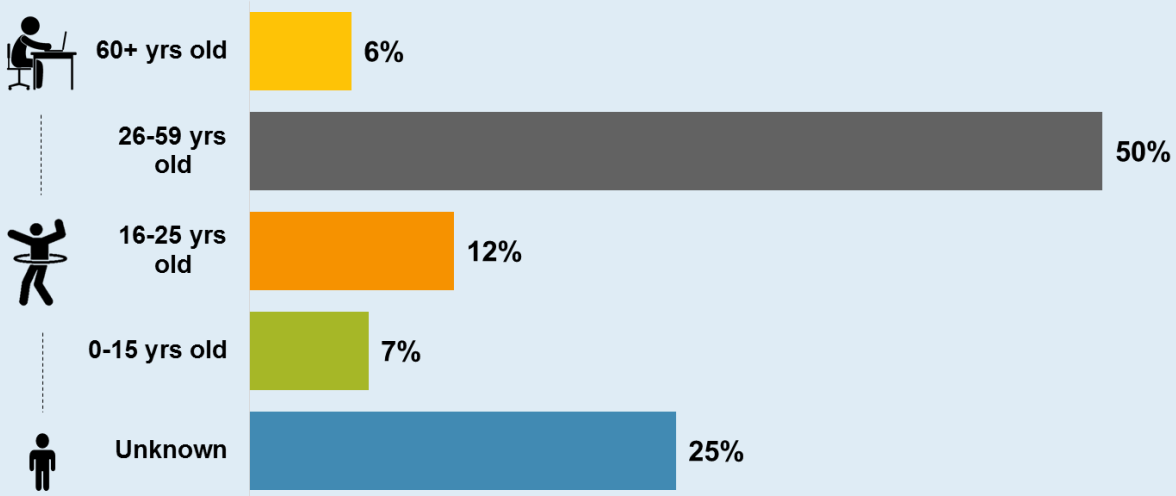
Artwork by Gabriel Horne

Fiscal Year 2018/19 Program Demographics

The charts below illustrate the demographic information provided by the Community Health Worker and Promotores de Salud programs in Fiscal Year 2018/19.

Age:

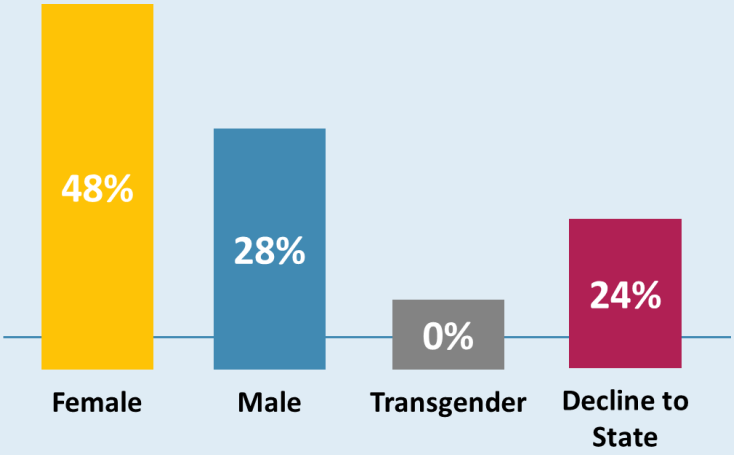
The majority of CHW/PdS participants, 50%, identified as 26-59 years old. There were 25% who are unknown. There were 12% who identified as 16-25 years old, 7% as 0-15 years old, and 6% as 60+ years old.



N = 82,351

Gender:

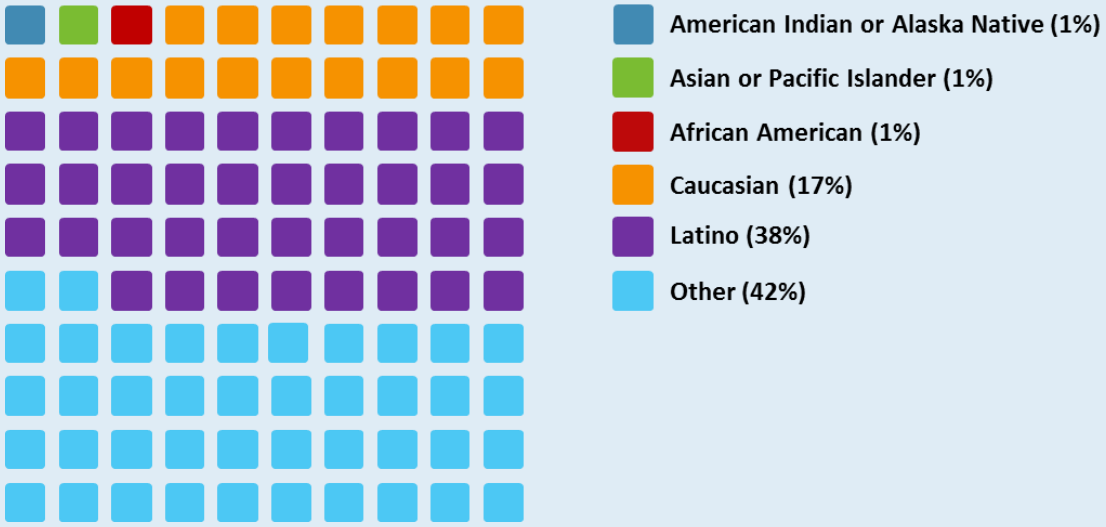
The graph below demonstrates the gender identity of CHW/PdS participants. There were 48% of participants who identified as female, 28% as male, and 24% who declined to state. None of the participants identified as transgender, non-binary, gender queer, or other not listed.



N = 68,161

Ethnicity and Ancestry:

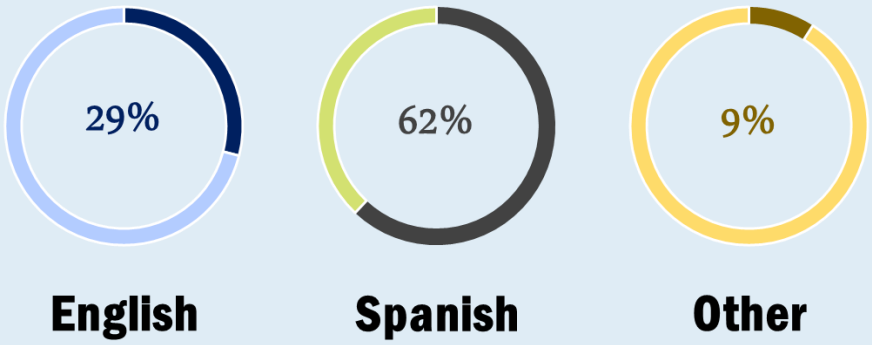
The graph below demonstrates that 42% of participants identified in a race or ethnicity category of Other. This category includes those who identified as other, more than one race, or declined to answer. Of the participants, 38% identified as Latino and/or Hispanic and 17% identified as Caucasian and/or White. Of the remaining categories, 1% identified as American Indian or Alaska Native, Asian or Pacific Islander, or African American and/or Black.



N = 83,414

Primary Language:

The graph below demonstrates that the majority of participants in the CHW/PdS identified Spanish (62%) as their primary language. There were 29% who identified English as their primary and 9% who identified a language other than those as their primary language.



N = 83,501

Veteran Status:

Of the CHW/PdS participants, less than 1% identified as being a veteran.

0.4% (347 individuals) of the CHW/PdS population in San Bernardino County identified as being a veteran.

N = 83,501

Promotores de Salud Certification Graduation

Success Stories

The Community Health Workers were asked to provide a mental health presentation at a local school targeted toward the LGBTQ+ population. The participants at this event included teachers, school staff, and administrators. The school's Gay Straight Alliance had expressed concerns surrounding the school's LGBTQ+ community and wanted to provide additional education. The presentation was very well received and the Community Health Workers have been asked to return for the next school year.

A potential participant, "Ana," was contacted by the Promotores de Salud during a home outreach activity. Ana disclosed to the Promotores symptoms indicating anxiety and depression. Ana was afraid to seek services but was continually visited by the Promotores. They were able to build trust with her and she agreed to seek services. Ana received early intervention services for six months and successfully completed her treatment. She now willingly leaves her home to participate in community events and volunteer in her child's classroom.

Program Challenges

The CHW program has had difficulty with recruitment and retention due to local expansion of community health worker positions, such as those in surrounding health care entities, offering competitive benefits. Additionally, the program had challenges with participants completing the demographic surveys. This is due to the stigma surrounding the sensitive nature of some survey questions as well as the short-term nature of the program.

The PdS program struggled with gathering survey data as well. Participants attending workshops and presentations did not want to complete the surveys.

Program Solutions

The CHW program has updated its recruitment process, including advertisements and outreach presentations. The program will also provide CHW trainings ongoing rather than annually. To mitigate the difficulty with demographic survey data, the CHW program continues to educate its participants of the importance of accurate data.

The PdS program was able to utilize incentives in order to encourage participants to complete the demographic surveys.

Program Updates

There are no planned program updates for the PdS/CHW program.

Collaborative Partners

- Advantage Health Care
- Akoma Unity Center
- Borrego Health
- California State University San Bernardino
- Chaffey College
- Chaffey High School
- Child Care Resource Center
- Children's Fund
- CHORDS Enrichment Youth Program
- First 5 of San Bernardino
- Foothill AIDS Project
- Inland Empire Concerned African American Churches
- Inland Empire Family Resource Coalition
- National Alliance on Mental Illness (NAMI)
- Options for Youth
- Rainbow Pride Youth Alliance
- Redlands Unified School District
- Rim Family Services
- Rim of the World School District
- Salvation Army
- San Bernardino City Police Department
- San Bernardino City Unified School District
- San Bernardino Community College District
- San Bernardino County Children and Family Services Department
- San Bernardino County Department of Public Health
- San Bernardino County Homeless Partnership
- San Bernardino County Preschool Services Department
- San Bernardino Valley College
- South Coast Community Services
- Teamsters
- TruEvolution
- Women, Infants, and Children (WIC)
- Young Visionaries
- Zion Elect New Generation Ministry

Behavioral Health Ministries Pilot Project

The Behavioral Health Ministries Pilot project is a short term pilot project that seeks to partner with a network of faith based organizations to assist in identifying the unmet behavioral health needs for the faith-based, African American Community. This pilot project is intended to be a collaboration between the Department of Behavioral Health (DBH) and the Inland Empire Concerned African American Churches (IECAAC) to address the behavioral health needs of IECAAC member churches. The goal is to provide participants with education and resources to address the behavioral health needs of their congregations within the church settings and provide appropriate and timely resources for members to access needed behavioral health resources. The pilot project will also inform and explore the development of a future comprehensive early intervention programs within faith-based entities that will increase behavioral health access for church members that may show signs of mental health issues and substance use disorder symptoms. This pilot project will provide the opportunity for African American families at risk of or living with behavioral health issues to receive supportive services in the safe environment of their church and access help without fear of stigma or discrimination.

> The IECAAC was formed over 20 years ago to unify the African-American churches and become a voice for the people they serve.

The church is the pillar of the African American community with the capacity to provide support through utilizing resources, facilitating spiritual as well as technical expertise. Churches are in positions to identify needs and provide support and resources to their members and communities. IECAAC is the body that organizes the efforts of over 20 churches in addressing various community needs through six committees. The committees are 1) Community Development, 2) Education, 3) Health, 4) Prayer, 5) Economic Development, and 6) Church Unity.

This pilot will be part of IECAAC's Health Committee. The goal of the committee is to promote comprehensive wellness within its churches and communities. The efforts of the committee are centered on promoting Behavioral Health awareness in order to reduce mental health disparities, stigma, and increase access to appropriate behavioral health care for African Americans. The committee is responding to its members' needs, as there is an increasing need in their communities for behavioral health services and resources. Additionally, church leaders are in need of behavioral health training and resources. This pilot supports a united effort to meet the growing need for behavioral health services, awareness, and acceptance through development and implementation of a comprehensive, targeted community outreach and stigma/discrimination reduction program implemented in collaboration with partnering faith based organizations serving

African Americans and San Bernardino County Department of Behavioral Health (DBH). The result will be Behavioral Health Ministries in each of the member churches/faith based organizations that elect to participate.

Projected Number to be…	
Trained	**Served**
40 Church Pastors and Leadership	300 IECAAC Members And Congregants

The pilot project will be developed and implemented through the following phases:

Phase I: Needs Assessment

- Recruitment of individuals interested in participating in the pilot project.
- Creation of a needs assessment survey to identify community needs.
- Collection of community needs data by community members via needs assessment surveys, town hall meetings, and key informant interviews.
- Mapping of existing resources.
- Analysis of needs assessment data and resources to determine training and resource needs.
- Development of training responsive to participants identified needs. Possible training topics may include: Mental Health First Aid, Suicide Prevention, Reducing Stigma, Substance Use Disorders and Recovery Services for all age groups: Children, TAY, Adults, Older Adults.
- Development Pre and Post Training Surveys to measure training effectiveness.
- Needs Assessment report and recommendations.

Phase II: Behavioral Health Education and Awareness

- Training of individuals included in the pilot project.
- Training survey collection and reporting.

Phase III: Community Engagement

- Regularly scheduled outreach presentations to faith-based and community groups.
- Targeted presentations to smaller groups, families, couples or individuals to address specific behavioral health topics.
- Regularly scheduled ongoing trainings for pilot project participants.
- Regularly scheduled meetings and focus groups to support pilot project participants and identify community unmet needs.
- Community engagement data collection and surveys.

Phase IV: Reporting

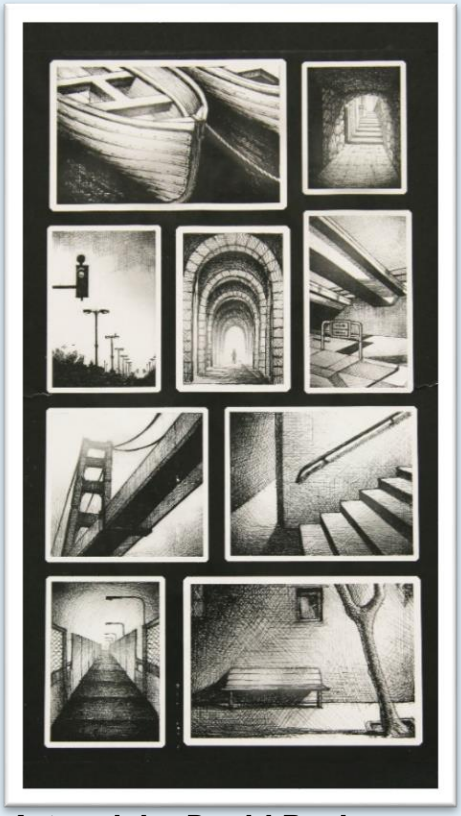
- Monthly Progress Reports
- Annual Report detailing deliverables and lessons learned.
- Final Pilot Project Report and recommendations to inform the San Bernardino County Mental Health Plan.

Expected Outcomes:

- An organized and established collaboration between the DBH and IECAAC to ensure IECAAC members and members of the faith based community are informed and able to connect individuals experiencing the onset of a behavioral health issue to the appropriate level of care.
- An increase in awareness within the IECAAC membership to reduce negative stigmas and biases about mental health and substance abuse disorders.
- Identification of strengths and limitations in DBH and IECAAC's collaboration.
- Identification of IECAAC's and other faith based organizations' capacity to provide or link to mental health services.
- Recommendations for policy or systems change to inform DBH's future collaboration with other faith based organizations interested in developing behavioral health ministries.
-

Targeted Audiences:

- All IECAAC members, congregants and church leadership.



Artwork by David Pacheco

MHSA Legislative Goals and Related Key Outcomes

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

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

Improve timely access to services for underserved populations:

- Increase extent to which individual or family from underserved population who need mental health services because of risk or presence of a mental illness receives appropriate services as early in onset as practicable.

Reduce prolonged suffering:

- Improve life satisfaction
- Decrease hopelessness/increase hope
- Increased resiliency
- Decreased impairment in general areas of life functioning

Reduce stigma and discrimination associated with mental illness:

- Increase accurate knowledge about mental illness
- Increase extent to seek services, if needed

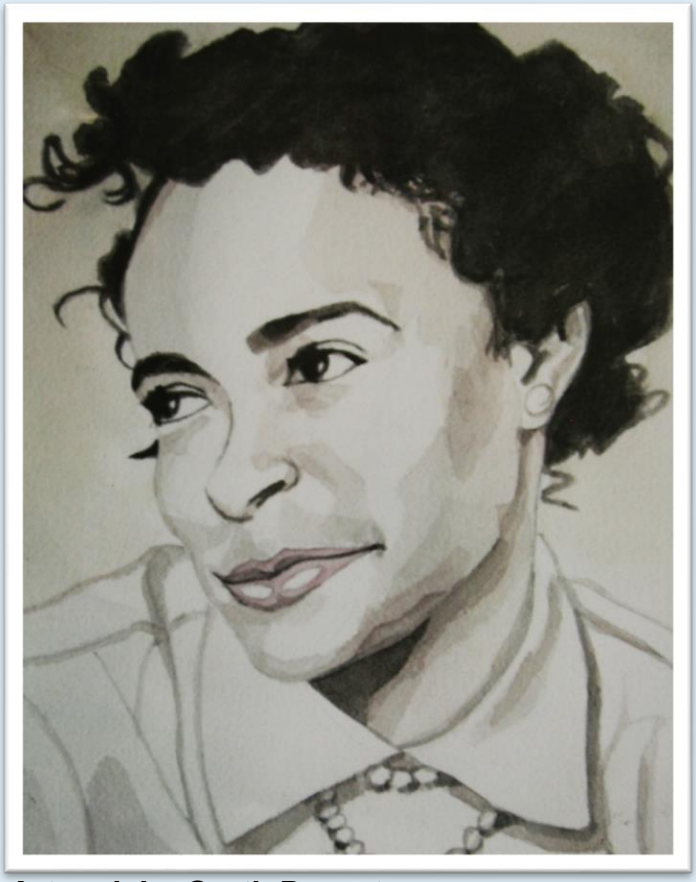
Project Quantifiable Outcomes

Behavioral Health Education and Awareness:

- 90% Increased knowledge about mental health, mental illness and services/resources available.
- 90% Increased knowledge of Substance Use Disorders and services/resources available.
- 80% Increased ability to connect children, adults, and seniors 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% Increased ability and comfort to address and present behavioral health topics to church members/congregates.

Community Engagement:

- 80% Increased knowledge of mental health, mental illness and behavioral health services, and resources
- 80% Increased knowledge of substance use disorders and behavioral health services, and resources
- 80% Increased awareness of behavioral health services and resources in their church and community
- 80% increased comfort in seeking services in their church/community for mental health and substance use issues
- 80% increased comfort in speaking with family and/or friends about mental health
- 80% increased comfort in seeking services, if needed
- 80% likelihood of utilizing information and resources to improve own mental health



Artwork by Garth Pezant

Child and Youth Connection (SE-2)

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

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

resources, identifying new mentoring organizations, and linking system-involved children and youth with the appropriate agencies.

MHSA Legislative Goals and Related Key Outcomes

Increase Early Access and Linkage to Medically Necessary Care and Treatment:

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

Reduce Stigma and Discrimination Associated with Mental Illness:

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

Reduce prolonged suffering associated with untreated mental illness:

- Reduce risk factors
- Reduce indicators
- Increase protective factors that may lead to improved mental emotional, and relational functioning
- Reduce symptoms, and
- Improve recovery including emotional and relations functioning.

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.

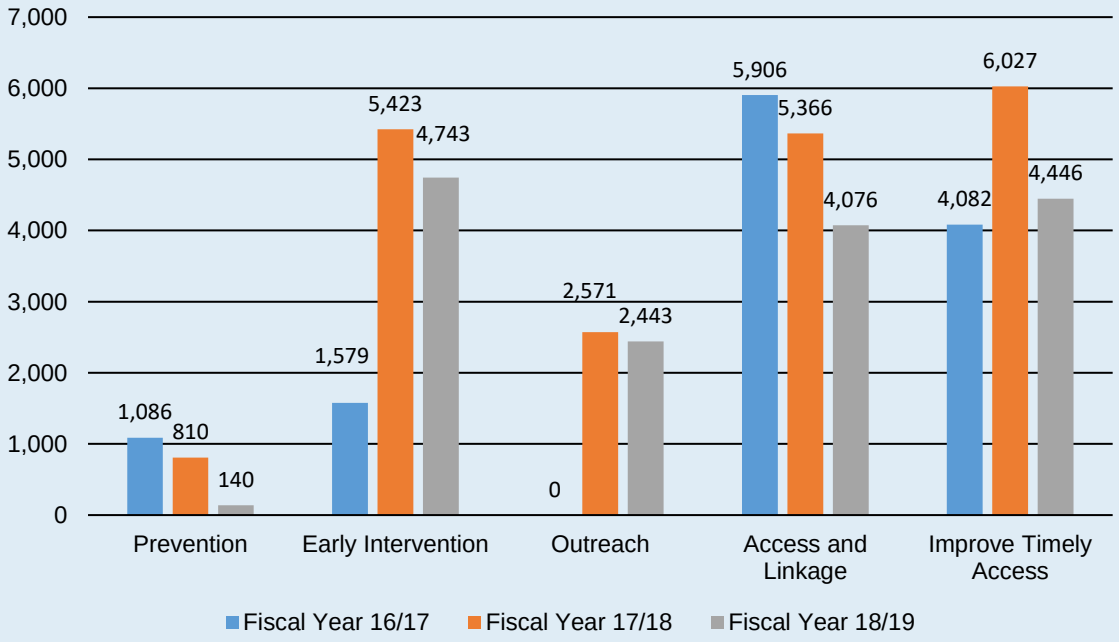
Positive Results

The CYC program providers are contracted to provide services to 6,613 unduplicated participants annually between the Mentoring Network, Juvenile Public Defender, and the various SART/EIIS providers.

In Fiscal Year 2016/17, the CYC program served 12,653 unduplicated participants. In Fiscal Year 2017/18, the program served 20,197 unduplicated participants. The program served 15,848 unduplicated participants in Fiscal Year 2018/19.

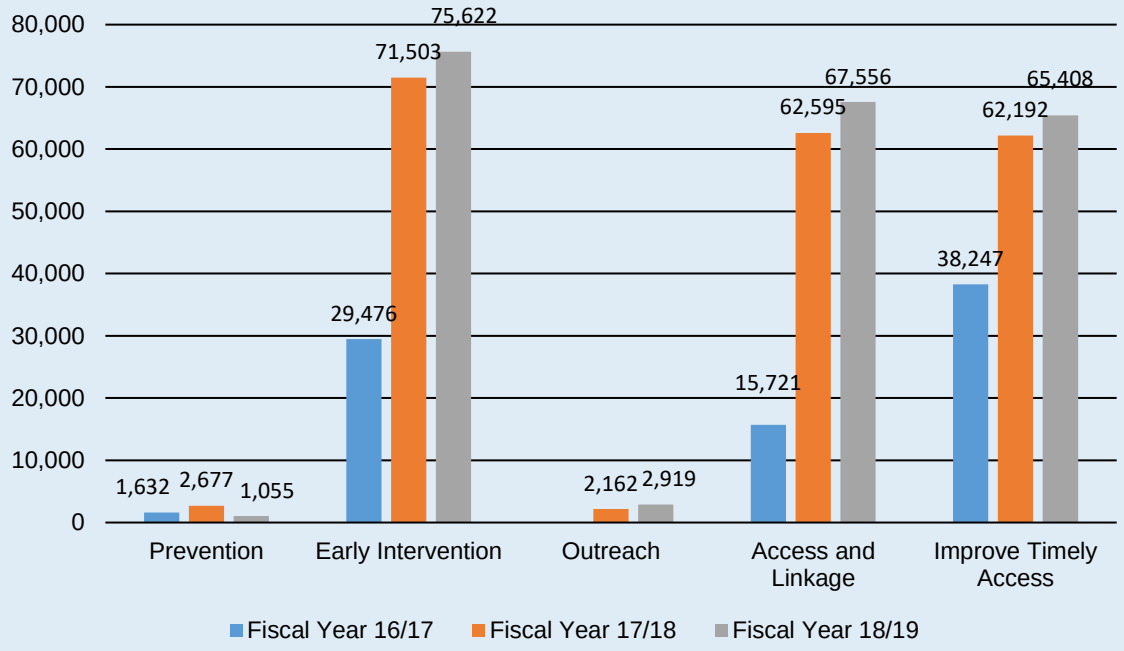
The table below illustrates the unduplicated participants in the categories of Prevention, Early Intervention, Outreach, Access and Linkage, and Improve Timely Access.

TOTAL UNDUPLICATED PARTICIPANT COUNT BY SERVICES AND FISCAL YEAR



The table below illustrates the number of services in the categories of Prevention, Early Intervention, Outreach, Access and Linkage, and Improve Timely Access.

TOTAL NUMBER OF SERVICES BY SERVICE AND FISCAL YEAR



Prevention

The CYC program providers offer prevention activities in order to reduce risk factors and increase protective factors to improve overall mental health function.

CYC provided the following Prevention services:

- Mental Health First Aid
- Prenatal Substance Exposure Workshop
- Infant Massage
- Incredible Years Parenting Group
- Multidisciplinary Collaboration

The table below illustrates the number of prevention participants and services for the last three fiscal years

Fiscal Year	Unduplicated Count	Number of Services
2016/17	1,086	1,632
2017/18	810	2,677
2018/19	405	1,055

Early Intervention

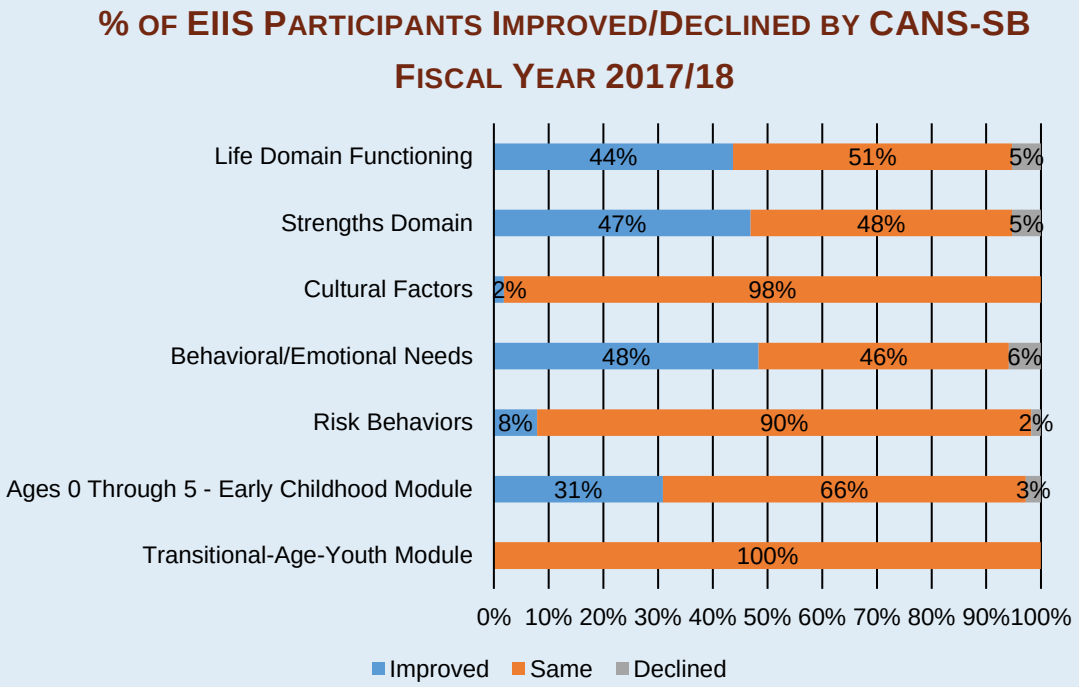
The CYC Screening, Assessment, Referral, and Treatment (SART) and Early Identification and Intervention Services (EIIS) programs use the Child and Adolescent Needs and Strengths - San Bernardino (CANS-SB) tool to evaluate participants' achievements. This assessment tool covers typical needs and strengths experienced by Children, Youth, and Transitional Aged Youth (TAY).

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

The following graphs display the percentage of children who required or needed immediate action on the following CANS-SB domains and resolved their challenges by the end of the treatment in the SART of EIIS programs for Fiscal Year 2017/18 and Fiscal Year 2018/19.

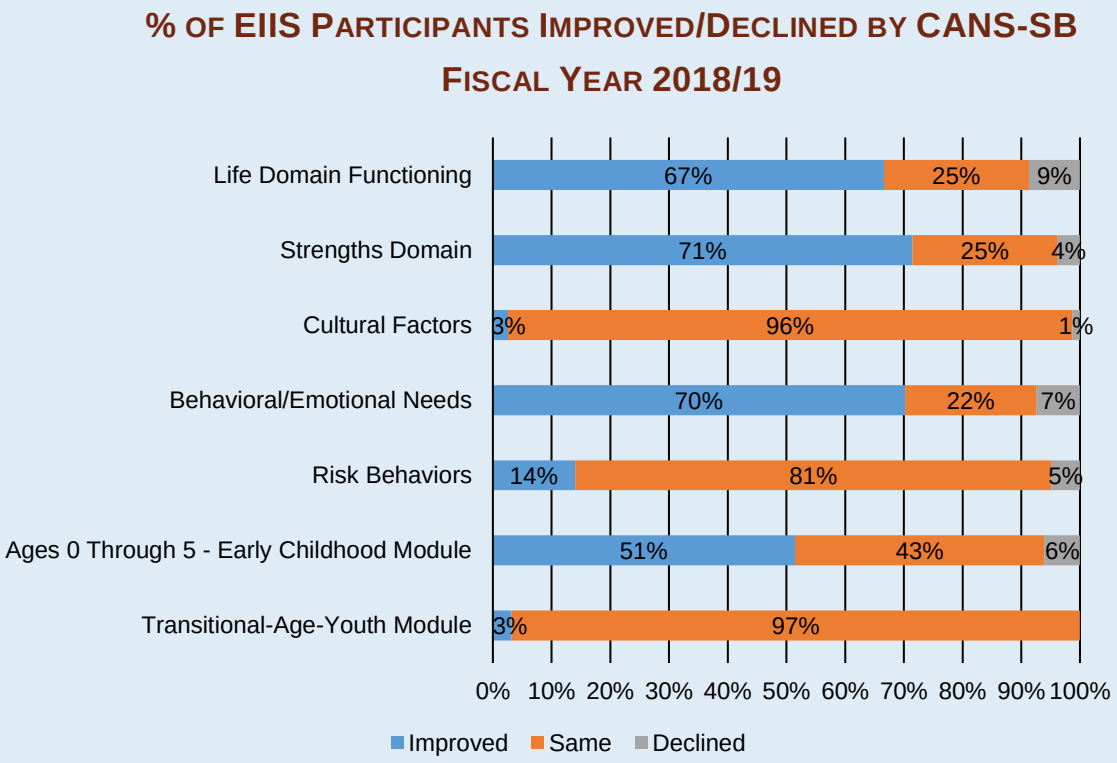
Artwork by Sarah Favorite

The graph below illustrates that in Fiscal Year 2017/18, 48% of CYC EIIS participants improved their behavioral/emotional needs, 47% improved their strengths domain, 44% improved their life domain functioning, 31% improved in the ages 0 through 5 - early childhood module, and 2% improved in cultural factors. Additionally, 100% remained the same in the transitional age youth module, 98% remained the same in cultural factors, 90% remained the same in risk behaviors, 66% remained the same in the early childhood module, 51% remained the same in life domain functioning, 48% in strengths domain, and 46% in behavioral/emotional needs. Finally, 6% declined in behavioral/emotional needs, 5% declined in strengths and life domain functioning, 3% declined in the early childhood module, and 2% in risk behaviors.



The graph that follows illustrates percentage of participants in the CYC EIIS program in Fiscal Year 2018/19 who improved or declined following the completion of early intervention services. In the category of strengths domain, 71% of participants improved. In behavioral/emotional needs, 70% improved following treatment. In the category of life domain functioning, 67% of participants improved. Additionally, 51% improved in the early childhood module. In the category of risk behaviors, 14% improved. In cultural factors and transitional age youth module, 3% of participants improved. Following treatment, 97% of those in transitional age youth module remained the same, as did 96% in the category of cultural factors. In risk behaviors, 81% remained the same following treatment. In the early childhood module, 43% remained the same. In both life domain functioning and strengths domain, 25% remained the same. Finally, 22% remained the same in behavioral/emotional needs. Of those who declined, 9% were in life domain functioning, 7% in behavioral/emotional needs, 6% in the early childhood module, 5% in risk behaviors, 4% in strengths domain, and 1% in cultural factors.

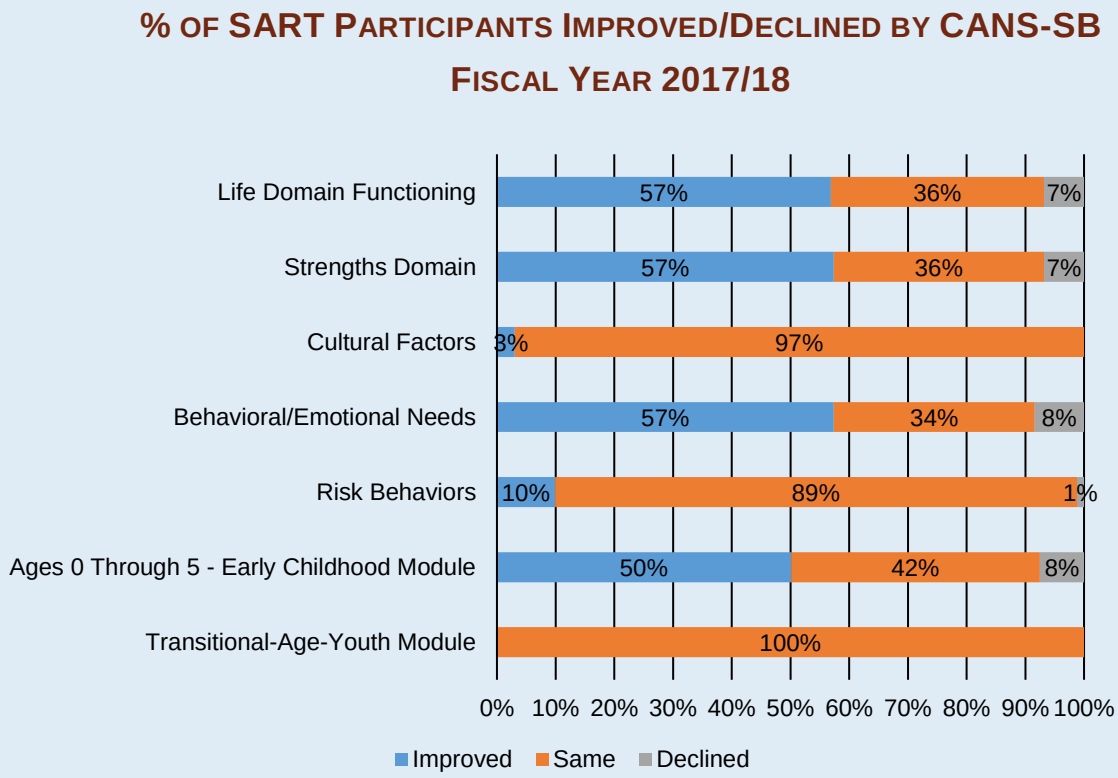
The graph below demonstrates that overall there was an improvement in all categories of needs following treatment in Fiscal Year 2018/19.



In Fiscal Year 2017/18, 57% of participants improved in life domain functioning, strengths domain, and behavioral/emotional needs. Also, 50% improved in the early childhood module.

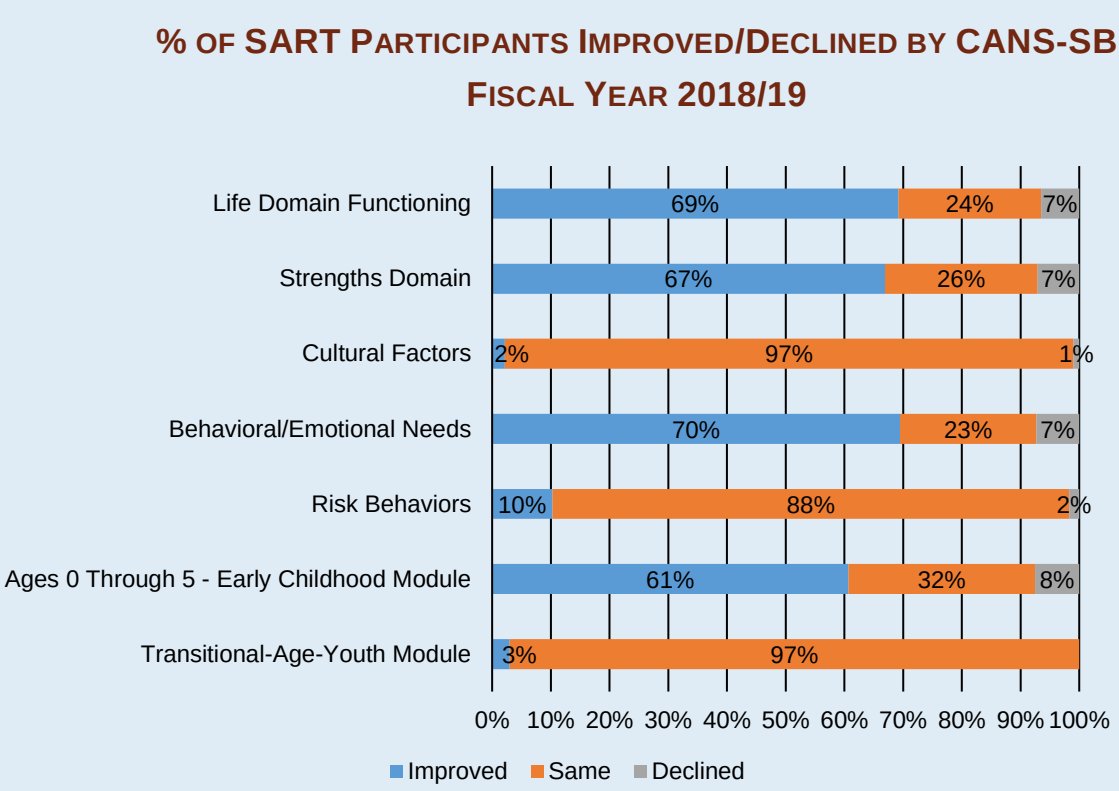
Additionally, 10% improved in risk behaviors and 3% improved in cultural factors. Of those who remained the same, 100% were in the transitional age youth module, 97% in cultural factors, 89% in risk behaviors, 42% in the early childhood module, 36% in life domain functioning and strengths domain, and 34% in behavioral/emotional needs. Of those who declined, 8% were in the early childhood module and behavioral/emotional needs, 7% in life domain functioning and strengths domain, and 1% in risk behaviors. None of the participants declined in cultural factors or the transitional age youth module.

Below the graph illustrates the percentage of CYC SART participants who improved or declined following early intervention treatment.



The graph that follows illustrates those who improved or declined in the CYC SART program for Fiscal Year 2018/19. In the category of behavioral/emotional needs, 70% improved. Also, 69% improved in life domain functioning and 67% improved in the strengths domain, while 61% improved in the early childhood module. In risk behaviors, 10% improved while 3% improved in the transitional age youth module and 2% improved in cultural factors. Of those who remained the same, 97% were in the transitional age youth module and the cultural factors. In risk behaviors, 88% remained the same. In the early childhood module, 32% remained the same as did 26% in the strengths domain, 24% in life domain functioning, and 23% behavioral/emotional needs. Of those who declined, 8% were in early childhood module, 7% were in the life domain functioning, strengths domain, or behavioral/emotional needs, 2% were in the risk behaviors, and 1% in cultural factors.

The graph demonstrates that overall, the CYC SART program's participants improved from Fiscal Year 2017/18 to Fiscal Year 2018/19.

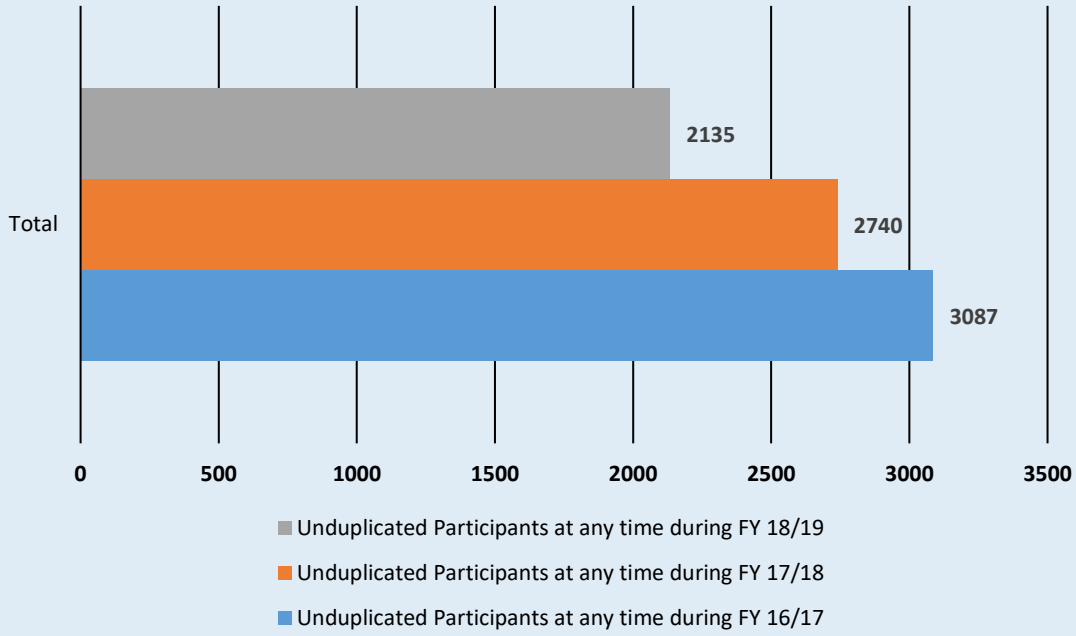


The CYC SART and EIIS programs provide early intervention services which include treatments and interventions to address children who have experienced trauma and/or display impaired functioning but do not require a multitude of ongoing services.

In Fiscal Year 2016/17, 3,087 unduplicated participants started a mental health treatment plan. In Fiscal Year 2017/18, there were 2,740 unduplicated participants who started a new mental health treatment plan and 2,135 in Fiscal Year 2018/19. The decrease in participants in Fiscal Year 2018/19 is possibly due to when participants started their mental health treatment plan. A participant whose open episode crosses fiscal years will count as unduplicated into the next fiscal year.

The table below illustrates the number of unduplicated participants who started a mental health treatment plan by fiscal year for the SART.

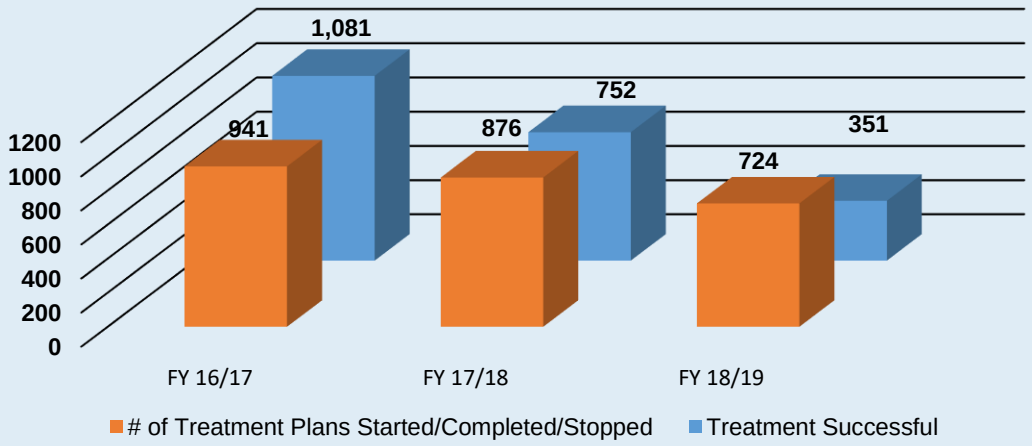
NUMBER OF PARTICIPANTS WHO STARTED A MENTAL HEALTH TREATMENT PLAN BY FISCAL YEAR FOR SART



In Fiscal Year 2016/17, 941 unduplicated participants started a mental health treatment plan and completed or stopped their plan and 1,081 participants successfully completed their mental health treatment plan. In Fiscal Year 2017/18, 876 unduplicated participants started a mental health treatment plan and completed or stopped their plan and 752 participants completed treatment successfully. In Fiscal Year 2018/19, 724 unduplicated participants started a mental health treatment plan and completed or stopped their plan and 351 participants completed treatment successfully. As with the previous graph, it is possible to have start a treatment plan in one fiscal year and have the treatment completed in the next fiscal year.

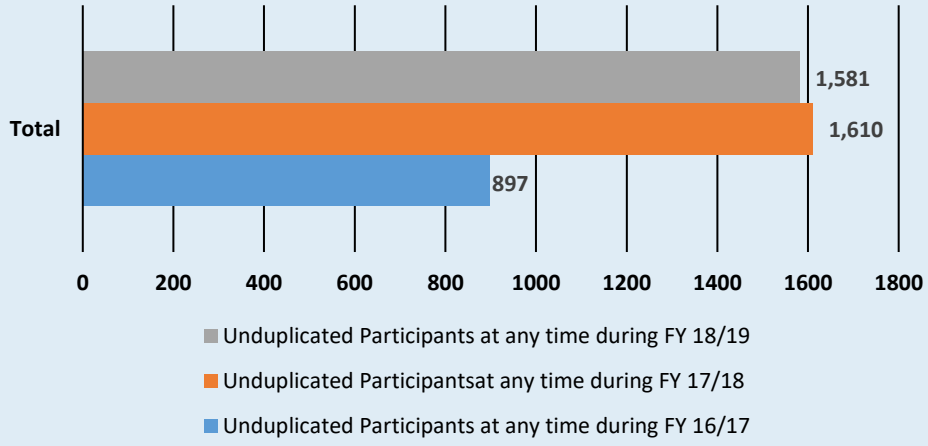
The table below illustrates the number of unduplicated participants who started a mental health treatment plan and completed or stopped their plan and those who successfully completed their mental health treatment plans for SART participants.

Successful Treatment by Fiscal Year and Number of Unduplicated Participants Who Started a Mental Health Treatment Plan and Completed or Stopped Plan by Fiscal Year for SART



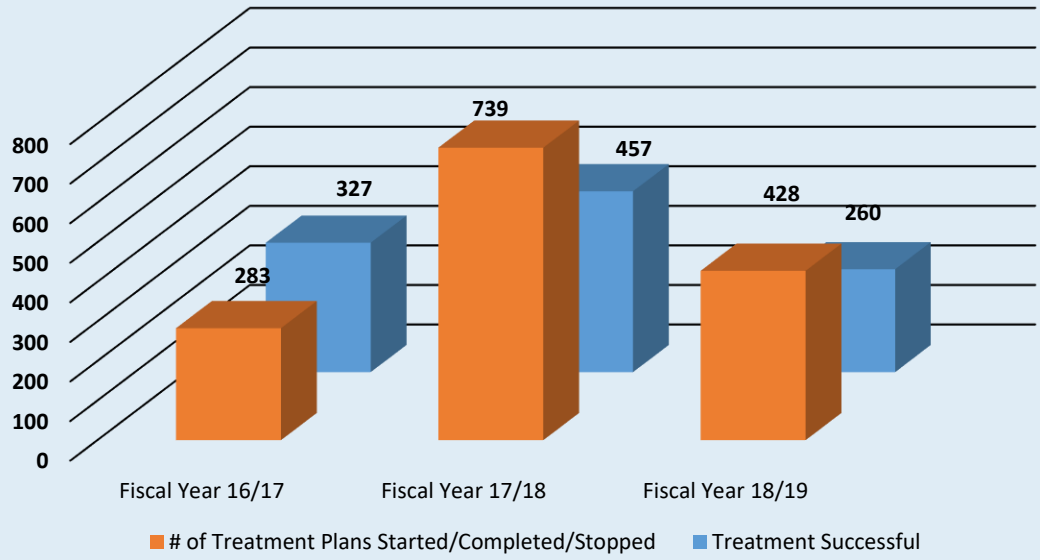
In Fiscal Year 2016/17, 897 unduplicated participants started a mental health treatment plan in EIIS. In Fiscal Year 2017/18, 1,610 unduplicated participants started a mental health treatment plan. In Fiscal Year 2018/19, 1,581 unduplicated participants started a mental health treatment plan.

Number of Participants who started a Mental Health Treatment Plan by Fiscal Year for EIIS



In Fiscal Year 2016/17, 283 unduplicated participants started a mental health treatment plan and completed or stopped their plan and 327 completed treatment successfully. In Fiscal Year 2017/18, 739 unduplicated participants started a mental health treatment plan and completed or stopped their plan and 457completed treatment successfully. In Fiscal Year 2018/19, 428 unduplicated participants started a mental health treatment plan and completed or stopped their plan and 260 completed treatment successfully. The table below illustrates the number of unduplicated participants who started a mental health treatment plan and completed or stopped their plan and those who successfully completed their mental health treatment plans for EIIS.

SUCCESSFUL TREATMENT BY FISCAL YEAR AND NUMBER OF UNDUPLICATED PARTICIPANTS WHO STARTED A MENTAL HEALTH TREATMENT PLAN AND COMPLETED OR STOPPED PLAN BY FISCAL YEAR FOR EIIS



Outreach for Increasing Recognition of Early Signs of Mental Illness

The CYC program's Mentoring Network component provides outreach services to participants with the goal of engaging, encouraging, educating, and/or training potential responders about ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness.

The CYC program began providing outreach services in Fiscal Year 2017/18 and provided services to 2,571 unduplicated participants. In Fiscal Year 2018/19 CYC provided services to 2,443 unduplicated participants.

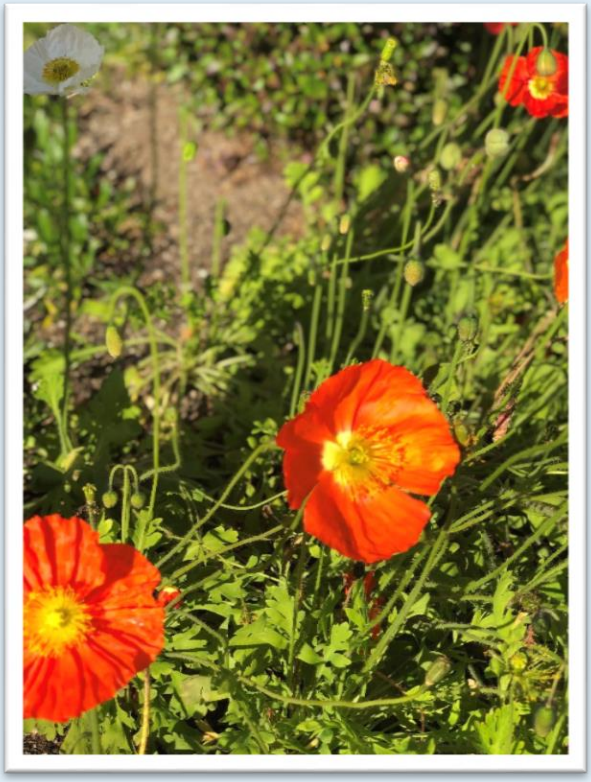
Below is an overview of the settings and types of responders reached in these outreach activities.

Outreach services were provided in the following settings:

- Schools
- Community-based organizations
- Community events
- Health centers
- County offices
- Behavioral health clinics
- Hospitals

The following types of responders were reached during these CYC outreach activities:

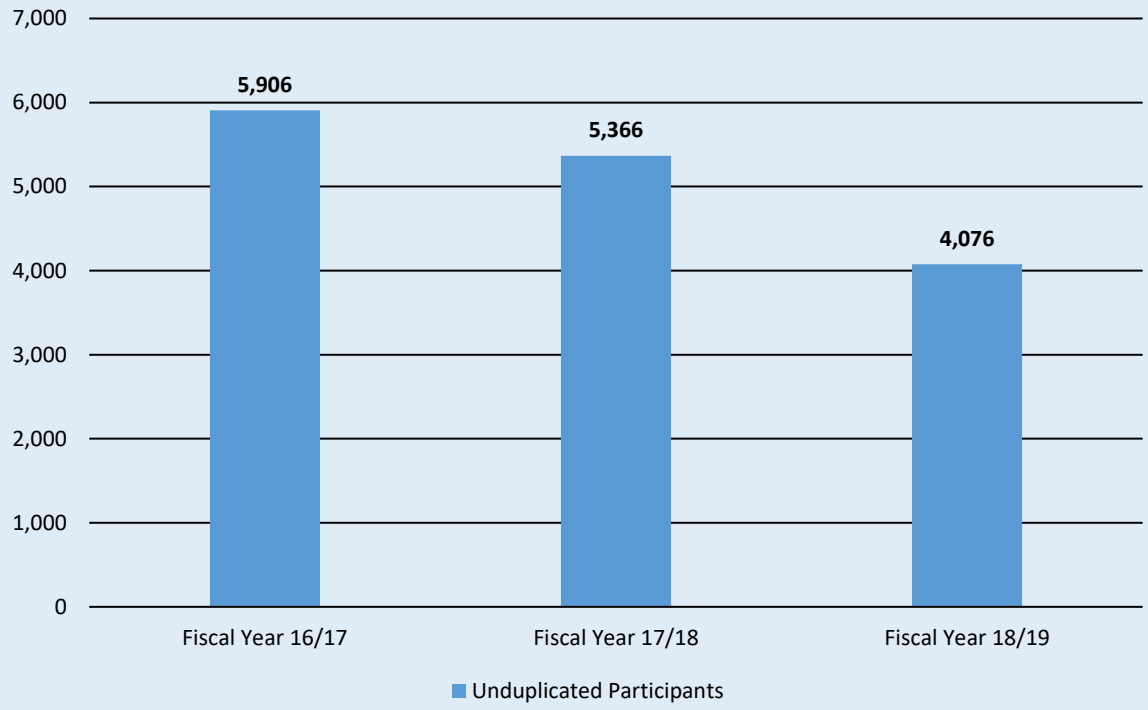
- Child protective services
- Community service providers
- Consumer family members
- Cultural brokers
- School personnel
- Peer providers
- Consumer family members
- Students and educators
- Homeless service providers



Artwork by Carmela Gonzalez

Access and Linkage to Treatment

The CYC SART and EIIS program providers make referrals to a higher level of treatment in order to connect participants and/or their families with mental health concerns as early in the onset as possible. The table below provides an overview of the number of unduplicated participants and the kind of treatment to which they were referred. The CYC program's SART and EIIS providers did not make any referrals to agencies outside of the County.



The CYC program participants were referred to the following kinds of treatment:

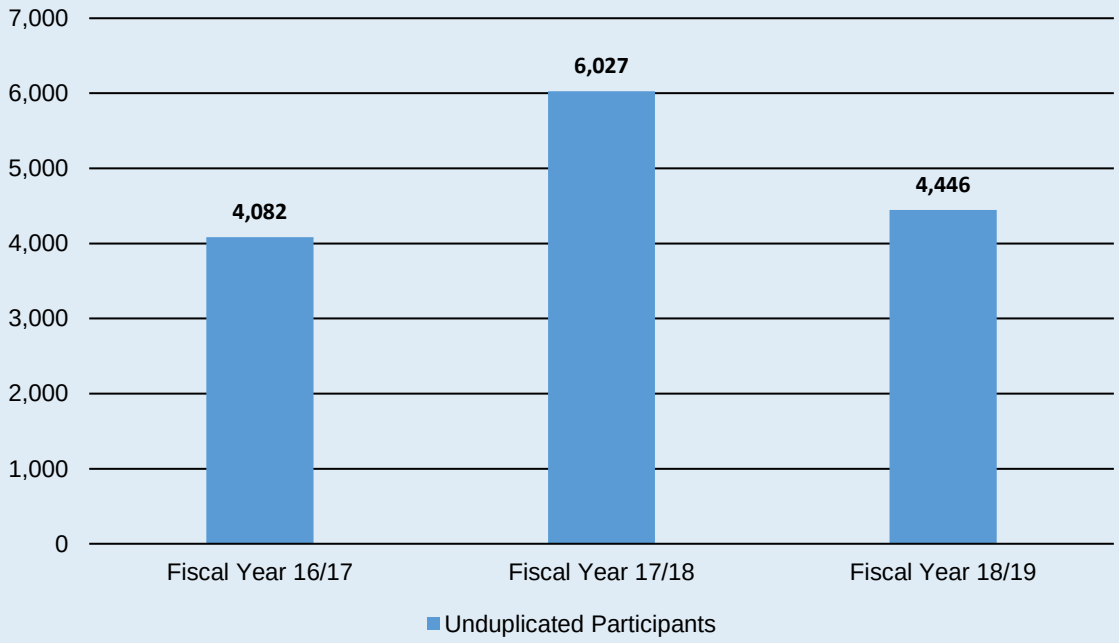
- Assessment
- Individual outpatient services
- Intensive Home-Based Mental Health Services
- Medication Management/Support/Education
- Occupational Therapy
- Psychological Testing
- Rehab/Activities of Daily Living Groups

Improve Timely Access to Treatment

To increase access to mental health services for underserved populations, the Improve Timely Access to Treatment strategy focuses on providing appropriate services based on the identified needs of those underserved populations. The CYC program providers provided services to the following identified underserved populations:

- African-American
- Children and Youth at risk for School Failure
- Children and Youth at risk of or Experiencing Juvenile Justice
- Children and Youth in Stressed Families
- Foster Children/Former Foster Children
- Latino
- Military and Veterans

The table below illustrates the number of unduplicated participants served by the Improve Timely Access to Underserved Populations strategy.

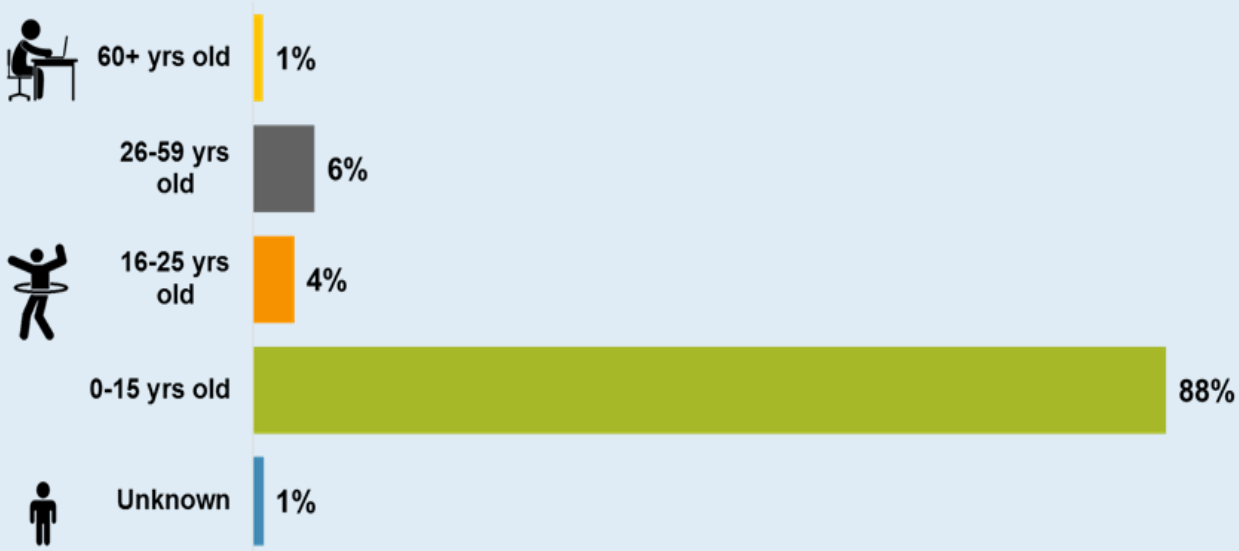


Fiscal Year 2018/19 Program Demographics

The following graphs illustrate the demographics in various categories of CYC participants.

Age:

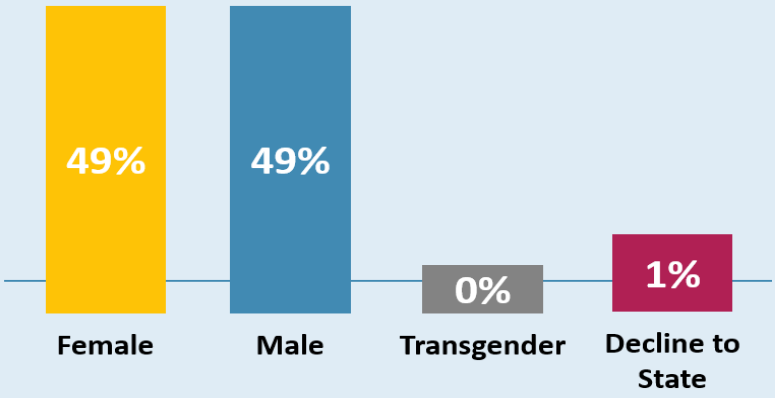
The graph below illustrates the ages of the CYC participants. As is consistent with the target population, 88% of participants were in the 0-15 age group. The remaining 12% fell into the category of 16-15 years old, 26-59 years old, 60+ years old, or unknown.



N = 6,666

Gender:

The graph below demonstrates that 99% of participants declined to state their gender identity. Due to the target population of CYC participants being in the age category of 0-15, in most cases it is deemed inappropriate to ask this particular demographic question.

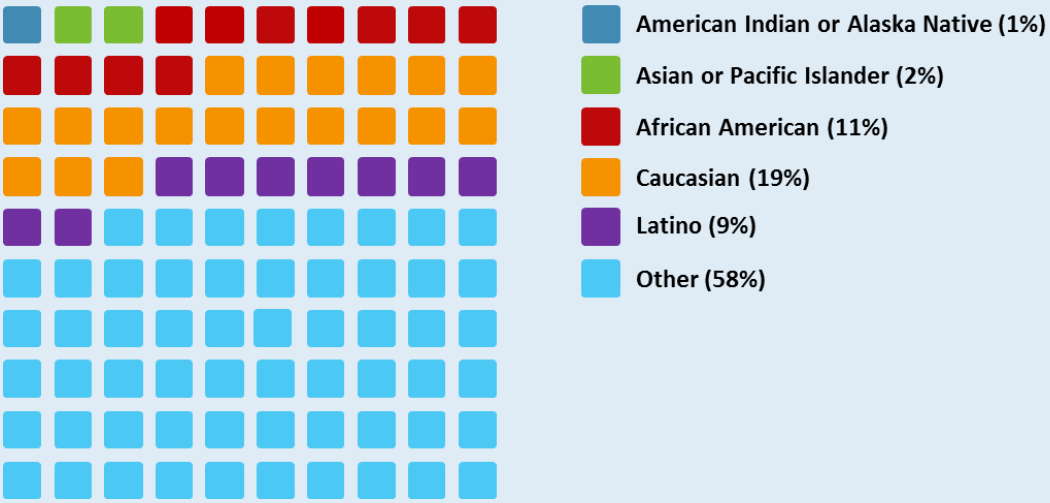


N = 6,544

Ethnicity and Ancestry:

The graph below illustrates the various ethnicities of participants of the CYC program.

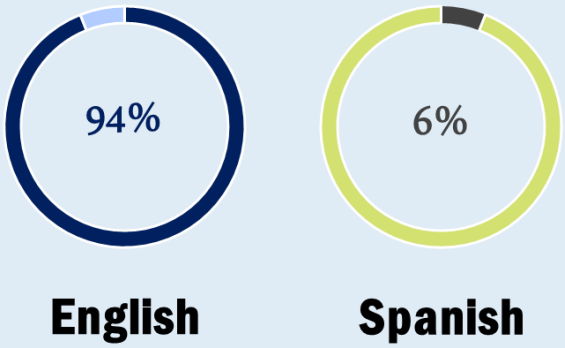
The largest group of participants was 58% in the category of Other. This category includes those who identified as other, more than one race, or declined to answer. The second largest category is Caucasian 19%. In the category of African American, 11% were identified. Additionally, 9% identified as Latino c. There were 2% who identified as Asian or Pacific Islander and 1% who identified as American Indian or Alaska Native.



N = 5,899

Primary Language:

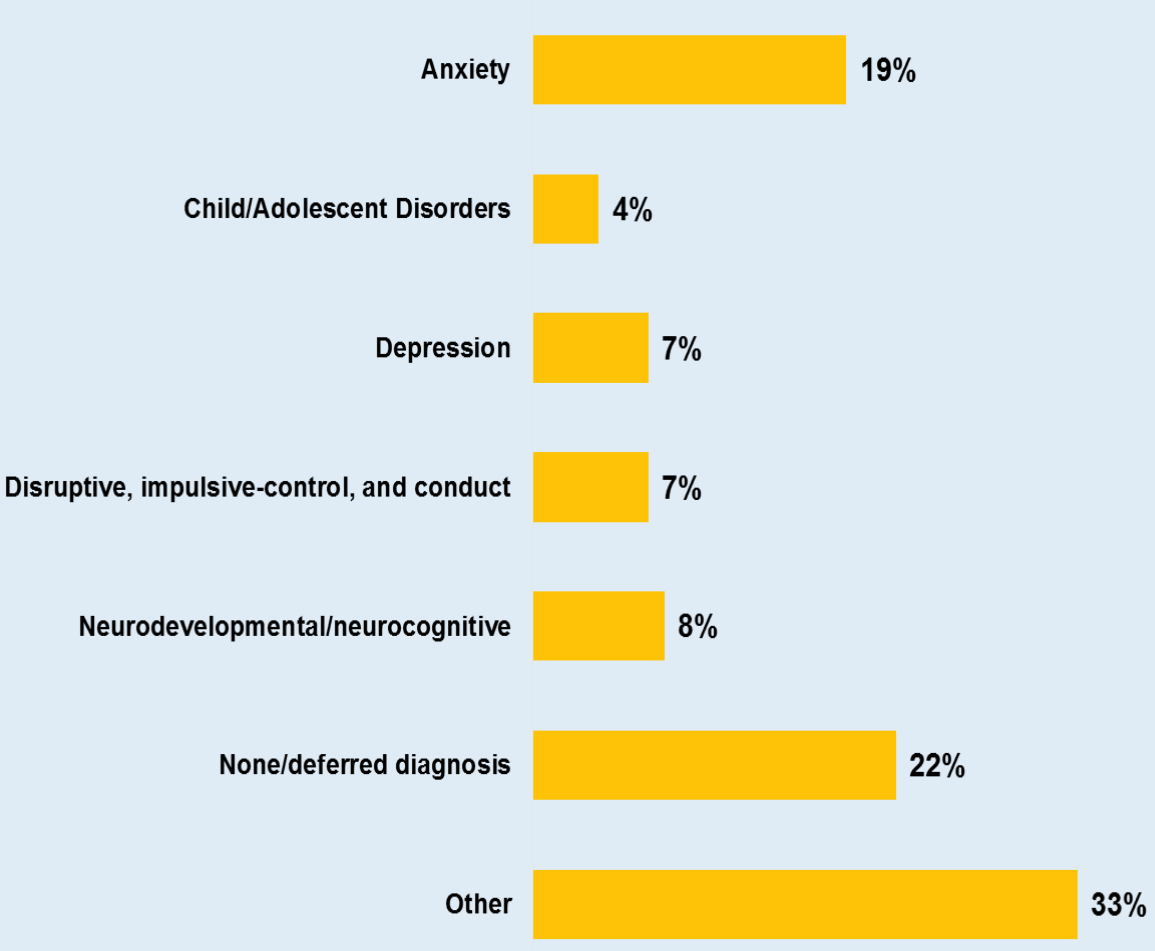
The graph below demonstrates that 94% of participants identified English as their primary language. There were 6% who identified Spanish as their primary language, and none who identified a language other than English or Spanish.



N = 6,664

Primary Diagnosis:

Those who receive early intervention services are categorized into diagnostic groups. The graph below illustrates the diagnostic groups of those in the CYC SART and EIIS programs who received early intervention services. The majority of participants, 33% were in the category of Other. This category includes those who had a different diagnosis than those listed or more than one. An additional 22% had no diagnosis or it was deferred. This means the participant either had no identifiable mental health need or the diagnosis was deferred pending further assessment. Also, 19% were diagnosed with anxiety, 8% with neurodevelopmental/neurocognitive disorders, 7% with disruptive, impulsive-control, and conduct disorder or depression, and 4% with child/adolescent disorders.



N = 6,676

Success Story

Four year old Joshua was referred for an evaluation from Children and Family Services. When he began treatment services, he had been removed from his mother's care due to neglect and was having difficulty being reunited with his father due to his behavioral issues. Through the course of Joshua's treatment including individual therapy and Parent-Child Interaction Therapy (PCIT), he began to trust his therapist so that he could engage more freely in each session. Joshua's father learned the necessary parenting skills in his role in the PCIT treatment by asking clarifying questions and completing his home assignments. At the conclusion of Joshua's treatment, he had met all of his treatment goals and was well on his way to a healthy parent-child relationship.

Program Challenges

The CYC providers have a variety of challenges ranging from weather and transportation in the mountains to changing regulations and streamlining communication challenges with partner agencies.

Program Solutions

In order to mitigate challenges with weather and transportation, providers travel to the most convenient places for clients. In addressing opportunities to improve communication with partner agencies, providers have utilized the Department of Behavioral Health to mediate communication between providers and partner agencies.

Program Updates

There are no planned program updates for the CYC program.

Collaborative Partners

- Allred Children's Center
- Barstow City Counsel
- Barstow Community College
- Children and Family Services
- Children's Fund
- El Sol
- Family Assistance Program
- First 5
- Fort Irwin
- Garden Pediatrics
- Great Hope Foundation
- Inland Empire United Way
- Loma Linda Children's Center
- Loma Linda Pediatrics
- Moses House
- Redlands Day Nursery
- San Bernardino County, Department of Public Health
- San Bernardino Family and Pregnancy Resource Center
- San Bernardino County, Probation Department
- Teddy Bear Tymes Child Care Center
- Various local school districts
- Women, Infants, and Children

Preschool PEI (PEI SI-2)

Preschool PEI Program (PPP) is a Prevention program that is a collaborative effort between The Department of Behavioral Health and Preschool Services Department to serve students enrolled in the County's Head Start program. The Preschool PEI Program provides support for preschool children (ages 2-5) and education for their parents and teachers. The program is designed to help children learn to understand and manage their emotions. It also works to promote and improve participants' academic competence such as language, reading, and social skills.

A bereavement and loss component is included in the program and works with preschool children to address losses related to death, separation (out-of-home placement) and divorce. This component provides a safe and healthy outlet for processing grief related to these losses.

Services offered include:

- Child, parent, and teacher training using the Incredible Years ® model to help strengthen children's social and emotional skills while reducing inappropriate and aggressive behaviors
- Early intervention services to address significant trauma
- Screening and assessments
- Resources and referrals
- Development of behavioral support plans
- Family support

Artwork by Amy Bojorquez

MHSA Legislative Goals and Related Key Outcomes

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

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

Improve Timely Access to Services:

- Increase extent to which an individual or family from an underserved population who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable.

Reduce prolonged suffering associated with untreated mental illness:

- Reduce risk factors
- Reduce indicators
- Increase protective factors that may lead to improved mental, emotional, and relational functioning.

Reduce stigma and discrimination associated with mental illness:

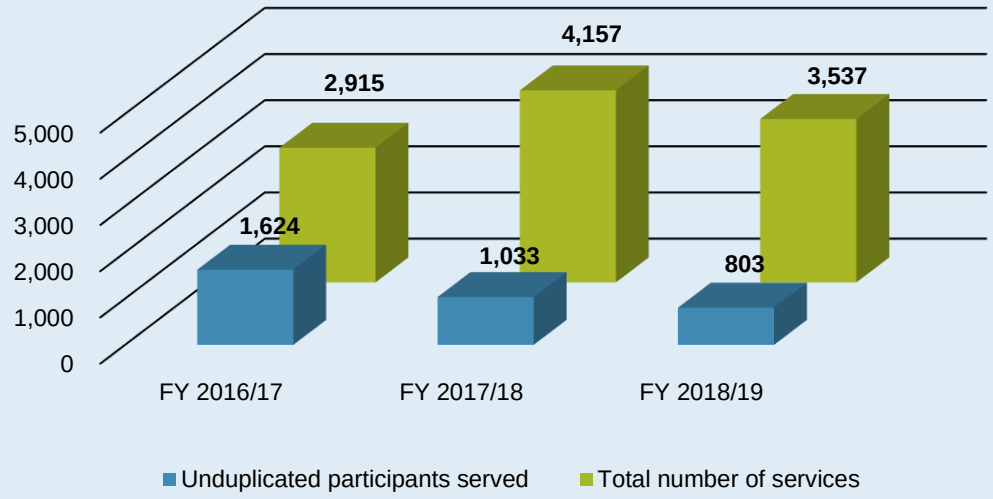
- Reduce negative feelings, attitudes, beliefs, perceptions, stereotypes, and/or discrimination related to having a mental illness, being diagnosed, or seeking services
- Increase acceptance, dignity, inclusion, and equity for individuals with mental illness and members of families.

Artwork by Michael Schertell

Positive Results

The Preschool PEI Program seeks to provide services to a minimum of 1,508 unduplicated participants each year. The chart below illustrates the total number of unduplicated participants and the total number of services provided for Fiscal Years 2016/17, 2017/18, and 2018/19.

TOTAL UNDUPLICATED PARTICIPANTS AND TOTAL NUMBER OF SERVICES FISCAL YEARS 2016/17, 2017/18, AND 2018/19



During Fiscal Year 2018/19 the total number of unduplicated participants decreased from 1,624 to 803 unduplicated participants, a 50% reduction from Fiscal Year 2016/17, due to improvements in the screening and referral process. During this time, the Preschool PEI program streamlined the referral and identification process for participants of the program to ensure they are receiving the appropriate supports. As a result in this change in process, the frequency of individual supports has increased with total services doubling from an average of two services per participant in Fiscal Year 2016/17 to four services per participant in Fiscal Year 2018/19.

Prevention Services

The Preschool PEI Program utilizes the screening tools below in providing prevention services.

Desired Results Developmental Profile (DRDP-2015)

The PPP uses the Desired Results Developmental Profile (DRDP) to gauge the effectiveness of the services being provided to the children in the program. The DRDP is an assessment instrument designed to observe, document, and reflect on the

learning, development, and progress of the child. The assessment results are used by the program staff to create individual care and treatment plans for the children that will guide continuous improvement. It is administered three times during the course of the interaction with the child. It is completed at initial contact, at midterm, and at the conclusion of services.

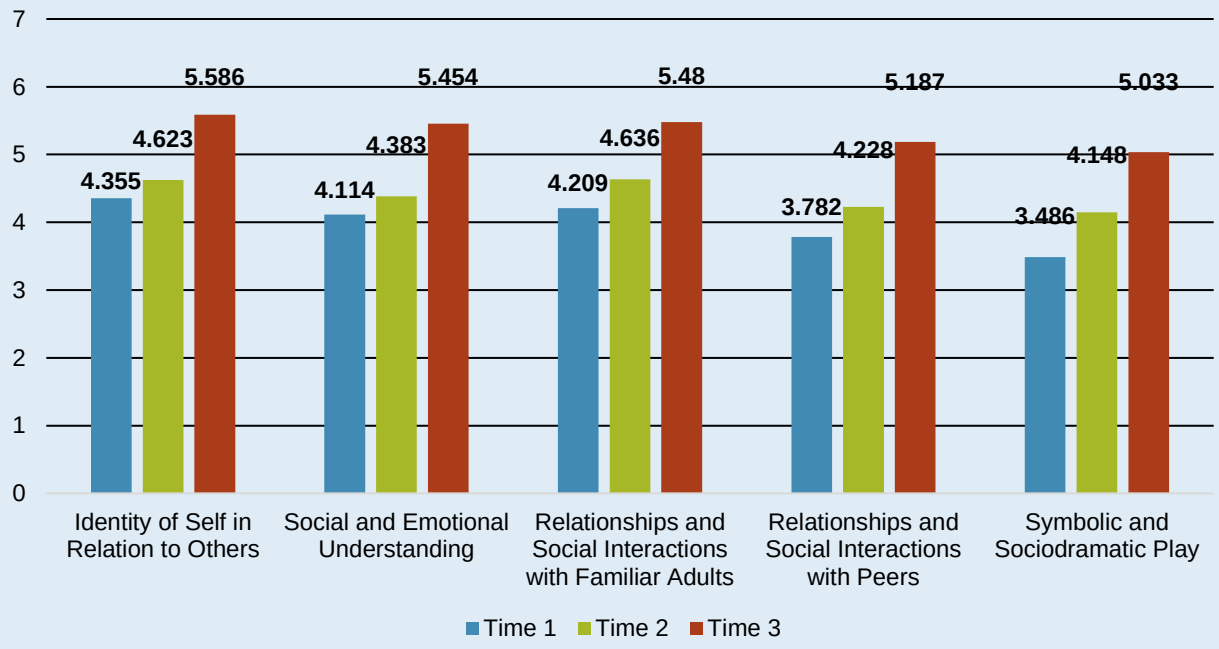
In Fiscal Year 2017/18, the DRDP showed a continuous improvement in five domains that specifically measure the social emotional development in preschool age children.

The five domains are as follows:

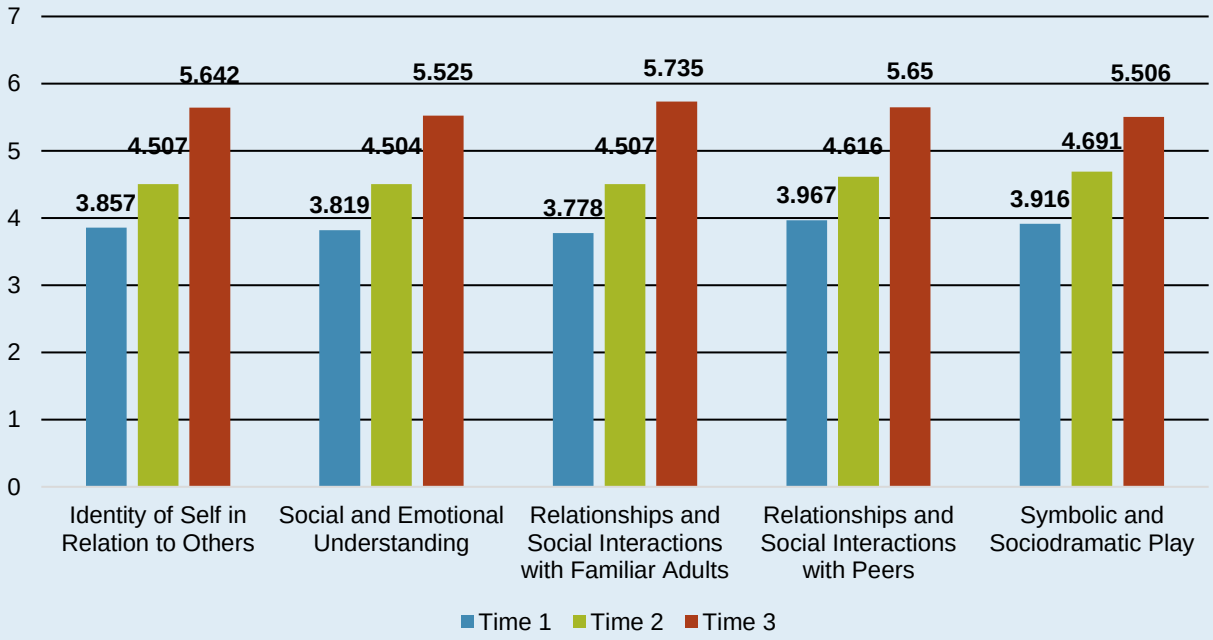
1. Awareness of self as related to others
2. An understanding of individuals behaviors, feelings, thoughts, and individual characteristics
3. How the child develops close relationships with one or more familiar adults
4. The ability to become increasingly competent and cooperative in interactions with peers and to develop relationships with peers
5. Developing the capacity to use objects to represent other objects or ideas and to engage in symbolic play with others

Periodic DRDP assessments are conducted over the course of the year. The charts below show the improvement of the participants from the initial assessment (Time 1), to the mid-point assessment (Time 2), and through the final assessment (Time 3) during Fiscal Year 2016/17, 2017/18, and 2018/19, respectively.

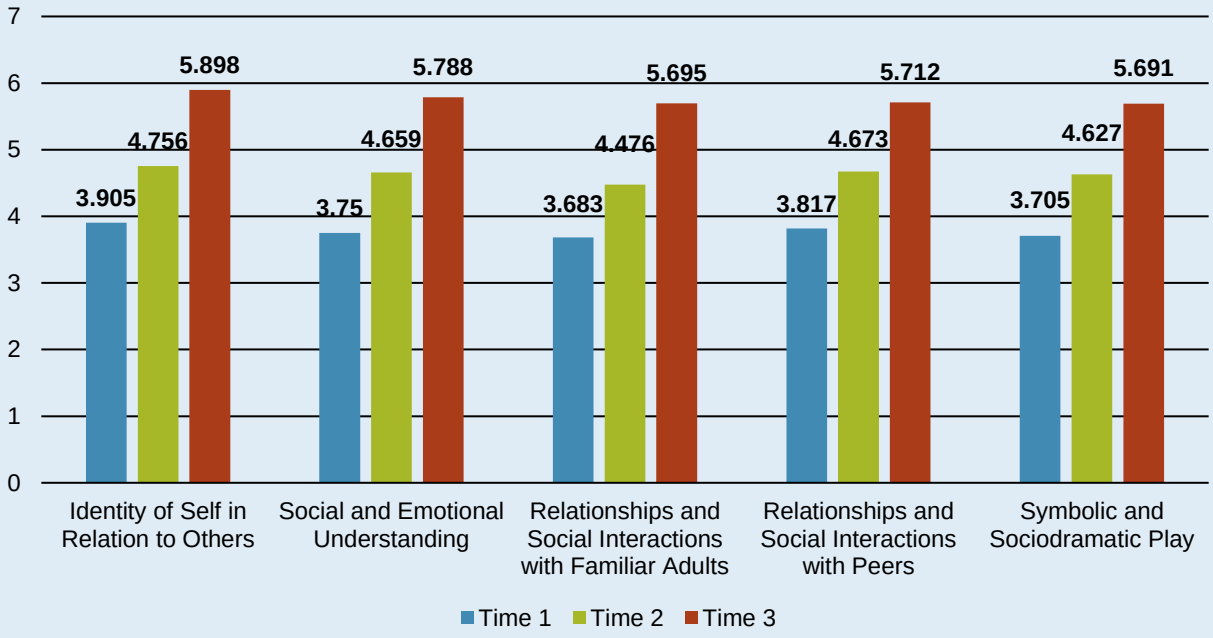
DRDP Scores Fiscal Year 2016/17



DRDP Scores Fiscal Year 2017/18



DRDP Scores Fiscal Year 2018/19



Access and Linkage to Treatment

When it appears that a participant may require treatment beyond early intervention, a Licensed Clinical Social Worker (LCSW) performs an assessment to determine whether a referral is necessary and provides appropriate referrals as needed.

The Preschool PEI Program referred three participants to treatment beyond early intervention in Fiscal Year 2018/19. One of the three participants followed through on the referral and engaged in treatment and engaged in treatment 75 days from the date of the initial referral.

Artwork by Lilian Iskander

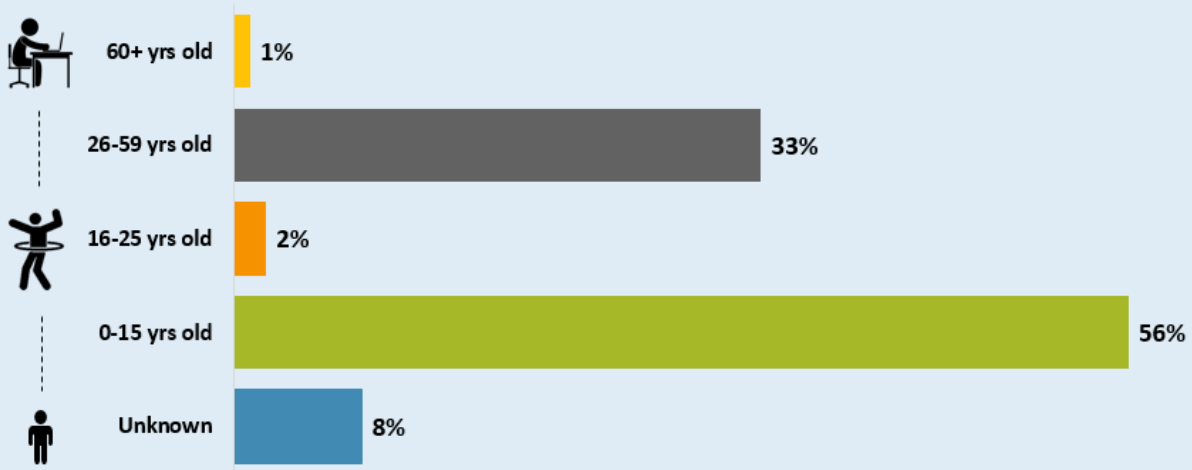
"Because of the Preschool PEI Program, my child learned to manage her anger and her temper tantrums decreased."

– *Preschool PEI Participant*

Fiscal Year 2018/19 Program Demographics

Age:

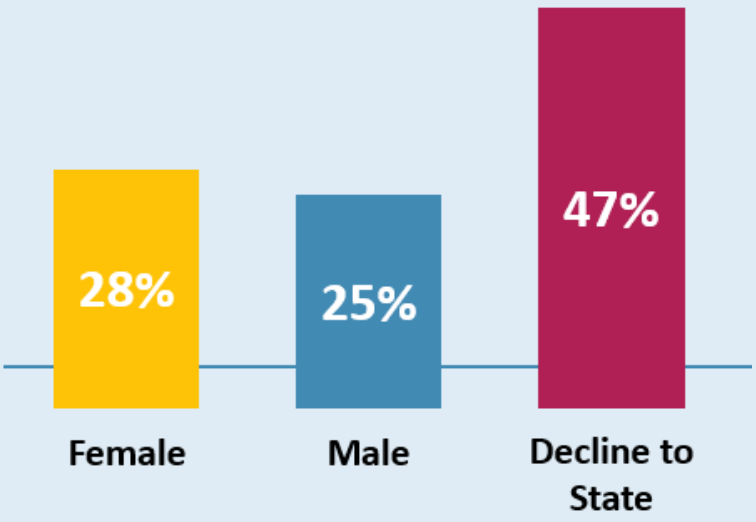
The graph below illustrates the ages of the Preschool PEI participants. The Preschool PEI program provides services to parents, caregivers, and teachers in addition to the preschool student participants and therefore all age groups are represented in this graph. The majority of participants served, 56%, were between the ages of 0-15 years old. Thirty-three percent of the program participants were between the ages of 26-59 years old. The TAY group, 16-25 years old, made up 2% of the Preschool PEI program participants, and 1% identified as 60+ years old. The remaining 8% of the population age groups is unknown or the participant declined to state.



N = 806

Gender:

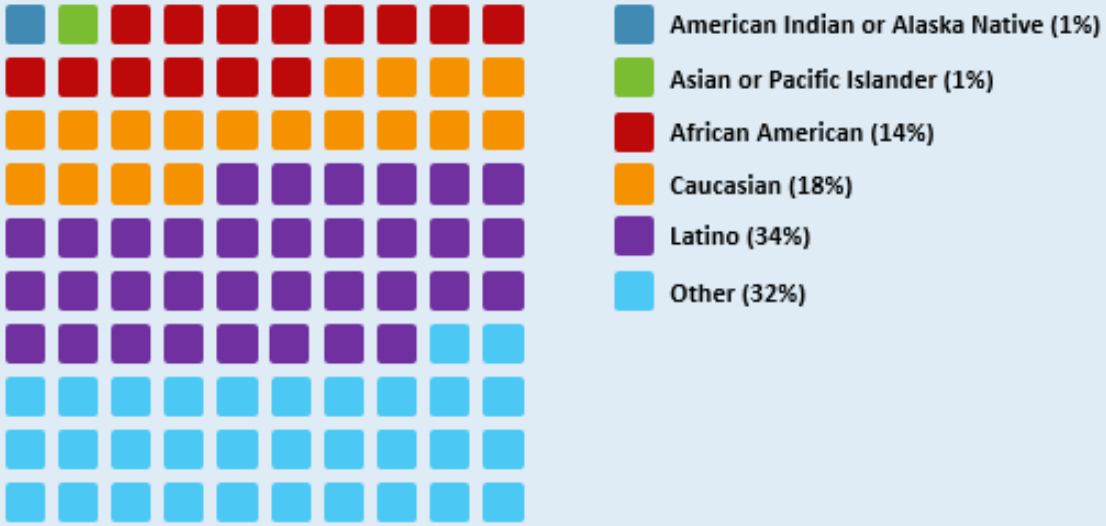
The graph below demonstrates that 28% of the Lift participant population identified as female, 25% identified as male, 47% declined to state.



N = 806

Ethnicity and Ancestry:

The graph below illustrates the various ethnicities of participants of the Preschool PEI program. The largest group was 34% in the category of Latino. The second largest category was Other at 32%. This category includes those who identified as other, more than one race, or declined to answer. There were 18% of participants in the Caucasian category and 14% in the African American category. Only 1% identified as American Indian or Alaska Native and 1% identified as Asian or Pacific Islander.



N = 1,201

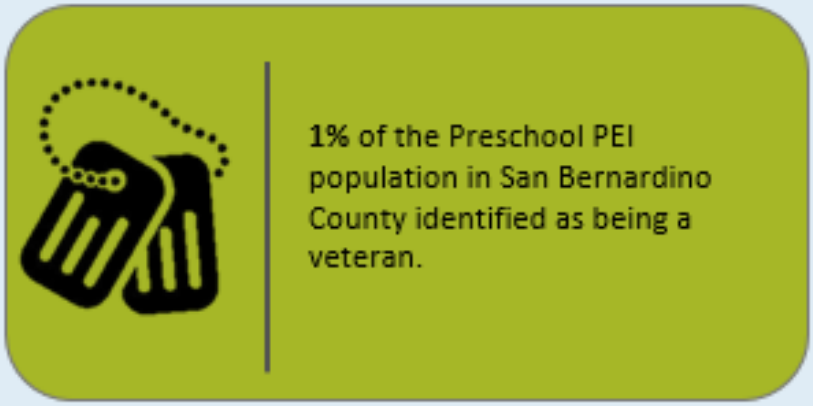
Primary Language

The graph below demonstrates that 79% of the Preschool PEI program participants identified English as their primary language while 10% identified Spanish and 11% identified a different language as their primary language.

N = 806

Veterans Status

The Preschool PEI program provides services to parents, caregivers, and teachers in addition to the preschool student participants. Of the Preschool PEI program participants, 1% identified as being veterans.



N = 806

Program Challenges

Children enrolling in the Preschool PEI program are exhibiting self-regulation concerns in the classroom, in the areas of social and emotional skills, school readiness, and engaging effectively as a classroom community member.

Program Solutions

The Preschool PEI program is examining the use of a Multi-Tiered System of Support (MTSS), such as the PBIS and Teaching Pyramid curriculum, to enable teaching staff to support and identify children needing additional resources, accelerate the performance of all students to learn, and apply social and emotional skills such as self-regulation and prosocial skills before behaviors escalate. The implementation of a multi-tiered system of support will allow teachers to have intensive support with the addition of ongoing mentoring and coaching. In addition, parents will be offered the opportunity to engage in multi-session parenting modules that will build upon one another. The Preschool PEI program is working on increasing participation in family engagement events.

Program Updates

The Preschool PEI Program has no updates to report for Fiscal Year 2020/21.

Success Story

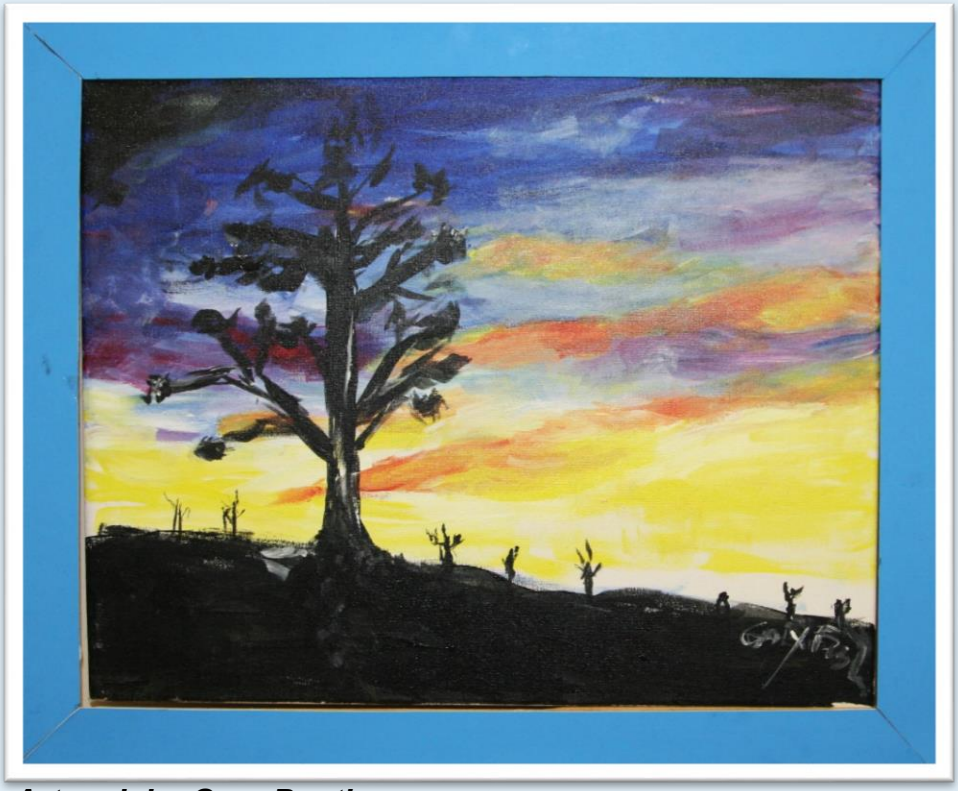
"Parker," a four year old preschool student, was referred to the Preschool PEI Program because she was exhibiting behaviors such as hyperactivity, clinging, anxiety, fear, impulsivity, attention seeking, and destructiveness, both at home and in school. Parker's mother was introduced to the program and acknowledged that she too could benefit from the services by receiving Preschool PEI Program information that provided guidance and assisted her in supporting Parker and her siblings.

Parker's mother actively applied the suggested interventions she learned from the Preschool PEI Program's Associate Marriage and Family Therapist (AMFT) to Parker's and her siblings' daily lives, which has had an immediate positive impact on Parker's social and emotional behaviors.

Parker's mother appreciates the in-home services and how the family relationships have improved. She has a new hope for a bright future as a result of being involved in the Preschool PEI

Collaborative Partners

- Cal Baptist University (CBU) MFT Intern Program
- Cal Baptist University (CBU) MSW Intern Program
- California University of San Bernardino Psychology Interns
- First 5 San Bernardino AmeriCorps
- Fontana Unified School District
- Making A Difference Association
- Norco College ECE Special Education Student
- San Bernardino County Superintendent of Schools
- Victor Community Support Services
- Volunteers of America



Artwork by Gary Bustin

Resilience Promotion in African American Children (SI-3)

The Resilience Promotion in African American Children (RPiAAC) program is a Prevention and Early Intervention State program that targets African American children and youth, ages 5-18. The program serves the Central and High Desert regions. RPiAAC program embraces African American values, beliefs, and traditions, and incorporates the culture into educational behavioral health services. The goal of the program is to promote resilience in African American children in order to reduce the risks factors that can lead to the development of a mental illness and or substance use disorder. Outreach and education services are designed to incorporate cultural education and historical education to diverse student populations, including African American populations, to encourage a positive social identity and generate awareness regarding the importance of mental health and wellness of all students at specific school sites. The program incorporates culturally specific strategies and approaches, including a curriculum-based education, cultural awareness activities, conflict resolution training educational workshops, weekly interventions, professional development presentations, individual and family therapy, groups, and linkage to additional resources.

MHSA Legislative Goals and Related Key Outcomes

Reduce prolonged suffering associated with untreated mental illness:

- Reduce risk factors.
- Reduce indicators.
- Increase protective factors that may lead to improved mental emotional and relational functioning.

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

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

Improve timely access to services:

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

Reduce stigma and discrimination associated with mental illness:

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

Positive Results

Prevention Services

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:

- Black Parent Empowerment Program
- Effective Black Parenting Curriculum
- NCTI Youth© Crossroads Curriculum, and
- Peacemakers

The Peacemakers and NCTI Youth Crossroads curricula are used for grade K-12 on school campuses and delivered during school hours and in afterschool programs. The students participate in weekly trainings 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.

The RPiAAC program also provides support to teachers during class. This allows program providers to identify and support students who exhibit behavioral challenges and require assistance redirecting and refocusing their energy to avoid disciplinary actions. These students are connected with the RPiAAC program to learn more about:

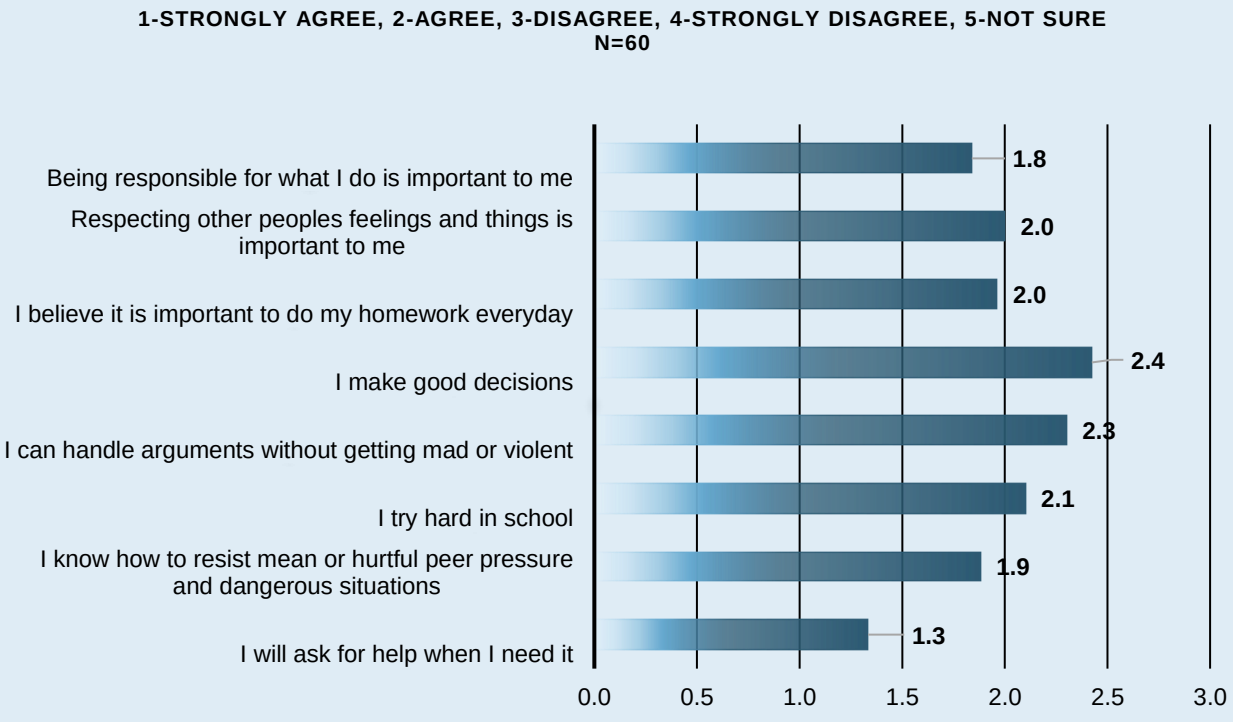
- Self-regulation
- Social skills, and
- Becoming a more positive member of the student body.

Program providers offer a supportive piece to the Peacemaker curriculum by providing afterschool services. During these meetings, students receive academic tutoring, health and wellness education, and opportunities to participate in various activities that focus on the arts.

In Fiscal Year 2018/19, the RPiAAC program had 394 students participate in the 12-week Peacemakers curriculum and or a curriculum similar to it. Of the 394 participants who started the curriculum, 249 of the participants completed it.

In addition to the curriculums offered the RPIAAC program works on increasing participants' protective factors, such as taking responsibility for ones actions and regulating ones emotions, which help mitigate risks that can contribute to the development of mental health and/or substance use disorders. To measure how students felt about self-regulation, taking responsibility for their actions and asking for help if they need it, after participating in some of the programs prevention activities in Fiscal Year 2018/19, students were given a post survey. The survey asked participants a series of questions that asked them to provide a rating on a scale ranging from one (1) to four (5), with one (1) indicating "Strongly Agree," and five (5) indicating "Not Sure." Sixty participants returned their post surveys. The chart below shows a sample of the average participant score for the survey questions.

Fiscal Year 2018/19 Youth Post Survey Average Scores



PEI: PREVENTION

Participants' average score for response, "Being responsible for what I do is important to me," was **1.8**. Indicating that on average the participants agreed that taking responsibility for their actions is important. Additionally, participants' average score for response, "I can handle arguments without getting mad or violent," was a **2.3.** Indicating on average, participants agreed they could regulate their emotions.

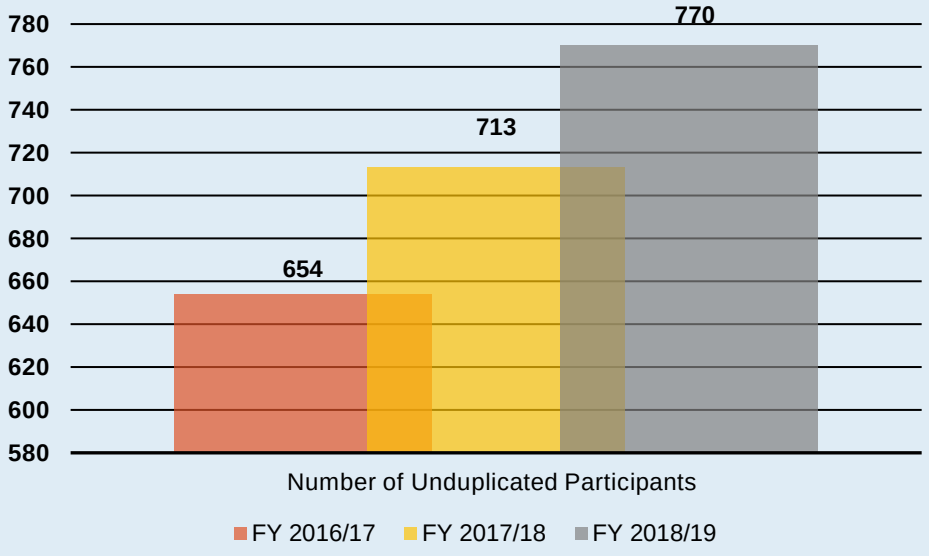
Other prevention activities provided by the program help participants gain academic competence, a sense of cultural identity and confidence that they can address life's challenges successfully and develop positive relationships in their community.

These activities include cultural relevant activities such as:

- Presentations on the historical trauma in African Americans
- Assembly presentations on black history and the historical accomplishments of recognized African Americans
- Meet-A Pro events where children and youth meet an African American professional.

Over the last three fiscal years, the program has steadily increased the number of unduplicated participants provided prevention services each year. The chart below illustrates the program's participant increase over the last three fiscal years.

NUMBER OF UNDUPLICATED PARTICIPANTS WHO RECEIVED PREVENTION SERVICES BY FISCAL YEAR



Early Intervention Services

In addition to prevention services, the RPiAAC program provides early intervention services to participants in need. Fiscal Year 2018/19 is the first year the program has integrated early intervention services into its scope of work. Providers are utilizing various screening and assessment tools to ensure participants receive mental health treatment services as soon as a mental health concern is identified. Some of the assessment tools used by the program are listed below:

- **San Bernardino Child and Adolescent Needs and Strengths (SB-CANS) Assessment** – a multipurpose tool developed for children's services to support decision-making.
- **Columbia Suicide Severity Rating Scale** – a suicidal ideation and behavioral rating scale used to evaluate suicide risk.
- **Life Events Checklist** – Is a self-report tool used to screen for potentially traumatic events in a patient's lifetime.

In Fiscal Year 2018/19, the RPiAAC program provided early intervention services to 89 unduplicated participants. Of the 89 participants who received early intervention services within the fiscal year, 21 of them reached their treatment plan goals by the end of the fiscal year and 34 of them partially met their treatment plan goals.

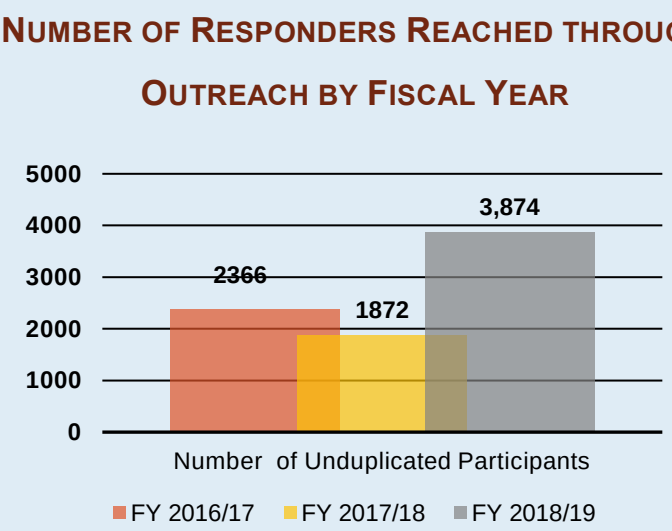
Outreach for Increasing Recognition of Early Signs

RPiAAC providers have worked diligently to incorporate outreach for increasing recognition of early signs of mental illness into the program's regular activities. Presentations that address stigma and suicide prevention in the African-American community are offered at school assemblies, workshops, and resource fairs. Potential responders are presented with information on identifying signs and symptoms of mental illness and the importance of seeking help.

The program also offers outreach education that provides African American historical trauma education and informs participants about difficulties African-Americans have faced when they have disregarded their mental health concerns. Through these services, the RPiAAC program seeks to educate responders on how to see beyond the stigma associated with mental health and to recognize early signs of mental illness.

The RPiAAC program has improved its outreach efforts since last year, reaching 3,874 unduplicated participants through outreach services in FY 2018/19. When compared to Fiscal Year 2017/18, there was a 107% increase in responders reached.

The chart below shows the number of unduplicated participants reached by fiscal year.



Over the past three fiscal years, the program has reached the following types of responders:

- Community Service Providers
- Consumer Family Members
- Families
- Leaders of Faith-Based Organizations
- People Who Provider Services to the Homeless
- Primary Health Care Providers
- School Personnel, and
- Others.

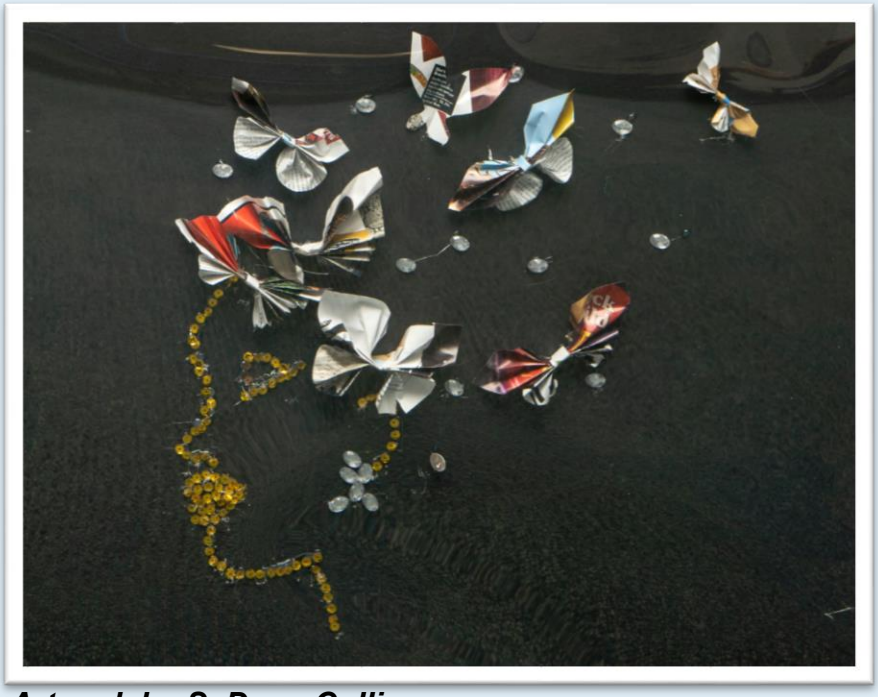
The program has provided outreach presentations and workshops in the following settings:

- Churches
- Community Based Organization's Facility
- Community Events
- Family Resource Centers
- Law Enforcement Departments, and
- Schools.

Improve Timely Access to Treatment

To ensure participants are being linked to services that appropriately meet their behavioral health needs, providers of the RPiAAC program have implemented a referral and screening process that improves timely access to treatment for the underserved African-American population and all other participants that have been identified as needing RPiAAC services. The screening and assessment process implemented allows for the program facilitator, in partnership with the program clinician, to determine whether a participant would benefit from another prevention or early intervention program, or a program that provides services beyond the scope of prevention and early intervention services.

In Fiscal Year 2018/19, the program provided improve timely access services to nine participants. Eight of the nine participants were referred and linked to early intervention services. One of the nine participants was linked to treatment beyond the scope of prevention and early intervention.



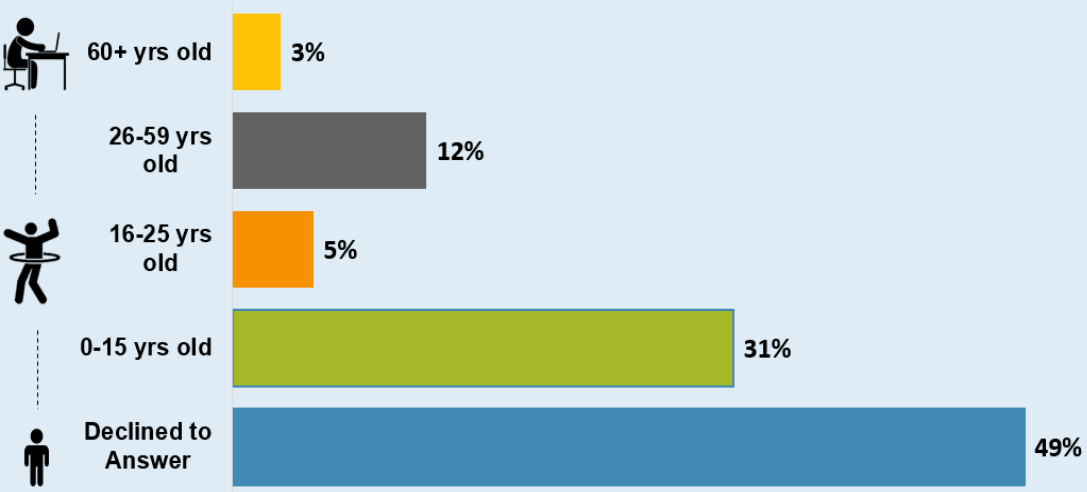
Artwork by SaDaun Collins

Fiscal Year 2018/19 Program Demographics

The following graphs reflect the demographic data collected from the RPiAAC participants for FY 2018/19.

Age:

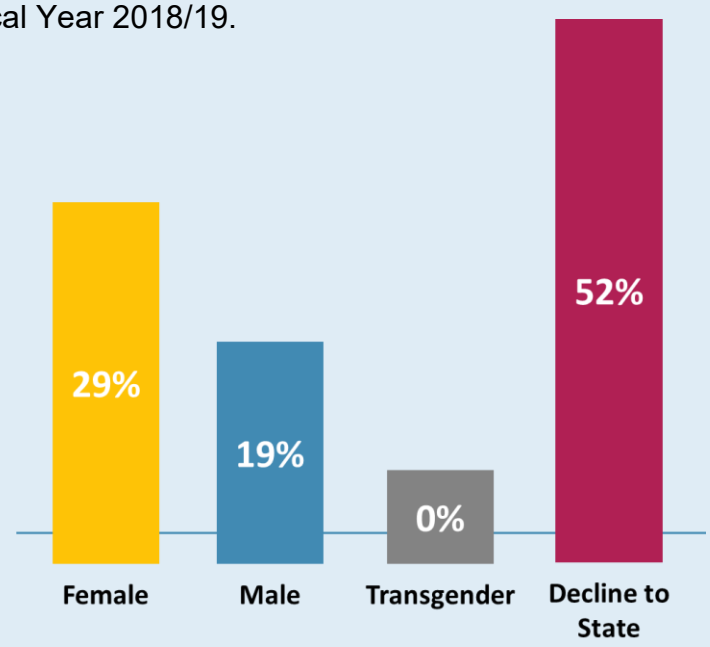
The following graph shows the reported *Age* demographics for the student participants for Fiscal Year 2018/19. Forty-nine percent (49%) of the participants *Declined to Answer,* 31% identified as *children,* 5% identified as *TAY,* 2% identified as *Adults,* and 3% identified as *Older Adults.*



N = 4,670

Gender:

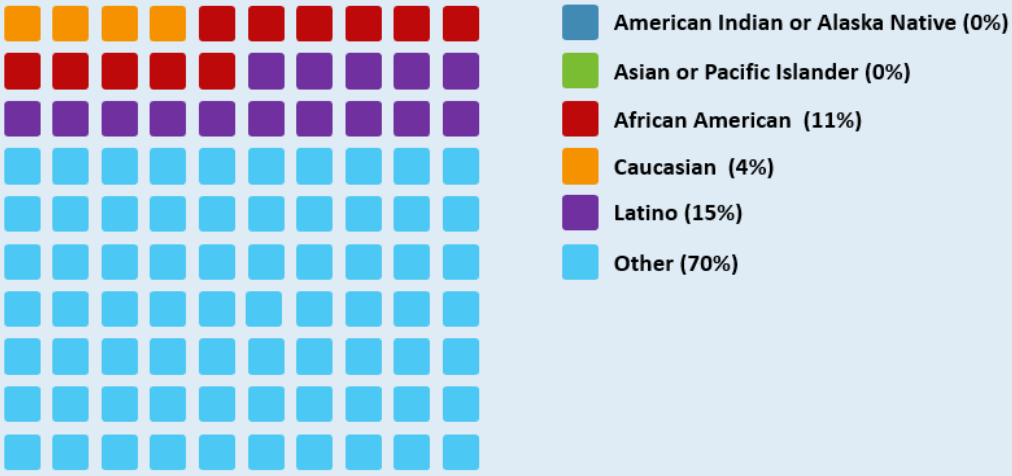
When participants were asked to identify their "gender," 29% of the participants identified as *Female* and 19% of the participants identified as *Male*. The program had many participants *Decline to Answer;* 51% of the programs participants declined to identify as male or female. The graph below reflects the gender demographics obtained by the program during Fiscal Year 2018/19.



N = 4,622

Ethnicity and Ancestry:

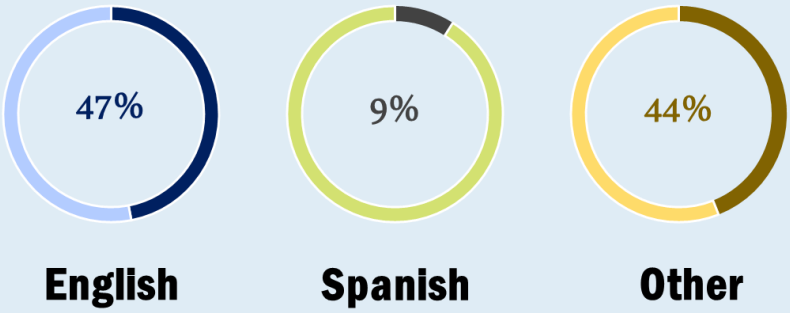
The RPiAAC program served participants of varying race and ethnic backgrounds. Though the program targets African American children, it is very inclusive as illustrated in the graph below. In Fiscal Year 2018/19, 11% of the programs participant identified as *African American and/or Black*, 4% of the participants identified as *Caucasian and/or White*, and 15% of the participants identified as *Latino and/or Hispanic*. The *Other* category reported in the graph below represents the participants who identified as *More than One Race*, *Other*, or selected *Decline to Answer*. Collectively, these three categories represent 70% of the participants that participated in the program.



N = 4,622

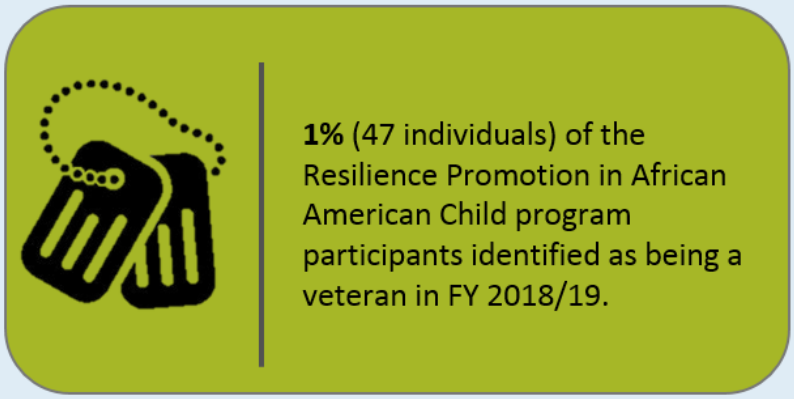
Primary Language:

In Fiscal Year 2018/19, the RPiAAC program had 47% of their participants report *English* as their primary language, 9% of the participants reported Spanish and 44% of the program participants selected *Other* or *Declined to Answer.* The *Other* category reported in the graph below represents the combined percentage for participants that selected *Other (42%)* or *Declined to Answer (2%)* on their demographic survey.



N = 4,671

Veteran Status:



N = 4,670

Success Story

"Kiara", an eight-year-old student participating in RPiAAC prevention activities, was referred to the RPiAAC counseling services due to a decline in her behavior. Kiara's parents had recently divorced. She was very close to her parents and struggled with the new visitation arrangement that was in place. Kiara's anxiety and sadness manifested through her behavior.

After a few counseling sessions, Kiara opened up about her sadness regarding her parents' divorce. She became willing to learn positive coping skills to deal with the anxiety and sadness she felt. Now, with her treatment plan completed, Kiara has learned that it is acceptable to talk about her feelings. She effectively communicates her feelings to her mother without whining and or acting out, and she is able to apply her newly learned coping skills whenever she feels sad or anxious.

Challenges

The RPiAAC program curriculum is integrated into San Bernardino County schools as an afterschool program and in some schools as a program that takes place during regular school hours. Presently, the program is challenged with retaining students' participation in the Peacemaker curriculum activities provided after school for the full term of the curriculum. This is often due to the program competing with other after school programs and or participants that do not want to stay after school.

Additionally, the program continues to struggle with obtaining buy-in from program participant parents as the attendance rate for the Effective Black Parenting course remains low. Parents often report they are unable to participate due to the time and location of classes.

Solutions in Progress

To address the challenge of retaining student participation in the Peacemakers curriculum, the RPiAAC providers are working collaboratively with school administration to determine and come to consensus on alternative ways to integrate the RPiAAC program into the school class schedule to maximize attendance for those participants that would most benefit from the services.

Historically, obtaining parent participation in the Effective Black Parenting workshops has been a challenge for the RPiAAC program. Many of the reported reasons for lack of attendance have been due to the time and location of workshops. To address this challenge, providers have started to offer the curriculum via a platform that allows parents to attend the workshops virtually. Additionally, providers have started to offer incentives to parents who start the Effective Black Parenting course and complete it.

Program Updates

The RPiAAC program has no program updates to report for Fiscal Year 2020/21.

Collaborative Partners

- Adelanto High School
- Barton Elementary
- Black Infant Program
- Blue Educational Foundation
- Bob Murphy Community Day School
- Cal State University, San Bernardino
- Carter High School
- Cedar Middle School
- Clay Counseling
- Columbia Middle School
- Eisenhower High School
- Frisbie Middle School
- High Desert Community Day School
- High Desert Premier Academy
- Hunt Elementary
- Lincoln Elementary
- Mesa Linda Middle School
- Mission Crest Elementary
- Oak Hills High School
- Rialto Middle School
- Richardson Prep Middle School
- San Bernardino Catholic Diocese
- San Bernardino City Unified School District
- San Bernardino High School
- San Bernardino Valley College
- Savant Preparatory Academy of Business
- Sierra High School
- University of California, Riverside
- Youth Action Project

Older Adult Community Services (OACS)

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

The program was designed to address key indicators that may lead to mental health concerns. In 2016, the California Mental Health Older Adult System of Care Project completed by UCLA Center for Health Policy Research identified that screening for the following indicators as critically important to older adults' mental health: depression, isolation, chronic physical health conditions, and lack of family support system. The OACS program uses individual suicide risk assessments, health screenings, assessment of close support and depression screenings during their program intake. Research indicates mental health concerns like depression and anxiety disorders are often unrecognized and undertreated in older adults. The detection and diagnosis of anxiety disorders in late life can be complicated by medical conditions, mental perception concerns, changes in life circumstances, and changes in the way older adults report anxiety symptoms.

In alignment with research, the OACS program prevention components include:

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

The program's early intervention services include mental health assessments and screenings, individual and group therapy, and case management. Early intervention services are intended to last less than 18 months, however can last up to four years depending on the client's individual needs.

MHSA Legislative Goals and Related Key Outcomes

Reduce stigma and discrimination associated with mental illness:

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

Improve timely access to services, for underserved populations:

- Increase extent to which individual or family from underserved population who need mental health services because of risk or presence of a mental illness receives appropriate services as early in onset as practicable.

Reduce prolonged suffering associated with untreated mental illness:

- Reduce risk factors
- Reduce indicators
- Increase protective factors that may lead to improved mental, emotional, and relational functioning.

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

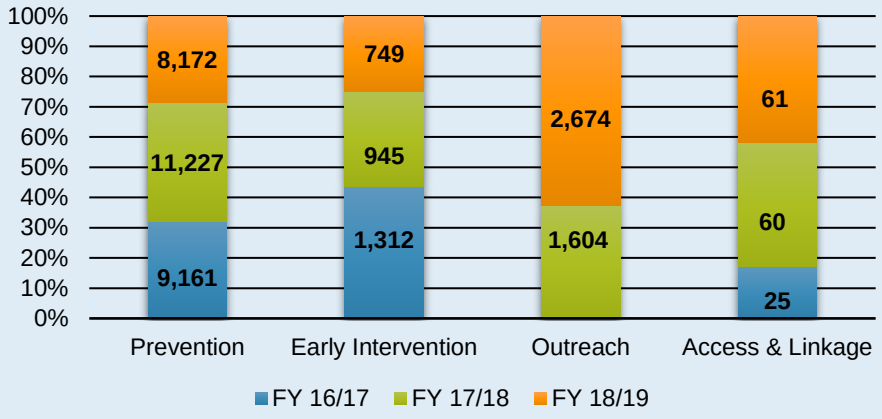
- Connect children, adults and seniors with severe mental illness and care as early in the onset of these conditions as practicable, to medically necessary care and treatment, including but not limited to, care provided by county mental health programs.

Positive Results

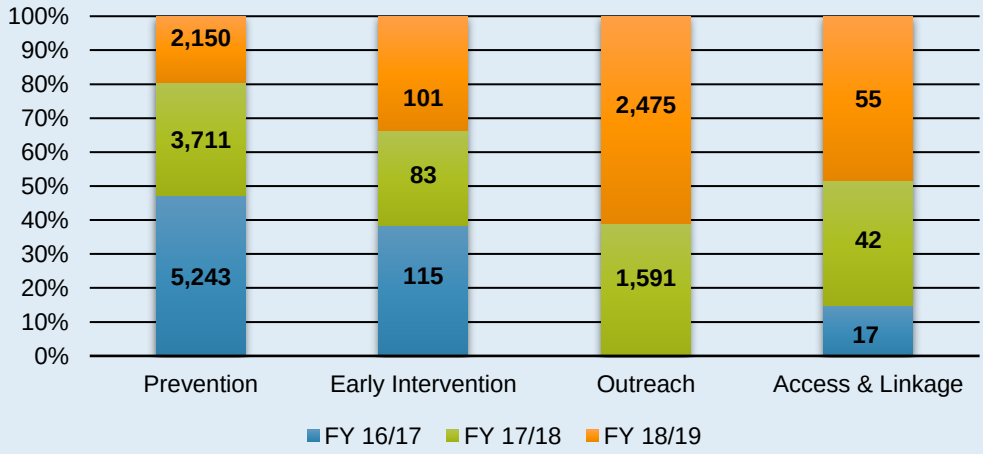
The OACS program contracts with four community based organizations and has a memorandum of understanding with the Department of Aging and Adult Services to provide services. Program providers are collectively contracted to serve 6,300 participants annually.

The following charts illustrate the number of participants served and the type of services provided according to the Prevention and Early Intervention State programs and strategies.

OACS Program Total Services



OACS Program Unduplicated Participants



Data collection and reporting methods changed from Fiscal Year 2016/17 to 2017/18. In Fiscal Year 2016/17, OACS providers were generally categorizing all of their services as Prevention or Early Intervention. In Fiscal Year 2017/18, we encouraged providers to separate their outreach services from prevention to better reflect the work that was done to help potential responders recognize the early signs and symptoms of mental illness. In Fiscal Year 2018/19, we received clarification regarding what constitutes a referral for Access and Linkage and emphasized that the referrals were for clients identified with a severe mental illness. The chart above reflects the trends for the changes in reporting requirements.

Total services provided by OACS followed the same trend as the unduplicated participants for reporting. Overall, the program has significantly increased its Outreach for recognizing the signs and symptoms of mental illness and Access and Linkage of participants with serious mental illness with higher levels of care.

Prevention Services:

The OACS program provides a wide range of prevention activities and services. The list below includes the Prevention activities that are available to OACS participants:

- **Monthly Craft Classes** - Craft activities are created by staff and volunteers to provide challenging tasks for the older adults which stimulate them both mentally and physically
- **Quarterly Luncheons** - Luncheons in which guest speakers provide educational presentations on Mental Health and Wellness topics
- **Life Skills Class** - Educating and empowering Older Adults with the knowledge needed to improve their sense of self-sufficiency and ability to ask for help
- **Fall Prevention/Home Safety** - Workshops offered throughout the County in order to assist Older Adults with home and personal safety to support independence.
- **Step Down Group** - Relapse Prevention for participants who have received or are receiving mental health services
- **safeTALK** - A half-day training program that teaches participants to recognize and engage persons who might be having thoughts of suicide and to connect them with community resources trained in suicide intervention. safeTALK stresses safety while challenging taboos that inhibit open talk about suicide. safeTALK is integrated in to the weekly group sessions.
- **PEARLS** - The Program to Encourage Active, Rewarding Lives (PEARLS) is a national evidenced-based program for late-life depression. PEARLS brings high quality mental health care into community-based settings that reach vulnerable adults. Six to eight week sessions that take place in the clients home and focus on brief behavioral health techniques.

The program utilizes a variety of activities based on the provider and geographic abilities. The following information provides data on the five regularly attended and offered activities across all providers.

The following prevention activities had 100% completion rates:

- Monthly craft classes
- Fall Prevention/Home Safety
- Transportation Reimbursement Escort Program (TREP)
- Nutrition classes
- Health clinics
- Wellness classes

Fall Prevention activity post survey results show that 87% of responders were likely to implement home safety practices before the Fall Prevention/Home Safety presentations. Wellness activity post survey results show that 65% of responders stated that they were more likely to participate in social or physical presentation.

Wellness presentation post survey results show that 81% of the participants surveyed felt that they developed a higher level of understanding about their chronic health condition after attending the clinic than before they attended.

Eighty-five percent of Mobile Outreach and Health Clinic participants surveyed stated that they had a better understanding of their health and how to access needed resourses for their health concerns.

The OACS program providers report that over the last three fiscal years, older adults are becoming increasingly aware of the services available to them and are successfully accessing needed services. Providers also report that participants are more comfortable with identifying serious mental health and medical concerns and more likely to seek mental and medical health services when they have a concern.

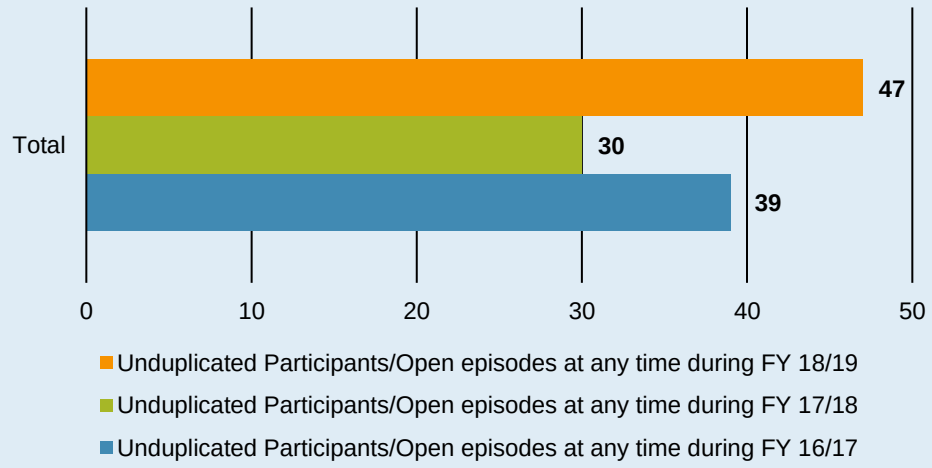
The older adults that have participated in the Nutrition and Wellness services have reported paying more attention to their diet and nutritional needs. They have also reported increasing their social activities and participating in wellness activities. OACS participants report finding support from their peers in the OACS social groups and enjoy spending time with each other and welcoming new participants.

I am able to walk longer periods of time and had no pain while doing so. – Walk with Ease participant

Early Intervention Services

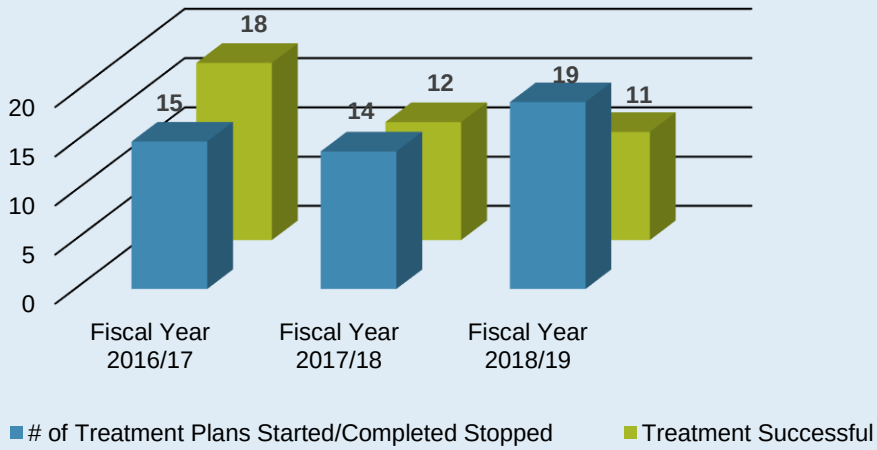
Early Intervention Services provided by the OACS program include, mental health screenings and assessments, individual and group therapy, and case management. The table below illustrates the Early Intervention unduplicated participants served per Fiscal Year.

NUMBER OF OPEN EPISODES BY FISCAL YEAR



The Early Intervention component has increased over the last three fiscal years. Most of the early intervention services provided by this program are to homebound seniors who need to have a therapist or case manager provide services in client's homes. In home services has helped to decrease the participant's feelings of isolation and has given them greater access to timely services.

SUCCESSFUL TREATMENT BY FISCAL YEAR AND NUMBER OF UNDUPLICATED PARTICIPANTS WHO STARTED A MENTAL HEALTH TREATMENT PLAN AND COMPLETED OR STOPPED PLAN BY FISCAL YEAR



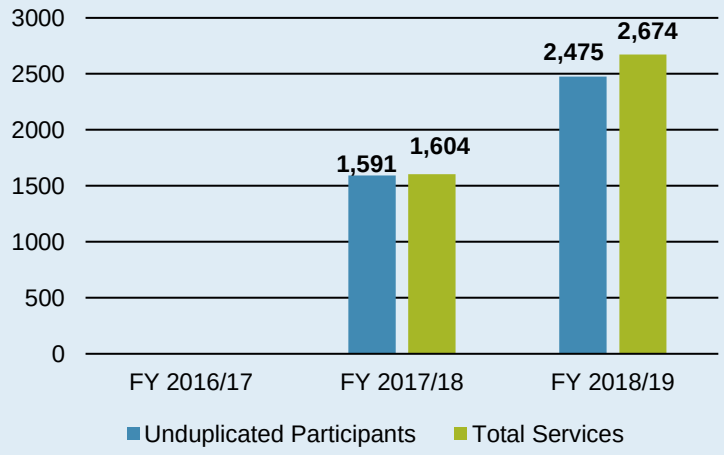
The above chart details the number of Early Intervention episodes that were opened and closed within each fiscal year and the number of successfully completed

treatments. The treatment successful count contains some episodes that may have been opened in a previous fiscal year. The majority of episodes open result participants meeting their treatment goals successfully.

Outreach for Increasing Recognition of Early Signs

OACS incorporates Outreach for increasing recognition of early signs and symptoms as a primary strategy within the Prevention program. In Fiscal Year 2016/17, OACS providers did not separately report their unduplicated participants and total services for Outreach services from their Prevention services. The table below shows that beginning in Fiscal Year 2017/18 OACS began separating their Outreach services and has a doubled the amount of Outreach provided in Fiscal Year 2018/19.

OLDER ADULT COMMUNITY SERVICES OUTREACH SERVICES



OACS program providers engaged with potential responders in the following settings:

- DBH Community Clubhouses
- Senior/Recreation Centers
- Churches
- Coffee Shops / Bakery
- Health & Wellness Fairs
- Community Festivals/Events
- Senior Housing/Apartments
- Community Based Organizations
- Physical Health Care Facilities
- Law Enforcement Facilities
- Government Service Offices
- Homeless Shelter/Camps

The following types of potential responders were engaged at the above settings:

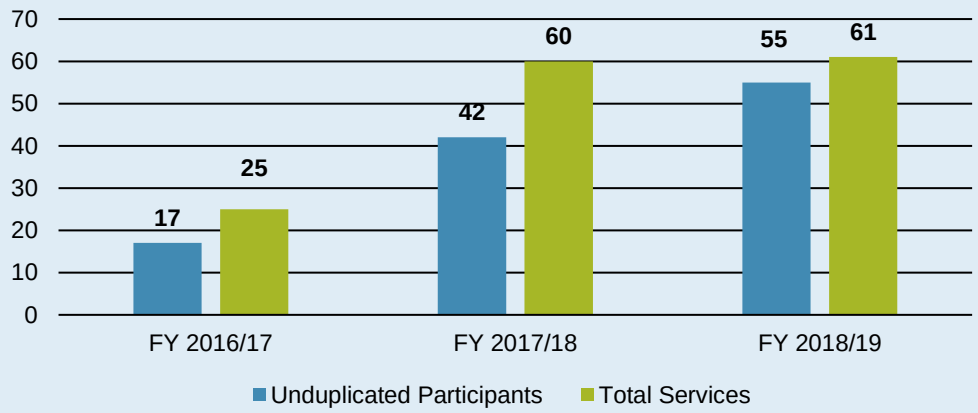
- Community members
- Law Enforcement staff
- Medical staff
- Religious leadership/staff
- Family Members
- Community Based Organization Staff
- Government service staff

Starting Fiscal Year 2019/20, a post survey will be distributed to responders to measure change in knowledge of mental health concerns and/or access to services.

Access and Linkage to Treatment

OACS providers use a variety of screenings and assessments to determine if a client has a serious mental illness and needs a higher level of care. The participants served and total services throughout the last three Fiscal Years are shown in the table below.

Older Adult Community Services Access and Linkage to Treatment Services

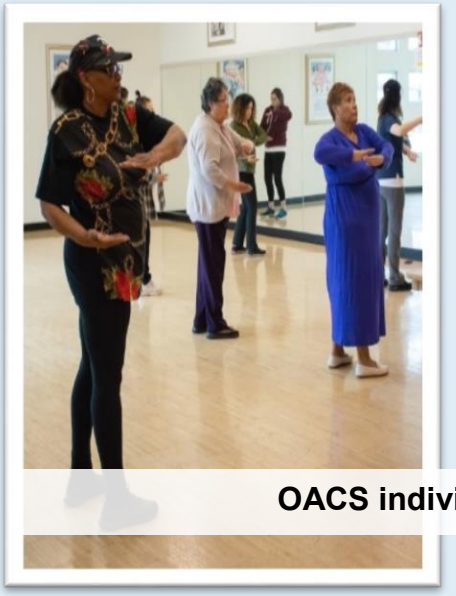


The PHQ-9, Becks Depression Inventory, and Geriatric Depression Scale are the most commonly used tools to assess a participants level of need for behavioral health intervention. If a participant is determined to have a serious mental illness and the symptoms are beyond the need that prevention and early intervention, services can provide, they are referred to higher levels of care.

OACS providers referred participants to mental health assessments, crisis stabilization, individual outpatient services, and psychotherapy groups.

The average number of days from the referral to the date engaged in treatment was four days for Fiscal Year 2018/19 and the standard deviation was two days. OACS program providers are trained to facilitate warm hand offs to the higher levels of care and follow up calls are made to the participants after their engagement to ensure that the referral was successful.

Overall the OACS program is successfully linking participants with the appropriate levels of care in a timely manner. The relationships and trust that the providers have with participants have lead to a reduction in prolonged suffering of untreated mental illness.



OACS individuals participating in Tai Chi

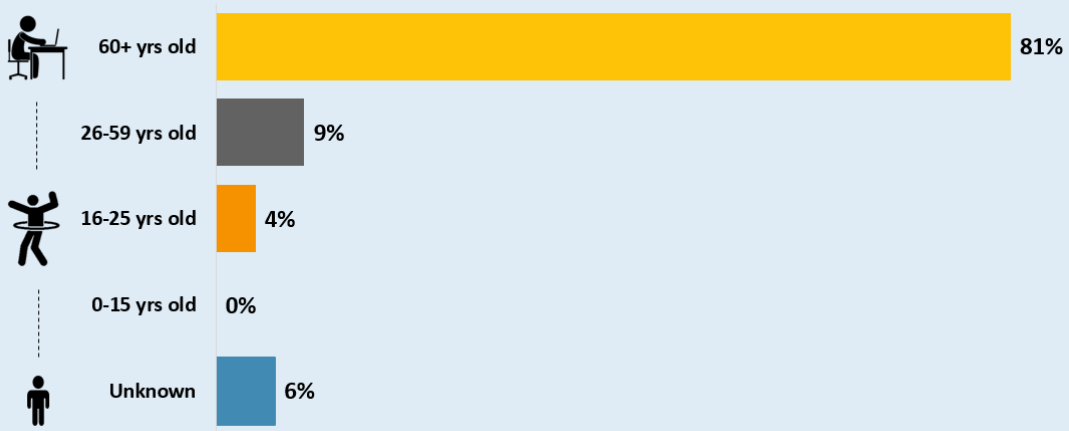
> *"The Tai Chi for Arthritis and Fall Prevention has helped me cope with stress and improved my mood."*
>
> *– Tai Chi participant*

Fiscal Year 2018/19 Program Demographics

The charts below illustrate the demographic information provided by the OACS program.

Age:

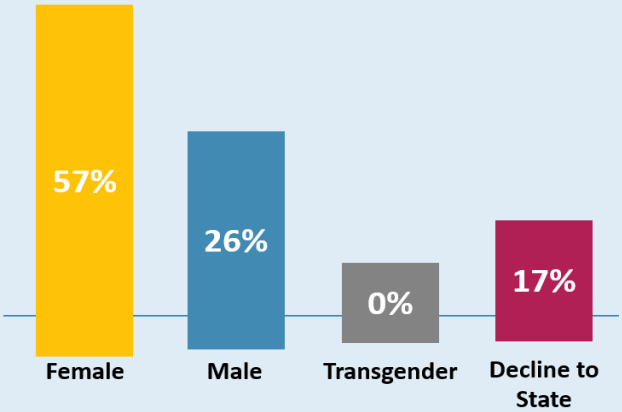
The graph below shows the age of participants in the OACS program for Fiscal Year 18/19. The program targets seniors ages 60 and above which make up 81% of the participants. The program also provides education and support services to family members and community members of whom 9% of participants were between the ages of 26-59 and 4% of participants were between the ages of 16-25. Six percent of participant ages were unknown or they declined to state.



N=4,394

Gender:

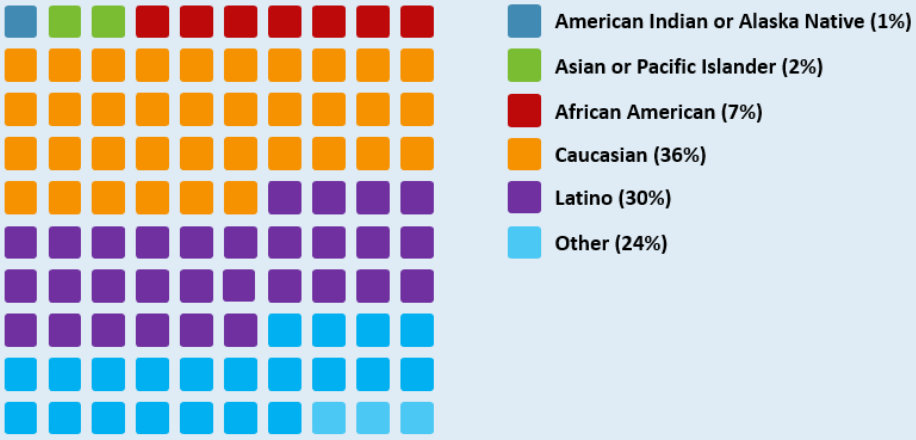
Females are the largest percentage of participants in the OACS program making up 57% of participants. 26% of participants identified as Male and 17% of participants declined to state their gender.



N= 4,592

Ethnicity and Ancestry:

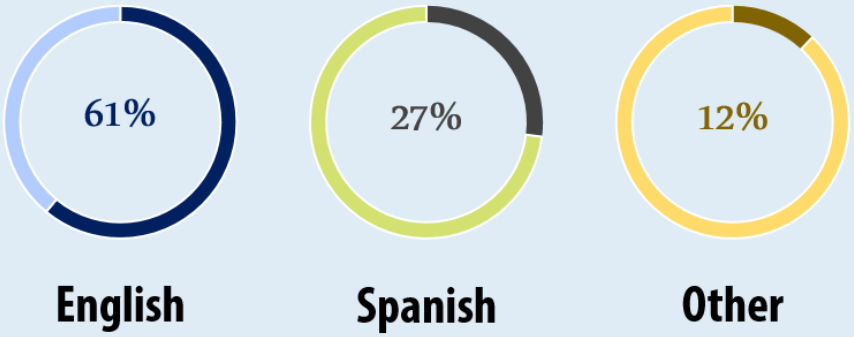
The graph below illustrates the various ethnicities of the OACS program. The majority of participants in the OACS program identified as Caucasian 36%, Latino 30% or Other 24%. The Other category can include those that identified as multiple ethnicities, other ethnicities not listed or they declined to state. Of the remaining participants, 7% identified African American, 2% Asian or Pacific Islander, and 1% American Indian or Alaskan Native.



N=5,232

Primary Language:

The OACS program strives to deliver services in the primary language that participants are most comfortable with. Most participants identified English as their primary language with 61%, next was Spanish with 27%, and 12% either selected another language or declined to state.



N=4,499

Veterans Status:

A total of 1% of the OACS program participants identified as veterans.

1% (58 individuals) of the Older Adult Community Services program population in San Bernardino County identified as being a veteran.

N=4,414

Success Story

An 80 year old participant regularly attended the Tai Chi classes to improve her balance and prevent potential falls. She was very self-conscious because she had poor balance and needed a cane to help her walk. The dependence on the cane caused her to avoid community outings which led to her feelings of depression and loneliness. After attending a few classes, she stated that the Tai Chi classes have improved her balance tremendously and have also assisted her with breathing and stress reduction. She said she is becoming more comfortable walking and no longer worried about falling. She also said that she has an improved confidence about herself in the community and feels her posture is more upright. Practicing Tai Chi in the OACS fitness program has improved her physical health and has improved her mental health. She states she is active in the community and is no longer experiencing depression or loneliness.

Program Challenges

Reoccurring challenges for the Older Adult population continues to be transportation, harsh weather conditions, financial stability, and the stigma of seeking/receiving mental health services.

Program Solutions

The OACS program providers are continually looking for partners to address the transportation needs of their participants. In Fiscal Year 2018/19, providers worked with OmniTrans, Mountain Transit, Dial-A-Ride, Go Go Grandparent and Transportation Reimbursement Escort Program (TREP) to assist with their transportation needs. Additional affordable resources, including those that can make accommodations for wheelchairs, are being researched for participants that have out-of-county appointments.

Harsh weather conditions are a difficult challenge but OACS providers have taken on the challenge by increasing the frequency and types of services that they can deliver to clients' homes, increasing the number of check-in calls, and providing participants with resources and trainings on what they can do and who they should contact in emergency situations where harsh weather conditions are a factor in accessing needed services.

OACS providers address participant's financial stability with offering financial literacy for senior classes, how to identify and report scams that are targeting seniors, and providing information and access to resources that are free or no cost.

OACS providers are finding success with the group luncheons, group arts and crafts and group fitness activities. These activities engage participants in a comfortable, welcoming, and fun way. Participating in these activities encourages participants to discuss a variety physical and mental health topics in a non-stigmatizing way and receive critical information on how to identify issues and appropriately respond to concerns.

Program Updates

There are no program updates for Fiscal Year 2020/21.

Collaborative Partners

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

Lift Program

The Lift Program is a Prevention program that is a result of a collaborative effort between the Department of Behavioral Health and the Preschool Services Department. It helps to improve the health, well-being and self-sufficiency of first-time pregnant and parenting mothers, their children, and their families. Services are delivered in the individual's home where nurses provide an educational service to promote the physical and emotional care of newborn children.

In home services encourages the mother to engage in preventative care for the healthy development of the infant/toddler.

Services offered include:

- Parent education and support
- Post Natal Depression screenings
- Nurturing activities to increase maternal attachment
- Developmental milestones education
- Life and employment skill development
- Substance use/abuse counseling
- Community referrals

The Lift Program encourages the involvement of family members, caretakers, and friends and promotes positive family relationships. Nurses provide linkage services to family members needing physical and mental health services.

Artwork by Erika Montesinos

MHSA Legislative Goals and Related Key Outcomes

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

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

Improve Timely Access to Services:

- Increase the 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 the onset as practicable.

Reduce prolonged suffering associated with untreated mental illness:

- Reduce risk factors
- Reduce indicators
- Increase protective factors that may lead to improved mental, emotional, and relational functioning.

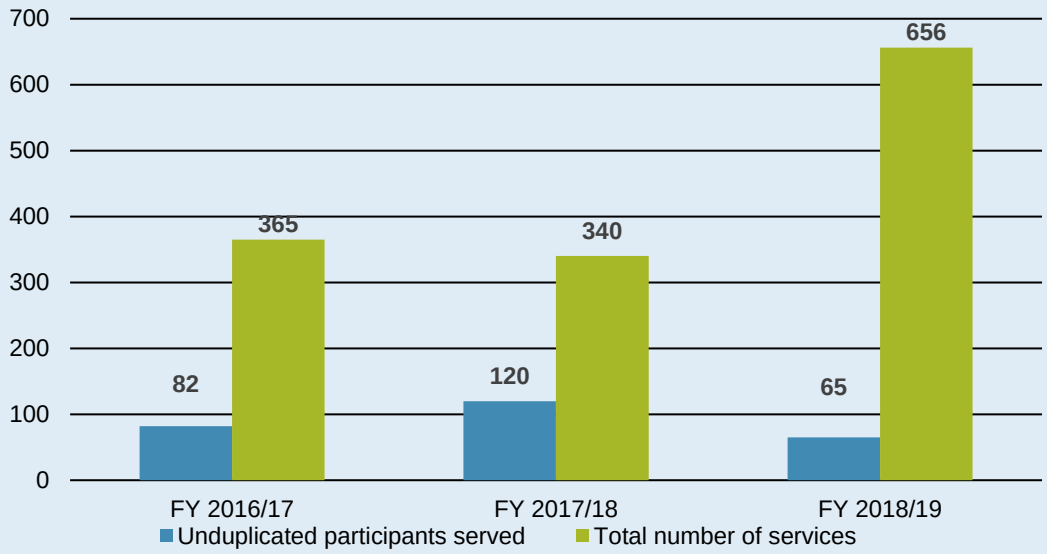
Reduce stigma and discrimination associated with mental illness:

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

Positive Results

The Preschool Services Department is the sole provider for the Lift program. Each year the program seeks to serve a minimum of 120 participants. The chart below illustrates the total number of participants served during Fiscal Years 2016/17, 2017/18, and 2018/19.

TOTAL UNDUPLICATED PARTICIPANTS AND TOTAL NUMBER OF SERVICES FOR FISCAL YEARS 2016/17, 2017/18, AND 2018/19



Prevention Services

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

The five tools and assessments used are:

- Maternal Fetal Attachment Scale
- Edinburgh Postnatal Depression Scale
- Life Skills Progression
- Fagerstrom Test for Nicotine Dependency
- High School Diploma / GED Completion

These screenings are typically done in a survey or conversation format. Lift nurses introduce referrals to partner agencies specializing in supportive services in these particular areas. These services help to increase protective factors by providing concrete support in challenging times by providing participants with specific information related to their individualized needs. This also enhances feelings of social connections,

as Lift nurses provide non-judgmental support and reassurance. As a result of the early screening and identification, participants increase their knowledge of parenting and child development as they explore the impact of smoking, attachment, and depression on the mother-child bond and the developing child.

Maternal Fetal Attachment Scale

The Maternal Fetal Attachment Scale is a tool determines the bond that expectant mothers develop with their unborn child. Higher scores represent higher levels of prenatal attachment. All sixty-five participants in the Lift program completed the Maternal Fetal Attachment Scale, which were then evaluated to determine individualized needs.

Lift nurses work with mothers participating in the program to increase attachment by providing individualized support in key areas identified with the Maternal Fetal Attachment Scale. Support includes education, positive nurturing activities, and family counseling resulting in more positive nurturing relationships.

Identifying and addressing early indicators of maternal fetal attachment increases the mother's protective factors by promoting positive attachment and early bonding with her child. This increases positive parent-child relationships, fostering social support, building self-esteem, and offering empowerment within the community.

Edinburgh Postnatal Depression Scale

Lift utilizes the Edinburgh Postnatal Depression Scale to identify participants that are at risk for perinatal depression. This is a 10-question, self-rated scale, using a point system ranging from zero to three points per question. It is based on a maximum score of 30. Scores ranging from 15 to 30 points signify a high likelihood of participants experiencing clinical depression. If a participating mother is identified as experiencing possible depression, a referral is generated and a Marriage and Family Therapist (MFT) is assigned to collaboratively work with the participant and nurse in order to provide the necessary resources and services.

In Fiscal Year 2018/19, two of the participants scored above 15 points, indicating a higher likelihood of the mother experiencing clinical depression. As a result, these two mothers received joint home visits from a team consisting of Lift nurses, and MFT intern, and a social worker. Both mothers received therapy and showed signs of improvement. The other 63 participants scored below 15 points, indicating a lower likelihood of the mother experiencing clinical depression. These mothers also received home visits from Lift nurses and MFT interns to help support their mental health, but

they did not require therapeutic intervention. All 65 mothers improved their scores during the course of participation in the Lift program.

Identifying and addressing possible signs of postnatal depression increases protective factors by fostering social support, encouraging skills for coping with stress and adversity, building self-esteem, offering empowerment within the community, and promoting positive attachment and early bonding with children.

Fagerstrom Test for Nicotine Dependency

The Lift Program uses the Fagerstrom Test for Nicotine Dependency to identify and reduce nicotine dependency of participating mothers. Risk factors associated with neurochemical imbalance and substance use/reliance are reduced by reducing nicotine dependency.

The Fagerstrom Test for Nicotine Dependence is a standard instrument that assesses the intensity of physical addiction to nicotine. The test is based on a 10 point system where scores of four or greater indicate a nicotine dependence and scores of six or greater indicate a severe nicotine dependence.

Eight mothers were smokers at the beginning of receiving Lift services and four of the mothers began working with their doctors for smoking cessation services.

Life Skills Progression

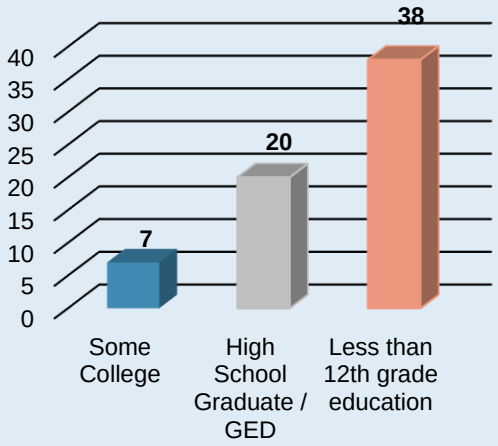
The Life Skill Progression tool demonstrates a portrait of the behaviors, attitudes, and skills of both parents and children. It helps to establish a baseline of participant profile and identifies their strengths and needs and plans for interventions and monitors outcomes to show that interventions are working.

The Life Skills Progression tool is based on a zero to five point scoring system, measuring 35 parental life skills across five areas:

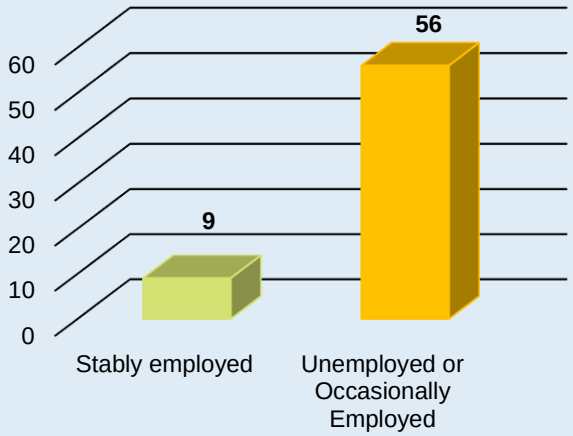
- Relationships
- Education and employment
- Parent & child health
- Mental health & substance use
- Basic essentials

The charts below illustrate the levels of education and levels of employment for the participants in the Lift program.

PARTICIPANT EDUCATION LEVEL



PARTICIPANT EMPLOYMENT LEVEL



Of the 65 participants in Fiscal Year 2018/19, seven mothers had completed some college, 20 had completed high school or obtained a GED certificate, and 38 had less than a 12th grade education. Correspondingly, nine mothers reported having stable employment with adequate salary and benefits, while 56 mothers reported being unemployed or working only occasionally. Families obtaining stable employment reduces risk factors by helping with self-esteem, self-efficacy, and economic security.

High School Completion / GED Certificate Programs

The Lift Program supports pregnant moms in earning their high school diploma through either the Career Online High School (COHS) program or through the GED Certificate program. Lift nurses provide referrals to the COHS or GED programs. They also help participants obtain library cards to support internet access and provide encouragement during their journey towards completing their diploma and moving forward on their path towards family self-sufficiency.

Completing high school and earning a high school diploma decreases risk factors and increases protective factors such as increasing empowerment, opportunity, and feelings of mastery and control as well as increasing self-esteem through accomplishment. Of the 65 participants served in Fiscal Year 2018/19, 38 of the participants had less than a 12th grade education and were offered referrals and support towards earning a high school diploma or GED certificate. Ten of the participants went back to school to obtain their high school diploma or GED. Seven of the ten participants finished their curriculum and received their high school diploma or GED. The remaining three participants are continuing to work towards completion.

Fiscal Year 2018/19 Program Demographics

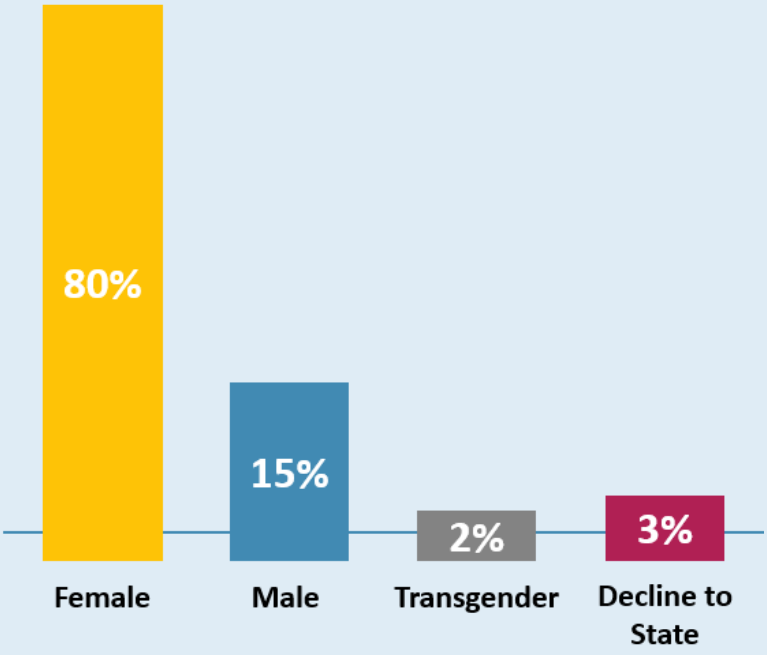
Age:

The graph below illustrates the ages of the families that participate in the Lift program. The majority of participants served, 41%, were between the ages of 0-15 years old. Thirty-one percent (31%) of participants were between the ages of 26-59 years old, and the TAY group, 16-25 years old, made up the remaining 28%.

N = 65

Gender:

The graph below demonstrates that 80% of the Lift participant population identified as female, 15% identified as male, 2% as transgender, and 3% declined to state.

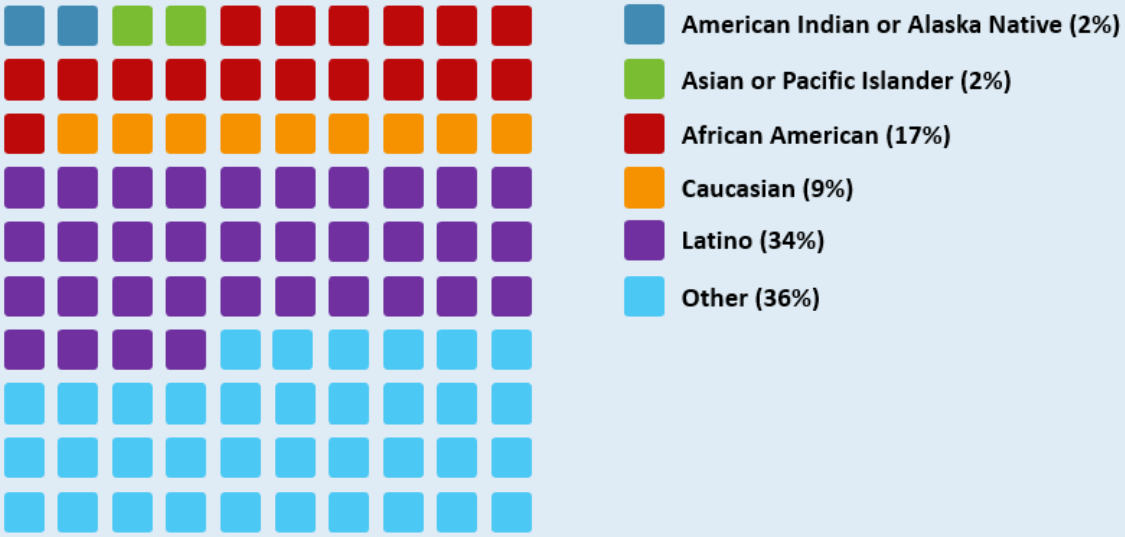


N = 65

PEI: PREVENTION

Ethnicity and Ancestry:

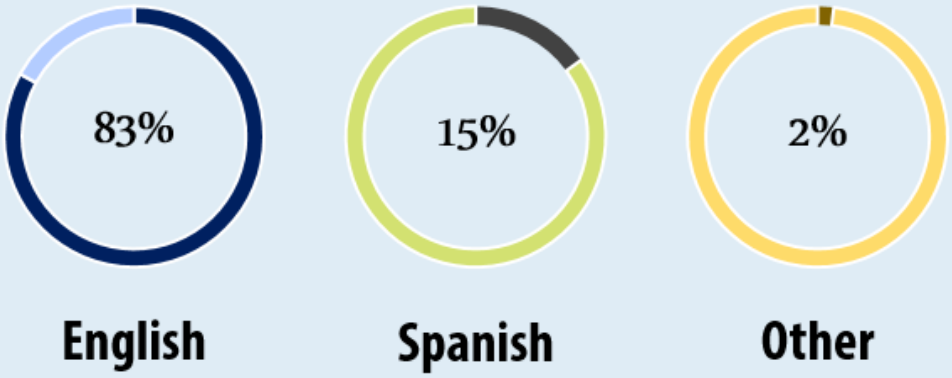
The graph below illustrates the various ethnicities of participants of the Lift program. The largest group was 36% in the category Other. This category includes those who identified as other, more than one race, or declined to answer. The second largest group identifies as Latino at 34%. There were 17% of participants who identified as African American, 9% Caucasian category, 2% American Indian or Alaska Native, and 2% Asian or Pacific Islander.



N = 65

Primary Language:

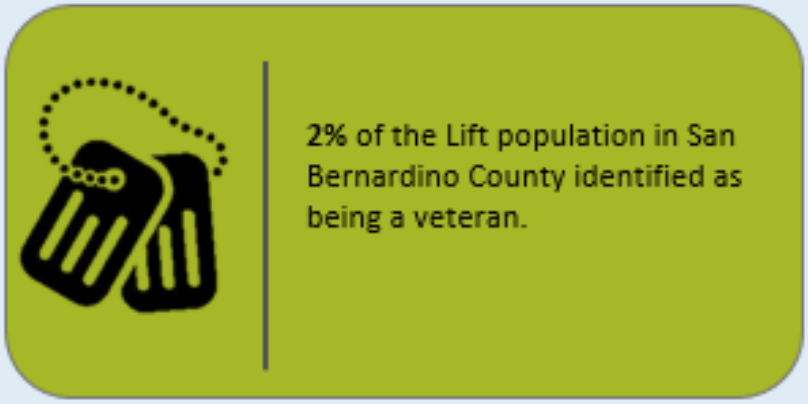
The graph below demonstrates that 83% of the Lift program participants identified English as their primary language, while 15% identified Spanish, and 2% identified a different language as their primary language.



N = 65

Veterans Status:

Of the Lift program participants, 2% identified as being veterans.



N = 65

Program Challenges

Maintaining a full staff of three full time Registered Nurses continues to be a challenge. In the nursing field, colleges have experienced a shortage of Registered Nurses choosing to be in the field of nursing. This shortage continues to make it difficult to recruit, hire, and retain Registered Nurses.

Program Solutions

The program has collaborated with Westcoast Nursing School to place job announcements in the forefront. The program has also connected with local colleges to advertise job openings and has teamed with the Department of Public Health to keep abreast of all of the changes in the field and to collaborate on efforts to employ Registered Nurses.

Program Updates

There are no planned program updates at this time.

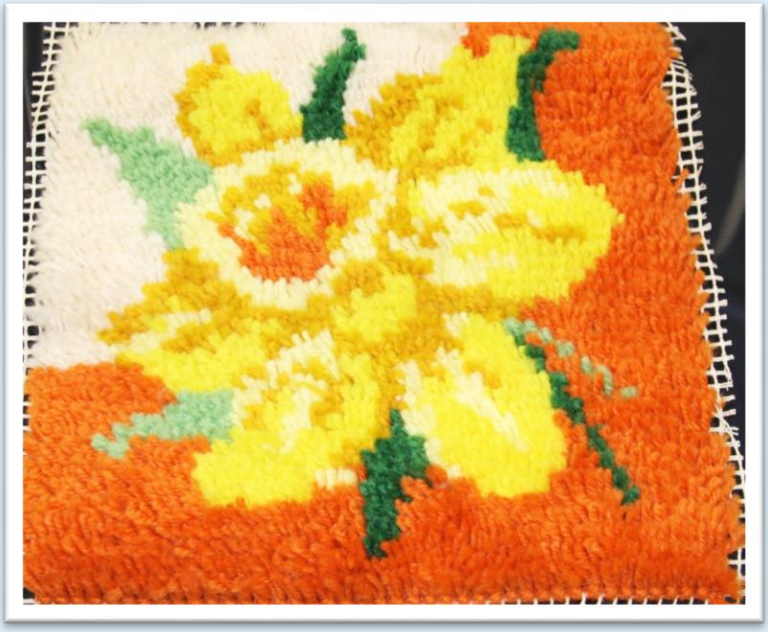
Success Story

"Sabrina" is a young woman who found out she was pregnant when she was 19. She has a history of familial neglect, substance use, and did not complete high school. Upon entering into the Lift program, she was adamant about not breastfeeding and struggled with creating a bond with her child.

As a result of the Lift Program, Sabrina is enrolled in a GED program and has received several awards for her accomplishments and her commitment to excel. Due to the education she received through the Lift program, Sabrina has decided to exclusively breastfeed her newborn child and has shared that she uses the time as her bonding time with her son. She has used the positive mentorship services she has received through the Lift program to increase her self-confidence and to create a safe environment for herself and her child. Sabrina is enrolled in parenting classes and expresses an interest to change the legacy of her family. She is committed to improving her life, her son's life, and is determined to succeed. Sabrina has emerged as a leader and has begun to change the trajectory of her family for generations to come.

Collaborative Partners

- Arrowhead Regional Medical Center
- County Homes Coalition
- Children and Family Services (CFS)
- Department of Family Social Service,
- First Step Recovery
- Planned Parenthood
- Salvation Army
- Samaritan Helping Hands
- San Bernardino County Black Infant Health Program
- San Bernardino County Probation Department, Juvenile Services
- Victor Community Support Services
- Women, Infant, and Children (WIC) Program



Artwork by Chuck Ayala

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

San Bernardino County's Coalition Against Sexual Exploitation (CASE) is a union of public and private agencies with a shared purpose to pool resources to fight the commercial sexual exploitation of children. CASE partner agencies combine their resources in the County to educate the community and protect, intervene, and treat children and youth that are victims of commercial sexual exploitation.

CASE provides direct services to those who have been identified as Commercially Sexually Exploited Children, also known as CSEC. Direct services are provided by a multidisciplinary team which consists of 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.

Artwork by Jeweleanna Carmichael

The CASE program provides the following direct services:

- Mental health assessments
- Crisis intervention
- Case management including linkage and referrals
- School enrollment assistance
- Therapeutic interventions
- Transportation assistance
- Advocacy and mentorship
- Tattoo removal
- Clothing assistance
- Placement/relocation assistance

The indirect services provided by CASE include educational trainings, presentations and networking. The goals of the indirect services are to teach potential responders how to identify, protect, and intervene and engage with CSEC youth.

MHSA Legislative Goals and Related Key Outcomes

Reduce stigma and discrimination associated with mental illness:

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

Improve timely access to services for underserved populations:

- Increase extent to which an individual or family from an underserved population who needs Mental Health services because of risk or presence of a mental illness receives appropriate services as early in onset as practicable.

Reduced prolonged suffering associated with untreated mental illness:

- Reduce Risk factors.
- Reduce Indicators.
- Increase protective factors that may lead to improved mental, emotional, and relational functioning.

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

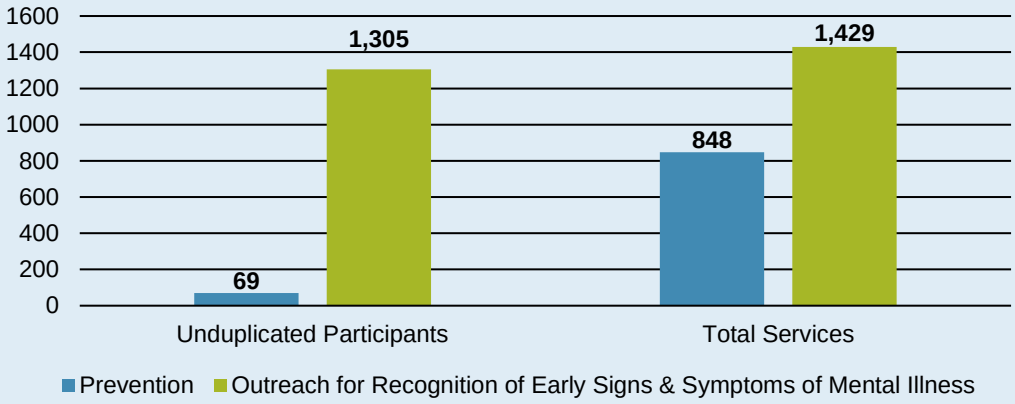
- Connect children, adults and seniors with severe mental illness and care as early in the onset of these conditions as practicable, to medically necessary care and treatment, including but not limited to, care provided by county mental health programs.

Positive Results

CASE served a total of 69 unduplicated participants and provided 848 total direct services. The CASE team participated in several resource fairs, hosted trainings and facilitated trainings with partnering agencies. CASE was able to reach 1,429 potential responders (i.e., family members, primary health care providers, nurses, school personnel, etc.) and prepare them with the tools needed to identify and respond.

Prevention Services:

CASE Unduplicated Participants and Total Services for Fiscal Year 2018/19



CASE used Multidisciplinary Collaboration and Trauma Resiliency and Harm Reduction models for effective methods in Fiscal Year 2018/19.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA, 2018), a trauma-informed approach reflects adherence to six (6) key principles rather than a prescribed set of practices or procedures. All members of the CASE multidisciplinary team (MDT) are trained to provide trauma informed care. These principles include:

1. Safety
2. Trustworthiness and transparency
3. Peer support
4. Collaboration and mutuality
5. Empowerment, voice, and choice
6. Cultural, historical, and gender issues

People who have been traumatized need support and understanding from those around them. It is critical to promote the concepts of resilience, survival, and empowerment in those individuals and families impacted by trauma.

Often, trauma survivors can be re-traumatized by well-meaning caregivers and community services providers. Re-traumatization is what happens when a person that has suffered trauma is exposed to people, incidents, discussions, or environments that cause them to relive the harmful experience almost as if it were occurring again.

Members of the CASE MDT are trained to discover the relation between the traumatic experiences and behaviors that the youth are displaying and relay the information with other service providers and/or caretakers that interact with the youth. Some common symptoms of trauma that the CSEC youth experience are anxiety, stress, avoidance, isolation, withdrawal, substance abuse, eating disorders, and depression.

The trauma-informed approach has changed some of the program interviewing practices when dealing with CSEC youth. When a CSEC victim is identified, they are quickly paired with an experienced interviewer that will be able to obtain the necessary information needed for law enforcement, children and family services, medical, and mental health treatment services. This change reduces the risk of having the youth re-traumatized from sharing their experiences to multiple agencies asking similar questions of the youth multiple times within a short timeframe.

CASE identified CSEC youth are introduced to a mentor that preferably has lived experience. They help them navigate the various governmental and legal systems as well as help them build resilience and survival skills that empower them to succeed. CASE providers have found that adding mentors to the MDT meetings have positively impacted their ability to stay updated with the youth's whereabouts and have created positive healthy bonds with adults other than their perpetrators.

CASE Prevention services consist of:

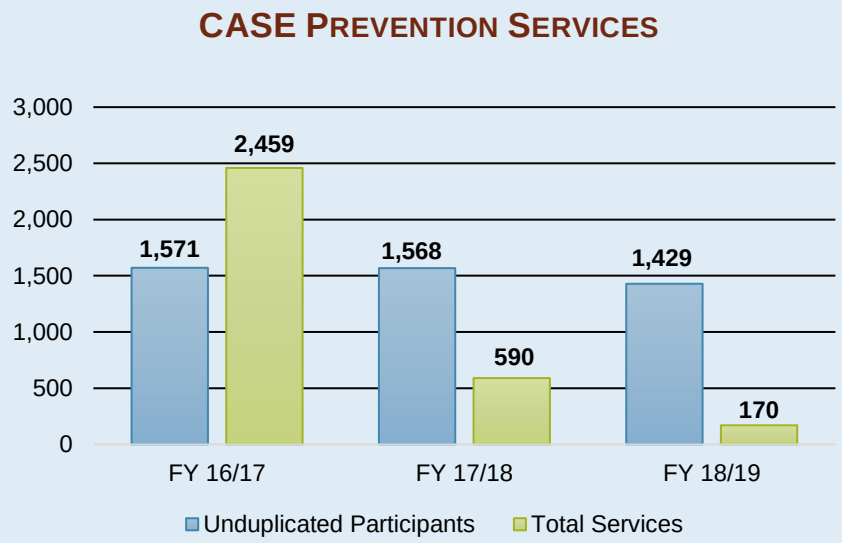
- Placement assistance, advocacy, safety planning and CASE Youth Resource cards to help reduce the risk factors for homeless/runaway youth.
- Support, consultations, and advocacy from the San Bernardino Superintendent of Schools, Probation, and the District Attorney's office to help reduce risk factors 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.
- Assignment of an Alcohol and Drug Counselor and/or Behavioral Health referral are services provided to youth identified as having a substance use disorder and assist them in creating a recovery plan.
- Mentor assignment, SafeTalk and ASIST trained staff, Girls Court, and Behavioral Health referrals help reduce risk factors for youth that have low self-esteem, at risk of suicide and/or need additional emotional support.
- Safety plans, placement assistance, therapy, mentorship, and advocacy are services used to help address the risk factors faced by LGBTQ youth.

- Placement assistance, clothing, transportation vouchers, and referrals for Transitional Assistance Department (TAD) services are provided to address the youth risk factors of poverty and lack of consistent access to basic needs (food, clothing, and shelter).

All of the services listed are coordinated in the MDT meetings with all servicing agencies represented to increase the appropriateness and timeliness of services. The prevention program services described above also contribute to reducing the following negative outcomes associated with untreated mental illness:

- Suicide
- Incarcerations
- School failure or dropout
- Unemployment
- Prolonged suffering
- Homelessness
- Removal of children from their homes

The following chart illustrates the unduplicated participant and total services counts by fiscal year.



The above chart shows a progressive decrease in unduplicated participants and total services. Youth assigned to the CASE program are currently assigned to a social worker in one of the following departments, Children and Family Services (CFS), Probation, or Public Defender. Each worker has a capacity to handle a maximum caseload of 20 youth at one time. In Fiscal Year 2017/18, the primary worker for CASE from CFS left. During this timeframe, CFS also transitioned to a regional worker system where one worker per region was designated as a CASE worker but were not solely assigned CASE participants. The overall capacity to service youth from CFS decreased because instead of one worker solely assigned up to 20 CSEC youth, three workers are assigned three to four CSEC youth due to their mixed caseloads.

CFS is still recruiting for a worker in one of the regions.

The CASE participant list as of June 2019 includes: 36 Active (two males), eight with unknown whereabouts, six out-of-state placement, and four in-custody.

There were 74 inactive participants at the end of Fiscal Year 2018/19. Participants are placed on the inactive list if they have been on a runaway status for over three months, or due to capacity issues.

Early Intervention Services

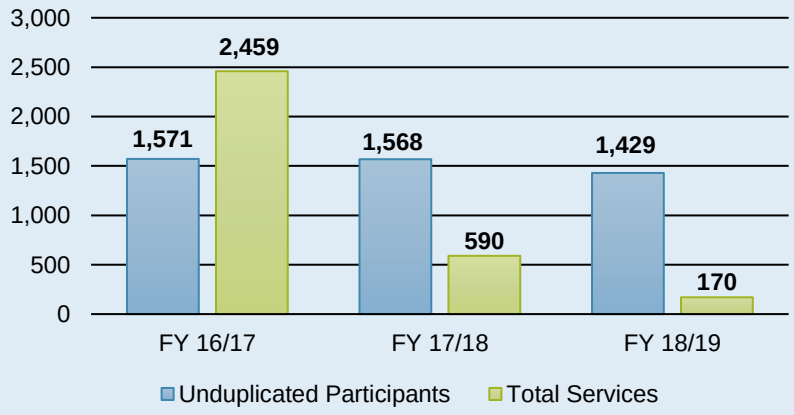
CASE, as a program, does not provide Early Intervention services, at this time, however the behavioral health representative on the CASE MDT screens the need for mental health services and ensures that CASE participants receive the appropriate level of mental health services.

Outreach for Increasing Recognition of Early Signs

CASE provides free community CSEC awareness, identification, and assessment trainings throughout the County of San Bernardino. The program also specifically targets training to key service providers and professionals that are most likely to interact with CSEC youth such as law enforcement, school faculty and administrators, medical health professionals, foster care, and group home staff. CASE provides access and referral information for CSEC victims upon request at child and youth related conferences, community events, staff meetings, and resource fairs. The program hosts an annual CASE Walk in January for National Human Trafficking awareness month and attracts between 200-500 participants annually.

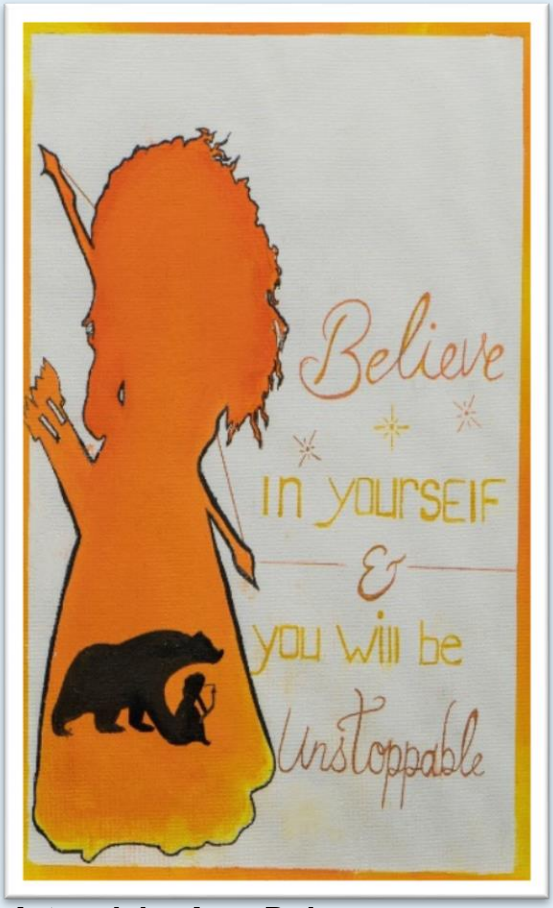
The following table provides an overview of CASE Outreach services.

CASE OUTREACH SERVICES



PEI: PREVENTION

In Fiscal Year 2018/19, CASE hosted 25 trainings, participated in 14 community resource fairs, provided training at the Sheriff's academy four times and conducted ten trainings at the Department of Behavioral Health. They also hosted an annual CASE Walk, sponsored The Apathy Effect Exhibit at Cal State University San Bernardino, and participated in multiple Human Trafficking Awareness Week workshops and activities. CASE recognizes that creating awareness with the general public, first responders, and direct service providers is vital to assist with identification and appropriate service delivery to the CSEC population. This year, CASE was able to successfully engage 247 law enforcement personnel and 951 community service providers. These responders were taught the common warning signs, tattoos/branding, and the complexity of the relationship between the victims and their traffickers.



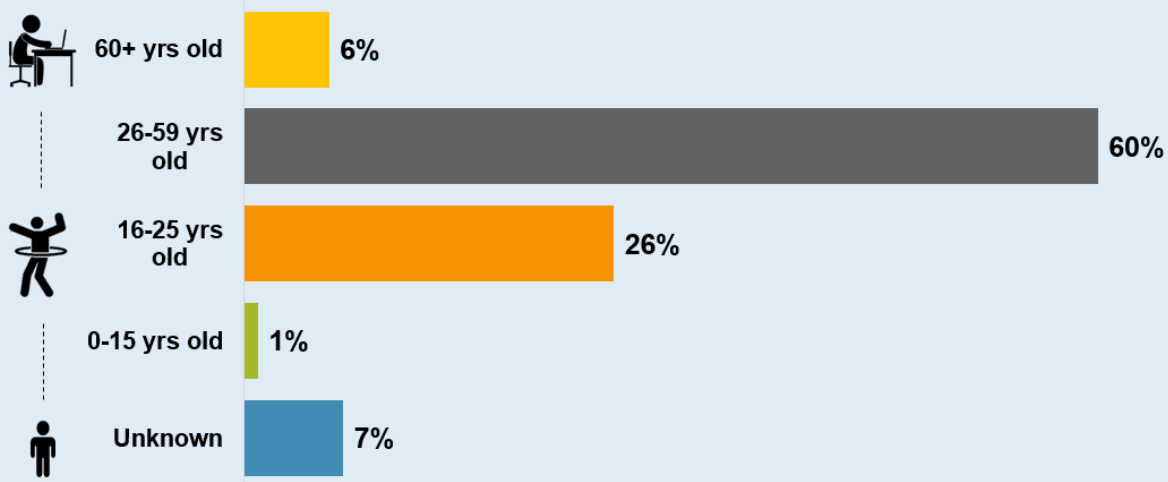
Artwork by Amy Bojorquez

Fiscal Year 2018/19 Program Demographics

The following charts illustrate the demographic information received from the CASE program.

Age:

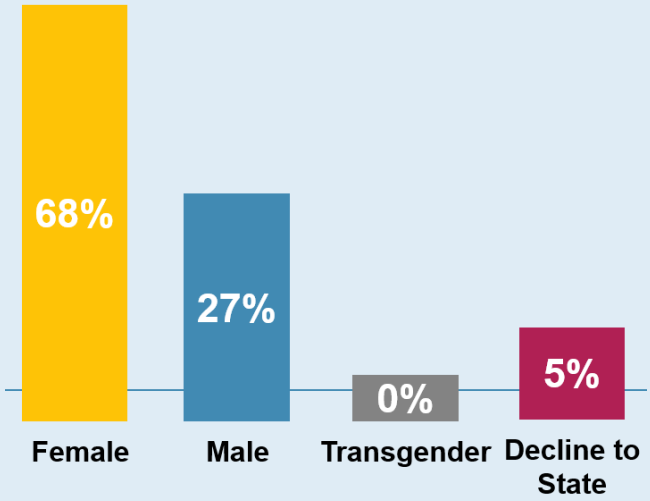
The graph below represents the ages of CASE youth participants as well as the ages of the potential responders reached through CASE outreach services. The majority of potential responders were ages 26-59 years old averaging 60%. The majority of CASE participants were between the ages of 16-25 averaging 26%. There were 6% of respondents that were 60+ years old, 1% were 0-15 years and 7% were unknown.



N= 2,557

Gender:

The majority of CASE participants were female as illustrated below with 68%. Twenty-six percent of participants identified as male and 5% declined to state.

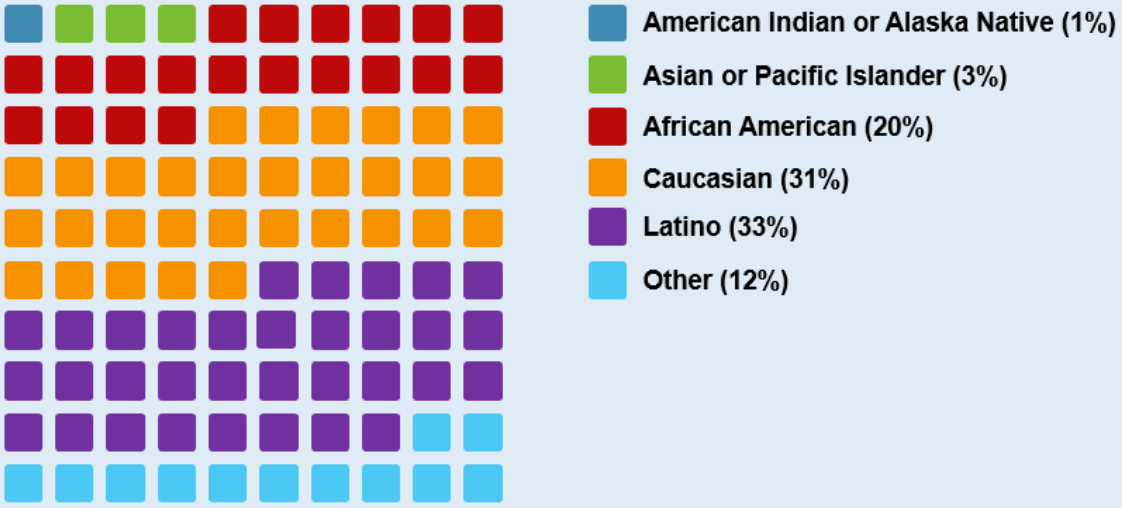


N= 2,480

PEI: PREVENTION

Ethnicity and Ancestry:

The chart below illustrates the diversity among the CASE participants. Thirty-three percent of participants identified as Latino, 31% identified as Caucasian, 20% identified as African American, 3% identified as Asian or Pacific Islander, 1% as American Indian or Alaskan Native and 12% identified as either multiple ethnicities, other ethnicity not stated or declined to answer.



N = 2,105

Primary Language:

Ninety-two percent of CASE participants identified English as their primary language. 8% declined to answer or stated another language not listed.

N= 2,527

Success Story

"Jordan" and two siblings were known to the Department of Children and Family Services (CFS) and placed in foster care for a couple of years before they were referred to CASE. Jordan had been in over a dozen of foster care placements, shelters, and group homes. She was aggressive towards staff and peers. She struggled with substance use and participated in sexual exploitation.

Jordan's parents were unable to provide adequate protection. After unsuccessful reunification, Jordan was assigned a Court Appointed Special Advocate (CASA) for mentoring and placement assitance and referred to CASE.

The CASE team was able to effectively collabrate with CFS, an advocate, and Jordans attorney to provide the services needed to support Jordan towards recovery and resiliency. Jordan is now placed in a supportive family environment where she is no longer running away. She is attending school regularly, in recovery from substance use disorder, and bonding with parental figures. Jordan is looking forward to graduating from high school and is setting an example of positive lifestyle changes for her peers. Throughout the process, Jordan is gaining trust in governmental systems and more likely to ask for support when needed.

Program Challenges

CASE participants require intensive specialized treatment and interventions to meet their various needs. Finding placements that are safe and staffed with CSEC skilled service providers continues to be a challenge within San Bernardino County.

In addition, it has been difficult to identify youth who are at risk or are currently a victim of sexual exploitation. Youth enter systems from various access points and there is not a standardized CSEC screening toll utilized.

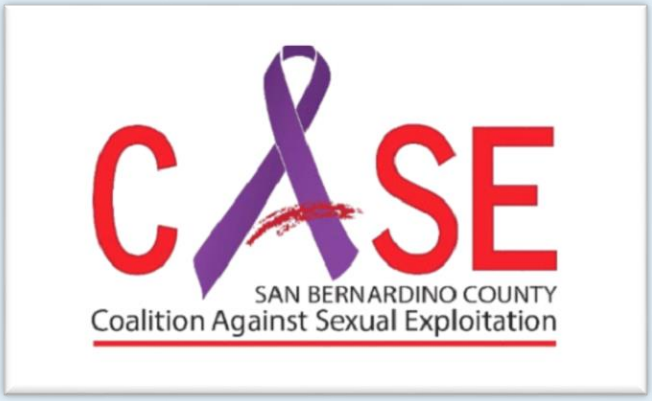
Another major challenge to the program is the high demand and lucrative nature of the business of trafficking minors.

Program Solutions

CASE continues to collaborate with other county agencies, such as, Probation and CFS to provide training and resources to placement families and group homes to house CSEC youth.

CASE recently identified a universal CSEC screening tool that will be implemented during FY 20/21 and each participating department is in the process of identifying how it will be implemented in their system. In addition, Behavioral Health will be modifying their San Bernardino Child and Adeloscent Needs and Strengths (CANS) assessment to create a Sexual Exploitation module. The CANS is a multi-purpose tool that was created to identify immediate treatment needs and allows for the monitoring of outcomes. These tools will aid in the identification of CSEC youth and increase the number of CSEC youth receiving treatment.

CASE continues to outreach to the community regarding Human Trafficking awareness and resources. CASE is also working closely with victims, the District Attorney and law enforcement to identify and prosecute the perpetrators.



Program Updates

CASE oversight and fiscal monitoring by the Department of Behavioral Health (DBH) will be transferring from the juvenile justice program to Children's Youth Collaborative Services (CYCS) within DBH by Fiscal Year 2020/21. With the passage of SB 855, sexually exploited youth are now receiving services through Children and Family Services (CFS) versus being involved in the juvenile justice system and CYCS works closely with youth involved in the child welfare system.

Recent updates to legislation provided for funding to the Children and Family Services department to address the needs of this underserved population. Thus, the department of behavioral health and its CASE partners are exploring opportunities to redesign the service delivery of the program. During this transition, program funds are being utilized to support additional behavioral health functions for CASE. These changes will result in temporary decrease in the use of Mental Health Services Act funds. Further updates to the program will be identified in subsequent updates to the Three Year Plan.

Collaborative Partners

- California State University of San Bernardino
- Commercial Sexual Exploitation of Children (CSEC) Action Team
- Court Appointed Special Advocates of San Bernardino (C.A.S.A.)
- Neighboring Counties CSEC units in Probation and CFS
- Prevention Against Child Trafficking (PACT)
- San Bernardino County Superintendent of Schools
- San Bernardino County, Children and Family Services
- San Bernardino County, Children's Network
- San Bernardino County, Department of Probation
- San Bernardino County, Department of Public Health
- San Bernardino County, District Attorney's Office
- San Bernardino County, Public Defender's Office
- San Bernardino County, Sheriff's Department
- Southern California Faith Coalition Against Human Trafficking
- Superior Court of California, Juvenile Court Division
- The Open Door, Human Trafficking Department

Family Resource Center (PEI CI-2)

Family Resource Centers (FRCs) offer a variety of prevention and early intervention services within local community areas to support the overall health and wellness of families and individuals. They are located within local communities, allowing services to be tailored to the specific needs and cultural requirements of individualized communities.

As a Prevention and Early Intervention Program, some of the services offered by Family Resource Centers include:

- Activities that support mental health and wellness
- After school youth projects and activities
- Behavioral health education workshops
- Connections and linkage to community resources
- Family counseling
- Individual therapy
- Maternal mental health
- NCTI® Crossroads® and Real Colors® education
- Parent and caregiver support and education
- Personal development activities
- Skills-based education for adults

Services and activities are offered at non-traditional locations, such as community centers, where other collateral services are also offered in order to reduce stigma associated with seeking mental health services, increasing the likelihood that community members will use the services.

Artwork by Serrano

MHSA Legislative Goals and Related Key Outcomes

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

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

Increase recognition of early signs of mental illness:

- Identify early signs of potentially severe and disabling mental illness.
- Provide support to individuals with mental illness.
- Recognize own symptoms.
- Refer individuals who need treatment or other mental health services.
- Respond to symptoms.

Improve Timely Access to Services:

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

Reduce prolonged suffering associated with untreated mental illness:

- Reduce risk factors.
- Reduce indicators.
- Increase protective factors that may lead to improved mental, emotional, and relational functioning.

Reduce symptoms:

- Improve recovery, including mental, emotional, and relational functioning.

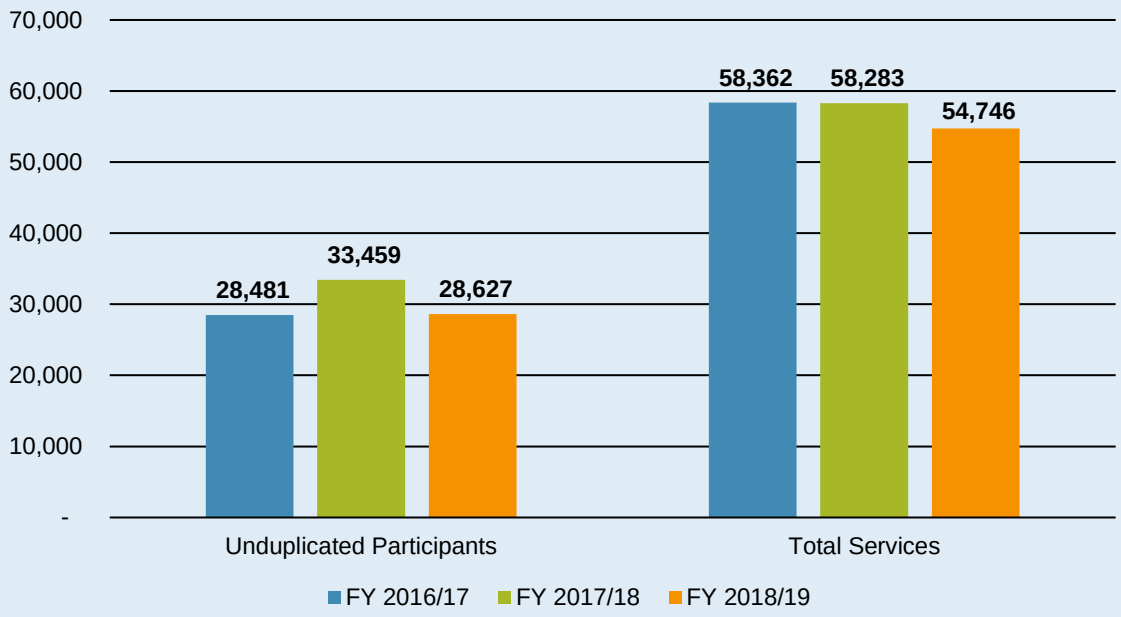
Reduce stigma and discrimination associated with mental illness:

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

Positive Results

The Family Resource Centers are projected to serve 26,945 participants per year. As shown in the chart below, the Family Resource Centers have exceeded these projections for each of the past three Fiscal Years, serving an average of 30,189 unduplicated participants and providing an average of 57,130 total services each year.

TOTAL UNDUPLICATED PARTICIPANTS AND TOTAL NUMBER OF SERVICES FOR FISCAL YEARS 2016/17, 2017/18, AND 2018/19



Prevention Services

Many of the prevention activities offered by Family Resource Centers are focused 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, building optimism and self-sufficiency, and providing access to support services. All activities are designed to increase protective factors and reduce risk factors.

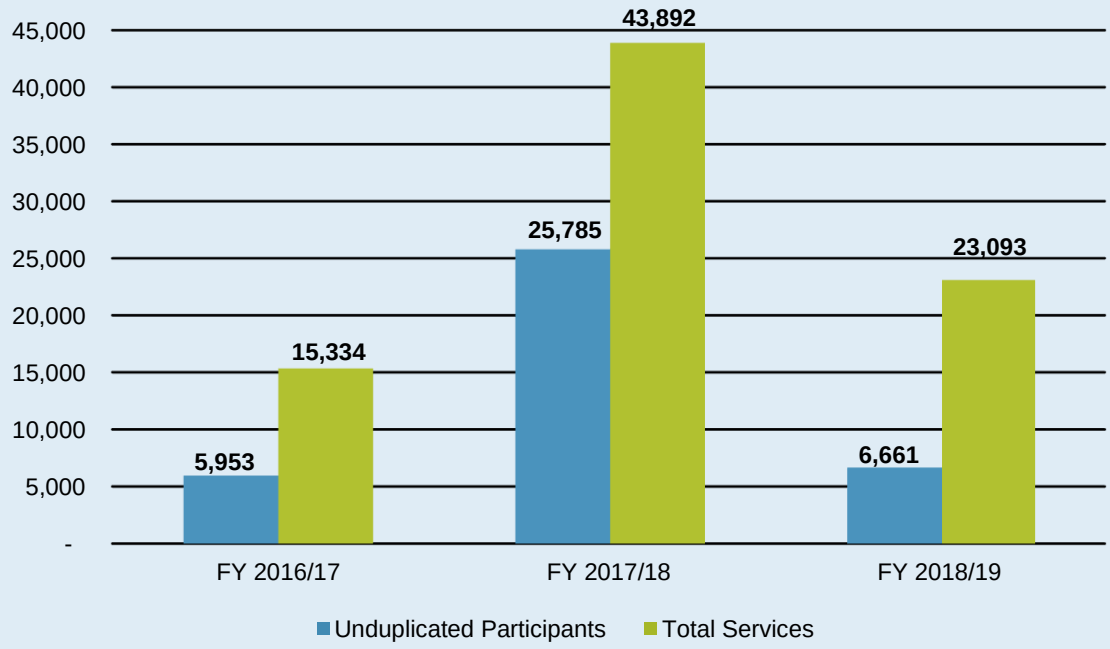
Protective factors are things that contribute to positive behavioral health and build resilience in overcoming challenges. Individuals with strong protective factors, such as healthy relationships and effective coping skills, will be better equipped to handle life's obstacles. On the contrary, risk factors can increase the likelihood that a person will develop a behavioral health problem.

The following is a sampling of the prevention activities offered at Family Resource Centers:

- **After school art / social skills group** – develops social skills and coping skills through art and other after school activities
- **Child enrichment support groups** – provides support and teaches appropriate coping skills for anxiety, depression, and anger management to individuals
- **Jellybean Jamboree** – develops social skills such as friendship skills, emotional skills, anger management skills and the value of making good decisions for Kindergarten and Transitional Kindergarten aged children.
- **Health and Wellness for Mommies** – support group for mothers
- **Mindfulness support group** – practice of maintaining a non-judgmental state of awareness of ones thoughts, emotions, and experiences
- **NCTI Real Colors ®** – teaches participants how to recognize personality strengths and attributes of themselves as well as others, and teaches effective communication skills
- **Nurturing parenting** – develops parenting skills designed to strengthen health relationships and strengthen bonds between parents and their children
- **Relapse prevention support groups** – support groups offering mental health education to learn how to care for our mental health
- **Seeking Safety** – interventions for individuals who have experienced trauma and substance abuse
- **Seven Habits for Teens** – Support group for teens 12-15 years old, teaching the value of hard work, setting and achieving goals, and taking responsibility and initiative
- **Transition to Independence** – provides tools and information to TAY aged youth that will help a healthy transition from adolescence to adulthood

The chart below compares the number of unduplicated participants served and the total number of services provided in prevention activities during Fiscal Years 2016/17, 2017/18, and 2018/19.

PREVENTION SERVICES FISCAL YEARS 2016/17, 2017/18, AND 2018/19



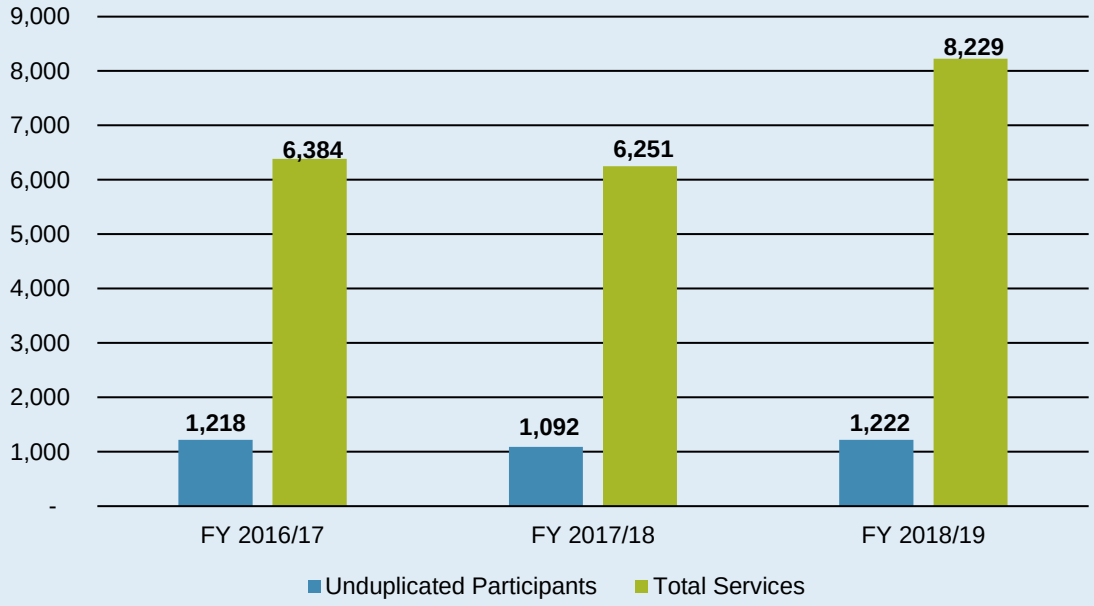
The number of unduplicated participants receiving prevention services and the total number of services received within the Family Resource Center program increased from 5,953 unduplicated participants and 15,334 total services in Fiscal Year 2016/17 to 6,661 unduplicated participants and 23,093 total services in Fiscal Year 2018/19.

In Fiscal Year 2017/18, there was a greater number of unduplicated participants and total services provided was due to Family Resource Center providers generally categorizing mental health promotion as prevention services as the providers were adjusting to the change in regulations and how the change affected reporting of services provided. In Fiscal Year 2018/19, providers were encouraged to separate their mental health promotion activities that were focused on providing education about recognizing early signs and symptoms of mental illness from prevention activities to better reflect outreach services and the work that was done to help potential responders recognize the early signs and symptoms of mental illness. As a result of re-categorizing some prevention activities, there is a decrease in the number of unduplicated participants utilizing prevention activities and an increase in the number of unduplicated participants receiving outreach activities.

Early Intervention Services

The Family Resource Center program provides early intervention services to address and promote recovery as early in its emergence as possible. Early intervention services include individual and group therapy, family therapy, mental health screenings and assessments. Over the past three years, the FRC program has provided early intervention services to an average of 1,177 participants each year. The graph below reflects the unduplicated participants services and total number of services provided by the FRC program by fiscal year.

EARLY INTERVENTION SERVICES
FISCAL YEARS 2016/17, 2017/18, AND 2018/19

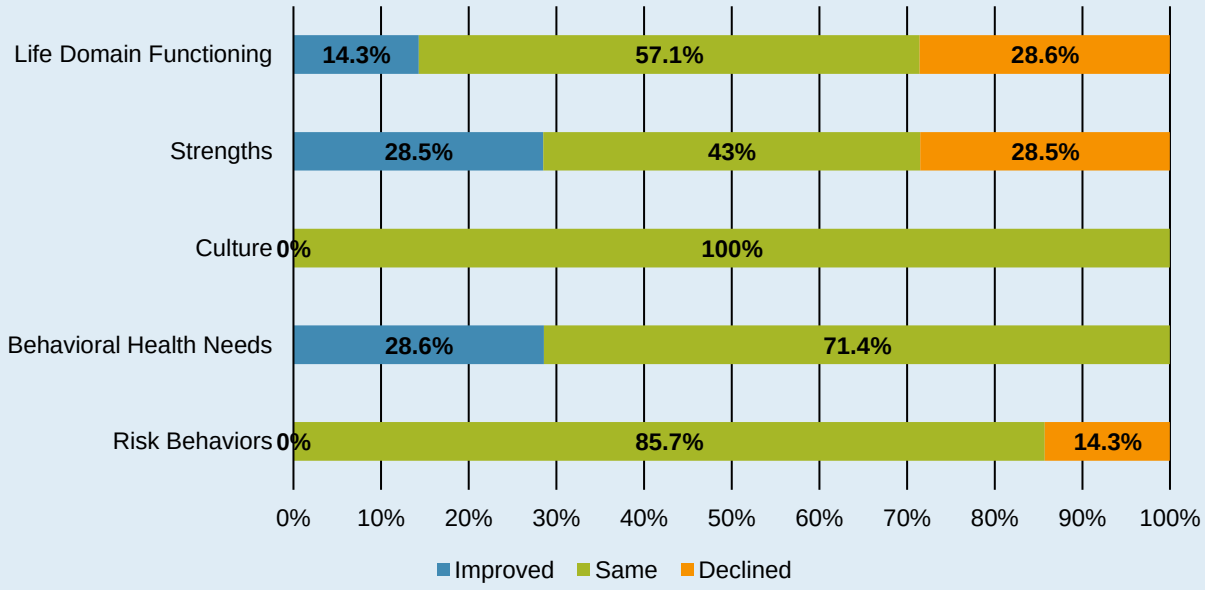


Providers of Family Resource Center early intervention services use the San Bernardino Adult Needs and Strengths Assessment - San Bernardino (ANSA-SB), a comprehensive assessment of psychological and social factors used for treatment planning. This assessment measures functioning in several important life domains and helps to support decision-making, level of care and service planning, and ensures projected goals are being met.

The following graphs illustrate the percentage of participants whose various life functionality components improved, remained the same, or declined from initial assessment to completion of treatment for Fiscal Year 2017/18 and Fiscal Year 2018/19.

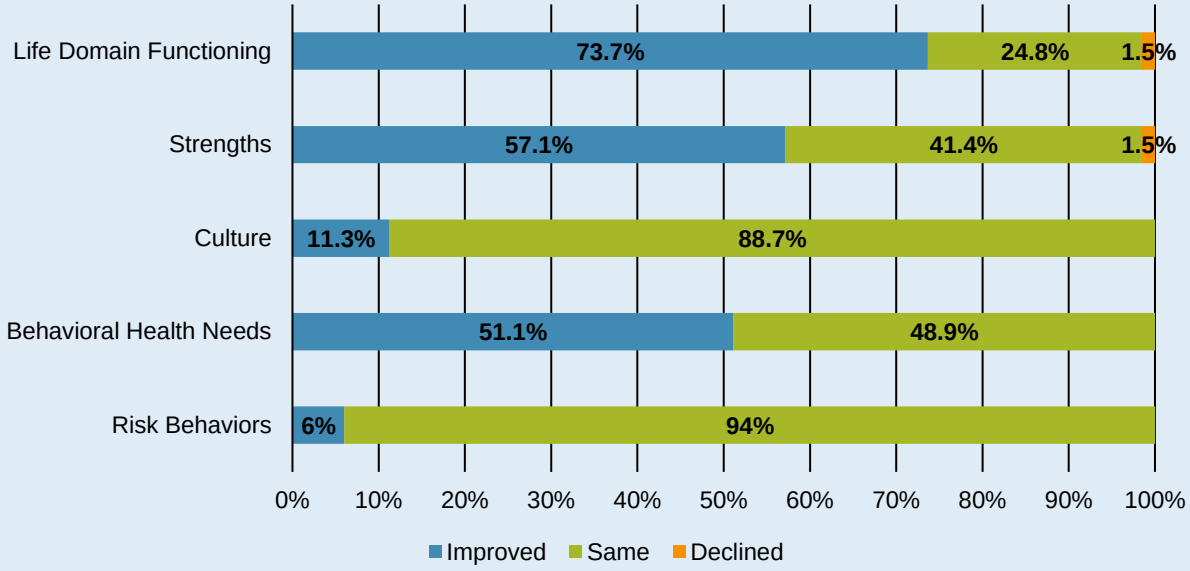
As shown in the graph below, 14.3% of participants showed improvement in life domain functioning, 28.5% showed improvements in strengths, and 28.6% showed improvements in behavioral health needs.

PERCENTAGE OF FRC PARTICIPANTS IMPROVED/DECLINED BY ANSA-SB FISCAL YEAR 2017/18



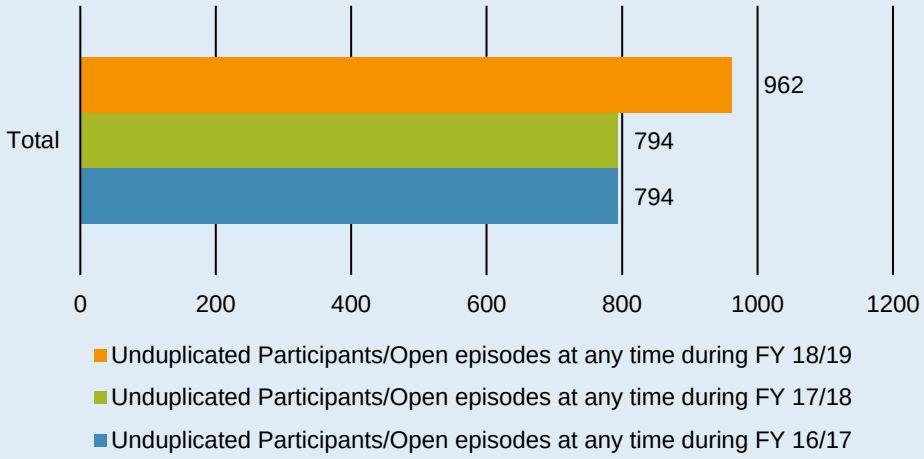
By comparison, there was a marked improvement in outcomes in these areas during Fiscal Year 2018/19 as shown in the graph below with 73.7% of participants improving in the area of life domain functioning, 57.1% improving in strengths, 11.3% improving in culture, 51.1% improving in behavioral health needs, and 6% improving in risk behaviors.

PERCENTAGE OF FRC PARTICIPANTS IMPROVED/DECLINED BY ANSA-SB FISCAL YEAR 2018/19



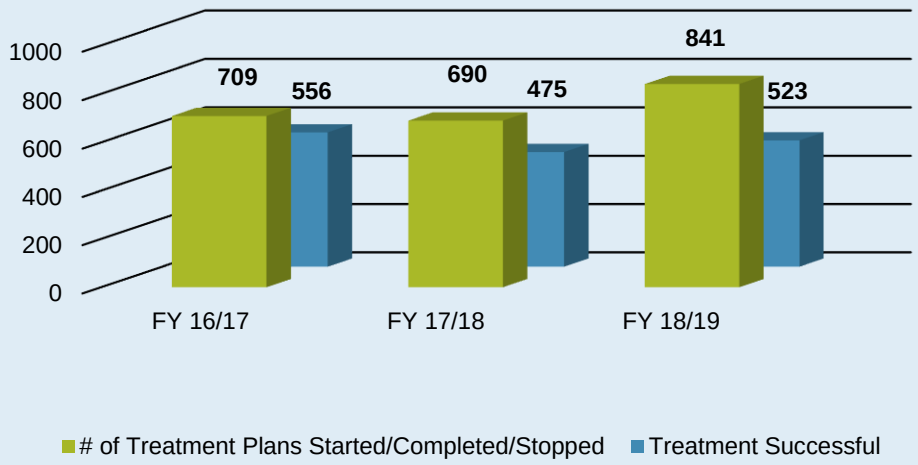
The chart below illustrates the number of unduplicated participants who started a mental health treatment plan in Family Resource Centers participants over past three (3) fiscal years.

NUMBER OF PARTICIPANTS WHO STARTED A MENTAL HEALTH TREATMENT PLAN BY FISCAL YEAR FOR FRC



The following illustrates the number of unduplicated participants who started a mental health treatment plan and completed or stopped their plan and those who successfully completed their mental health treatment plans for Family Resource Center participants.

Successful Treatment by Fiscal Year and Number of Unduplicated Participants Who Started a Mental Health Treatment Plan and Completed or Stopped Plan by Fiscal Year for FRC



Artwork by Sonia Stockton

Outreach for Increasing Recognition of Early Signs

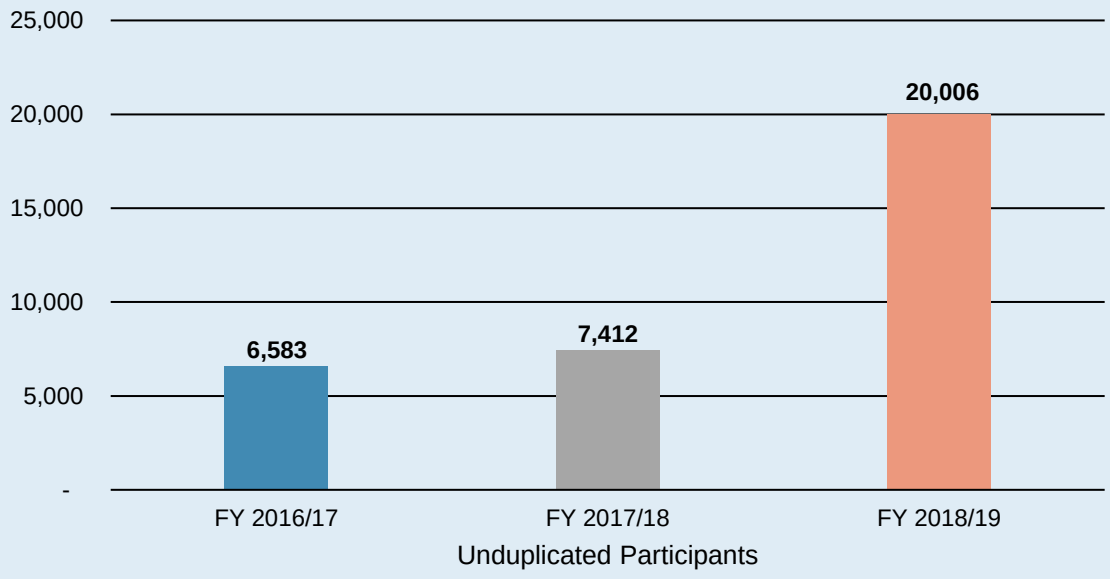
Family Resource Centers offer outreach services that seek to educate potential responders about mental health and provide them with knowledge that will aid them in identifying mental health illnesses.

Potential responders are engaged through numerous activities offered by the Family Resource Centers including orientations, presentations, community health fairs, workshops, Cultural Competency Sub-committee meetings, and other local events (stakeholder meetings and strategically relevant cultural events).

One of the Family Resource Center locations has established support for a Mental Health Awareness Group (MAG), consisting of juniors and seniors at local high schools. MAG is a branch of Health Occupations Students of America, a national program for students who plan to enter the health occupation field. With support from the Family Resource Center, MAG has implemented a peer-to-peer support program on local campuses to increase mental health awareness, recognizing symptoms of mental health disorders, increase suicide awareness, recognize signs of bullying, and to decrease stigma.

Shown in the following chart, the number of potential responders reached by outreach activities has increased by more than 300% from Fiscal Year 2016/17 to Fiscal Year 2018/19.

OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS FISCAL Y 2016/17, 2017/18, AND 2018/19



Through these activities presented during Fiscal Year 2018/19, Family Resource Centers staff taught 20,006 potential responders about recognizing and responding to early signs of mental illness in the following settings:

- Behavioral health clinics
- Churches
- Community-based organizations
- Community events
- County facilities
- Cultural organizations
- Faith based organizations
- Family resource centers
- Law enforcement departments
- Libraries
- Recreation centers
- Residences
- Schools
- Senior centers
- Shelters

The potential responders reached included the following:

- Child protective services
- Community service providers
- Consumer family members
- Cultural brokers
- Emergency medical service providers
- Employers
- Families
- Leaders of faith based organizations
- Mediators
- Military personnel
- Peer providers
- People who provide services to individuals who are homeless
- Primary health care providers
- School personnel
- Veterans

Access and Linkage to Treatment

Access and Linkage to Treatment services are integrated into the Family Resource Center program to connect participants and their family members with severe mental health concerns, as early in the onset as possible, to care and treatment that will meet their needs.

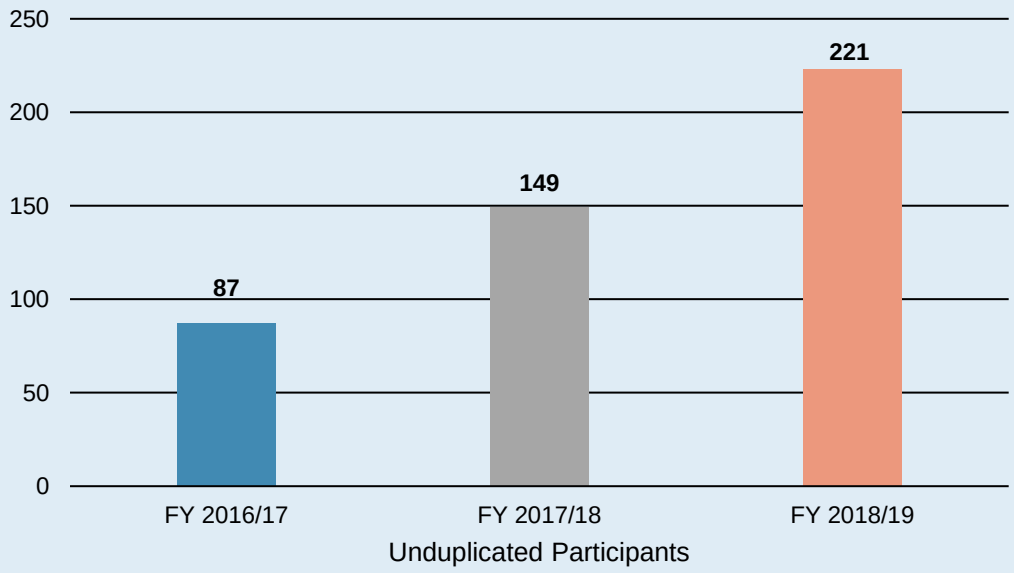
In order to identify the level of care a participant needs, Family Resource Center staff conducts intake assessments. When the assessment indicates that a higher level of care and treatment may be required, Clinical supervisors will review the information. Once completed, a referral and linkage to higher level of care services is made for the participant. FRC staff provides linkage services to help ensure that connections are made and the participant is able to follow through on receiving treatment. Based upon agency guidelines and the presence of release

> *"I have been going through very hard times and the Family Resource Center has helped me overcome so many obstacles. I am so grateful. Thank you for all that you do in our community!"*
>
> *– FRC Participant*

agreements, FRC staff follows up with the individual participants or the referred to agencies to determine whether the participant engaged in treatment.

The Access and Linkage to Treatment chart shows the total number of participants who received referrals to higher levels of care during Fiscal Years 2016/17, 2017/18, and 2018/19.

ACCESS AND LINKAGE TO TREATMENT
FISCAL YEARS 2016/17, 2017/18, AND 2018/19



Family Resource Center participants were referred to the following kinds of treatment during Fiscal Year 2018/19:

- Assessment
- Crisis interventions
- Crisis stabilizations
- Hospitalization evaluations
- Individual outpatient services
- Intensive home based mental health services
- Psychiatric services
- Rehabilitation / activities of daily living groups
- Therapeutic behavioral services
- Treatment of substance problems

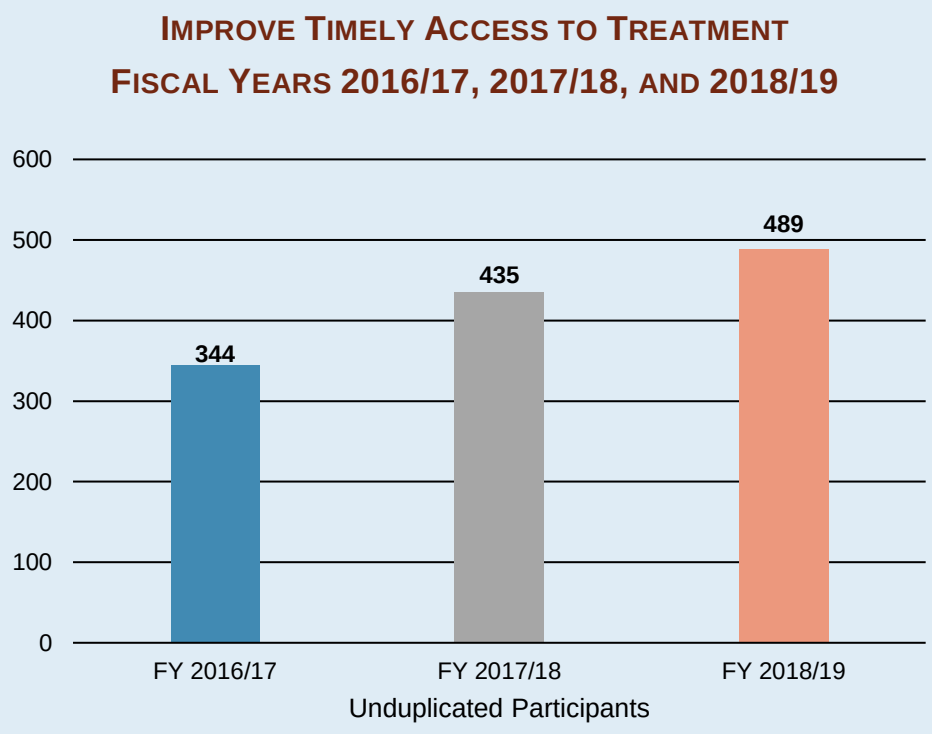
Improve Timely Access to Treatment

To increase timely access to appropriate mental health services for participants from underserved populations, the Family Resource Center focuses on providing appropriate prevention, early intervention, and treatment beyond early intervention services and referrals based on community needs such as accessibility, cultural and language appropriateness, transportation, available hours, and cost of services.

The program has provided services and/or referrals to several underserved populations including:

- Children at risk of school failure
- Children in stressed families
- Individuals with co-occurring disorders
- Members of underserved minority groups, ethnicities and sexual orientation
- Trauma exposed individuals
- Veterans
- Victims of human trafficking

The chart below provides an overview of the unduplicated participants for each of the last three Fiscal Years.

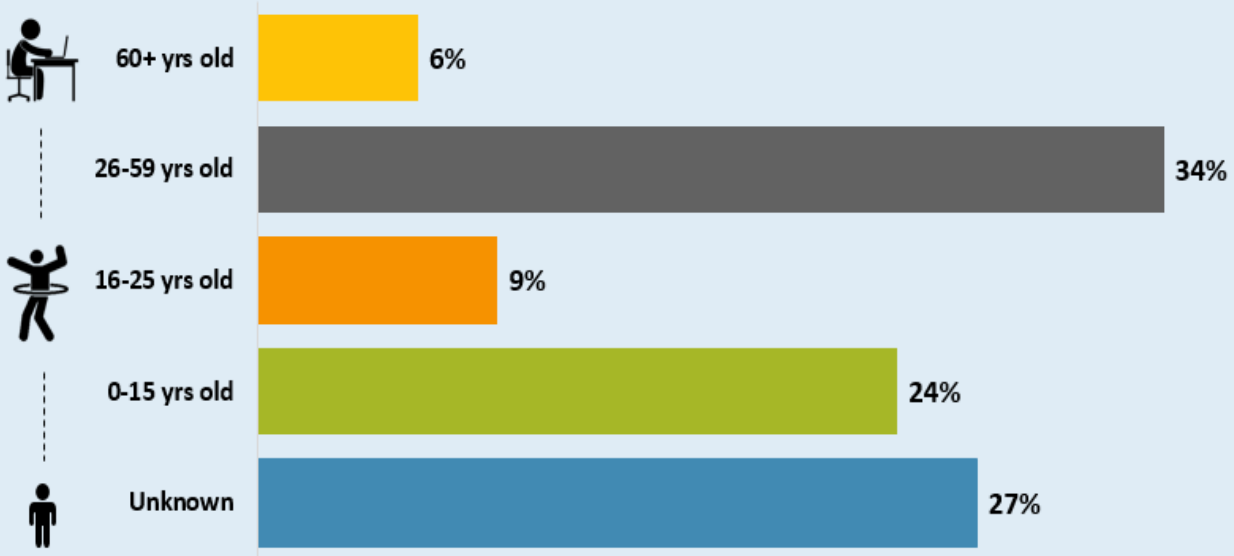


Fiscal Year 2018/19 Program Demographics

The following graphs illustrate the demographics in various categories of the Family Resource Center participants.

Age:

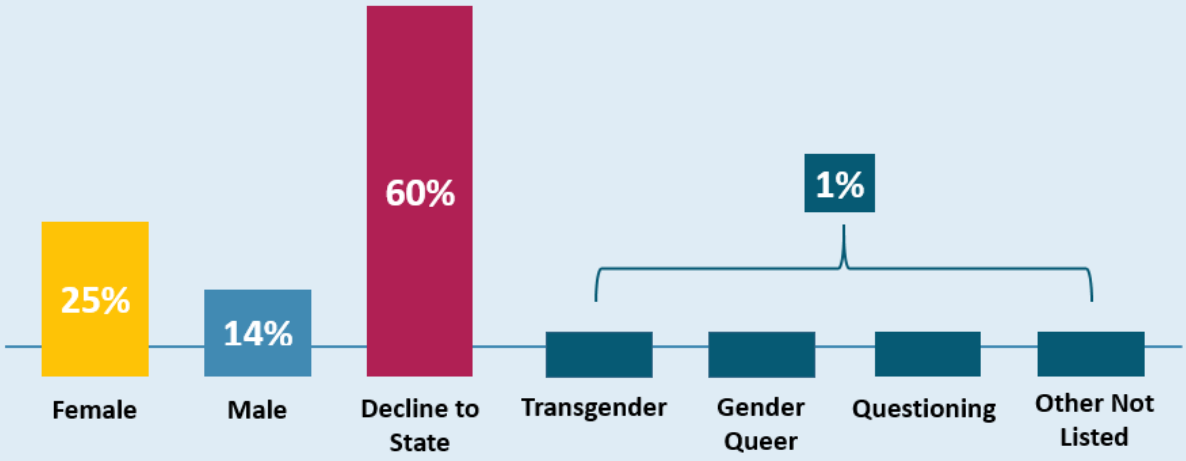
The graph below illustrates the ages of the Family Resource Center participants. The majority of participants served, 34%, were between the ages of 26-59 years old. Twenty-four percent of participants were between the ages of 0-15 years old. The TAY group, 16-25 years old, made up 9% of the Family Resource Center participants, and 6% identified as 60+ years old. The remaining 27% of the population age groups is unknown or the participant declined to state.



N = 22,457

Gender:

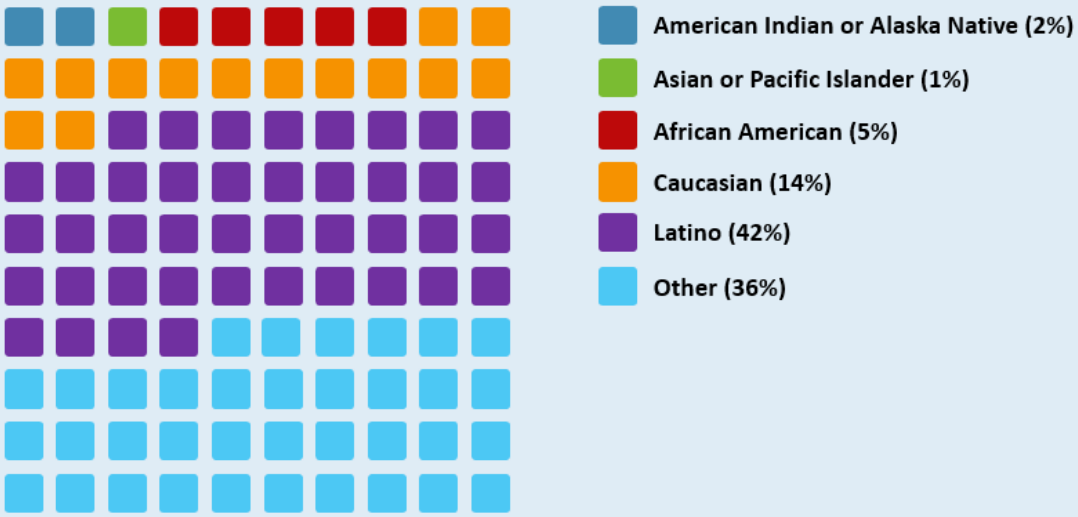
The graph below demonstrates that 25% of the Family Resource Center participant population identified as female, 14% identified as male, 60% declined to state and 1% of the participants identified as transgender, gender queer, questioning, or other not listed.



N = 22,457

Ethnicity and Ancestry:

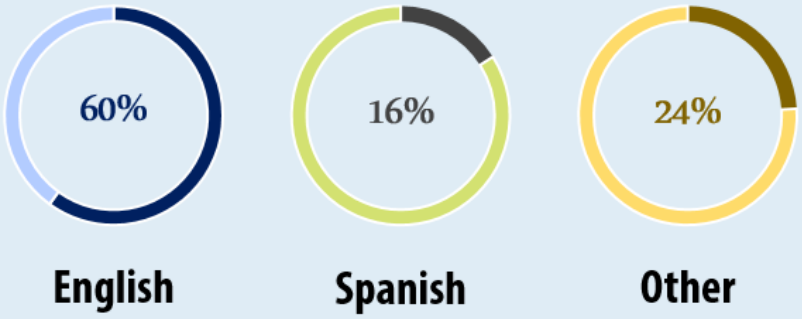
The graph below illustrates the various ethnicities of participants of the Family Resource Center program. The largest group was 42% in the category of Latino. The second largest category was Other at 36%. This category includes those who identified as other, more than one race, or declined to answer. There were 14% of participants in the Caucasian category and 5% in the African American population. Only 2% identified as American Indian or Alaska Native and 1% identified as Asian or Pacific Islander.



N = 36,071

Primary Language:

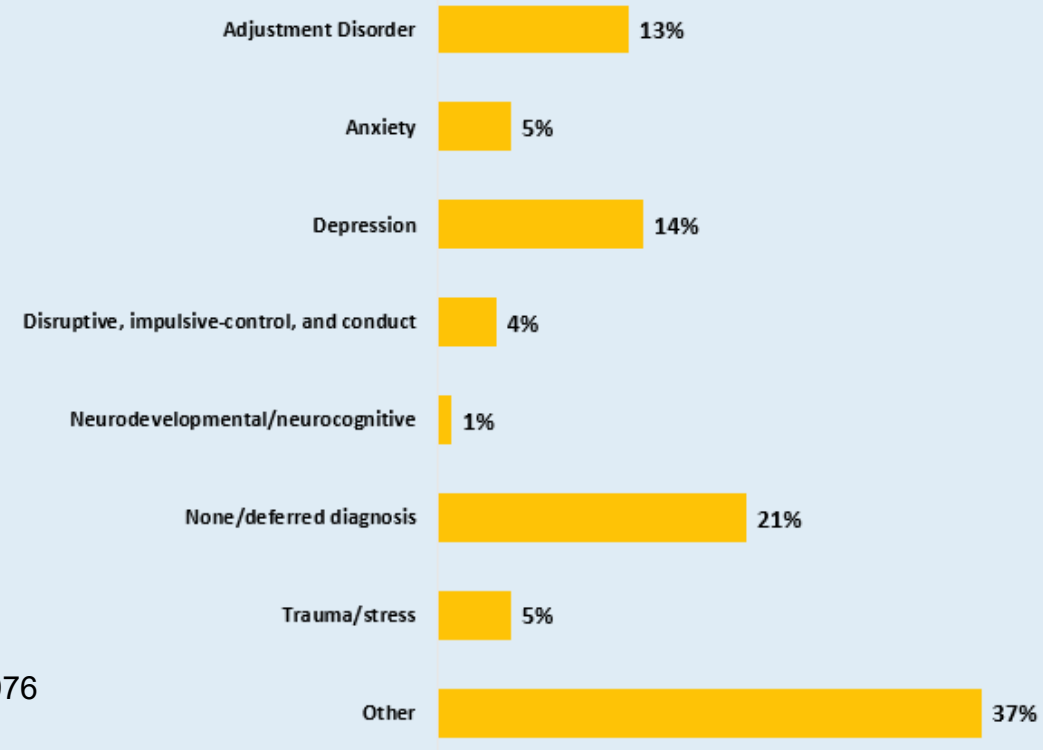
The graph below demonstrates that 60% of the Family Resource Center participants identified English as their primary language while 16% identified Spanish and 24% identified a different language as their primary language.



N = 22,397

Primary Diagnosis:

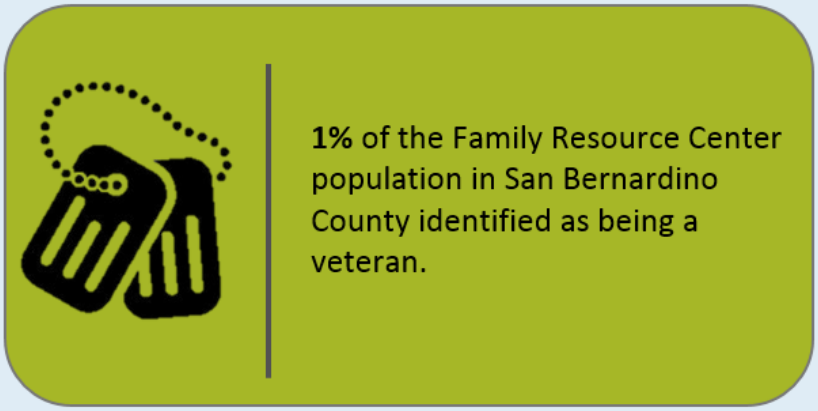
The graph below illustrates the diagnostic groups of Family Resource Center participants who received early intervention services. Most of the Family Resource Center participants receiving early intervention services, 37%, fall under the category of *Other*. These participants either had a different diagnosis, or more than one. The 21% of participants with no diagnosis or a deferred diagnosis either did not have an identifiable mental health need or the diagnosis was deferred pending further assessment. Of the remaining diagnoses, 14% were diagnosed with depression, 13% with adjustment disorder, 5% with anxiety, 5% with trauma/stress, 4% with disruptive, impulsive-control, and 1% with neurodevelopmental/neurocognitive disorders.



N = 976

Veterans Status:

Of the Family Resource Center participants, 1% identified as being veterans.



N = 22,457

Success Story

"Sandra" entered a Family Resource Center seeking help. She was experiencing anxiety as a result of her husband being on life support and she had been asked to make preparations for her husband's passing. In addition to worrying about the potential loss of her spouse, she was concerned about expenses of his services, her rent, and other living expenses for her and her young son. Through the Family Resource Center, Sandra was able to receive mental health services to deal with her anxiety as well as case management services to connect her with resources to help alleviate the stress associated with overwhelming financial concerns. The Family Resource Center was able to provide counseling to help Sandra and her son cope with their grief and loss. At the end of her treatment plan, both Sandra and her son showed improvement and completed their counseling sessions.

Program Challenges

Some challenges to the Family Resource Center that have been identified during Fiscal Year 2018/19 include a continuing need to reduce barriers to seeking mental health services within many communities. Collaboration with partners such as the Mexican and Guatemalan Consulates has identified the need to expand the reach of mental health services, mental health awareness workshops, and other mental health resources to nearby communities.

Program Solutions

The solutions implemented by Family Resource Centers to address program challenges include educating the community about mental health services and resources available in order to help promote prevention and early intervention for better mental health. In addition, Family Resource Centers developed collaboration with new partners in the surrounding communities to provide local mental health awareness workshops and information about mental health resources within the community.

Program Updates

There are no planned program updates for Fiscal Year 2020/21.

Collaborative Partners

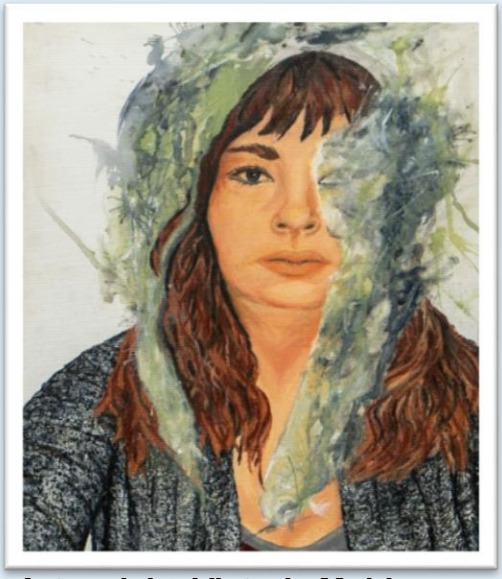
- Advantage Health Care Services
- African American Health Coalition
- Anti-Bullying task Force
- Assistance League of the Foothill Communities
- Basin Wide Foundation
- Borrego Health
- C.A.S.A. of San Bernardino County
- California Conservation Corp
- Catholic Charities
- Cesar Chavez/Dolores Huerta Center of Education District Parent Center
- Children's Fund
- Consulate of Guatemala
- Consulate of Mexico
- Eagle's Nest Community Center
- El Sol Neighborhood Educational Services
- Family Assist
- First 5 San Bernardino
- Foothill Family Shelter
- Hi-Desert Behavioral Health
- House of Ruth
- IEHP Resource Center San Bernardino
- Inland Career Education Center
- Inland Empire Career and Education Center
- Inland Empire Job Corps
- Inland Empire United Way
- Inland Fair Housing Mediation Board
- Inland Regional Center
- Inland Valley Hope Partners
- Inland Valley Recovery Services
- Isaiah's Rock Food Distribution
- Loma Linda University
- Maternal Mental Health Group
- Mental Health Systems
- Mercy House
- Molina Healthcare
- Morongo Basin Community Health Care District
- Morongo Unified School District
- Option House Inc. San Bernardino
- Options for Youth
- Our Lady of Hope
- Park Tree Community Health Center
- Planned Parenthood San Bernardino
- Project Sister
- Reach Out
- Safe Families for Children (Olive Crest)
- Salvation Army
- San Bernardino Sexual Assault Services
- San Bernardino Valley College
- Sam Bernardino County, Children & Family Services
- Shoes That Fit
- South Coast Community Services
- Supremo Llamamiento Church
- Telacu
- The Way of the World Outreach
- Times for Change
- TruEvolution
- Unidos por la Musica
- Unity Home
- University of Phoenix Counseling Services

Community Wholeness and Enrichment (SE-3)

The Community Wholeness and Enrichment (CWE) program is categorized as a Prevention and Early Intervention program that targets Transitional Age Youth (TAY) ages 16-25, adults ages 26-59, and family members of those living with a behavioral health condition. The CWE program is designed for those who are experiencing the initial onset of a mental or emotional illness and/or substance use disorder. The program provides services that include, but are not limited to:

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

Additionally, CWE provides community education which helps to de-stigmatize mental health issues and bring awareness to the mental health system in order to increase access and linkage to services.



Artwork by Victoria Muldoon

MHSA Legislative Goals and Related Key Outcomes

Improve timely access to services for underserved populations:

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

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

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

Reduce prolonged suffering associated with untreated mental illness:

- Reduce risk factors
- Reduce indicators
- Increase protective factors that may lead to improved mental emotional, and relational functioning
- Reduce symptoms, and
- Improve recovery including emotional and relations functioning.

Reduce stigma and discrimination associated with mental illness:

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

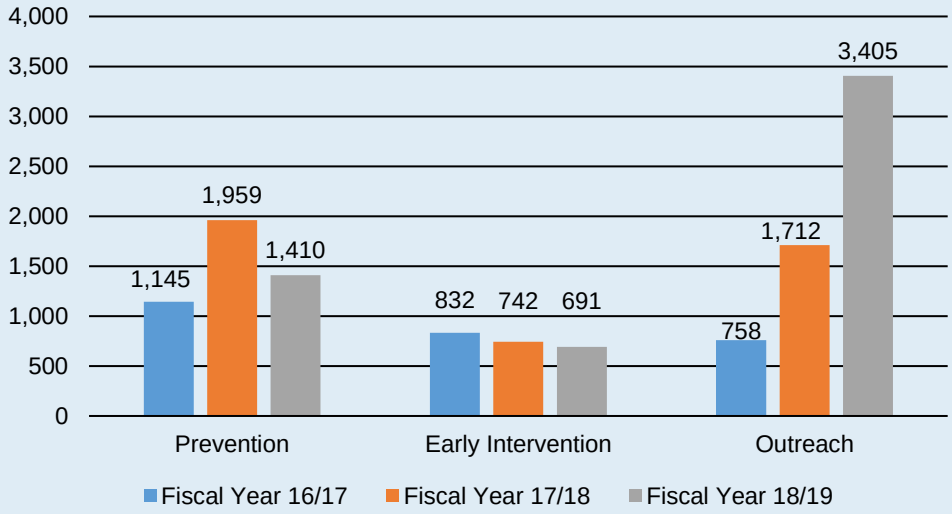
Increase acceptance, dignity, inclusion, and equity for individuals with mental illness and members of families.

Positive Results

The CWE providers are contracted to provide services to 3,067 unduplicated participants annually. In Fiscal Year 2016/17, the CWE program served 3,392 unduplicated participants. The program served 4,414 unduplicated participants in Fiscal Year 2017/18, and served 5,618 unduplicated participants in Fiscal Year 2018/19. The CWE program has seen a steady increase in participation over the last three fiscal years.

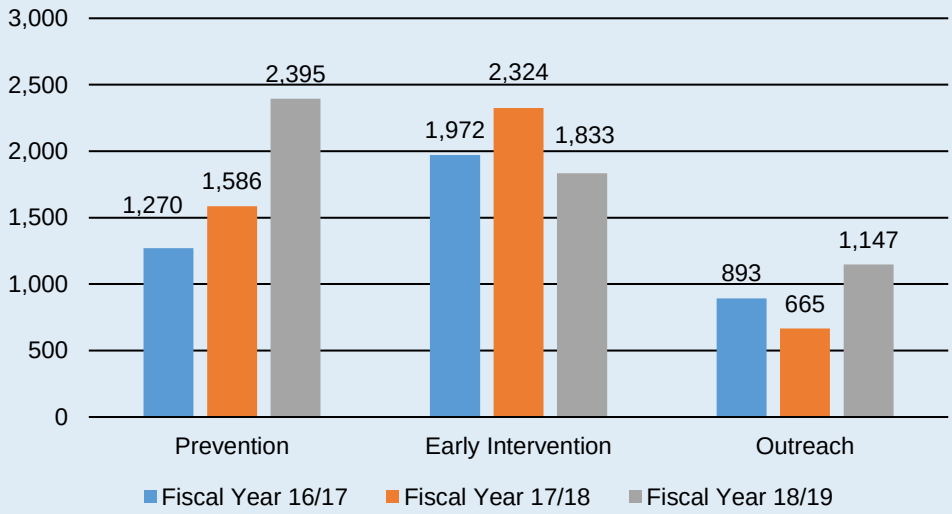
The following tables illustrate the unduplicated participants served and number of services by fiscal year in the categories of Prevention, Early Intervention, and Outreach.

TOTAL UNDUPLICATED PARTICIPANT COUNT BY SERVICE TYPE AND FISCAL YEAR



The table below illustrates the total number of services by fiscal year. CWE had a steady increase in prevention services over the last three fiscal years. This is due to an increase in activities that extend over the course of several days rather than a one-time activity.

TOTAL NUMBER OF SERVICES BY SERVICE TYPE AND FISCAL YEAR



Prevention Services

Over the last three fiscal years, CWE providers offered various prevention activities with the goal of reducing risk factors and increasing protective factors for mental health.

CWE offered the following prevention activities:

- SafeTalk a workshop which teaches first responders how to prevent suicide by recognizing signs, engaging a person, and connecting them to an intervention resource for further support.
- ASIST Training a two day interactive workshop that prepares caregivers to provide life-assisting suicide first-aid intervention.
- SuicideTALK a one to two hour suicide awareness presentation which provides information for suicide prevention. Additionally, the presentation explores the issues of suicide, attitudes toward suicide, and how an individual can prevent suicide in their communities.
- Mental Health First Aid a skills-based training course that teaches participants about mental health and substance-use issues.
- The National Curriculum and Training Institute (NCTI) a cognitive behavior change program that offers educational groups such as substance abuse and stress management.
- Seeking Safety an evidence-based, present-focused counseling model to help people attain safety from trauma and/or substance use.
- The Community Resiliency Model trains community members to not only help themselves but to help others within their wider social network. The goal is to help to create “trauma-informed” and “resiliency-focused” communities that share a common understanding of the impact of trauma and chronic stress on the nervous system and how resiliency can be restored or increased using this skills-based approach.

The table below illustrates the number of Prevention participants and services by fiscal year.

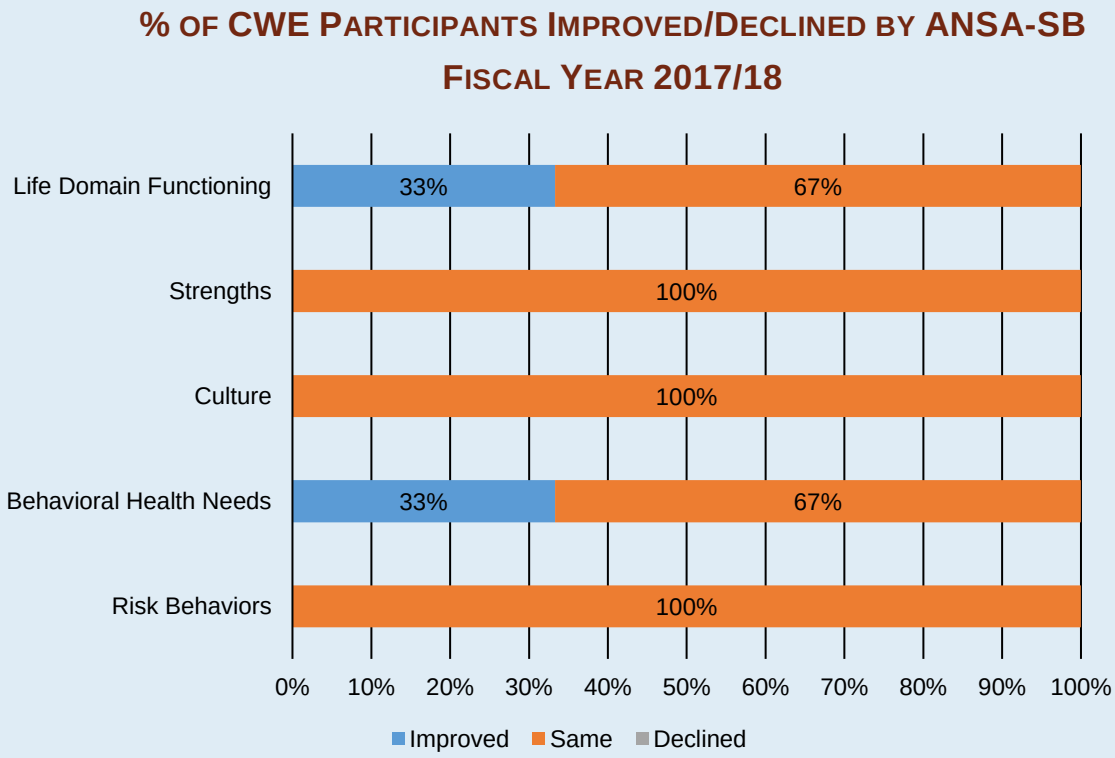
Fiscal Year	Unduplicated Count	Number of Services
16/17	1,145	1,270
17/18	1,959	1,586
18/19	1,410	2,395

Early Intervention

The CWE program provides early intervention services which include treatment and other services and interventions to address and promote recovery and related functional outcomes for a mental illness early in its emergence.

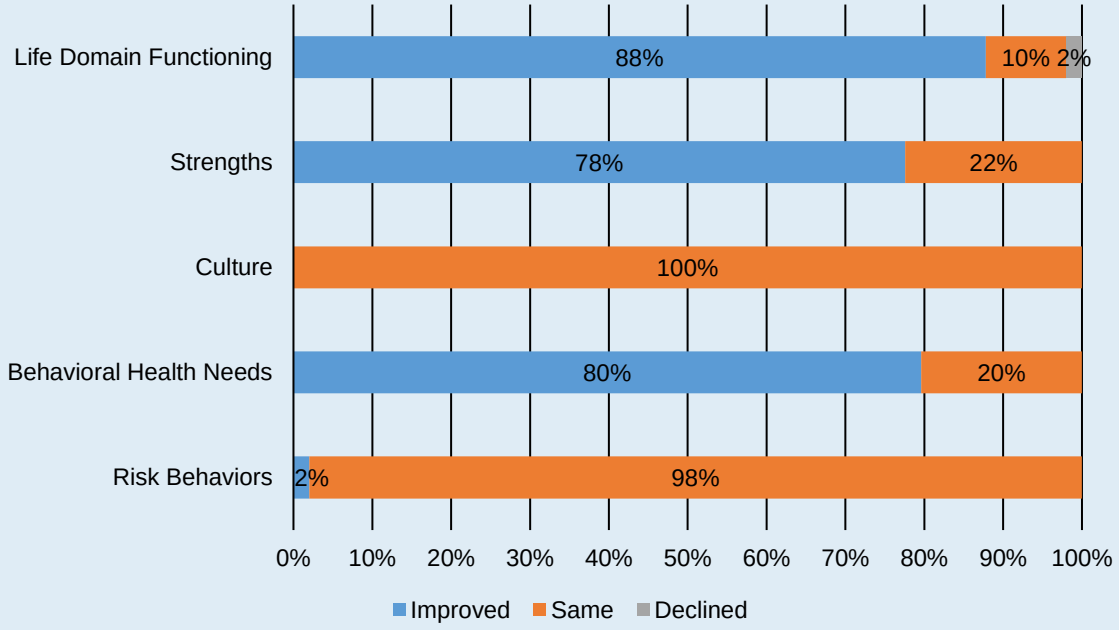
Providers of CWE early intervention services utilize the San Bernardino Adult Needs and Strengths Assessment - San Bernardino (ANSA-SB), a comprehensive assessment of psychological and social factors used for treatment planning. This assessment measures functioning in several important life domains and helps to support decision making and level of care and service planning, and ensure projected goals are being met.

The following graphs illustrate the percentage of participants whose various life functionality components improved, remained the same, or declined from initial assessment to completion of treatment for Fiscal Year 2017/18 and Fiscal Year 2018/19. For Fiscal Year 2017/18, 33% of participants improved their life domain functioning and behavioral health needs while 67% remained the same. In the remaining categories, 100% of participants remained the same. None of the CWE participants declined.



In the graph below, for Fiscal Year 2018/19, 88% of participants improved their life domain functioning, 80% improved in behavioral health needs, 78% improved their strengths, and 2% improved their risk behaviors. Of the participants whose needs remained the same, 100% were in culture, 98% in risk behaviors, 22% in strengths, 20% in behavioral health needs, and 10% in life domain functioning. There were 2% of participants who declined in the category of life domain functioning.

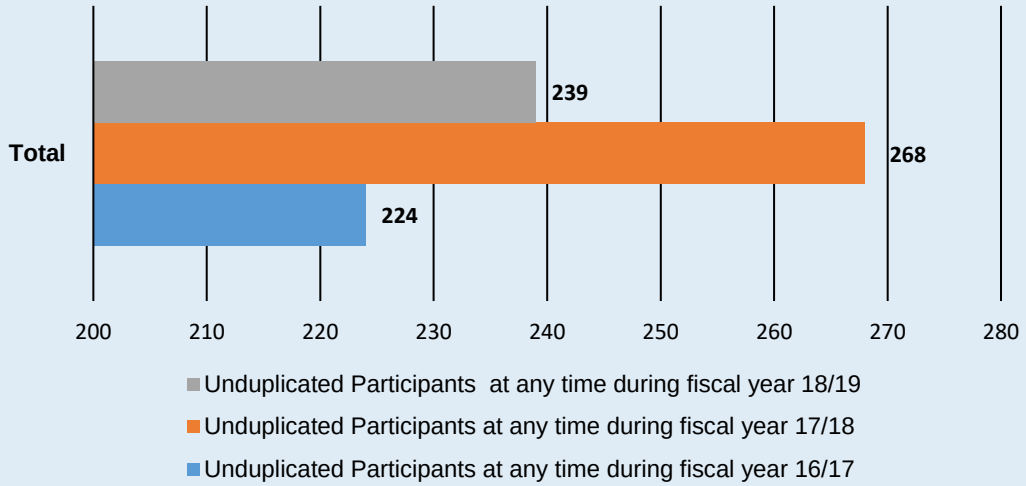
% OF CWE PARTICIPANTS IMPROVED/DECLINED BY ANSA-SB
FISCAL YEAR 2018/19



In Fiscal Year 2016/17, 224 participants started a mental health treatment plan. In Fiscal Year 2017/18, 268 unduplicated participants started a mental health treatment plan. In Fiscal Year 2018/19, 239 unduplicated participants started a mental health treatment plan. These are participants who have not previously received early intervention treatment services. The decrease in participants in Fiscal Year 2018/19 is possibly due to when the participant engaged in treatment. A participant whose treatment plan crosses fiscal years will count as unduplicated into the next fiscal year.

The tables below illustrates the number of unduplicated participants who started a mental health treatment plan at any time during Fiscal Year 2016/17, 2017/18, and 2018/19.

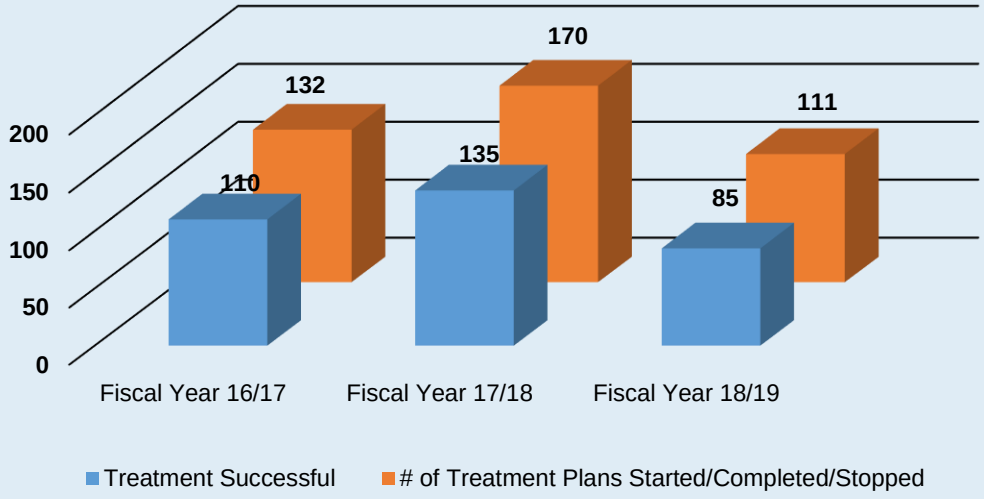
NUMBER OF PARTICIPANTS WHO STARTED A MENTAL HEALTH TREATMENT PLAN BY FISCAL YEAR



In Fiscal Year 2016/17, 132 unduplicated participants started a mental health treatment plan and completed or stopped their plan. One hundred and ten unduplicated participants completed their treatment successfully. In Fiscal Year 2017/18, 170 unduplicated participants started a mental health treatment plan and completed or stopped their plan. One hundred and five participants completed their treatment successfully. In Fiscal Year 2018/19, 111 unduplicated participants started a mental health treatment plan. Eighty-five participants completed their treatment successfully. An treatment plan may start in one fiscal year and closed in the next, dependent upon when the treatment plan was opened. The majority of the treatment plans that were started resulted in participants meeting their treatment goals successfully.

The table that follows illustrates the number of open and closed episodes by fiscal year and those with successful treatment.

SUCCESSFUL TREATMENT BY FISCAL YEAR AND NUMBER OF UNDUPLICATED PARTICIPANTS WHO STARTED A MENTAL HEALTH TREATMENT PLAN AND COMPLETED OR STOPPED PLAN BY FISCAL YEAR



Outreach for Increasing Recognition of Early Signs of Mental Illness

In the last three fiscal years, CWE has provided outreach services to a combined 5,875 unduplicated potential responders. In fiscal year 2016/17, CWE served 758 unduplicated participants. The program increased its Outreach services in fiscal year 2017/18 by 126% reaching 1,712 unduplicated participants. In fiscal year 2018/19, the program increased their numbers reached through outreach by 98%, reaching 3,405 unduplicated participants.

In the last three fiscal years, outreach services were provided in the following settings:

- Schools
- County facilities
- Foster family agencies
- Homeless Coalition
- Family Resource Centers
- Churches
- Community-based organizations
- Behavioral health clinics

The following types of responders were reached during these CWE outreach activities:

- Peer providers
- Students
- School personnel
- Community agency employees
- Homeless outreaches
- Teachers
- Clergy members
- Leaders of faith-based organizations
- Consumer family members
- Emergency medical service providers

Access and Linkage to Treatment

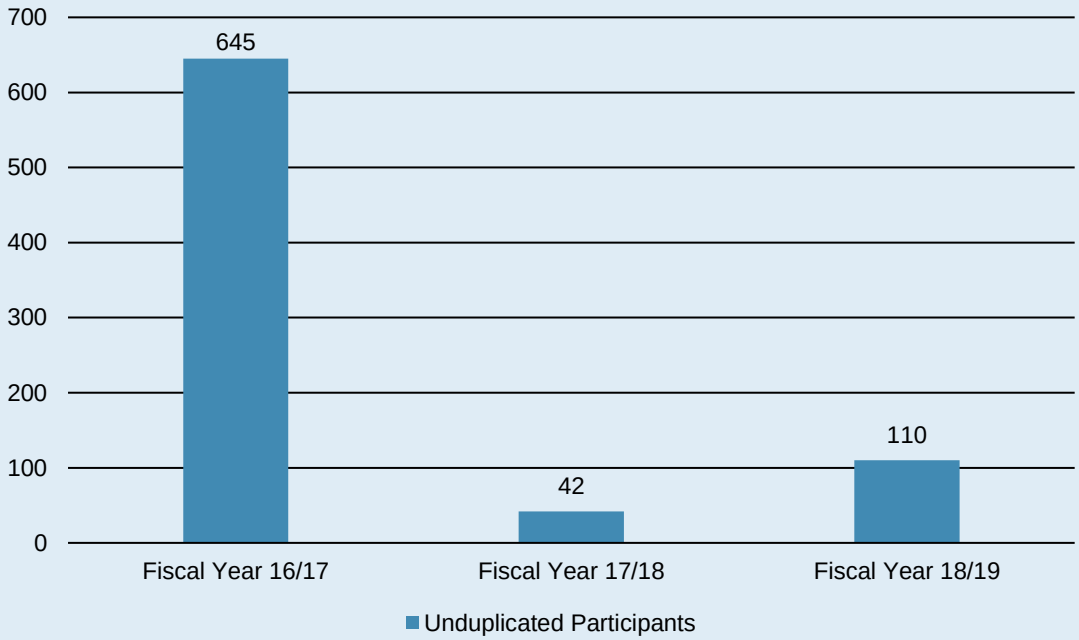
Access and Linkage to Treatment services provide participants with referrals to higher level of care services. These services connect participants and/or their families with severe mental health concerns, as early in the onset of these conditions as possible, to care and treatment that will meet their needs. In Fiscal Year 2016/17, the CWE program made 12 referrals to treatment beyond early onset, one referral in Fiscal Year 2017/18, and two referrals in Fiscal Year 2018/19. Participants are referred to treatment beyond the scope of services offered through Prevention and Early Intervention. The kinds of treatment to which participants were referred included assessments, individual outpatient services, medication management, treatment of substance use issues, and local TAY centers.

Improve Timely Access to Treatment for Underserved Populations

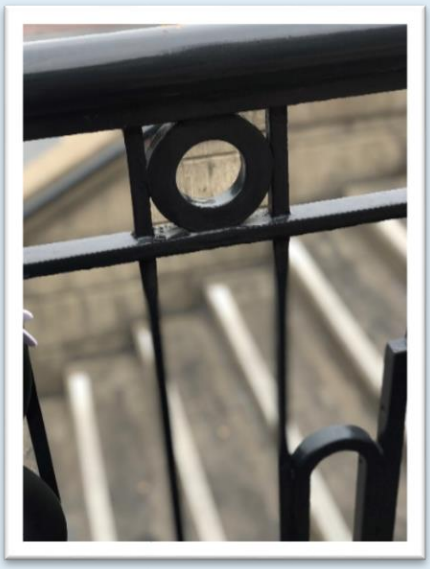
The CWE program providers refer participants to appropriate services in categories of Prevention, Early Intervention, and Treatment Beyond Early Onset for those from underserved populations. The purpose of this strategy is to increase the accessibility of appropriate mental health services for those from underserved populations. The program has provided services to several underserved populations including African-American, Latino, foster children, LBGTQ+, veterans, homeless adults and TAY youth, as well as those suffering from a trauma.

The table below provides an overview of the unduplicated participants for each of the last three fiscal years.

TOTAL UNDUPLICATED PARTICIPANTS PROVIDED IMPROVE TIMELY ACCESS SERVICES BY FISCAL YEAR



The new regulations were implemented in Fiscal Year 2016/17, and providers were adjusting to the new requirements. Fiscal Year 2017/18 and Fiscal Year 2018/19 more closely reflect the results of the new requirements.



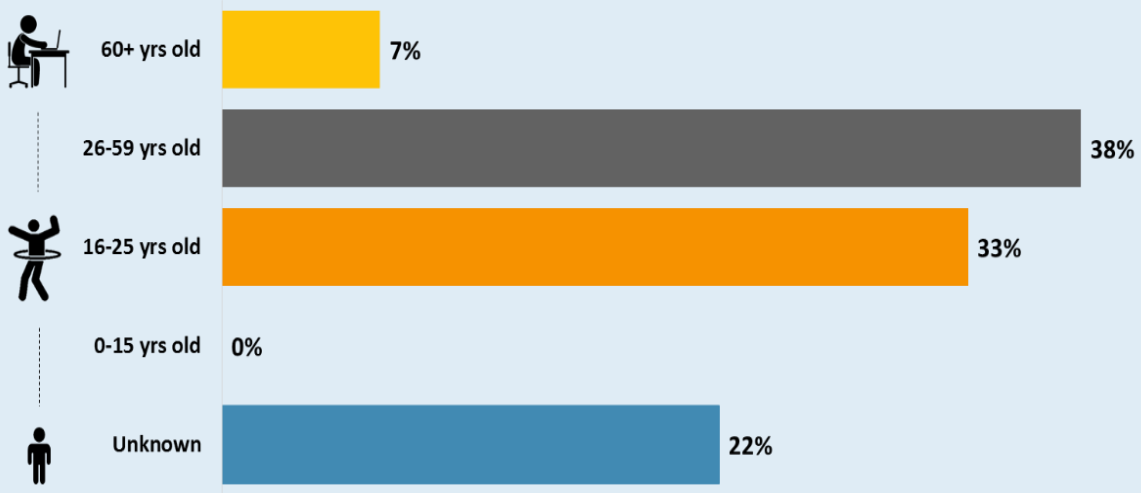
Artwork by Carmela Gonzalez

Fiscal Year 2018/19 Program Demographics

The following graphs illustrate the demographics in various categories of CWE participants.

Age:

The graph below illustrates the ages of CWE participants. The majority of participants served, 38%, were between the ages of 26-59 years old. The second largest group was between the ages of 16-25 years old at 33%. There were 7% of participants who identified as 60+ and 22% identified as unknown or declined to state. This graph is representative of the CWE target population of adults and TAY being the majority served.

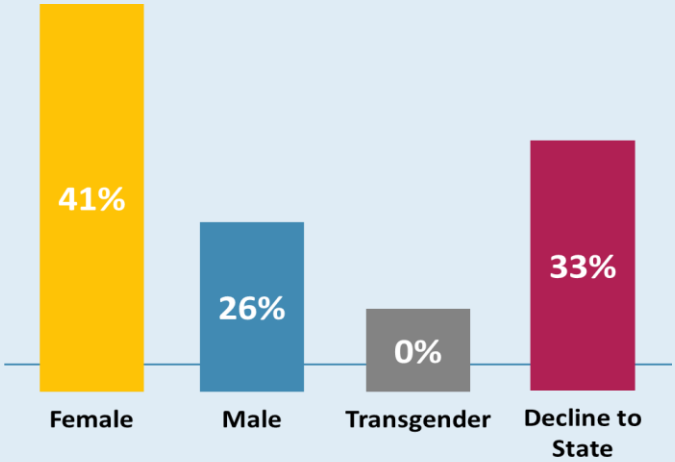


N = 4,703

Gender:

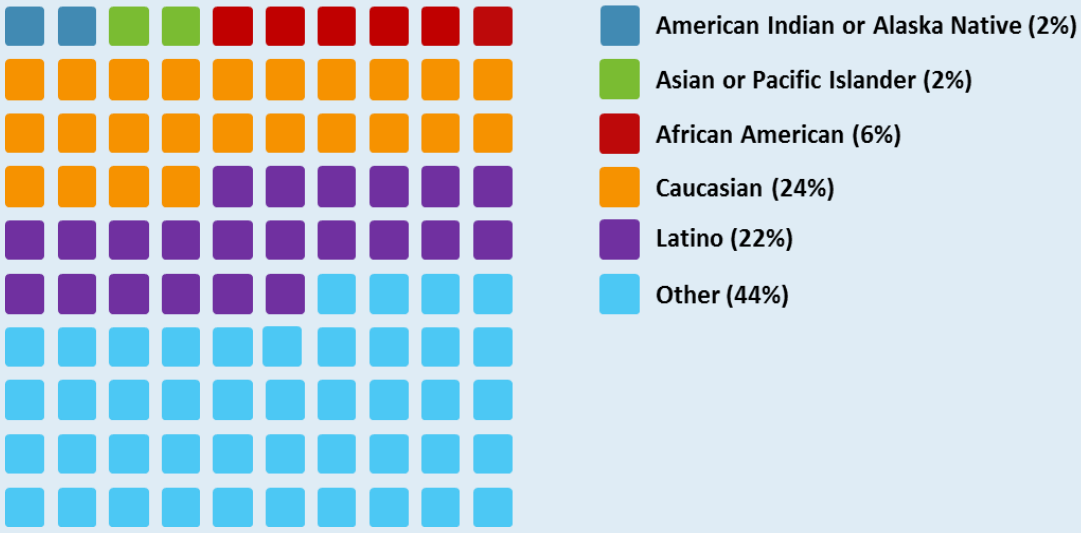
The graph below demonstrates that 41% of CWE participants identified as female, 26% identified as male, and 33% declined to state. None of the participants identified as transgender, non-binary, gender queer, or other not listed.

N = 4,710



Ethnicity and Ancestry:

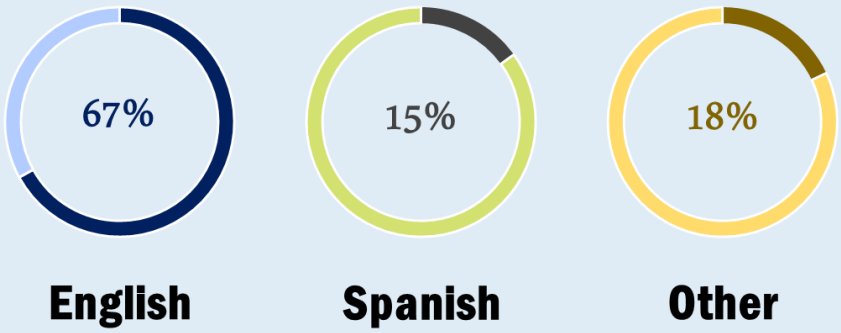
The graph below illustrates the various ethnicities of participants of the CWE program. The largest group of participants was 44% in the category of Other. This category includes those who identified as other, more than one race, or declined to answer. The second largest category was Caucasian at 24%. Following that, 22% identified as Latino. An additional 6% identified as African American. Finally, 2% identified as American Indian or Alaska Native or Asian or Pacific Islander.



N = 4,714

Primary Language:

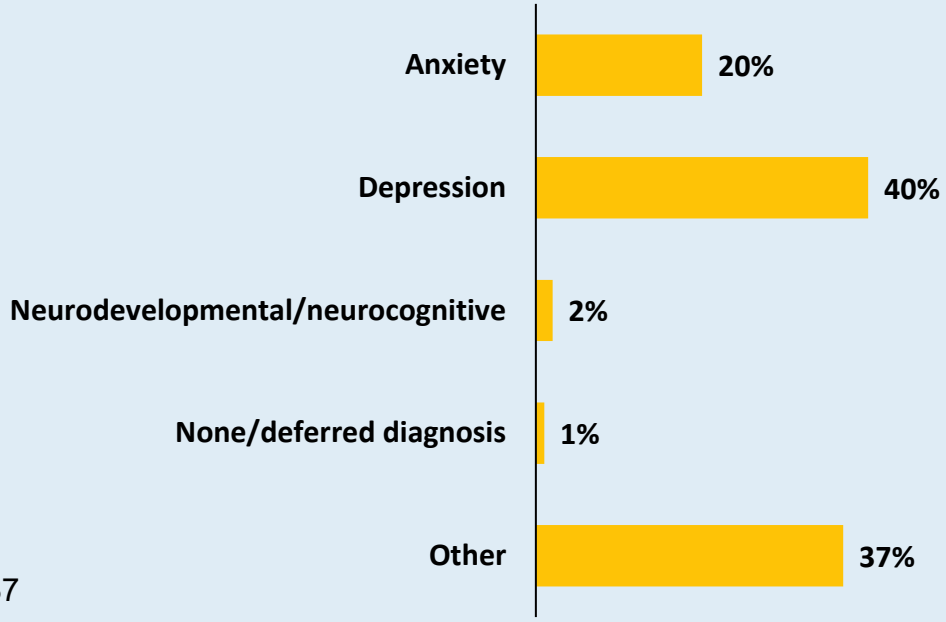
The graph below demonstrates that 67% of CWE participants identified English as their primary language. Additionally, 15% identified Spanish as the primary language, and 18% identified their primary language as something other than English or Spanish.



N = 4,738

Primary Diagnosis:

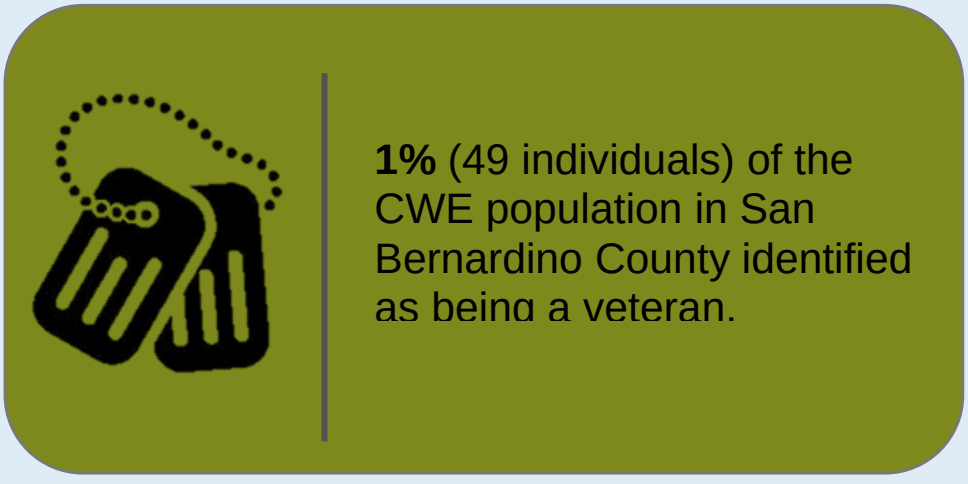
The graph below illustrates the diagnostic groups of CWE participants who received early intervention services. Most of the participants of CWE early intervention services fall under the category of Other. This category includes those who had a different diagnosis than those listed or more than one. The 1% of participants with no diagnosis or a deferred diagnosis either did not have an identifiable mental health need or the diagnosis was deferred pending further assessment. Of the remaining diagnoses, 40% were diagnosed with depression, 20% with anxiety, and 2% with neurodevelopmental/neurocognitive disorders.



N = 4,837

Veteran Status:

Only 1% of the CWE population identified themselves as veterans.



N = 4,746

Success Story

Beth, a local high school student, entered the program seeking services for difficulty coping with constant anxiety and frequent panic attacks. The goals for Beth's treatment were to decrease her panic attacks and increase her motivation. Her sessions focused on learning and practicing coping skills for negative emotions and understanding the effect of her thinking on her behaviors. Several sessions focused on identifying her values, beliefs about herself and the world, and what she considered important. At the conclusion of her treatment, Beth reported that she had developed long term goals for what she hopes to accomplish in her life, including attending college. Beth is no longer experiencing panic attacks and is much more motivated in her life.

Program Challenges

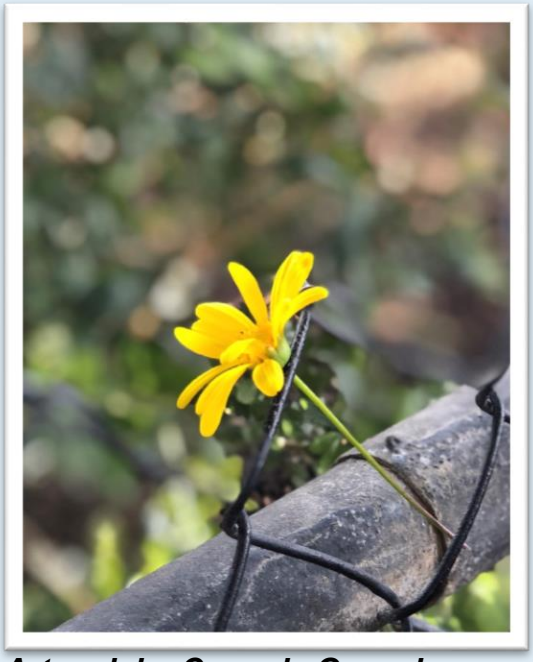
The CWE program had challenges related to staffing. When a clinician is on leave, it is difficult to fill the position temporarily. Additionally, primary care provider offices lack the knowledge of available mental health and substance abuse services making referrals difficult. An ongoing challenge has also been meeting the contractual requirement of establishing survivors of suicide groups due to the stigma of mental illness and suicide.

Program Solutions

To mitigate staffing issues, CWE providers continue to network with partnering agencies in order to create connections, and timely link participants to appropriate services when there is a shortage in staffing. In addition, CWE providers have continued to build relationships with local primary care providers in order to educate and provide information about available County programs. The program continues to work to establish suicide survivor groups by continuing to provide information on suicide prevention to faith-based leaders, local doctors, first responders, and family members.

Program Updates

Beginning in Fiscal Year 2020/21, the CWE program will be collaborating with one of its providers to launch a pilot program in collaboration with Chaffey Community College. This pilot program will expand CWE programs specifically to the Chaffey campuses in order to increase the accessibility of CWE services targeted toward those experiencing the early onset of a mental illness.



Artwork by Carmela Gonzalez

Collaborative Partners

- Adventist Medical Evangelism Network (AMEN) Clinic
- Arrowhead Regional Medical Center
- California Highway Patrol
- California State University, San Bernardino
- Chaffey Joint Union High School
- City of Rancho Cucamonga
- DBH Crisis Walk-in Centers
- Etiwanda School District
- Grand Terrace High School
- Hearts and Lives
- Heritage Intermediate School
- Highland Avenue Community Church
- Holy Innocents Catholic Church
- Inland Empire Health Plan (IEHP) Community Resource Center
- Lightfoot Elementary School
- March of Dimes
- Mexican Consulate of San Bernardino
- Mesa Community Counseling
- Mountain Community Hospital
- Mountain Counseling and Training
- Mountain Homeless Coalition
- National Alliance on Mental Illness (NAMI) Redlands
- Ontario Montclair School District
- Redlands Christian Reformed Church
- Redlands Church on the Hill
- Rim Community for Youth Coalition
- Rim of the World School District
- San Bernardino County Sheriff's Department
- St. John of God Health Care Services
- St. Mary's Hospital
- Transitional Care Management Team from Loma Linda
- Upland Health Care Center/AIDS Prevention
- Victor Valley Community College

Military Services and Family Support (SE-4)

The Military Services and Family Support (MSFS) program is categorized as a State Prevention and Early Intervention program that targets active military members, veterans, service members of the Reserves and National Guard, retired veterans, and their families. The program addresses the negative effects of traumatic events, and other unique challenges of military life, by providing in-home and/or community-based prevention and early intervention services.

To increase access to services and decrease stigma associated with mental health services, the MSFS program services are delivered in the homes of participants as well as at various sites that are conveniently located throughout San Bernardino County.

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

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

Prior to Fiscal Year 2019/20, the MSFS program offered services exclusively to service members and their families who served on or after September 11, 2001. As a result of overwhelming stakeholder and community feedback, the MSFS program has been expanded to include all military service members.

MHSA Legislative Goals and Related Key Outcomes

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

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

Improve timely access to services for underserved populations:

- 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 receives appropriate services as early in onset as practicable.

Reduce prolonged suffering:

- Reduce risk factors
- Reduced indicators
- 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.

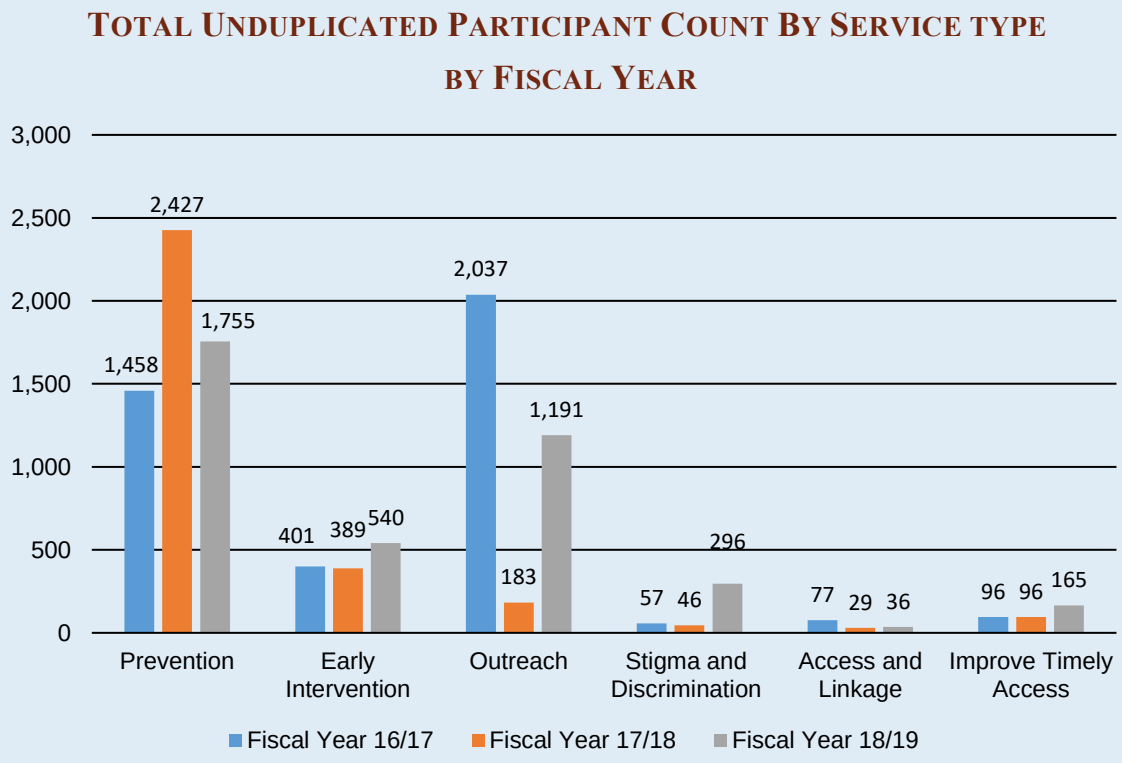
Increased acceptance, dignity, inclusion, and equity for individuals with mental illness and members of families.

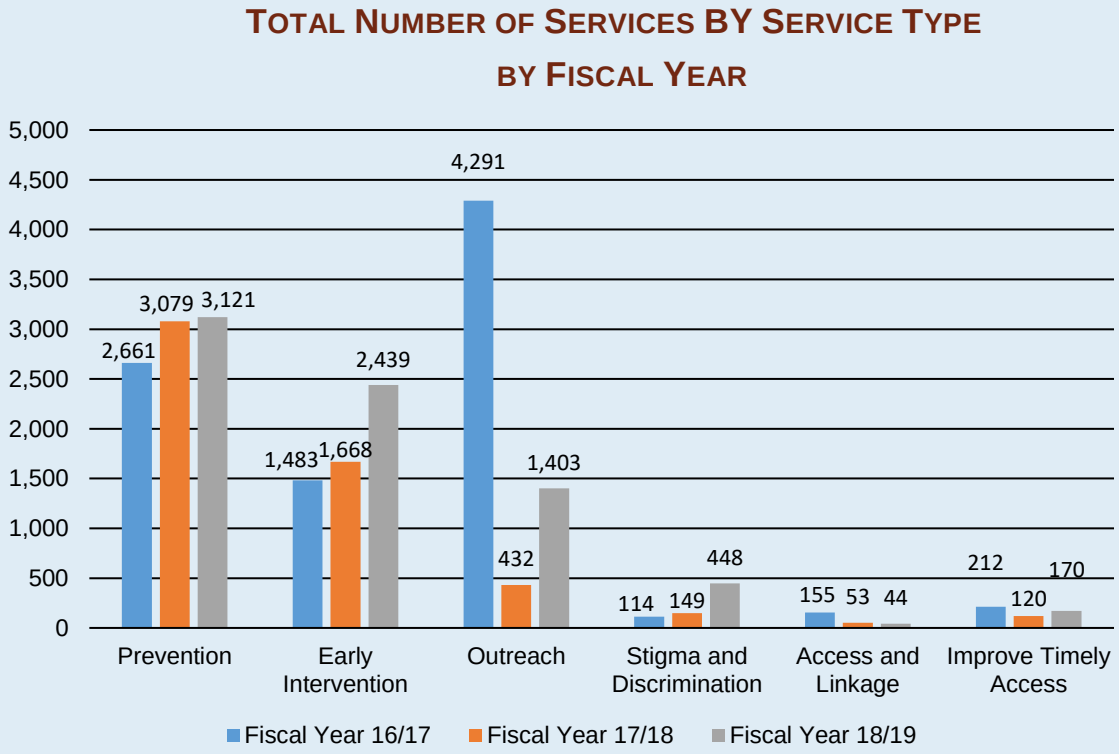
Artwork by Mauricio

Positive Results

Collectively, the MSFS program providers are contracted to serve 3,605 unduplicated participants annually. In Fiscal Year 2016/17, the MSFS program exceeded their contractual obligation by 521 unduplicated participants, serving 4,126 unduplicated participants. In Fiscal Year 2017/18 and Fiscal Year 2018/19, there was a slight decrease in unduplicated services. The program served 3,170 unduplicated participants in Fiscal Year 2017/18, and 3,983 unduplicated participants in Fiscal Year 2018/19. The decrease in unduplicated participants was possibly due to the ongoing challenges MSFS providers face with mental health stigma surrounding the military population. Additionally, the providers often have to re-establish some collaborative partnerships with military personnel due to relocation of previously established partnerships with military personnel.

The following tables illustrate the unduplicated participants served and number of services by fiscal year in the categories of Prevention, Early Intervention, Outreach, Stigma and Discrimination, Access and Linkage, and Improve Timely Access:





Prevention Services

The MSFS program has prevention activities that are designed to reduce risk factors for developing a potentially serious mental illness while building protective factors and increasing support. These activities promote positive cognitive, social, and emotional development and encourage a state of well-being that allows the individual to function well in the face of changing and sometimes challenging circumstances. The program has provided over 50 prevention activities each year for the last three fiscal years. Below are some of the activities offered:

- Community Resiliency Model which is used to assist participants in learning to increase sensations of wellness and resiliency.
- Equine Assisted Therapy and Learning which helps participants to uncover underlying issues related to their mental illness. This activity is often used in conjunction with early intervention therapy services.
- The National Curriculum and Training Institute (NCTI) © is a leader of cognitive behavior change programs. MSFS providers offer educational groups such as substance abuse and stress management. A component of NCTI © is the Adult Crossroads curriculum which includes programs specific to adults within the criminal justice system.
- Systemic Training for Effective Parenting (STEP) is a multicomponent parenting education curriculum which helps parents learn effective ways to relate to their children from birth to adolescence.
- The Parent Project offers parenting skills education designed for parents with strong-willed children.

- Mental Health First Aid is a skills-based training course that teaches participants about mental health and substance-use issues.
- United Service Organizations (USO) Deployment Curriculum for Children is an educational program for children and families of those who have been deployed.

Over the last three fiscal years, the MSFS program has observed a 20% increase in participant completion rate in their NCTI © curriculum and a 7% increase in participant completion rate in their Adult Crossroads Curriculum.

The table below illustrates the number of prevention participants and services by fiscal year.

Fiscal Year	Unduplicated Count	Number of Services
2016/17	1,458	2,661
2017/18	2,427	3,079
2018/19	1,755	3,121

Early Intervention

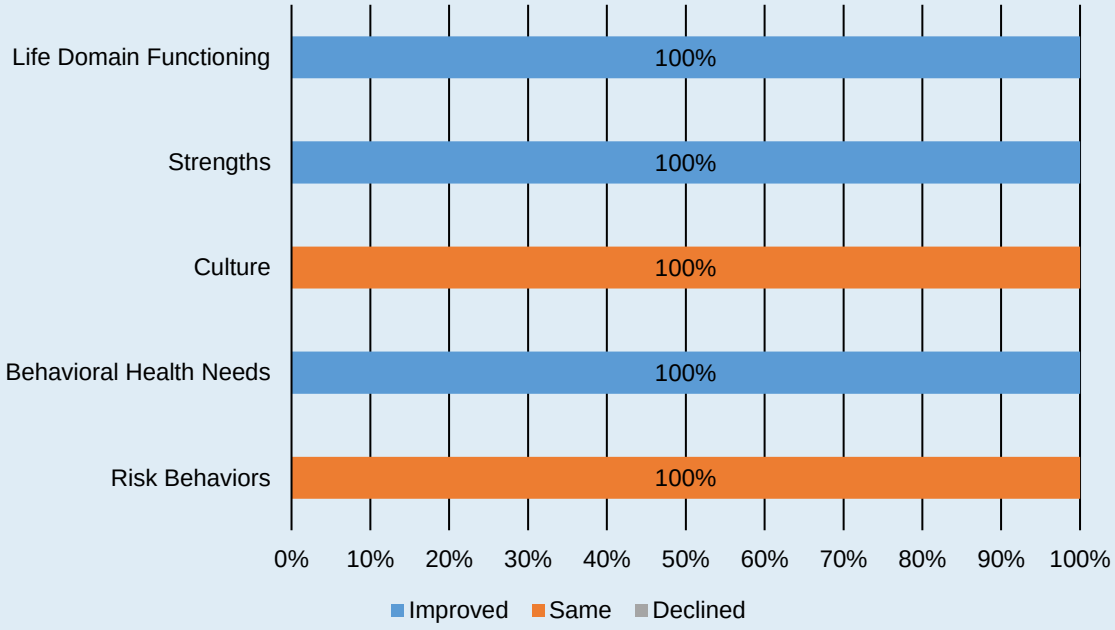
The MSFS program provides early intervention services which include treatment and interventions, and other services including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence.

Providers of MSFS early intervention services utilize the San Bernardino Adult Needs and Strengths Assessment - San Bernardino (ANSA-SB), 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.

The following graphs illustrate the percentage of participants whose various life functionality components improved, remained the same, or declined from initial assessment to completion of treatment for Fiscal Year 2017/18 and Fiscal Year 2018/19.

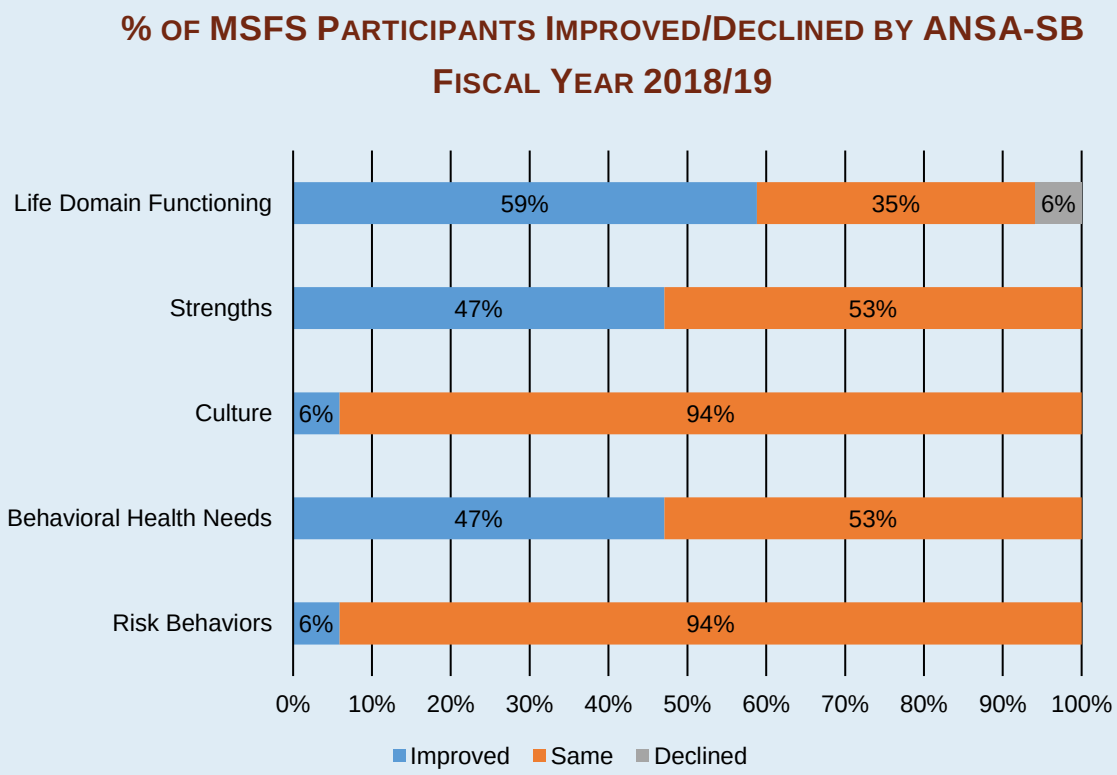
In the graph below, 100% of participants improved their life domain functioning, strengths, and behavioral health needs. Additionally, 100% of participants remained the same in the areas of culture and risk behaviors. None of the MSFS participants declined in any of the measured areas of needs and strengths in Fiscal Year 2017/18.

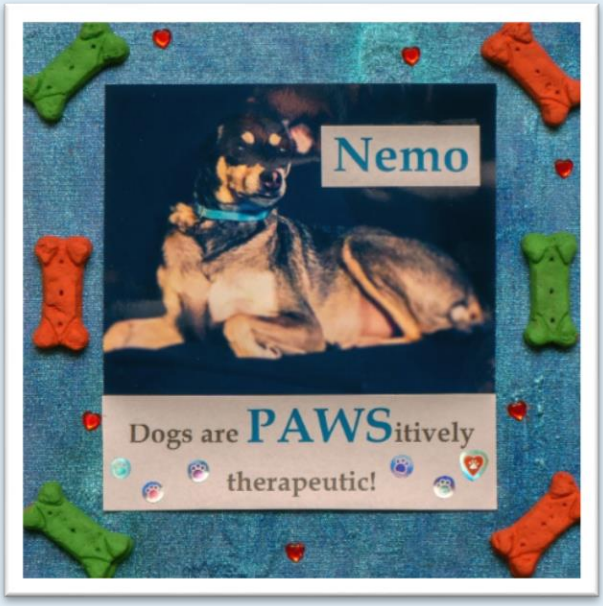
% of MSFS Participants Improved/Declined by ANSA-SB
Fiscal Year 2017/18



Artwork by Roxanne G.

In Fiscal Year 2018/19, the graph below illustrates that 59% of participants improved their life domain functioning while 35% remained the same. In the category of strengths and behavioral health needs, 47% improved while 53% remained the same. In the areas of culture and risk behaviors, 6% improved and 94% remained the same. Only 6% of participants declined and that is in the area of life domain functioning.

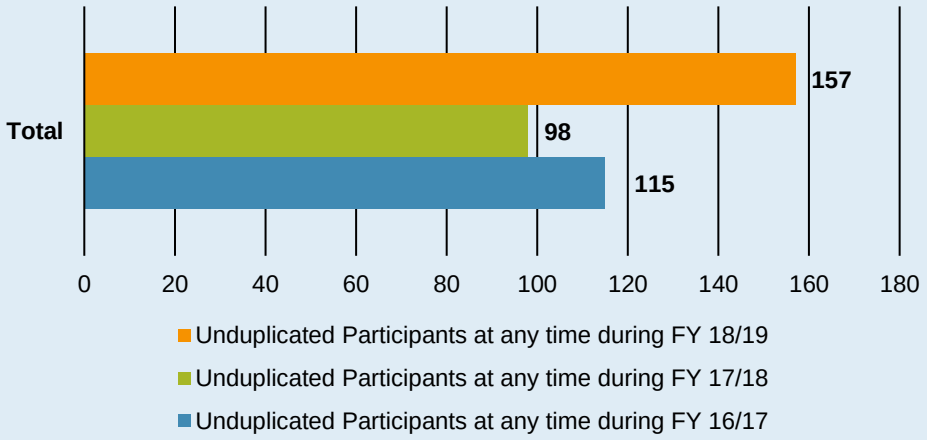




Artwork by Casset

The graph below illustrates the number of unduplicated MSFS participants who started a mental health treatment plan by fiscal year. In fiscal year 2016/17, the MSFS program had 115 participants who had no previous treatment with an open treatment plan. There were 98 participants in Fiscal Year 2017/18 with an open treatment plan in the fiscal year, and 157 in Fiscal Year 2018/19. This graph demonstrates the increase in early intervention services in Fiscal Year 2018/19, as providers of MSFS services have continued to focus heavily on these treatment services.

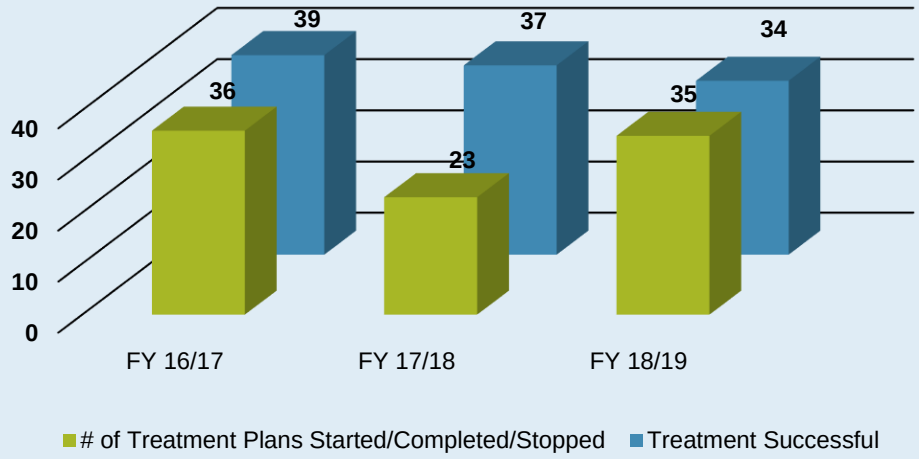
Number of Participants Who Started a Mental Health Treatment Plan by Fiscal Year for MSFS



The Successful Treatment by Fiscal Year and Number of Unduplicated Participants Who Started Mental Health Treatment Plan and Completed or Stopped by Fiscal Year for MSFS graph on the next page illustrates the number of unduplicated participants who started a mental health treatment plan and completed or stopped their plan and those who successfully completed their mental health treatment plans.

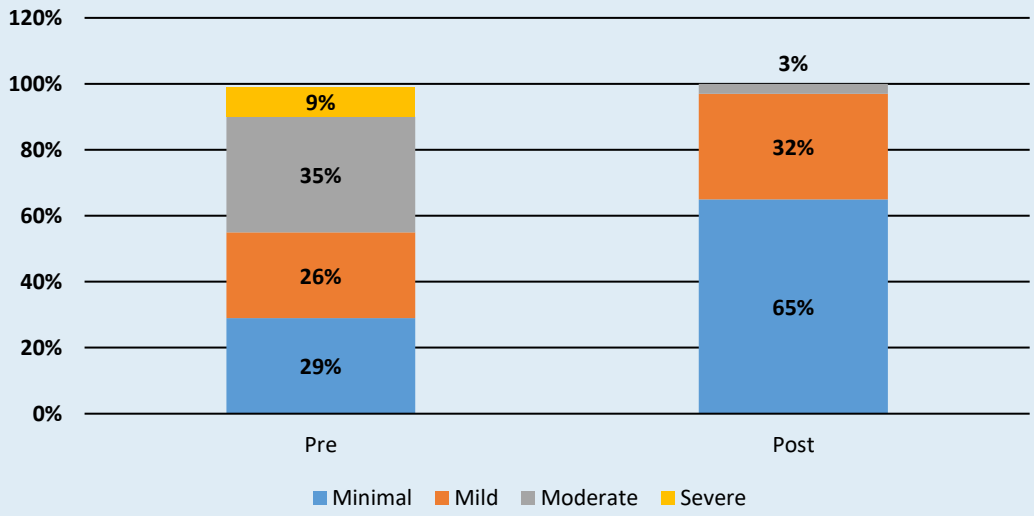
In Fiscal Year 2016/17, there were 36 unduplicated participants who started a mental health treatment plan. In the same fiscal year, 39 participants completed their treatment successfully. In Fiscal Year 2017/18, there were 23 participants who started a mental health treatment plan in the fiscal year, and 37 participants completed treatment successfully. In Fiscal Year 2018/19, there were 35 participants who started a mental health treatment plan and 34 participants completed treatment successfully. A treatment plan may be opened in one fiscal year and closed in the next, dependent upon when the treatment plan was started. The majority of treatment plans started resulted in participants meeting their treatment goals successfully.

SUCCESSFUL TREATMENT BY FISCAL YEAR AND NUMBER OF UNDUPLICATED PARTICIPANTS WHO STARTED A MENTAL HEALTH TREATMENT PLAN AND COMPLETED OR STOPPED PLAN BY FISCAL YEAR FOR MSFS



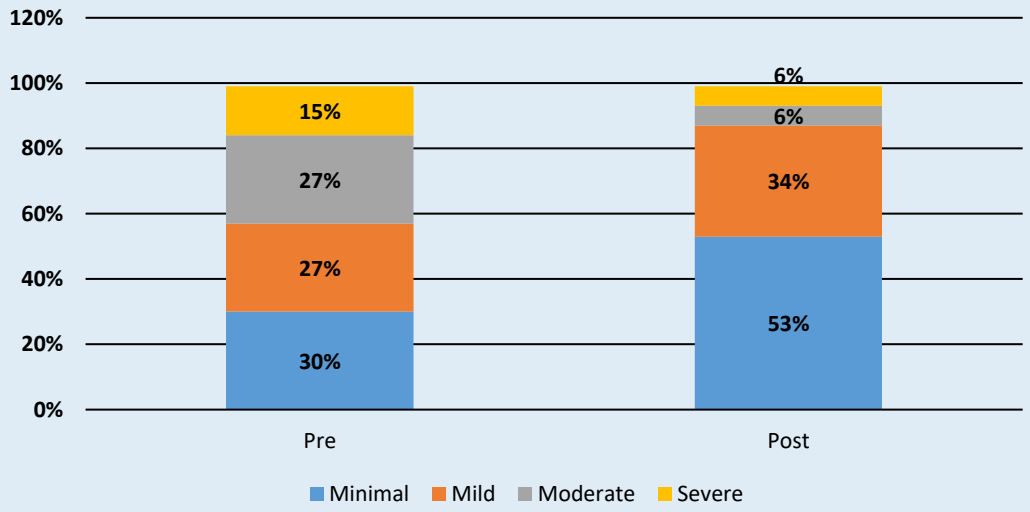
The graph shown below depicts the comparison of client pre to post scores for the Becks Depression Inventory. Higher scores indicate greater depressive symptoms. Using the threshold criteria established for this scale, clients' scores were categorized according to varying levels of minimal to severe depressive symptoms. Before receiving treatment, several clients (70%) reported scores that met either Severe, Moderate, or Mild Depression criteria. Following early intervention treatment, there was a significant reduction in depressive symptoms reported for all clients, with 97% of clients meeting only *Minimal* or *Mild* Depression criteria, 3% meeting Moderate Depression criteria, and *no* clients (0%) meeting the Severe Depression criteria. In turn, the results indicate that clients significantly reduced their depressive symptoms during their participation in MSFS services.

MSFS FISCAL YEAR 2018/19 PRE TO POST COMPARISON DEPRESSION RESULTS



The graph shown below depicts the comparison of client pre to post scores for Becks Anxiety Inventory. Higher scores indicate greater symptoms of anxiety. Using the threshold criteria established for this scale, clients' scores were categorized according to varying levels of minimal to severe symptoms of anxiety. Before receiving treatment, 69% of clients reported scores that met Mild, Moderate, or Severe Anxiety criteria. However, following Early Intervention treatment, there was a significant reduction in anxiety symptoms reported for all clients, with only 46% falling under the criteria for Mild, Moderate, or Severe Anxiety and more than half of clients (53%) met criteria for only *Minimal* levels of anxiety. In turn, the results indicate that there was a substantial reduction of anxiety symptoms at the conclusion of clients' participation in the MSFS program.

MSFS Fiscal Year 2018/19 Pre to Post Comparison Depression Results



Outreach for Increasing Recognition of Early Signs of Mental Illness

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. In the past three fiscal years, MSFS has provided outreach services to a combined total of 3,460 unduplicated potential responders. In Fiscal Year 2016/17, MSFS provided outreach services to 2,037 unduplicated participants. 232 unduplicated participants were reached in Fiscal Year 2017/18. In Fiscal Year 2018/19, 1,191 unduplicated participants received outreach services. Below is an overview of the settings and types of responders reached in these outreach activities for the last three fiscal years.

Outreach services were provided in the following settings:

- Community-based organizations
- Community events
- Hospitals
- Law enforcement departments
- Schools
- Military bases
- County offices
- Health centers
- Behavioral health clinics

The following types of responders were reached during these MSFS outreach activities:

- Child protective services personnel
- Community services providers
- Consumer family members
- Cultural brokers
- Emergency medical service providers
- Employers
- Families
- Law enforcement personnel
- Military personnel or veterans
- Peer providers
- Primary health care providers
- Community service providers
- Homeless services providers
- School personnel
- Students and educators

In Fiscal Year 2017/18, the MSFS program had challenges with their outreach activities due to ongoing stigma surrounding mental health in the military. The MSFS program providers continue working to build relationships with the military bases so as to provide mental health services to its target population.

Stigma and Discrimination

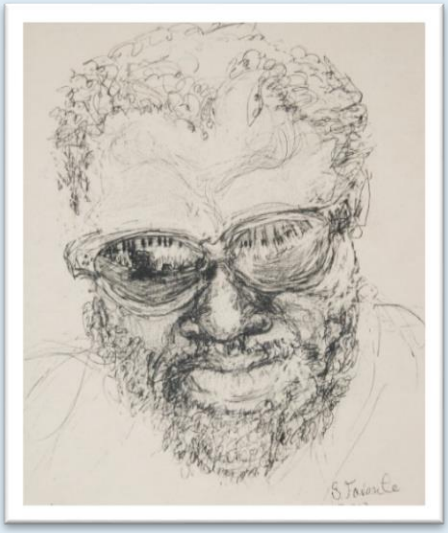
The County strives to incorporate non-stigmatizing and non-discriminatory strategies to promote, design, and implement programs that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental health concern, having a mental health concern, or seeking mental health services, and making services accessible, welcoming, and positive. The MSFS program does this by offering suicide awareness education, cultural competency trainings, multidisciplinary collaboration, and outreach education in non-stigmatizing settings with individuals that understand military culture and norms.

The table below illustrates the unduplicated participants in the Stigma and Discrimination strategy activities. This table demonstrates the increasing efforts of the MSFS service providers as they continue to strive to reduce the stigma surrounding seeking mental health services in the military population.

Fiscal Year	Unduplicated Participants	Number of Services
2016/17	57	114
2017/18	46	149
2018/19	296	448

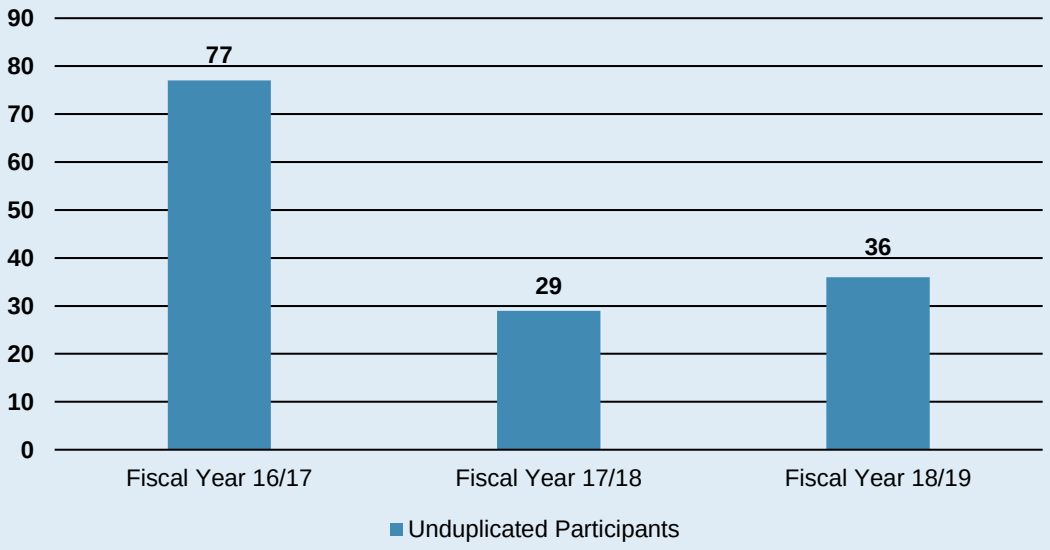
Access and Linkage to Treatment

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, as early in the onset of these conditions as possible, to care and treatment that will meet their needs.



Artwork by Sarah Favorite

The table below provides an overview of the number of unduplicated participants who received referrals to a higher level of treatment. MSFS providers partner with the surrounding military bases, local veteran services providers including San Bernardino County Department of Veterans Affairs, local community colleges, and others to provide linkage services and assist participants in obtaining the appropriate level of care for their condition.



The MSFS program participants were referred to the following kinds of treatment:

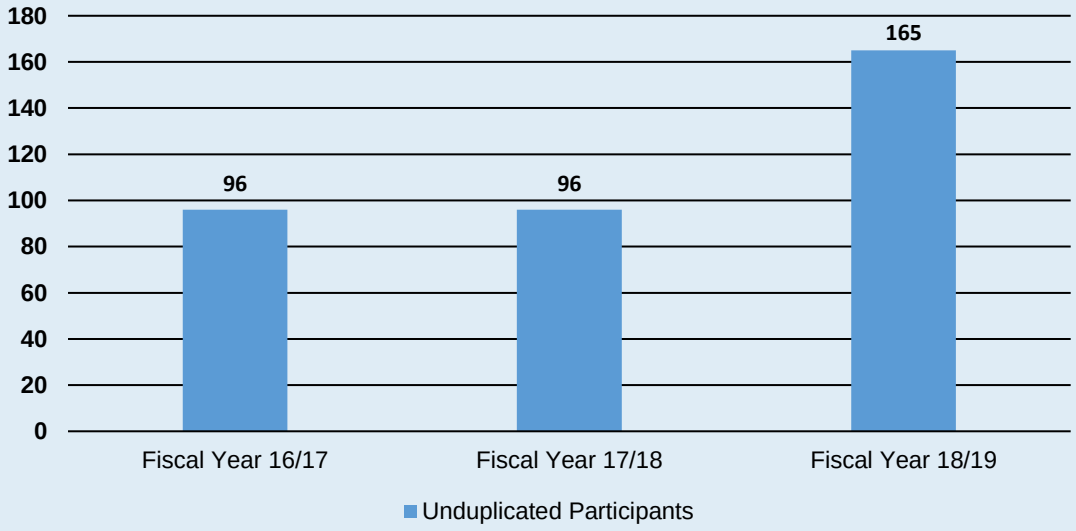
- Assessment
- Individual Outpatient Services
- Rehab/Activities of Daily Living Groups
- Crisis Intervention
- Crisis Stabilization
- Intensive Home-Based Mental Health Services
- Medication Management/Support/Education
- Psychotherapy Groups
- Psychological Testing
- Therapeutic Behavioral Services (TBS)
- Recovery-Based Engagement Support Teams (RBEST)

In Fiscal Year 2018/19, the Access and Linkage to Treatment strategy began tracking whether the referrals were County-funded agencies or non-County funded agencies. Of the referrals made in Fiscal Year 2018/19, all participants were referred to County-funded agencies.

Improve Timely Access to Treatment

In order to increase access to appropriate mental health services for underserved populations, the Improve Timely Access to Treatment strategy focuses on providing appropriate services based on needs such as accessibility, cultural and language appropriateness, transportation, family focus, available hours, and cost of services.

The underserved populations provided services by the MSFS program include active military members, service members of the Reserves and National Guard, recently retired military/veterans and their family members. In addition, the MSFS program served members of minority groups including ethnicities and sexual orientation, trauma-exposed individuals, or children in stressed families.



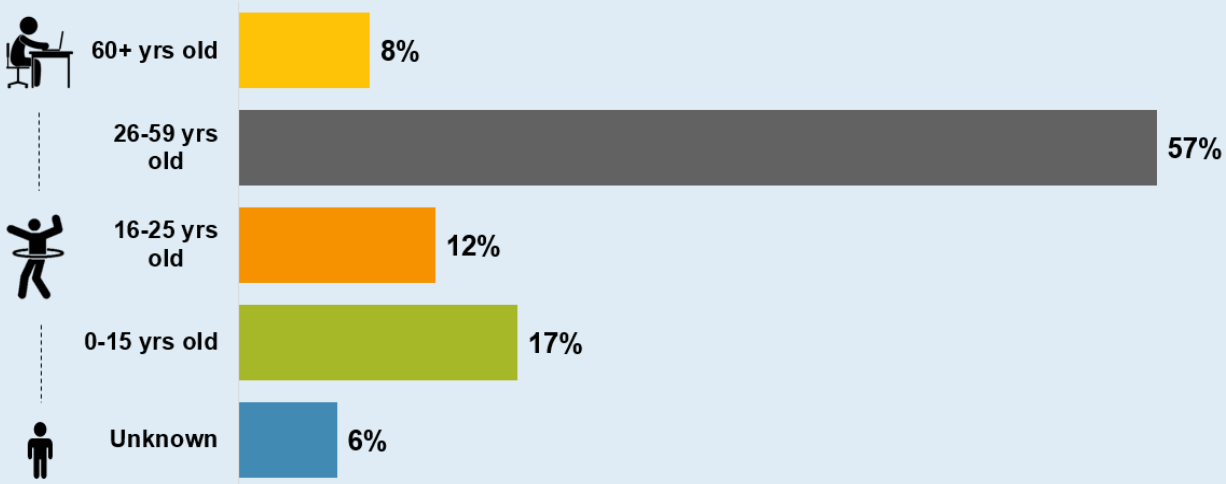
Artwork by Raquel Acosta

Fiscal Year 2018/19 Program Demographics

The following graphs illustrate the demographics in various categories of the MSFS participants.

Age:

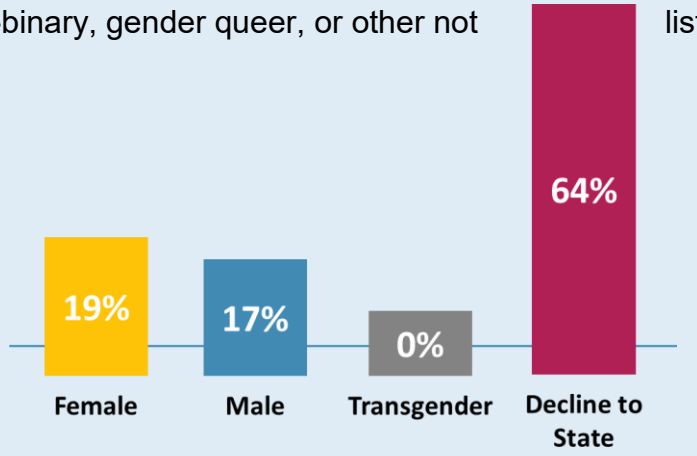
The graph below illustrates the ages of the MSFS participants. The majority of participants served, 56%, were between the ages of 26-59 years old. The second largest group was 0-15 years old at 15%. The TAY group, 16-25 years old, comprised 12% of the MSFS participants, and 8% identified as 60+ years old. The remaining 6% of the population age groups is unknown or the participant declined to state.



N = 3,295

Gender:

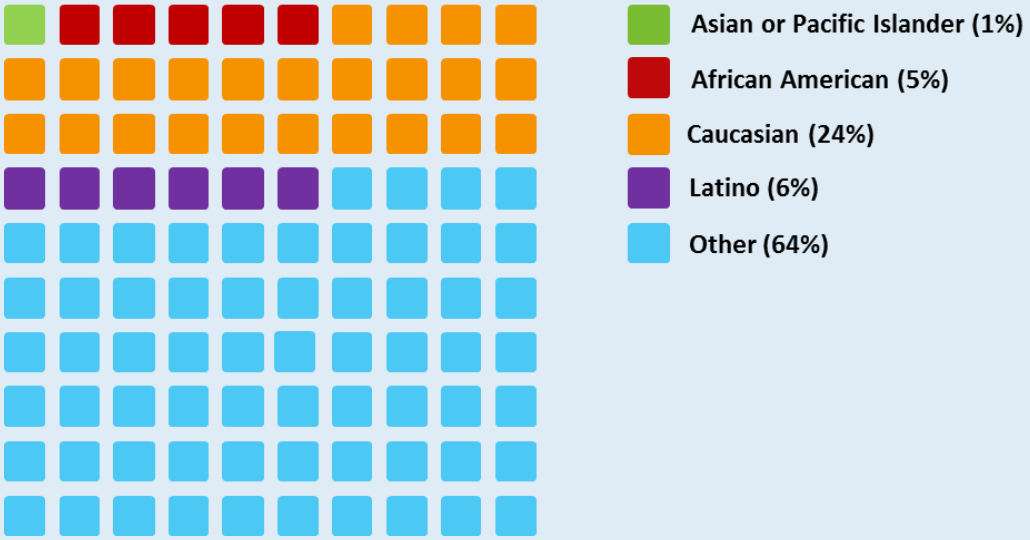
The graph below demonstrates that 19% of the MSFS participant population identified as female, 17% identified as male, and 64% declined to state. None of the participants identified as transgender, non-binary, gender queer, or other not listed.



N = 3,285

Ethnicity and Ancestry:

The graph below illustrates the various ethnicities of participants of the MSFS program. The largest group was 64% in the category of *Other*. This category includes those who identified as other, more than one race, or declined to answer. The second largest category was Caucasian and/or White at 24%. There were 6% of participants in the Latino and/or Hispanic category. The African American and/or Black population made up 5% of participants. Only 1% identified as Asian or Pacific Islander and 0% identified as American Indian or Alaska Native.



N = 3,221

Primary Language:

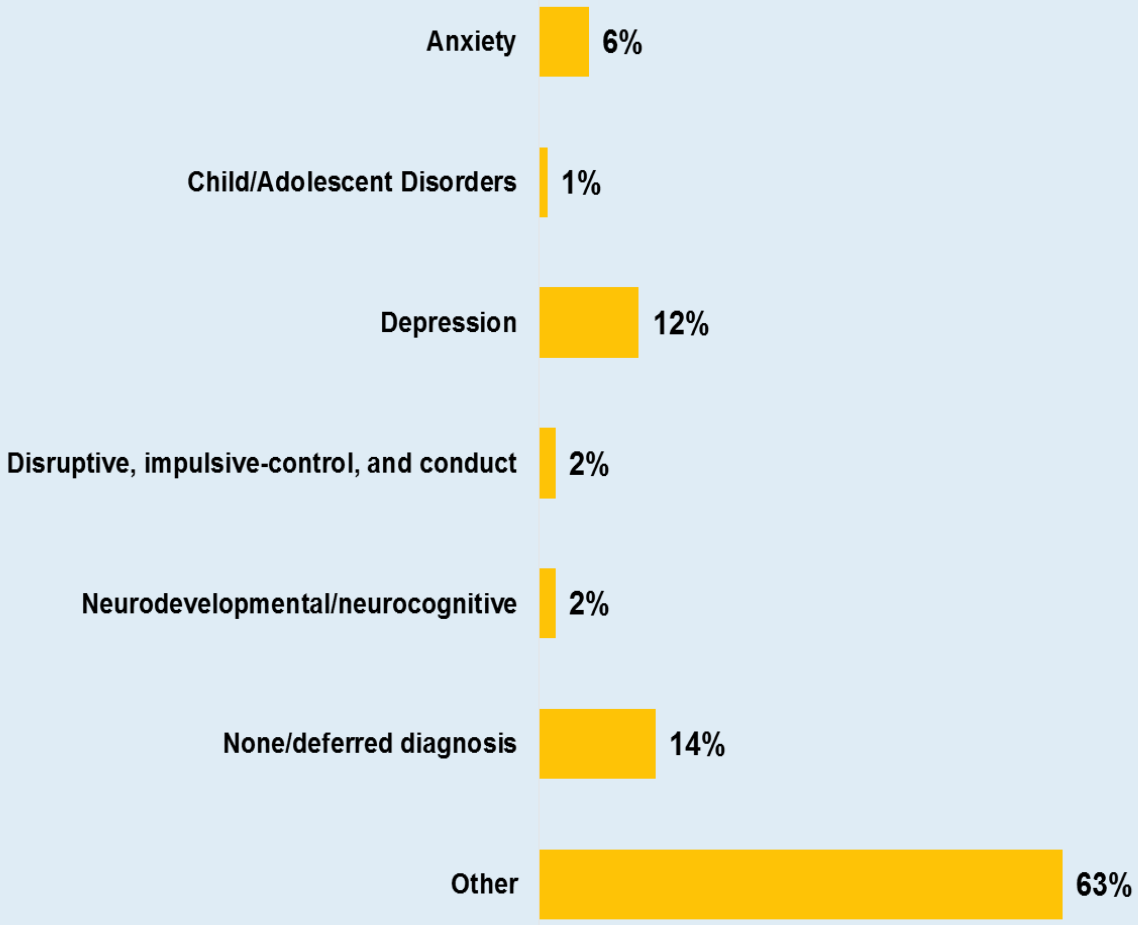
The graph below demonstrates that 100% of MSFS participants identified English as their primary language. None of the participants identified Spanish or a different language as their primary.

English

N = 3,295

Primary Diagnosis:

The graph below illustrates the diagnostic groups of MSFS participants who received early intervention services. Most of the participants of MSFS early intervention services fall under the category of Other. These participants either had a different diagnosis, or more than one. The 14% of participants with no diagnosis or a deferred diagnosis either did not have an identifiable mental health need or the diagnosis was deferred pending further assessment. Of the remaining diagnoses, 12% were diagnosed with depression, 6% with anxiety, 2% with disruptive, impulsive-control, and conduct or neurodevelopmental/neurocognitive disorders, and 1% with child/adolescent disorders.



N = 3,349

Veteran Status:

Of the MSFS participants, 17% identified as being veterans. The MSFS program serves the whole military family, so the majority of those served would not necessarily be veterans. Additionally, due to the stigma surrounding seeking mental health services in the military, not all participants are comfortable identifying their military status and therefore may decline to state.

17% (556 individuals) of the MSFS population in San Bernardino County identified as being a veteran.

N = 3,295

Artwork by Eric Olinger

Success Story

A family of siblings lost their uncle, a Marine veteran. They were exhibiting typical symptoms of bereavement due to the loss and trauma. Due to their mother grieving the loss of her brother, the children struggled to express their emotions as they did not want to upset their mother further. Through the MSFS program, the children received Early Intervention therapy services that trained the family to acknowledge their resources, utilize both the emotional and logical sides of the brain, and replace negative core beliefs with more adaptive, meaningful ones. After participating in the program, the children were able to share their positive memories of their uncle, and see some of his positive qualities in themselves and each other. The family made remarkable progress in their early intervention services and were anticipated to be discharged from services the week following their uncle's birthday.

Program Challenges

The MSFS program has experienced a challenge with referral resources. If a client needs a referral to a higher level of care, there is often a challenge with finding psychiatric care in the more rural areas of the County. This is due in part to finding a psychiatrist who accepts the military administered Tri-Care health insurance and/or a provider's driving distance.

Program Solutions

For immediate need, the MSFS program refers participants to the nearest Crisis Walk-In Center (CWIC) who accepts Tri-Care. In addition, the MSFS providers work with the Department of Veterans Affairs and through multidisciplinary collaboration to prioritize needs and find other resources for care.

Program Updates

There are no planned program updates for the MSFS program.

Collaborative Partners

- Barstow Homeless Shelter
- Barstow Outreach Center for Veterans
- Equus Medendi
- Fort Irwin National Training Center
- Loma Linda Veterans Administration
- Major Gwenyth Hobson
- San Bernardino Valley College
- Twenty-nine Palms Marine Corps Air Ground Combat Center
- Veterans Affairs
- Veterans Partnering with Communities
- Veterans Services at Barstow Community College

Student Assistance Program (SAP) (PEI SI-1)

The Student Assistance Program (SAP) uses a school-based approach to provide focused services to Kindergarten through 12th grade students needing interventions for substance use, mental health, academic, emotional, and/or social issues.

SAP student and family services include:

- Mental Health and Substance Use Screenings and Assessments
- Mental Health Educational Presentations
- Critical Incident Stress Debriefing
- Social Skill/Coping Skills groups
- Alcohol and Drug Education and Intervention
- Caregiver Support
- Case Management
- Suicide Prevention support and presentations
- Individual and group counseling

Southern Regional Student Wellness Conference

The SAP program also provides support and education to the County's schools and school districts with the partnership of San Bernardino County Superintendent of Schools (SBCSS). SBCSS provides Positive Behavioral Intervention and Supports (PBIS) training and implementation services as well as school system navigation training and support to the SAP services contract providers.

Another popular form of support and training provided by the SAP program is the annual Southern Region Student Wellness conference sponsored by the Department of Behavioral Health and SBCSS. This conference provides education, trainings and supports on identification of behavioral issues, positive behavior interventions, and resource and referral information to SAP providers, school staff and other educational partners that are responsible for working with students.

MHSA Legislative Goals and Related Key Outcomes

Reduce prolonged suffering associated with untreated mental illness:

- Reduce risk factors.
- Reduce indicators.
- Increase protective factors that may lead to improved mental, emotional, and relational functioning.

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

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

Improve Timely Access to Services:

- Increase extent to which individual or family from underserved population who need mental health services because of risk or presences of a mental illness receives appropriate services as early in onset as practicable.

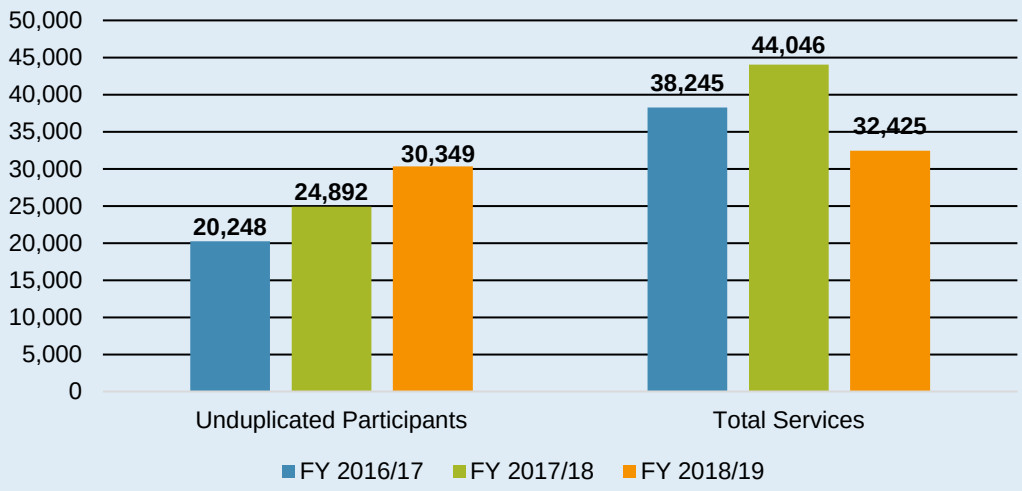
Reduce stigma and discrimination associated with mental illness:

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

Positive Results

The SAP program served over 30,000 participants in Fiscal Year 2018/19. The chart below shows a steady increase of unduplicated participants over the previous years. The chart also indicates a decrease in total services provided by the program. In Fiscal Year 2018/19, the SAP program refocused its services to provide increased Early Intervention services. This change coupled with providers adjusting their business processes and staffing to accommodate the change led to a slight decrease in total services provided during the fiscal year. The program providers have reported an increase in service delivery which will be reflected in the upcoming report.

SAP Program Unduplicated Participants



Prevention

The SAP program's prevention activities address the following topics:

- Alcohol and drug education and interventions
- Anger management
- Healthy dating and relationships
- Life/social skill building
- Teen pregnancy
- Truancy
- Suicide prevention

> *"I was able to use some of the techniques and skills used during a classroom group session. This was helpful with maintaining my classroom. I wish we could have this kind of classroom support all year."*
>
> *-Elementary School Teacher*

The criteria used to determine a student's eligibility for the SAP program consists of a review of the students' school attendance, behavioral concerns at home or school, decrease in school achievement, youth at risk of juvenile justice involvement, early onset of mental health concerns, and exposure to trauma. School counselors, teachers, and/or parents can make referrals to the SAP program providers for screening and assessments. The students enrolled in the SAP program are able to receive services at their school, which increases the access and participation in the needed services. The SAP providers also provide general prevention services to their designated schools

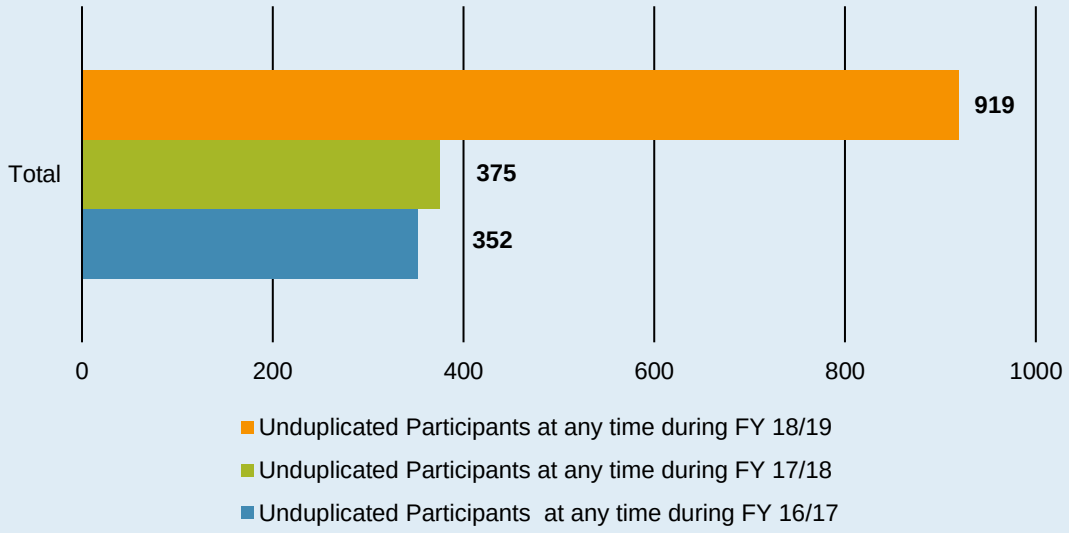
schoolwide in the form of presentations at school assemblies and afterschool group activities.

Early Intervention

Early Intervention services provided by the SAP program include: mental health assessments, individual and group counseling, case management, relapse prevention and referrals for higher level of care if needed. These services are available at the child's home, school, or in the provider's clinic office.

The chart below shows consistent increases in successful early intervention treatment services. Successful treatment is defined by a participant completing their treatment goals by the end of their individual treatment plan timeframe. Most SAP early intervention treatment plans are completed within six months.

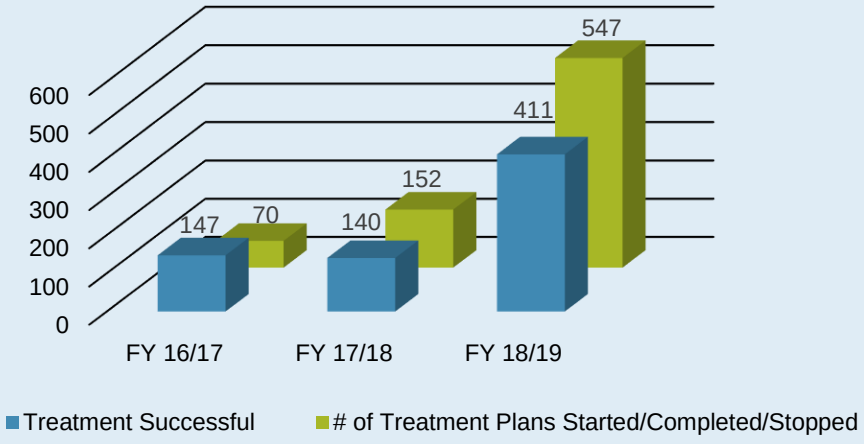
NUMBER OF PARTICIPANTS WHO STARTED A MENTAL HEALTH TREATMENT PLAN BY FISCAL YEAR



This chart also reflects the increased focus on early intervention services in Fiscal Year 2018/19. In 2017 California schools were mandated to implement and or increase their mental health services available on campus. The SAP program was refocused to assist schools and school districts that have students with high risk factors, which may contribute to mental health concerns. The refocus also includes schools that need additional support implementing a mental health support program on their campuses.

The following chart illustrates the number of Early Intervention episodes that were both opened and closed within the given fiscal year. It also provide detailed counts for the number of treatment plans completed successfully. The treatment successful count contains some episodes that may have been opened in a previous fiscal year. The majority of episodes open result in participants meeting their treatment goals successfully.

SUCCESSFUL TREATMENT BY FISCAL YEAR AND NUMBER OF UNDUPLICATED PARTICIPANTS WHO STARTED A MENTAL HEALTH TREATMENT PLAN AND COMPLETED OR STOPPED PLAN

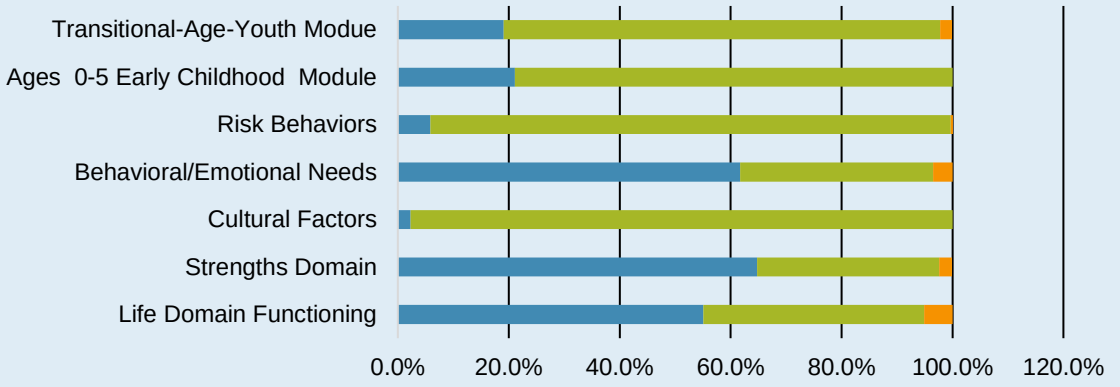


All students participating in Early Intervention services through the SAP program receive a Child and Adolescent Needs and Strengths (CANS) clinical assessment. Participants are assessed at the beginning of treatment, every six months, and at the completion of services.

Artwork by Faith Ikeda

The chart below shows that a majority of participants improved in the areas of behavioral and/or emotional needs, strengths, and life functioning upon completion of their treatment plans.

SAN BERNARDINO CANS PERCENTAGE OF CLIENTS WHO IMPROVED/DECLINED FOR FISCAL YEAR 2018/19



	Life Domain Functioning	Strengths Domain	Cultural Factors	Behavioral/Emotional Needs	Risk Behaviors	Ages 0-5 Early Childhood Module	Transitional-Age-Youth Modue
Improved	55.1%	64.8%	2.3%	61.7%	5.9%	21.1%	19.1%
Same	39.8%	32.8%	97.7%	34.8%	93.8%	78.9%	78.7%
Declined	5.1%	2.3%	0.0%	3.5%	0.4%	0.0%	2.1%

Artwork by Gil

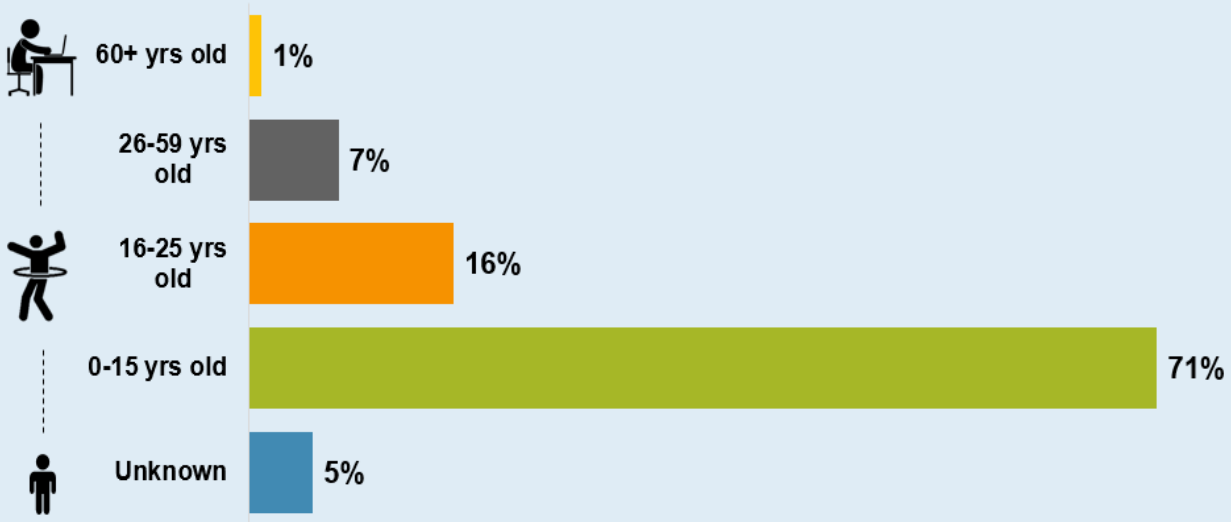
Fiscal Year 2018/19 Program Demographic

The following charts illustrate the demographics provided by the Student Assistance Program in Fiscal Year 2018/19. The SAP program targets children and youth for service delivery.

Age:

The following chart illustrates the age breakdown of SAP participants. SAP is a program that targets school aged children and therefore 72% of participants are children ages

0-15 and Transitional Aged Youth ages 16-25. The SAP program also services adults ages 26-59 and older adults 60+ years old via parents/caretakers and school personnel which make up a combined 8%. The other 5% of participant age groups were unknown or declined to answer.

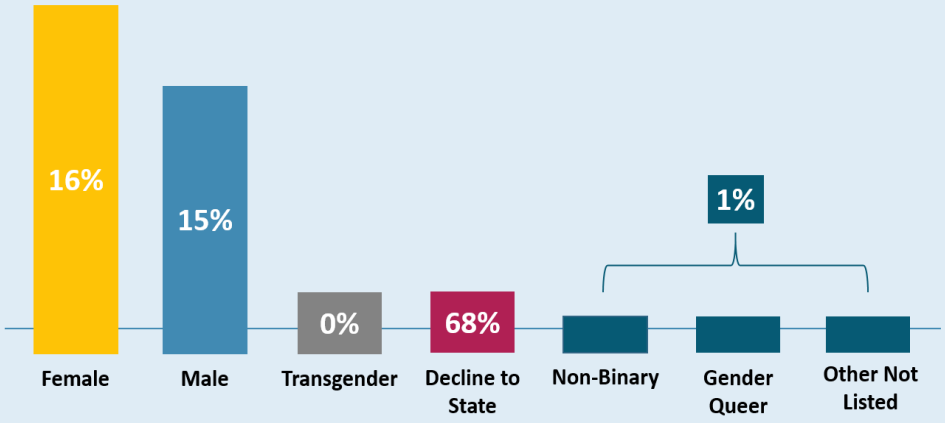


N=26,551

Gender:

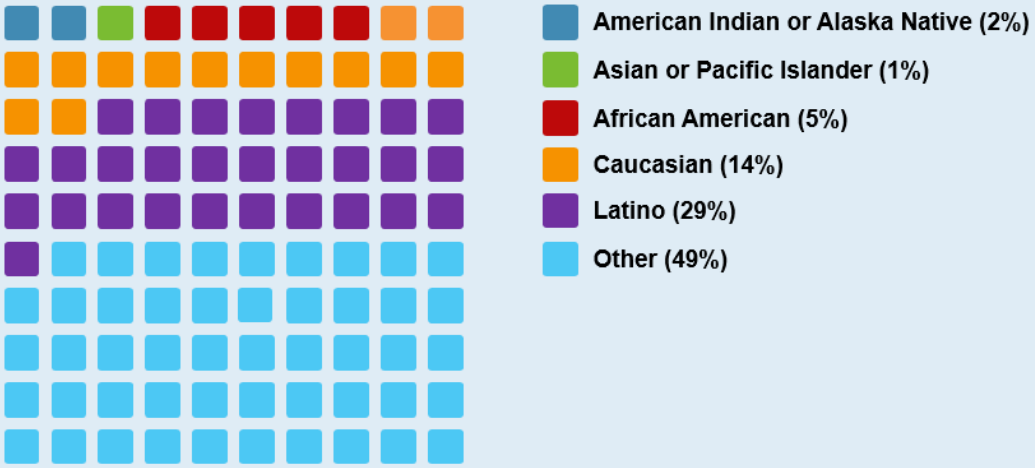
The chart below illustrates the SAP participants' gender identity. Sixteen percent of SAP participants identified as female, 15% identified as male, 0% identified as transgender, 1% identified as Non-binary, Gender Queer or Other not listed and 68% declined to state.

N= 26,548



Ethnicity and Ancestry:

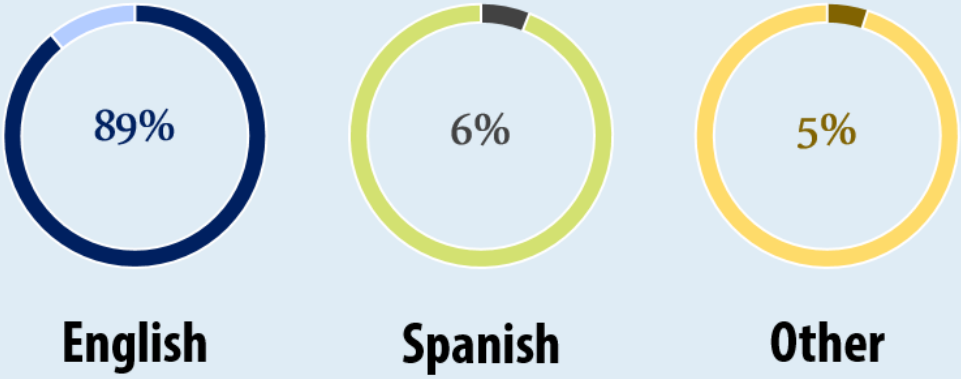
The graph below illustrates the various ethnicities of the SAP participants. The majority of participants identified as Other at 49%. This includes those that identified as multiple ethnicities, other ethnicities not listed, or declined to state. Additionally, 29% identified as Latino and 14% identified as Caucasian. There were 5% of participants who identified as African American, 2% who identified as American Indian or Alaska Native, and 1% who identified as Asian or Pacific Islander.



N= 43,405

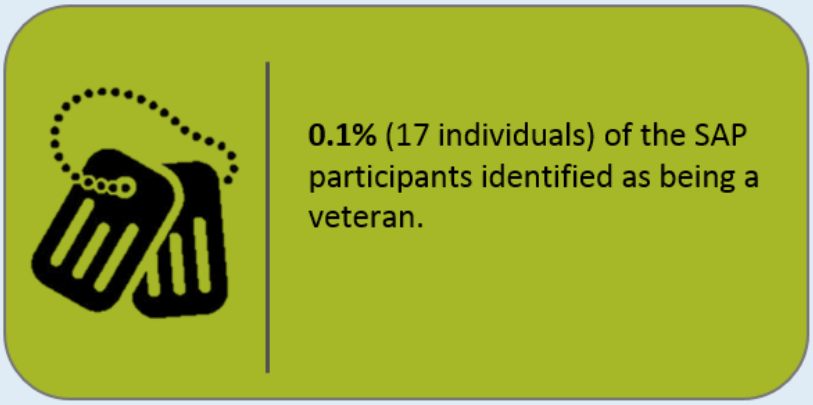
Primary Language:

The SAP program seeks to provide services to participants in their primary language. The chart below shows that 89% identified English and 6% identified Spanish as their primary language. Five percent of participants selected other languages or declined to answer.



N=26,555

Veteran Status:



N=26,551

Success Story

"Melody" is a child living with her mother, grandmother, and siblings. The student was referred to SAP for counseling by her school counselor. Melody's mental health assessment revealed that she was exposed to some traumatic environmental events which caused her family to move from their native country to California. As the family settled into their new home, Melody began to have trouble sleeping, irrational crying, and refusal to attend school.

The SAP program was able to provide Melody and her family therapy and teach them skills to help effectively express and manage Melody's emotions. The SAP team helped Melody find enjoyable activities in school. Melody did so well that she was recognized for outstanding citizenship. Melody told her counselor that she was grateful to receive services in her native language because she was homesick and had a hard time adjusting to the new school and culture.

Program Challenges

SAP program providers stated that student drug use and suicidal ideation were particularly challenging in Fiscal Year 2018/19. The providers also struggled with maintaining adequate capacity to serve the demand and meet the needs associated with an increase in Medi-Cal reporting requirements.

Program Solutions

The SAP program increased their alcohol and drug education and intervention groups. They also provided and plan on continuing to provide Suicide prevention presentations to the community and school personnel. The SAP providers are partnering with community organizations to help increase awareness and provide resources to the communities with the highest risk for substance abuse and communities with a history of known suicide attempts.

The SAP providers are meeting quarterly to discuss capacity concerns and share best practices regarding meeting program reporting requirements.

Program Updates

There are no planned program updates for Fiscal Year 2020/21.

Collaborative Partners

- Desert Mountain Children's Center
- Lutheran Social Services of Southern California
- Mountain Counseling & Training
- San Bernardino County Superintendent of Schools
- South Coast Community Services
- Victor Community Support Services
- West End Family Counseling Services

Early Psychosis Care Program

Psychosis is a severe disturbance in mental health in which thought and emotions are so impaired that contact is lost with external reality. Early warning signs and symptoms, lasting from days to several years, often foreshadow the onset of a serious and persistent mental illness with psychotic features. This early warning phase is a powerful point of intervention for curbing escalating psychiatric symptoms, distress, and functional disability. People experiencing this early phase are considered to be at a Clinical High Risk (CHR) for developing a serious illness.

Artwork by Carmela Gonzalez

For the majority of individuals who experience psychosis, the onset of symptoms occurs between the ages of 16 and 25. Research of existing treatment models indicate that some individuals can avoid a lifetime of disability and find fulfillment in daily life with appropriate and timely intervention.

The intent of the Early Psychosis Care program is to identify individuals with a clinical high risk as early as possible in the warning phase of psychosis and/or intervene as soon as possible during the first episode of psychosis.

The Challenge

A brief review of research indicates that three out of 100 people experience psychosis at some time in their lives, with approximately 100,000 adolescents and young adults in the U.S. experiencing a first episode psychosis each year. People presenting with early psychosis usually present with multiple problems such as suicidal ideation, aggressive behavior, legal difficulties, school challenges, and are often diverted to other systems such as the criminal justice system. Additionally, treatment delays are common throughout the U.S. Research suggests that 68% of patients in the U.S. who experience a psychotic episode for the first time present a Duration of Untreated Psychosis (DUP) greater than 6 months. Additional information published by the National Council for Behavioral Health suggests that of persons experiencing psychosis, the average person does not engage with treatment until an average of 74 weeks (approximately 18 months) after the onset of the illness.

Longer durations of untreated psychosis are associated with:

- Increases in severity of symptoms,
- Increased numbers of psychiatric hospitalizations and relapse rates,
- Reduced social and cognitive functioning, and
- Poor responses to treatment.

Psychosis can be treated and early treatment increases the chance of a successful recovery. Recent studies conducted show that early intervention services, which include anti-psychotic medication, yield high rates of remission, ranging from 75% to 85% over a period of 1 to 2 years. Overall, studies consistently suggest that compared with standard care, an early intervention approach to treatment of early psychosis results in modestly superior benefits for a wide range patients through high rates of remission, better symptom management, and greater adherence to and retention in treatment. Similarly, an early intervention approach results in better social and vocational outcomes.

Existing Efforts

Currently, the Department of Behavioral Health provides a continuum of services ranging from prevention and early intervention, crisis services, and include an array of outpatient and short term residential services that vary in intensity according to the needs of individuals. The continuum allows individuals to access care through multiple avenues and provides an existing infrastructure to identify and address first episodes of psychosis and the precursor signs and symptoms (i.e., Clinical High Risk or prodromal phase). Included in the continuum is the grant funded Premier program. The Premier program currently serves individuals who are identified as experiencing their first episodes of psychosis. Typically, individuals participating in the Premier program are identified and referred from inpatient psychiatric facilities. The Premier program is limited to the requirements identified in the funding and serves 10-15 consumers per year. Several Department of Behavioral Health programs serve this population. Currently, a more systematic and evidence-based response could lead to improved outcomes.

Program Overview

The Early Psychosis Care (EPC) program will build on the existing infrastructure within the continuum of services offered by the Department of Behavioral Health through development of several Coordinated Specialty Care (CSC) teams focused on first episodes of psychosis and identification of individuals at high clinical risk. The CSC teams will enhance programming and be based in existing programs such as the Transitional Aged Youth (TAY) Full Service Partnership (FSP) and the Premier Program. Additionally, a centralized team of expert consultants will utilize evidence-based models to work with enhanced programs to wrap services and supports around

the individual experiencing psychosis and consumer identified friends and family members. This includes utilization of standardized measures of clinical characteristics, interventions, and early psychosis outcomes to create a unified informatics approach to study variations in treatment, quality, clinical impact, and value.

The support and consultation team will be comprised of a Clinical Supervisor, Clinical Therapists, Social Worker IIs, a Peer and Family Advocate, a Program Specialist II, an Office Assistant, and include a portion of time of a Psychiatrist.

The program will support and measure delivery of services in detail utilizing the First Episode Psychosis Services Fidelity Scale (FEPS-FS). Components of the CSC could include but are not limited to the following:

- **Team Meetings:** A range of healthcare workers who are members of different disciplines (e.g. Psychiatrists, Social Workers, Peer and Family Advocates, etc.), that provide specific services to the consumer and come together to improve care planning and coordination.
- **Case Management**: Assistance by case manager who helps clients and family members navigate their treatment options.
- **Psychiatry Services with close monitoring of medication**: Communication about the importance of medication even after symptom improvement.
- **Psychotherapy**: Use of evidence-based interventions for psychosis provided for individuals, groups, and family.
- **Family Education and Support**: Consumers chose who they want involved in their recovery, and families/supports receive information to play an active role in recovery.
- **Supported employment and education**: Fostering autonomy and setting goals to live to the fullest.
- **Advocacy**: Delivering peer support that reduces barriers consumers and families face in accessing mental health care.
- **Outreach**: Assertively outreaching to individuals, at-risk populations and their families, which could include home visitation.

In addition to the direct services provided to individuals, the Early Psychosis Care program centralized team of expert consultants will provide support and assistance to the CSC teams and coordinate the delivery of specialized workshops that build the capacity and expertise of the entire care system. Examples of workshop topics include Prodromal Assessment, Family Focused Treatment, Cognitive Behavioral Therapy for Psychosis, and utilization of the FEPS-FS in the delivery of care.

Target numbers served and age group(s)

Recipients of mental health services, will be included in the MHSA or grant funded program in which they are being served. The numbers represented below in TAY and Premier are provided for reference to demonstrate the expanded number of individuals anticipated to be served for fiscal years (FY) 2020-21 through 2022-23. The counts for the TAY program will be included in the TAY One Stop in future years.

The Premier program will be enhanced to serve an additional five individuals through MHSA funded services and supports. The table below illustrates the anticipated number of participants to be served over the next three fiscal years.

Fiscal Year	Service/Activity	TAY FSP Program	Premier Program	Total
2020-2021	**Mental Health Service Recipients**	100	5	105
2021-2022	**Mental Health Service Recipients**	100	5	105
2021-2022	**Mental Health Service Recipients**	100	5	105

MHSA Legislative Goals and Related Key Outcomes

Increase Early Access and Linkage to Medically Necessary Care and Treatment:

- Connect children and transitional aged youth with severe mental illness to care as early as possible. This will include, but is not limited to, care provided by county mental health programs.

Reduce prolonged suffering associated with untreated mental illness:

- Reduce risk factors
- Reduce indicators
- Increase protective factors that may lead to improved mental emotional, and relational functioning
- Reduce symptoms, and
- Improve recovery including emotional and relational functioning.

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.

Measures of Effectiveness

The Early Psychosis Care program will utilize the First Episode Psychosis Services Fidelity Scale (FEPS-FS 1.0) © to monitor the fidelity of services. The tool monitors broad implementation across 32 individual evidence-based practice domains with each domain containing critical items that must be met to meet fidelity for the domain.

Items evaluate client and program level data and address team functioning and outcomes over a one year period. Data will be collected quarterly. The data collected will be used to assess and monitor fidelity and support ongoing quality improvement.

Additional items will be collected by fidelity monitors through conducting site evaluations. Site visits will consist of interviews with consumers and family members, observations of team meetings, and review of client charts and programs. These observations are useful in reviewing domains related to care processes, such as shared decision making.

DBH intends to build on existing data collection and reporting systems to incorporate the FEPS-FS tool data collection and monitoring activities. Output information will be reported annually and included in MHSA Plans.

Examples of variables to be evaluated and rated via the FEPS-FS 1.0© include the following:

- Timeliness of contact with referred individuals
- Assessment of psychosocial needs for care plan
- Patient and family involvement in assessments and care planning
- Medication Management
- Implementation of Evidence-based therapies
- Community Living Skills

Artwork by Pacheco

COMMUNITY SERVICES AND SUPPORTS

Community Services and Supports (CSS)

Artwork by Lekesha Lafayett

Introduction

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

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

The majority of MHSA funding **(80%)** is mandated to be directed toward the Community Services and Supports (CSS) component. In contrast to the Prevention and Early Intervention (PEI) component that focuses on population health and early intervention, the CSS component provides access to an expanded continuum of care for persons living with Serious Mental Illness or Serious Emotional Disturbance made possible through MHSA Investments. Seriously Emotionally Disturbed refers to children and youth with difficulty functioning in multiple life domains such school, home, and/or community. Serious Mental Illness (SMI) is a term defined by Federal regulations that describes mental disorders that significantly interfere with some area of functioning.

- WIC § 5892(a)(5) states:
- The majority of MHSA funding **(80%)** is mandated to be directed toward the Community Services and Supports (CSS) component.
- CSS provides enhanced mental health services for Seriously Emotionally Disturbed (SED) children and youth and Seriously Mentally Ill (SMI) adult populations.

Community Services and Supports (CSS) Goals

- Reduce the subjective suffering from serious mental illness for adults and serious emotional disorders for children and youth
- Reduce homelessness and increase safe and permanent housing
- Increase in self-help and consumer/family involvement
- Increase access to treatment and services for co-occurring problems; substance abuse and health
- Reduction in disparities in racial and ethnic populations
- Reduce the number of multiple out-of-home placements for foster care youth

- 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 intent or purpose, but may serve different target populations. In Fiscal Year 2019/20 some programs were expanded, reorganized, and streamlined to better meet the needs of the consumers and families they serve. 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 eight Full Service Partnership (FSP) Programs that contained in the FSP section; and programs that provide Housing, Long Term Supports, and Transitional Care are also contained within their own section. In Fiscal Year 2019/20 a year a Peer Support Programs section was also created to highlight programs that are consumer driven and work from a lived experience perspective. Peer Support programs include Clubhouses and a new Family Support Program to support family members and loved ones. All CSS programs provide the necessary services and support to help consumers achieve their mental health and treatment plan goals.

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

- Augmenting existing services
- Establishing a system of care for crisis services
- Creating collaborations and partnerships with various County agencies to maximize and leverage resource to serve consumer needs.
- Creating culturally competent programs that are responsive to the cultural needs of our diverse population.
- Developing programming to address the needs of Older Adults
- Developing supportive housing and maximizing MHSA, SNHP, and NPLH funds for housing opportunities.
- Enhancing and expanding wraparound services to children
- Expansion of adult Full Service Partnerships to serve underserved populations

There are currently 16 CSS programs designed to serve all age groups within the behavioral health systems of care. The programs are as follows:

Crisis System of Care Programs:

- A-5: Triage Transitional Services (TTS and TEST)
- A-6: Community Crisis Response Team (CCRT)

Crisis Stabilization Continuum of Care

- A-4: Crisis Walk-In Centers (CWICs)/Crisis Stabilization Units (CSUs)
- A-10: Crisis Residential Treatment Program (CRT)
  - ◊ Adult
  - ◊ Transitional Age Youth (TAY)

Peer Support Programs

- A-1: Clubhouse Expansion

Outreach, Access, and Engagement Programs

- A-9: Access, Coordination, and Enhancement (ACE)
- A-15: Recovery Based Engagement Support Team (RBEST)

Full Service Partnerships

- C-1: Comprehensive Children and Family Support Services (CCFSS)
- C-2: Integrated New Family Opportunities (INFO)
- TAY-1: Transitional Age Youth (TAY) one Stop Centers
- A-2: Adult Criminal Justice Continuum of Care
- A-3: Assertive Community Treatment Programs
- A-11: Regional Adult Full Service Partnership (RAFSP)
- OA-1: Age Wise

Homeless Services, Long-Term Supports, and Transitional Care Programs

- A-7: Housing, and Homeless Services Continuum of Care Programs
- A-13: Adult Transitional Care Programs

Artwork by Carolyn Laun

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Artwork by Carolyn Laun

Capacity Assessment

The Community Services and Supports component is comprised of seventeen 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 accordance with 9 CCR § 3650, 9 CA ADC §3650, each program was developed through the Community Program Planning process and includes a description of services, goals of the program, 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.

As part of program implementation, the Department of Behavioral Health is committed to ongoing review of community behavioral health needs, the capacity of staff and the public behavioral health system, and implementation of continuous improvement efforts based on qualitative and quantitative data and informatics.

DBH collects, prepares, and presents data and information with its stakeholders. Stakeholders review the information and provide feedback related to identifying additional populations, program improvement and design, priorities, as well as unmet need.

Priority Issues by Age Group

Based on a recent analysis of stakeholder data from the past 5 years, the following priorities have been identified by age group.

Children/Youth	Transitional Age Youth	Adults	Older Adults
Family and Peer problems; at risk of out of home placement	Homelessness	Homelessness	Access to care
School Failure related to unaddressed behavioral health needs	Institutionalization and incarceration	Frequent hospitalizations and emergency room visits	Frequent hospitalizations, episodes of emergency care, and relapse episodes
Child Welfare/Juvenile justice involvement	Frequent hospitalizations and emergency room visits	Employment issues: inability to work	Inability to manage independence

Children/Youth	Transitional Age Youth	Adults	Older Adults
Acute Psychiatric inpatient hospitalization	Employment issues: inability to work	Inability to manage independence	Homelessness
Substance Use Disorders experienced by youth and families dealing with mental illness	Inability to live independently	Institutionalization and incarceration	Isolation
Access to Care	Access to Care	Access to Care: Transportation	
Cultural Sensitivity	Cultural Sensitivity	Cultural Sensitivity	Cultural Sensitivity
	Inclusivity	Inclusivity	Inclusivity
Community O&E	Community O&E	Community O&E	Community O&E
	Agency/Public collaboration	Agency/Public collaboration	Agency/Public collaboration
		Increased collaboration with faith-based programs	Increased collaboration with faith-based programs

Artwork by Amanda Feinner

Demographic Overview

The Department of Behavioral Health 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 individuals in the county.

According to California Department of Finance estimates for 2018, San Bernardino County has a total population of 2,174,931 with a projected growth of 28% between 2020 and 2045. The current breakdown of the population into gender, age, and racial and ethnic categories is indicated in the chart below.

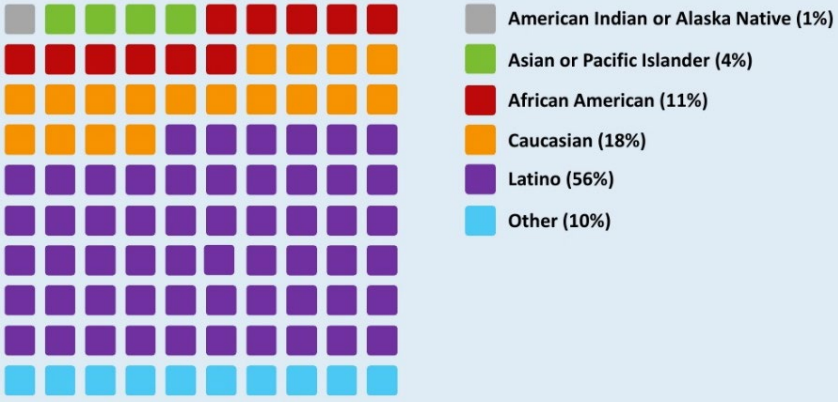
Total Population	2,174,931
Gender	%
Female	50.30%
Male	49.70%
Age	%
0-15 years	25.50%
16-25 years	16.70%
25-59 years	44.70%
60 years and up	13.10%
Ethnicity	%
African American	8.50%
Asian/Pacific Islander	6.30%
Caucasian	32.90%
Latino	49.60%
Native American	0.40%
Other/Unknown	2.30%

Medi-Cal Beneficiaries

In Fiscal Year 2018/19, an estimated 780,478 San Bernardino County residents were Medi-Cal beneficiaries. The infographics below provide an overview of the demographics for San Bernardino County Medi-Cal eligible beneficiaries.

Ethnicity and Ancestry:

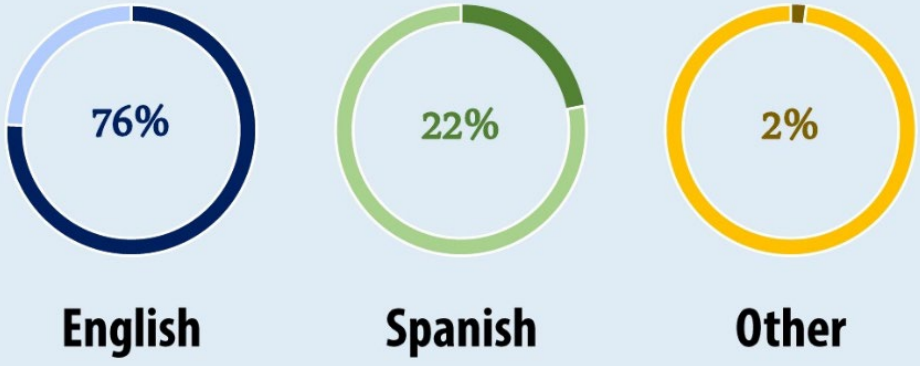
Medi-Cal eligible beneficiaries by Ethnicity and Ancestry was as follows: 11% were African American, 4.6% were Asian/Pacific Islander, 17.8% were Caucasian, 56.1% were Latino, .2% were Native American, and 10.2% identified as Other.



N=780,478

Language:

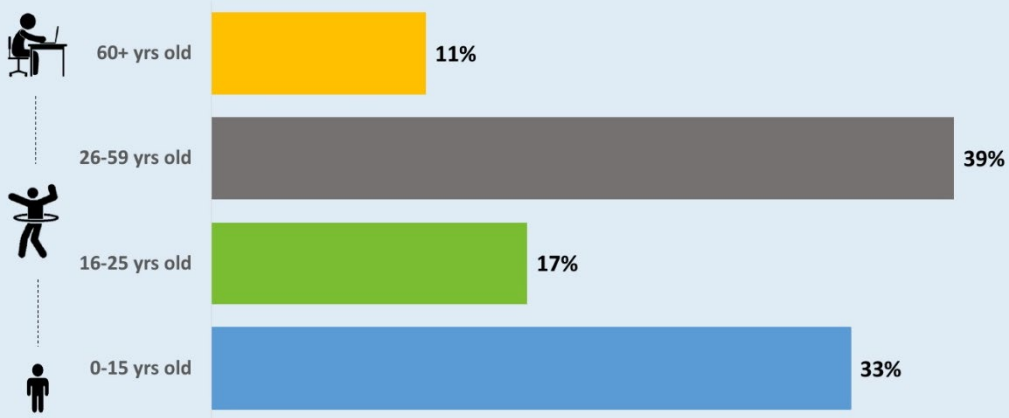
Medi-Cal eligible beneficiaries language preference was as follows: Cambodian .1%, English 75.7%, Spanish 21.9%, Vietnamese .4% and 1.9% identified as Other.



N=780,478

Age:

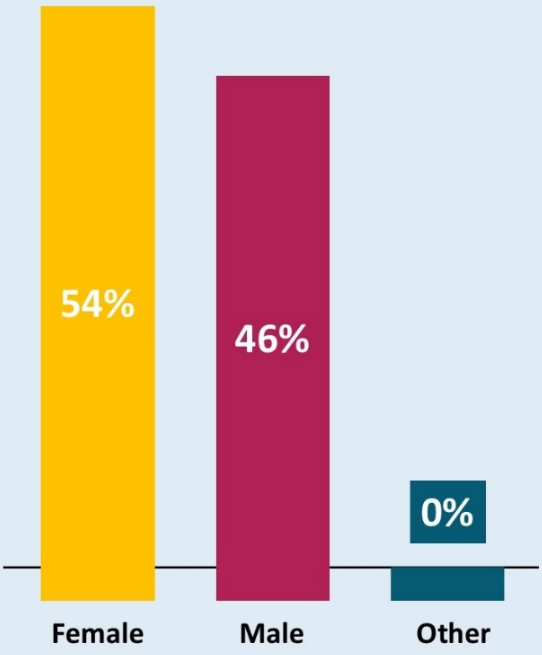
Medi-Cal eligible beneficiaries by age group was as follows: 33.4% were children (0-15 years), 16.5% were TAY (16-25 years), 38.8% were adults (26-59 years), and 11.2% were older adults (60 years and up).



N=780,478

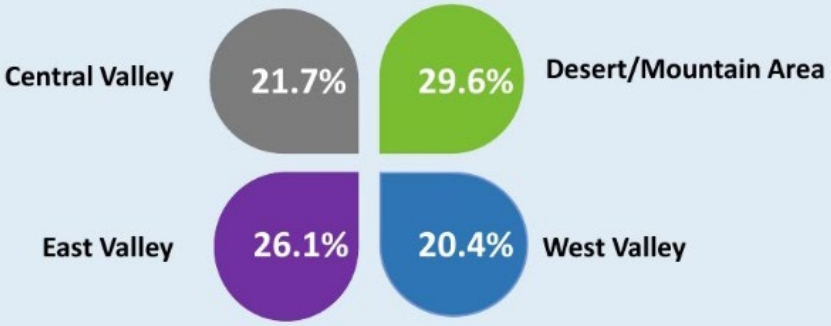
Gender:

Medi-Cal eligible beneficiaries by gender were as follows: 54.4% were female and 45.6% were male.



N=780,478

The Medi-Cal population is geographically distributed throughout the County as follows: 29.6% reside in the Desert/Mountain region, 26.1% reside in the East Valley region, 21.7% in the Central Valley, and 20.4% in the West Valley. The remaining 2.2% not highlighted in the graph below, represented stakeholders from a broad range of regions throughout Southern California, including neighboring counties.



N=780,478

Estimation of Needs

Disparities can be identified by comparing the Medi-Cal eligible beneficiaries group to the Mental Health Medi-Cal consumers served in Fiscal Year 2018/19.

Gender:

In terms of gender, fewer Medi-Cal beneficiaries served were female compared to those who were Medi-Cal eligible (48.2% versus 54.4%). In contrast, 51.7% of Medi-Cal beneficiaries served were male, which was greater than their percentage of the Medi-Cal eligible population of 45.6%. By gender, the penetration rate was higher for males versus females (4.3% versus 5.5%).

Age:

In terms of age, Transitional Age Youth (TAY) 16-25 years constituted 19.1% of beneficiaries served, compared to 16.5% of Medi-Cal eligible. Adults 26-59 years constituted 40.7% of beneficiaries served, compared to 38.8% of Medi-Cal eligible. Older Adults 60+ years constituted 6.4% of beneficiaries served compared to 11.2% of Medi-Cal eligible. The percentage of Children served was equivalent (33.8%) to the percentages of the Medi-Cal eligible population. By age group, the lowest penetration rate was for Older Adults (60+) at 2.8%. While the penetration rates for TAY and Adults was over 5%, the rate for children was 4.9%.

Ethnicity and Ancestry:

In terms of Ethnicity and Ancestry, although Latinos represented 56.1% of Medi-Cal eligible beneficiaries, they only represented 42.7% of beneficiaries served. A similar trend was found with the Asian/Pacific Islander population. Although 4.6% of Medi-Cal eligible, they represented only 2.3% of the beneficiaries served. In contrast, the opposite trend was noted with the African American and Caucasian populations. The African American group represented 11.0% of Medi-Cal eligible beneficiaries and 16.4% of beneficiaries served; Caucasians represented 17.8% of Medi-Cal eligible and 28.8% of beneficiaries served.

Although Asian/Pacific Islanders are underrepresented as Medi-Cal consumers served they may also be considered as inappropriately served by the system. They have the highest rate of inpatient rate of treatment services (24 hour care) compared to other racial/ethnic groups. In FY18/19, Asian/Pacific Islanders received 9.9 inpatient services per consumer versus 8.4 for African American consumers; 8.6 for Caucasian consumers, 7.0 for Latino consumers; and 3.6 for Native American consumers. The same holds true when analyzing the Residential Rate per Consumer as well.

Asian/Pacific Islanders had the highest rate at 69.1 of residential treatment per consumer during FY18/19. Caucasians had a 66.5 average rate, Latino consumers a 67.1 rate, Other Ethnicities 59.3 and African American 52.4 rate per consumer. The lowest rate centered on Native Americans at 41.5 of residential treatment per consumer during FY18/19. The percentages of Native American and Other Medi-Cal beneficiaries served were more proportional to the percentages of these groups who were eligible for Medi-Cal. For example, Native Americans were less than one percent (0.2%) of Medi-Cal eligible, and less than one percent (0.5%) of beneficiaries served in FY18/19. However, this can also be interpreted as an overrepresentation of Native Americans among beneficiaries served, despite their small numbers overall. They were a very small percentage of the overall County population, a very small percentage of the Medi-Cal population, but were served at the highest penetration rate (10.8%).

Language:

In terms of preferred languages of Medi-Cal eligible beneficiaries and Medi-Cal consumers (See Table 2), 21.9% of Medi-Cal eligible beneficiaries preferred Spanish, while only 6.7% of Medi-Cal consumers served preferred Spanish. The vast majority of Medi-Cal consumers preferred English (90.6%). In comparison, 75.7% of Medi-Cal beneficiaries preferred English. The data may suggest that we are underserving the Spanish speaking Medi-Cal population. The penetration rate for the preferred Spanish language group was 1.5%, the lowest for all the language groups. The second lowest penetration rate was for the preferred Vietnamese language group (3.0%).

Determination of Persons in Need

The estimated prevalence for severe mental illness or emotional disturbance in the Medi-Cal eligible population is 8.8%. Under this construct, approximately 69,000 persons from all age groups could be considered in need of some level of behavioral health services, either through a managed care organization or the mental health plan.

- In FY 2018/19, approximately 44,800 individuals received a mental health service from the mental health plan (this number excludes individuals participating in prevention programs or mental health services coordinated through a Managed Care Organization).
- Additional review of data from FY 18-19 indicates that of individuals served by the mental health plan:
    - ◊ About 39,000 met medical necessity criteria and were served by the mental health plan.
    - ◊ Around 4,500 individuals participate(d) in a Full Service Partnership to be considered fully served.
    - ◊ An additional 6,007 individuals were provided early intervention services through Prevention and Early Intervention component programs.

Limitations of this analysis include the absence of data summarizing the number of individuals provided mental health services via the managed care organizations serving San Bernardino County in FY 2018/19. Data provided by one MCO in 2017, indicates that between 9,251 and 10,908 individuals utilized behavioral health services during two 6 month periods of time, or approximately 1.64% of their beneficiaries. Using the snapshot of data provided, it is estimated that approximately 601,355 beneficiaries were enrolled in this plan. Thus, approximately 9,922 individuals received mental health services through the plan.

Using all available date, it is estimated that approximately 15,000 of qualifying persons in the county could remain in need of some level of mental health intervention and could possibly be unserved. The first CSS Component Plan from February 2006 identified an estimated 54,893 individuals that could be in need of behavioral health services. In comparison, this is a notable improvement.

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

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 concerns

Focus on the Criminal Justice Population

In addition to the standard capacity analysis, DBH is also participating in a Data Driven Recovery Project (DDRP) with four other California counties, Yolo, Nevada, Plumas, and Sacramento (MHSA/MHSOAC funded via Innovation Incubator project). The DDRP is an initiative to improve sustained outcomes for adult behavioral health consumers in the criminal justice system. The goal is to identify strategies for reducing incidence, duration, and recurrence of arrests and incarcerations of people with behavioral health conditions. As part of the project, DBH and criminal justice partners are developing a set of analytic tools to assist in identifying programmatic and systemic improvements in the county system. As part of the project, DBH will assess the capacity of the current delivery system and create a plan that may include:

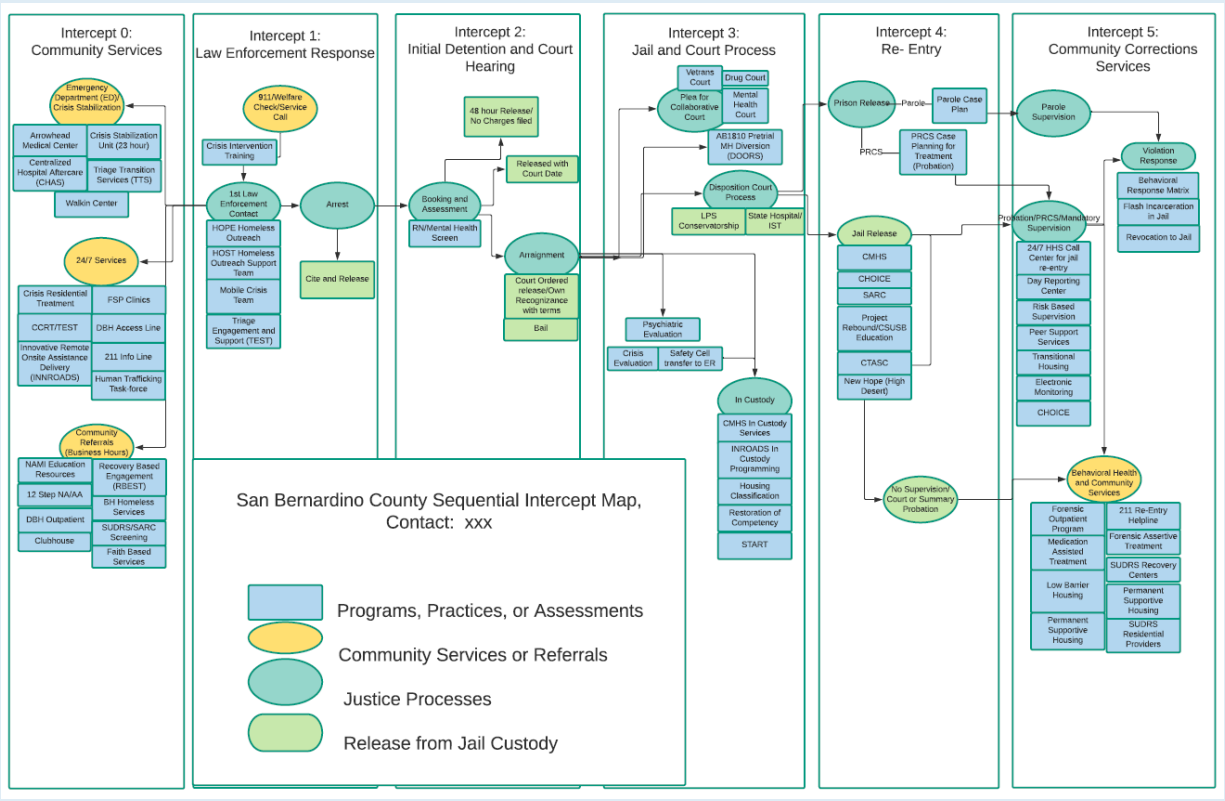
- A data governance plan and cross-agency analytic plan to use and identify consumers in multiple systems, while maintaining privacy and confidentiality.
- Development of baselines for prevalence and outcomes for justice-involved behavioral health consumers based on merged data.

- Inform process improvement for priority areas for the county such as jail re-entry and continuity of services
- Develop the Sequential Intercept Model (SIM) to inform system resources, gaps, and priorities.

On February 5, 2020, DBH and criminal justice partners engaged in a Sequential Intercept Model (SIM) Mapping process, a method designed to identify system resources, gaps, and priorities. Representatives from DBH systems of care along with representatives from the Public Defender, District Attorney, Courts, Law Enforcement, hospitals, and community providers convened to participate in the process of identifying existing programming across the various agencies, identifying the gaps across the county and determining priority areas to focus system improvement.

The SIM can help leaders and staff more effectively collaborate to divert people with mental and substance use disorders away from the justice system and into treatment. The SIM is used as the basis for a workshop that produces an actual map of a community's resources across the intercepts. During the many SIM mapping workshops over the years, it has become clear that tracking and understanding services across the intercepts is a critical part of developing a robust continuum of behavioral health services and reducing justice system involvement of people with mental illnesses and co-occurring substance use disorders.

The results of this process will include the development of a Sequential Intercept Map and list of gaps and opportunities to be prioritized for improvement. The next steps will include analysis of the data to support the development of a local action plan for incremental cross-system improvements.



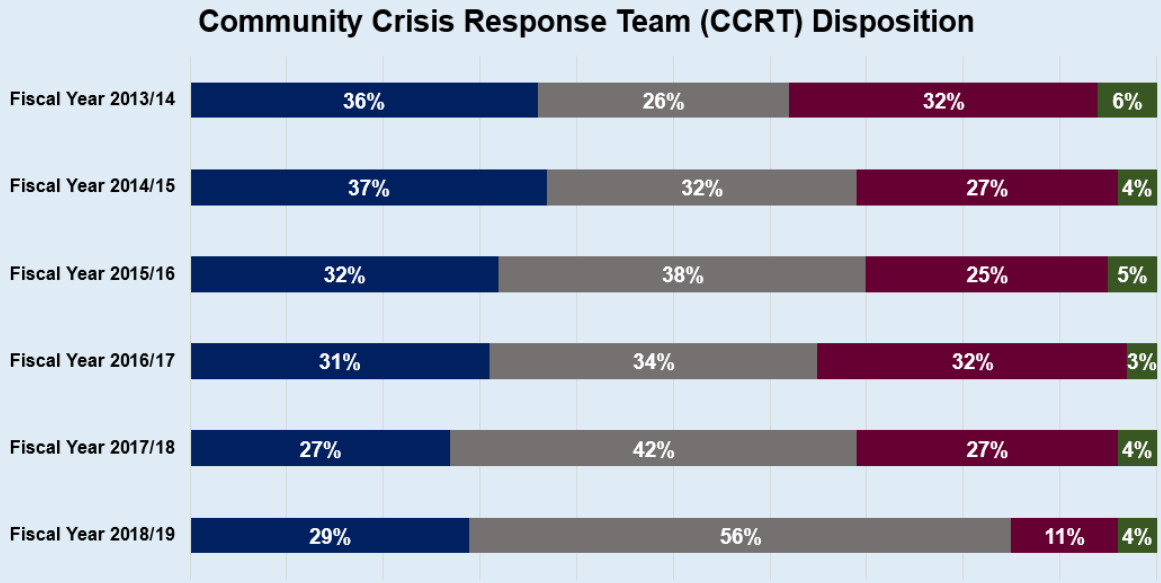
Crisis System of Care

Crisis System of Care (CSOC) programs are considered system development strategies that help develop the capacity to provide values-driven, evidence-based services for the MHSA populations. Through system development, counties improve program services and supports for all consumers and families to 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. Field-based responses provided by these programs are prompted by calls from the community, agency partners, or consumers experiencing a behavioral health crisis and facilitate access to walk-in centers, stabilization units, and crisis residential facilities in an effort to divert from psychiatric hospitalization when a more appropriate level of care is available.

The primary intent of CSOC is to reduce hospital emergency room and unnecessary acute psychiatric hospitalization, improve consumer participation in outpatient services after a crisis, and reduce the percentage of consumers who return for additional crisis services within a short time frame.

Artwork by Stephanie Banuelos

A review of the past six fiscal years of data for the Community Crisis Response Team (CCRT) in the chart below demonstrates the disposition of the contacts made for each year. The majority of consumers experiencing a behavioral health crisis were able to be stabilized to avoid acute psychiatric hospitalization and/or referred and linked to resources.



	Fiscal Year 2018/19	Fiscal Year 2017/18	Fiscal Year 2016/17	Fiscal Year 2015/16	Fiscal Year 2014/15	Fiscal Year 2013/14
Diversions	1,443	1,526	2,295	2,078	2,136	2,225
Referrals	2,804	2,352	2,523	2,469	1,893	1,598
Involuntary Hospitalizations	534	1,518	2,386	1,638	1,597	1,990
Voluntary Hospitalizations	206	225	282	359	253	644

Target Populations

The chart below indicates the target populations to be served by each Crisis System of Care program.

Crisis Stabilization Continuum of Care Programs				
Program Name	**Target Population**			
	Children	**TAY**	**Adults**	**Older Adult**
Triage Transitional Services (TTS)		X	X	X
Triage Engagement and Support Teams (TEST)	X	X	X	X
Community Crisis Response Team (CCRT)	X	X	X	X
Crisis Intervention Training (CIT)		X	X	X

Projected Number to be Served

The table below represents the projected number of consumers to be served by programs within the Crisis System of Care for the upcoming three fiscal years (Fiscal Year 2020/21 - 2022/23). For each fiscal year, the projected total is broken up into two MHSA categories: age and service. MHSA age categories are: Children, TAY, Adult, and Older Adult. MHSA service categories are: Full Service Partnership (FSP), General System Development (GSD), and Outreach and Engagement (O&E).

Program	Fiscal Year	Ages Served	Service Area
Triage Transitional Services (TTS)	2020/21	300 TAY 1,000 Adults 100 Older Adults	1,400 GSD
		TOTAL = **1,400**	TOTAL = **1,400**
	2021/22	300 TAY 1,000 Adults 100 Older Adults	1,400 GSD
		TOTAL = **1,400**	TOTAL = **1,400**
	2022/23	300 TAY 1,000 Adults 100 Older Adults	1,400 GSD
		TOTAL = **1,400**	TOTAL = **1,400**

*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 mental health services offered and linking consumers to the appropriate services.

The table below represents the projected number of consumers to be served by programs within the Crisis System of Care for the upcoming three fiscal years (Fiscal Year 2020/21 - 2022/23). For each fiscal year, the projected total is broken up into two MHSA categories: age and service. MHSA age categories are: Children, TAY, Adult, and Older Adult. MHSA service categories are: Full Service Partnership (FSP), General System Development (GSD), and Outreach and Engagement (O&E).

Program	Fiscal Year	Ages Served	Service Area
Triage Engagement and Support Teams (TEST)	2020/21	300 Children 440 TAY 960 Adults 300 Older Adults	2,000 GSD 675 O&E
		TOTAL = **2,000**	TOTAL = **2,675**
	2021/22	300 Children 440 TAY 960 Adults 300 Older Adults	2,000 GSD 675 O&E
		TOTAL = **2,000**	TOTAL = **2,675**
	2022/23	300 Children 440 TAY 960 Adults 300 Older Adults	2,000 GSD 675 O&E
		TOTAL = **2,000**	TOTAL = **2,675**

*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 mental health services offered and linking consumers to the appropriate services.

The table on the following page represents the projected number of consumers to be served by programs within the Crisis System of Care for the upcoming three fiscal years (Fiscal Year 2020/21 - 2022/23). For each fiscal year, the projected total is broken up into two MHSA categories: age and service. MHSA age categories are: Children, TAY, Adult, and Older Adult. MHSA service categories are: Full Service Partnership (FSP), General System Development (GSD), and Outreach and Engagement (O&E).

Program	Fiscal Year	Ages Served	Service Area
Community Crisis Response Team (CCRT)	2020/21	1,800 Children 1,250 TAY 1,650 Adults 300 Older Adults	5,000 GSD 17,500 O&E
		TOTAL = **5,000**	TOTAL = **22,500**
	2021/22	1,800 Children 1,250 TAY 1,650 Adults 300 Older Adults	5,000 GSD 17,500 O&E
		TOTAL = **5,000**	TOTAL = **22,500**
	2022/23	1,800 Children 1,250 TAY 1,650 Adults 300 Older Adults	5,000 GSD 17,500 O&E
		TOTAL = **5,000**	TOTAL = **22,500**
Crisis Intervention Training (CIT)	2020/21	300 TAY 1,600 Adults 100 Older Adults	2,000 O&E
		TOTAL = **2,000**	TOTAL = **2,000**
	2021/22	300 TAY 1,600 Adults 100 Older Adults	2,000 O&E
		TOTAL = **2,000**	TOTAL = **2,000**
	2022/23	300 TAY 1,600 Adults 100 Older Adults	2,000 O&E
		TOTAL = **2,000**	TOTAL = **2,000**

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

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

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

Diversion Programs (A-5)

Diversion programs, such as Triage Transitional Services (TTS) and Triage Engagement and Support Teams (TEST), are designed to: 1. increase the use of alternatives to unnecessary inpatient psychiatric hospitalization, 2. screen, assess, and intervene in crises with those consumers who are voluntarily seeking help, and 3. provide linkages and referrals to community resources. TTS provides services through co-location in a hospital setting, while TEST provides services in the field through key co-location sites throughout the community.

Triage Transitional Services (TTS)

Triage Transitional Services (TTS) was designed to assess consumers who voluntarily present to the County hospital, Arrowhead Regional Medical Center – Behavioral Health Unit (ARMC-BHU), to determine if they meet 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 TTS program is located within the Psychiatric Emergency Department (ED) of ARMC-BHU. Many consumers enter emergency departments requesting behavioral health services which can be more effectively and efficiently met in an outpatient setting. Once medically cleared by the hospital, TTS staff complete assessments of these consumers to determine if their behavioral health needs can be best met outside of the hospital environment and assist with case management and linkage to these resources when appropriate. Services include:

- 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 service agencies
- Family and caretaker education
- Consumer advocacy

MHSA Legislative Goals and Related Key Outcomes

Reduce the frequency of emergency room visits and unnecessary hospitalizations:

- Reduced rate of emergency room visits for mental health concerns
- Increase use of alternative crisis interventions (e.g., CWIC, CCRT, CSU)
- Increase in number of individuals diverted from unnecessary psychiatric hospitalization

Positive Results

In Fiscal Year 2018/19, TTS served 1,258 consumers. Of those, 28% were diverted from admission to the psychiatric emergency department. An additional 32% were provided referrals and linkages from the psychiatric emergency department. Therefore, a total of 60% of consumers served by TTS were able to avoid unnecessary psychiatric inpatient hospitalization due to the interventions and services provided.

Program Challenges

Challenges faced during Fiscal Year 2018/19 stemmed from ongoing changes within the co-located site and procedures with partner agencies. Changes to business processes impacted ongoing support TTS provides.

Program Solutions

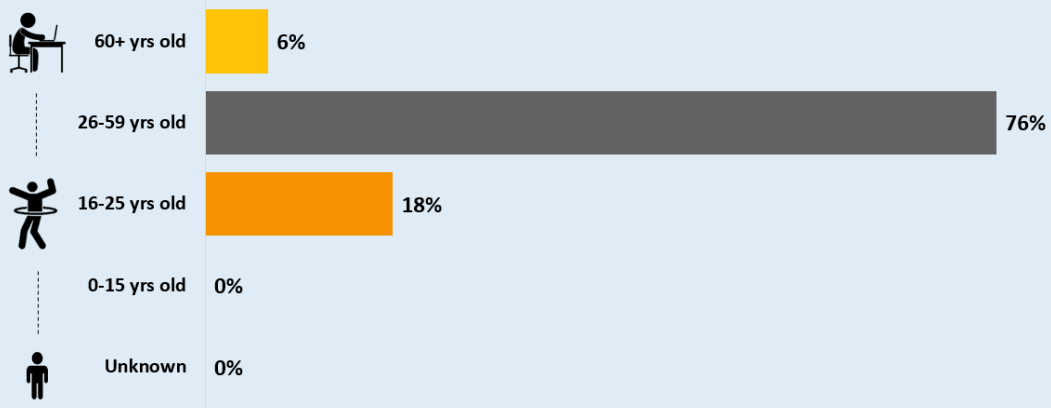
The TTS program continues to collaborate with partner agencies, outpatient clinics, and community agencies in an effort to network and gather resource information and contacts with the goal of improving service and providing additional linkages for consumers. Centralized Hospital Aftercare Services (CHAS) Administration implemented monthly collaborative meetings between DBH and ARMC Administrators and Supervisors in order to improve communication and collaboration, as well as quickly problem solve any new challenges that arise. In addition, TTS staff continually attend training opportunities to learn improved methods for service delivery.

Fiscal Year 2018/19 Program Demographics

The following graphs illustrate the demographics in various categories of TTS consumers.

Age:

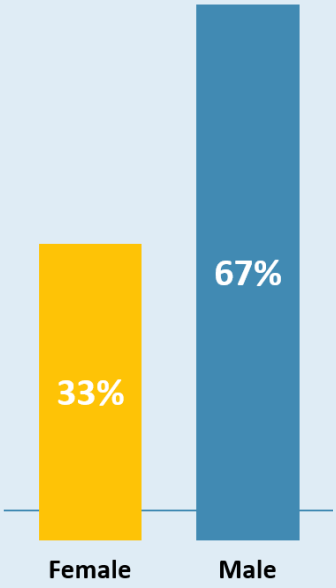
The graph below illustrates the ages of TTS consumers. 76% of those served were between the ages of 26-59 years old. 18% ranged between the ages of 16-25, and 6% of consumers were age 60+. This graph is representative of the TTS target population served, a majority of whom were adults.



N = 1,258

Gender:

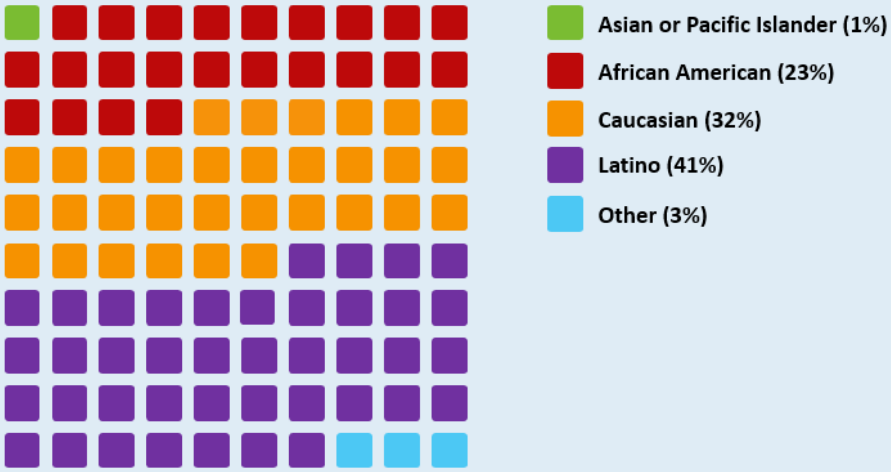
The graph below demonstrates that 67% of TTS consumers identified as male and 33% as female. None of the consumers identified as transgender, non-binary, gender queer, or other not listed.



N = 1,258

Ethnicity and Ancestry:

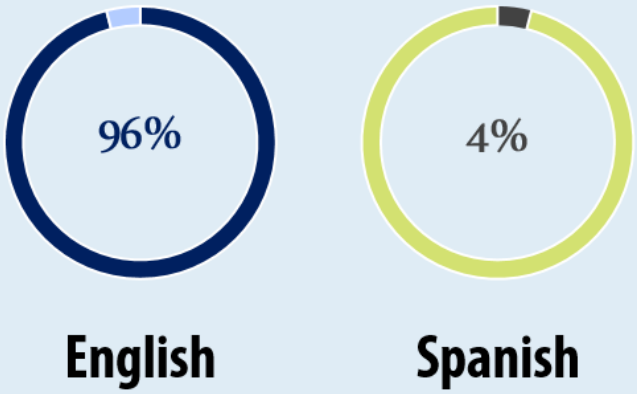
The graph below illustrates the various ethnicities of consumers of the TTS program. 41% identified as Latino, 32% identified as Caucasian, and 23% idenitifed as African American. An additional 3% identified with an ethnicity not listed (Other). This category includes those who identified as other, identified with more than one race, or declined to answer. Lastly, 1% idenitified as Asian or Pacific Islander.



N = 1,258

Primary Language:

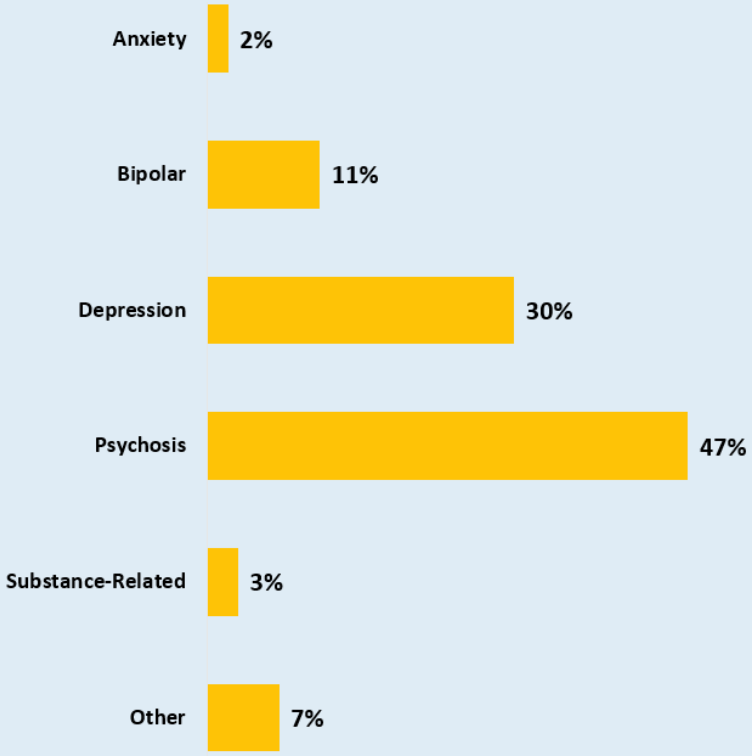
The graph below demonstrates that 96% of TTS consumers identified English as their primary language. Additionally, 4% identified Spanish as their primary language. No other primary languages were identified.



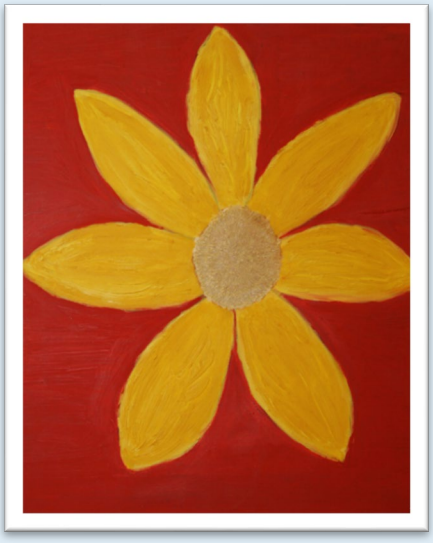
N = 1,258

Primary Diagnosis:

The graph below illustrates the diagnostic group of TTS consumers who received services. 47% of TTS consumers were diagnosed under the category of Psychosis. Of the remaining consumers, 30% were diagnosed under the category of Depression Disorders, 11% with Bipolar Disorders, 3% with Substance-Related Disorders, and 2% with Anxiety Disorders. The remaining 7% comprise the category of either other diagnoses than those listed or more than one diagnosis.



N = 789



Artwork by Judy Whiting

Outreach and Engagement

In Fiscal Year 2018/19, Triage Transitional Services (TTS) organized and/or participated in the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Crisis Intervention Team (CIT) Field Training Officers (FTO) Training	2	40
DBH Case Manager Monthly Meeting	1	32
Total	**3**	**72**

Success Story

"Frank" is an adult male who relocated from out-of-state. He recently experienced several traumatic events, including the loss of his job, end of his marriage, and potential loss of his housing. He came into contact with TTS when he was experiencing suicidal ideation with limited social support. Frank had difficulty connecting to services in his area. TTS assisted in locating and linking Frank to outpatient services that accepted his out-of-state health care provider. After successfully linking to services, Frank's housing stabilized. He was diverted from hospitalization, and required no further crisis services.

Collaborative Partners

- Arrowhead Regional Medical Center (ARMC)
- Contracted Fee-For-Service hospitals
- Helping Hearts of California
- Law enforcement agencies throughout San Bernardino County
- Los Angeles, Orange, and Riverside County Department of Mental Health
- San Bernardino County, Children and Family Services (CFS)
- San Bernardino County, Department of Aging and Adult Services (DAAS)
- San Bernardino County, Office of the Public Guardian
- San Bernardino County, Probation
- State Parole
- Telecare Corporation

Triage, Engagement, and Support Teams (TEST)

The Triage, Engagement, and Support Teams (TEST) program was developed to provide crisis intervention and intensive case management services to unserved/underserved individuals who are experiencing a behavioral health crisis in San Bernardino County. In November 2014, San Bernardino County was awarded a crisis triage grant through the Mental Health Services Oversight and Accountability Commission (MHSOAC) based on Senate Bill (SB) 82, also known as the Investment in Mental Health Wellness Act of 2013. The grant allowed for the expansion of the crisis system of care and the hiring of additional County staff to provide these services. SB 82 grant funding expired on June 30, 2018. Due to the continued need and the ongoing success of the program, in Fiscal Year 2018/19, TEST transitioned to be included as part of the MHSA Plan.

As of Fiscal Year 2018/19, TEST staff are co-located within 25 internal and external County partner agencies, including, but not limited to:

- Law enforcement agencies,
- Hospital Emergency Departments, and
- College campuses

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 then provides follow-up case management services for up to 59 days to link consumers with needed resources for ongoing stability.

Services include, but are not limited to:

- 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, and
- Education and support to law enforcement and community partners regarding behavioral health concerns and resources

MHSA Legislative Goals and Related Key Outcomes

Reduce the frequency of emergency room visits and unnecessary hospitalizations:

- Increase access to and use of existing community resources (e.g., housing, mental health services, substance use services, medical treatment, education services, etc.)
- Increased use of alternative crisis interventions (e.g., CWIC, CCRT, CSU)
- Increase in number of individuals diverted from hospitalization

Positive Results

- In Fiscal Year 2018/19, TEST staff engaged in 4,642 consumer encounters that resulted in 11,080 referrals to behavioral health and community resources.
- In the previous fiscal year, the program facilitated improved consumer outcomes in the following areas, but not limited to:
    - ◊ 83.7% increase in routine outpatient services
    - ◊ 224.2% increase in alternative crisis intervention and treatment (e.g., CWIC, CCRT, CSU)
    - ◊ 11.2% decrease in the number of days consumers were in crisis
    - ◊ 64% of TEST crisis interventions were diverted from hospitalization
        - Of those who were hospitalized following a TEST encounter, 13.8% were voluntarily hospitalized

Program Challenges

Each year, the demand grows for TEST services at co-location sites throughout San Bernardino County. With this growth comes the challenges inherent in incorporating and integrating into new locations, including balancing staffing needs and budgetary constraints. Additionally, each co-location site requires the building and maintaining of an effective collaborative relationship. In Fiscal Year 2018/19, the TEST program expanded by adding nine co-location sites, including Chino Police Department, Desert Valley Hospital (Victorville), Kaiser Hospital (Fontana), Loma Linda University Medical Center Emergency Department, Ontario Police Department, Redlands Police Department, Upland Police Department, Victor Valley College (Victorville), and Yucaipa Sheriff's Office. These challenges will continue, as the plan for the coming year is to have TEST collaborate and provide services at an additional five co-location sites throughout the county.

Program Solutions

Solutions in progress include continued active efforts to build and maintain relationships with law enforcement and community partners. These efforts include regular meetings with all co-location partners to ensure that the partners are aware of the purpose of TEST staff. When requests for new TEST sites are made, data (both internal and provided by collaborative partners) is analyzed to help determine which areas and sites would most benefit from TEST services. Finally, filling TEST staff vacancies continues to be a priority to help meet the staffing needs.

Success Story

"Francine" is an adult female living with a mood disorder. Francine had recently suffered the loss of a sibling, a divorce, and the overall loss of her support system. As a result, she was not eating, not following through with her medication regime, and unable to manage her symptoms appropriately. Multiple calls had been made to local law enforcement and CCRT regarding Francine's welfare and suicidal ideations. TEST staff engaged her through home visits and intensive case management. Within a short time frame, she was ready to seek outpatient services. After successfully linking to outpatient services, Francine has had no further contact with law enforcement or CCRT.

Outreach and Engagement

In Fiscal Year 2018/19, Triage Engagement and Support Teams (TEST) organized and/or participated in the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
National Night Out	1	250
Homeless Sweep Rialto Police Department	1	50
Suicide Prevention Presentation (multiple locations including area high schools)	3	225
SHOCK/Scared Straight Presentation	1	75
Police Mental Health Collaborative	1	6
Building Community Partners	1	26
Department of Aging and Adult Services (DAAS) APS MDT	2	30
Total	**10**	**662**

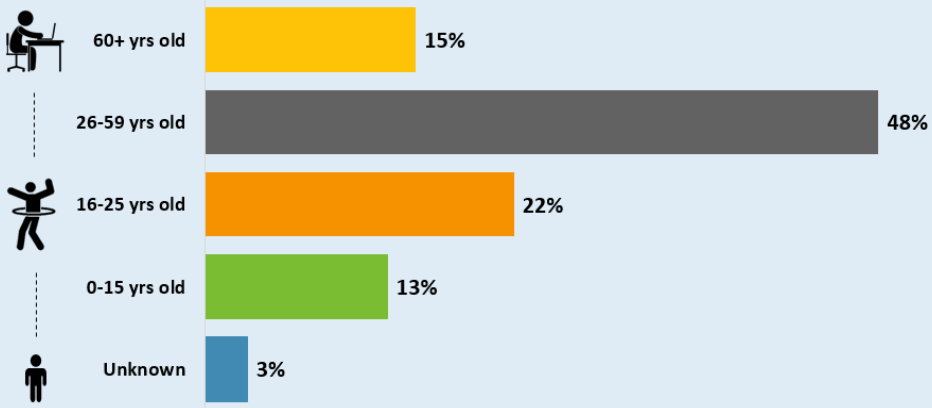
Artwork by Peter Millar

Fiscal Year 2018/19 Program Demographics

The following graphs illustrate the demograhics in various categories of TEST consumers.

Age:

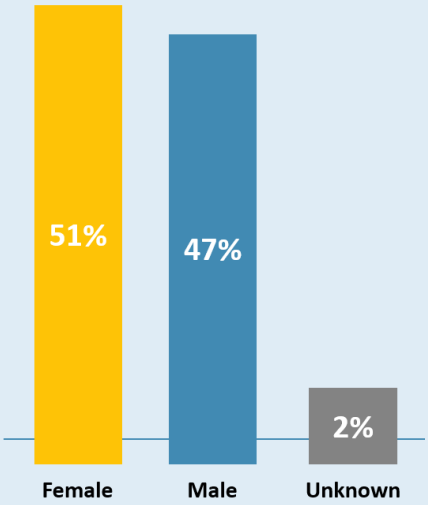
The graph below illustrates the ages of TEST consumers. The majority of consumers served, 48%, were between the ages of 26-59 years old. The second largest group was between the ages of 16-25 years old at 22%. There were 15% of consumers who identified as 60+ and 13% identified as 0-15 years old. Finally, 3% were unknown. This graph is representative of the TEST target population of adults and TAY being the majority served.



N = 1, 748

Gender:

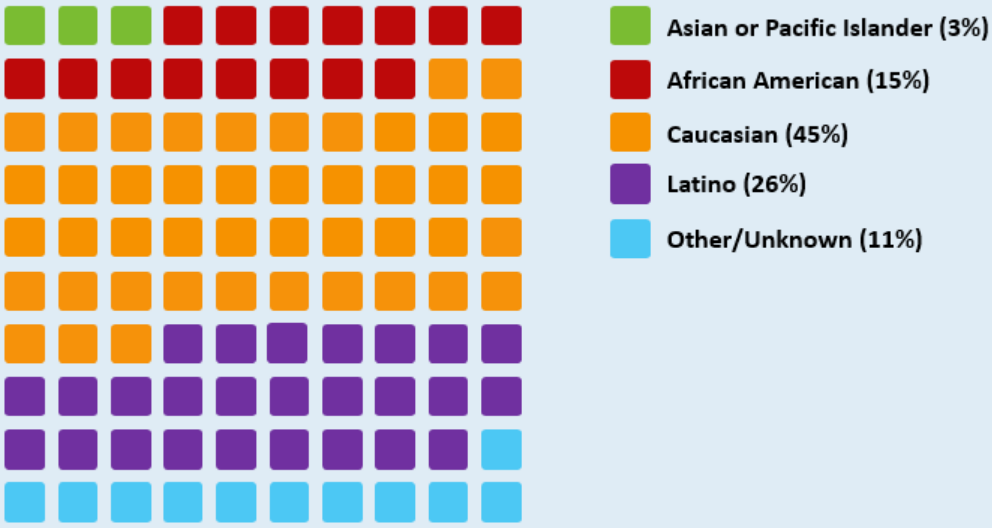
The graph below demonstrates that 51% of TEST consumers identified as female, 47% as male, and 2% as unknown. None of the consumers identified as transgender, non-binary, gender queer, or other not listed.



N= 1,748

Ethnicity and Ancestry:

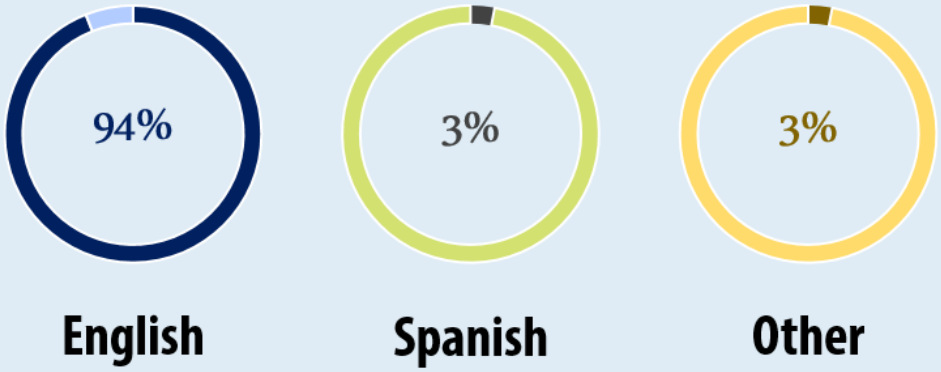
The graph below illustrates the various ethnicities of consumers of the TEST program. The largest group of consumers was 45% in the category of Caucasian. The second largest category was Latino at 26%. Following that, 15% identified as African American. An additional 3% identified as Asian or Pacific Islander. Finally, 11% identified as Other/Unknown. This category includes those who identified as other, more than one race, or declined to answer.



N = 1,748

Primary Language:

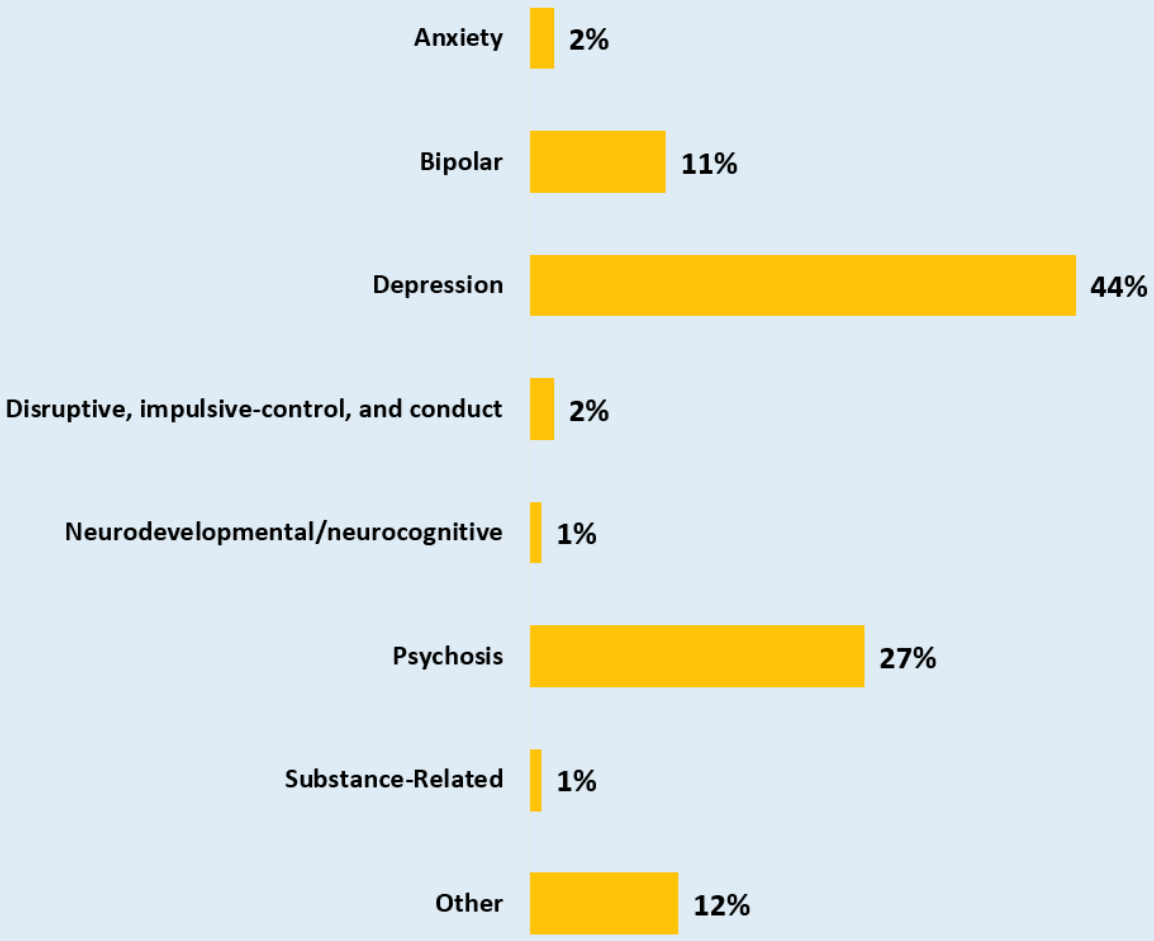
The graph below demonstrates that 94% of TEST consumers identified English as their primary language. Additionally, 3% identified Spanish as the primary language, and 3% identified their primary language as something other than English and Spanish.



N = 1,748

Primary Diagnosis:

The graph below illustrates the diagnostic group of TEST consumers who received services. Most of the consumers of TEST were diagnosed under the category of Depression. 12% of consumers comprise the category of either other diagnose than those listed or more than one diagnosis. 27% were diagnosed under the category of Psychosis, 11% with Bipolar Disorder, 2% with Disruptive, Impulsive-Control, and Conduct Disorders, 2% with Anxiety Disorders, 1% with Neurodevelopmental/Neurocognitive Disorders, and 1% with Substance-Related Disorders.



N = 971

Collaborative Partners

- Apple Valley Sheriff's Office
- Barstow Police Department
- Barstow Sheriff's Office
- Big Bear Sheriff's Office
- California State University, San Bernardino
- Chino Police Department
- Desert Valley Hospital Emergency Department
- Fontana Police Department
- Fontana Sheriff's Office
- Hesperia Sheriff's Office
- Highland Sheriff's Office
- Joshua Tree Probation
- Kaiser Hospital
- Loma Linda University Medical Center Emergency Department
- Ontario Police Department
- Rancho Cucamonga Public Defender's Office
- Redlands Police Department
- Rialto Police Department
- San Bernardino Police Department
- St. Mary's Medical Center Emergency Department
- Twin Peaks Sheriff's Office
- Upland Police Department
- Victorville Sheriff's Office
- Victor Valley College
- Yucaipa Sheriff's Office

Crisis System of Care Programs (A-6)

The Crisis System of Care's Community Crisis Response Team (CCRT) provides urgent behavioral health services to residents of San Bernardino County, and the Crisis Intervention Training program (CIT) provides training to law enforcement and community partners who may respond to calls that involve a consumer experiencing a behavioral health crisis.

Community Crisis Response Team (CCRT)

The Community Crisis Response Team (CCRT) utilizes specially trained, multidisciplinary mobile crisis response staff to provide crisis interventions, assessments, and urgent medication referrals. CCRT has regional teams located in the East/Central Valley, High Desert and West Valley areas of San Bernardino County. CCRT responds to community locations through collaboration with law enforcement, schools, Department of Behavioral Health (DBH) clinics and contractors, specialty programs, group homes, Board and Care (B&C) facilities, family members, and self-referrals. Anyone in San Bernardino County may call CCRT in the event of a behavioral health crisis. CCRT is committed to assisting San Bernardino County consumers in the least restrictive manner by providing behavioral health services on site where the consumer is experiencing their crisis. Response settings may include parks, parking lots, and other public locations. CCRT staff may also provide the consumer and family members with referrals and linkage to necessary and appropriate behavioral health and non-behavioral health resources and services.

MHSA Legislative Goals and Related Key Outcomes

Reduce the frequency of emergency room visits and unnecessary hospitalizations:

- Reduced rate of emergency room visits for mental health concerns
- Increased use of alternative crisis interventions (e.g., CWIC, CCRT, CSU)
- Increase in number of individuals diverted from hospitalization

Increase a network of community support services:

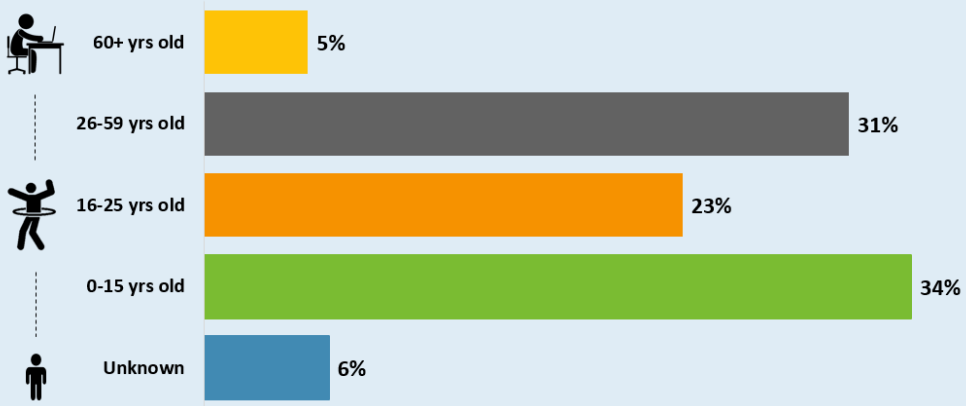
- Increase in number of collaborative partners

Fiscal Year 2018/19 Program Demographics

The following graphs illustrate the demographics in various categories of CCRT consumers.

Age:

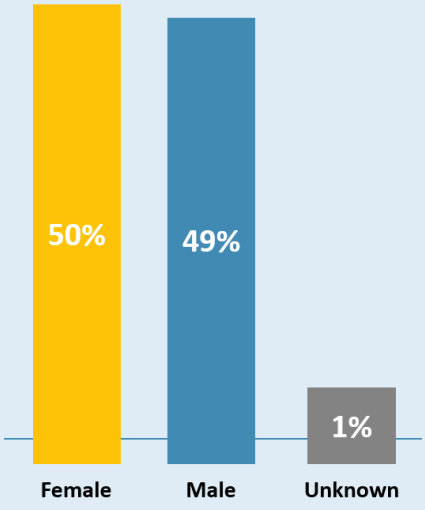
The graph below illustrates the ages of CCRT consumers. The majority of consumers served, 34%, were between the ages of 0-15 years old. The second largest group was between the ages of 26-59 years old at 31%. There were 23% of consumers who identified as 16-25, 5% as 60+, and 6% as unknown. This graph is representative of the CCRT target population being a combination of all age groups.



N = 5,070

Gender:

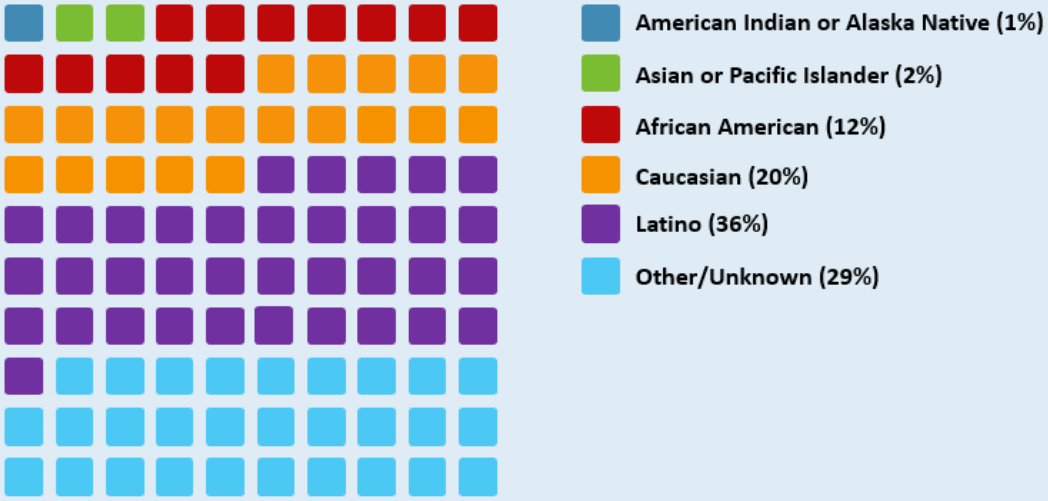
The graph below demonstrates that 50% of CCRT consumers identified as female, 49% identified as male, and 1% unknown. None of the participants identified as transgender, non-binary, gender queer, or other not listed.



N = 5,070

Ethnicity and Ancestry:

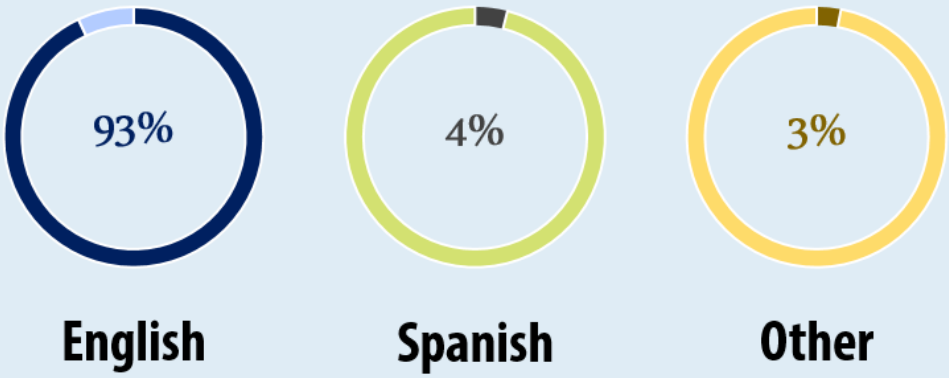
The graph below illustrates the various ethnicities of consumers of the CCRT program. The largest group of consumers was 36% in the category of Latino. The second largest category was Other at 29%. This category includes those who identified as other, more than one race, or declined to answer. Following that, 20% identified as Caucasian. An additional 12% identified as African American. Finally, 2% identified as Asian or Pacific Islander and 1% as American Indian or Alaska Native.



N = 5,070

Primary Language:

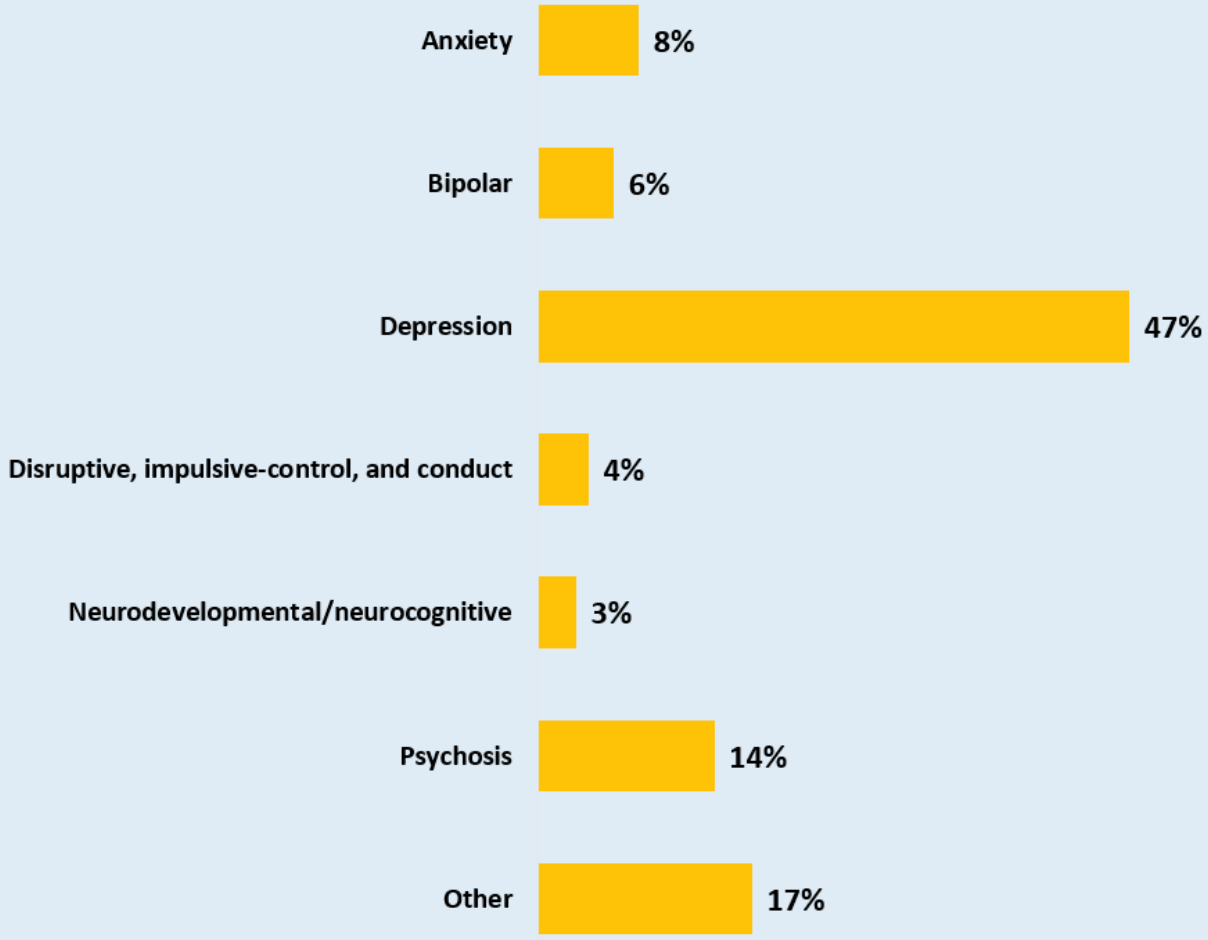
The graph below demonstrates that 93% of CCRT consumers identified English as their primary language. Additionally, 4% identified Spanish as the primary language, and 3% identified their primary language as something other than English or Spanish.



N = 5,070

Primary Diagnosis:

The graph below illustrates the diagnostic groups of CCRT consumers who received services. Most of the consumers of CCRT were diagnosed under the category of Depression. 17% of consumers comprise the category of either other diagnoses than those listed or more than one diagnosis. 14% were diagnosed under the category of Psychosis, 8% with Anxiety Disorders, 6% with Bipolar Disorders, 4% with Disruptive, Impulsive-Control, and Conduct Disorders, and 3% with Neurodevelopmental/Neurocognitive Disorders.



N = 1,985

Positive Results

- In Fiscal Year 2018/19, 1,312 consumers were diverted from unnecessary psychiatric hospitalization:
  - ◊ Three were diverted to Crisis Residential Treatment (CRT) facilities
  - ◊ 317 were diverted to Crisis Stabilization Unit (CSU) facilities
  - ◊ 443 were diverted to a Crisis Walk-In Center
  - ◊ 549 were diverted to other qualified crisis intervention alternatives
- In Fiscal Year 2018/19, CCRT collaborated with 131 partners, an 18% increase from the 111 collaborative partners in Fiscal Year 2017/18.

Program Challenges

CCRT has experienced challenges in obtaining and maintaining appropriate staffing levels for all positions. High Desert CCRT continues to have staffing challenges due to the rural location, extended hours, weekend shifts, and extended hospital sit times awaiting evaluation and/or admittance.

Program Solutions

DBH secured a pay differential for CCRT leadership, to support the recruiting and retaining of leadership staff. In acknowledgement of the extended sit times at the hospitals, DBH managers and Human Resources are working to establish a department-wide “sit list.” The sit list will be used to alleviate the burden placed solely on CCRT when extended wait times are required at the hospitals. Lastly, current CCRT and DBH employees are strongly encouraged to apply for internal promotional opportunities.

Outreach and Engagement

In Fiscal Year 2018/19, Community Crisis Response Team (CCRT) organized and/or participated in the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Community Presentation/Meetings	77	6,344
Referral and Linkage Calls	2,084	2,084
Law Enforcement Briefings/Collaborative Meetings	39	1,735
School Outreach	38	6,664
Hospital/Medical Offices	31	674
Total	**2,269**	**17,501**

Success Story

CCRT staff responded to a call about "George," an adult male experiencing a crisis. George was living with depression and suicidal ideation. Unfortunately, this was negatively impacting his marriage. CCRT staff engaged both George and his spouse and discussed various treatment options. George voluntarily agreed to transportation to seek services at a local hospital for psychiatric evaluation. His spouse and CCRT staff remained supportive during admittance for hospitalization. A few months later, George's spouse contacted CCRT. She expressed her appreciation for helping her spouse and saving their marriage. George was successfully linked to outpatient treatment and was improving.

Collaborative Partners

- Arrowhead Regional Medical Center
- Barstow Community Hospital
- Barstow Police Department
- Bear Valley Community Hospital
- Canyon Ridge Hospital
- Chino Police Department
- Chino Valley Hospital
- Colton Police Department
- Desert Valley Medical Center
- Family Resource Centers
- Fontana Police Department
- Hi-Desert Medical Center
- Inland Regional Center (IRC)
- Juvenile Group Homes
- Kaiser Hospital Emergency Department and Outpatient Services
- Loma Linda Behavioral Medical Center
- Loma Linda University Medical Center
- Montclair Police Department
- Mountains Community Hospital
- National Alliance of Mental Illness (NAMI)
- Needles Desert Community Hospital
- Office of Veterans Affairs
- Ontario Police Department
- Private Providers (Medical and Psychiatric)
- Public and Private Schools
- Redlands Community Hospital
- Redlands Police Department
- Rialto Police Department
- San Antonio Regional Hospital
- San Bernardino Community Hospital
- San Bernardino County, Children and Family Services (CFS)
- San Bernardino County, Department of Aging and Adult Services (DAAS)/Office of the Public Guardian
- San Bernardino County, Probation
- San Bernardino County, Sheriff
- St. Bernadine Medical Center
- St. Mary Medical Center
- The Counseling Team International
- Upland Police Department
- Victor Valley Global Medical Center

Crisis Intervention Training (CIT)

The Crisis Intervention Training (CIT) program provides training to first responders and community partners who encounter behavioral health crises in the community. The goal of each training is to enhance participants' ability to recognize signs of a mental health crisis, utilize communication and de-escalation skills, and access behavioral health resources for persons in crisis.

The CIT program provides the following trainings:

- In collaboration with San Bernardino County Sheriff's Department:
  - ◊ 40-hour CIT course (quarterly; formerly a 32-hour course which transitioned to 40 hours in September 2019)
  - ◊ 8-hour Senate Bill 29 (SB 29) Field Training Officer (FTO) CIT Course (quarterly)
- In collaboration with Probation:
  - ◊ 8-hour CIT course (biweekly)
- Multiple collaborative partner trainings (monthly)

These trainings have resulted in:

- Increased first responder awareness of stigma associated with mental health concerns,
- First responder ability to access appropriate community resources,
- An increase in first responder safety in the field, and
- Increased awareness of de-escalation tactics that promote the safety of consumers experiencing a crisis.

In Fiscal Year 2018/19, the CIT program welcomed an additional Social Worker II (SWII) to assist first responders with navigating resources in San Bernardino County through the First Responder Resources Hotline (FRRL). This SWII assists the Triage, Engagement, and Support Team (TEST) program in following up on CIT forms. CIT forms are generated by Sherriff's Deputies throughout the County when they respond to calls for service that are determined to be a mental health crisis. These CIT forms include a summary and the outcome of the call for service, providing information to the SWII.

MHSA Legislative Goals and Related Key Outcomes

Reduction in criminal and juvenile justice involvement:

- Decreased rate of incarcerations
- Decreased arrests
- Decreased in jail bookings
- Decreased sustained allegations
- Reduced jail/prison recidivism

Reduce the frequency of emergency room visits and unnecessary hospitalizations:

- Reduced rate of emergency room visits for mental health concerns
- Increased use of alternative crisis interventions (e.g., CWIC, CCRT, CSU)
- Increase in number of individuals diverted from hospitalization

Increase a network of community support services:

- Increase in number of collaborative partners
- Increased coordination of care

Positive Results

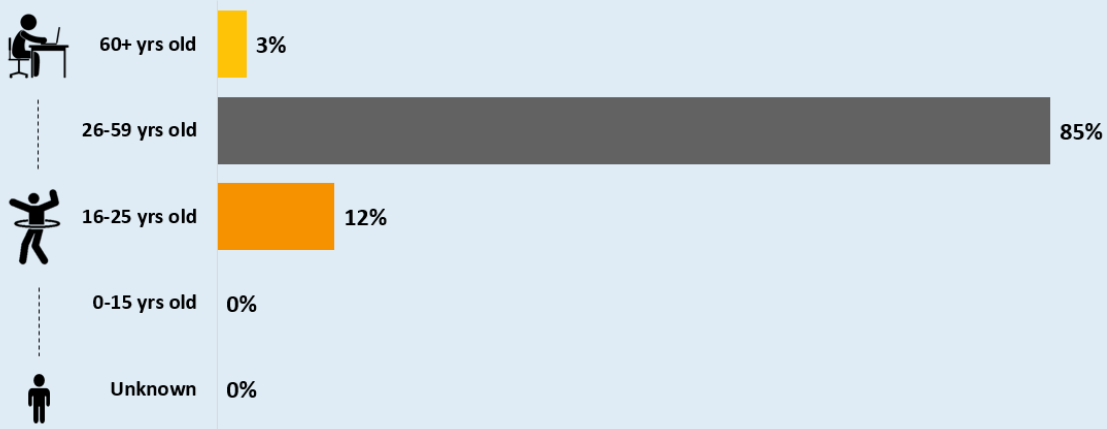
- In Fiscal Year 2018/19, a total of 1,871 law enforcement and community partners received training through the CIT Program:
  - ◊ 195 law enforcement personnel completed the 32-hour CIT course
  - ◊ 69 Field Training Officers (FTO) completed the 8-hour FTO CIT course
  - ◊ 762 Probation Officers and Probation Correctional Officers completed the 8-hour CIT course
  - ◊ 845 community partners, including fire personnel, public employees, nonprofit agency personnel and emergency department personnel received specialized training from the CIT program
- Of 260 consumers contacted through the CIT forms submitted by Sherriff's Deputies and assigned to the CIT SWII, 135 successful linkages to resources were made.

Fiscal Year 2018/19 Program Demographics

The following graphs illustrate the demographics in various categories of CIT consumers.

Age:

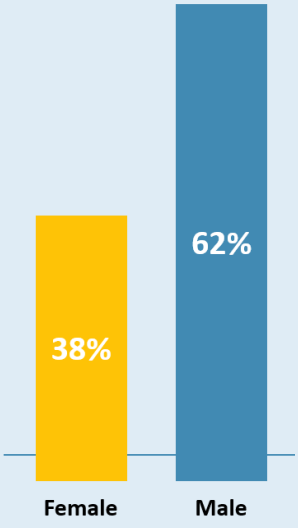
The graph below illustrates the ages of CIT participants. The majority of participants served, 85%, were between the ages of 26-59 years old. The second largest group was between the ages of 16-25 years old at 12%. There were 3% of participants who identified as 60+. This graph is representative of the CIT target population of adults being the majority served.



N = 505

Gender:

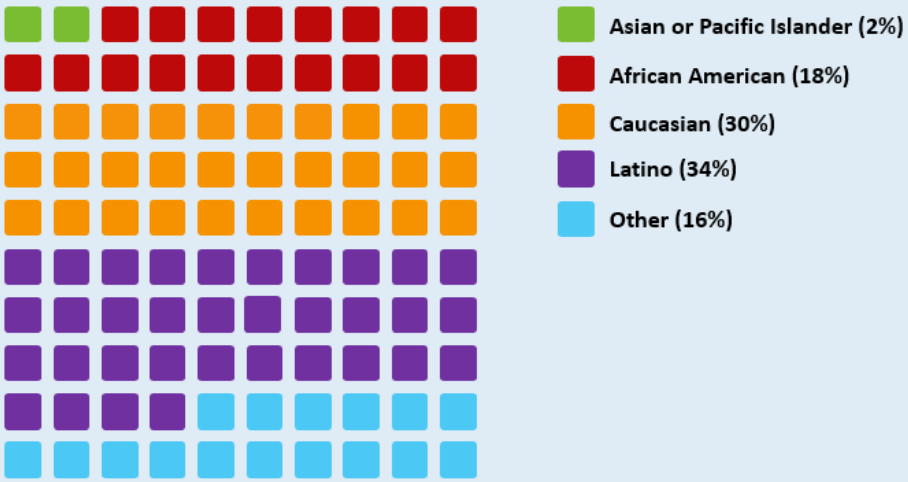
The graph below demonstrates that 62% of CIT participants identified male and 38% identified as female. None of the consumers identified as transgender, non-binary, gender queer, or other not listed.



N = 505

Ethnicity and Ancestry:

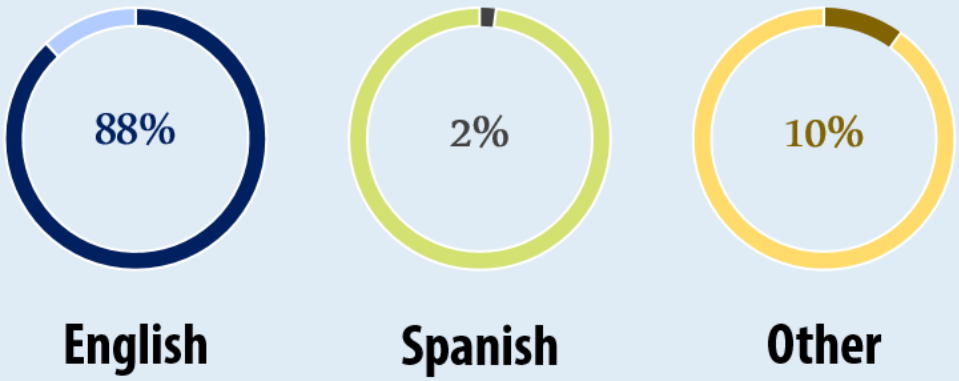
The graph below illustrates the various ethnicities of participants of the CIT program. The largest group of participants was 34% in the category of Latino. The second largest category was Caucasian at 30%. Following that, 18% identified as African American. An additional, 16% identified as Other. This category includes those who identified as other, more than one race, or declined to answer. Finally, 2% identified as Asian or Pacific Islander.



N = 505

Primary Language:

The graph below demonstrates that 88% of CIT participants identified English as their primary language. Additionally, 2% identified Spanish as the primary language, and 10% identified their primary language as something other than English or Spanish.



N = 505

Program Challenges

One of the challenges for the CIT program has been establishing collaborative relationships with city police departments whose police offices are unfamiliar with CIT training.

Program Solutions

The CIT program has employed a full-time Sheriff's Deputy who will be assisting CIT staff in providing outreach efforts to city police departments and educating them in CIT training opportunities.

Outreach and Engagement

In Fiscal Year 2018/19, Crisis Intervention Training (CIT) organized and/or participated in the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Crisis Stabilization Unit Grand Openings	2	300
Crisis Residential Treatment Center Grand Opening	3	500
Terrorism Early Warning Group	1	75
Youth Justice Center Open House	1	40
ACE Child Abuse Collaborative	2	35
National Night Out	1	200
Coffee with a Cop Community Meeting	11	214
Mountain Area Collaborative Meeting	1	20

Activity Type (cont.)	Number of Activity Type	Total Number of Participants
San Bernardino County Homeless Coalition Meeting	1	15
Ontario Police Department Pinning Ceremony	1	65
Case Manager's Meeting	2	65
Ontario Police Department Briefing	31	610
Chino Valley Behavioral Health Collaborative	3	57
Law Enforcement Collaborative	1	45
Teen Suicide Discussion Symposium	1	75
Gangs and Drug Taskforce Meeting	6	255
California Highway Patrol San Bernardino Open House	1	20
Hospital Collaborative Meeting	2	105
LGBTQ Awareness Meeting	4	43
Rialto Fire Ground Breaking Ceremony	1	75
United Way Mentoring Meeting	1	30
Upland High School Suicide Prevention Presentation	1	50
Rancho Cucamonga Family Resource Suicide Prevention Presentation	1	70
Chino Valley Behavioral Health Collaborative	3	57
Law Enforcement Collaborative	1	45
Emergency Medical Services (EMS) Officers Meeting	1	15

Activity Type (cont.)	Number of Activity Type	Total Number of Participants
Teen Suicide Discussion Symposium	1	75
Gangs and Drug Taskforce Meeting	6	255
California Highway Patrol San Bernardino Open House	1	20
Hospital Collaborative Meeting	2	105
LGBTQ Awareness Meeting	4	43
Rialto Fire Ground Breaking Ceremony	1	75
United Way Mentoring Meeting	1	30
Upland High School Suicide Prevention Presentation	1	50
Rancho Cucamonga Family Resource Suicide Prevention Presentation	1	70
Re-entry Meeting	1	60
Inland Empire Disabilities Collaboration	1	60
Fontana Community Action Partnership Collaborative	1	16
Interagency Council on Homelessness (ICH) Meeting	1	80
San Bernardino & Riverside County School Community Safety Symposium	1	20
West End Quality Improvement Group	1	15
CalFresh Meeting	1	70
Wavelengths Facility Visit	1	10
Belvedere Career Day	1	150
Total	**89**	**3,460**

Collaborative Partners

- CAL Fire
- California Highway Patrol
- City of Chino Police Department
- Inland Counties Emergency Medical Agency
- Inland Regional Center
- National Alliance on Mental Illness (NAMI)
- Office of Veteran Affairs (Federal)
- San Bernardino County, Children's Network
- San Bernardino County, Department of Aging and Adult Services/Office of the Public Guardian (DAAS/OPG)
- San Bernardino County, Probation
- San Bernardino County, Sheriff
- The Counseling Team International
- Valley Star Inc.

Artwork by Greg Barton

Crisis Walk-In Centers (A-4)

The Crisis Walk-In Centers (CWIC) are unlocked, voluntary, 23-hour psychiatric urgent care centers that offer a positive and safe environment to consumers of all ages experiencing a behavioral health crisis in this County. Consumers can be evaluated and referred to an appropriate level of care and may be diverted from unnecessary psychiatric hospitalization. The CWICs are located in Joshua Tree (Morongo Basin Region) and Victorville (High Desert Region). Centers are staffed by a multi-disciplinary team who focuses on stabilizing consumers, providing linkage to resources within the community for follow-up behavioral health care and continued stabilization. At these contracted CWICs, services are offered 24 hours per day, 7 days a week. In collaboration with the Community Crisis Response Teams (CCRT) and the Triage, Engagement, and Support Teams (TEST), the CWICs work to reduce inappropriate hospitalizations and improve the quality of life for their consumers.

MHSA Legislative Goals and Related Key Outcomes

Reduce the subjective suffering from serious mental illness for adults and serious emotional disorders for children and youth:

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

Reduce the frequency of emergency room visits and unnecessary hospitalizations:

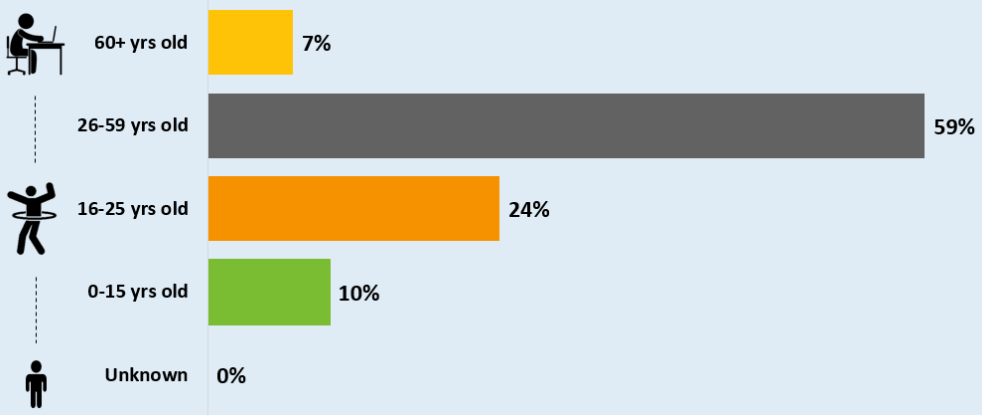
- Reduced rate of emergency room visits for mental health concerns
- Increase use of alternative crisis interventions (e.g., CWIC, CCRT, CSU)
- Increase in number of individuals diverted from hospitalization

Fiscal Year 2018/19 Program Demographics

The following graphs illustrate the demographics in various categories of CWIC consumers.

Age:

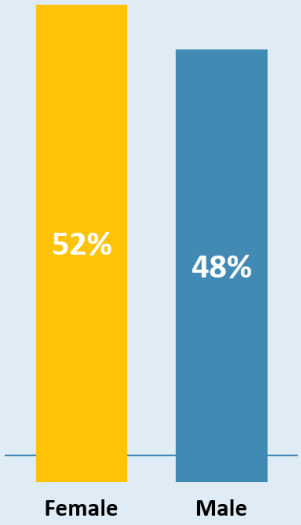
The graph below illustrates the ages of CWIC consumers. The majority of consumers served, 59%, were between the ages of 26-59 years old. The second largest group was between the ages of 16-25 years old at 24%. There were 10% of consumers, ages 0-15 years old. The remaining 7% of consumers were 60+ years of age. This graph is representative of the CWIC target population of adults and TAY being the majority served.



N = 2,413

Gender:

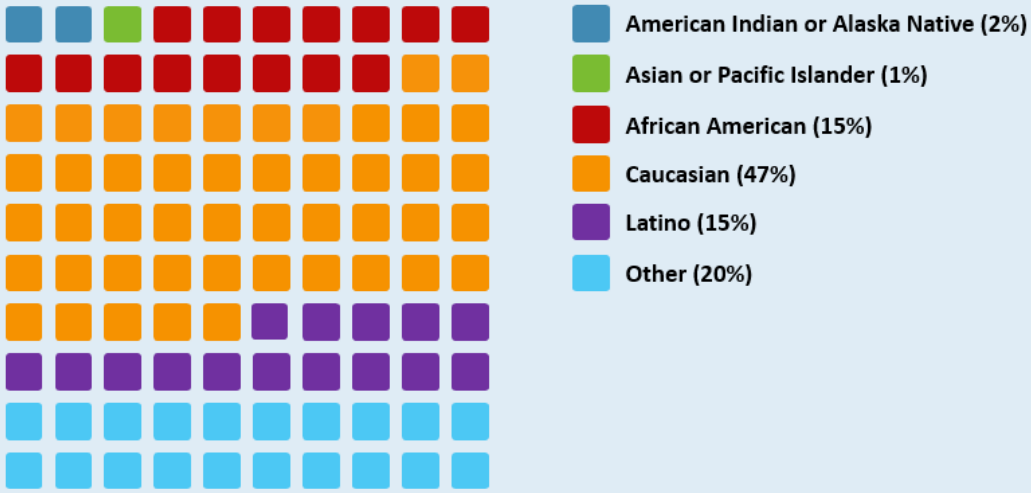
The graph below demonstrates that 52% of CWIC consumers identified as male and 48% as female. None of the consumers identified as transgender, non-binary, gender queer, or other not listed.



N = 2,413

Ethnicity and Ancestry:

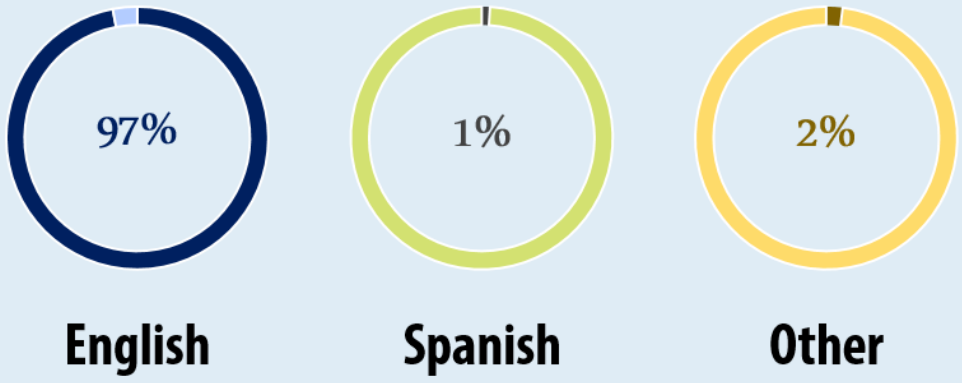
The graph below illustrates the various ethnicities of consumers of the CWIC program. The largest group of consumers was 47% in the category of Caucasian. The second largest category was Other at 20%. This category includes those who identified as other, more than one race, or declined to answer. Following that, 15% identified as African American and another 15% identified as Latino. Finally, 2% identified as American Indian or Alaska Native and 1% as Asian or Pacific Islander.



N = 2,413

Primary Language:

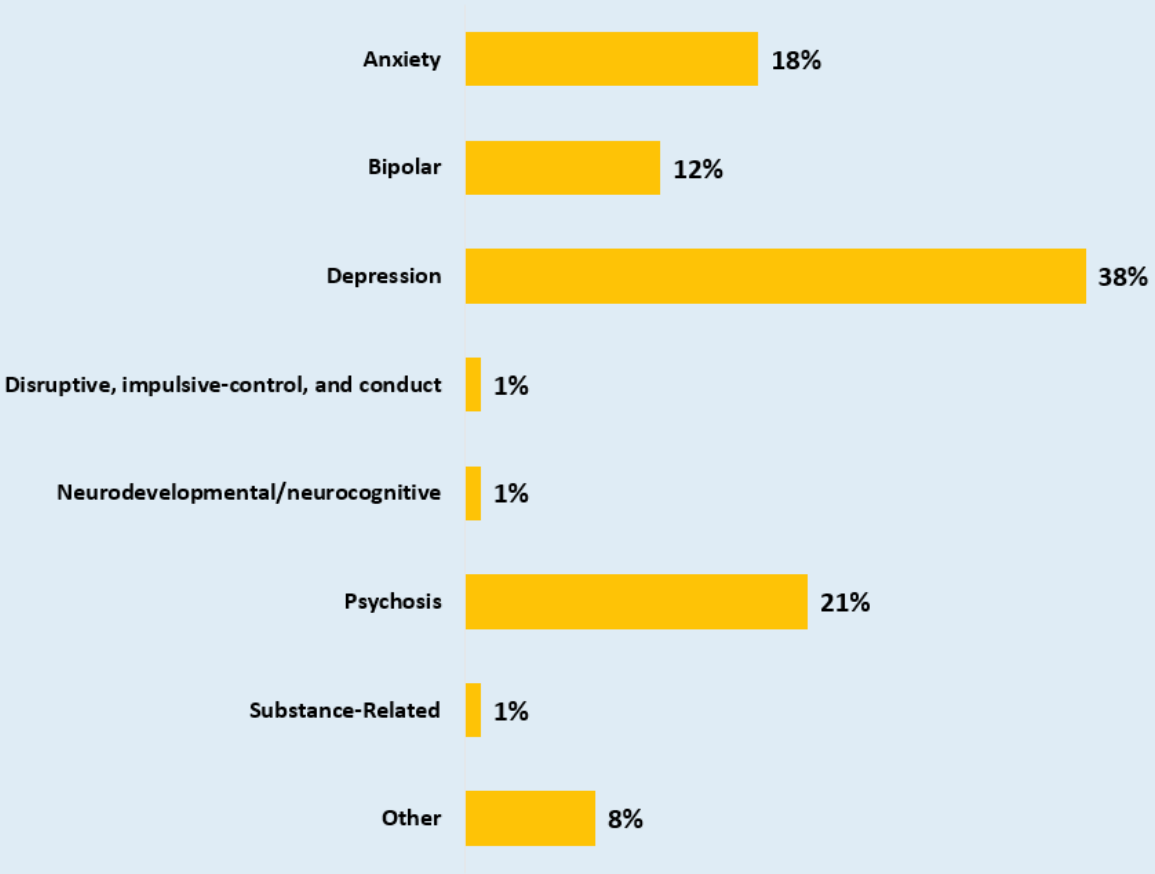
The graph below demonstrates that 97% of CWIC consumers identified English as their primary language. Additionally, 1% identified Spanish as the primary language, and 2% identified their primary language as something other than English and Spanish.



N = 2,413

Primary Diagnosis:

The graph below illustrates the diagnostic group of CWIC consumers who received services. Most of the consumers of CWIC fall under the category of Depression. The second largest category was diagnosed under the category of Psychosis at 38%. Following that, 18% were diagnosed under the category of Anxiety Disorders. Of the remaining diagnoses, 12% were diagnosed under the category of Bipolar Disorder, 1% with Disruptive, Impulsive-Control, and Conduct Disorders, 1% with Neurodevelopmental/Neurocognitive Disorders, and 1% with Substance-Related Disorders. Lastly, 8% of consumers who fall under the category of Other received a different diagnosis than those listed or more than one diagnosis.



N = 2,413

Positive Results

The CWICs served a combined total of 2,399 consumers in Fiscal Year 2018/19. Of these, 2,234 (93.1%) were diverted from hospitalization. The following linkages and referrals were provided:

- 1,002 referrals to outpatient clinics
- 864 referrals to medication support services
- 359 referrals for community supports such as food banks, legal assistance, and others
- 241 referrals for housing resources
- 46 linkages to health care providers

*Consumers may have received multiple linkages or referrals upon discharge.

Annually, the program surveys customer satisfaction. In Fiscal Year 2018/19, the program had 2,032 respondents. Of these, the below percentages represent those who agreed “somewhat” or “very much”:

- 97.69% - “I was treated with dignity and respect while at the CWIC.”
- 93.48% - “Staff understood my cultural background.”
- 95.35% - “I was treated as if I am not helpless and provided with hope and felt that I can overcome my struggle.”
- 96.41% - “I felt safe and supported during my crisis.”
- 93.38% - “Staff helped me develop a plan for when I leave the CWIC.”
- 86.10% - “I was introduced to Wellness Recovery Action Plan (WRAP).”
- 91.72% - “I was provided useful information about my medication and health.”
- 91.70% - “I was introduced to resources in my community.”
- 97.84% - “Staff took the time to listen to what I needed.”
- 95.49% - “Staff helped me feel safe and develop a safety plan if needed.”
- 87.60% - “I was offered food while I was here if I was hungry.”

Program Challenges

One challenge experienced this past fiscal year has been a lack of placement resources in rural areas, especially for individuals who are attempting to manage substance abuse disorders.

Additionally, the CWICs continue to receive consumers who are not experiencing a mental health crisis and are referred by various community sources including hospitals, law enforcement, and the population of individuals who identify as homeless or at risk of homelessness.

Program Solutions

CWICs have developed extensive placement lists that include, among others, numerous Room and Board facilities throughout San Bernardino County. Additionally, the addition of the Crisis Residential Treatment (CRT) programs has provided new treatment options for individuals in crisis and has assisted the CWICs with steering these consumers to appropriate levels of care. CWICs continue to collaborate with community partners in locating placement or housing options for consumers who may be more difficult to place.

The programs continue to provide outreach to educate community partners on the services provided by the CWICs and the factors that indicate an appropriate referral.

Success Story

"Danica," an adult female, was homeless after leaving a relationship with inter-partner violence. When she first arrived at the CWIC, she felt hopeless and thought her life would end if she continued to be homeless. After she obtained much needed medical assistance, the CWIC staff were able to successfully link Danica to an appropriate DBH program.

Collaborative Partners

- Arrowhead Regional Medical Center (ARMC)
- Barstow Community Hospital
- Barstow Police Department
- Bear Valley Community Hospital
- Canyon Ridge Hospital
- Chino Valley Medical Center
- Children's Intensive Case Management Services
- Coalition Against Sexual Exploitation (CASE)
- Community Hospital of San Bernardino
- Desert Valley Medical Center
- Family Resource Centers
- Hi-Desert Medical Center
- Loma Linda University Behavioral Medical Center
- Loma Linda University Medical Center (LLUMC)
- Mountains Community Hospital
- National Alliance of Mental Illness (NAMI)
- Needles Desert Community Hospital
- Office of Veterans Affairs
- Private providers (medical and psychiatric)
- Public and private schools
- Red Carnation House
- Redlands Community Hospital
- San Antonio Regional Hospital
- San Bernardino County Children's Network
- San Bernardino County, Children and Family Services (CFS)
- San Bernardino County, Department of Aging and Adult Services (DAAS)
- San Bernardino County, Probation Department
- San Bernardino County, Sheriff's Department
- St. Bernadine Medical Center
- St. Mary Medical Center
- The Counseling Team International
- Upland Police Department
- Victor Valley Global Medical Center
- Yucca Valley Chamber of Commerce

Crisis Stabilization Unit

The Crisis Stabilization Units (CSUs) provide voluntary crisis stabilization services to consumers ages 13 and older. Each facility has sixteen spaces for adult consumers age 18 and older, and four spaces for adolescent consumers age 13 to 17. Consumers may stay up to 23 hours and 59 minutes to receive psychiatric urgent care services including intervention for immediate and acute mental health crisis, crisis risk assessments, medication support and, when necessary, evaluation for hospitalization. Discharge planning includes linkage and referral to other community-based resources, including CRT facilities and other outpatient treatment programs. CSU facilities are intended to serve as a home-like, community-based alternative to unnecessary incarceration or psychiatric hospitalization.

MHSA Legislative Goals and Related Key Outcomes

Reduce the subjective suffering from serious mental illness for adults and serious emotional disorders for children and youth:

- Decrease hopelessness/increased hope
- Increased resiliency
- Decreased impairment in general areas of life functioning (e.g., health/ self-care/housing, occupation/education, legal, managing money, interpersonal/social)

Reduce the frequency of emergency room visits and unnecessary hospitalizations:

- Reduced rate of emergency room visits for mental health concerns
- Reduced number of emergency room visits for routine medical concerns
- Reduced administrative hospital days
- Increase use of alternative crisis interventions (e.g., CWIC, CCRT, CSU)
- Increase in number of individuals diverted from hospitalization

Increase a network of community support services:

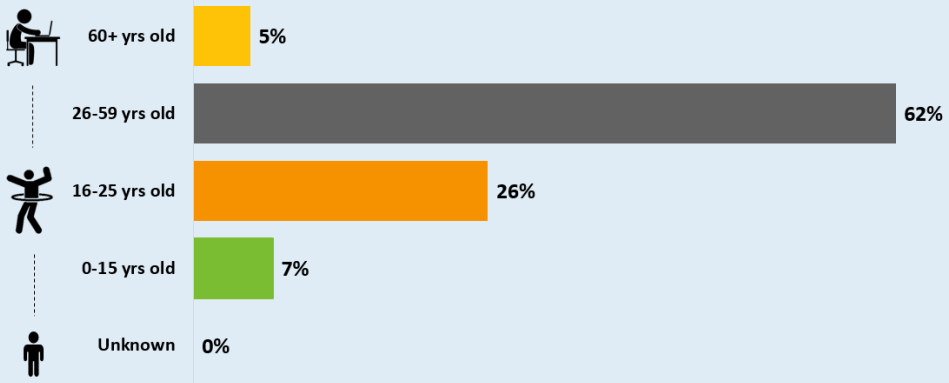
- Increase in self-help/support/12-step/community/school group or healthcare provider attendance and frequency per consumer
- Increased coordination of care

Fiscal Year 2018/19 Program Demographics

The following graphs illustrate the demographics in various categories of CSU consumers.

Age:

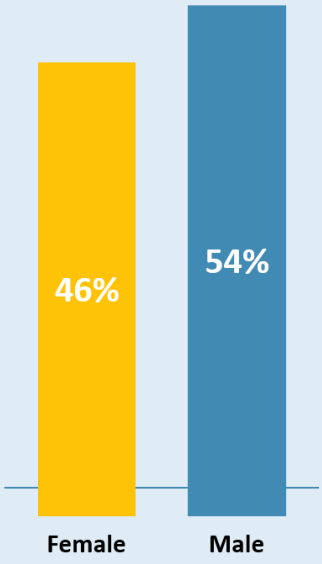
The graph below illustrates the ages of CSU consumers. The majority of consumers served, 62%, were between the ages of 26-59 years old. The second largest group was between the ages of 16-25 years old at 26%. 7% of consumers were between the ages of 0-15 years old and 5% were 60+ years old. This graph is representative of the CSU target population of adults and TAY being the majority served.



N = 2,309

Gender:

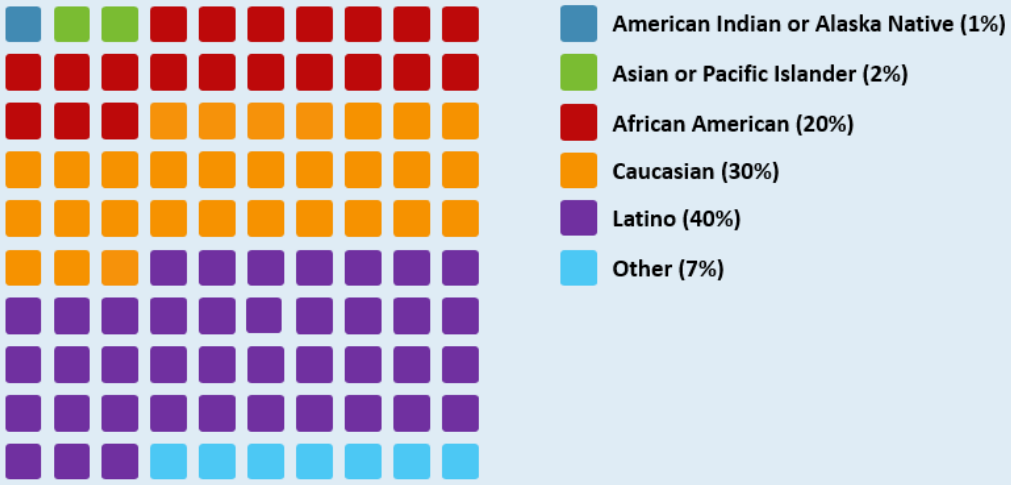
The graph below demonstrates that 54% of CSU consumers identified as male and 46% as female. None of the consumers identified as transgender, non-binary, gender queer, or other not listed.



N = 2,309

Ethnicity and Ancestry:

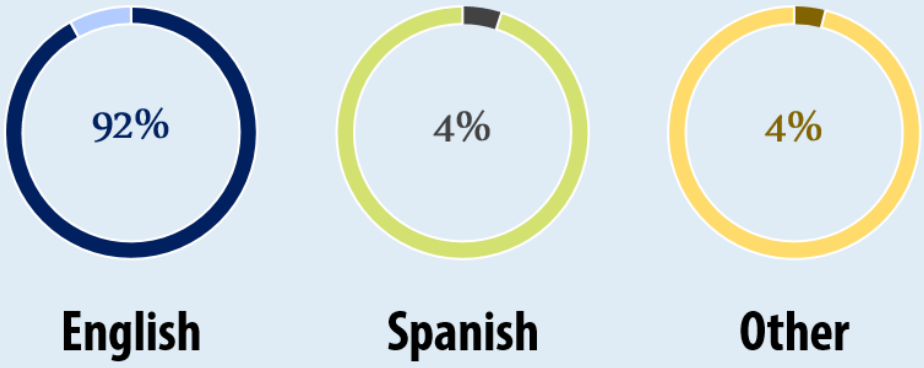
The graph below illustrates the various ethnicities of consumers of the CSU program. The largest group of consumers was 40% in the category of Latino. The second largest category identified as Caucasian at 30%. Following that, 20% identified as African American. An additional 7% identified as Other. This category includes those who identified as other, more than one race, or declined to answer. Finally, 2% identified as Asian or Pacific Islander and 1% as American Indian or Alaska Native.



N = 2,309

Primary Language:

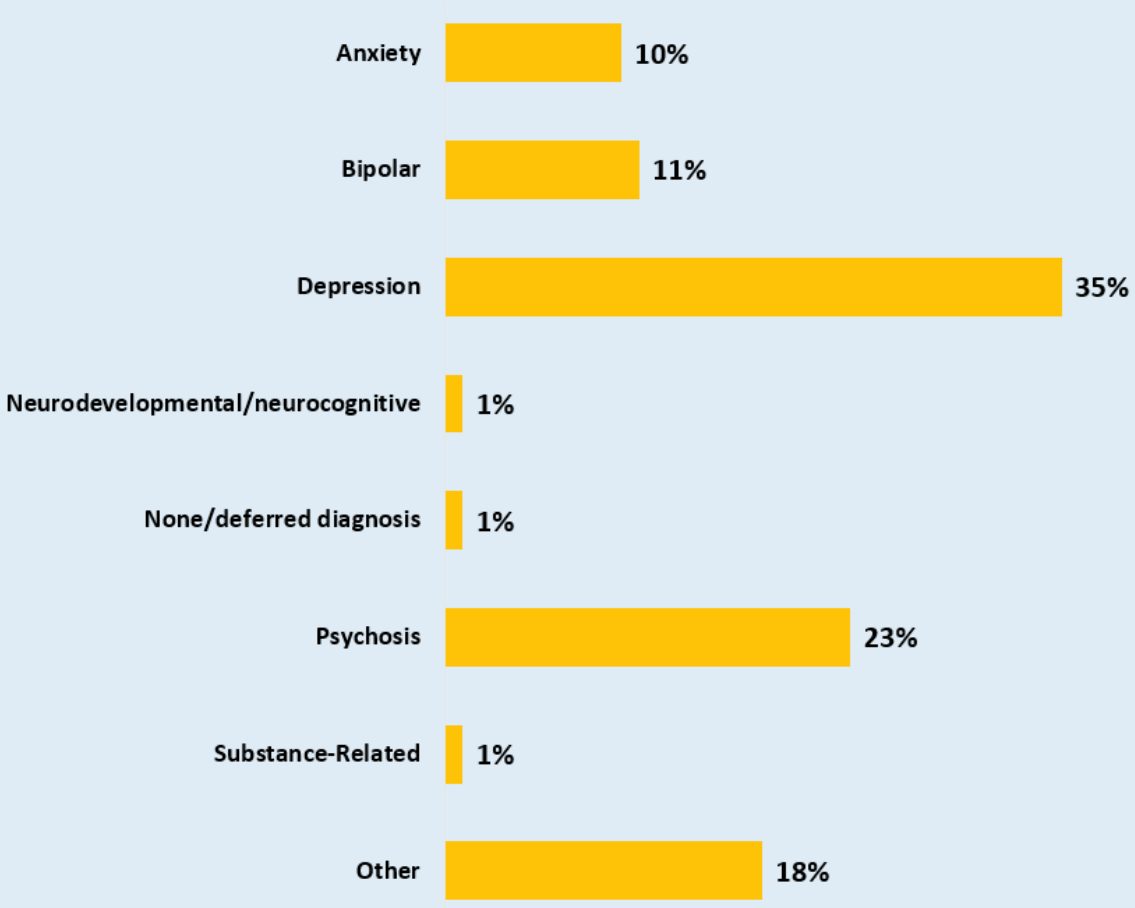
The graph below demonstrates that 92% of CSU consumers identified English as their primary language. Additionally, 4% identified Spanish as the primary language, and 4% identified their primary language as something other than English and Spanish.



N = 2,309

Primary Diagnosis:

The graph below illustrates the diagnostic groups of CSU consumers who received services. Most of the consumers of CSU were diagnosed under the category of Depression at 35%. The second largest category was Psychosis with 23% of given diagnoses. Following that, 18% of consumers were diagnosed under the category of Other, who have a different diagnosis than those listed or more than one diagnoses. Of the remaining diagnoses, 11% were diagnosed under the category of Bipolar Disorder, 10% with Anxiety Disorders, and 1% with Neurodevelopmental/Neurocogntive Disorders. Lastly, 1% of consumers were diagnosed under the category of no diagnosis or deferred diagnosis.



N = 2,309

Positive Results

The CSUs served a combined total of 2,371 consumers in Fiscal Year 2018/19. Of these, 2,252 (95%) were diverted from hospitalization. The following linkages and referrals were provided upon discharge:

- 1,364 (57.5%) received referrals to peer support and self-help groups.
- 204 (8.6%) received referral or linkage to housing assistance.
- 199 (8.3%) received transportation referral or linkage, including bus passes.
- 133 (5.6%) received referrals or linkage to a DBH or DBH contracted mental health clinic.
- 92 (3.9%) received referrals for medication management services.
- 49 (2%) were linked to Crisis Residential Treatment facilities.
- 335 (14.1%) received referrals or linkage to other resources, including legal assistance, Substance Use Disorder and Recovery Services (SUDRS), food banks, or other unspecified services.

Annually, the program surveys customer satisfaction. In Fiscal Year 2018/19, the program had 1,385 respondents. Of these, the below percentages represent those who agreed “somewhat” or “very much”:

- 95.00% - Timeliness of being seen
- 93.50% - Feeling respected
- 92.00% - Staff’s responsiveness to consumer’s problems
- 92.80% - Cultural sensitivity
- 92.00% - Sensitivity to other language needs (non-English speakers)
- 93.80% - Likeliness to return for services

Program Challenges

CSU programs experienced an initial low bed census due to the challenges that relate to implementing a new program and integrating into the surrounding community and continuum of care. The program experienced difficulty finding placement options for their consumers within limited time constraints and encountered obstacles in arranging transportation from emergency medical response personnel for consumers on 5150 involuntary psychiatric holds. CSUs continue to receive inappropriate referrals from various community agencies and self-referrals from individuals who are not in crisis and are simply seeking shelter or other resources.

Program Solutions

Extensive community outreach has led to a significant spike in utilization of both programs, as demonstrated by the 277% increase from 173 consumers served in the first quarter of Fiscal year 2018/19 to 652 consumers served in the second quarter. CSUs continue to provide this outreach and are anticipating even higher utilization in the coming year.

Placement concerns have been addressed by building relationships with community partners to be able to provide a variety of aftercare options at various levels of care. Resource binders have also been created with various community contacts for CSU staff to consult when seeking the next step for their consumers.

Merrill CSU purchased a multi-passenger van with protective caging to allow direct transportation of 5150 consumers. Additionally, continued outreach and collaboration are in progress with emergency medical response organizations and personnel at Arrowhead Regional Medical Center (ARMC) to allow for more seamless transitions for these consumers.

Inappropriate referrals are being mitigated through regular collaboration with community partners to improve continuity of care. Referrals to the CSU from hospitals and detention centers have progressed with improved coordination of care and communication. Implementing the availability of a nurse-to-nurse consult upon discharge from the referring facility has been helpful in gathering information about the consumer, especially when discharge takes place after regular business hours.

Success Story

“Christian” was brought to the hospital by his parents after being informed of their son’s suicide attempt. Due to high acuity, there were no beds available for psychiatric hospitalization. CSU staff successfully engaged with Christian and his family. During his 24-hour stay, Christian and his family participated in individual and family therapy to identify and resolve stressors at home. After being evaluated to safely return home, he felt hopeful and excited to return to school.

Outreach and Engagement

In Fiscal Year 2018/19, Crisis Stabilization Units (CSUs) organized and/or participated in the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Law Enforcement briefings/collaborations	21	387
Community collaborations	14	222
Presentations	8	146
Digital outreach to faith-based organizations, schools, nonprofits and community organizations	35	35
Telephone outreach to faith-based organizations, schools, nonprofits and community organizations	26	26
Total	**104**	**816**

"I love your services and support that everyone has here, thank you."

– CSU Consumer

"This is a very helpful place and everyone is very helpful. We need more placed like this."

– CSU Consumer

Collaborative Partners

- Arrowhead Regional Medical Center
- Canyon Ridge Hospital
- Community Hospital of San Bernardino
- Local law enforcement
- Local Room and Board facilities
- Local schools/universities
- Loma Linda University Behavioral Medicine Center
- Path of Life
- Salvation Army
- San Bernardino County, Children and Family Services (CFS)
- San Bernardino County, Department of Aging and Adult Services/Office of the Public Guardian (DAAS/OPG)
- San Bernardino County, Probation Department
- San Bernardino County, Sheriff's Department
- Set Free
- St. Bernadine Medical Center

Artwork by Linda Ballard

Crisis Residential Treatment (A-10)

The Crisis Residential Treatment (CRT) program consists of short-term (30 days initially, with the option of two 30-day extensions based on medical necessity, not to exceed 90 days) voluntary crisis residential treatment for San Bernardino County residents, age 18 to 59. Services are intended for individuals who are experiencing an acute psychiatric episode or crisis and are in need of short-term crisis residential treatment services to deter acute psychiatric hospitalization. CRTs consist of a home-like environment that supports and promotes the consumer's recovery, wellness, and resiliency within the community. Services are offered 24-hours a day, 365 days a year (24/7).

Adult Crisis Residential Treatment

San Bernardino County currently operates four CRT facilities for this age range:

- Casa Paseo CRT in San Bernardino opened on September 15, 2017
- Desert Hill CRT in Victorville opened on September 5, 2018
- Morongo Oasis CRT in Joshua Tree opened on October 3, 2018
- Wellspring CRT in Fontana opened on October 9, 2018

Each facility includes a living/common space area, family room, group rooms, separate interview rooms, bedrooms designed with separate living and visiting spaces, laundry room, cooking facilities, an outdoor patio, and gardening areas.

Consumers in need of this level of care will be provided with mental health services and case management. The program is designed to empower and support diverse consumers in the process of stabilization and transition to an appropriate level of care. It provides the following structured recovery-based, enriched treatment services and activities:

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

MHSA Legislative Goals and Related Key Outcomes

Reduce the subjective suffering from serious mental illness for adults and serious emotional disorders for children and youth:

- Decrease hopelessness/increased hope
- Increased resiliency
- Decreased impairment in general areas of life functioning (e.g., health/ self-care/housing, occupation/education, legal, managing money, interpersonal/social)

Reduce the frequency of emergency room visits and unnecessary hospitalizations:

- Reduced rate of emergency room visits for mental health concerns
- Reduced number of emergency room visits for routine medical concerns
- Reduced administrative hospital days
- Increased use of alternative crisis interventions (e.g., CWIC, CCRT, CSU)
- Increase in number of individuals diverted from hospitalization

"I feel that the entire floor staff has played an instrumental part in my recovery process. I have saved all my group handouts and will utilize all the coping skills."

– Adult CRT Consumer

"They were very kind at all times, even when I felt I didn't deserve it."

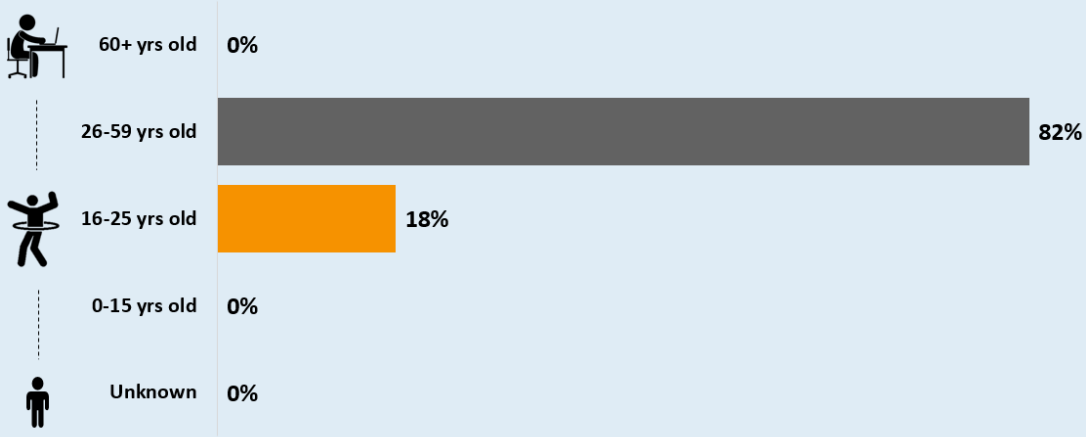
– Adult CRT Consumer

Fiscal Year 2018/19 Program Demographics

The following graphs illustrate the demographics in various categories of Adult CRT consumers.

Age:

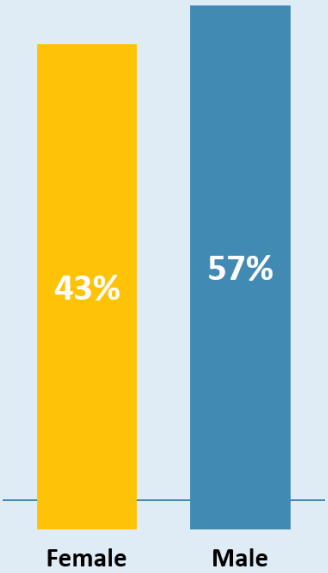
The graph below illustrates the ages of Adult CRT consumers. The majority of consumers served, 82%, were between the ages of 26-59 years old. The remaining 18% identified as 16-25 years old. This graph is representative of the Adult CRT target population of adults being the majority served.



N = 452

Gender:

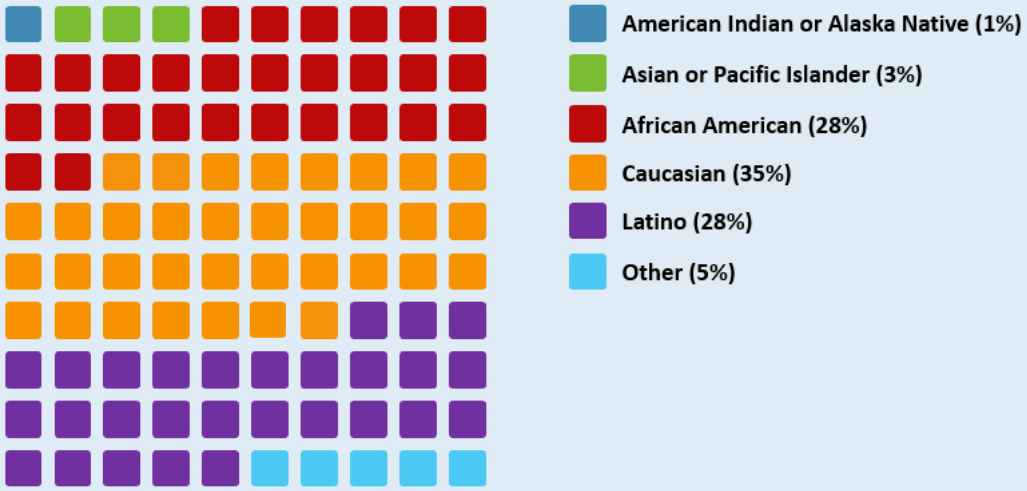
The graph below demonstrates that 57% of Adult CRT consumer identified as male and 43% identified as female. None of the consumers identified as transgender, non-binary, gender queer, or other not listed.



N = 452

Ethnicity and Ancestry:

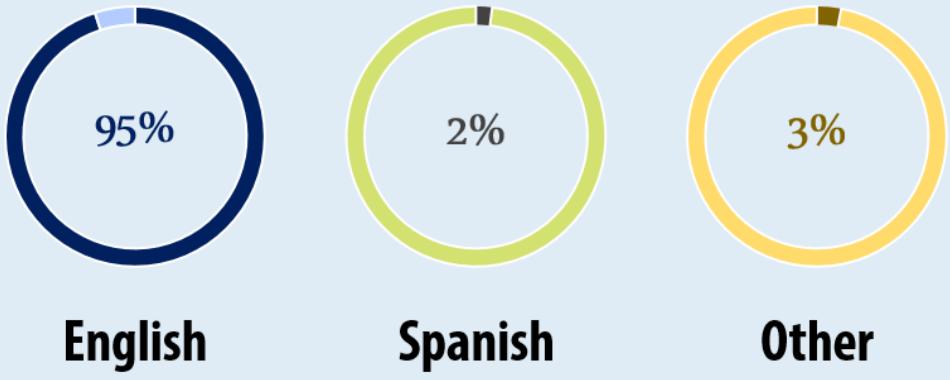
The graph below illustrates the various ethnicities of consumers of the Adult CRT program. The largest group of consumers was 35% identifying as Caucasian. The second largest categories are comprised those who identified African American or Latino at 28% for each category. Following that, 5% identified as Other. This category includes those who identified as other, more than one race, or declined to answer. Finally, 3% identified as Asian or Pacific Islander and 1% as American Indian or Alaska Native.



N = 452

Primary Language:

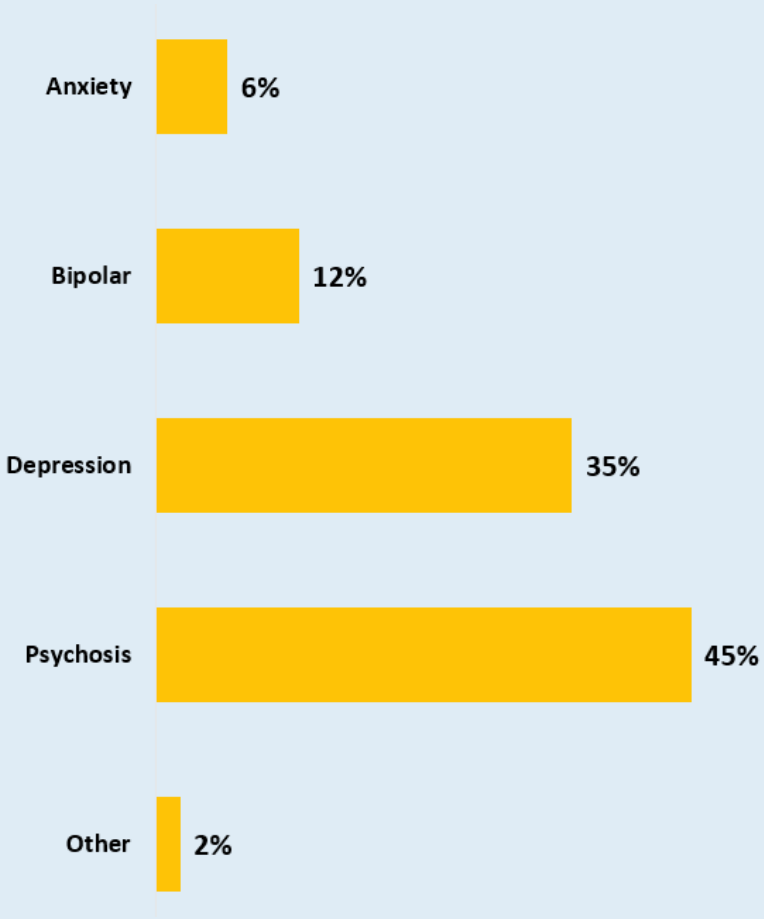
The graph below demonstrates that 95% of Adult CRT consumers identified English as their primary language. Additionally, 2% identified Spanish as the primary language, and 3% identified their primary language as something other than English or Spanish.



N = 452

Primary Diagnosis:

The graph below illustrates the diagnostic groups of Adult CRT consumers who received services. Most of the consumers of Adult CRT were diagnosed under the category of Psychosis. The second largest category was diagnosed under the category of Depression at 35%. Following that, 12% of consumers were diagnosed under the category of Biploar Disorder. Of the remaining diagnoses, 6% were diagnosed with under the category of Anxiety Disorders and 2% were diagnosed Other disorders. Those in the category of Other had a different diagnoses than those listed or more than one diagnosis. Lastly, 1% of consumers received no diagnosis or a deferred diagnosis.



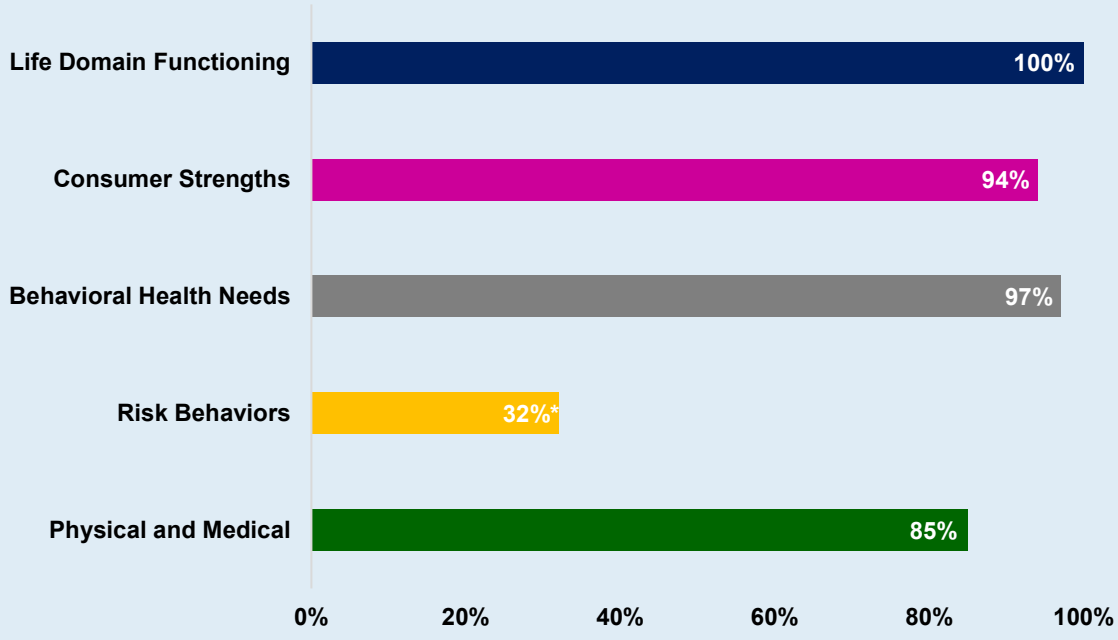
N = 452

Positive Results

During Fiscal Year 2018/19, 442 unduplicated consumers were served at the four CRT facilities. Between July 1, 2018 and December 1, 2018, 88 consumers were discharged. 55 (62.5%) had been psychiatrically hospitalized prior to CRT admission. Of these 55 consumers, hospitalizations decreased by 55.4% (from 101 hospitalizations within the six-month period prior to CRT to 45 hospitalizations within the six-month period following CRT discharge).

Consumer satisfaction surveys among the four adult CRTs demonstrated a 90% overall satisfaction rate with the services provided, considering factors including, but not limited to, personal development, group support, staff support, connection to resources in the community, and cultural competence.

Results from the Adult Needs and Strengths Assessment (ANSA) show the percentage of consumers who presented with a significant issue, and had that issue improve by the end of participation in the program in Fiscal Year 2018/19:



* 32% of consumers presented with improvement in Risk Behaviors, with 68% staying the same. No consumers presented with worsened behaviors.

Program Challenges

Adult CRT programs faced several challenges during Fiscal Year 2018/19. Several CRT facilities experienced issues that caused delays or impediments to service due to newly-constructed buildings that are still being fine-tuned. Some CRT programs experienced “CRT shopping”, specifically from those identified with co-occurring disorders. Some of these individuals were not yet ready to completely yield from substances and left the facilities against medical advice with the intent to reengage at a different CRT facility. Furthermore, initial low bed census followed opening dates. Lastly, a small percentage of consumers utilized multiple CRTs and engaged in dangerous or unsafe behavior, resulting in immediate discharge from the program.

Program Solutions

DBH and San Bernardino County Facilities Management continue to be diligent about addressing facilities concerns and making repairs to the buildings and equipment as they become necessary. As time goes on, these programs continue to develop and acclimate to their facilities, and fewer repairs are needed after the initial start-up troubleshooting.

Program staff are now supporting attendance at Alcoholics Anonymous and Narcotics Anonymous meetings for consumers living with co-occurring disorder who enter the CRT programs. These efforts are intended to prevent the consumers from discharging in order to reengage in substance use and assist with their Substance Use Disorder (SUD) recovery.

While Casa Paseo saw a significant increase in bed census following their opening date due to community outreach and further integration into their community’s continuum of care, they experienced a decrease in admissions once the subsequent facilities opened, which offered a wider variety and greater availability of local resources to County residents. Through continued education of County programs and community agencies, the programs continue to build their membership and encourage individuals in need of mental health crisis services to utilize CRT resources as an alternative to unnecessary hospitalization.

Programs have also established protocols through which they address violent or dangerous behaviors. The programs communicate with DBH and law enforcement, when necessary, to ensure that individuals are directed appropriately and may be seen at a level of care that best meets their unique needs.

Outreach and Engagement

In Fiscal Year 2018/19, Adult Crisis Residential Treatments (CRTs) organized and/or participated in the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Tours	8	71
Collaborations/Multidisciplinary Teams	15	262
Law Enforcement Briefings	3	68
Presentations	3	53
Tours	8	71
Total	**37**	**525**

Artwork by Sonia Stockton

Collaborative Partners

- Arrowhead Regional Medical Center
- Aurora Charter Oak Hospital
- Canyon Ridge Hospital
- Community Hospital of San Bernardino
- Pacific Grove Hospital
- Redlands Community Hospital
- San Bernardino County, Children and Family Services (CFS)
- San Bernardino County, Department of Aging and Adult Services/Office of the Public Guardian (DAAS/OPG)
- San Bernardino County, Probation Department
- San Bernardino County, Sheriff's Department
- Other local LPS facilities

Success Story

When "Blake" accessed services at the CRT, he was initially agitated, intrusive, and lacking motivation and interest in his recovery. The CRT staff continued to engage Blake, build rapport, and encourage him to look at the challenges and consequences of how he was living and interacting with others. Through group psychoeducation and staff and peer support, he was able to address his legal issues, improve family relationships, identify goals for his recovery, and develop a plan for his aftercare. The CRT staff encouraged and supported Blake's transition to an outpatient co-occurring program. After Blake's discharge, his mental health symptoms continued to decrease significantly and he was motived in his recovery from substance use. Blake contacted the CRT after several weeks of discharge to share he was doing well, engaging in his program, and was actively involved in 12-step meetings.

TAY Crisis Residential Treatment

The STAY is a short-term, voluntary 14 bed crisis residential treatment center for the TAY population, ages 18 to 25, who are experiencing an acute psychiatric episode or crisis, and are in need of a higher level of care than board and care residential, but a lower level of care than psychiatric hospitalization. The program is currently contracted, and services are provided by Valley Star Behavioral Health, Inc. (Valley Star). The STAY increases access to appropriate mental health services for TAY aged individuals in a mental health crisis.

Valley Star has developed a psychiatric rehabilitation program for The STAY that is comprehensive, multidisciplinary/interdisciplinary, and designed to meet the following objectives:

- Improve residents' adaptive functioning through their acquisition of skills essential for successful independent or semi-independent living in the community (less restrictive environment)
- Prevent residents' regression to a lower level of functioning through their acquisition of skills essential to their recovery

Services include therapeutic and psycho-educational groups, activities that focus on daily living skills-training, behavioral intervention/modification training, individual and group counseling, crisis intervention, medication support, substance use disorder counseling/referrals, recreational therapy, educational assistance, and pre-release and discharge preparation and planning.

The program bases itself within a structured, consistent, and therapeutic milieu designed to enhance the self-image of the residents, and to promote healthy and supportive interactions among the residents and staff. The multidisciplinary design includes diverse input from the psychiatric, nursing, social service, and vocational and recreational activity disciplines.

MHSA Legislative Goals and Related Key Outcomes

Reduce the subjective suffering from serious mental illness for adults and serious emotional disorders for children and youth:

- Decrease hopelessness/increased hope
- Increased resiliency
- Decreased impairment in general areas of life functioning (e.g., health/ self-care/housing, occupation/education, legal, managing money, interpersonal/social)

Reduce the frequency of emergency room visits and unnecessary hospitalizations:

- Reduced rate of emergency room visits for mental health concerns
- Reduced administrative hospital days
- Increased use of alternative crisis interventions (e.g., CWIC, CCRT, CSU)
- Increase in number of individuals diverted from hospitalization

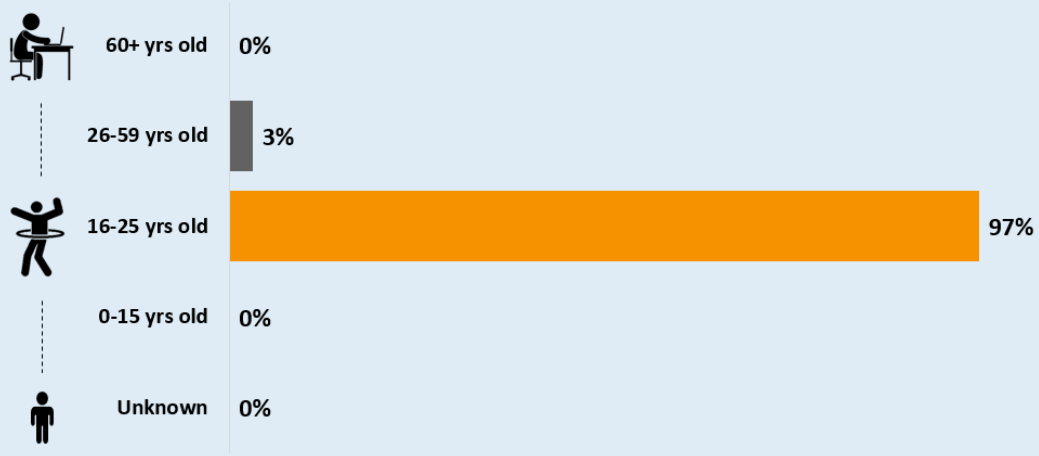
Artwork by Lakesha Lafayett

Fiscal Year 2018/19 Program Demographics

The following graphs illustrate the demographics in various categories of TAY CRT consumers.

Age:

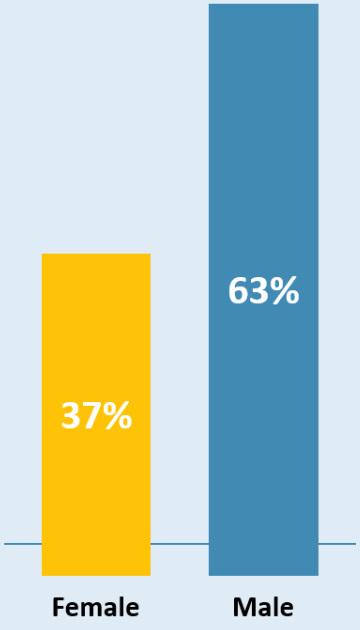
The graph below illustrates the ages of TAY CRT consumers. The majority of consumers served, 97%, were between the ages of 16-25 years old. The remaining 3% identified as 26-59 years old. This graph is representative of the TAY CRT target population of TAY being the majority served.



N = 111

Gender:

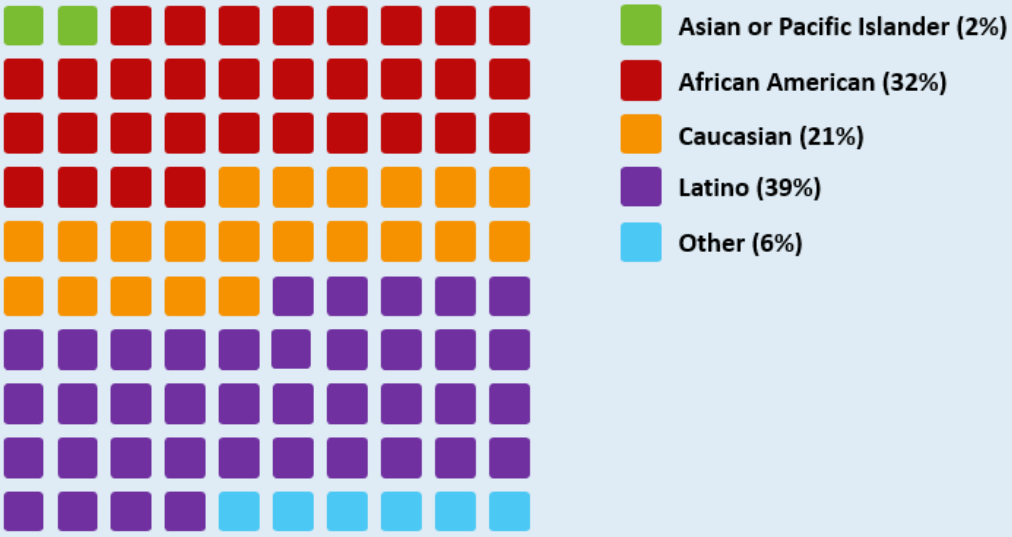
The graph below demonstrates that 63% of TAY CRT consumer identified as male and 37% identified as female. None of the consumers identified as transgender, non-binary, gender queer, or other not listed.



N = 111

Ethnicity and Ancestry:

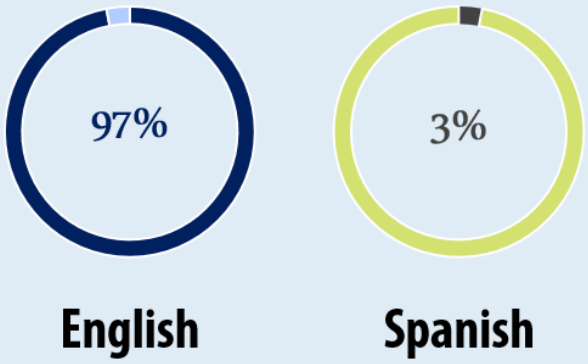
The graph below illustrates the various ethnicities of consumers of the TAY CRT program. The largest group of consumers was 39% in the category of Latino. The second largest category was African American at 32%. Following that, 21% identified as Caucasian. Finally, 6% identified as Other and 2% as Asian or Pacific Islander. The Other category includes those who identified as other, more than one race, or declined to answer.



N = 111

Primary Language:

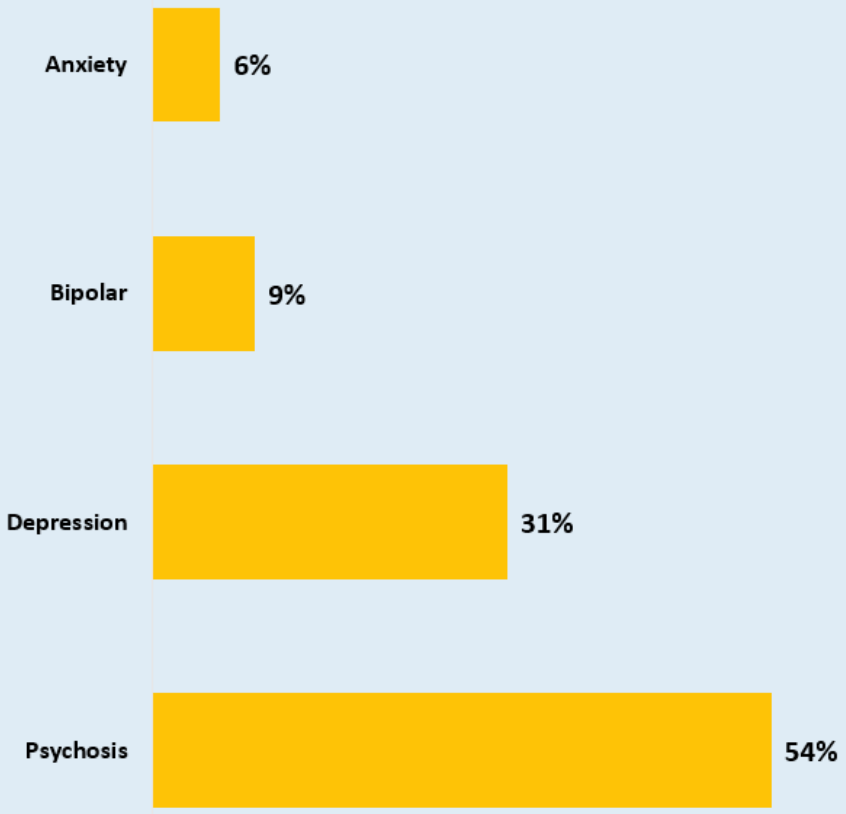
The graph below demonstrates that 97% of TAY CRT consumers identified English as their primary language. Additionally, 4% identified Spanish as the primary language.



N = 111

Primary Diagnosis:

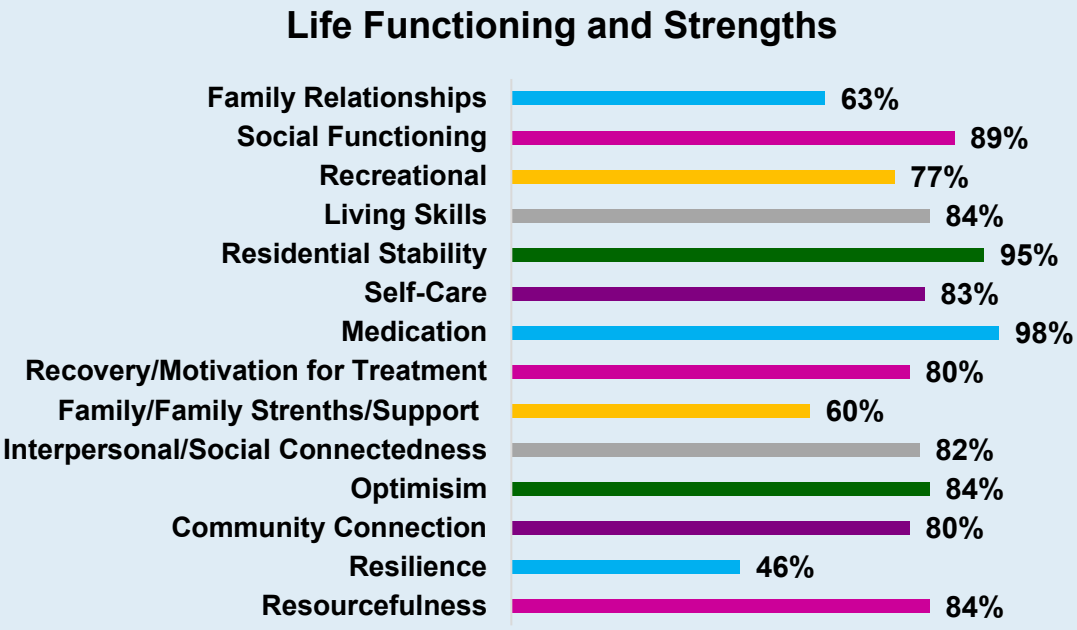
The graph below illustrates the diagnostic groups of TAY CRT consumers who received services. Most of the consumers of TAY CRT were diagnosed under the category of Psychosis at 54%. The second largest category was Depression Disorder at 31%. Of the remaining diagnoses, 9% were diagnosed under the category of Biploar Disorder and 6% under the category of Anxiety Disorders.



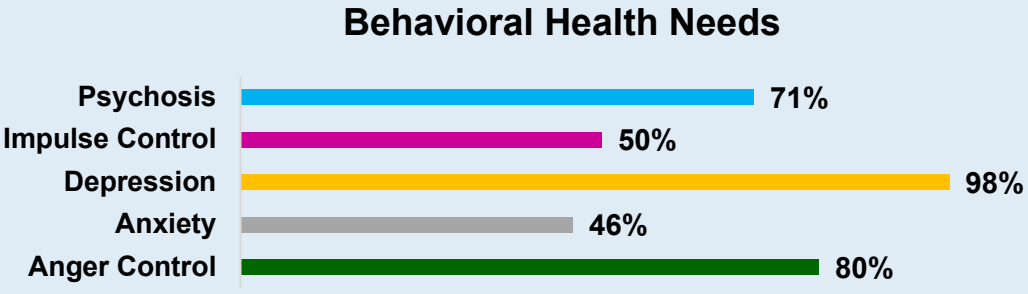
N = 111

Positive Results

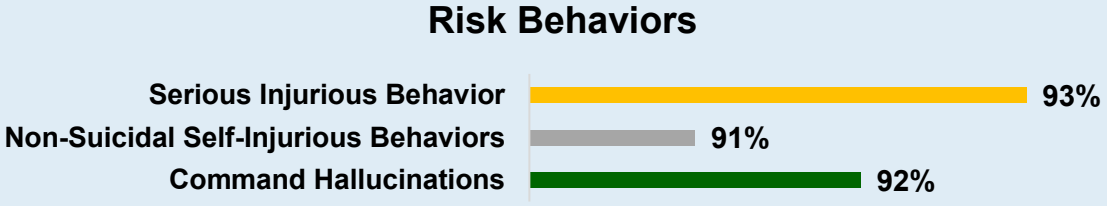
Results from the Adult Needs and Strengths Assessment (ANSA) show the percentage of youth who presented with a significant issue on an item within the Life Functioning and Strengths domains and had that issue improve by their completion in the program in Fiscal Year 2018/19:



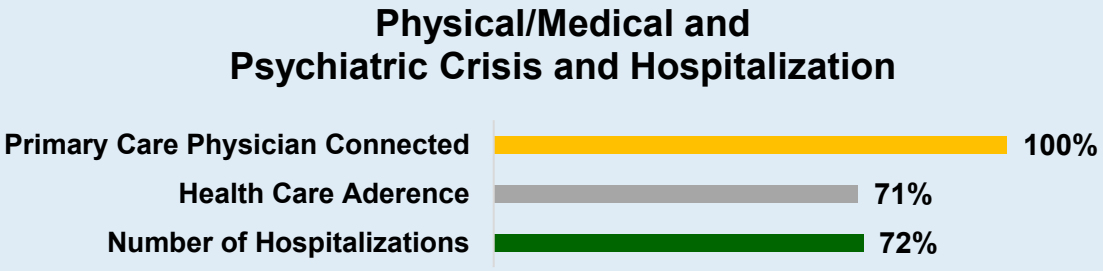
Results from the Adult Needs and Strengths Assessment (ANSA) show the percentage of youth who presented with a significant issue on an item within the Behavioral Health Needs domain, and had this issue improve by their completion in the program in Fiscal Year 2018/19:



Results from the Adult Needs and Strengths Assessment (ANSA) show the percentage of youth who presented with a significant issue on an item within the Risk Behaviors domain, and had this issue improve by their completion in the program in Fiscal Year 2018/19:



Results from the Adult Needs and Strengths Assessment (ANSA) show the percentage of youth who presented with a significant issue on an item within the Physical/Medical and Psychiatric Crisis and Hospitalization domains, and had this issue improve by their completion in the program in Fiscal Year 2018/19:



Success Story

"Stacey" was scared and hopeless when she first arrived at the TAY CRT. She had a history of losing placements. She lost all hope in herself and her ability to find the starting point to an improved life. She identified the TAY CRT as the first step in her journey. She successfully completed the program. She was grateful for the staff who understood her and helped her "bloom into the rose [she] was meant to be."

Program Challenges

The TAY CRT experienced untimely maintenance requests.

Program Solutions

The TAY CRT is currently increasing communication to remedy timely completion of requests. Weekly reports are provided to the Program Manager with the status of all requests.

Collaborative Partners

- Arrowhead Regional Medical Center
- Aspiranet
- Canyon Ridge Hospital
- Cedar House
- Community Hospital of San Bernardino
- Davis Residential Living Room and Board
- Job Corp
- Molding Hearts
- Orchid Court
- Premier Program
- San Bernardino County, Public Guardian's Office (PGO)
- Red Carnation Homeless Program
- True Vines Women's Home
- White Oak Hospital

Peer and Family Support Programs

Peer Support Programs offer stigma-free, emotional support for consumers living with serious mental illness in recovery. This holistic, strengths-based approach embraces and incorporates each individual's lived experience into the recovery and support process. Clubhouses are located throughout the county to assist and support consumers through their recovery.

Clubhouses are peer support centers that are recovery orientated for consumers 18 years or older that operate with minimal support from department staff. There are nine clubhouses located throughout the county that are dedicated to assisting consumers living with a serious mental illness. They are primarily consumer operated, and members have significant opportunity for input related to support groups, classes and activity choices.

Each Clubhouse uses a Recovery, Wellness and Resilience Model programs in stigma-free environments in an effort to improve the consumers' overall wellness in alignment with their personal recovery goals. The classes and activities assist consumers with developing skills that improve their relationships and assist with community reintegration. The chart below illustrates the steady increased involvement in this self-help program over the past ten years.

Target Populations

The table below identifies the target population of consumers to be served by the Clubhouse Expansion program for the upcoming three fiscal years (Fiscal Year 2020/2021 – 2022/2023).

Peer and Family Support Programs				
Program Name	Target Population			
	Children	TAY	Adults	Older Adult
Clubhouse Expansion			X	

Projected Number to be Served

The tables below represent the projected number of consumers to be served by programs within the Clubhouse Expansion program for the upcoming three fiscal years (Fiscal Year 2020/21 - 2022/23). For each fiscal year, the projected total is broken up into two MHSA categories: age and service. MHSA age categories are: Children, TAY, Adult, and Older Adult. MHSA service categories are: Full Service Partnership (FSP), General System Development (GSD), and Outreach and Engagement (O&E).

Program	Fiscal Year	Ages Served	Service Area	Total Served
Clubhouse Expansion	• 2020/21	• 30,352 Adults	• 10,352 GSD • 20,000 O&E	**30,352**
	• 2021/22	• 33,352 Adults	• 11,352 GSD • 22,000 O&E	**33,352**
	• 2022/23	• 33,352 Adults	• 12,352 GSD • 23,000 O&E	**35,352**

*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 mental health services offered and linking consumers to the appropriate services.

Artwork by Peter Milar

Clubhouse Expansion (A-1)

Clubhouses are peer-driven support centers for members in recovery. Clubhouses provide peer-run programs using a Recovery, Wellness, and Resilience model in a stigma free environment for adult members living with a serious mental illness. There are nine clubhouses located throughout the county that are dedicated to enhancing and supporting recovery. The Clubhouses are located in the cities of Barstow, Fontana, Loma Linda, Lucerne Valley, Morongo Basin, Ontario, Rialto, San Bernardino, and Victorville.

The main objectives of the Clubhouse Expansion Program are to assist members in making their own choices, providing peer support, and reintegrating into the community as contributing members, thereby achieving a fulfilling life in alignment with their personal recovery goals. Clubhouses are operated by the members through peer elected governing boards. In an effort to increase overall functioning and community reintegration, members meet regularly and are encouraged to provide input to program and activity choices.

Numerous support groups and activities provide growth opportunities for members to assist in their ability to reintegrate and cope within their community. Members plan and facilitate daily activities and determine workshop topics. Clubhouses also sponsor regularly scheduled 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.

Topics and activities can include:

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

In addition, the program provides transportation to stakeholder meetings in order to ensure the consumer's feedback is being captured in the stakeholder process.

MHSA Legislative Goals and Related Key Outcomes

Reduce the subjective suffering from serious mental illness for adults:

- Improved life satisfaction
- Increased resiliency

Increase in self-help and consumer/family involvement:

- Increase in program attendance and frequency per consumer
- Increase in self-help/support/12 step group attendance and frequency per consumer

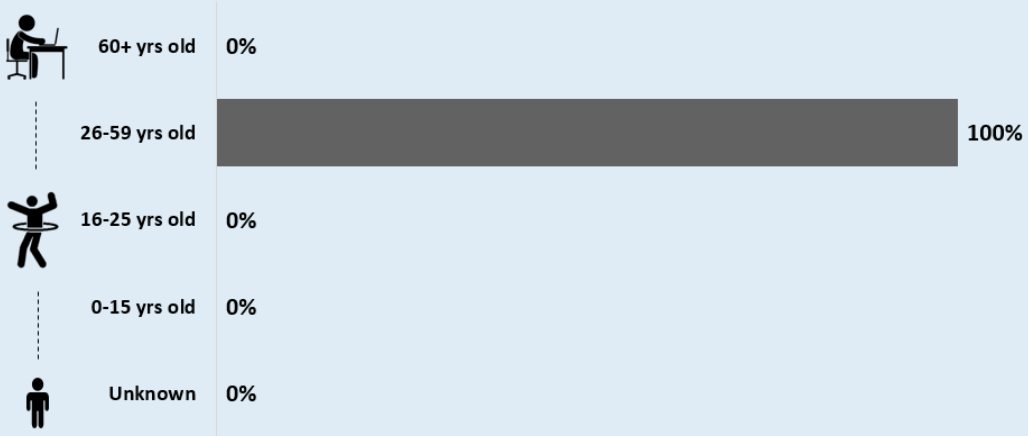
Artwork by Erika Montesinos

Fiscal Year 2018/2019 Program Demographics

The following graphs illustrate the demographics in various categories of CWE participants.

Age:

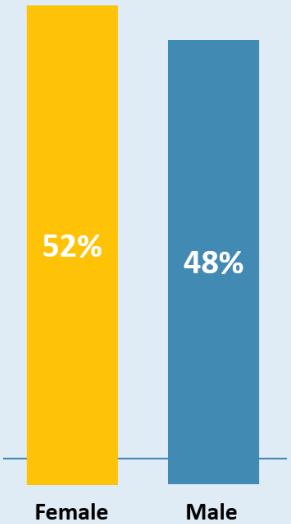
The graph below illustrates the age of the Clubhouse Expansion program members. 100% of the members were between the ages of 26-59 years old. This graph is representative of the majority of the target population of adults being served. Demographics for members who identify as 60+, or TAY is not currently being collected.



N=10,252

Gender:

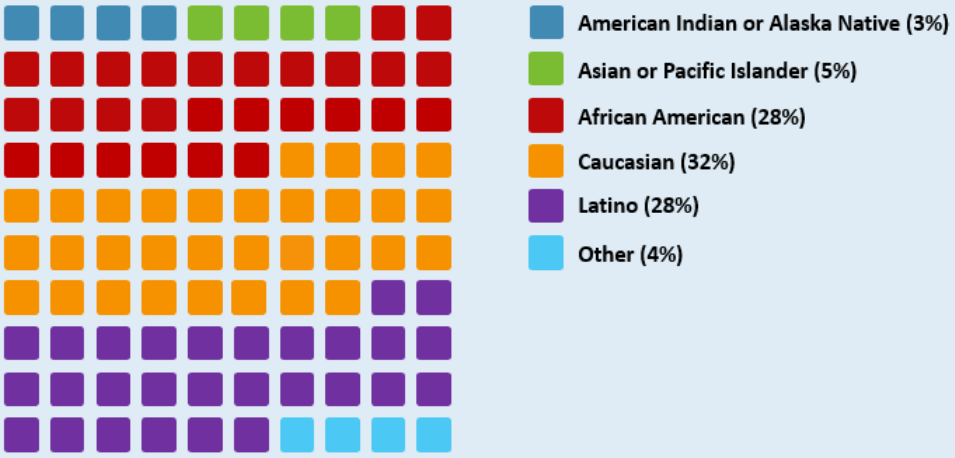
The graph below demonstrates that 52% of Clubhouse Expansion members identified as female, and 48% identified as male.



N= 10,252

Ethnicity and Ancestry:

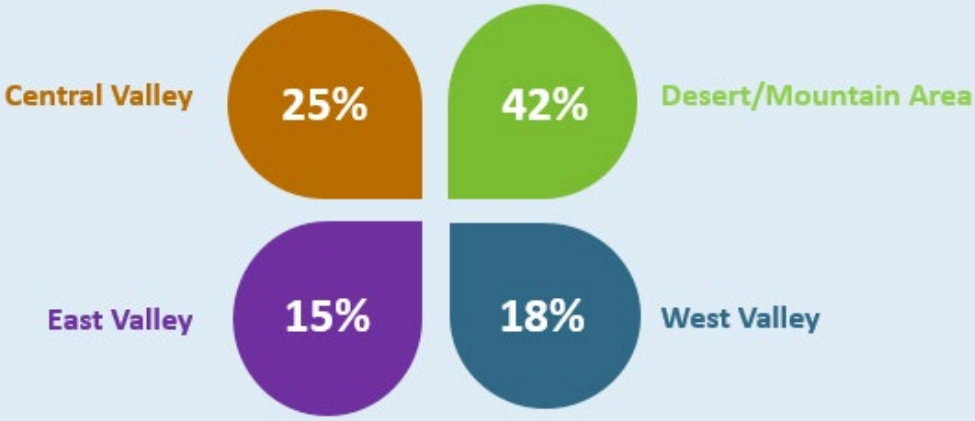
The graph below illustrates the various ethnicities of members of the Clubhouse Expansion program. The largest group of members was Caucasian at 32%. The second largest category, African American, was tied with Latino at 28% respectively. Following that, 5% identified as Asian or Pacific Islander. An additional 4% identified in the category of Other. This category includes those who identified as other, more than one race, or declined to answer. Finally, 3% identified as American Indian or Alaska Native.



N = 10,252

San Bernardino County Region:

The graph below illustrates the region in San Bernardino in which the Clubhouse Expansion members were served. The largest group of members, 42%, were served in the Desert/Mountain region. The second largest group of members, 25% were served in the Central Valley region. An additional 18% were served in the West Valley region. Finally, 15% were served in the East Valley.



N = 10,252

Positive Results

The Clubhouse Expansion program has continued to experience growth in the number of members attending, number of groups being offered and the amount of participation in each group. The Clubhouse Expansion program increased group attendance by offering over 189 groups per month with attendance totaling over 16,884 throughout the year. Clubhouses are designed to be inclusive and provide supports and activities to diverse members such as LGBTQ focused activities and trainings, cultural celebrations, and awareness surrounding the rights and accommodations for Adults with Disabilities.

Of the 189 groups that were run per month in the clubhouses, 179 (95%) were managed directly by members. All nine clubhouses were operated by an elected board of peers. The boards made all decisions related to clubhouse operations including activity planning, budget allocation, and consumer concerns. Members were also consulted on all Clubhouse Expansion program staff hiring decisions.

Clubhouse members participated in 215 community integration excursions over the year with 1,720 total members in attendance. These excursions exposed members to resources in their community and provided historical understanding. These excursions also gave the members the opportunity to work on their daily living skills in new and challenging environments which allowed them to explore potential employment opportunities, and to experience the community that can accompany recovery.

Each clubhouse participated in multiple community service activities. These ranged from community clean-ups, participating in resource fairs, outreach to law enforcement and hospitals, and making cards for local senior centers and individuals that were home or institution bound.

The Clubhouse Expansion program experienced a decrease in the number of times members accessed emergency services for physical health challenges due to an increase in education and linkages to physical health and nutrition resources. Transportation was provided to non-crisis and voluntary settings as requested by members in order to avoid unnecessary hospitalizations.

Partnerships with the National Alliance on Mental Illness (NAMI) continued including referring consumer family members to family support classes. Members also held 11 “Friends and Family” events where family members were able to spend time at the clubhouse connecting with their loved ones who utilize the program.

Program Challenges

As Clubhouse attendance continues to increase, space limitations and insufficient commodity resources (comprised of food and nonfood items) has continued to be a challenge.

Capturing effective evaluation methods to reflect peer-based, self-reported outcomes, and demographic information continues to be a challenge.

Program Solutions

Clubhouses staff and members have been partnering with the DBH Research and Evaluation team to support the design and development of an appropriate Clubhouse evaluation method. The results of the evaluation will be included in future MHSA Plan Updates. As a result of this process, a sub-committee of the DBH System Wide Program Outcomes Committee (SPOC) emerged, the Consumer Evaluation Council (CEC) Sub-Committee. More information about the CEC can be located in the Community Program Planning section of this Plan.

New as well as expanded facilities are in the planning stages for multiple locations to address the increase in consumer participation.

Clubhouses continue to collaborate with local community and faith-based organizations to meet the various consumer commodity resources (comprising of food and nonfood items).

"Clubhouse saved my life. It's a good distraction from my stress. I'm learning how to communicate with people."

– Clubhouse Expansion Consumer

Program Updates

During the next three fiscal years, (FY 2020/21-2022/23), the funding for the Peer and Family programs will increase based on the need to expand three Clubhouses, TEAM House Clubhouse in San Bernardino, Desert Stars Clubhouse in Barstow, and the Serenity Clubhouse in Victorville. The increased funding will fund an additional Clubhouse in Needles that will include amenities including laundry and shower facilities.

The increased funding will also allow for an increase in staff at all sites, including Social Workers and Mental Health Specialists. Additional staff will allow for more case management which will assist members with their self-identified recovery goals.

As a result of the increased participation in the Clubhouse Expansion program, all Clubhouses will be able to serve the increased number of members in an environment that is more suitable for utilizing and enhancing social and recovery skills.

Success Story

"William" experienced metal health challenges. William began attending the peer run support groups several times a week for a couple of years and began to feel accepted. William is now taking his medication regularly, is stable, lives independently and continues to attend the peer run support groups a couple of times per week.

Outreach and Engagement

In Fiscal Year 2018/2019, the Clubhouse Expansion program organized and/or participated in the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
All Clubhouse Holiday Gatherings	12	2,200
Educational Presentations	16	250
Health Fairs	7	2,750
Community Services Activities	11	950
Crisis Intervention Team Building	20	1,200
Community Presentations	24	1,900
Cultural Competency Events	24	1,500
Evening with the Stars Education and Recognition Event	1	65
Behavioral Health Wellness Triathlon	3	900
Clinic Appreciation Events	8	1,500
Community Food Distribution	39	2,400
Community Speakers	30	650
Mental Health Solidarity Day	1	750
Inter-Clubhouse Outreach Day	1	200
Homeless Outreach	8	750
Consumer Advisory Board	3	90
Consumer Evaluation Council	6	120
Total	**214**	**18,175**

Collaborative Partners

- Agua Caliente Clippers of Ontario
- Alcoholics Anonymous
- American Red Cross
- California Science Center
- California State University San Bernardino
- California Association of Mental Health Peer Run Organizations (CAMHPRO)
- Catholic Charities
- Chino Air Museum
- City of Fontana
- City of Rialto
- Community Action Partnership of San Bernardino
- Del Taco Restaurants, Inc.
- Dr. Andrea Letamendi
- Fontana Police Department
- Fontana Senior Center
- Frazee Community Center
- Goodwill Industries, Inc.
- High Desert Outreach Center
- Hillside Community Church
- Inland Empire 66ers
- Inland Valley HOPE Partners Food Pantry
- Inland Valley Regional Services
- J. Paul Getty Museum
- Jet Propulsion Laboratory
- Legal Aid Society
- Loma Linda University Behavioral Medicine Center
- Los Angeles Angels ™
- Los Angeles Chargers
- Los Angeles Lakers
- Mental Health Systems, Inc.
- Morongo Band of Mission Indians
- Museum of Tolerance
- National Alliance on Mental Illness (NAMI) Inland Valley
- National Alliance on Mental Illness (NAMI) Riverside
- National Alliance on Mental Illness (NAMI) San Bernardino
- National Alliance on Mental Illness (NAMI) Victor Valley

- Narcotics Anonymous
- Natural History Museum of Los Angeles County
- NorCal Mental Health America (MHA) Mental Health America
- OmniTrans
- Ontario Police Department
- Ontario Reign
- Pacific Clinics
- Panera Bread Company
- Rancho Cucamonga Library
- Rancho Cucamonga Quakes
- Reach Out.com
- Recovery International
- Rimrock Villa Convalescent Hospital
- San Bernardino County, Aging and Adult Services
- San Bernardino County, Museum
- San Bernardino County, Patients' Rights
- San Bernardino County, Probation
- San Bernardino County, Public Health
- San Bernardino County, Sheriff's Department
- San Bernardino County, Transitional Assistance Department
- San Bernardino County, Veterans Affairs
- San Bernardino Room and Board Coalition
- San Juan Capistrano Mission
- San Manuel Casino
- South Coast Community Services
- SOVA Community Food and Resource Program
- Sprout's Farmer's Markets, Inc.
- Starbucks®
- Stater Brothers
- The ROCK Church and World Outreach Center
- The Salvation Army
- Trader Joe's
- United Way
- Victor Community Support Services
- Victor Valley College
- Volunteers of America

Outreach, Access and Engagement Programs

Outreach, Access, and Engagement programs are programs that provide expeditious access to mental health services, and to provide consumers, who have been discharged from a psychiatric hospital, or a walk-in clinic, referral to a regional outpatient clinic where a follow up appointment can be scheduled as soon as possible. The Access, Coordination, and Enhancement (ACE) program provides psychiatric evaluations between 7 days of a hospital discharge and within fourteen days of a walk-in clinic requests. The Behavioral Health Urgent Care Center (BHUCC) program is a psychiatric urgent care center that evaluates consumers experiencing a behavioral health crisis and provides a centralized location for triage, assessment and scheduling for all County Outpatient Clinics.

Outreach, Access and Engagement programs are programs that also provide linkage to services, advocacy, case management services, care navigation, family education and support. The Recovery Based Engagement Support Team (RBEST) program is a voluntary, consumer-centered project, which provides community (field-based) services which are not structured around any specific model of benefits, to individuals with untreated mental illness in an effort to activate them into appropriate treatment. Out of the need to support families, RBEST staff developed a support program called Connecting Families that is projected to expand to provide families with support, education and empowerment to continue caring for their loved ones in their community.

Target Populations

The table below identifies the target population of consumers to be served by Outreach, Access and Engagement programs for Fiscal Years 2020/21-2022/23.

Community Services and Supports Programs				
Program Name	**Target Population**			
	Children	**TAY**	**Adults**	**Older Adult**
Access, Coordination, and Enhancement (ACE)	X	X	X	X
Behavioral Health Urgent Care Center (BHUCC)	X	X	X	X
Recovery Based Engagement Support Teams (RBEST) • Connecting Families			X	

Projected Number to be Served

The tables below indicates the number of consumers that were referred to the ACE program and the number of children and youth to be served by FSP programs for the upcoming three fiscal years (Fiscal Year 2020/21 - 2022/23). MHSA age categories are: Children, TAY, Adult, and Older Adult. Also represented are the projected numbers to be served in each service category. MHSA service categories are: Full Service Partnership (FSP), General System Development (GSD), and Outreach and Engagement (O&E).

Program	Fiscal Year	Ages Served	Service Area	Total Served
Access, Coordination, and Enhancement (ACE)	2020/21	2,652		**2,652**
	2021/22	2,652		**2,652**
	2022/23	2,652		**2,652**
Behavioral Health Urgent Care Center (BHUCC)	2020/21	• 250 Children • 250 TAY • 1,700 Adult • 50 Older Adult	• 2,250 GSD	**2,250**
	2021/22	• 250 Children • 250 TAY • 1,700 Adult • 50 Older Adult	• 2,250 GSD	**2,250**
	2022/23	• 250 Children • 250 TAY • 1,700 Adult • 50 Older Adult	• 2,250 GSD	**2,250**
Recovery Based Engagement Support Teams (RBEST)	2020/21	• 300 Adults	• 300 O&E	**300**
	2021/22	• 300 Adults	• 300 O&E	**300**
	2022/23	• 300 Adults	• 300 O&E	**300**
Connecting Families	2020/21	• 120 Adults	• 120 GSD	**120**
	2021/22	• 120 Adults	• 120 GSD	**120**
	2022/23	• 120 Adults	• 120 GSD	**120**

*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 mental health services offered and linking consumers to the appropriate services.

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

The Access, Coordination, and Enhancement (ACE) for Quality Behavioral Health Services programs seeks to improve the timeliness of access to the Department of Behavioral Health (DBH) outpatient services. 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) specifically for assessments, hospital discharges, and care coordination.

With implementation of the Affordable Care Act (ACA) and Medi-Cal expansion, the ACE program enhanced the redesign of the outpatient care system to ensure that consumers receive the right services customized to meet their needs. ACE program staff perform initial screenings, intake assessments, and evaluate the best level of care for the consumer. ACE provides psychiatric 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, referral to a regional outpatient clinic where a follow up appointment can be scheduled as soon as possible.

Services provided through the ACE program include:

- Mental health assessments
- Psychiatric evaluations
- Substance Use Disorder (SUD) screenings
- Referrals and linkage to Full Service Partnership (FSP), Crisis Stabilization Unit (CSU) or Crisis Residential Treatment (CRT)
- Access to appropriate services

The ACE program operates at each clinic from 8:00 a.m. to 5:00 p.m. Monday through Friday. Individual consumers and families seeking mental health treatment can access services either by walking in without a scheduled appointment or by calling the clinic to request an initial assessment appointment.

Additionally, the DBH Access Unit, Managed Care organizations (Inland Empire Health Plan and Molina Healthcare), and psychiatric hospital discharge staff refer consumers for treatment at the clinics. Appointment priority is given to all patients discharging from a psychiatric hospital, and they are given an appointment within seven calendar days from discharge.

Consumers seeking services are provided with an initial crisis screening by a clinical therapist. Consumers in crisis are immediately evaluated to determine the most appropriate path for the consumer. All other individuals receive a mental health assessment or may be scheduled for a more convenient time for the consumer to return for their assessment.

Medical necessity is the state's eligibility criteria based on the consumer's diagnosis and the functional impairments cause by their mental disorder. Clinical therapists conduct initial assessments to determine if the consumer meets medical necessary for Specialty Mental Health Services. When consumers meet this criteria, the clinical therapist will consult with the psychiatrist regarding the need for psychiatric evaluation and medication assessment. Treatment is based on the consumer's symptoms and their ability to function in the community.

Consumers who do not meet medical necessity for Specialty Mental Health Services can be assigned to a case manager for:

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

ACE program staff are an incredible resource for consumers, allowing them to access the necessary medical care that directly impacts their mental health and daily functioning in a timely and efficient manner. Staff link consumers to medical care, improve consumer access and communication with pharmacy services, and provide necessary education and access to reduce crisis situations and inpatient hospitalization. ACE staff allow other clinical staff to focus their efforts on providing ongoing care, thus improving the overall care at each clinic.

Behavioral Health Urgent Care Center

The Behavioral Health Urgent Care Center (BHUCC) was formerly under the Crisis System of Care section, under the A-4 Crisis Walk-In Centers (CWIC) and referred to as the Rialto Crisis Walk-In Center (CWIC). BHUCC is a psychiatric urgent care center that offers a positive and safe environment to consumers of all ages experiencing a behavioral health crisis. Consumers are evaluated for a higher level of care, if necessary.

The Center is staffed by a multi-disciplinary team who focus on stabilizing consumers and providing linkage to resources within the community for follow-up behavioral health care and continued stabilization. The facility operates Monday through Friday from 8:00 a.m. – 8:00 p.m., and on Saturdays from 8:00 a.m.-5:00 p.m. In collaboration with Centralized Hospital Aftercare Services (CHAS), BHUCC provides a centralized location for triage, assessment and scheduling for all County Outpatient Clinics.

MHSA Legislative Goals and Related Key Outcomes

Provide scheduled or non-scheduled appointments from inpatient referrals:

- Decrease the wait time from hospital discharge to first outpatient service

Provide capacity in response to the demand for care:

- Decrease the wait time from hospital discharge to first therapy appointment
- Provide shorter waiting times and shorter times between appointments
- Decrease the time from the first service to necessary/needed medication support service

Reduce the frequency of emergency room visits and unnecessary hospitalizations:

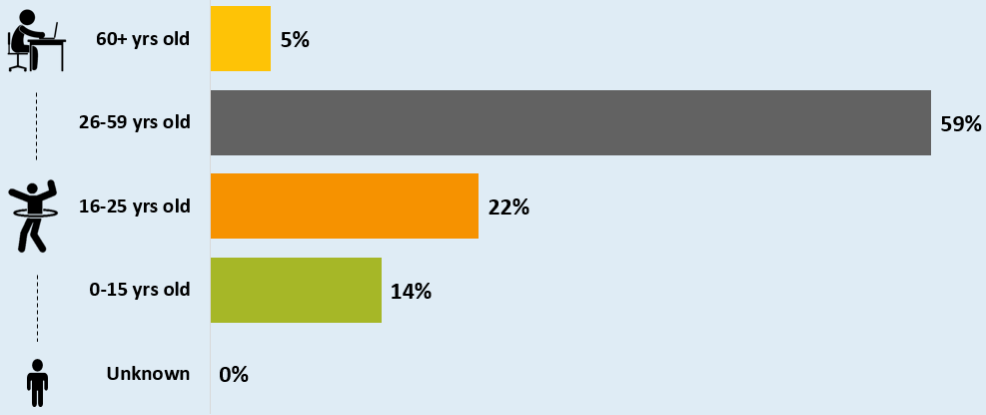
- Reduced rate of emergency room visits for mental health concerns
- Increased use of alternative crisis interventions (e.g. CWIC, CCRT, CSU)
- Increase in number of individuals diverted from hospitalizations

Fiscal Year 2018/2019 Program Demographics

The following graphs illustrate the demographics in various categories and are inclusive of the ACE and BHUCC programs:

Age:

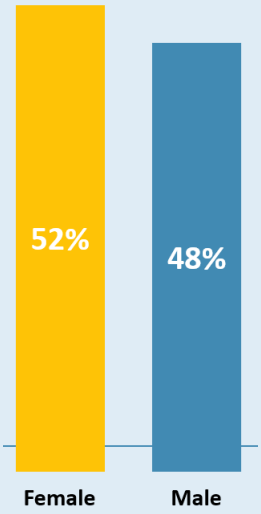
The graph below illustrates the ages of ACE and BHUCC consumers. The majority of consumers served, 59%, were between the ages of 26-59 years old. The second largest group was between the ages of 16-25 years old at 22%. There were 14% of consumers who identified as 0-15 and 5% identified as 60+.



N = 4,482

Gender:

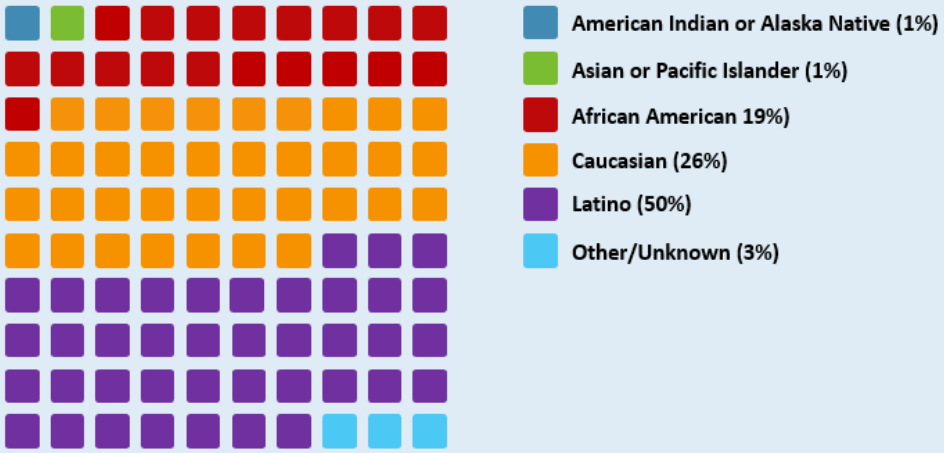
The graph below demonstrates that 52% of the ACE and BHUCC program consumers identified as female and 48% identified as male.



N = 4,482

Ethnicity and Ancestry:

The graph below illustrates the various ethnicities of consumers of the ACE and BHUCC programs. The largest group of consumers was 50% that identified as Latino. The second largest category was Caucasian at 26%. Following that, 19% identified as African American. An additional 3% identified as Other. This category includes those who identified as other, more than one race, or declined to answer. Finally, 1% identified as American Indian or Alaska Native and 1% identified as Asian or Pacific Islander.



N = 4,482

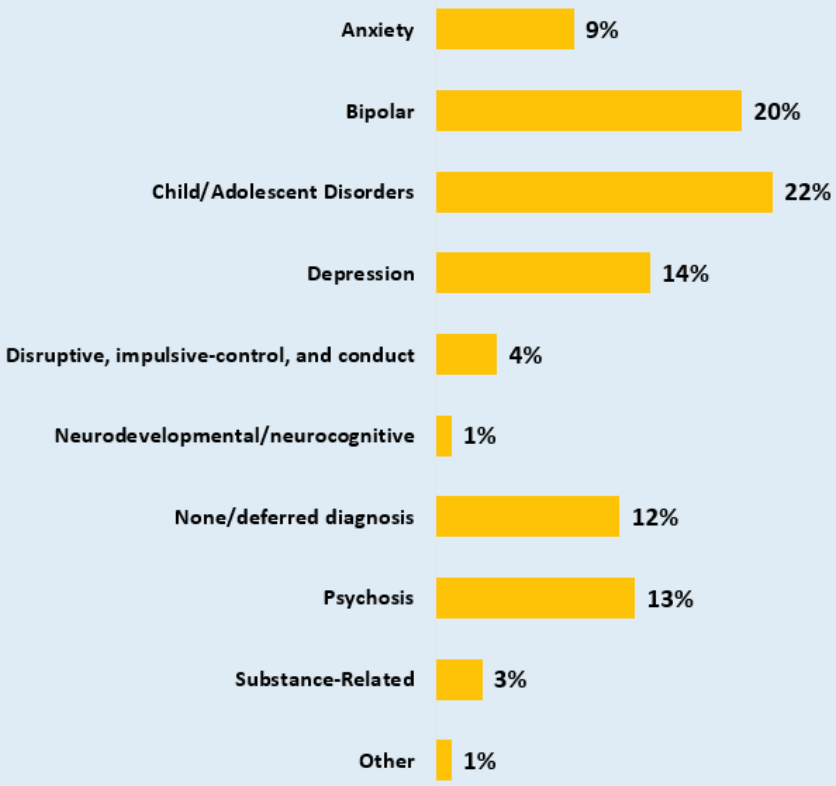
Primary Language:

The graph below demonstrates that 90% of ACE and BHUCC consumers identified English as their primary language. Additionally, 9% identified Spanish as their primary language, and 1% identified their primary language as something other than English or Spanish.

N = 4,482

Primary Diagnosis:

The graph below illustrates the diagnostic groups of the ACE and BHUCC consumers. Almost a quarter, 22%, of consumers were diagnosed with child/adolescent disorders. Following that, 20% of consumers were diagnosed with bipolar disorder. Of the remaining diagnoses, 14% were diagnosed with depression, 13% with psychosis, 12% with no diagnosis or a deferred diagnosis either did not have an identifiable mental health need or the diagnosis was deferred pending further assessment, 9% with anxiety, 4% with disruptive, impulsive-control and conduct disorder, 3% with substance-related disorder, 1% neurodevelopment/neurocognitive disorder, and 1% were diagnosed as Other. This category includes those who had a different diagnosis than those listed or more than one.



N = 4,482

"I am more open-minded now and can understand my diagnosis better."

– ACE consumer

Positive Results

- There were a total of 2,247 referrals to the ACE program for new consumers being discharged from acute care psychiatric hospitals in Fiscal Year 2016/17.
- Of the 2,247 referrals received by the ACE program, 29% (652) were scheduled for an appointment within seven days of discharge from the hospital and 73% (1,645) of the referrals had an appointment within 14 days of discharge.
- Increased outreach efforts, communication, and visibility in our local substance abuse treatment centers and the local psychiatric units at local hospitals.

Program Challenges

- ACE has identified a need to improve strategies for consumer hospital discharge coordination with DBH outpatient clinics.
- Given the shortage of qualified and trained psychiatric physicians, there is a challenge arranging a psychiatric evaluation within 14 days to provide timely medication support services to consumers discharged from a hospital.
- Recruiting, hiring and retaining qualified staff for the ACE program.
- Due to the geographic distance from remote or extremely rural areas to behavioral health clinics combined with a lack of transportation, consumer accessibility to behavioral health resources and supportive services is a challenge.
- Supportive services and training for staff which service rural or remote areas.
- Providing a consistent method of referral post psychiatric hospitalization.

"This place has kept me sane and able to cope for the past two years. Thank God they are here for us."

– ACE Consumer

Program Solutions

- Psychiatric hospitals inform DBH when a DBH consumer has been admitted. This has helped the ACE staff coordinate appointments for consumers upon being discharged.
- Increased outreach efforts, communication and visibility in our local substance use treatment centers and psychiatric hospitals. Collaborating with community agencies, and crisis residential treatment programs to provide shelter as needed.
- Enhanced our relationships with the Room and Board Coalition and provide them with the psychoeducation to describe our consumers and their unique needs.
- Increase the number of staff to assist us in our clinics for case management services to be able to contact contacts to reschedule their appointments.
- Decreased wait times from hospital discharge to initial intake and psychiatric assessments.
- Collaborated with the City of Needles to utilize larger venues to allow for larger group meetings and therapy.
- Increased utilization of the Children's Fund to assist consumers with more resources.
- Increased utilization of Peer and Family Advocates to improve community outreach and mental health education.
- The ACE program is able to see consumers after a hospital visit when an appointment to an Outpatient Clinic is not immediately available.

Artwork by Ray French

Outreach and Engagement

In Fiscal Year 2018/19, the Access, Coordination and Enhancement program organized and/or participated in the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Needles Community Health and Safety Fair	2	220
Needles Unified School District-Suicide Prevention	1	200
Total	**3**	**420**

Success Story

"Ian" had a history of multiple and recent hospitalizations when he entered the ACE program. He struggled with aggression and had poor medication compliance. Ian was at risk of homelessness, had increased criminal justice involvement, homicidal ideations, and difficulty interacting with the community. The ACE program provided intensive case management and Ian's involvement in treatment increased; he is now attending appointments regularly and is taking his medication. As a result, Ian is able to work part-time, is happier and has more fulfilling personal relationships.

Collaborative Partners

- ABC Pharmacies
- American Surgical Pharmacy
- Arrowhead Regional Medical Center (ARMC) – Behavioral Health Unit
- Association of Community Based Organizations (ACBO)
- California Department of Motor Vehicles (DMV)
- Canyon Ridge Hospital
- Catholic Charities
- Cedar House Life Changing Center
- Chemehuevi Indian Tribe
- Children's Fund
- Colorado River Medical Center
- Community Hospital of San Bernardino
- Croal's Pharmacy
- Desert Mana
- Fort Mohave Indian Tribe
- Gibson House
- Goodwill Southern California
- Helping Hearts
- Inland Empire Health Plan (IEHP)
- Inland Valley Recovery Services
- Kaiser Permanente
- Local Law Enforcement
- Local faith based organizations
- Local primary care physicians
- Loma Linda University Behavioral Medical Center
- Lutheran Social Services
- MHS Needles Center for Change
- Molina Healthcare
- Needles Unified School District
- Needles Mental Health Services (MHS) Center for Change
- North Rialto Drug
- Other designated Lanterman-Petris-Short (LPS) hospitals
- Other local pharmacies
- Redlands Community Hospital
- Rialto Fire Department
- Rialto Police Department
- Salvation Army
- San Antonio Community Hospital

- San Bernardino County, Probation
- San Bernardino County, Sheriff's Department
- San Bernardino County, Transitional Assistance Department (TAD)
- Social Security Administration
- St. Vincent de Paul Church
- U.S. Department of Veterans Affairs-Veterans Administration (VA)
- Westcare Arizona
- Westside Family Health Center

Artwork by Marcy Grebus

Recovery Based Engagement Support Teams

RBEST is a voluntary, consumer-centered project which provides community (field-based) services which are not structured around any specific model of benefits, to individuals with untreated mental illness in an effort to activate them into appropriate treatment. RBEST is not a treatment model and does not intend to provide endless mobile services to identified consumers. The project is "non-clinical" in its orientation with a primary focus on the needs and goals of the consumer and helping that consumer meet those goals while eliminating obstacles through appropriate mental health treatment. The multidisciplinary nature of the engagement teams presents a holistic approach to the needs of the consumers and is highly flexible, unencumbered by traditional limits of services organized around benefit structures. RBEST staff provide an opportunity for shared decision making in an unstructured, field-based environment when presenting treatment options to consumers and families, encourages deliberation, and elicits care preferences within what is possible.

RBEST staff are trained and utilize the Listening, Empathizing, Agreeing, and Partnering (LEAP) model to engage consumers into treatment. RBEST services include: outreach, engagement, linkage to services, advocacy, case management services, care navigation, family education and support.

RBEST started as a MHSA Innovation Component project, approved in March 2014 by California's Mental Health Oversight and Accountability Commission and ended in September 2019. Based on community stakeholder support and learning from the project RBEST has been transitioned to the Community Services and Supports Component effective October 2019. The RBEST Final report is currently being drafted and will display the positive outcomes, learning and challenges encountered by RBEST staff and consumers. The RBEST Final report is tentatively scheduled to be posted to the DBH website in Spring of 2020. You will be able to find the report at www.sbcounty.gov/dbh.

MHSA Legislative Goals and Related Key Outcomes

Reduce the subjective suffering from serious mental illness for adults and serious emotional disorders for children and youth:

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

Reduce the frequency of emergency room visits and unnecessary hospitalizations:

- Reduced rate of emergency room visits for mental health concerns
- Increase use of alternative crisis interventions (e.g., CWIC, CCRT, CSU)
- Increase in number of individuals diverted from hospitalization

Target Populations

Adults over the age of 18, and:

- Not active or successful in seeking and receiving necessary psychiatric care.
- Known to the community and other safety net programs, but not known to the public mental health system.
- Individuals who access treatment at points in the health care system that do not deliver effective care in meeting the psychiatric needs of that individual (category added after project implementation).
- The “invisible” 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 (category added after program implementation).
- Unable to navigate the behavioral health system of care to obtain appropriate treatment (category added after program implementation).

RBEST Expansion: Connecting Families

The Connecting Families program provides support for family members, significant others, or caregivers of adults or older adults living with a serious mental illness. The primary function of the Connecting Families Program is to assist family members in coping with the illness of their loved one through information, education, and support. Additionally, the program provides education and assistance to family members in their interaction with service providers and the mental health system, as members of the staff are themselves family members and are sensitive to the concerns of other family members.

For many adults and older adults living with a serious mental health condition, family members are not automatically engaged and/or educated about mental health disorders. Often families have become separated/estranged after years of untreated mental illness amongst the family. Being diagnosed with a serious mental illness can lead to many questions or concerns, both for the individual diagnosed and their family members and friends. Family members can be an invaluable resource for individuals dealing with serious mental illnesses. By learning more about the illness, family members can support loved ones through diagnosis and beyond. The more family members learn about what to expect, the easier it is to provide appropriate supports.

Current Efforts

Connecting Families is a direct result of learning that was obtained through the implementation of the MHSA Innovation project, Recovery Based Engagement Support Team (RBEST). RBEST is a voluntary, consumer-centered project which provides community (field-based) services which are not structured around any specific model of benefits, to individuals with untreated mental illness in an effort to activate them into appropriate treatment. RBEST is not a treatment model and does not intend to provide endless mobile services to identified consumers. The project is “non-clinical” in its orientation with a primary focus on the needs and goals of the consumer and helping that consumer meet those goals while eliminating obstacles through appropriate mental health treatment.

One of the learning goals of the RBEST project was to increase the understanding and knowledge regarding mental illness for families of individuals living with mental illness, as well as improve and increase the strategies in caring for their loved one. Implementation of strategies to support this learning goal resulted in identification of an opportunity to enhance the continuum of services by offering a family/caregiver support program.

Program Overview

The Connecting Families program is an educational/support group for families and caretakers with loved ones living with a severe and persistent mental illness. The goal is to increase awareness among family members/caretakers about issues relating to mental illness as well as to provide a network of support for this population.

The program consists of an educational series provided in a group setting. The series consists of eight modules that are provided to program participants two times per month (bi-weekly). To ensure maximum flexibility, educational sessions are drop-in in nature to allow access to families in accordance with their schedules and comfortability. Each session will allow for 20 people per group and each participant will have an opportunity to share the common experience of having a loved one living with a mental illness. In addition to educational topics, the groups will also include opportunities for peer supports.

Educational presentations are provided according the needs of the participating families.

Examples of topics include:

- Psychoeducation for understanding mental illness, substance use disorders, and co-occurring disorders
- Utilization of the evidence-based Listen-Empathize-Agree-Partner (LEAP) model to:
    - ◊ Help families understand symptoms,
    - ◊ Develop effective communication strategies, and
    - ◊ Support boundaries
- Medication Overview
- Information Sharing and Health Insurance Portability Accountability Act (HIPAA)
- Resources & System Barriers
    - ◊ Crisis Situations
    - ◊ Community Resources
    - ◊ Treatment/LPS Facilities (Psychiatric Hospitals)
    - ◊ Housing and Shelter
    - ◊ Advocacy
- Self-Care

Additionally, the Connecting Families program will coordinate with local National Alliance on Mental Illness (NAMI) chapters to be able to connect families with additional peer supports.

Connecting Families provides an opportunity to improve connections by:

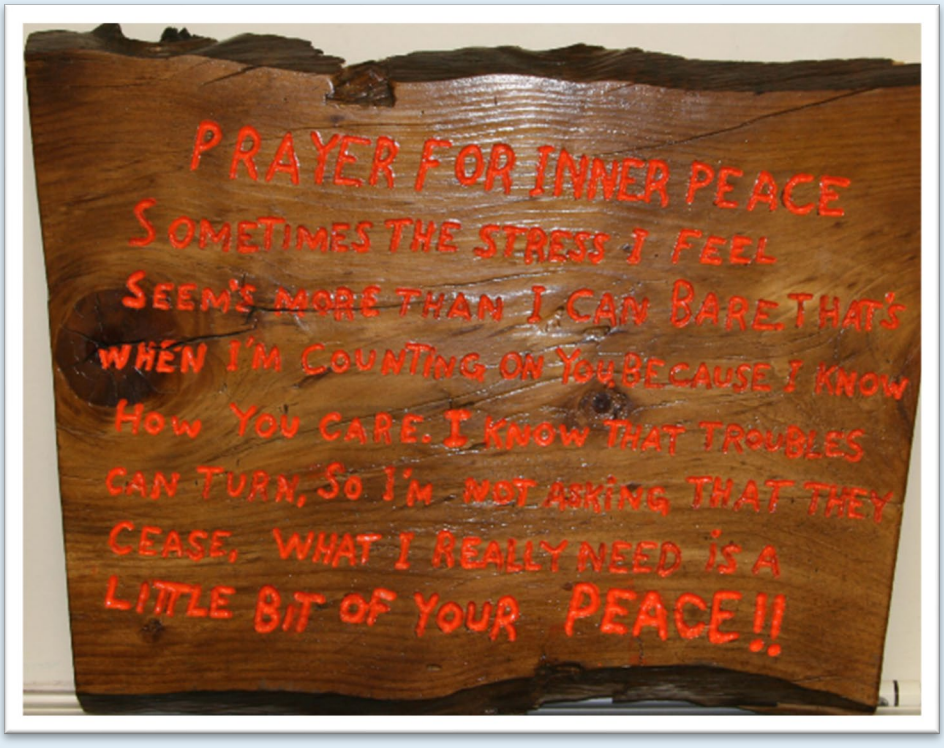
- Engage families in the recovery process
- Learn skills for improved communication through LEAP model trainings

Program Goals and Key Outcomes

- Increasing network of supports
- Decreasing subjective suffering

Evaluation

- Quality of life satisfaction survey
- Participation reports



Artwork by Tim Jackson

Full Service Partnerships (FSP)

Full Service Partnership (FSP) programs provide intensive case management 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 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.

Target Populations

The chart below indicates the target populations to be served by each FSP program.

Community Services and Supports Programs				
Program Name	**Target Population**			
	Children	**TAY**	**Adults**	**Older Adult**
Comprehensive Children and Family Support Services (CCFSS)	X	X		
Integrated New Family Opportunities (INFO)	X	X		
Transitional Age Youth (TAY) One Stop Centers		X		
Adult Criminal Justice Continuum of Care Programs			X	X
Assertive Community Treatment Programs (MAPS/ACT)			X	
Regional Adult Full Service Partnerships (RAFSP)			X	
Age Wise				X

*For information pertaining to FSP Homeless Services please refer the Housing and Homeless Services Continuum of Care Program located in the Community Services and Supports: Housing, Long-Term Supports and Transitional Care section of this Plan.

Projected Number to be Served

The table below indicates the children and youth to be served by FSP programs for the upcoming three fiscal years (Fiscal Year 2020/21 - 2022/23). MHSA age categories are: Children, TAY, Adult, and Older Adult. Also represented are the projected numbers to be served in each service category. MHSA service categories are: Full Service Partnership (FSP), General System Development (GSD), and Outreach and Engagement (O&E).

Children and Youth Programs

Program	Fiscal Year	Ages Served	Service Area	Total Served
Comprehensive Children and Family Support Services	2020/21	• 5,342 Children • 1,296 TAY	• 3,188 FSP • 3,450 O&E	**6,638**
	2021/22	• 5,342 Children • 1,296 TAY	• 3,188 FSP • 3,450 O&E	**6,638**
	2022/23	• 5,342 Children • 1,296 TAY	• 3,188 FSP • 3,450 O&E	**6,638**
Integrated New Family Opportunities (INFO)	2020/21	• 81 Children • 159 TAY	• 146 GSD • 94 FSP	**240**
	2021/22	• 85 Children • 167 TAY	• 153 GSD • 99 FSP	**252**
	2022/23	• 89 Children • 175 TAY	• 160 GSD • 104 FSP	**264**
Transitional Age Youth (TAY) One Stop Centers	2020/21	• 6,180 TAY	• 611 GSD • 5,223 O&E • 346 FSP	**6,180**
	2021/22	• 6,180 TAY	• 611 GSD • 5,223 O&E • 346 FSP	**6,180**
	2022/23	• 6,180 TAY	• 611 GSD • 5,233 O&E • 346 FSP	**6,180**

*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 mental health services offered and linking consumers to the appropriate services.

The table below indicates the adults and older adults to be served by FSP programs for the upcoming three fiscal years (Fiscal Year 2020/21 - 2022/23). MHSA age categories are: Children, TAY, Adult, and Older Adult. Also represented are the projected numbers to be served in each service category. MHSA service categories are: Full Service Partnership (FSP), General System Development (GSD), and Outreach and Engagement (O&E).

Adult and Older Adult Programs

Program	Fiscal Year	Ages Served	Service Area	Total Served
Adult Criminal Justice Continuum of Care	2020/21	• 592 Adults • 25 Older Adults	• 617 FSP	**617**
	2021/22	• 622 Adults • 25 Older Adults	• 647 FSP	**647**
	2022/23	• 677 Adults • 25 Older Adults	• 677 FSP	**677**
Assertive Community Treatment Programs (MAPS/ACT)	2020/21	• 285 Adults	• 150 O&E • 135 FSP	**285**
	2021/22	• 285 Adults	• 150 O&E • 135 FSP	**285**
	2022/23	• 285 Adults	• 150 O&E • 135 FSP	**285**
Regional Adult Full Service Partnership (RAFSP)	2020/21	• 930 Adults	• 930 FSP	**930**
	2021/22	• 930 Adults	• 930 FSP	**930**
	2022/23	• 930 Adults	• 930 FSP	**930**
Age Wise	2020/21	• 1,220 Older Adults	• 1,000 O&E • 220 FSP	**1,220**
	2021/22	• 1,220 Older Adults	• 1,000 O&E • 220 FSP	**1,220**
	2022/23	• 1,220 Older Adults	• 1,000 O&E • 220 FSP	**1,220**

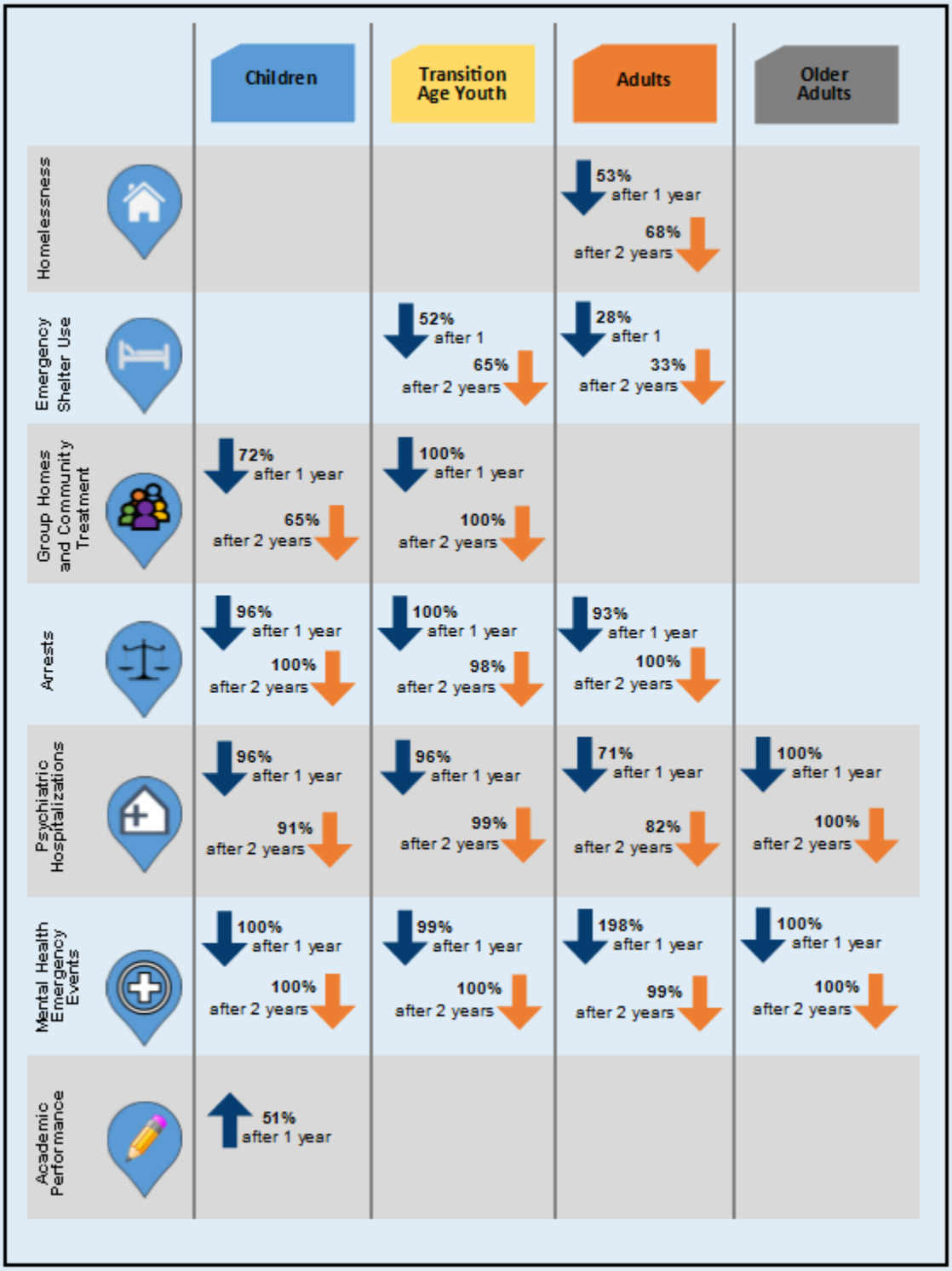
*Full Service Partnership (FSP) consumers represent the number of consumers participating in FSP programs and services.

*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.

Full Service Partnership Outcomes

Listed below are the average FSP outcomes reported during Fiscal Years (FYs) 2016/17-2018/19. Outcomes were calculated based on improvement during the first year of FSP services and up to two years after initial services are provided.



Comprehensive Children and Family Support Services (C-1)

The Comprehensive Children and Family Support Services (CCFSS) program uses the Core Practice Model (CPM) and provides services to children and youth living with severe 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.

CCFSS consists of three individualized and targeted Full Service Partnership (FSP) subprograms:

- **Children's Residential Intensive Services (ChRIS)** integrates the FSP approach within the residential care of children and youth placed in group homes or Short-Term Residential Therapeutic Programs (STRTP) by either Children and Family Services (CFS) or Probation.
- **Wraparound** is a collaborative program between the Department of Behavioral Health (DBH) and Children and Family Services (CFS) designed to serve wards and dependents who are at risk of needing group home services. All referrals are received from CFS or Probation.
- **Success First/Early Wrap** is a short-term, wrap-informed, FSP serving children and youth who are not eligible for Wraparound services as outlined in Senate Bill (SB) 163 but are having sufficient difficulty that without intervention, a higher level of service is likely to be required.

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.

Notable events in CCFSS during FY 2018/19 were the expansion of Success First/Early Wrap services allowing contractors to meet additional service demands, including increased focus on engaging probation youth in the services, and continued evolution of the ChRIS program. During FY 2018/19, the ChRIS program experienced a reduction in providers, however the total number of youth involved in the program increased significantly as programs became more adept at capturing Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

MHSA Legislative Goals and Related Key Outcomes

Reduce the subjective suffering from severe emotional disturbance in children and youth

- Improve life satisfaction
- Decrease hopelessness/increase hope
- Increase resiliency
- Decrease impairment in general areas of life functioning (e.g., health, self-care, housing, occupation/education, legal, money management, interpersonal/social)

Reduce homelessness and increase safe and permanent housing

- Increase residence stability

Reduce criminal and juvenile justice involvement

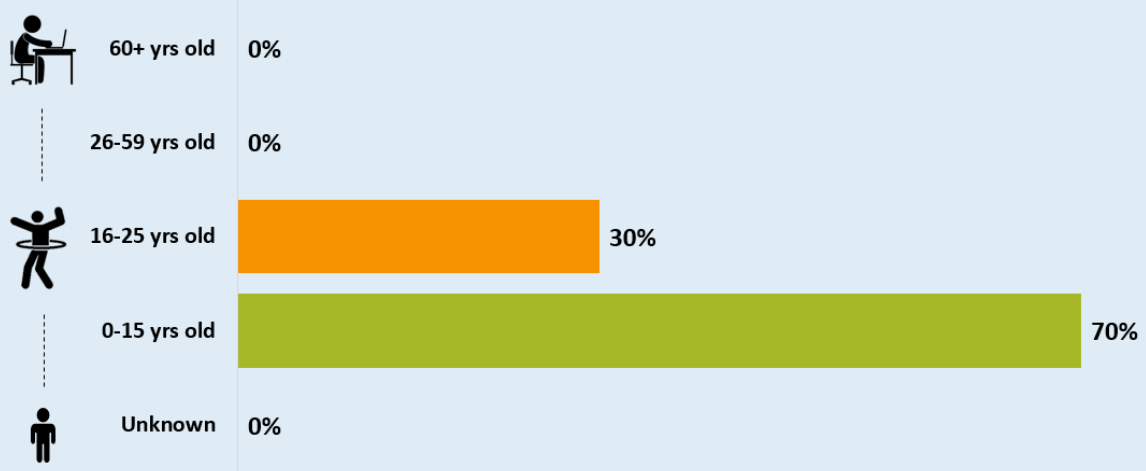
- Reduce behaviors that increase the likelihood of juvenile justice involvement
- Reduce difficulties related to conduct disorders

Artwork by Kazina Francis

Fiscal Year 2018/19 Program Demographics

Age:

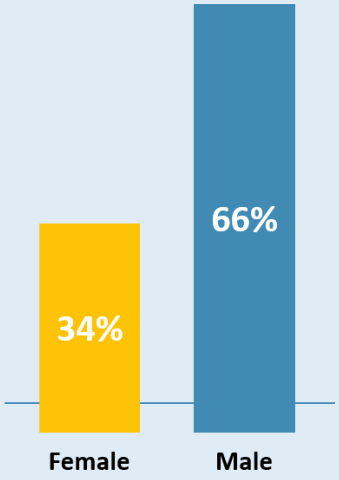
The graph below illustrates the ages of CCFSS participants. The majority of participants served, 70%, were between the ages of 0-15 years old. The second largest group was between the ages of 16-25 years old at 30%. There were no participants who identified as ages 26-59, and 60+, or as unknown or declined to state. This graph is representative of the CCFSS target population of children being the majority served.



N=3,089

Gender:

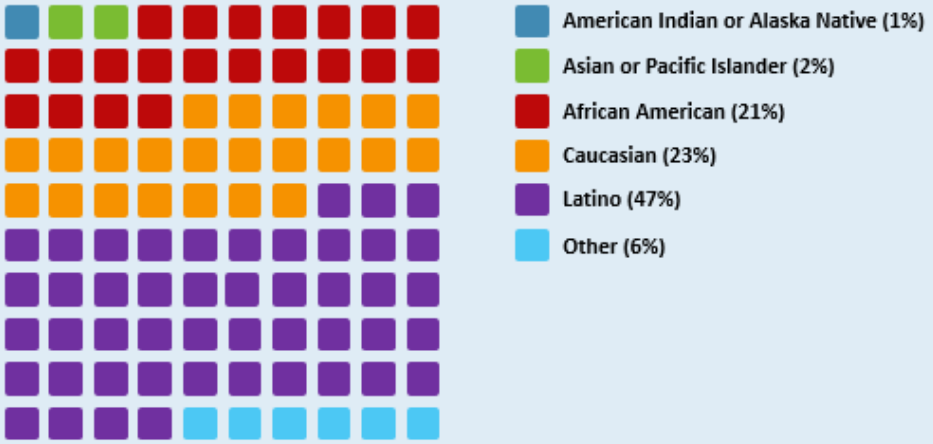
The graph below demonstrates that 34% of CCFSS participants identified as female and 66% identified as male. None of the participants declined to stated, or identified as transgender, non-binary, gender queer, or other not listed.



N=3,089

Ethnicity and Ancestry:

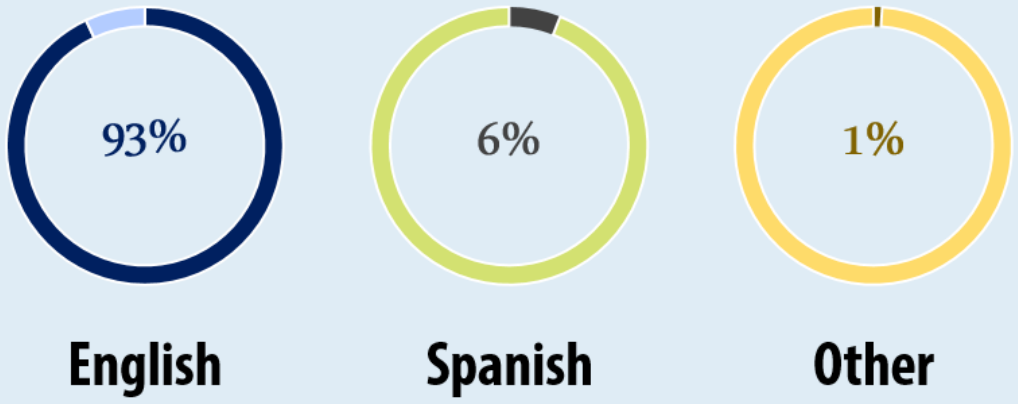
The graph below illustrates the various ethnicities of participants of the CCFSS program. The largest group of participants was 47% in the category of Latino. The second largest category was Caucasian at 23%. Following that, 21% identified as African American. An additional 2% identified as Asian or Pacific Islander. Finally, 1% identified as American Indian or Alaska Native. Additionally, 6% identified as Other. This category includes those who identified as other, more than one race, or declined to answer.



N=3,089

Primary Language:

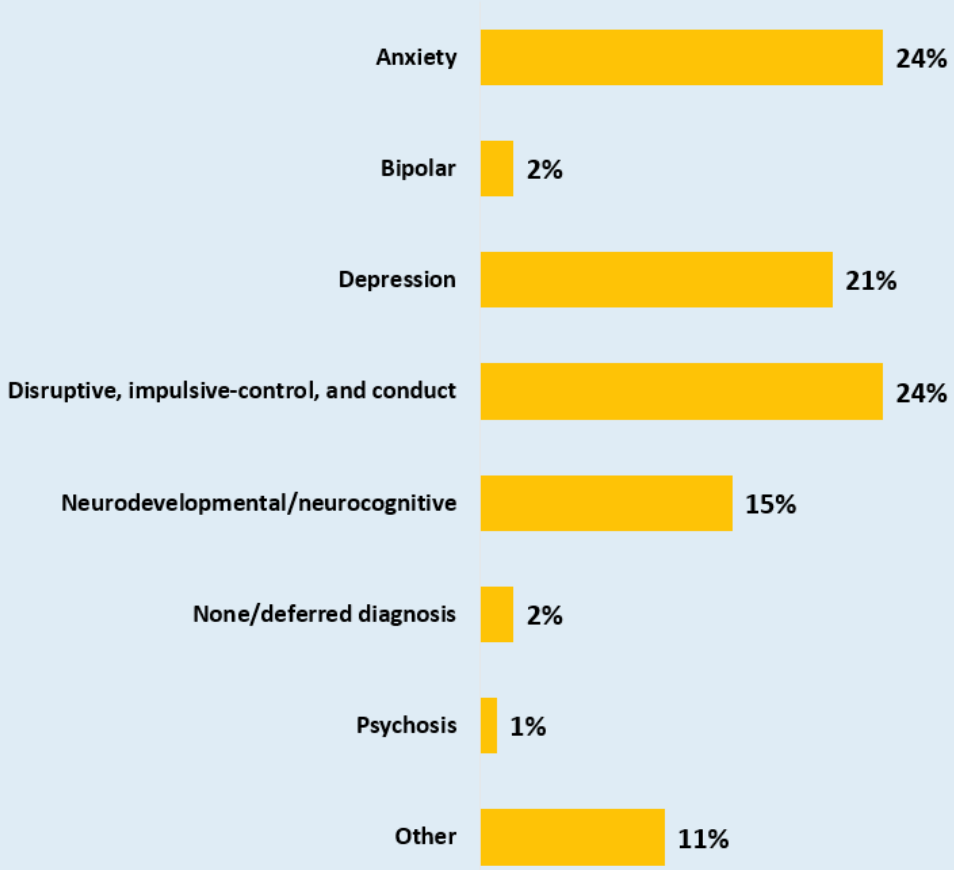
The graph below demonstrates that 93% of CCFSS participants identified English as their primary language. Additionally, 6% identified Spanish as their primary language, and 1% identified their primary language as something other than English or Spanish.



N=3,089

Primary Diagnosis:

The graph below illustrates the diagnostic groups of CCFSS participants who received services. Most of the participants of CCFSS services fall under the category of Anxiety at 24% or Disruptive, Impulse-Control, and Conduct, also at 24%. The second largest category was Depression at 21% followed by Neurodevelopmental or neurocognitive at 15%. Finally, 5% fell under the categories of Bipolar, Psychosis, or Non/Deferred Diagnosis. Additionally, 11% fell under the category of Other. This category includes those who had a different diagnosis than those listed or more than one.



N=3,089

"It has helped me as a parent set boundaries and keep them. Having another set of adults on my team as a single parent backing me up and supporting my son at the same time. There have been no violent outbursts since this program began and school attendance improved for the regular school year."

-CCFSS Parent

Positive Results

The Child Adolescent Needs and Strengths (CANS) assessment tool is utilized within all CCFSS programs and is analyzed in two ways:

- Global Measurement
- 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 analysis considers only those children and youth who presented with a significant need for help on that item/construct and reports the percentage of those children and youth no longer needing help at the conclusion of service.

Of all the children and youth who started an FSP program, 69% of them successfully completed the program and had a planned discharge. Of those children and youth the following presentation percentages and improvement are described below:

Global Measurement of Life:

- 97.69% of children and youth entering CCFSS programs were scored as having at least one area of impaired life functioning (Progression Report).
- 71.0% of these children showed significant improvements upon exiting the program (Reliable Change Index Report).

Specific Areas of Life Functioning (Impact Report):

Family Difficulties:

- 87% of the children needed help with family difficulties.
- Of those, 67% showed sufficient improvement in this area that no additional help was needed at the time of exiting the program.

Social Functioning:

- 80% of the children needed help improving their social functioning.
- Of those, 64% showed sufficient improvement in this area that no additional help was needed at the time of exiting the program.

Recreational:

- 51% of children needed help with positive recreational leisure time activities.
- Of those, 59% showed sufficient improvement in this area that no additional help was needed at the time of exiting the program.

Sleep:

- 46% of the children needed help with sleep disruption.
- Of those, 72% showed sufficient improvement in this area that no additional help was needed at the time of exiting the program.

School Behavior:

- 65% of the children needed help with behavior in school.
- Of those, 72% showed sufficient improvement in this area that no additional help was needed at the time of exiting the program.

School Achievement:

- 64% of the children needed help with academic achievement.
- Of those, 63% showed sufficient improvement in this area that no additional help was needed at the time of exiting the program.

School Attendance:

- 37% of the children needed help with school attendance deterrents.
- Of those, 74% showed sufficient improvement in this area that no additional help was needed at the time of exiting the program.

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

- 98.1% of children and youth entering CCFSS programs were scored as having at least one significant behavioral or emotional need. (Progression Report)
- 70.8% of these children showed statistically significant improvements upon exiting the program. (Reliable Change Index Report)

Specific Areas of Behavioral and Emotional Needs (Impact Report):
In areas of Behavioral and Emotional Needs, the following presentation percentages and improvement percentages were seen:

Impulsivity/Hyperactivity:

- 59% of the children needed help with impulsivity/hyperactivity.
- Of those, 55% showed sufficient improvement in this area that no additional help was needed at the time of exiting the program.

Depression:

- 59% of the children needed help improving their depression.
- Of those, 67% showed sufficient improvement in this area that no additional help was needed at the time of exiting the program.

Anxiety:

- 50% of children needed help with anxiety.
- Of those, 66% showed sufficient improvement in this area that no additional help was needed at the time of exiting the program.

Anger Control:

- 81% of the children needed help with anger control.
- Of those, 73% showed sufficient improvement in this area that no additional help was needed at the time of exiting the program.

Adjustment to Trauma:

- 60% of the children needed help with adjustment to trauma.
- Of those, 55% showed sufficient improvement in this area that no additional help was needed at the time of exiting the program.

Emotional and/or Physical Dysregulation:

- 74% of the children needed help with emotional and/or physical dysregulation.
- Of those, 63% showed sufficient improvement in this area that no additional help was needed at the time of exiting the program.

The concept of residential stability is quite different for children than it is for adults. Children coming to the CCFSS programs are in a variety of situations regarding their residence. Of the children residing with biological families, some may have involvement with child welfare systems and some may not. Some children are placed into a family by child welfare and others are placed into a group home or Short-Term Residential Therapeutic Program (STRTP) by Children and Family Services (CFS) or Probation.

In addition to the basic question of residential stability for the caregiver, the key outcomes likely to increase residential stability for a child are:

- Being with a caregiver likely to be involved once the child has grown.
- How well the child is functioning within the family home.
- How involved and knowledgeable the caregiver is in regards to the needs of the child.

These items are indicative of the level of engagement from the caregiver as more engaged caregivers are less likely to work toward having the child removed from their home.

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

Caregiver's Residential Stability:

- 8% of the caregivers involved in the CCFSS programs indicated needing help in obtaining a more stable residence. 58% of those in need of residential stability were able to obtain this by the end of services.
- 70% of the children were identified as needing help improving functioning within their living situation. 72% were able to significantly improve on this item, indicating a decrease in conflict within the home.
- 20% of the caregivers were uninvolved in relation to the mental health needs of their children at the time of admission. 75% of these caregivers were appropriately involved by the end of services.
- 52% of the caregivers showed a low level of knowledge regarding the child's mental health needs at the start of services. 63% of these caregivers gained enough knowledge related to the child's needs that this was no longer a concern by the end of the program.

Success Story

When "Sarah" entered the Success First/Early Wrap program she was struggling with substance use and was involved with Children and Family Services (CFS). The Success First team offered resources and stabilization for her family by providing the coaching and role-modeling that allowed her to build independent living skills, complete her legal obligations, and be assertive about her needs.

While participating in the Success First/Early Wrap program she was able to successfully increase her positive family relationships, and parenting skills. Sarah now enjoys spending quality time with her child, and has remained sober upon discharge from the Success First/Early Wrap program.

A significant number of children seen in a CCFSS program (78.6%) needed help with issues related to criminal or juvenile justice involvement; however, only 24% of those had specific difficulties related to formal legal charges. Evaluating the effectiveness of CCFSS on reducing the likelihood of juvenile justice involvement focuses on the impact made on the specific issues listed below that could lead to juvenile justice involvement.

Specific indicators likely to increase juvenile justice involvement:

Delinquency:

- 25% of the children were engaging in delinquent type of behaviors that could result in an arrest at the start of services.
- 66% of these children were no longer seen as needing help on this upon exiting the programs.

Danger to Others:

- 38% of the children needed help to address aggressive behavior.
- 73% of these children were no longer considered to be at risk for harming others at the end of the program.

Runaway:

- 22% of children were engaging in runaway behaviors at the start of services.
- 71% of them successfully managed to stop these behaviors by the end of services.

Conduct Disorder Behaviors:

- 31% of the children displayed conduct disorder behaviors requiring intervention at the start of services.
- 72% of these children improved to the point of not needing help with this issue upon discharge.

Oppositional Behaviors:

- 69% of the children needed help with oppositional behaviors at the start of services.
- 66% of these children improved to the point of not needing help with this issue upon discharge.

"I am the only one in my family to go to college."

- CCFSS Consumer

Program Challenges

One challenge pertains to meeting the demands for intensive services for youth. As referrals by Children and Family Services (CFS), the Department of Behavioral Health (DBH), and the community exceeded the available resources, additional services were needed in the Success First/Early Wrap program. Furthermore, consultation with Probation confirmed that added supports were required to effectively engage their youth in the needed intensive services, adding to the increased demand.

Child Welfare, Probation, and Behavioral Health departments have made great strides in coordinating efforts between departments, however, ongoing work is needed to efficiently and effectively master the tracking of youth entering and exiting counties, management of the referral process, and to assess and treat the youth in accordance with Assembly Bill (AB) 1299.

Another set of challenges relate to supporting residential care providers. In FY 2018/19, the ChRIS program increased in number of youth served from 515 to 894 the previous fiscal year. However, the overall number of providers decreased from 34 to 28, as providers either closed or discontinued their contracts with the Department of Behavioral Health (DBH). Providers cited philosophical differences with the Short-Term Residential Therapeutic Program (STRTP) mandates or providers outside of San Bernardino as a business decision to focus on their local county as reasons for ending the contracts.

The remaining ChRIS providers required an extensive degree of technical assistance to develop and maintain the complex billing, information technology, and clinical processes to deliver EPSDT Medi-Cal Mental Health Services. This support is offered in the form of regular meetings, trainings, consultations, guides, dedicated clinical staff liaisons, and annual site reviews.

"It was helpful that the team was considerate and were patient. They gave me good advice and had a lot of experience with keeping a positive relationship. They always understood where I was coming from."

- CCFSS Consumer

Program Solutions

In order to address the challenge of increased demand, the budget for Success First/Early Wrap was increased by $9,000,000. This increase will result in an expected 1,591 unduplicated youth being served. To more effectively engage Probation youth in services, the referral form was modified and Probation staff attended an orientation to services with Success First/Early Wrap providers. The use of these services by Probation youth will be closely monitored.

To address the barriers to treatment inherent in the AB1299 process, DBH determined to consolidate the referral management and clinical processes under the Children Youth Collaborative Services (CYCS) umbrella instead of the shared process with the ACCESS unit. This change under one Clinic Supervisor will result in less redundancy, streamlined communication, and uniform oversight.

As noted above, the ChRIS programs already receive a significant amount of assistance from DBH and CYCS staff. To improve on this support, CYCS is developing targeted reports and dashboards focusing on service delivery, treatment progress, youth current strengths and needs, and clinician activity. Access to this data with ongoing feedback loops, in conjunction with the clinical and system of care expertise of CYCS staff, will promote the provision of high quality mental health services in the ChRIS programs.

Outreach and Engagement

In Fiscal Year 2018/19, Comprehensive Children and Family Services organized and/or participated in the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Referral Coordination and Outreach	3,391	2,742
Consultations	2,977	263
Total	**6,368**	**3,005**

Program Updates

Assembly Bill (AB) 1299

In 2016, AB 1299 initiated presumptive transfer to provide children and youth in foster care, who are placed outside their counties of original jurisdiction, timely access to Specialty Mental Health Services (SMHS). San Bernardino County Department of Behavioral Health (DBH) initially set up its Access and Referral Unit to be the central hub for receiving the out-of-county referrals and coordinating evaluations with Children and Youth Collaborative Services (CYCS). However, challenges in coordination led to the process being transferred entirely to CYCS in January, 2020.

In the next three years, as procedures and practices of AB 1299 continue to be refined and both child welfare staff and behavioral health staff become aware of the presumptive transfer process, the numbers of youth who are treated under the guidance of AB 1299 will continue to rise. Because the tracking process is quite complex, exact numbers are difficult to obtain. However, the California Department of Social Services (CDSS) indicates that about 2,100 dependents from other counties reside in San Bernardino County, at any given time. All of these youth are screened as possibly qualifying for mental health treatment and it is estimated are that about two-thirds will meet criteria for SMHS.

In order to successfully meet the service needs of children and youth placed in San Bernardino County, CYCS is utilizing the Outreach and Engagement portion of CCFSS to identify and evaluate these youth, and the FSP portion through Success First/Early Wrap, Wraparound, and ChRIS to provide comprehensive, intensive treatment.

Senate Bill (SB) 439 and SB 80

Senate Bill (SB) 439 establishes a minimum age of juvenile court jurisdiction for status and delinquency offenses in California in order to protect children under 12 years old from the adverse consequences of justice involvement, and to encourage more effective alternatives to prosecution. SB 439 outlines that:

- Counsel and release should be the default in the vast majority of cases.
- Responses thereafter should be the least restrictive alternatives through available school, health, and community-based services.

Behavioral health interventions will be a critical component as an alternative to prosecution.

SB 80 Family Urgent Response System (FURS) refers to a coordinated statewide, regional, and county level system designed to provide collaborative and timely state-level, phone-based response, and county-level, in-home and in-person mobile response, during situations of instability. The purpose is to preserve the relationship of the caregiver and the child or youth by providing developmentally appropriate relationship conflict management and resolution skills, stabilizing the living situation, mitigating the distress of the caregiver, child, or youth, and connecting the caregiver and child or youth to the existing array of local services while promoting a healthy and healing environment for children, youth, and families.

County child welfare, probation, and behavioral health agencies are establishing a joint county-based mobile response system that includes the following components:

- Phone response at the County level that facilitates entry into mobile response services.
- A process for determining when a mobile response and stabilization team will be sent, or when other services will be used.
- A mobile response and stabilization team available 24/7 with the ability to provide immediate, in-person, face-to-face response from individuals with specialized training in trauma and the foster care system, including peer partners and those with lived experience when possible.

Because the implementation of both SB 439 and SB 80 are in early phases, there are many unknowns about the exact nature of the program development. At this time, CCFSS is planning on meeting the increased demand through existing services.

Artwork by Kimberly Casteel

Collaborative Partners

- All God's Children
- Alpha Connections Youth and Family Services
- Aspiranet
- Berhe Group Home
- Boys Republic
- Childhelp, Inc.
- Children's Hope Group Home
- Crittenton Services
- South Coast Children's Society
- David and Margaret Youth and Family Services
- DBH Transitional Age Youth Centers
- East Valley CHARLEE
- Eggleston Youth Centers, Inc.
- Ettie Lee Homes, Inc.
- Father's Heart – A Ranch for Children
- Field's Comprehensive Youth Services
- First Step Group Homes
- Girls Republic
- Guiding Light Home for Boys, Inc.
- Inland Empire Residential Center
- Inspire A Youth, Inc.
- Lutheran Social Services
- McKinley's Childrens Center
- Mental Health Systems, Inc.
- Mountain Valley Child & Family
- New Dawn
- Oak Grove Center
- PHILOS Adolenscent Treatment
- Plan It Life, Inc.
- Riverstones Residential Treatment Centers
- Rosemary Children's Services
- San Bernardino County, Children and Family Services (CFS)
- San Bernardino County, First Five
- San Bernardino County, Probation
- San Gabriel Childrens Center, Inc.
- School Attendance Review Boards
- School Districts
- Silence Aloud, Inc.
- South Coast Community Services

- Starshine Treatment Center
- Tender Loving Care Home for Boys (Corinthians)
- Trinity Youth Services
- Uplift Family Services
- Victor Community Support Services
- Victor Treatment Centers

Artwork by Larry Spargo

Integrated New Family Opportunities (C2)

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

MHSA Legislative Goals and Related Key Outcomes

Increase self-help and consumer/family involvement

- Increase in number of encounters with collateral contacts, such as family members and informal supports

Reduce criminal and juvenile justice involvement

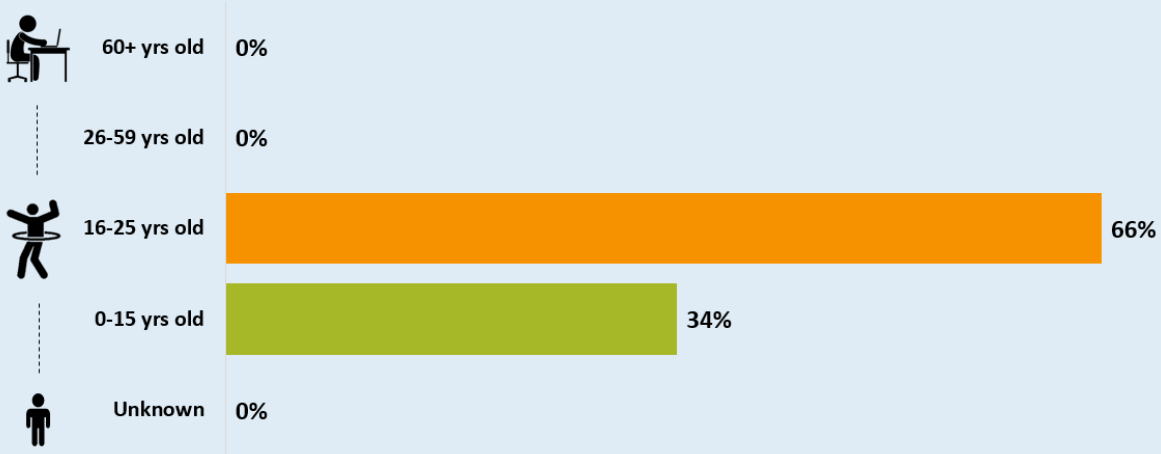
- Decrease sustained allegations
- Reduce jail/prison recidivism
- Decrease jail days

Artwork by Kira Henderson

Fiscal Year 2018/19 Program Demographics

Age:

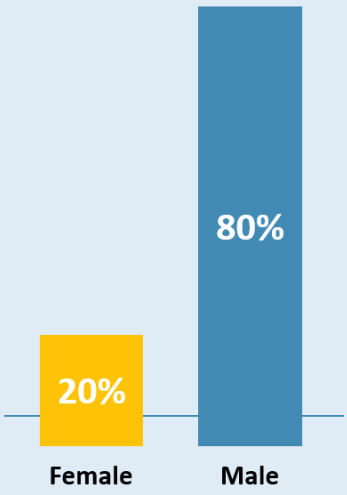
The graph below illustrates the ages of INFO participants. The majority of participants served, 66%, were between the ages of 16-25 years old. The second largest group was between the ages of 0-15 years old at 34%. There were no participants who identified as ages 26-59, and 60+, or as unknown or declined to state. This graph is representative of the INFO target population of children being the majority served.



N=228

Gender:

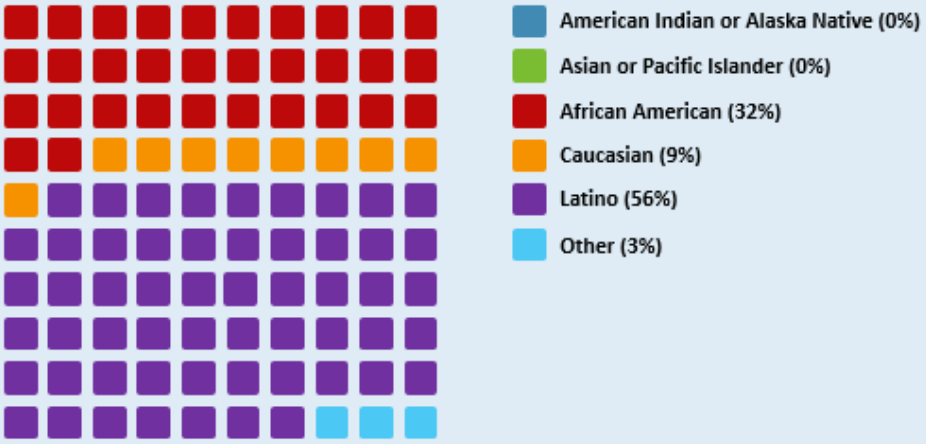
The graph below demonstrates that 20% of INFO participants identified as female and 80% identified as male. None of the participants declined to state, or identified as transgender, non-binary, gender queer, or other not listed.



N=228

Ethnicity and Ancestry:

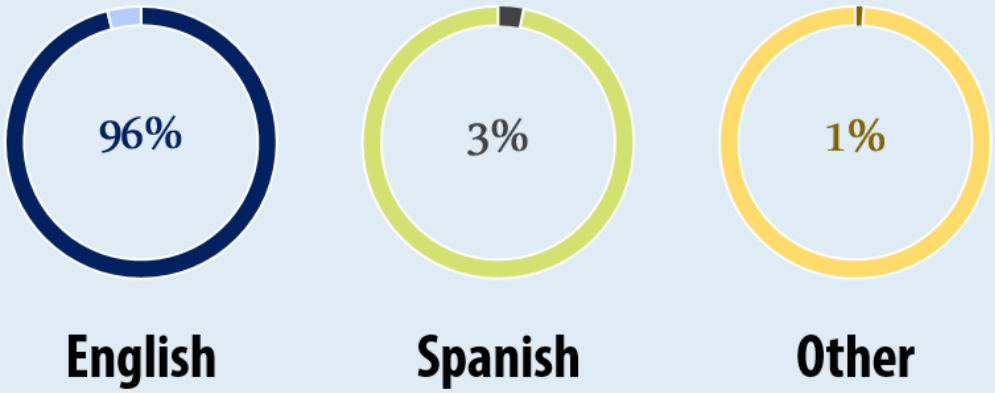
The graph below illustrates the various ethnicities of participants of the INFO program. The largest group of participants was 56% in the category of Latino. The second largest category was African American at 32%. Following that, 9% identified as Caucasian. Finally, 3% identified as Other. This category includes those who identified as other, more than one race, or declined to answer. There were no participants who identified as American Indian or Alaska Native, or Asian or Pacific Islander.



N=228

Primary Language:

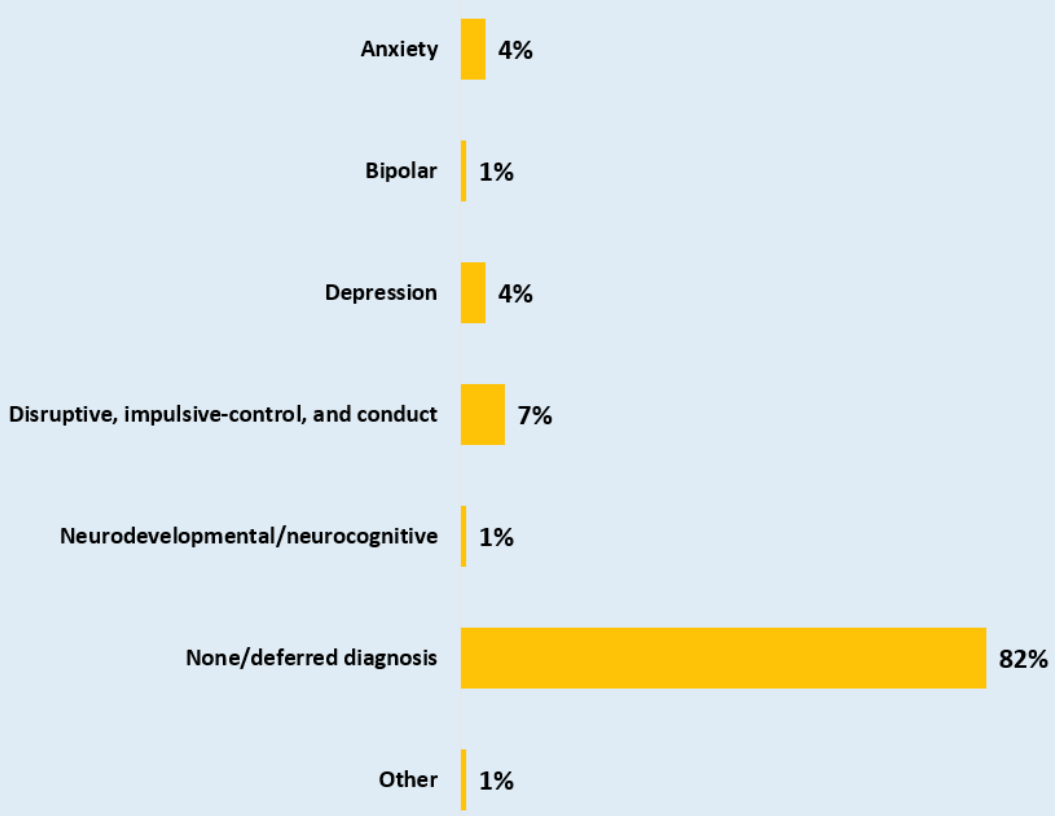
The graph below demonstrates that 96% of INFO participants identified English as their primary language. Additionally, 3% identified Spanish as their primary language, and 1% identified their primary language as something other than English or Spanish.



N=228

Primary Diagnosis:

The graph below illustrates the diagnostic groups of INFO participants who received services. Most of the participants of INFO services fall under the category of None/Deferred Diagnosis at 82%. The second largest category was Disruptive, Impulse Control, and Conduct at 7% followed by Anxiety at 4% and Depression at 4%. Finally, 2% fell under the categories of Bipolar, Neurodevelopmental or Neurocognitive. Additionally, 1% fell under the category of Other. This category includes those who had a different diagnosis than those listed or more than one.



N=228

"If it wasn't for them I would not have changed."

- INFO Consumer

Positive Results

The INFO program increased collateral contacts from 1,680 in FY 2017/18 to 2,782 in FY 2018/19, increasing the number of encounters with family members and informal supports by 65%.

During FY 2018/19 participants of the INFO program experienced:

- 44% less time in detention than those who declined services
- Sustained allegations for participants decreased by 81%

Additionally, those who declined services were 1.85 times more likely to experience recidivism than those who were receiving INFO services.

Program Challenges

In FY 2018/19, the INFO program experienced the following challenges:

- Difficulty coordinating the team to support the collaborative approach necessary for the Functional Family Therapy (FFT) model to produce optimal results.
- Experiencing the loss of the General Services Worker position inhibiting the ability to ensure that youth and their families are able to utilize services and resources offered by the program.

Program Solutions

The INFO program has implemented on-going training on the Functional Family Therapy model with Probation staff as well as teambuilding exercises and affirmations built within weekly multidisciplinary team meetings. In addition to team building, the INFO program has implemented the repurposing of other staff members to provide support for critical staff to attend appointments and provide linkage and consultation services. Efforts are also being made to reestablish the General Services Worker position.

Program Updates

Planned program changes over the next three Fiscal Years include continuing to increase caseload capacity in High Desert region in which additional services will be provided to the youth and families involved in the juvenile justice system. The program funding will also increase to include an additional full time Clinical Therapist.

Success Story

"Bob" was referred to the INFO program after displaying aggressive behavior. Upon entering the program, it was identified that he was having difficulty coping with trauma related to extreme domestic violence and was struggling with a history of substance use. Bob and his family were fully engaged and participated in INFO while abiding to the terms and conditions of Bob's probation.

With the help of the INFO program, Bob is now attending school regularly, is receiving all passing grades, and there have been no reports of physical violence in the home. Bob was able to complete therapy and is now clean and sober.

"I was very happy to be part of this program. It has helped me stay out of trouble and get good grades."

-INFO Consumer

Collaborative Partners

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

"They really changed me."

- INFO Consumer

Transitional Age Youth One Stop Centers (TAY-1)

The Department of Behavioral Health supports four (4) Transitional Age Youth (TAY) One Stop Centers in each region of San Bernardino County. TAY One Stop Centers provide integrated services to the unserved, underserved, and inappropriately served children and adolescents, ages 16 to 25, of San Bernardino County. The TAY One Stop Centers targeted populations are youth who are below 200% of the federal poverty level living with mental health concerns and includes an emphasis on Latino and African American youth who are disproportionately over represented in the justice system and in out-of-home placements (e.g., foster care, group homes, and institutions).

TAY individuals are living with an emotional disturbance and/or serious and persistent mental illness, may be experiencing, or are at risk of:

- Homelessness
- Involuntary or high users of acute care facilities (e.g., hospitals, emergency departments)
- Suffering from co-occurring disorders
- Experiencing their first episode of serious mental illness
- Aging-out of the child welfare system or juvenile justice system
- Involved in the criminal justice system

Centers are modeled as drop-in centers in an effort to improve TAY participation and allow TAY to:

- Selectively utilize services needed to maximize their individual potential (Recovery, Wellness, and Resilience Model) while living in the community
- Prepare them for re-entry into the community

TAY Centers partner with the San Bernardino County Department of Probation, the Department of Children and Family Services (CFS), and numerous other community partners who assist TAY in achieving the goals of:

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

Centers provide drop-in services to TAY and when appropriate their families. These services address employment, educational opportunities, housing, behavioral health, physical well-being, drug and alcohol use, legal issues, trauma domestic violence, and physical, emotional, and/or sexual abuse.

CSS: FULL SERVICE PARTNERSHIPS

Centers provide Full Service Partnership (FSP) services, which include behavioral health outpatient services for youth with serious emotional disturbances and/or serious mental illness. Services include, but are not limited to:

- Assessment
- Evaluation
- Treatment plan development (Individual Service and Supports Plan)
- Therapy (individual and group)
- Crisis intervention
- Medication support services
- Targeted case management
- Collateral services
- Rehabilitative activities of daily living
- Counseling
- Substance use disorder and co-occurring services
- Peer support and peer driven groups/activities
- Housing assistance
- Employment assistance
- Education assistance
- Legal assistance
- Transportation assistance

FSPs operate under the "whatever it takes" mandate in providing the full spectrum of community services to assist consumers in achieving their goals. Centers also offer TAY participants shower and laundry facilities, a resource room with computer and internet access, recreational activities, access to co-located services, and referrals to appropriate community based services.

Outreach and Engagement services and events are provided to unserved TAY, and when appropriate their families, to engage and educate them on the County's behavioral health system. Services include, but are not limited to, health fairs, job fairs, street outreach, and weekly orientations.

"Every day may not be good, but there is something good in every day."

- TAY Consumer

MHSA Legislative Goals and Related Key Outcomes

Reduce the subjective suffering from serious mental illness for adults and severe emotional disturbance for children and youth

- Increase resiliency
- Decrease impairment in general areas of life functioning (e.g., health, self-care, housing, occupation/education, legal, money management, interpersonal/social)

Reduce homelessness and increase safe and permanent housing

- Decrease rate of homelessness for consumers
- Increase independent living skills

Increase a network of community support services

- Increase number of collaborative partners

Artwork by Rachel Hart

Fiscal Year 2018/19 Program Demographics

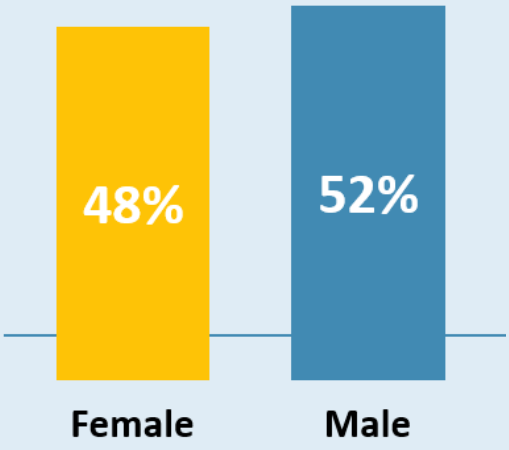
Age:

The graph below illustrates the ages of TAY participants. The majority of participants served, 94%, were between the ages of 16-25 years old. The second largest group was between the ages of 26-59 years old at 6%. There were no participants who identified as ages 0-15, and 60+, or as unknown or declined to state. This graph is representative of the TAY target population of transitional age youth being the majority served.

N=336

Gender:

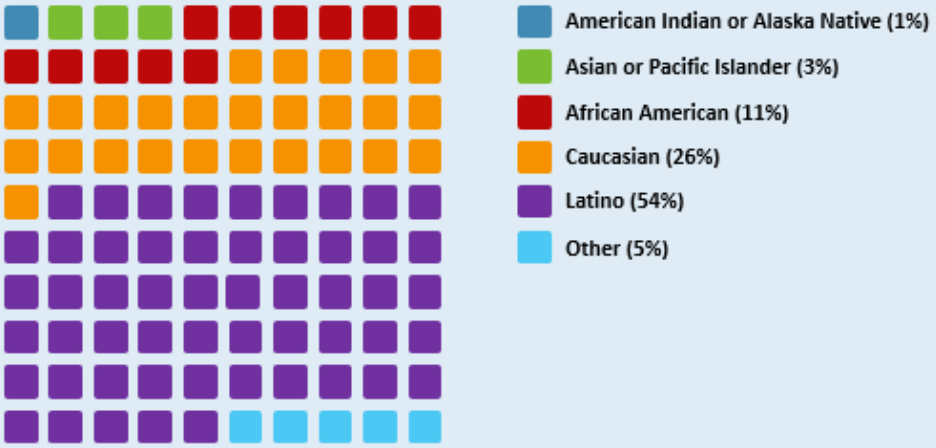
The graph below demonstrates that 48% of TAY participants identified as female and 52% identified as male. None of the participants declined to state, or identified as transgender, non-binary, gender queer, or other not listed.



N=336

Ethnicity and Ancestry:

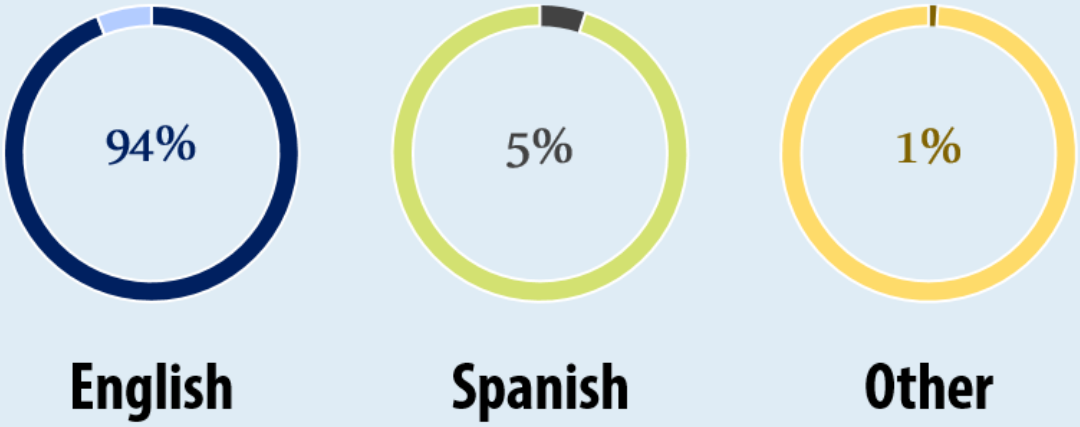
The graph below illustrates the various ethnicities of participants of the TAY program. The largest group of participants was 54% in the category of Latino. The second largest category was Caucasian at 26%. Following that, 11% identified as African American, and an additional 3% identified as Asian or Pacific Islander. Finally, 1% identified as American Indian or Alaska Native. Additionally, 5% identified as Other. This category includes those who identified as other, more than one race, or declined to answer.



N=336

Primary Language:

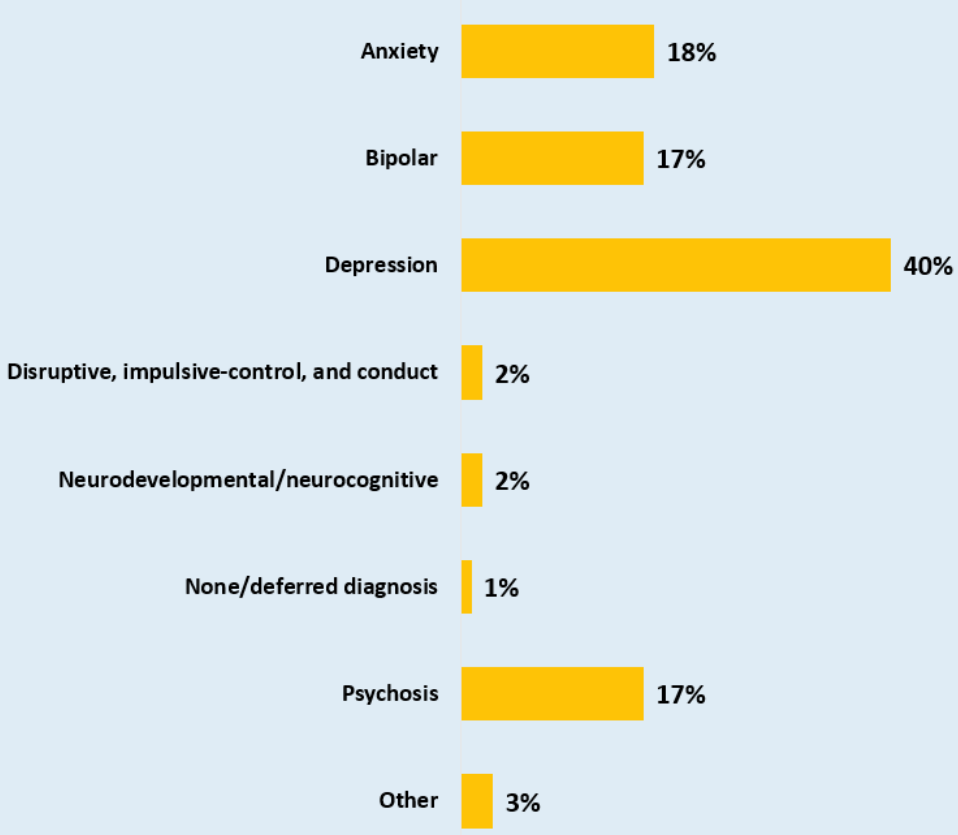
The graph below demonstrates that 94% of TAY participants identified English as their primary language. Additionally, 5% identified Spanish as their primary language, and 1% identified their primary language as something other than English or Spanish.



N=336

Primary Diagnosis:

The graph below illustrates the diagnostic groups of TAY participants who received services. Most of the participants of TAY services fall under the category of Depression at 40%. The second largest category was Anxiety at 18% followed by Bipolar at 17% and Psychosis also at 17%. Finally, 5% fell under the categories of Disruptive, Impulse-Control, or Non/Deferred Diagnosis. Additionally, 3% fell under the category of Other. This category includes those who had a different diagnosis than those listed or more than one.



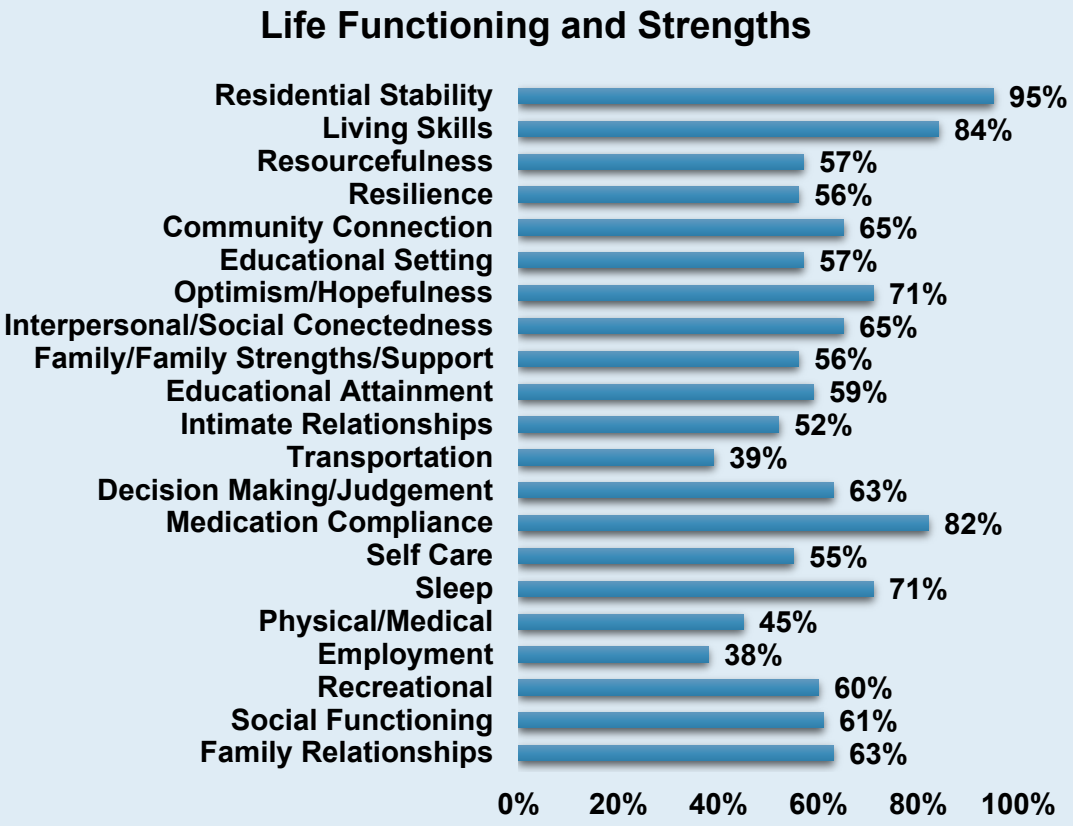
N=336

"Even the darkest night will end and the sun will rise."

- TAY Consumer

Positive Results

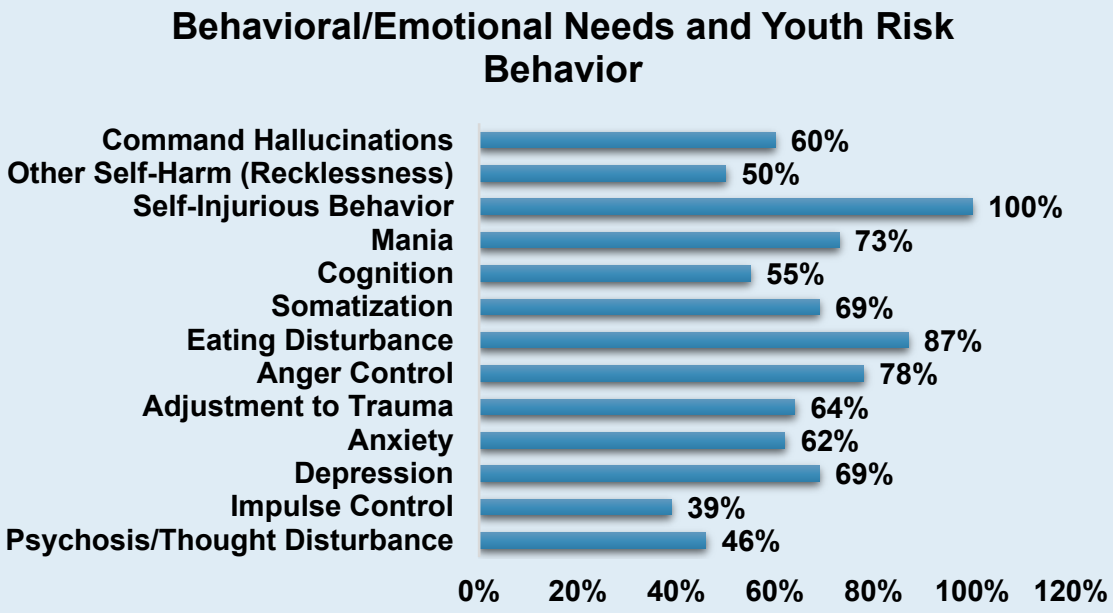
Results from the ANSA show the percentage of youth who presented with a significant issue on an item within the Life Functioning and Strengths domains and had that issue improve by the completion of the program, in Fiscal Year 2018/19.

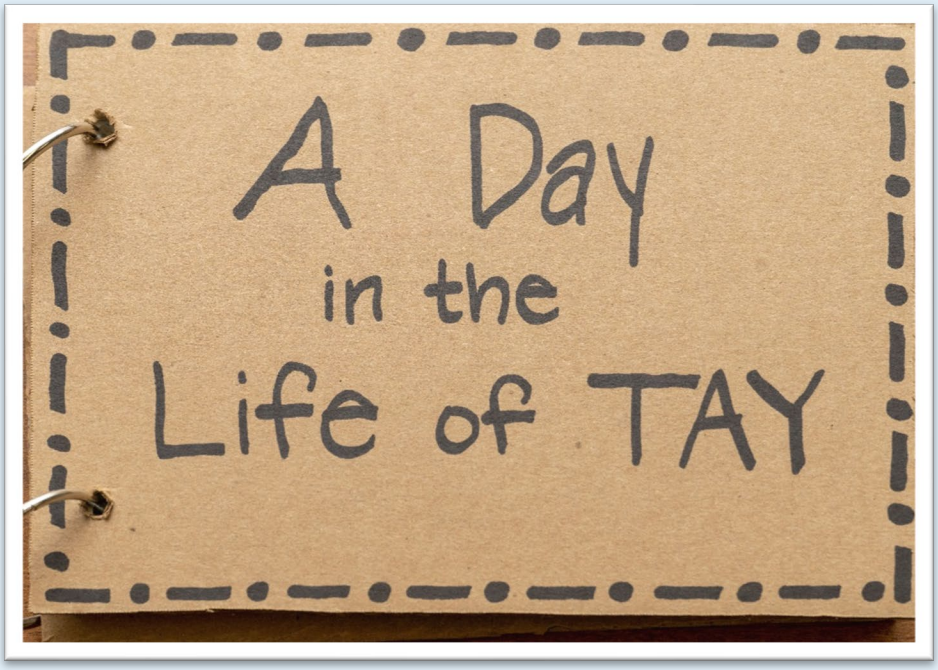


"Leadership is the ability to get extraordinary achievement from ordinary people."

- TAY Consumer

Results from the ANSA show the percentage of youth who presented with a significant issue on an item within the Behavioral/Emotional Needs and Youth Risk Behavior domains, and had this issue improve by the completion of the program.





Artwork by Cabrera

Program Challenges

- **Housing:** Finding housing for TAY consumers was a significant challenge encountered by TAY youth in the West End, Victorville, and Yucca Valley areas. These areas have very limited housing services for homeless youth and limited housing for TAY with children.

- **Lack of employment and other services:** TAY youth in the High Desert and Yucca Valley have reported challenges in finding employment and drug/alcohol treatment services. Additionally, accessing crisis stabilization beds has been a challenge for TAY in the High Desert region.

- **Lack of consumer engagement in program:** The Yucca Valley TAY Center staff have experienced an increase in consumers utilizing drop-in center services rather than committing to Full Service Partnerships (FSPs), and group attendance has decreased.

- **Staff retention:** For the Ontario TAY Center and the Yucca Valley TAY Centers, there was an increase in staff turnover causing a deficiency in staffing.

- **Increased substance use by consumers:** Yucca Valley TAY Center staff have noticed an increase in substance use by TAY consumers during the year.

- **Health care and insurance:** San Bernardino TAY Center has experienced a number of health insurance related issues. Out of county consumers experience difficulty getting the appropriate level of care for their mental health issues. Staff have experienced challenges with serving consumers who have private insurance but who are seeking service through the TAY Center because private insurance does not provide the level of care the County provides for mental health. Additionally, consumers have ongoing dental health treatment that is beyond what Medi-Cal covers.

"Don't let yesterday take up too much of today"

- TAY Consumer

Program Solutions

- **Housing:** To address the challenge of limited housing for homeless youth and TAY with children, Mental Health Systems, who run the Ontario TAY Center, connected with other housing programs to link consumers for services. Ontario TAY staff increased outreach to programs that help youth with children. Ontario TAY has also received funding for housing and has hired a housing coordinator to assist with finding options for TAY youth. For Yucca Valley TAY Center FSP consumers, housing contacts have been implemented to ensure FSP members receiving assistance with housing are progressing toward independent living arrangements. These contracts make individual and group participation mandatory for these consumers, as well as the development of a viable plan for establishing permanent living arrangements.

  TAY Center staff in Victorville have linked homeless youth to local housing providers, homeless shelters, cooling/heating centers, and local food banks. They have added a clothing closet to their homeless services. Additionally, TAY staff in the High Desert attended meetings with supervisory and case management staff at the Sunset Hill Crisis Residential Treatment center to understand how to better refer consumers for crisis residential treatment.

  TAY One Stop Center San Bernardino staff continue to refer callers wanting housing only to 211 for appropriate housing assistance. Youth are encouraged to be honest about substance use during substance use disorder assessments to ensure they receive appropriate level of care and housing.

- **Lack of employment and other services:** To address the issue of lack of employment, the TAY Center in Victorville has collaborated with the Department of Rehabilitation to provide onsite employment services. However, they continue to have struggles with youth obtaining employment due to economic conditions in the area. To assist members with establishing employment in Yucca Valley, the TAY Center provides resume building, cover letter assistance, and mock interviews to increase interview skills. Yucca Valley TAY uses flex funds to cover the cost of required employment preparation such as a Food Handler's cards to assist with employment. Yucca Valley TAY has collaborated with the First Institute Training Program to provide externships to members with little to no work experience as an opportunity to gain experience. This provides them with an opportunity to develop work skills in order to become more employable. The externships have a maximum number of payable hours, with the possibility of permanent employment.

- **Lack of FSP enrollment:** Yucca Valley TAY center staff are working with new members to increase FSP enrollment. A renewed emphasis on positive engagement strategies has attracted new (FSP) members, and information provided to them on the benefits of FSP services seems to be working. Current FSP members have also been an asset to the program by advertising it through word-of-mouth. The implementation of incentives and the provision of meals for attendees has helped to increase group attendance.

- **Staff retention:** To address the issue of staff retention and deficiencies, Ontario TAY management looked into providing competitive pay and now provides incentives for staff retention. The Yucca Valley TAY Center hired a new Program Manager and Peer and Family Advocate (PFA) in February 2019. They also promoted a per diem employee to a full-time billing clerk position. An additional PFA position was offered in June 2019 with a start date of July 8, 2019.

- **Increased substance use by consumers:** To address the issue of increased substance use amongst their consumers, Yucca Valley TAY Center hired a Substance Abuse Counselor to provide individual and group services.

- **Health care and insurance:** To address the issues of consumers receiving the care they need, the San Bernardino TAY Center staff keep continuous contact with counties of origin to get necessary paperwork and approvals for services. Staff also stay in contact with parents to evaluate consumer's benefits, both private and Medi-Cal, to ensure consumers receive appropriate mental health services. To address dental health issues for consumers, staff have identified and referred consumers to community resources and donations to assist youth in receiving dental health treatment.

Success Story

Through individual therapy, group therapy, and case management services, "John" has maintained his recovery and improved his emotional regulation skills, ability to utilize healthy social skills, and has improved his overall social interactions. John has adjusted well to the TAY program and has been utilizing the services TAY has offered. He continues to actively work on accomplishing his mental health treatment goals and has started community college while continuing to work on his social communication and language difficulties.

Outreach and Engagement

In Fiscal Year 2018/19, the Transitional Age Youth (TAY) One Stop Centers organized and/or participated in the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Career Fair/Conference	1	52
Resource Fair	11	180
Program Tours	6	25
Health Fair	4	196
Presentation	465	8,389
Street Outreach	19	19
DCFS Building Community Family Meetings	4	81
Total	**510**	**8,942**

Program Updates

In Fiscal Year (FY) 2020/21 the TAY program will closely monitor the ratio of full time employees to services provided to ensure the requirements set forth by the Department of Health Care Services (DHCS) are being met. The ongoing monitoring of the Department of Behavioral Health's (DBH's) full time employee capacity is measured by the Network Adequacy Certification Tool (NACT). An increase of funding will be provided to create a more robust buffer that will help ensure DBH is clearly meeting NACT requirements.

Additionally, due to this increase in funding and full time employees, the TAY program is looking to expand field-based services in the remote mountain Crestline area for consumers who are unable to travel. TAY is also planning to connect with San Bernardino County schools to provide services to students that leave school but are still in need of services.

Collaborative Partners

- Alta Loma High School
- Apple Valley Unified School District Workforce Investment Opportunities Act (WIOA) Work Experience Resource
- Basin Wide Foundation
- CalWORKS Advisory Committee
- Chaffey College Independent Scholars and EOPS
- Chaffey High School
- Chamber of Commerce - Yucca Valley
- Children's Fund
- Children's Network Collaborative
- Chino Neighborhood House
- Cobalt Institute for Math and Sciences
- Colony High School
- Community Crisis Response Team
- Copper Mountain College
- Cut Studio
- Department of Aging and Adult Services
- Desert Hills Presbyterian Church
- Desert Mountain Children's Center
- Etiwanda High School
- Five Star Catering
- Helendale Community Services District
- Hesperia Unified School District Family Resource Center
- Hesperia Unified School District Hispanic Community Liaison
- Hi-Desert Behavioral Health
- High Desert Senior & Disability Collaborative
- Homeless Youth Taskforce
- House of Ruth
- Interagency Council on Homelessness
- Kiwanis of Yucca Valley
- Los Osos High School
- Molding Hearts Housing
- Montclair School District
- Morongo Basin Community Coalition
- Morongo Basin Haven
- Morongo Basin Sexual Assault Services
- Morongo Basin Unified District
- Moses House

CSS: FULL SERVICE PARTNERSHIPS

- Native American Resource Center
- Ontario High School
- Operation New Hope
- Options for Youth
- Probation Department
- Rancho Cucamonga Center
- Rancho Cucamonga HS
- Rotary of Yucca Valley
- Saint Phillip Neri Catholic Church
- San Bernardino County, Children and Family Services
- San Bernardino County, Department of Behavioral Health Children's Services
- Silverado High School
- Snowline Joint Unified School District
- Town of Yucca Valley
- Twenty-Nine Palms High School
- Valley Star Crisis Walk in Clinic
- Valley Star STAY
- Valley View High School
- Victor Community Support Services Victorville Campus
- Victor Valley Behavioral Health Clubhouse
- Victor Valley College
- Victor Valley High School
- Walden Family Services
- Yucca Valley High School

"Don't let failure stop you from succeeding"

- TAY Consumer

"Keep your head up, stay strong, and follow your goals."

- TAY Consumer

Adult Criminal Justice Continuum of Care (A-2)

The Adult Criminal Justice Continuum of Care program is designed to serve adults living with serious mental illness, who are involved in the criminal justice system, and consists of six (6) sub-programs designed to target specific populations.

The **Corrections to a Safer Community (CTASC)** and **Choosing Healthy Options to Instill Change and Empowerment (CHOICE)** programs are designed to provide an array of voluntary re-entry services for consumers with serious mental illness that are being released from Type II County Jails including mental health and substance use services.

The **Supervised Treatment After Release (STAR)** and **Forensic Assertive Community Treatment (FACT)** programs serve consumers living with serious mental illness who are under formal supervision of the Mental Health Courts and agree to voluntarily participate in the programs as a condition of their probation. The FACT program differs from STAR as it assists consumers who have difficulty participating in traditional outpatient mental health services. With the FACT program, services are provided in the home.

The **Community STAR (CSTAR)** and **Community FACT (CFACT)** programs operate in the same capacity of the STAR and FACT programs, 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.

"My case manager really helped me a lot. She did not judge me when I relapsed, but encouraged me to get back up."

- Adult Criminal Justice Consumer

Mental Health Courts

Beginning in the late 1990s, the establishment of Mental Health Courts throughout the United States began, pursuant to federal legislation and funding. With the growing community concern for more effective interventions for mentally ill offenders, the Mental Health Court system expanded, both nationally and locally in San Bernardino County. San Bernardino County currently has four Mental Health Courts located in the cities of San Bernardino, Rancho Cucamonga, Victorville, and Joshua Tree. These Mental Health Courts offer voluntary court-referred treatment programs for defendants living with severe and persistent mental illness who agree to make mental health and substance use treatment part of the terms and conditions of their probation.

Additionally, Valley Star Behavioral Health is the contracted provider agency providing mental health treatment services to consumers participating in the Joshua Tree Superior Mental Health Court located in the Morongo Basin. A multidisciplinary treatment team meets at each of the courts to discuss and determine consumer appropriateness for Mental Health Court. The team consists of Judiciary personnel, the Public Defender, District Attorney's Office, Sheriff, Probation department officers, and the Department of Behavioral Health (DBH).

Supervised Re-Entry Services

The CHOICE program was developed as a result of Assembly Bill 109. This program is part of the Probation Day Reporting Centers (DRC) and is co-located at four of the San Bernardino County Probation offices (Fontana, San Bernardino, Barstow, and Victorville). The program offers probationers a one-stop service setting to meet with Probation personnel and receive behavioral health treatment services along with temporary housing, financial assistance, medical, and employment support. Mental health and substance use services are made available on a voluntary basis to all Probationers deemed needing some level of treatment intervention. CHOICE offers outpatient and intensive outpatient substance use services including educational and supportive treatment groups, mental health process groups, and individual therapy along with psychiatric and medication support services. All psychiatric services are located at the Colton clinic and transportation services are offered to consumers in order to ensure and encourage their participation.

A comprehensive, recovery-oriented treatment plan is utilized to assist participants in reaching their treatment goals. Substance Use Disorder (SUD) certified outpatient clinics are available at DRCs located in Fontana and Victorville and provide onsite SUD outpatient treatment, allowing consumers convenient accessibility to service needs. In addition, the CHOICE program works with other justice and community partners such as Correctional Mental Health Services (CMHS) in the jails, the Public Defender's Office, and other Adult Criminal Justice Programs to coordinate behavioral health treatment services for individuals re-entering the community after periods of incarceration.

The STAR program is made available to justice involved individuals including those incarcerated on a voluntary basis. This treatment program is tailored for individuals who suffer from severe and persistent mental illness, are classified as having serious mental illness (SMI), and have a history of recidivism in the criminal justice system. Consumers are referred by the multidisciplinary team (MDT) from the Mental Health Courts and accept voluntary participation in this program as a condition of their probation. The STAR program is a Full Service Partnership designed to reduce hospitalizations and incarcerations by assisting participants in re-entering society successfully. Through day treatment rehabilitation or intensive outpatient modalities, consumers receive individual and group therapy, psychiatric and medication support services, and case management services. These services include housing, medical, financial, and vocational assistance. For individuals diagnosed with a substance use co-occurring disorder, drug and alcohol treatment services are also available and include assessment, individual, family and group counseling, crisis intervention, case management, drug education, and referral to aftercare services.

The FACT program is available on a voluntary basis to adults diagnosed and identified as living with serious and persistent mental illness. These individuals present with a complex need for treatment intervention as a result of their mental illness. They have had repeated arrests and contacts with the criminal justice system, are now under the supervision of the Mental Health Court, have difficulties linking with and remaining engaged in the traditional outpatient clinic model, and may also have a co-occurring substance use disorder. FACT is a Full Service Partnership that provides wraparound services geared toward reducing recidivism in both jail and psychiatric hospitalization and includes community based, 24/7, intensive mental health and case management services to support recovery, self-management, and to increase public safety. Case management, mental health rehabilitation, individual and group counseling/therapy, crisis intervention, and medication support services are provided primarily in the community where the consumers live, using a “whatever it takes” approach based on the consumer’s individualized treatment needs. The intensity of services is based on the consumer’s level of recovery, and may include in-home services. The FACT team also provides assistance with housing, social support, and outreach services to program consumers. The FACT program personnel are part of a multidisciplinary team and meet with all other MDT team members to report on consumer’s program progress and challenges.

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

Unsupervised Re-Entry Services

The CTASC program is primarily designed to address needed re-entry linkage services for incarcerated individuals who have been classified as SMI inmates and are scheduled for release from County Type II Jails. The CTASC Team works closely with the San Bernardino County Sheriff's Department, the Probation Department, the Public Defender, various Department of Behavioral Health (DBH), and other community programs. The CTASC program design aims to reduce the likelihood of individual's risk for disengagement in their continuum of care, as it relates to mental health and substance use treatment upon their jail release. The program functions under the notion that continued care will minimize possible immediate consumer decompensation, thus, preventing criminogenic behaviors and increasing their progress toward mental health stabilization.

The purpose is to have CTASC staff beginning at jail intake and extending beyond release through collaboration with community partners, justice professionals, and other county partners. CTASC conducts a general needs intake assessment to identify the consumer's needs, coordinates linkage to the most appropriate community services, collaborates with the justice and community partners to arrange release/transportation, and facilitates a warm-hand off to the identified community program. The CTASC team works closely with the Sheriff's Correctional Mental Health Services (CMHS) to expedite the voluntary participant's release from the jails to community treatment resources. CTASC participants in need of a higher level of care are transitioned to Full Service Partnership services.

In 2015, the CSTAR and CFACT programs were implemented as an expansion of the STAR and FACT programs. Both programs are Full Service Partnerships that provide similar behavioral health services as STAR and FACT for those consumers exiting Adult Criminal Justice Programs and are no longer under formal supervision, but still remain in need of specialty behavioral mental health and substance use services. These two programs are expected to be short term and their goal remains to reduce recidivism in the jails/prisons and lessen the potential for psychiatric hospitalizations.

The purpose of the CSTAR and CFACT programs is to support the recovery of individuals living with a chronic behavioral health condition(s) who remain at risk of recidivism in the criminal justice system and/or from having repeated psychiatric hospitalizations. CSTAR and CFACT program staff engage in collaborative efforts with DBH community partners from all justice systems as well as Public Health, other DBH outpatient and specialty clinics, community based agencies, and philanthropic organizations to identify consumers who may benefit from the multifaceted services offered by the programs.

These services take place in a community outpatient setting and they target consumers who are voluntarily seeking continuous transitional assistance to help them maintain stabilization upon their re-entry to a community setting. Program criteria for this targeted population include:

- History of persistent mental illness and justice involvement
- High users of the criminal justice system and psychiatric hospitals settings
- No felony probation or parole supervision, although may have misdemeanors interconnected to summary probation (Proposition 47)
- In need of additional time to establish permanent supportive services that will help maintain independent self-care and linkage to stable support systems for continued successful reintegration into the community

The CSTAR and CFACT programs deliver mental health services in an outpatient setting. Services include but are not limited to, screening, assessment, psychotherapy, medication support, group and individual therapy, case management, crisis intervention, and transportation. Assistance is also offered with the transition to a lower level of care, including successful re-entry into the community for consumers enrolled in the program that are homeless or at risk of becoming homeless and/or require emergency shelter housing services. CSTAR and CFACT treatment is intended to offer their services on a short-term basis, however the length of participation in the program varies because consumer need is assessed on a case by case basis and considers the severity of the individual's behavioral health conditions and level of need to achieve full person sustainability and stabilization.

Artwork by Kyana Thompson

MHSA Legislative Goals and Related Key Outcomes

Reduce the subjective suffering from serious mental illness for adults

- Improve life satisfaction
- Decrease hopelessness/increase hope
- Increase resiliency
- Decrease impairment in general areas of life functioning (e.g., health, self-care, housing, occupation/education, legal, money management, interpersonal/social)

Reduce homelessness and increase safe and permanent housing

- Decrease rate of homelessness for consumers
- Increase residential stability

Reduce criminal justice involvement

- Decrease rate of incarcerations
- Decrease arrests
- Decrease jail bookings
- Decrease sustained allegations
- Decrease jail days
- Reduce jail/prison recidivism
- Reduce behaviors which increase likelihood of criminal justice involvement

Reduce the frequency of emergency room visits and unnecessary hospitalizations

- Reduce rate of emergency room visits for mental health concerns
- Reduce number of emergency room visits for routine medical concerns
- Reduce administrative hospital days
- Increase use of alternative crisis interventions (e.g., CWIC, CCRT, CSU)
- Increase number of individuals diverted from hospitalization

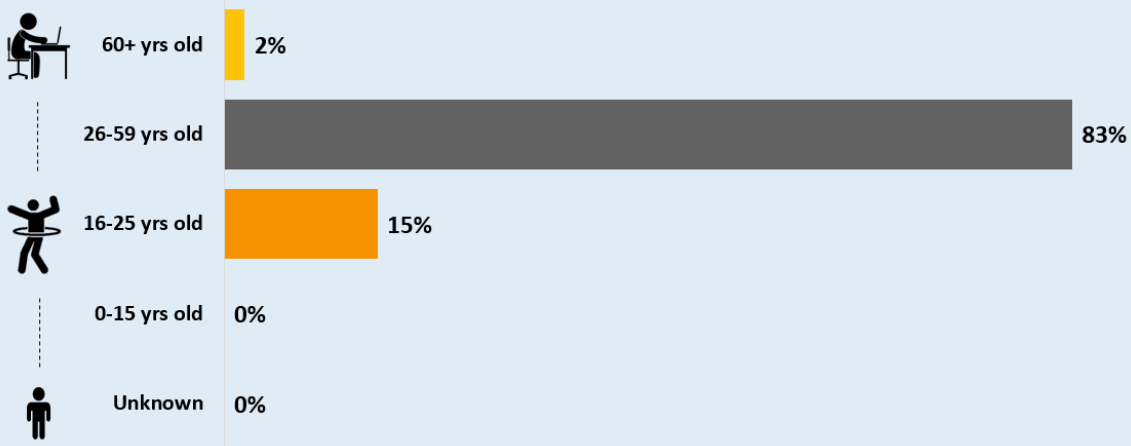
"I like coming here. The groups are good because I actually learn different ways of controlling my anger."

- Adult Criminal Justice Consumer

Fiscal Year 2018/19 Program Demographics

Age:

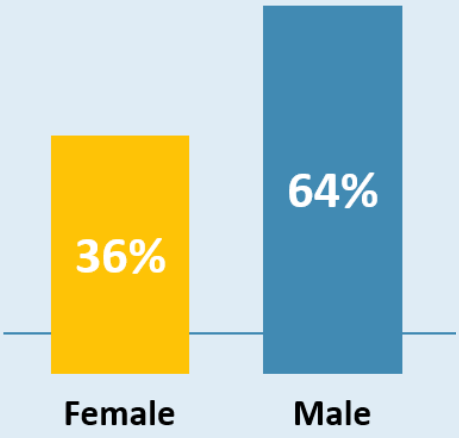
The graph below illustrates the ages of the Adult Criminal Justice Continuum of Care participants. The majority of participants served, 83%, were between the ages of 26-59 years old. The second largest group was between the ages 16-25 years old at 15% and 2% identified as ages 60+. There were no participants who identified as ages 0-15 or as unknown or declined to state. This graph is representative of the Adult Criminal Justice Continuum of Care target population of adults being the majority served.



N=257

Gender:

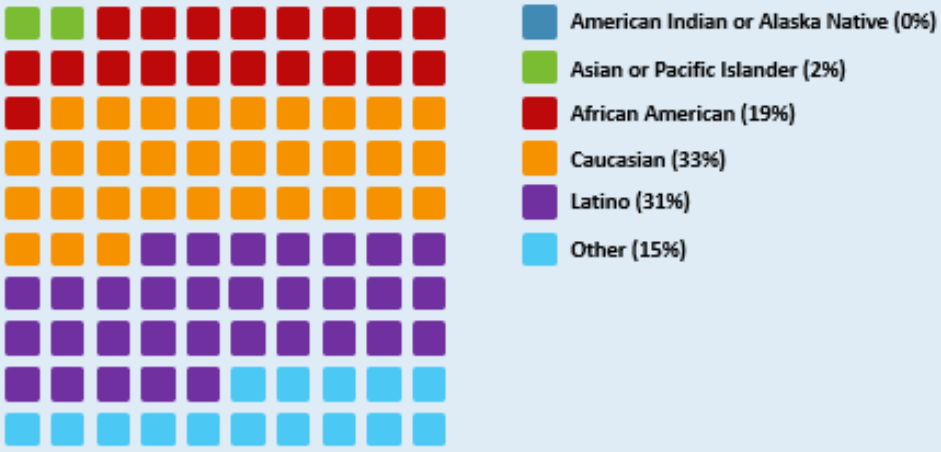
The graph below demonstrates that 36% of Adult Criminal Justice Continuum of Care participants identified as female and 64% identified as male. None of the participants declined to state, or identified as transgender, non-binary, gender queer, or other not listed.



N=257

Ethnicity and Ancestry:

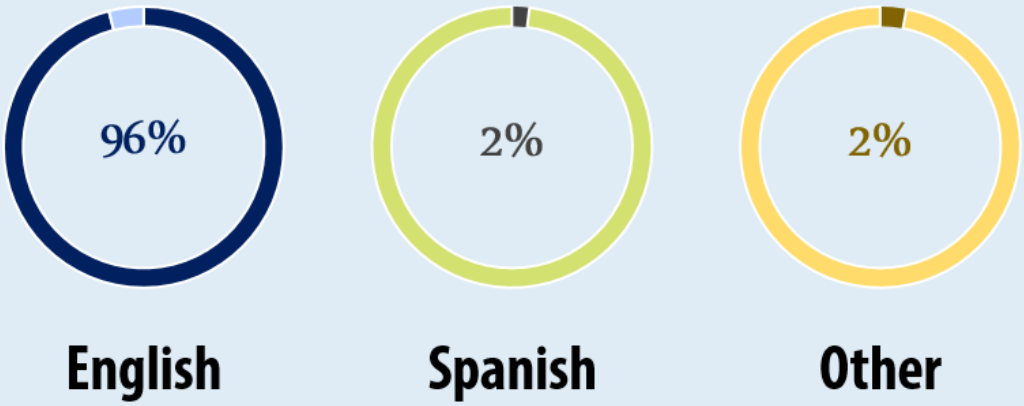
The graph below illustrates the various ethnicities of participants of the Adult Criminal Justice Continuum of Care program. The largest group of participants was 33% in the category of Caucasian. The second largest category was Latino at 31%. Following that, 19% identified as African American, and an additional 2% identified as Asian or Pacific Islander. Additionally, 15% identified as Other. This category includes those who identified as other, more than one race, or declined to answer. There were no participants that identified as American Indian or Alaska Native.



N=257

Primary Language:

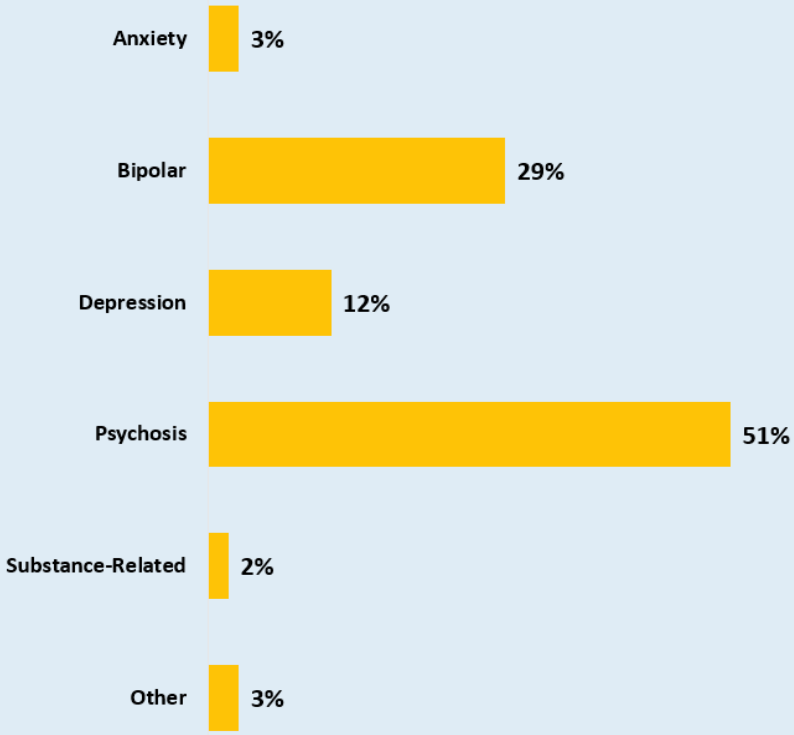
The graph below demonstrates that 96% of the Adult Criminal Justice Continuum of Care participants identified English as their primary language. Additionally, 2% identified Spanish as their primary language, and 2% identified their primary language as something other than English or Spanish.



N=257

Primary Diagnosis:

The graph below illustrates the diagnostic groups of Adult Criminal Justice Continuum of Care participants who received services. Most of the participants of Adult Criminal Justice Continuum of Care services fall under the category of Psychosis at 51%. The second largest category was Bipolar at 29% followed by Depression at 12%. Finally, 3% fell under the category of Anxiety, and 2% were Substance-Related. Additionally, 3% fell under the category of Other. This category includes those who had a different diagnosis than those listed or more than one.



Success Story

"Leia" came back to visit the program and share her success since her mental health court program completion and graduation. She shared how she is now a college student and involved with new hobbies. She was excited to have bought her own vehicle and is now successfully living on her own.

Positive Results

- Through participation in the program (typically 1.5 to 2 years), homelessness for all participants decreases to 0% since the programs facilitate or provide housing for them.
- In comparison to pre-enrollment levels, participants enrolled in the Adult Criminal Justice programs have shown high rates of diversion from incarceration resulting in a decrease in jail beds each year. The following data represents the reduction in jail days for FY 2018/19:

Program	Percentage of Reduction
STAR	85%
CSTAR	99.8%
JT MHC	76%
FACT	87%

- In comparison to pre-enrollment levels, participants enrolled in the Mental Health Court and/or CHOICE programs have shown high rates of diversion from psychiatric hospitalization, resulting in a decrease in unnecessary hospitalizations each year. The following data represents the reduction in psychiatric hospital admissions for FY 2018/19:

Program	Percentage of Reduction
STAR	50%
CHOICE	55.71%
JT MHC	92.31%
FACT	37.5%

Program Challenges

Transportation and housing has continued to be a barrier in FY 2018/19 for the Adult Criminal Justice Continuum of Care programs throughout the San Bernardino and Morongo Basin areas, specifically for the Barstow and Joshua Tree regions as the rural geographic location is a large contributing factor. Housing barriers include availability of appropriate shelter services and Board and Care providers. STAR has faced challenges in staffing due to several staff promoting throughout the year. Utilization of staff and identifying strengths of the staff became pertinent to program success.

Program Solutions

DBH and contract providers have worked toward meeting program challenges and barriers with positive resolutions in the current fiscal year. DBH has increased housing contract monitoring in the first quarter of FY 2019/20. Corrective action plans have been requested for providers who are found to be in violation of their contract. Providers are allowed timely resolve for deficiencies and subsequently undergo re-inspection to allow shelter placement to continue. DBH has also increased consumer transportation access with additional adult criminal justice drivers in the San Bernardino programs to ensure consumers are attending their medical appointments and the program is meeting their needs. DBH participated in a recent hiring fair to recruit specialized Clinical Therapists and Mental Health Specialists for the forensic programs.

Outreach and Engagement

In Fiscal Year 2018/19, Adult Justice Continuum of Care organized and/or participated in the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
MHC Graduations	2	18
Recovery Happens	1	45
Art Classes	20	86
Friday Night Fun	32	160
Yucca Valley High School Fair	2	60
Sexual Assault Services Presentation	2	24
Total	**59**	**393**

Program Updates

In Fiscal Year (FY) 2020/21, the Adult Criminal Justice Continuum of Care anticipates an increase in program funding in order to staff and additional Mental Health Clinic Supervisor and Clinical Therapist I for the CHOICE program, and 2 Clinical Therapists I, 2 Clinical Therapists II, and 2 Mental Health Specialists for the CSTAR program.

This increase will allow the program to provide more services, as the program anticipates an increase of more than 30 consumers per year. Additional positions allotted to the Adult Criminal Justice Continuum of Care program, along with internal day to day clinic operational changes, are likely to bring an increase in direct services to consumers. The CSTAR program anticipates an ongoing increase of consumers due to diversion referrals and the absorption of consumers from partnering agencies.

Additionally the CHOICE walk-in model has been established for the Victorville, Fontana, and San Bernardino CHOICE Day Reporting Center (DRC) locations. These changes have increased the caseload size each month and continuous growth is anticipated. The program is also exploring the expansion of Medication Assisted Treatment (MAT) services at the main Cooley Clinic to include the provision of MAT treatment for SUD consumers along with a psychiatrist providing onsite MAT services to the justice involved population at the DCRs on a weekly basis.

Collaborative Partners

- Abria Del Cielo Assisted Living
- Adult Day Health Care Programs
- Adult Protective Services
- Alzheimer Association
- American Sports University Student Dormitory
- American Surgical Pharmacy
- Avila's Room and Board
- Behavioral Health Commissioners
- Cal State San Bernardino
- California State University of San Bernardino CARE Team
- Cedar House Life Change Center
- Cedar House Rehabilitation Center
- Center for Employment Training
- Chaffey College
- Coalition Against Sexual Exploitation (CASE)
- Comfort Place Room and Board
- County of San Bernardino Correctional Mental Health Services

- County of San Bernardino Probation Department
- County of San Bernardino Sheriff Department
- County of San Bernardino Transitional Assistance Department (TAD)
- CR Sober Living
- D'Langs Community Center Room and Board
- Del Rosa Villa Nursing Center
- Department of Aging and Adult Services
- Department of Vocational Rehabilitation
- District Attorney's Office
- Emergency Shelter Services Housing Providers
- Gibson House for Men
- Gibson House for Women
- Goodwill of Southern California
- Helping Hands 24/7 Sober Living Home
- Hernandez Room and Board
- Hi-Desert Behavioral Health Services
- Hope Homes
- House of Angels Sober Living
- Inland Counties Legal Services
- Inland Empire Concerned African American Churches
- Inland Regional Center
- Inland Valley Recovery Services
- Institute for Public Strategies
- J's Famous Residential Room and Board
- Judges/Commissioners of San Bernardino County Superior Courts (Victorville, Joshua Tree, Rancho Cucamonga, and San Bernardino)
- Kai's Room and Board
- Loma Linda Veteran's Affairs Healthcare System
- Mental Health Clubhouses/Wellness Centers
- Mission Adult Day Health Care Center
- Mt. San Antonio College
- National Alliance on Mental Illness (NAMI)
- New Hope Missionary Baptist Church
- NP Guest Home Room and Board
- Office of Veteran Affairs
- OmniTrans
- Our Place Clubhouse (South Coast Community Services)
- Pacific Clinics
- Patton State Hospital
- Rialto Kiwanis Club
- SACHS Norton

CSS: FULL SERVICE PARTNERSHIPS

- San Bernardino Adult Day Health Care Center (formerly Catleya Adult Day Health Care Center)
- San Bernardino Adult School
- San Bernardino City Police Department
- San Bernardino County, Sheriff's Department/West Valley Detention Center
- San Bernardino County, Superior Mental Health Courts
- San Bernardino County, District Attorney's Office
- San Bernardino County, Public Defender Offices
- San Bernardino Valley College
- Saving Grace Sober Living
- Serenity Sisters Sober Living
- Shanti House Board and Care
- Social Security Administration's Institutions Unit
- Solvang Room and Board
- St. John of God Health Care Services
- Steps 4 Life Sober Living
- Telecare Crisis Walk-In Center
- Tender Heart Adult Day Health Care
- The Center for Effective Change
- The Counseling Team International
- The Ranch Recovery Centers, Inc.
- Valley Healthcare Center Skilled Nursing Facility
- Veteran's Center of Colton
- Waterman Convalescent Hospital
- Westside Action Group
- Women of Courage Sober Living

Assertive Community Treatment Programs (A-3)

The Members Assertive Positive Solutions (MAPS) and Assertive Community Treatment (ACT) Full Service Partnership programs serve San Bernardino County resident adults, 18 years and older, living with a behavioral health condition. These programs exist to assist consumers in living successfully within the community and support positive progress towards achieving individual personal recovery goals, while avoiding unnecessary psychiatric hospitalization.

The difference between the two programs is that ACT specializes in assisting those who may be transitioning from institutional settings, such as state hospitals, Institutions for Mental Disease (IMDs) or locked psychiatric facilities, whereas MAPS assists those who are historically high users of acute psychiatric inpatient and crisis services. These consumers may also have a history of a co-occurring substance use disorder or a history of identifying as homeless. In Fiscal Year 2018/19, MAPS served 82 and ACT served 77 unique full service partners.

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.

The team members share responsibility for the consumers being served.
Staff-to-consumer ratio is small (approximately one to ten) and the range of services are comprehensive and flexible. Most services are provided within the community where consumers live, work, and socialize.

DBH contracts to provide both MAPS and ACT services for consumers with serious mental illness, and to create a recovery-centered experience for consumers served. The program is staffed by a multidisciplinary team that include psychiatrists, nurses, Master’s level prepared Clinical Managers, Team Leads and Personal Service Coordinators. Additionally, the program promotes peer advocacy and support with staff who have lived experience and knowledge of how to navigate the behavioral health system of care, and positively engage consumers to continue their recovery milestones.

MHSA Legislative Goals and Related Key Outcomes

Reduce the subjective suffering from serious mental illness for adults

- Improve life satisfaction
- Increase resiliency
- Decrease hopelessness/increase hope
- Decrease impairment in general areas of life functioning (e.g., health, self-care, housing, occupation/education, legal, money management, interpersonal/social

Reduce homelessness and increase safe and permanent housing

- Decrease rate of homelessness for consumers
- Increase residence stability

Increase self-help and consumer/family involvement

- Increase number of encounters with collateral contact, such as family members and informal supports

Increase access to treatment and services from co-occurring problems; substance abuse and health

- Increase encounters in specialty co-occurring and substance abuse interventions
- Increase transportation to non-mental health co-occurring appointments (such as substance use disorder, integrated health, primary care, etc.) provided

Reduce disparities in racial and ethnic populations

- Reduce mental health and health care disparities

Reduce the frequency of emergency room visits and unnecessary hospitalizations

- Reduce rate of emergency room visits for mental health concerns
- Increase use of alternative crisis interventions (e.g., CWIC, CCRT, CSU)
- Increase number of individuals diverted from hospitalization

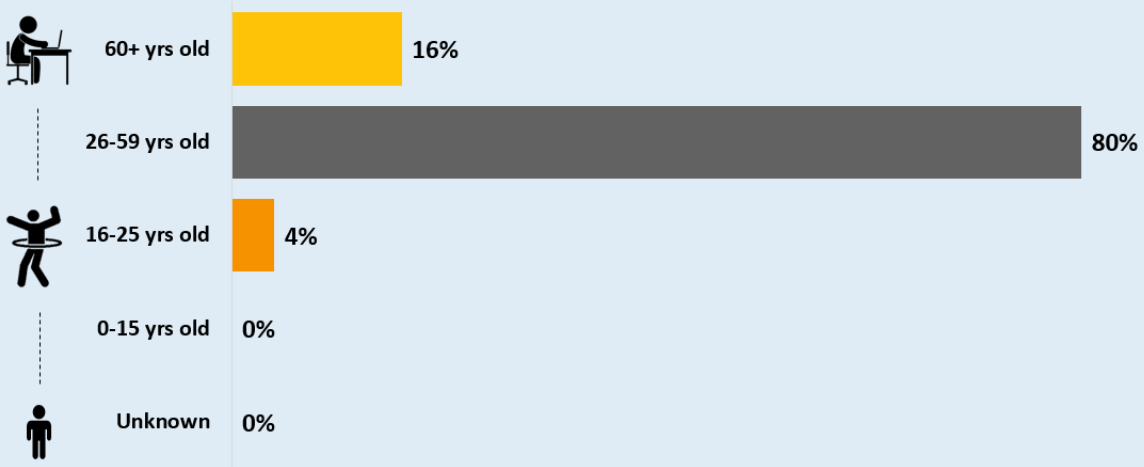
"Telecare has always been there for me."

- MAPS Consumer

Fiscal Year 2018/19 Program Demographics

Age:

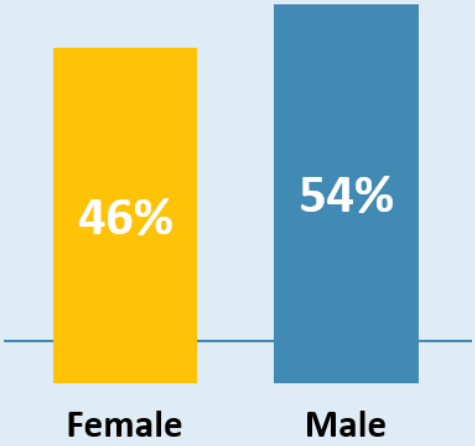
The graph below illustrates the ages of the MAPS/ACT participants. The majority of participants served, 80%, were between the ages of 26-59 years old. The second largest group were ages 60+ years old at 16% and 4% identified as ages 16-25 years. There were no participants who identified as ages 0-15 or as unknown or declined to state. This graph is representative of the MAPS/ACT target population of adults being the majority served.



N=159

Gender:

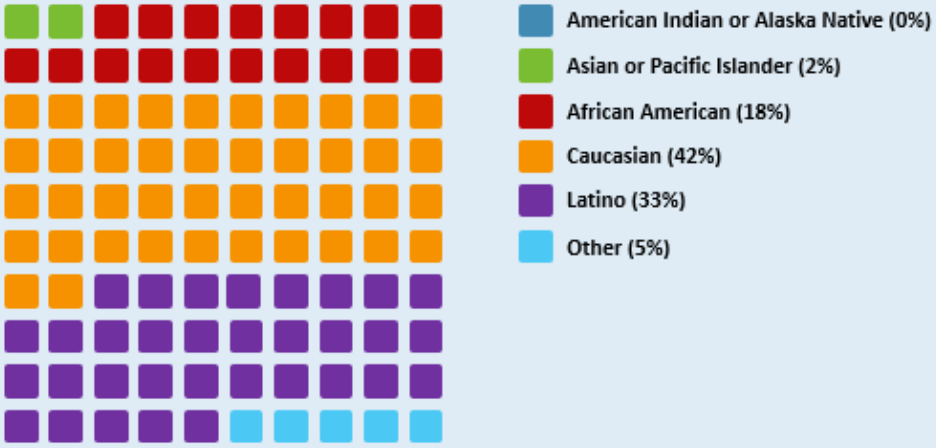
The graph below demonstrates that 46% of MAPS/ACT participants identified as female and 54% identified as male. None of the participants declined to state, or identified as transgender, non-binary, gender queer, or other not listed.



N=159

Ethnicity and Ancestry:

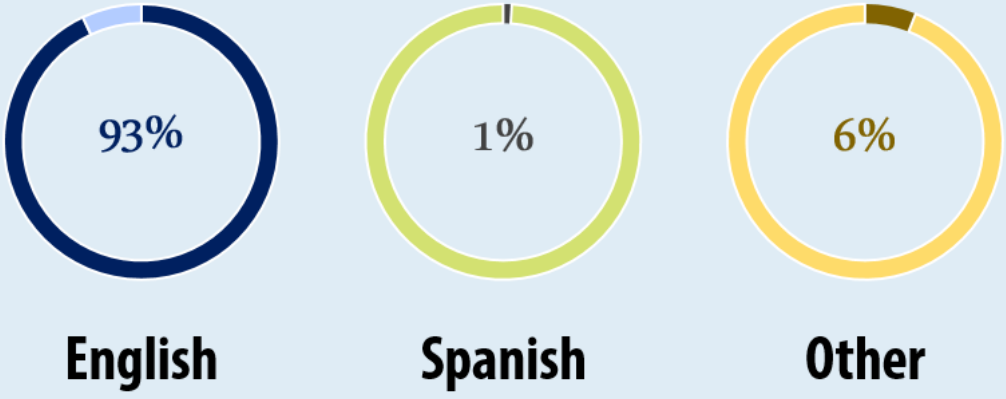
The graph below illustrates the various ethnicities of participants of the MAPS/ACT programs. The largest group of participants was 42% in the category of Caucasian. The second largest category was Latino at 33%. Following that, 18% identified as African American, and an additional 2% identified as Asian or Pacific Islander. Additionally, 5% identified as Other. This category includes those who identified as other, more than one race, or declined to answer. There were no participants that identified as American Indian or Alaska Native.



N=159

Primary Language:

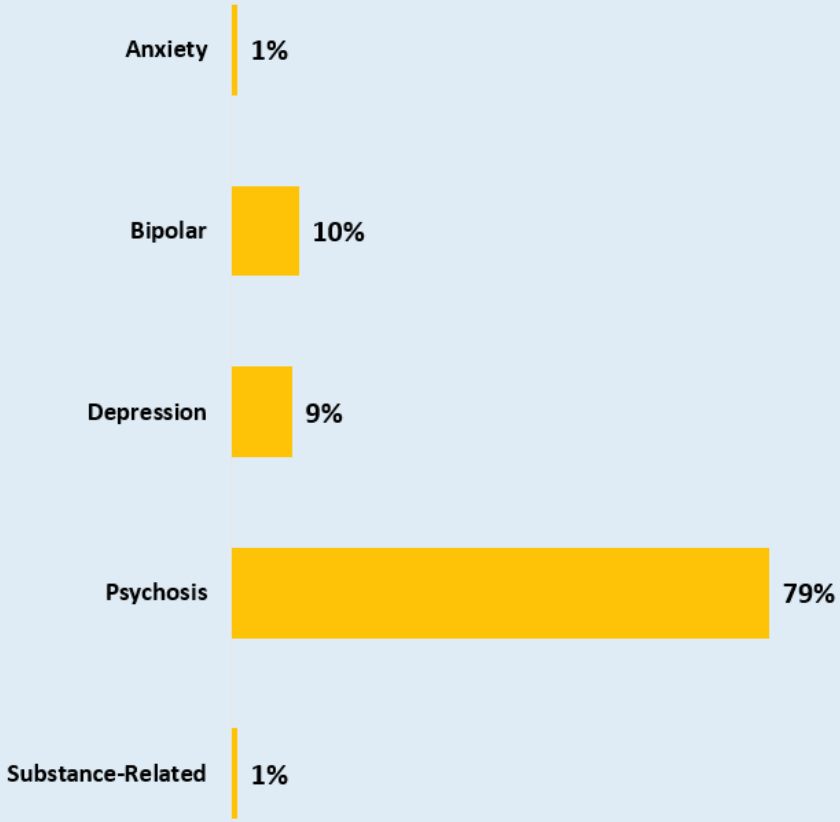
The graph below demonstrates that 93% of MAPS/ACT participants identified English as their primary language. Additionally, 1% identified Spanish as their primary language, and 6% identified their primary language as something other than English or Spanish.



N=159

Primary Diagnosis:

The graph below illustrates the diagnostic groups of MAPS/ACT participants who received services. Most of the participants of MAPS/ACT services fall under the category of Psychosis at 79%. The second largest category was Bipolar at 10% followed by Depression at 9%. Finally, 2% fell under the categories of Anxiety or were Substance-Related.



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Artwork by Greg Barton

Positive Results

MAPS

- Of 82 members during Fiscal Year 2018/19, 72 members (88%) were able to successfully manage their symptoms with medication and avoid psychiatric hospitalization
- Consumers experienced one or more of the following living arrangements in Fiscal Year 2018/19:
  - ◊ Living independently, alone, or with adult family member: 10 out of 82 members
  - ◊ Unlicensed but supervised placement: 41 out of 82 members
  - ◊ Licensed community care facility (Board and Care): 20 out of 82 members
  - ◊ Acute medical hospital: 2 out of 82 members
  - ◊ Acute living facility: 2 out of 82 members
  - ◊ Assisted living facility: 2 out of 82 members
  - ◊ Jail: 3 out of 87 members
  - ◊ Licensed residential program: 2 out of 82 members
  - ◊ Not recorded: 0 out of 87 members.
- 100% of MAPS consumers maintained stable housing
- Approximately 29% of members served have family involved in treatment
- Out of the 82 members, 95% were linked to transportation for non-mental health appointments
- 6 of the 82 members served have been linked to residential programs
- 15 were encouraged to attend substance use support groups
- Of the 82 members served during FY 2018/19, 15 members went voluntarily to the hospital and 12 members went involuntarily to the hospital
- Emergency interventions provided: 17 out of 82 members were related to mental health, and 3 out of 82 members were related to substance abuse.

"My son would not be here without the help from the MAPS team."

- MAPS Parent

ACT

- Out of 77 members served during Fiscal Year 2018/19, 58 members (75%) were able to successfully manage their symptoms with medication and avoid psychiatric hospitalization
- Out of 77 total members served throughout Fiscal Year 2018/19, living arrangements are detailed as follows:
  - ◊ Living independently, alone, or with adult family member: 9 out of 77 members
  - ◊ Unlicensed but supervised placement: 14 out of 77 members
  - ◊ Licensed community care facility (Board and Care): 46 out of 77 members
  - ◊ Acute medical hospital: 2 out of 77 members
  - ◊ Single room occupancy: 3 out of 77 members
  - ◊ With one or both biological/adoptive parents: 3 out of 77 members
- 100% of ACT consumers maintained stable housing
- Approximately 44% of members served have family involved in treatment
- Out of the 77 members, 92% were linked to transportation for non-mental health appointments
- Out of the 77 members, 5 members have been linked to residential programs and 12 were encouraged to attend substance use support groups
- Of the 77 members served during FY 2018/19, only 27 members went either voluntarily or involuntarily to the hospital
- Emergency intervention provided: 8 of 77 members were related to mental health, and 4 out of 77 members were related to their physical health

Success Story

"Frank" joined the ACT program after being discharged from an Institution for Mental Disease (IMD) and a psychiatric hospital stay. In less than a year, he was able to finish vocational rehabilitation, successfully transition to a lower level of care, and interview for jobs. The ACT team and Frank achieved this by regular meetings that focused on medication consistency, managing symptoms of mental illness, and fostering coping skills. The ACT team assisted with bus passes and other transportation, and empowered him to learn bus routes. The program promoted confidence in wardrobe choices and résumé for his upcoming interviews as he graduates from vocational rehabilitation.

Program Challenges

The MAPS/ACT program has experienced some challenges with maintaining housing for consumers. The contracted providers continue to work on developing relationships with licensed Board and Care and Room and Board facilities to address these issues. Members have been linked to shelters, Crisis Stabilization Units (CSU) and Crisis Residential Treatments (CRT) to ensure that consumers are able to have a safe place to sleep while working to address other personal challenges.

Another identified challenge is providing services to members who do not have an income. During FY 2018/19, the program provided assistance with rent, groceries, and hygiene items while cases were being reviewed by the Social Security Administration (SSA). Linkages to an SSA liaison were provided to ensure consumers were able to get the financial support needed.

Other challenges relate to members attending primary care physician (PCP) appointments and working in conjunction with program staff to follow the physician's recommendations. The other challenge is working with consumers to understand the importance of medication compliance. Peer Support Counselors (PSC) and nurses educate members on the importance of attending doctor appointments and complying with recommendations. Members are offered additional support during these periods to ensure they understand the importance of taking care of themselves. Non-compliance with attending their PCP appointments greatly impacts the members' behavioral health conditions, increasing symptoms that can result in acute psychiatric hospitalizations.

Success Story

"Kendra" enrolled with MAPS and was struggling with substance use. She had been in contact with the court system and was a victim of domestic violence. The MAPS team engaged weekly with Kendra to help her increase her coping skills, reduce her depression symptoms, and substance use. The MAPS team has encouraged independent living skills, such as utilizing public transportation, engaging with her community, and scheduling time with her sponsor. Through the use of motivational interviewing, Kendra is optimistic in pursuing sobriety.

Program Solutions

The program is working to coordinate additional resources in housing, which are utilized by other community providers in surrounding areas. Both programs have gained relationships with new Room and Board housing vendors in the county.

For consumers who are unable to manage their funds, the treatment team will advocate on behalf of the consumer with their psychiatrist, and if needed, will coordinate with SSA to initiate a change in payee.

The program continues to foster independence by encouraging consumers to be comfortable taking public transportation, while working in collaboration with managed care organization to coordinate additional transportation. Consumers are encouraged to purchase bus passes, and the team assists with completing the application and working on coping skills to help alleviate any stressors related to the use of public transportation.

Medication compliance has been a primary focus of treatment. Nurses are encouraged to provide health awareness and introduce various tools to help members stay on track with taking medications as prescribed and are providing coordinated care with the facilities in which members reside to improve monitoring of daily medications. Nurses are also increasing their home visits with members discharged from the hospital and are immediately reporting to their psychiatrist any changes to medications. In addition, nurses are also increasing communication with Board and Care (B&C) operators to ensure that they are aware of the right medication regimen authorized by the program's psychiatrist, and providing education to the consumers regarding the importance of attending any medical appointments with their primary care physician and how failure to do so can negatively impact their recovery.

Treatment teams are working to provide members' families with resources for services in the community, as well as for themselves to help with the "burn out" of having to manage the consumer's symptoms without support. The treatment team is working towards motivating family members to take some moments to share how they will contribute to the consumer's treatment and to increase their participation with the consumer's recovery.

Both programs continue to link members to Clubhouses, adult day health centers, food banks, and assistance with OmniTrans disability bus passes. MAPS has maintained relationships with various pharmacies that provide delivery services to members to ensure continuity of care. Members have also been working with the MAPS teams to receive assistance with whole person care, physical health linkage, and support. MAPS also has gained relationships with new room and board housing vendors in the county.

ACT is working on starting their co-ed groups beginning in October, and there will be open groups where anyone can participate. Behavioral Health Integrated Care Coordination Initiative (BHICCI) teams are also administering Substance Use Disorder (SUD) tools with members to identify the risk factors in using substances. These teams are working with ACT to coordinate beneficial services.

Outreach and Engagement

In Fiscal Year 2018/19, Assertive Community Treatment programs organized and/or participated in the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Members Recognition Event	1	60
Harvest Festival	1	30
Turkey Day Lunch	1	30
Holiday Party	1	28
Total	**4**	**148**

Collaborative Partners

- Cash Assistant Program for Immigrants (CAPI)
- Catholic Charities
- Community Action Partnership (CAP) of San Bernardino County
- Habitat for Humanity
- Home Energy Assistance Program (HEAP)
- Humane Society
- Mary's Table
- MHSA Housing Program
- The Rock Church and World Outreach Center
- San Bernardino County, Department of Adult and Aging Services/Office of the Public Guardian (DAAS/OPG)

Regional Adult Full Service Partnerships (A-11)

The Regional Adult Full Service Partnership (RAFSP) offers Full Service Partnership (FSP) programs in the Barstow, Phoenix, Mesa, Mariposa, and Victor Valley Department of Behavioral Health (DBH) Community Clinics, and contracts for FSP Services with Hi-Desert Medical Center and Valley Star Behavioral Health, Inc., to provide additional FSP services throughout the various regions of San Bernardino County. The RAFSP programs operate by linking consumers to services in the community and providing full wraparound care to these individuals. These services include intensive at home, or field based, services that assist individuals in accessing various levels of care and housing and/or step down to a lower level of care in the least restrictive setting possible.

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

RAFSP promotes the principles of recovery, wellness, and resilience to assist individuals to have lives that are more satisfying, hopeful, and fulfilling based on their own values and cultural framework. Mental health services provided through DBH focus on the consumer's strengths and possibilities so they can move toward new levels of functioning in the community.

Individuals requiring this level of care are often unable to maintain independence in the community without the assistance of intensive case management support. The ratio of staff to consumers is typically one to ten to allow for intense support for consumers 24 hours a day/7 days per week, but can include larger numbers as appropriate.

The RAFSP offers full wraparound services with the goal of connecting consumers to available resources such as housing, medication support services, therapy, intensive case management, and care coordination. RAFSP service providers help individuals cope with their behavioral health challenges by linking them to community programs

and agencies through direct, one-to-one support. RAFSP treatment services include clinical assessments, risk assessments, assistance with obtaining housing, coordination of care and transportation with mental health and substance abuse outpatient clinics, physical healthcare physicians, and insurance providers.

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

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

RAFSP Target Population

The RAFSP's target population serves diverse county residents ages 18 and older, experiencing and/or living with serious mental illness who will benefit from wraparound treatment services. These include:

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

Transition of the Big Bear FSP

In FY 2018/19 the Big Bear Full Service Partnership program was integrated as part of RAFSP. This Full Service Partnership (FSP) is no longer a stand-alone program, however services in the geographically isolated Big Bear region are still provided through Valley Star Full Service Partnership. Additionally, outcomes related to the Big Bear Full Service Partnership program are not independently reported on, but rather integrated into Valley Star FSP's overall outcomes and data.

MHSA Legislative Goals and Related Key Outcomes

Reduce the subjective suffering from serious mental illness for adults

- Improve life satisfaction and increase resiliency
- Decrease hopelessness/increase hope
- Decrease impairment in general areas of life functioning (e.g., health, self-care, housing, occupation/education, legal, money management, interpersonal/social)

Reduce homelessness and increase safe and permanent housing

- Decrease rate of homelessness for consumers
- Increase residence stability

Increase self-help and consumer/family involvement

- Increase ratio of voluntary to involuntary mental health services
- Increase program attendance and frequency per customer
- Decrease no-show rate of appointments

Increase access to treatment and services for co-occurring problems; substance abuse and health

- Increase encounters in specialty co-occurring and substance abuse interventions
- Increase encounters in integrated health clinic and/or with primary care providers
- Increase transportation to non-mental health co-occurring appointments (such as substance use disorder, integrated health, primary care, etc.)

Reduce disparities in racial and ethnic populations

- Reduce mental health and health care disparities

Reduce criminal justice involvement

- Decrease rate of arrests and incarcerations
- Reduce jail/prison recidivism

Reduce the frequency of emergency room visits and unnecessary hospitalizations

- Reduce number of emergency visits for routine medical concerns
- Reduce administrative hospital days
- Increase number of individuals diverted from hospitalization

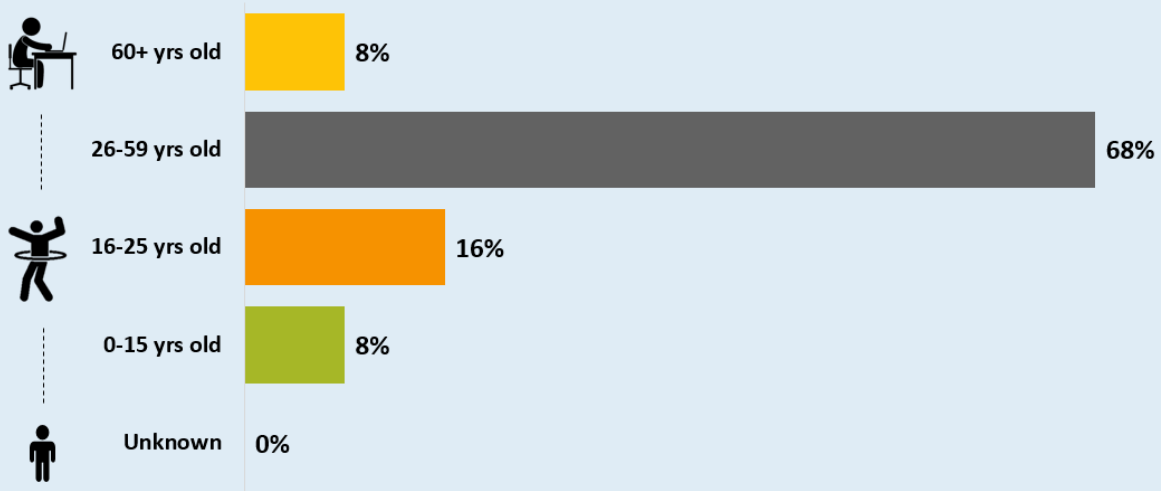
Increase network of community support services

- Increase coordination of care

Fiscal Year 2018/19 Program Demographics

Age:

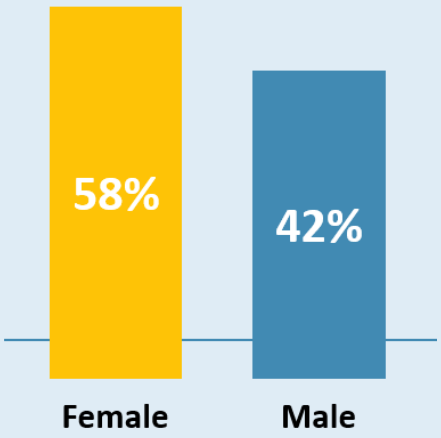
The graph below illustrates the ages of the RAFSP participants. The majority of participants served, 68%, were between the ages of 26-59 years old. The second largest group was between the ages 16-25 years old at 16%, 8% identified as ages 0-15 years old, and 8% identified as ages 60+. There were no participants who identified as ages unknown or declined to state. This graph is representative of the RAFSP target population of adults being the majority served.



N=900

Gender:

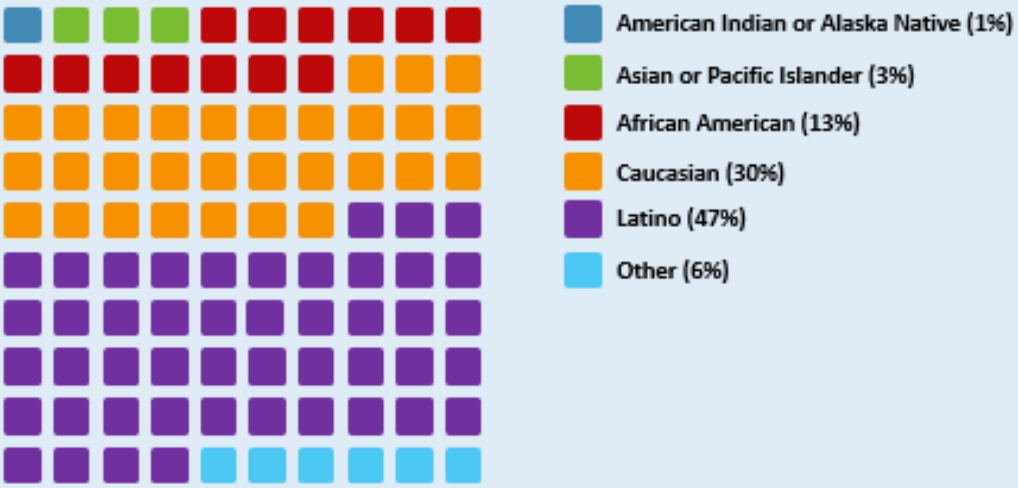
The graph below demonstrates that 58% of RAFSP participants identified as female and 42% identified as male. None of the participants declined to state, or identified as transgender, non-binary, gender queer, or other not listed.



N=900

Ethnicity and Ancestry:

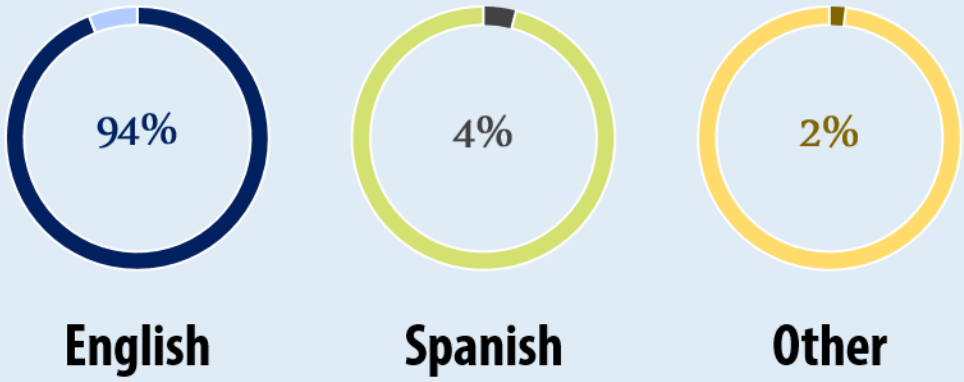
The graph below illustrates the various ethnicities of participants of the RAFSP program. The largest group of participants was 47% in the category of Latino. The second largest category was Caucasian at 30%. Following that, 13% identified as African American, and an additional 3% identified as Asian or Pacific Islander. Finally, 1% identified as American Indian or Alaska Native. Additionally, 6% identified as Other. This category includes those who identified as other, more than one race, or declined to answer.



N=900

Primary Language:

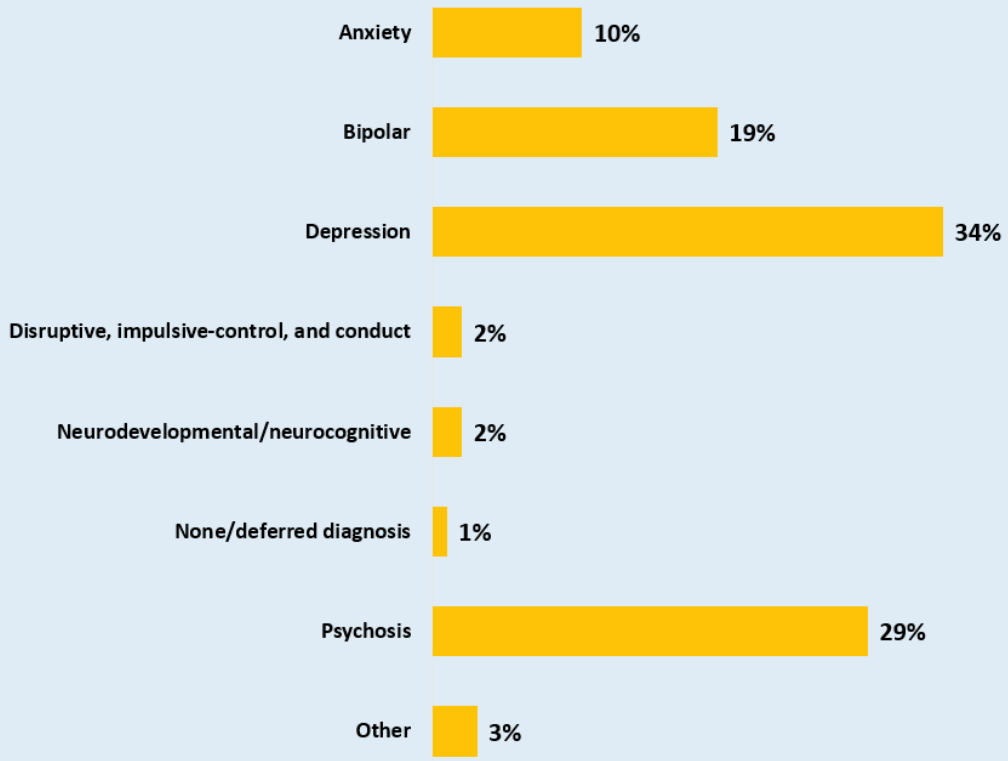
The graph below demonstrates that 94% of RAFSP participants identified English as their primary language. Additionally, 4% identified Spanish as their primary language, and 2% identified their primary language as something other than English or Spanish.



N=900

Primary Diagnosis:

The graph below illustrates the diagnostic groups of RAFSP participants who received services. Most of the participants of RAFSP services fall under the category of Depression at 34%. The second largest category was Psychosis at 29% followed by Bipolar at 19% and Anxiety at 10%. Finally, 5% fell under the categories of Disruptive, Impulse-Control, and Conduct, Neurodevelopmental or Neurocognitive, or None/Deferred Diagnosis. Additionally, 3% fell under the category of Other. This category includes those who had a different diagnosis than those listed or more than one.



N=900

"I couldn't do it without you."

- RAFSP Consumer

Positive Results

Barstow Counseling Center

- In Fiscal Year 2018/19, there were 34 consumers that received FSP services, of which 97% did not have a hospitalization for the fiscal year.
- For the consumers hospitalized, there was a 83% decrease in the number of bed days from the previous fiscal year.

Valley Star Full Service Partnership

- In Fiscal Year 2018/19, there were 57 consumers that received FSP services, of which 96% did not have a hospitalization for the fiscal year.
- For these hospitalizations, there was a total of 10 bed days.

Phoenix Community Counseling Center

- In Fiscal Year 2018/19, there were 83 consumers that received FSP services, of which 83% did not have a hospitalization for the fiscal year.
- For the consumers hospitalized, there was a 7% decrease in the average length of stay in the hospital (bed days) from the previous fiscal year.

Mariposa Community Counseling

- In Fiscal Year 2018/19, there were 32 consumers that received FSP services, of which 91% did not have a hospitalization for the fiscal year. This is a 59% decrease in hospitalizations from the previous fiscal year.
- For the consumers hospitalized, there was a 38% decrease in the number of bed days from the previous fiscal year.

Mesa Counseling Center

- In Fiscal Year 2018/19, there were 63 consumers that received FSP services, of which 84% did not have a hospitalization for the fiscal year.
- For the consumers hospitalized, there was a 49% decrease in the number of bed days from the previous fiscal year.

Victor Valley Counseling Center

- In Fiscal Year 2018/19, there were 133 consumers that received FSP services, of which 84% of these consumers did not have a hospitalization for the fiscal year.
- There was a 14% decrease in the hospitalizations from the previous fiscal year.

In FY 2018/19, the FSP team has been able to house several consumers in MHSA low income apartments through the housing program, consumers have gained employment, started college programs, and become more independent by getting their SSI benefits

and learning to manage their income. Additionally, many consumers without income have been housed in shelter bed programs during the process of gaining SSI benefits or employment so they can transition to more independent living.

The goal of the FSP program is to provide intensive case management and treatment to allow for a reduction of inpatient hospitalizations. This data is tracked through the Data Collection and Reporting System (DCR) via the Key Event Tracking (KET) forms. The FSP program offers various groups as needed. As RAFSP identifies a need with consumers the program will add a group that assists consumers in meeting their goals. As consumers allow, RAFSP teams collaborate with family members who are willing to engage in helping consumers meet their goals.

The FSP team assists with transportation to medical appointments as well as the consumer's psychiatrist. When requested, staff will stay with the consumer in their appointment to assist the consumer in understanding their health and advocating for themselves. FSP team members will arrange for primary and dental care appointments for consumers. Several consumers have been linked with substance use treatment including inpatient treatment, as appropriate, when the consumer is willing to engage.

Success Story

"Grace" had both physical and psychological limitations and was living in a non-supportive environment, as she had nowhere else to go. RAFSP was able to assist her on numerous occasions while she waited for SSI approval and independent housing. On a couple of occasions, we received calls from Grace indicating she was afraid for her safety. We were able to transport her from that environment and offer shelter. Additionally, issues of codependency and exploitation were addressed in therapy, and addressed by Adult Protective Services. She now has income, a place to live, and solid boundaries with her family members. She appears happy and healthy.

Program Challenges

The Barstow clinic experienced challenges in FY 2018/19 due to being short-staffed for the majority of the year. The short staffing was, in part, caused by the community based resources (contract agency) being unable to travel to the rural area of Barstow in order to provide services.

Mariposa experienced a shortage of housing for low income individuals, as well as a shortage of safe places for homeless women and families. Other challenges included difficulties providing integrated medical and behavioral health treatment.

Mesa FSP is continuously challenged with finding housing for consumers due to limited numbers of shelter placements for those without income as well as few Board and Care facilities in the area for those who need that level of care and have income. Low income housing and the low number of MHSA units available with subsidized rental assistance is also challenging once consumers receive SSI benefits. Transportation is another challenge at times as the program has one driver and many consumers are not yet able to use public transportation independently.

In Victorville, resources tend to be the most difficult challenge the program faces in assisting consumers attain stability in housing and reduce psychiatric hospitalizations. Food bank availability and transportation to the donation sites has been challenging for consumers. There are several complex cases in which housing stability is unattainable due to severely limited Board and Care beds available because the High Desert has no augmented Board and Care facilities. This presents difficulty for assisting with housing for individuals with high risk behaviors or conditions that are not able to be safely monitored in a room and board.

Phoenix has also experienced a lack of housing for low or no income individuals and a lack of safe places for homeless women and families. There has also been a challenge in integrating medical and behavioral health treatment.

"Even when I don't feel good, I come here because these are my people."

- RAFSP Consumer

Program Solutions

The Barstow clinic has hired two case managers that will serve the Barstow area.

Mariposa is participating in the IEHP Health Home project, and has implemented an integrated treatment team. There has also been increased linkage to collateral resources such as contract providers and Board and Care facilities.

Mesa is reaching out to various programs to find housing for consumers. Supervisors attend housing meetings monthly to find out about vacancies in the MHSA apartment complexes that DBH is involved with to advocate for consumers gaining access to those units when appropriate. Mesa is also connecting consumers with IEHP bus passes or transportation programs if they qualify.

Victorville has developed a contract with Valley Star to provide FSP services in the High Desert region which should significantly support this underserved community.

Phoenix is also participating in the IEHP Health Home project and is utilizing the homeless program to increase housing options.

Outreach and Engagement

In Fiscal Year 2018/19, Regional Adult Full Service Partnership programs organized and/or participated in the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Cooking Group	52	520
Trip to Mount Baldy	1	10
IEHP Workshops	2	6
Total	**55**	**536**

"Thank you for your help because things are sometimes hard for me and I don't know how to do it."

- RAFSP Consumer

Collaborative Partners

- Adult Protective Services/Child Protective Services
- Arrowhead Regional Medical Center
- Barstow College
- Barstow Police Department
- Barstow Unified School District
- Borrego Health
- Caring by Nature
- Catleya Day Treatment Program
- Cedar House
- City Link Water of Life Ministries
- Clubhouses
- Crisis Residential Treatment
- Crisis Stabilization Units
- Department of Behavioral Health Shelter Bed Providers
- Department of Motor Vehicles
- Department of Rehabilitation
- Desert Mana
- Desert Sanctuary
- Holistic Campus
- Inland Valley Recovery Services
- Lanterman-Petris-Short Act Designated Facilities
- Lutheran Mission
- Lutheran Social Services
- Mental Health Systems
- MHSA Housing
- OmniTrans
- Recovery Based Engagement Support Teams (RBEST)
- Resource Oversight & Guidance Incorporated
- Salvation Army
- San Bernardino County, Board and Care Facilities
- San Bernardino County, Transitional Assistance Department (TAD)
- San Bernardino County, YMCA
- Serenity Clubhouse
- Shelter Contract Providers
- Social Security Administration
- South Coast Community Services
- Summit Payee Services
- Tender Hearts

- Valenta Eating Disorder Program
- Valley Star Crisis Walk In Center
- West Side Clinic
- Women, Infants, and Children (WIC) Program

Artwork by Michelle Romero

Age Wise (OA-1)

The Age Wise program provides access to Full Service Partnership (FSP) mental health, substance use disorder, and case management services throughout San Bernardino County to older adults, age 59 and older, living with mental illness or co-occurring disorders. The program works to increase access to services for the older adult community and decrease the stigma that is associated with mental illness within the older adult community.

Research shows older adults are especially vulnerable to the difficulties of accessing available services due to stigma, lack of behavioral health education, and other factors such as limited funds and transportation. Age Wise addresses these vulnerabilities by providing therapy and case management in the home, thereby providing older adults a more accessible form of care.

Through collaboration, the program focuses on assisting unserved, underserved, and inappropriately served older adults develop integrated care with respect to their physical and behavioral health needs. Additionally, this program provides outreach and engagement activities in the community to educate agencies, primary care providers, and the public about the behavioral health needs of the older adult population.

In January 2019, the Age Wise program, in its entirety, was officially transitioned for implementation under the San Bernardino County, Department of Aging and Adult Services/Office of the Public Guardian (DAAS/OPG). As a result of this transition, an assessment of services determined that Age Wise I and Age Wise II should be consolidated to one program. This consolidation hopes to achieve alignment of services, access to additional DAAS/OPG resources and ultimately, enhancement of consumer care.

To achieve the goals of attaining housing and preventing homelessness for older adults living with mental illness, DBH has enhanced the focus on wellness and recovery. This focus assists older adults in remaining independent and active in their communities for as long possible. This component requires collaborative partnerships between staff and community agencies, DAAS/OPG, the Social Security Administration (SSA) and other community organizations to aid older adults in obtaining needed support.

The program continues to work with the MHSA Housing program to develop senior apartments and create stable and affordable housing complexes for older adults living with mental illness. The staff work with the apartment management to develop beneficial activities and programs that help keep consumers engaged in stable housing.

MHSA Legislative Goals and Related Key Outcomes

Reduce the subjective suffering from serious mental illness for older adults

- Improve life satisfaction
- Increase resiliency
- Decrease hopelessness/increase hope
- Decrease impairment in general areas of life functioning (e.g., health, self-care, housing, occupation/education, legal, money management, interpersonal/social)

Reduce homelessness and increase safe and permanent housing

- Decrease rate of homelessness for consumers
- Increase residence stability

Increase self-help and consumer/family involvement

- Increase ratio of voluntary mental health services to involuntary mental health services
- Increase number of encounters with collateral contact, such as family members and informal supports

Increase access to treatment and services for co-occurring problems; substance abuse and health

- Increase encounters in integrated health clinic and/or with primary care/health specialist providers

Reduce disparities in racial and ethnic populations

- Reduce mental health and health care disparities

Reduce the frequency of emergency room visits and unnecessary hospitalizations

- Reduce number of emergency visits for routine mental health concerns
- Increase use of alternative crisis interventions (e.g., CWIC, CCRT, CSU)
- Increase number of individuals diverted from hospitalization

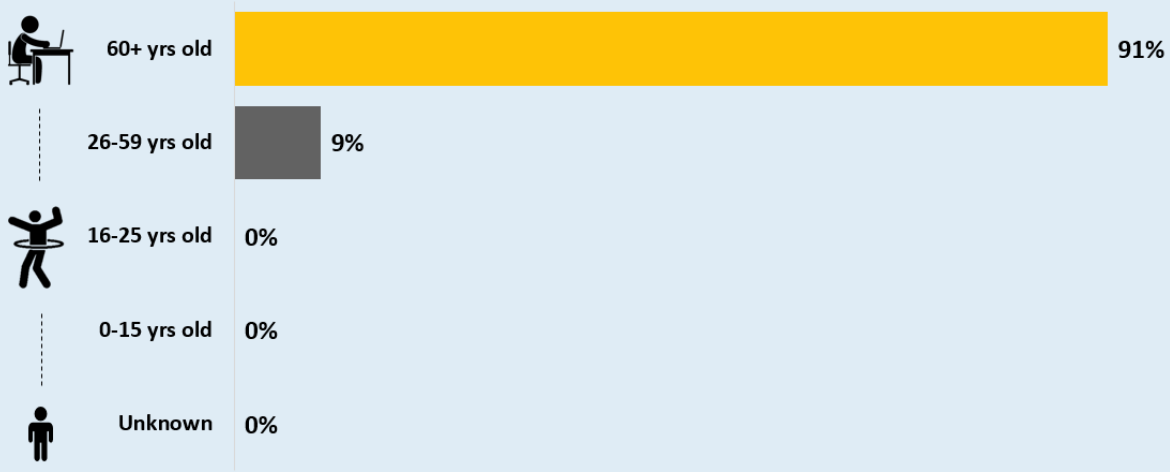
Increase network of community support services

- Increase number of collaborative partners
- Increase coordination of care

Fiscal Year 2018/19 Program Demographics

Age:

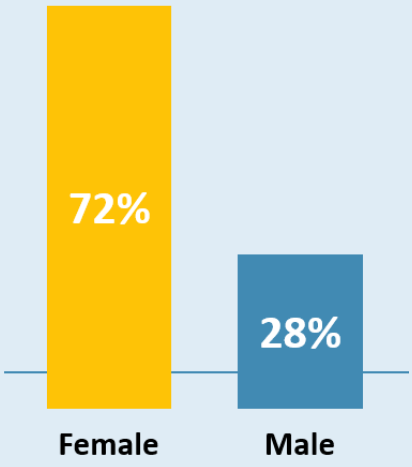
The graph below illustrates the ages of the Age Wise participants. The majority of participants served, 91%, were ages 60+ and the second largest group was between the ages 26-59 years old at 9%. There were no participants who identified as ages 0-15 and 16-25 years old, or as unknown or declined to state. This graph is representative of the Age Wise target population of older adults being the majority served.



N=118

Gender:

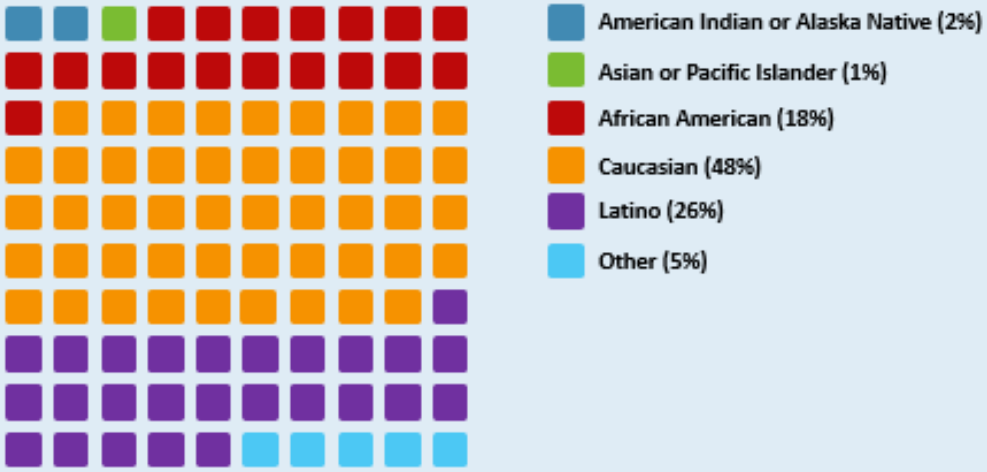
The graph below demonstrates that 72% of Age Wise participants identified as female and 28% identified as male. None of the participants declined to state, or identified as transgender, non-binary, gender queer, or other not listed.



N=118

Ethnicity and Ancestry:

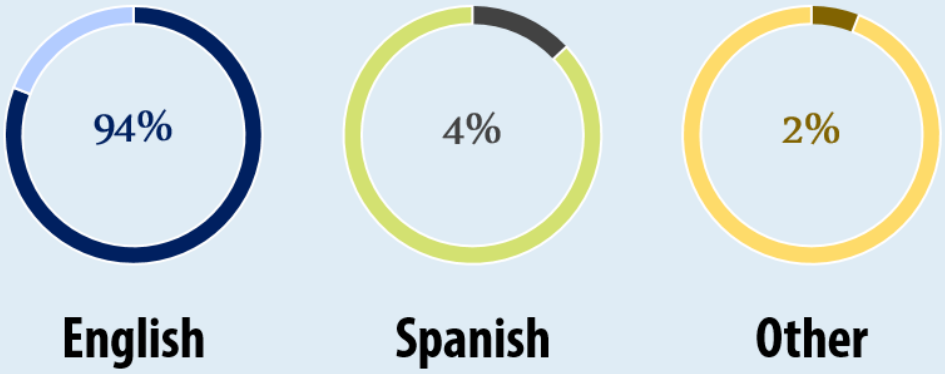
The graph below illustrates the various ethnicities of participants of the Age Wise program. The largest group of participants was 48% in the category of Caucasian. The second largest category was Latino at 26%. Following that, 18% identified as African American, and an additional 2% identified as American Indian or Alaska Native. Finally, 1% identified as Asian or Pacific Islander. Additionally, 5% identified as Other. This category includes those who identified as other, more than one race, or declined to answer.



N=118

Primary Language:

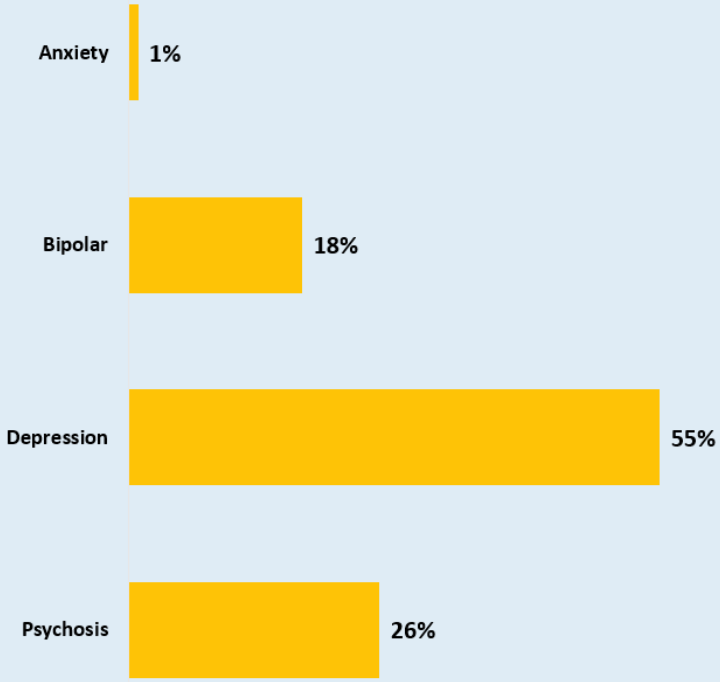
The graph below demonstrates that 94% of Age Wise participants identified English as their primary language. Additionally, 4% identified Spanish as their primary language, and 2% identified their primary language as something other than English or Spanish.



N=118

Primary Diagnosis:

The graph below illustrates the diagnostic groups of Age Wise participants who received services. Most of the participants of Age Wise services fall under the category of Depression at 55%. The second largest category was Psychosis at 26% followed by Bipolar at 18%. Finally, 1% fell under the category of Anxiety.



N=118

"I am so glad I can call you and get the resources I need."

- Age Wise Consumer

Positive Results

San Bernardino Central Valley Area:

- One new older adult was placed in safe and permanent subsidized housing, one was placed into a skilled nursing facility due to increased medical issues to provide the necessary services and the remaining 73 maintained safe and permanent supportive housing.

High Desert Area:

- During FY 2018/19, of 34 consumers, one was placed in License Board and Care, one was placed into a low income subsidized housing and the remaining 32 maintained in safe housing.
- Of the 34 consumers served, 91% of the consumers were able to avoid unnecessary hospitalization.

Additional Outcomes:

- 100% of consumers served by Age Wise maintained appropriate stable housing.
- 88% of consumers are stable and can seek outside assistance to locate their own resources. Family supports among these consumers vary in frequency and duration, as it relates to family tolerance.
- 100% of consumers are linked to their Primary Care Physicians (PCPs).

"The person who answers your phone brightens my day."

- Age Wise Consumer

Program Challenges

A pressing concern for the older adult population, as they retire on a limited income, is affordable housing. That issue, coupled with the loss of lifelong support persons through illness, death, and managing medical issues of their own, presents great challenges. With the sharp increase of individuals within this age demographic, social service systems and programs are likely at the cusp of an era of being overwhelmed with a demand for services and resources.

Reliable transportation to needed resources also remains a challenge, especially in the more rural areas, such as the High Desert, where resources tend to be scarce and spread across vast geographic distances.

Another area of concern is the rise of financial elder abuse by means of scams perpetrated by increasingly sophisticated, technologically savvy, individuals who utilize fear tactics or lures of significant enrichment to bait vulnerable seniors.

And lastly, the vulnerability of elders to the dangers of dependence and addiction to substances, whether prescribed, legal or illicit, remains a growing concern, and factors into the necessity and challenge of obtaining clear and accurate diagnoses, in order to properly address the impairing behaviors and issues being manifested.

Success Story

"Jason" walked into the Adult Protective Services (APS) office completely overwhelmed because he was unable to buy groceries and pay his utilities due to unexpectedly losing his income. Jason became depressed and suicidal, and was taken to a Crisis Walk-In Center (CWIC) for evaluation and stabilization. APS staff referred Jason to Age Wise for additional services and support. Age Wise staff began working with him and provided him support in getting his life back on track. Through his participation with Age Wise, Jason received therapy to address his depression and isolation, received assistance in securing Social Security to provide a source of income, was linked to medical services to establish regular ongoing medical care and linked to community activities to help him gain socialization. With tears in his eyes, Jason expressed to Age Wise staff how grateful he was for their assistance at a time when he was depressed, completely overwhelmed and didn't know what to do to help himself.

Program Solutions

In addition to providing needed mental health treatment solutions via comprehensive assessments, treatment plans, and ongoing services, the Age Wise staff is working diligently to address the housing issue by educating consumers on the current availabilities of affordable housing, facilitating housing resolutions by placing consumers on wait lists, and continually monitoring and following up for all possible solutions (e.g. MHSA housing availabilities, apartments and rooms for rent, subsidized housing, Section 8 listings, etc.). Once settled in housing, Age Wise staff continues working with consumers to maintain their housing through consumer advocacy and consultation with property managers, landlords, and other involved parties.

To address transportation issues, Age Wise staff provides education, training, and ongoing consultation to link consumers to available resources while also providing the much needed transportation for necessary appointments when other means are not convenient or available.

Education is also provided to minimize vulnerability to financial scams and other types of elder abuse. Finally, Age Wise staff takes on a consultative role with physical and psychiatric health care providers to ensure they receive the accurate and current information relevant to their treatment provision for mutually shared consumers.

Success Story

"Maya" was a non-English speaking consumer suffering with mental illness. She reported that despite serious medical issues, she simply had no motivation to care for herself. She was guarded, withdrawn, and resistant. Over time, both clinician and the interpreter began to forge a very strong and therapeutic rapport.

Maya began to commit to services and invest in her wellbeing. As the therapist and interpreter team continued, she began to feel comfortable enough to converse without fear of being judged. She stated that she felt comfortable with the services she was receiving and continues to build on the empowerment, resilience, self-determination and self-actualization to move ahead with tenacity and grace.

Collaborative Partners

- Barstow Counseling
- Behavioral Health Integrated Complex Care
- Cash Assistant Program for Immigrants (CAPI)
- Catholic Charities
- Community Action Partnership (CAP)
- In Home Supportive Services (IHSS), Adult Protective Services (APS) Programs
- Habitat for Humanity
- Home Energy Assistance Program (HEAP)
- Humane Society
- Loveland Food Pantry
- Mary's Table
- Mission City Psychiatric Care
- Rock Church
- Rolling Start
- Salvation Army
- St. Joan of Arc
- St. John of God
- Tender Hearts
- Victor Valley Behavioral Health

"If it wasn't for Age Wise, I don't know where I would be by now."

- Age Wise Consumer

Housing and Homeless Services Continuum of Care Program (A-7)

The Housing and Homeless Services Continuum of Care Program (HHSCCPs) is comprised of programs that include consumer and family services such as peer support, education, and advocacy services; provide intensive outreach and engagement and seamless transition o treatment for MHSA populations; and offer permanent supportive housing coupled with intensive treatment to serve persons living with serious mental illness and their families who are homeless or at risk of homelessness.

The intent of these programs are to engage consumers and families as active participants in their care, provide increased access to effective services that are continually reviewed and revised to meet the needs of underserved groups, increase self-help and consumer/family involvement, and increase a network of community supports.

Artwork by Nancy Corona

Target Populations

The table below represents the target populations to be served by the Housing and Homeless Services Continuum of Care Program.

Housing and Homeless Services Continuum of Care Program				
Program Name	**Target Population**			
	Children	**TAY**	**Adults**	**Older Adult**
Adult Residential Facilities Certified in Social Rehabilitation Services		X	X	X
Community Reintegration Services (CRS)		X	X	X
Enhanced Assisted Living Program		X	X	X
Homeless Outreach Support Team (HOST)		X	X	X
Housing Services Program		X	X	X
Employment Services Program		X	X	X

Artwork by Evandro Yanes

Housing and Homeless Services Continuum of Care Program (A-7)

The Housing and Homeless Services Continuum of Care Program (HHSCCP) formerly known as Homeless Assistance Resource and Treatment (HART), is a continuum of services for individuals that are at-risk of homelessness, chronically homeless, or are homeless and living with a serious mental illness and/or substance use disorder. The HHSCCP works in conjunction with the county-wide Coordinated Entry System (CES) and other County and community partners to provide a full system of care to its homeless residents.

In Fiscal Year 2016/17, all homeless services for were restructured as a stand-alone program and was expanded to include Full Service Partnership Supportive Services. The program continues to undergo further changes to meet the expanding needs of the community. In Fiscal Year 2019/20, all services were restructured and renamed to HHSCCP. HHSCCP now includes: Outreach and Engagement, Community Outreach and Response, Housing Navigation, Emergency Shelter and Bridge Housing, Emergency Shelter Case Management, and Permanent Supportive Housing Full Service Partnership Supportive Services.

Artwork by Eric Olinger

Projected Number to be Served

The tables below represent the projected number of consumers to be served by the Housing and Homeless Services Continuum of Care Program (HHSCCP) for the upcoming three fiscal years (Fiscal Years 2020/21 - 2022/23). For each fiscal year, the projected total is broken up into two MHSA categories: age and service category.

MHSA age categories are: Children, TAY, Adult, and Older Adult. MHSA service categories are: Full Service Partnership (FSP), General System Development (GSD), and Outreach and Engagement (O&E).

Program	Fiscal Year	Ages Served	Service Area	Total Served
Housing and Homeless Services Continuum of Care Programs	2020/21	• 7 TAY FSP • 566 Adult FSP • 139 Older Adult FSP	• 712 FSP • 465 GSD • 375 O&E	**1,552**
	2021/22	• 7 TAY FSP • 599 Adult FSP • 139 Older Adult FSP	• 745 FSP • 465 GSD • 375 O&E	**1,585**
	2022/23	• 7 TAY FSP • 612 Adult FSP • 139 Older Adult FSP	• 758 FSP • 465 GSD • 375 O&E	**1,598**

*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 mental health services offered and linking consumers to the appropriate services.

Homeless Outreach and Engagement

The Homeless Outreach and Support Team (HOST) provides outreach and engagement to consumers experiencing homelessness with a focus on those that are living with a mental illness and/or substance use disorder. The program promotes the principles of recovery, wellness, and resilience to support individuals on the road to living more satisfying, hopeful, and fulfilling lives, based on their own personal values and cultural framework. Services focus on the consumer's strengths and abilities and assists with linkages to appropriate community resources.

HOST staff also "ride along" with the San Bernardino County Sheriff's Homeless Outreach Proactive Enforcement (HOPE) team and other law enforcement. Homeless Outreach and Support Team is currently supporting Redlands, Rialto and Fontana Police Departments in their efforts to assist their homeless citizens.

Activity Type	Number of Activity Type	Total Number of Participants
Outreach and Engagement in the field along Law Enforcement	79	234
Specific Site Outreach and Engagement (i.e., community fairs, health fairs, etc.)	2	50
Total	**81**	**284**

Community Outreach and Response

The Homeless Outreach and Support Team (HOST) provides consultation to community partners, provides resources and information at community events, and provides expertise with other Outreach and Engagement Teams in working with the seriously mentally ill.

Housing Navigation

Homeless Outreach and Support Teams also act as Housing Navigators for the Housing Authority of the County of San Bernardino (HACSB). When HACSB has a Permanent Supportive Housing Voucher available, they notify the County's Coordinated Entry System (CES) which then generates a referral. This referral is then given to HOST to locate the individual and assess if they meet the behavioral health requirement. Once the individual's eligibility is determined, HOST staff work with their new consumer to assist them in navigating the housing system culminating in permanent housing. HOST then links and hands off the newly housed individual to their new Supportive Services staff.

Success Story

"Alex" was living behind a dumpster when he was approached by the Homeless Outreach and Support Team. Alex had been homeless for the five years. Alex was eventually able to secure housing after working with HOST. Today, Alex continues to be housed and plans on reuniting with his father. In discussing these plans he noted, "I haven't seen my father in four years. I didn't want to see him and still be homeless. Now I can go see him and tell him that I'm getting my life together."

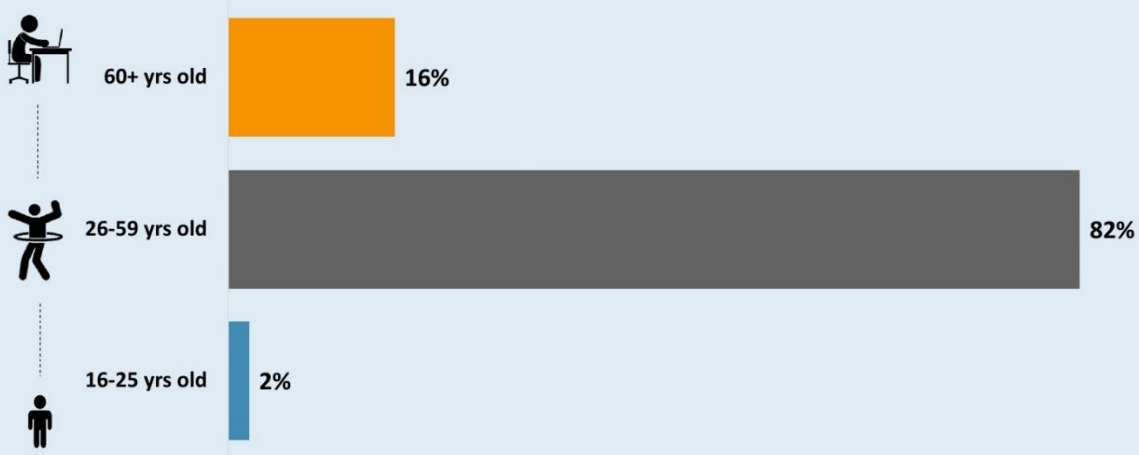
Artwork by Manuel Cordoba

Fiscal Year 2018/19 Program Demographics

Homeless Outreach and Support Team (HOST)

Age:

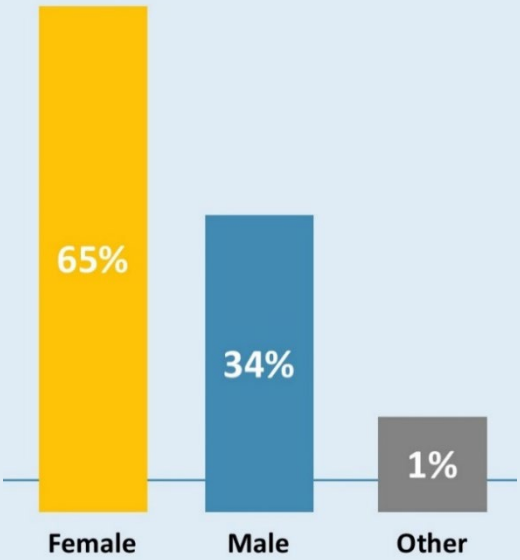
The graph below illustrates the ages of the consumers in the HOST program. The majority of participants served, 82%, were between the ages of 26-59 years old. The second largest group at 16%, were consumers identified as being 60+. Only 2% of consumers identified as being between the ages of 16-25 years old.



N=320

Gender:

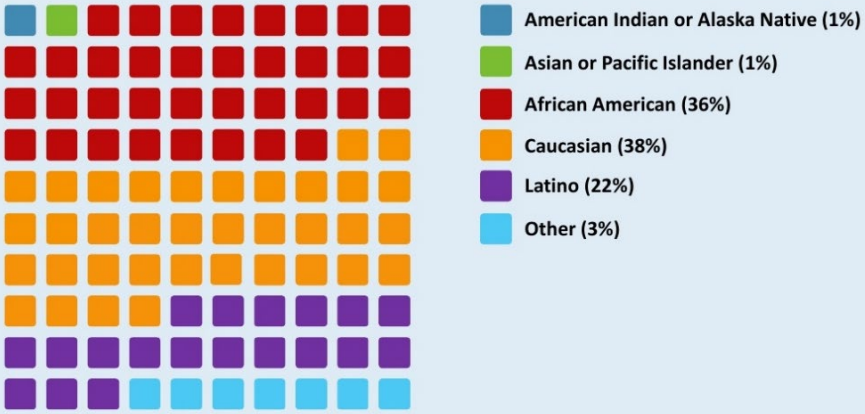
The graph below demonstrates that 65% of consumers in the HOST program identified as female, 34% identified as male, and 1% Unknown.



N=320

Ethnicity and Ancestry:

The graph below illustrates the various ethnicities of consumers of the HOST program. The largest group of participants were the Caucasian category at 38% and the African American category at 36%. The second largest group were Latinos at 22%. The remaining 5% identified as American Indian or Alaska Native at 1%, and Other/Unknown at 3%. The Other/Unknown category includes those who identified as other, more than one race, or declined to answer.



N=320

Primary Language:

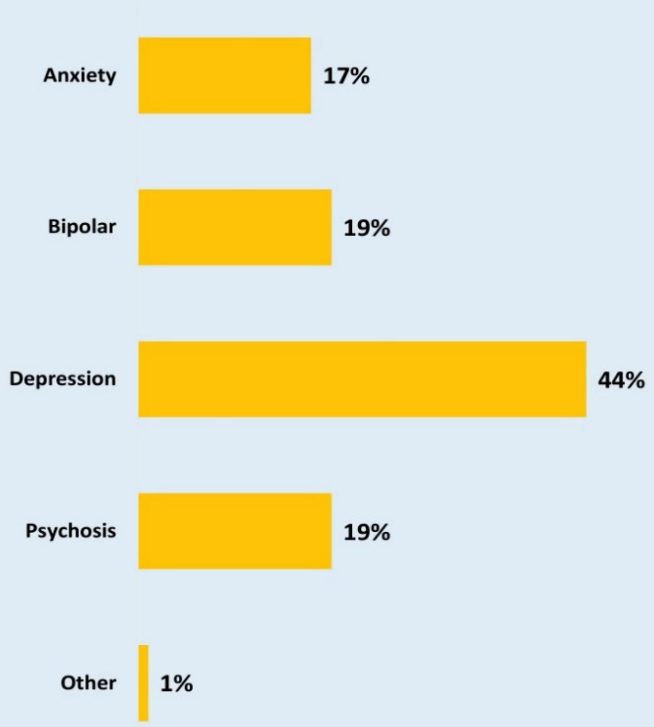
The graph below demonstrates that 94% of HOST consumers identified English as their primary language. The other 5% of consumers identified their primary language as either Spanish at 2%, or other at 4%.

N=320

CSS: HOUSING AND HOMELESS SERVICES CONTINUUM OF CARE PROGRAM

Primary Diagnosis:

The graph below illustrates the diagnostic groups of HOST consumers who received transitional services. The majority of the consumers' primary diagnosis was Depression at 44%, followed by Bipolar and Psychosis both at19%, and Anxiety at 17%. Other diagnosis were identified as 1%.



N=320

Success Story

"Janice" and her two sons were homeless and lived in their car, motels, and numerous shelters over a two year period. Janice often worried and thought about how she would feed her family or where they would sleep next.

After meeting the Homeless Outreach and Support Teams she was able to get treatment for her mental illness and eventually found a home. Her HOST case manager helped Janice to achieve stable housing. Janice shared that both of her sons were excited about having their own room in their new home. Janice's future plans now include getting a job and eventually going back to school so she can "better provide for my sons".

Emergency Shelter Services

Emergency Shelter and Bridge Housing

DBH has emergency shelter beds for consumers that are living with a serious mental illness and/or substance use disorders. There are currently 261 emergency shelter beds that serve Transitional Age Youth (TAY), Adults, Older Adults and Criminal Justice involved Adults. These shelter beds are located throughout the County and are owned and operated by DBH Contracted Vendors. Referrals to these shelter beds are made through DBH programs. Eligible consumers must be homeless, without income, are already or willing to participate in treatment services, and they must be able to manage their own activities of daily living.

DBH Emergency Shelter Services Staff are also responsible for the contract monitoring and oversight of the contracted vendors. Staff regularly visit DBH emergency shelter sites to ensure that they are safe, and meet contract requirements.

Emergency Shelter Case Management

DBH Emergency Shelter Services Staff provide consumers with ongoing, intensive case management which includes, housing planning, assistance in navigating housing resources, and linkages to community and County resources. Consumers are also linked to employment services or given assistance in obtaining entitlements and benefits, e.g., Social Security Income.

Permanent Supportive Housing

Full Service Partnership Supportive Services

The Department of Behavioral Health is responsible for providing Supportive Services for the County's Permanent Supportive Housing (PSH). DBH and its contractors are currently serving:

- MHSA Housing – 54 consumers on 5 sites (42 additional older adult consumers are being served by the Department of Aging and Adult Services – Age Wise program)
- Tenant-Based Vouchers from HASCB – 350
- Project-Based Vouchers from HASCB – 52
- Master Leased Units – 14
- Golden Apartments – 32 (Supported by contract with Mental Health Services, Inc.)
- Tenant-Based and Project-Based Vouchers from Step Up on Second – 121

Supportive Services include:

- Intensive and ongoing case Management.
- Linkages to health services (mental health, substance use disorder, medical, and dental).
- Assistance with accessing benefits and entitlements to assist the consumer in securing assistance from programs where they meet eligibility requirements, such as Social Security Income.
- Employment services including assessment for employment, group job skills training, and employment leads.
- Social supports coordination and referrals such as DBH clubhouse and other entities.
- Other linkages as identified by consumers.

These voluntary supportive services are provided to all consumers that are housed in Permanent Supportive Housing for as long as needed. Consumers that maintain their housing stability and are appropriately linked and served by their community are able to terminate from services. Consumers are always welcome to reach out for additional supports as their needs change.

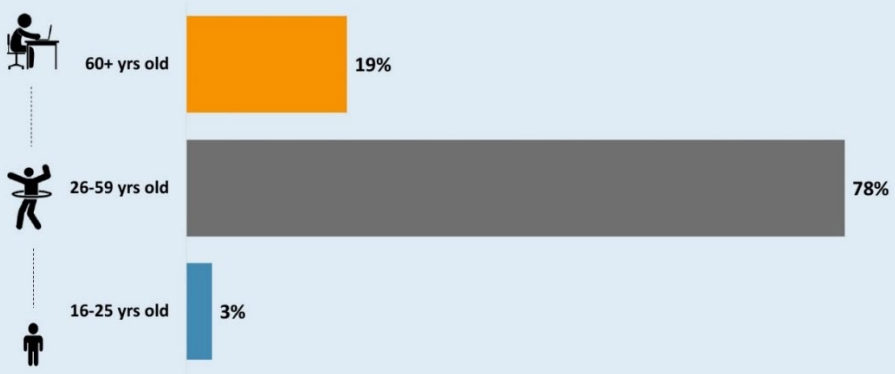
Fiscal Year 2018/19 Program Demographics

Permanent Supportive Housing Full Service Partnership Supportive Services

(The data reflected below in each demographic category is for FSP housing services provided by Step-Up on Second)

Age:

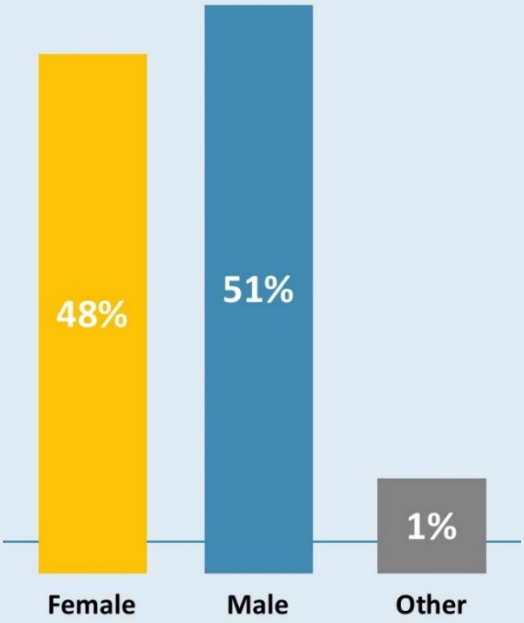
The graph below illustrates the ages of the consumers in the FSP program. The majority of participants served, 78%, were between the ages of 26-59 years old. The second largest group at 19%, were consumers that were 60+ years old. Only 3% of consumers identified as being between the ages of 16-25 years old.



N=149

Gender:

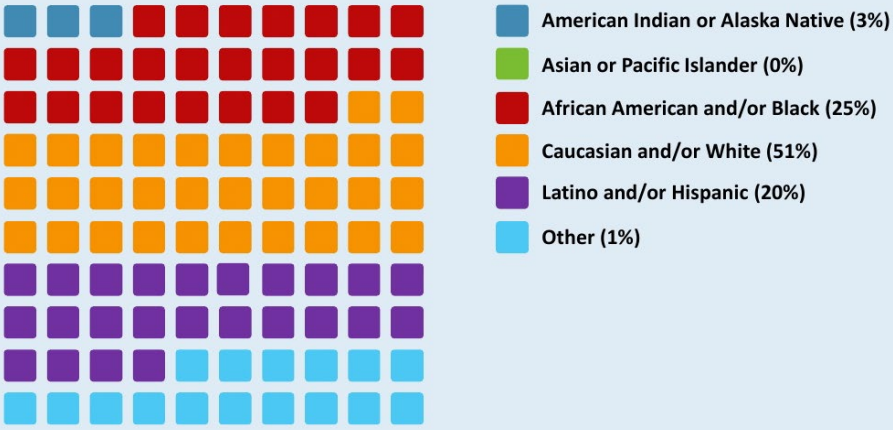
The graph below demonstrates that 51% of consumers in the FSP program identified as male, 48% identified as female, and 1% were identified as unknown.



N=149

Ethnicity and Ancestry:

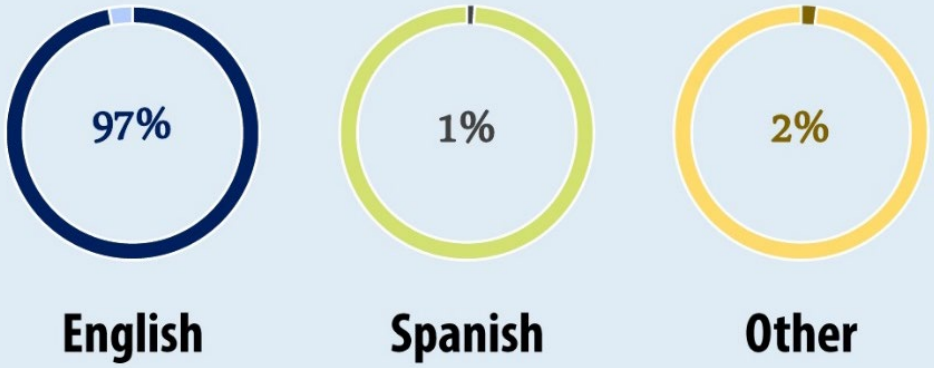
The graph below illustrates the various ethnicities of consumers in the FSP program. The largest group of participants was 51% in the category of Caucasian. The second largest category was African American at 25%. Following that, 20% identified as Latino. Finally, the remaining 4% identified as American Indian or Alaska Native 3% and Other/Unknown at 1%. The Other/Unknown category includes those who identified as other, more than one race, or declined to answer.



N=149

Primary Language:

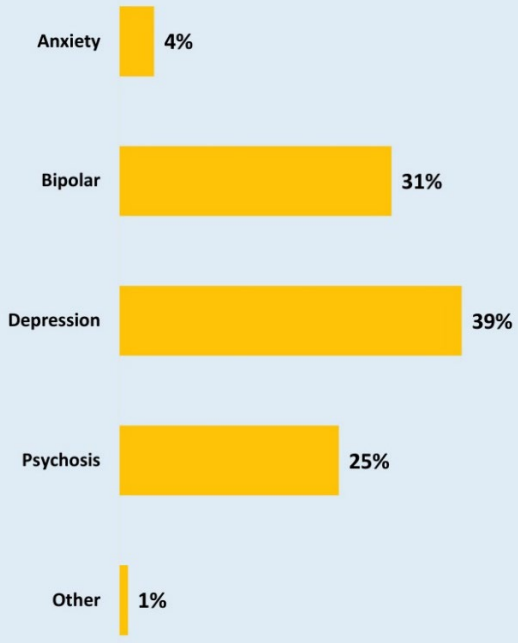
The graph below demonstrates that 97% of FSP consumers identified English as their primary language. The other 3% of consumers identified their primary language as either Spanish at 1%, or other at 2%.



N=149

Primary Diagnosis:

The graph below illustrates the diagnostic groups of FSP consumers. The primary diagnosis of the majority of consumers' was Depression at 39%, Bipolar at 31%, and Psychosis at 25%. The other two primary diagnosis was Anxiety at 4% and other at 1%



N=149

MHSA Legislative Goals and Related Key Outcomes

Reduce the subjective suffering from serious mental illness for adults:

- Improved life satisfaction
- Decreased hopelessness/increased hope
- Increased resiliency

Reduce Homelessness and increase safe and permanent housing:

- Decrease rates of homelessness for consumers
- Increased residence stability and safe and permanent housing

Reduce the frequency of emergency room visits and unnecessary hospitalizations:

- Reduced number of emergency room visits for mental health concerns
- Increased use of alternative crisis interventions

Increase network of community support services:

- Increase in number of collaborative partners
- Increase self-help/support/12-step/community/school group or healthcare provider attendance and frequency per consumer
- Increased coordination of care

Positive Results

- The Homeless Outreach and Support Team is increasing the number of law enforcement agencies that they “ride along” with to provide outreach and engagement and case management to the County’s homeless residents.
- DBH and DBH contractors currently support 663 in Permanent Supportive Housing. This is an increase of 77 consumers that have been housed in the past fiscal year.
- There are currently four developers working with the County to build new affordable housing. DBH will provide the supportive services for these additional 129 Permanent Supportive Housing units.
- DBH Emergency Shelter Beds provide 95,265 safe bed nights/year to homeless residents living with serious mental illness.

“I never thought I would have my own place again and actually be happy.”

-HOST Consumer

CSS: HOUSING AND HOMELESS SERVICES
CONTINUUM OF CARE PROGRAM

Program Challenges

- There is not enough affordable housing to house our homeless population.
- Housing funding prioritization currently focuses on providing Permanent Supportive Housing (PSH) for chronically homeless individuals only. This leaves those individuals who live with a serious mental illness and/or substance use disorder and are at-risk for homelessness or homeless for less than a year with very few resources.
- There is a lack of shelter and housing for consumers with pets and for unaccompanied women.
- There is a lack of resources to assist those experiencing chronic homelessness to apply for Social Security Income.

Program Solutions

- A pilot program is being conducted to work with our chronically homeless consumers in receiving Social Security Income. This allows consumers that have not been linked to services in the past to gain access to a psychologist with knowledge of homeless culture, trauma and serious mental illness to complete an application. The goal is to allow the psychologist to address gaps in treatment, to expedite and to better assist homeless consumers who are applying to qualify for benefits.
- The Coordinated Entry System (CES) is working with County partners to meet the needs of the community. This includes being able to access referrals by region and funding resource.
- DBH currently has funding to assists consumers with application and credit check fees, holding deposits, move-in costs, utility deposits, and provides basic “welcome home” supplies for consumers upon move in.
- The Housing Urban Development (HUD) department has shifted their population focus from veterans only to now include the chronically homeless unaccompanied women category. This additional funding will allow DBH to better service the unaccompanied women population.

Housing

No Place Like Home (NPLH)

On July 1, 2016, the Governor of California passed legislation enacting the No place Like home (NPLH) program. The program uses a percentage of existing Mental Health Services Act (MHSA) monies allocated to counties and captures a percentage of these monies prior to distribution to counties to be used to develop permanent supportive housing, specifically for personal living with a behavioral health condition and who are also experiencing literal homelessness, chronic homelessness, or who are at-risk of homelessness. Additionally, the state has declared California housing first state, supporting the removal of eligibility barriers that traditionally may have acted as obstacles to housing. The No Place Like Home (NPLH) program aligns with the housing first approach to help increase the number of permanent supportive housing units available and to quickly and successfully connect individual and families who are experiencing homelessness with permanent supportive housing. San Bernardino County adheres to the housing first policy that supports low barrier access to housing.

DBH has received input and feedback from its stakeholders, identifying the regions in the county where housing is needed and is currently in the process of working with other County departments to develop a strategic plan for the development of new permanent supportive housing projects based on stakeholder input. The County is currently supporting two developers in applying for both competitive and non-competitive NPLH funding.

"A wide range of housing project are needed to meet the specific needs of our homeless community. Flexibility in housing options and how these options are accessed at the service level is important."

-Community Stakeholder

MHSA Housing

The Mental Health Services Act (MHSA) Housing Program provides funding for the capital costs and operating subsidies to develop Permanent Supportive Housing for individuals living with a serious mental illness who are homeless, or at risk of homelessness, and who meet the MHSA Housing Program target population(s) which are defined as adults, transition-age youth with serious mental illness, children with severe emotional disorders and their families. The MHSA Housing Program was jointly launched in 2007 by the former California Department Mental Health (State DMH), now the Department of Health Care Services (State DHCS) and the California Housing Finance Agency (CalHFA) to support the development of housing for individuals with serious mental illness and their families who are at-risk of being homeless or homeless.

DBH currently supports seven MHSA Housing Projects that include 94 Permanent Supportive Housing units. These units are for those who are living with a serious mental illness and/or substance use disorder.

Horizons at Yucaipa

Collaborative Partners

- Community Development and Housing Agency (CDHA)
- Contracted Vendors for Emergency Shelter Beds
- Creating Community Solutions
- Fontana Police Department
- Housing Authority of the County of San Bernardino
- Inland Housing Solutions
- Knowledge and Education for Your Success (KEYS)
- Lighthouse Social Services
- Mental Health System, Inc.
- Office of Homeless Services
- Redlands Police Department
- Rialto Police Department
- San Bernardino County Homeless Partnership
- San Bernardino County Sheriff's Department Hope Team
- Step-Up on Second
- United Way (*211 Coordinated Entry System)
- US Vets
- Valley Star
- Veteran's Affairs

DBH's Homeless Outreach Support Team (HOST)

Employment Services

In Fiscal Year 2019/20, the Employment program was restructured as a stand-alone program within the Housing and Homeless Services Continuum of Care, to better serve and streamline employment services for consumers that had an interest in securing employment, volunteer opportunities, and to increase the overall number of DBH consumers that were employed. The employment staff, through an agreement with the Department of Rehabilitation (DOR), coordinate and provide consumers employment education to promote job search skills, including an overview of the soft skills that are necessary to secure and to maintain employment. These strategies build on and work in conjunction with each other to provide consumers with the necessary skills and supports needed to secure a paid or volunteer position as they move towards self-efficacy and self-sufficiency, and as a consumer moves through their own path towards recovery.

Artwork by Stephanie Bañuelos

Projected Number to be Served

The tables below represent the projected number of consumers to be served by the Employment program for Fiscal Years 2020/21-2022/23. For each fiscal year, the projected total is broken up into two MHSA categories: age and service.

MHSA age categories are: Children, TAY, Adult, and Older Adult. MHSA service categories are: Full Service Partnership (FSP), General System Development (GSD), and Outreach and Engagement (O&E).

Fiscal Year		Projected No. of Consumers and Services			
Housing, Long-Term Supports, and Transitional Care Employment Program					
2020 – 21	**Age**	**TAY**	**Adult**	**Older Adult**	**TOTAL**
		45	**215**	**10**	**270**
	Services	**GSD**	**O&E**	**FSP**	**TOTAL**
		270	**0**	**20**	**290**
2021 – 22	**Age**	**TAY**	**Adult**	**Older Adult**	**TOTAL**
		45	**215**	**10**	**270**
	Services	**GSD**	**O&E**	**FSP**	**TOTAL**
		270	**0**	**20**	**290**
2022 – 23	**Age**	**TAY**	**Adult**	**Older Adult**	**TOTAL**
		45	**215**	**10**	**270**
	Services	**GSD**	**O&E**	**FSP**	**TOTAL**
		270	**0**	**20**	**290**

MHSA Legislative Goals and Related Key Outcomes

Reduce the subjective suffering from serious mental illness for adults:

- Improved life satisfaction
- Decreased hopelessness/increased hope
- Increased resiliency
- Decreased impairment in the general areas of life functioning (e.g., health/self-care/housing, occupation/education, legal

Reduce Homelessness and increase safe and permanent housing:

- Decrease rates of homelessness for consumers
- Increased residence stability and safe and permanent housing

Reduction in criminal and juvenile justice involvement:

- Decreased rate of incarcerations
- Reduced jail/prison recidivism

Reduce the frequency of emergency room visits and unnecessary hospitalizations:

- Reduced rate of emergency room visits for mental health concerns
- Increased use of alternative crisis interventions (e.g., CWIC, CCRT,CSU)

Increase a network of community support services:

- Increase in number of collaborative partners
- Increase in self-help/support/12-step/community/school group or healthcare provider attendance and frequency per consumer

Positive Results

- In Fiscal Year 2018/19 there were 36 DBH consumers that were successfully employed.
- A consumer who was successful in securing employment in working with DBH's Employment program, was recently highlighted in a video that was featured on DBH's Facebook page.

Program Challenges

- The Employment staff is working to educate and inform other entities or groups that are not familiar with mental health conditions.
- There is currently a lack of adequate space within the clinics to hold regular groups and employment seminars to assist and develop consumers.

Program Solutions

- The Employment staff have increased their outreach efforts to employers to engage them in hiring consumers.
- The Employment staff is working to identify additional meeting locations for groups and workshops and is considering using some of DBH's contracted provider locations.
- The Employment staff is working to improve department awareness of employment services.

Success Story

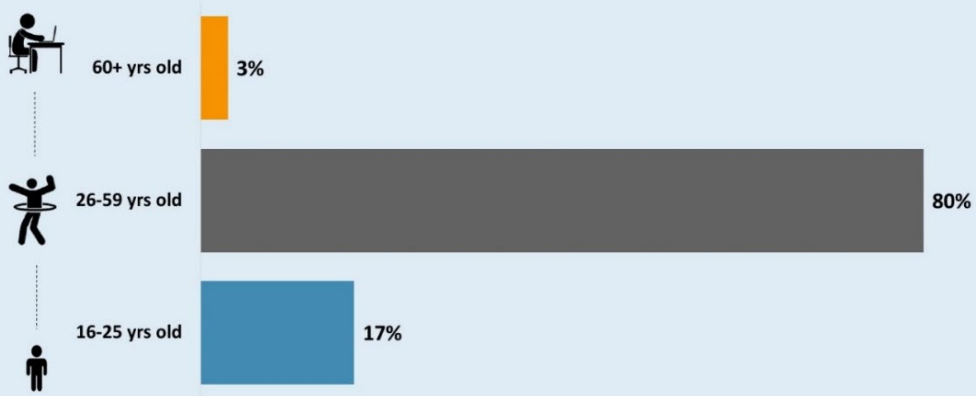
"Larry" was referred to the employment program as he was eager to start working in any capacity. Due to his mental illness, Larry had been unable to work for many years. Larry worked with the employment team to set goals, to identify job leads, and also worked with them to create his employment documents including a resume and cover letter. The employment team also worked with him on refining his interviewing skills and regularly conducted mock interviews where Larry could practice his responses.

Today, Larry works at a local restaurant and is doing well in his position. Larry's long-term goal is to work as a Peer and Family Advocate (PFA) for DBH and he plans on applying soon.

Fiscal Year 2018/19 Program Demographics

Age:

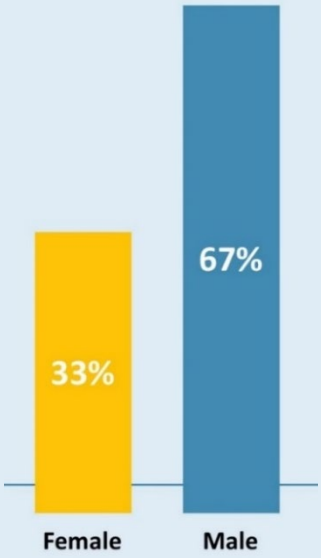
The graph below illustrates the ages of the consumers in the Employment program. The majority of participants served, 80%, were between the ages of 26-59 years old. The second largest group at 17%, were consumers between the ages of 16-25 years. Only 3% of consumers identified as being 60+.



N=348

Gender:

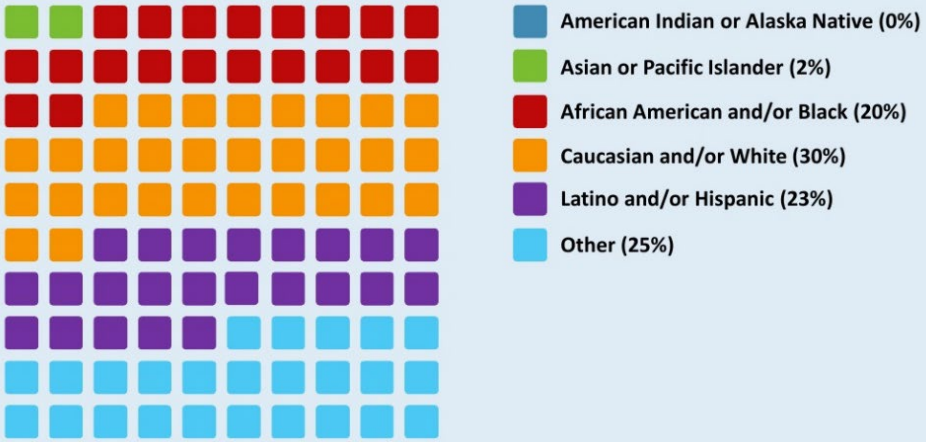
The graph below demonstrates that 67% of consumers in the Employment program identified as male and 33% identified as female.



N=348

Ethnicity and Ancestry:

The graph below illustrates the various ethnicities of consumers of the Employment program. The largest group of participants was 30% in the category of Caucasian. The second largest category was Latino at 23%, followed by those who identified as African American at 20%. Finally, the 2% identified as Asian or Pacific Islander and the remaining 24% identified as Other/Unknown. The Other/Unknown category includes those who identified as other, more than one race, or declined to answer.



N=348

Primary Language:

The graph below demonstrates that 77% of consumers in the Employment program identified English as their primary language. Additionally, 3% identified Spanish as their primary language, and 20% identified their primary language as something other than English or Spanish.

N=348

Collaborative Partner

- California Department of Rehabilitation (DOR)

Artwork by Cat French

Adult Transitional Care Programs (A-13)

Adult Transitional Care Programs are a continuum of behavioral health services designed to serve unique 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 below described programs have been grouped together to better streamline services and improve overall care. Services under this continuum implement a strength-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.

Services in this continuum include comprehensive medical and psychiatric services designed to promote skill building and Activities of Daily Living (ADL) to assist consumers to move toward new levels of functioning in the community. The subcomponents that comprise the continuum of services in each program range from specialized rehabilitative psychiatric mental health care in a long term or transitional residential setting, services to assist consumer's 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.

The Adult Transitional Care program is comprised of three focus areas:

- Adult Residential Facilities Certified in Social Rehabilitation Services
- Community Reintegration Services
- Enhanced Assisted Living Program

Artwork by Sonia Stockton

Projected Number to be Served

The tables below represent the projected number of consumers to be served by the Adult Transitional Care programs for the upcoming three fiscal years (Fiscal Years 2020/21 - 2022/23). For each fiscal year, the projected total is broken up into two MHSA categories: age and service category.

MHSA age categories are: Children, TAY, Adult, and Older Adult. MHSA service categories are: Full Service Partnership (FSP), General System Development (GSD), and Outreach and Engagement (O&E).

Adult Transitional Care Programs

Program	Fiscal Year	Ages Served	Service Area	Total Served
Adult Residential Facilities Certified in Social Rehabilitation Services	2020/21	• 108 Adults	• 108 GSD	**108**
	2021/22	• 108 Adults	• 108 GSD	**108**
	2022/23	• 108 Adults	• 108 GSD	**108**
Community Reintegration Services (CRS)	2020/21	• 50 Adult FSP	• 50 O&E	**50**
	2021/22	• 50 Adult FSP	• 50 O&E	**50**
	2022/23	• 50 Adult FSP	• 50 O&E	**50**
Enhanced Assisted Living Program	2020/21	• 5 Adult FSP	• 5 FSP	**5**
	2021/22	• 5 Adult FSP	• 5 FSP	**5**
	2022/23	• 5 Adult FSP	• 5 FSP	**5**

*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 mental health services offered and linking consumers to the appropriate services.

Adult Residential Facilities Certified in Social Rehabilitation Services

The Adult Residential facilities are certified through the state to deliver Social Rehabilitation services, which provide for specialized rehabilitative psychiatric mental health treatment in a long-term or transitional residential setting for adult consumers. Adults who enter this program have been discharged from higher level placements such as acute psychiatric hospitals and Institutions for Mental Disease (IMD) or are consumers for whom the traditional board and care level of care was unsuccessful, including enhanced board and care. Long-term and transitional residential treatment facilities are necessary for consumers who are no longer in need of acute hospital-level care, but are determined to be in need of further rehabilitation prior to reintegration into the community.

DBH contracts for these structured services in an effort 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.

Artwork by Maria Esperanza

MHSA Legislative Goals and Related Key Outcomes

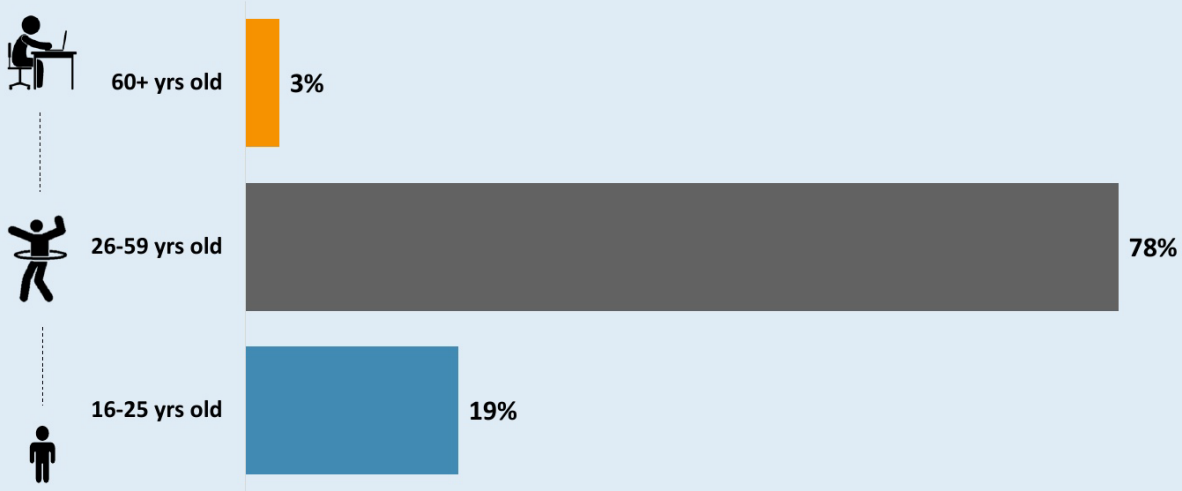
Reduce the frequency of emergency room visits:

- Reduced rate of emergency room visits for mental health concerns
- Reduced number of emergency room visits for routine medical concerns
- Reduced administrative hospital days
- Increased use of alternative crisis interventions (e.g., CWIC, CCRT, CSU)
- Increase in number of individuals diverted from hospitalizations

Fiscal Year 2018/19 Program Demographics

Age:

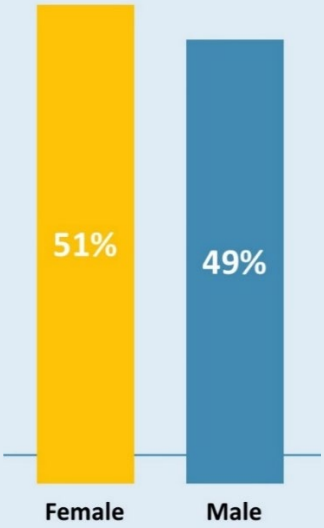
The graph below illustrates the ages of the consumers of the Adult Residential Facilities Certified in Social Rehabilitation Services program. The majority of participants served, 78%, were between the ages of 26-59 years old. The second largest group at 33%, were consumers between the ages of 16-25 years. Finally, 3% of consumers identified as being 60+.



N=97

Gender:

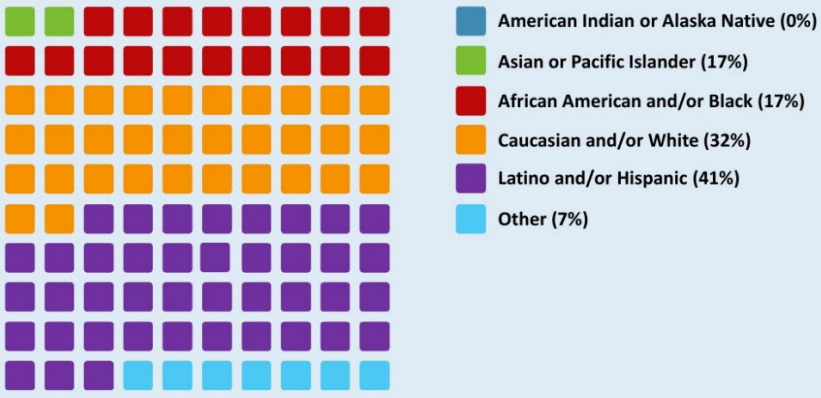
The graph below demonstrates that 51% of Adult Residential Facilities Certified in Social Rehabilitation Services program consumers identified as female and 49% identified as male. None of the consumers identified as transgender, non-binary, gender queer or other not listed.



N=97

Ethnicity and Ancestry:

The graph below illustrates the various ethnicities of consumers of the Adult Residential Facilities Certified in Social Rehabilitation Services program. The largest group of participants was 41% in the category of Latino. The second largest category was Caucasian at 32%. Following that, 17% identified as African American. Finally, the remaining 10% identified as Asian or Pacific Islander at 3% and Other/Unknown at 7%. The Other/Unknown category includes those who identified as other, more than one race, or declined to answer.



N=97

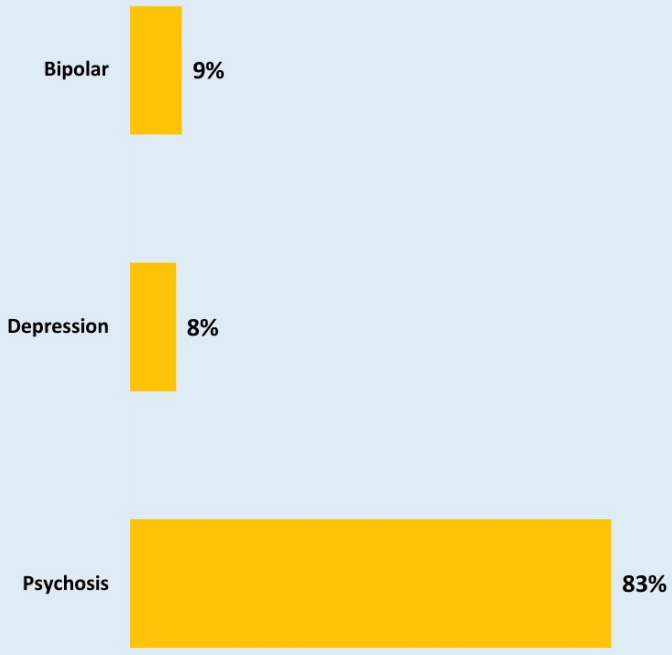
Primary Language:

The graph below demonstrates that 96% of Adult Residential Facilities Certified in Social Rehabilitation Services consumers identified English as their primary language. Additionally, 2% identified Spanish as their primary language, and 2% identified their primary language as something other than English or Spanish.

N=97

Primary Diagnosis:

The graph below illustrates the diagnostic groups of Adult Residential Facilities Certified in Social Rehabilitation Services consumers who received transitional services. Most (83%) of the consumers were primarily diagnosed under the category of Psychosis. The two second most common primary diagnosis were under the categories of Bipolar Disorders at 9% and Depression Disorders at 8%



N=97

Positive Results

- Of the 97 consumers that were served in Fiscal Year 2018/19, only 12 were hospitalized in an acute psychiatric hospital, highlighting the program's success in diverting 87% of their consumers from hospitalization.

Program Challenges

- Licensing applications and certifications are taking longer than anticipated resulting in delays.
- The recruitment of skilled direct care and administrative staff remains a challenge.

Program Solutions

- Program staff continue to communicate, collaborate, and follow up with local cities, community groups, and State entities to promote services and to enhance working relationships.
- The current contracted provider has started working with a recruitment agency to enhance the quality of new staff hires.

Artwork by Erika Montesinos

Outreach and Engagement

In Fiscal Year 2018/19, the Adult Residential Facilities Certified in Social Rehabilitation Services program organized and/or participated in the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Homeless Task Force Meeting-Mayor of Colton	3	8
Meeting with Azusa Pacific University-Contract for MSW Interns	2	4
Loma Linda University Intern Fair	2	2
SACH Health Systems-Outreach Coordination of Care Meeting	2	9
NAMI Presentation Victorville	26	26
Community Care Licensing Meeting	3	5
Presentation for the Community Crisis Response Team (CCRT)	1	10
Total	**39**	**64**

"Helping Hearts gave me another chance when other places wouldn't let me come back."

-Adult Residential Facilities Consumer

Success Story

"Laura" was a consumer who enrolled in the program after having an extended hospitalization due to medical complications. Upon admission into the program, she reported being depressed and having suicidal thoughts. While in treatment, her child and family would visit Laura to help her with bonding and to support her. Laura participated in process groups, uplifted her peers, and was able to become stabilized. After being in treatment for a year, she was terminated from conservatorship and was reunited with her child and significant other.

Today, Laura reports an improvement in her depression, self-image, and overall wellbeing. During her time in the program, Laura worked with her treatment team and put in the effort to repair the relationships she had damaged with friends and loved ones. Upon discharge, she was able to return home with family support due to the work she did around healing her relationships and support network. Laura's treatment team is proud to be part of her story and continue to support her in reaching her goals of becoming independent as she focuses on her physical, mental, and spiritual growth.

Artwork by Gabriel Horne

Collaborative Partners

- Azusa Pacific University
- California State University, San Bernardino
- Chicago School of Psychology
- Helping Hands Pantry
- Inland Empire Health Plan (IEHP)
- Local law enforcement
- Local hospitals
- Loma Linda University PsyD Program
- University of Southern California (USC) Department of Social Work

Artwork by Pilar Rodriguez

Community Reintegration Services

The Community Reintegration Services (CRS) program is designed to serve adults in San Bernardino County who are living with severe mental illness or untreated co-occurring disorders. In many cases, these consumers have recently been released from State Hospitals and/or institutionalized care. These adults are at imminent risk of homelessness, incarceration, hospitalization, or re-hospitalization if appropriate levels of care and behavioral health services are not provided as part of transitional care and institutional discharge planning. CRS promotes the principles of recovery, wellness, and resilience to assist consumers in maintaining lives that are more satisfying, hopeful, and fulfilling based on their own values and cultural framework. Services utilize a strengths-based approach by focusing on the consumer's strengths and possibilities in order to move toward new levels of functioning in the community.

Consumers requiring this level of care are often unable to maintain independence in the community without the assistance of intensive case management support. The ideal ratio of staff to consumers is one to fifteen to allow for proper support of the consumers.

Community Reintegration Services offers a true one-stop center for all available resources in one location, including, but not limited to:

- Housing, including licensed board and care homes
- Medication support services
- Intensive case management

CRS providers assist consumers to cope with behavioral health challenges by linking them to community programs and agencies through direct, one-to-one support. This intense, interactive support from case managers and other community resources benefits the CRS consumers by contributing to their increased independence and reduced psychiatric hospitalization, enhancing their overall quality of life. This holistic approach meets the consumer's needs by providing coordination of care with behavioral health and substance use outpatient clinics, as well as physical health providers.

CRS also assists consumers in obtaining social service benefits through programs such as Supplemental Security Income (SSI), San Bernardino County Housing Authority and other assistance programs based on the consumer's needs and eligibility. This consumer-centered approach ensures that each consumer's needs are met based on where the consumer is in their process of recovery.

MHSA Legislative Goals and Related Key Outcomes

Reduce the subjective suffering from serious mental illness for adults:

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

Reduce Homelessness and increase safe and permanent housing:

- Decrease rates of homelessness for consumers
- Increased residence stability and safe and permanent housing

Increase in self-help and consumer/family involvement:

- Increase in number of encounters with collateral contact, such as family members and informal supports
- Increase in program attendance and frequency per consumer
- Increase in self-help/support/12-step group attendance and frequency per consumer

Reduction in criminal and juvenile justice involvement:

- Decreased arrests
- Reduced jail/prison recidivism

Reduce the frequency of emergency room visits and unnecessary hospitalizations:

- Reduced rate of emergency room visits for mental health concerns
- Reduced number of emergency room visits for routine medical concerns
- Increased use of alternative crisis interventions (e.g., CWIC, CCRT, CSU)
- Increase in number of individuals diverted from hospitalization

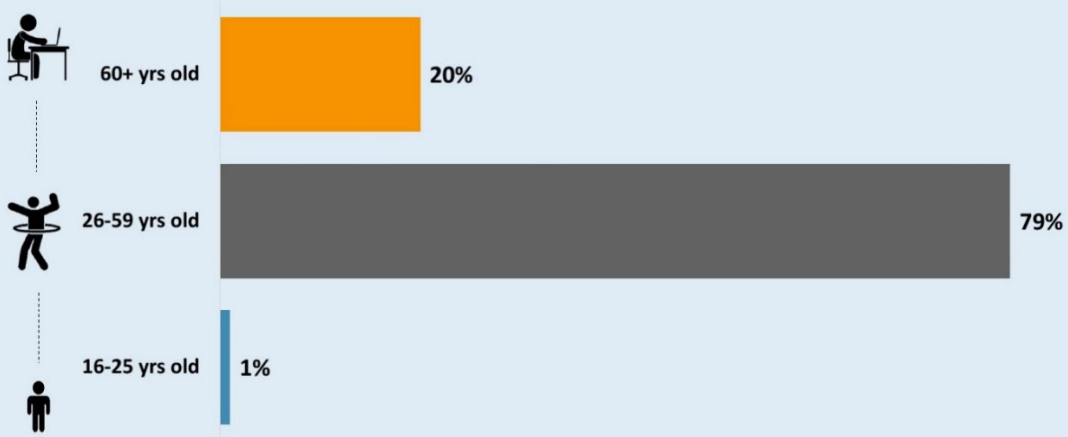
Increase network of community support services:

- Increase in number of collaborative partners
- Increased coordination of care

Fiscal Year 2018/19 Program Demographics

Age:

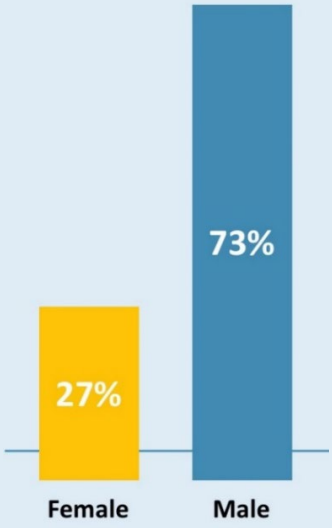
The graph below illustrates the ages of the consumers in the CRS program. The majority of participants served, 79%, were between the ages of 26-59 years old. The second largest group at 20%, were consumers between the ages of 16-25 years. Only 1% of consumers were age 60+.



N=66

Gender:

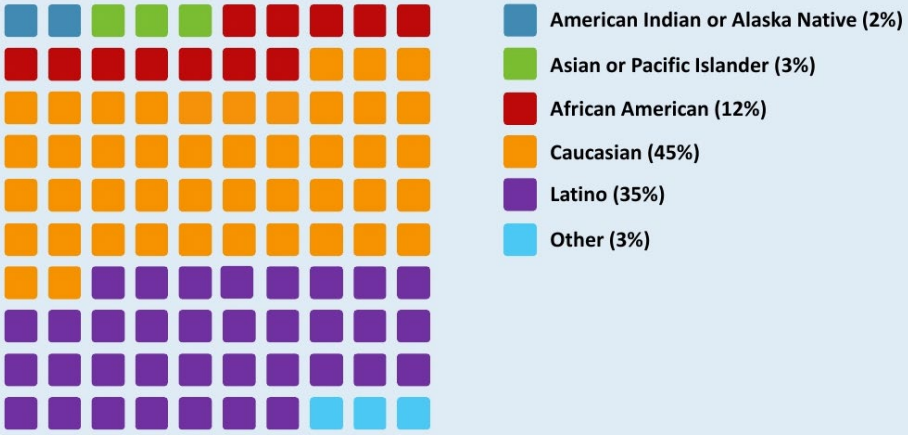
The graph below demonstrates that 73% of consumers in the CRS program identified as male and 27% identified as female.



N=66

Ethnicity and Ancestry

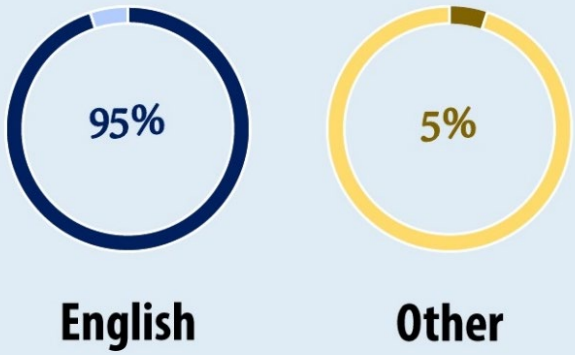
The graph below illustrates the various ethnicities of consumers of the CRS program. The largest group of participants was 45% in the category of Caucasian. The second largest category was Latino at 32%. Following that, 12% identified as African American. Finally, the remaining 8% identified as Asian or Pacific Islander at 3%, American Indian or Alaska Native at 2%, and Other/Unknown at 3%. The Other/Unknown category includes those who identified as other, more than one race, or declined to answer.



N=66

Primary Language:

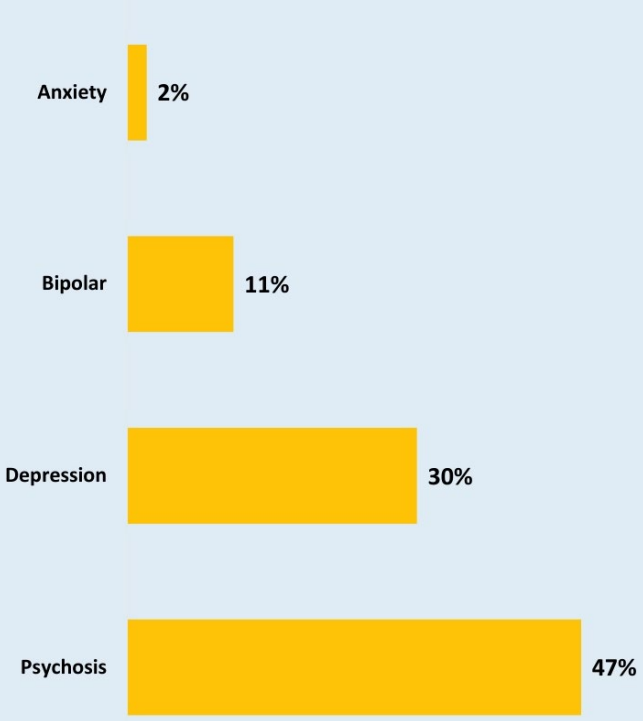
The graph below demonstrates that 95% of CRS consumers identified English as their primary language. The other 5% of consumers identified Spanish as their primary language.



N=66

Primary Diagnosis:

The graph below illustrates the diagnostic groups of CRS consumers who received transitional services. Most of the consumers' primary diagnosis were under the categories of Psychosis at 47% and of Depression at 30%. The remaining primary diagnosis categories were under Bipolar Disorders at 11% and Anxiety Disorders at 2%.



N=66

Artwork by Romero

Positive Results

- 85% of the 66 consumers served are receiving some type of Social Security benefit.
- Only one consumer served returned to homelessness, as 99% of CRS consumers were able to maintain stable housing.
- None of the CRS consumers were incarcerated or arrested during Fiscal Year 2018/19, which is a 100% success rate in meeting this goal.
- 89% of 66 consumers did not have psychiatric hospitalizations during their time in the program.
- 95% of the 66 consumers did not have any medical hospitalizations.
- Of the consumers that were hospitalized, 100% of these hospitalizations were deemed medically necessary.
- The CRS team has increased collaboration with the Behavioral Health Integrated Complex Care Initiative program, which has resulted in better medical care for several seriously ill consumers.
- The CRS team has increased collaboration with local inpatient psychiatric hospitals as well as with staff from the Crisis Residential Treatment programs to better serve consumers in transition to the community.
- The CRS Team has increased their Outreach and Engagement efforts to promote their services which, as a result, has also allowed them to expand their network of community support service providers.

Outreach and Engagement

In Fiscal Year 2018/19, Community Reintegration Services organized and/or participated in the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
DBH and Collaborative Agency Staff Meeting Presentations	2	25
Connections with community based housing providers	10	40
Total	**12**	**65**

Program Challenges

- Limited community resources such as licensed Adult Residential Facilities, as well as lower-level housing accommodations such as room and boards.
- Appropriate social activities for consumers.
- Managing updated processes for accessing housing.
- Delays in the processing of consumer applications for SSI/SSDI create limited housing options for consumers due to lack of income.
- System challenges that impacted access to entitlements.

Program Solutions

- Increased networking with community based housing programs to identify additional housing options for consumers.
- Increased training for staff in navigating the SSI/SSDI application process.
- Increased dedication to investigating available housing and social resources for consumers.

Artwork by Feliciana Torres

CSS: HOUSING AND HOMELESS SERVICES
CONTINUUM OF CARE PROGRAM

Success Story

"Alice" is an older adult female consumer who was referred to the Community Reintegration Services (CRS) program after being on conservatorship. Alice had a history of repeated psychiatric hospitalization due to her delusions, and was in need of appropriate housing.

During her time in the program, Alice worked with her case manager to develop her independent living skills and to develop structure to help her manage her illness. As Alice's condition improved, she was able to transition into a room and board facility which gave her more independence. Although Alice had previously worked, she did not know how to access her pension. With the support of her CRS case manager, Alice was able to gain access to her pension and, as a result, became qualified and eligible for Social Security.

Alice's level of functioning has steadily increased. Today, she lives independently and has been removed from conservatorship. Alice has successfully transitioned from being dependent on others for simple tasks to now living independently and asking for and receiving assistance when appropriate. With the support of the CRS program, Alice has been able to

Collaborative Partners

- ABC Pharmacy
- Abria del Cielo Board and Care Facility
- Behavioral Health Integrated Complex Care Initiative
- California Department of Rehabilitation (DOR)
- Catleya Day Program
- Claremont Guest Home
- Frazee Community Center
- Goodwill Industries
- Health Advocates
- Inland Empire Health Plan (IEHP)
- Lab Corps
- Lighthouse Board and Care
- Mrs. G's Room and Board Home
- Montclair Guest Home
- OmniTrans
- Orchid Court Board and Care Home
- Our House – Day Treatment Program
- "Our Place" Team House
- Pathways to Recovery Team House
- Quest Diagnostics
- Rialto Pharmacy
- San Bernardino County, Transitional Assistance Department (TAD)
- Second Chance Board and Care
- Set Free Ministries
- Social Security Administration
- TEAM House
- The Clothing Closet

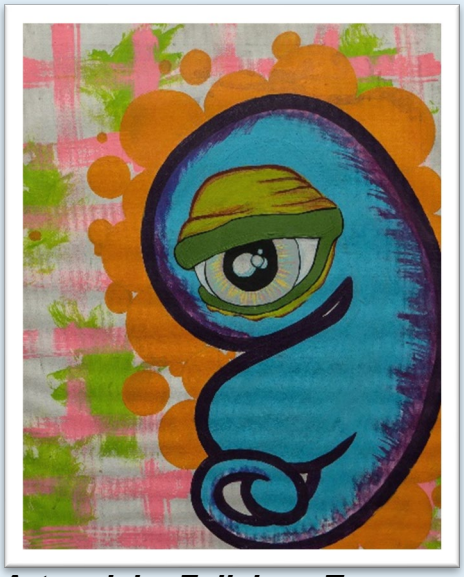
"I have never felt better than I do now. I can see how the alcohol clouded my thinking and behaving. Now, not only can I see more clearly and make better choices, but I have more money and a job. Thank you to the CRS program."

- CRS Consumer

Enhanced Assisted Living Program

The Enhanced Assisted Living Program is a newly added MHSA-funded program designed to serve unique consumers over the age of 50 who have serious behavioral health conditions coupled with critical medical concerns. Services include, but are not limited to, 24-hour observation and comprehensive medical and psychiatric services designed to promote daily living skills, medication management and social/life enrichment activities. Enhanced staffing provides therapeutic intervention and groups to lessen the impact of the consumer's behavioral health condition, including skill building and Activities of Daily Living (ADL), which are strength-based and focused on the consumer's functioning. The Centralized Hospital Aftercare Services (CHAS) Program's Community Reintegration Services team collaborates with this program by providing on-going case management services which include, but are not limited to, gatekeeping activities, linkage and consultation, treatment team participation and discharge planning.

The program is licensed to provide both behavioral health and medical services to consumers whose needs require a secured setting for their psychiatric and medical care. Due to the severity and complexity of behavioral and medical condition(s) experienced by these consumers, adequate placements are often difficult to locate. Placement of consumers in Enhanced Assisted Living offers an appropriate level of care which is significantly less costly than State Hospitals, which are currently the County's only other alternative for placement. Through the provision of these services, DBH will be able to transition appropriate consumers from State Hospitals and other locked facilities to a comparable level of service at a lower overall cost, both financially and subjectively, by shortening the consumer's length of stay in a State Hospital or acute psychiatric facility. It also affords the consumer the ability to remain in a less restrictive placement in a community setting, allowing them to be closer to loved ones and family support.



Artwork by Feliciana Torres

MHSA Legislative Goals and Related Key Outcomes

Reduce the subjective suffering from serious mental illness for adults:

- Decreased impairment in general areas of life functioning

Reduce Homelessness and increase safe and permanent housing:

- Decrease rates of homelessness for consumers
- Increased residence stability

Reduce the frequency of emergency room visits and unnecessary hospitalizations:

- Reduced number of emergency room visits for routine medical concerns
- Reduce administrative hospital days

Artwork by Michael Durado

Innovation


INNOVATION
SUCCESS
COMMUNICATION
GOAL
SKILL
VISION
TEAMWORK
SOLUTION
IDEA

Innovation

The goal of the Innovation component of the Mental Health Services Act (MHSA) is to test methods that adequately address the behavioral health needs of unserved and underserved populations through short-term projects. This is accomplished by expanding or developing services and supports that are considered to be innovative, novel, creative, and/or ingenious behavioral health practices that contribute to learning rather than a primary focus on providing services.

Innovation projects create an environment for the development of new and effective practices and/or approaches in the field of behavioral health. Innovation projects are time-limited, must contribute to learning, and be developed through a process that is inclusive and representative, especially of unserved, underserved, and inappropriately served populations.

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

- Introduce a behavioral health practice or approach that is new to the overall behavioral health system, including, but not limited to, prevention and early intervention.
- Make a change to an existing practice in the field of behavioral health, including, but not limited to, application to a different population.
- Apply to the behavioral health system a promising community-driven practice or an approach that has been successful in a non-behavioral health context or setting.

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

MHSA Legislative Goals for the Innovation Component

The overall MHSA goal of the Innovation component is to implement and test novel, creative, time-limited, or ingenious mental health approaches that are expected to contribute to learning, transformation, and integration of the mental health system.

Every Innovation project must identify one of the following primary purposes as part of the project's design:

- Increase access to mental health services to underserved groups.
- Increase the quality of mental health services, including measurable outcomes.
- Increase access to mental health services.
- Promote interagency and community collaboration related to mental health services, supports, or outcomes.

Challenges and Solutions

The challenge inherent in the MHSA Innovation component is to test ideas that defy, alter, or even question previous ways of providing traditional behavioral health services. These challenges have included:

- Identifying appropriate evaluation strategies to gauge performance outcomes for unique and innovative projects where logic models and evaluation tools do not currently exist.
- Maintaining high levels of community interest and education surrounding continuing Innovation projects.
- Implementing programs within multiple organizational partners and complex relationships.
- Lastly, quantifying and applying knowledge learned in realistic cost effective ways that improve quality of services.

DBH's Research and Evaluation staff continue working on developing evaluation activities to obtain statistical information and assisting with data analysis needed to evaluate effectiveness of programs and other learning objectives for the purposes of future program planning. DBH has maintained on-going contact with the MHSOAC staff for guidance and direction with regard to all aspects of the administration of Innovation projects. Initiating Innovation stakeholder meetings to encourage and promote

community involvement around all phases of the Innovation projects has been another helpful solution. Additionally, Innovation staff is working to make connections with existing DBH programs so lessons learned can be applied in real-time in the most appropriate areas of the service-delivery system.

New Innovation Projects

The Department of Behavioral Health (DBH) is currently working on developing new community supported Innovation projects. Through the Community Program Planning process, homelessness and increased collaboration amongst DBH partners has been identified as a means to improve the delivery of behavioral health services in San Bernardino County.

DBH has been successful in the ongoing engagement of stakeholders during the design, implementation, and evaluation of Innovation projects since 2005. The following stakeholder feedback has been captured and these have been identified according to the four Innovation primary purposes as identified in statute (WIC § 5830(b)(i)(A-D)).

To increase access to mental health for underserved groups:

- Specific types of youth and children's programs
- Increased and specific services for vulnerable and unserved/underserved populations
- Increased, diverse, community outreach
- Efforts aimed at reducing stigma
- Increased family supports

To increase the quality of mental health services, including measurable outcomes:

- Increased community education
- Increased capacity building for providers
- Specific program elements, and service techniques for specific populations

To promote interagency and community collaboration:

- Increased specific links with education
- Increased interagency information sharing
- Increased transportation and accessibility
- Increase collaboration with the health sector
- Increase collaboration with faith-based organizations

To increase access to mental health services:

- New and increased effective use of digital and online media
- Proactive community-based services with community defined approaches
- Use of mobile services
- Use of transportation for treatment

All Innovation projects have been developed through extensive collaboration with DBH partners, stakeholders, consumers, and community members. Innovation projects are subject to approval by the local Behavioral Health Commission, San Bernardino County Board of Supervisors, and the MHSOAC.

Innovation Stakeholder Meeting

Innovation

10 Years of Innovation

INNOVATIVE PROJECTS

2010

Online Diverse Community Experience (ODCE): **September 2010 - June 2013**

Established the department's presence on social media sites (Facebook and Twitter).

Coalition Against Sexual Exploitation (CASE): **September 2010 - June 2014**

A collaborative partnership to provide a model of interventions and services with the goal of reducing the number of children affected by sexual exploitation.

Community Resiliency Model (CRM): **December 2010 - December 2013**

A community-based model of wellness skills that provides mental health education, including coping skills, trauma response skills, and resiliency techniques.

2011

Holistic Campus: **October 2011 - June 2015**

Brought together a diverse group of individuals, family members, and community providers to create their own individual-focused resources, networks, and strategies, growing out of cultural strengths.

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 2018 - March 2017**

Short-term, 14 bed, crisis residential treatment program for the Transitional Age Youth (TAY) population who are experiencing an acute psychiatric episode or crisis, and are in need of a higher level of care than a board and care residential, but lower level than psychiatric hospital.

2014

Recovery Based Engagement Support Teams (RBEST): **October 2014 - September 2019**

Provides 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 2023**

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: **TBD**

A comprehensive flexible interagency model of interventions and services for those diagnosed with an eating disorder.

Cracked Eggs: **TBD**

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: **TBD**

A collaborative partnership between multiple counties and Third Sector to create a data-informed approach to improving FSP consumer outcomes.

Integrated Behavioral Health Care Innovation Project: **TBD**

A partnership with IEHP to deliver integrated behavioral and physical health services to Medi-Cal enrollees at two pilot clinic sites.

Recovery Based Engagement Support Teams (INN-07)

RBEST was approved in March 2014 by California's Mental Health Services Oversight and Accountability Commission as an Innovation project under the Mental Health Services Act (MHSA) Innovation component. The Innovation component's main function is to design and fund short term projects for learning purposes. RBEST's primary purpose is to examine the viability of providing different outreach and engagement services to community members who are considered to be chronically mentally ill, are currently inappropriately served, and in some cases, are not served at all. The objectives of RBEST include:

- Learn and explore alternative options to the Assisted Outpatient Treatment (AOT) Law, otherwise known as Laura's Law, in order to meet the spirit and intent of the law;
- Activating individuals in the community into needed psychiatric care;
- Empowering families and caretakers to continue providing care for their mentally ill loved ones in their community-based environment; and
- Reducing the frequency and duration of hospitalizations for individuals who are hospitalized for psychiatric purposes without outpatient follow-up in the community.

RBEST is a voluntary, client-centered project which provides community (field-based) services which are not structured around any specific model of benefits, to individuals with untreated mental illness in an effort to activate them into appropriate treatment. RBEST is not a treatment model and does not intend to provide endless mobile services to identified consumers. The project is "non-clinical" in its orientation with a primary focus on the needs and goals of the consumer and helping that consumer meet those goals while eliminating obstacles through appropriate mental health treatment. The multidisciplinary nature of the engagement teams presents a holistic approach to the needs of the consumers and is highly flexible, unencumbered by traditional limits of services organized around benefit structures. RBEST staff provide an opportunity for shared decision making in an unstructured, field-based environment when presenting treatment options to consumers and families, encourages deliberation, and elicits care preferences within what is possible. RBEST staff are trained and utilize the Listening,

Empathizing, Agreeing, and Partnering (LEAP) model to engage consumers into treatment. RBEST services include: outreach, engagement, linkage to services, advocacy, case management services, care navigation, family education and support.

The RBEST project was created to address a priority for the County in response to community stakeholder inquiries regarding how the Department of Behavioral Health (DBH) intended to address Assembly Bill 1421 (AB 1421), Assisted Outpatient Treatment (AOT) known as Laura's Law.

Addressing the Spirit of "Laura's Law"

Assisted Outpatient Treatment (AOT), also known as Laura's Law, was signed into California law in 2002. The purpose of AOT was to provide a legal procedure for the court to compel an individual to follow a behavioral health treatment plan. The goal was to improve access and adherence to behavioral health services. Court orders issued for AOT are for treatment services only and does not cover court-ordered medication delivery. In order to qualify, an individual must have a serious mental illness with a recent history of psychiatric hospitalization, imprisonments, or violent acts or threats of violence toward others or themselves. Additionally, the individual must have been offered an opportunity to voluntarily participate in a treatment plan, but *actively* fails to engage in any form of treatment.

Extensive stakeholder work groups were conducted concerning the implementation of this law, as well as possible alternatives, which focused on community mental health and general treatment needs. Based on an analysis of the elements of AOT law and the different models of care, DBH determined that the spirit and intent of the law could be addressed by creating a voluntary, client-centered project that would address the issues associated with individuals who are not participating in effective psychiatric care.

The decision to implement RBEST versus a more judicially driven AOT program was based on the existing DBH service markets that offered traditional therapies requiring the consumer to leave their living environment and go to an alternative setting for services. While specific field-based services were available, they were not activating a small population of consumers into care, and therefore, did not meet the *spirit* and intent of the AOT law. Additionally, current evidence-based, field-centered practices only targeted consumers and families already willing and motivated for treatment. AOT would require adapted strategies for County residents who had been inappropriately served, underserved, or unserved and suffer from untreated, severe, chronic and persistent mental illness. This includes historically resistant and "invisible" consumers who primarily receive care through their families and are not known to the public mental health system, but become more vulnerable as caregivers age or other challenges

arise. These consumers and families would not be served with existing DBH service markets and field-based strategies.

Target Population

Adults over the age of 18, and:

- Not active or successful in seeking and receiving necessary psychiatric care.
- Known to the community and other safety net programs, but not known to the public mental health system.
- Individuals who access treatment at points in the health care system that do not deliver effective care in meeting the psychiatric needs of that individual (category added after project implementation).
- The “invisible” client who is being cared for by family members and not linked or known to the public mental health system.
- Resistant to traditional engagement strategies due to a neurological condition (i.e. anosognosia) which disallows insight into their own behavioral health condition (category added after program implementation).
- Unable to navigate the behavioral health system of care to obtain appropriate treatment (category added after program implementation).

Number of Consumers Served per Fiscal Year

Fiscal Year	Projected No. of Consumers	No. of Unduplicated Consumers Served
2014 – 15	300	186[1]
2015 – 16	300	441
2016 – 17	300	421
2017 – 18	300	450
2018 – 19	300	208
2019 – 20	75[2]	157

[1] RBEST project was not fully implemented until the last quarter of Fiscal Year 2014-15, so only a partial year is reported.
[2] Projected number of consumers served for FY 2019-20 has been prorated to account for the sun setting of RBEST as an Innovation Project.

Project Results and Next Steps

Since the goal of every Innovation project is learning, each Innovation project establishes learning goals as part of the project design. The learning goals for the RBEST project are:

Learning Goals		
	1	Disruption of the existing system will occur through utilizing engagement and outreach strategies targeting individuals who are non-compliant and/or resistant to treatment.
	2	Identify individuals who are high users of inpatient psychiatric services, reducing the frequency and duration of inpatient admissions through activation strategies.
	3	Increase the understanding and knowledge regarding mental illness for families of individuals living with mental illness as well as improve and increase the strategies in caring for their loved ones.

In the upcoming final report, a thorough description of each of the learning goals and outcomes will be shared. RBEST's success and challenges have been documented as well as many client experiences and will be included in the final report.

RBEST has ended as an Innovation project effective September 2019. Based on community stakeholder feedback and support starting in October of 2019 RBEST has transitioned under the Community Services and Supports component. Additional RBEST information will be found in the CSS section of this report.

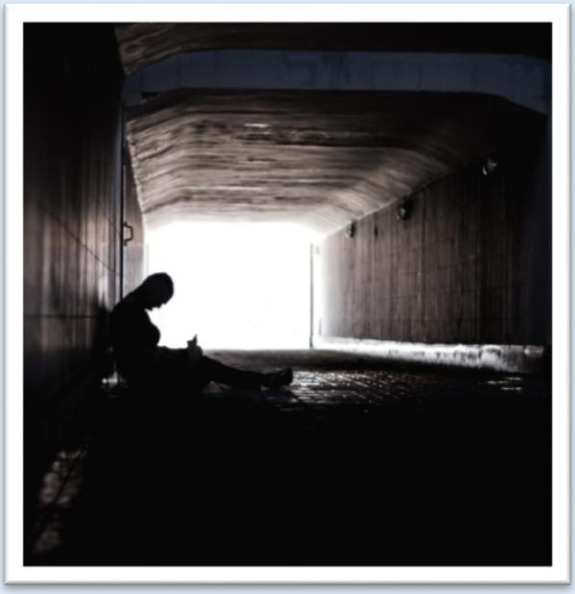
InnROADs: Innovative Remote Assistance Delivery (INN-08)

InnROADs was approved in February 2019 by California's Mental Health Services Oversight and Accountability Commission and by San Bernardino County's Board of Supervisors in March 2019 as an Innovation project under the Mental Health Services Act (MHSA) Innovation component. The Innovation component's main function is to design and fund short term projects for learning purposes. InnROADs' primary purpose is the creation of an 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. Simply put, this project seeks to disrupt the existing model of engagement and treatment that requires individuals to "come to" services and supports in favor of the creation of a system where the needed services and supports "go to" the individual in need, no matter where they are located within San Bernardino County.

April 2019

InnROADs begins as an Innovation project.

InnROADs is a voluntary, client-centered project which provides field-based services, not structured around any specific model of benefits, to individuals with untreated mental illness and experiencing homelessness. The primary focus of this project is the needs and goals of the consumer and helping that consumer meet those goals while eliminating obstacles through appropriate mental health treatment. The multidisciplinary nature of the engagement teams presents a holistic approach to the needs of the consumers and is highly flexible. InnROADs staff provide the opportunity for shared decision making in an unstructured, field-based environment when presenting treatment and housing option to consumers. InnROADs staff will deliberate and elicit care preferences within what is possible. Based on previous learning from other Innovation projects, InnROADs staff is trained and utilize the Listening, Empathizing, Agreeing, and Partnering (LEAP) model of communication to engage consumers into treatment.



Innovation

The InnROADs project addresses a priority for the County in response to community stakeholder inquiries and concerns regarding how the Department of Behavioral Health (DBH) intended to help individuals experiencing homelessness in the rural and unincorporated areas of the County of San Bernardino.

Addressing Homelessness

San Bernardino County is one of 58 counties that comprise California and is geographically the largest county in the contiguous 48 states, covering 20,105 square miles. Like all counties in California, San Bernardino County has been impacted by the increases in the homeless population. According to the *San Bernardino County 2018 Homeless Count and Subpopulation Survey Final Report*, the increase to San Bernardino's homeless population was solely in the unsheltered category (2018). The unsheltered homeless population is of particular concern for this County because the majority of territory within San Bernardino County is considered rural or frontier, as opposed to suburban or urban classifications. Even within areas that can be considered urban, large undeveloped tracts of land where homeless communities may be located exist. This includes the Santa Ana River basin which offers a large area of undeveloped land that runs through San Bernardino City into Riverside County. These large undeveloped areas of land are remote and can be away from standard public services, transportation, and assistance. These areas tend to be attractive to larger homeless communities because of their secluded nature, leading to the description of individuals experiencing homelessness in rural and/or unincorporated areas being called the "hidden homeless" (Murakami, K. (2016). *HIDDEN HOMELESS: Rural homelessness a national challenge*. CNHI Washington Bureau).

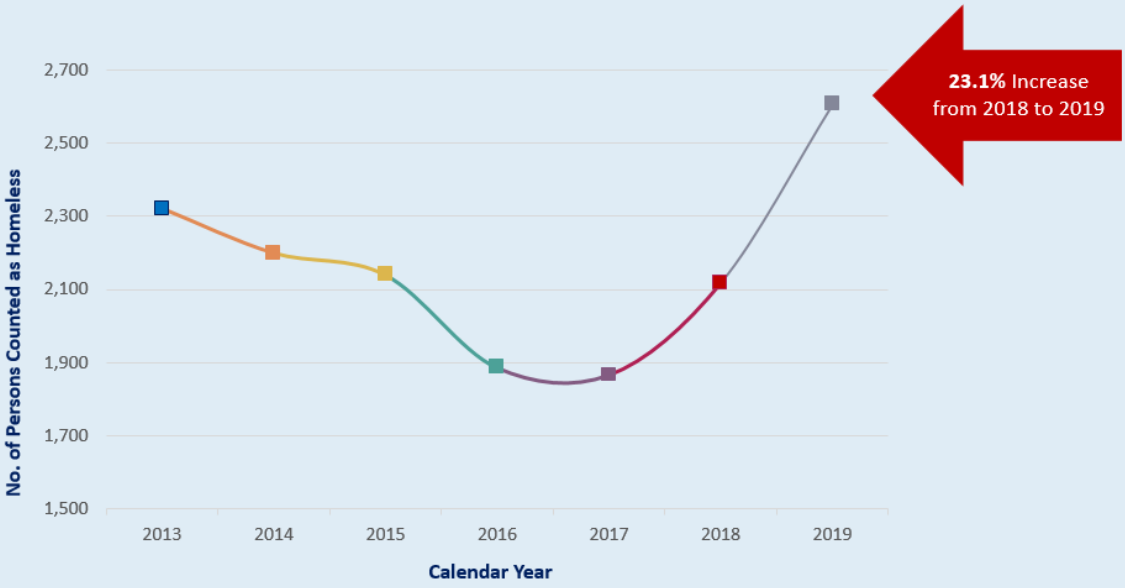
> In California, 34 people per 10,000 are experiencing homelessness compared to the national average of 17 people per 10,000.

Traditional forms of engagement and outreach to homeless communities that are effective in urban and suburban areas often do not work in the same manner with the rural homeless population (Office of Community Planning and Development. (2009). *Rural Continuums of Care*. U.S. Department of Housing and Urban Development.). Some differences between the urban and rural homeless populations that impact outreach and engagement strategies are that individuals within rural homeless communities are:

- Employed, but typically in temporary jobs with no benefits
- Less likely to have access to medical and mental health care due to the long standing shortage of practitioners in rural areas
- Without medical care and insurance, even after the advent of the Affordable Care Act

- Describing their homelessness as a choice to live “off-grid”
- Less likely to go to walk-in clinics, either for physical or mental health, where assistance would “normally” be expected and provided

Change in Homeless Population (2013 – 2019)



Note: Better methodologies for counting individuals experiencing homelessness were used in 2019. This accounts for a portion of the 23.1% increase. **Source:** 2019 San Bernardino Homeless Count and Subpopulation Survey Final Report.

Target Population

InnROADs expects to serve 1,400 consumers over the course of five years.

The population to be served by this project includes youth, adults, older adults (60+), and families that are:

- Prevented from accepting the Housing First model 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 in San Bernardino County’s rural and unincorporated communities, and/or
- Experiencing unsheltered homelessness within San Bernardino County.

Innovation

Projected Number of Consumers Served

Fiscal Year	Projected No. of Consumers
2018 – 19	N/A*
2019 – 20	280
2020 – 21	280
2021 – 22	280
2022 – 23	280
2023 – 24	280

*InnROADs project start date was 4/1/2019. No consumers were engaged from 4/1/2019 – 6/30/2019 due to recruitment, hiring, and training.

Learning Goals

Since the goal of every Innovation project is learning, each Innovation project establishes learning goals as part of the project design. The learning goals for the InnROADs project are:

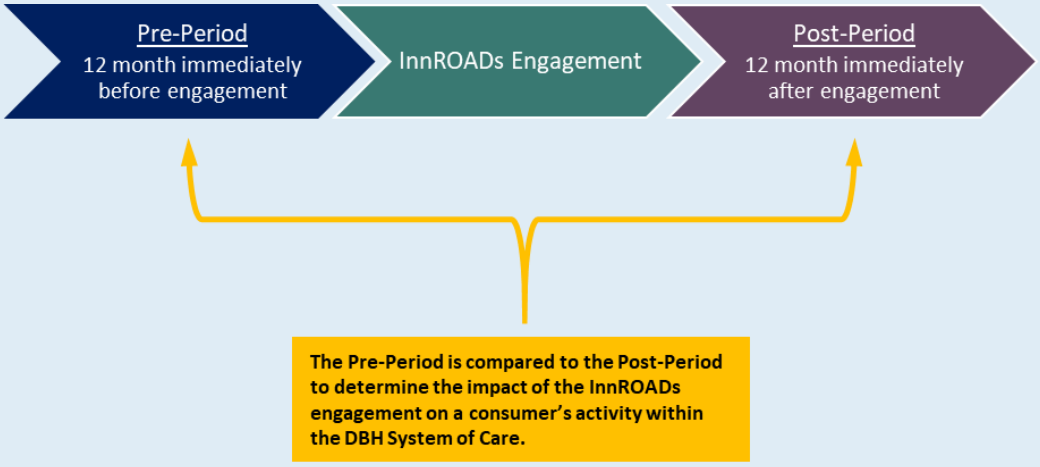
Learning Goals	**1**	What makes a mobile, multi-agency team effective in serving and supporting the needs of those individuals experiencing homelessness – as individuals, as family units, and as communities? How does collaboration to address multiple, interrelated needs "save" time, and resources, for both consumers and partner agencies?
	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?
	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?
	4	How can geographic information system (GIS) be used as a collaborative tool to better understand patterns, needs, and opportunities for continuous quality improvement by front-line staff, supervisors, administrators, and county-level agencies?

Based on the learning goals listed above, some process indicators that will be used in the InnROADs project include tracking the team's engagements, including services provided, encounters and resources provided to individuals in needs. The team's notes will be used to identify the engagement techniques used, treatments provided and any clinical measures taken, when applicable. Demographics and diagnosis information will be used to identify the diversity of the populations served. Qualitative data will gathered in the form of interviews with consumers, staff and family members. For the geographic information system related goal, geolocation will be tracked, as well as encounters at those locations. Staff notes and client interviews related to the geolocation will also be used to help tell the story of homelessness.

Methodology for Evaluating the Learning Goals

Service Utilization before InnROADs Engagement Compared to after InnROADs Engagement (3-Tier Utilization Analysis)

The 3-tiered utilization methodology analyzes hospitalizations as well as crisis and outpatient services in the pre and post InnROADs engagement (i.e. intervention) time period.



Focus Groups

As part of the evaluation process, InnROADs consumers and staff will be assembled to participate in a guided discussion about InnROADs services. The discussion questions and topics included effective use of geographic information system (GIS) software, effective engagement strategies, effectiveness of the LEAP training, barriers to treatment, and consumer readiness for treatment.

Surveys

Surveys will be used to collect self-reported data from InnROADs consumers. Survey questions will focus on InnROADs consumer experience with this new engagement method as compared to prior experiences with homeless outreach groups (both from the public mental health system and community non-profits).

Geographic Information Systems (GIS)

The use of GIS software will allow this project to study and analyze the interaction between homeless communities and their interaction with resources and services that are needed for them to survive and option permanent supportive housing.

Implementation Timeline

Months 3-12: Team Development and Logistics

The main focus will be the recruitment, hiring, and training of InnROADs team members. SBC-DBH will also be reaching out to other departments within the County for collaboration opportunities. The goal is to have input from all collaborative county agencies and to have active involvement during the development, approval, implementation, and evaluation stages of the project. From these early "reach-out" meetings, a steering group will be created to facilitate the shared creation of business processes, ensure applicable county policies are adhered to, and resolve any cross-agency barriers to service.

Months 6-18: Final Approval of Initial Business Practices and Evaluation Metrics

Evaluation metrics will be presented to all interested stakeholders groups for review and comment. Stakeholder groups will be included in the identification of "real-time" metrics that will be used to evaluate methods used and will be part of ongoing learning that can be incorporated into our larger system of care and assist with SBC-DBH's ongoing departmental improvement processes. Complete hiring of new staff, as appropriate.

Months 6-54: Full Implementation

Set-up Mobile Engagement and Treatment Teams for community work and begin to engage individuals experiencing homelessness. Keep community stakeholders updated.

Learning Achieved

- **PROBLEMATIC RECRUITMENT** - Hiring and retaining staff for geographically remote areas is challenging. Managers and Supervisors assigned to this Innovation project continue to work with Human Resources (HR) to schedule employee recruitments while also publicizing general job availability within the geographical region.
- **IMPORTANCE OF COMMUNITY PARTNERS** - Gathering resources for our target population has been successful, and has led to collaborations with community-based behavioral health agencies and homeless network providers.
- **ESTABLISHMENT OF BOUNDARIES** - Ongoing team discussions have focused on the importance of the project establishing relationships with community partners to provide resources for our target population vs. staff personally providing the resources.

Innovation Stakeholder Meeting

Innovation

Eating Disorder Collaborative (INN-*)

The Eating Disorder Collaborative is scheduled to be on the California's Mental Health Services Oversight and Accountability Commission (MHSOAC) agenda for March 2020. If approved by the MHSOAC this project will be presented to the San Bernardino County's Board of Supervisors in April 2020 as an Innovation project under the Mental Health Services Act (MHSA) Innovation component. The Eating Disorder Collaborative will focus on increasing the regional understanding of eating disorders (EDOs) to facilitate early identification and access to effective treatments. 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

The newly created multidisciplinary teams will consist of the following positions:

- Behavioral Health Provider
- Case Manager
- Family Coordinator (a peer position)
- Program Specialist
- Dietician/Nutritionist specializing in EDOs
- Nursing Staff

These multidisciplinary teams will be involved in the treatment of clients referred to this program. Use of the more robust initial EDO assessment tool will aid team staff in identifying the appropriate level of care to include, but is not limited to:

- Residential Care - Contracted with a Community Based Organization (CBO)
- Partial Hospitalization Program - Contracted with a CBO
- Intensive Outpatient Program - Clinic Based - Contracted with a CBO
- Intensive Outpatient Services - Home Based - Provided by EDO Team in conjunction with the Primary Care Physician
- Home Based Eating Disorder Services - Provided by EDO Team in conjunction with the Primary Care Physician
- Clinic Based Eating Disorder Services - Provided by EDO Team and/or local provider in conjunction with the Primary Care Physician

- Follow-up Care without Specialty Mental Health Services - Provided by EDO Team in conjunction with the Primary Care Physician

The Eating Disorder (EDO) Teams will be utilized in the revision and modification of the existing Eating Disorder Examination Questionnaire (EDE-Q) to create a more robust standardized assessment tool. Revisions to the EDE-Q will include measures that go beyond using a medical approach to include psychosocial factors (e.g., family relationships, informal supports, additional resources, motivation, behavior, perception) and barriers to treatment (e.g., work schedule, travel time/distance, transportation, other family obligations, technological access) that are important in the assessment, treatment, and ultimate outcomes. By creating a more holistic-driven assessment tool, we can identify a wider range of factors that are important in determining appropriate treatment. This revised assessment tool can be completed by a variety of people who are concerned about an EDO (e.g, clients, potential clients, students, family members, primary care providers, school faculty) and will provide information for centralized reception of potential cases for the multidisciplinary teams who can assist with access and care as appropriate.

This project will also include outreach efforts targeting local community colleges, universities, primary care providers, substance used disorder providers, and behavioral health providers. Collaborating with these entities will provide a regional partnership which will help to facilitate dissemination of the enhanced EDO screening and assessment tool.

Trainings and informational materials targeting colleges and universities will focus on public information campaigns and materials which could be utilized in public settings (e.g., dorm halls, student centers) as well as informational trainings for staff. College and university staff who work with campus health will be included in the training efforts for primary medical care staff and behavioral health staff. Trainings and informational materials for primary care physicians and allied health staff will include:

- Efficient and effective EDO screenings,
- Simplified referral processes, and
- Standards for monitoring essential aspects of physical health during the course of care.

Specialized Continuum of Care

Eating Disorders (EDOs) are the mental illness with the highest mortality rate, making early detection, intervention, and treatment extremely important in giving an individual the best chance at recovery (Arcelus, Mitchel, Wales & Nelson Mortality rates in patients with Anorexia Nervosa and other eating disorders. Archives of General Psychiatry. 2011). Current information suggests that the onset of EDOs occurs typically

between 18 and 21 years of age with the average age of onset for anorexia being 19 years old, bulimia 20 years old, and binge eating disorder at 25 years old (Eating disorders on the College Campus. National Eating Disorders Association. Feb 2013). With EDOs affecting so many of our transitional age youth, awareness, information dissemination, and screening opportunities need to be prevalent in places that work with this population. In San Bernardino County, there are 22 college and/or university campuses. Of those, only six campuses maintain a student body of 4,000 or more students with an accompanying health center. Currently, there are no coordinated education or training efforts being done regionally in the college/university setting or within the community.

Anorexia Nervosa is the third most common chronic illness in adolescents and has one of the highest mortality rates of any mental illness. Approximately one in 10 cases of anorexia nervosa ends in death.

Eating Disorders are complex; no one professional has the expertise to fill all of the patient's medical and psychiatric needs. An efficient system is needed to manage these complex cases, but that system does not exist for many reasons, including frequent changes in staff, lack of resources, no clear funding stream for EDO clients, and lack of cooperation from clients and family. Additionally, the current assessment tool lacks factors like environmental/emotional supports or other psychosocial factors that would allow for better EDO treatment planning. There are inconsistencies in EDO treatment options, availability, and coordination due to insufficient training and experience of many health care professionals, the lack of screening/assessment tools that take psychosocial factors and barriers into account giving best practice indicators, and inadequate/inconsistent coverage among different insurance providers.

Target Population

The Eating Disorder Collaborative expects to serve 4,175 consumers over the course of five years.

The Eating Disorder Collaborative has two separate project components, each with different targeted populations:

Project Component	Target Population
Interventions and Treatment	Transitional-aged youth (16 – 25 yrs. old) and adults (over 26 yrs. old), residing in San Bernardino County, diagnosed with an eating disorder.

Project Component	Target Population
Regional Knowledge and Resource Directory	The Inland Empire's behavioral health professionals (both public and private), primary-care physicians, contracted providers, and community partners.

Projected Number of Consumers Served

Fiscal Year	Projected No. of Consumers Treated	Outreach & Engagement
2019 – 20	25	800
2020 – 21	30	800
2021 – 22	35	800
2022 – 23	40	800
2023 – 24	45	800

*Eating Disorder Collaborative anticipated project start date 4/1/2020.

Learning Goals

Since the goal of every Innovation project is learning, each Innovation project establishes learning goals as part of the project design. The learning goals for the Eating Disorder Collaborative are:

Learning Goals	**1**	Examine if a collaborative approach with local colleges can result in the development and utilization of public information campaigns and materials to educate populations most at risk for developing disordered eating practices at the multiple college campuses within one county.
	2	Examine if the development and dissemination of a screening tool which may be used in a variety of settings (e.g., college student centers, health centers, substance use disorder providers physician's offices) is effective at increasing the number of individuals assessed for disordered eating issues.
	3	Examine if the development and utilization of the engagement assessment facilitates better linkage to effective treatment services.
	4	Examine if the use of multidisciplinary team, all comprised of MHP staff, can effectively liaise with the variety of organizations (e.g., Colleges, College Health Centers, individual Physician Offices, Independent Physician Associations, Management Care Plans, and behavioral health providers) to (1) provide additional assessment services, (2) facilitate effective referrals, and (3) provide ongoing care as needed.

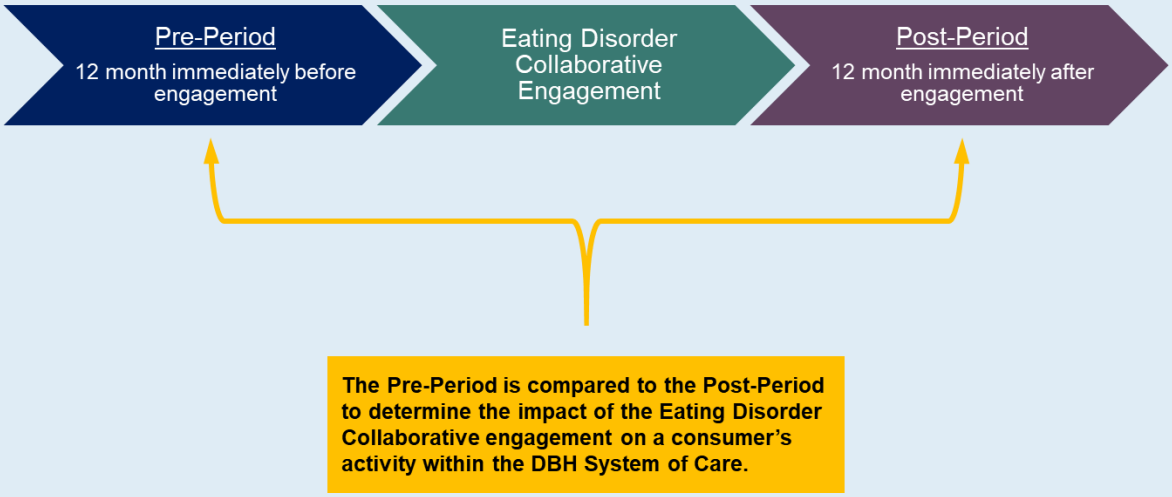
Methodology for Evaluating the Learning Goals

Adult Needs & Strengths Assessment (ANSA)

The Adult Needs & Strengths Assessment (ANSA) is a comprehensive assessment of psychological and social factors used in adult behavioral health services. The ANSA will be utilized in the Eating Disorder Collaborative as a method to monitor the outcomes of treatment and services for clients served. The ANSA measures client's needs, functioning and mental health while taking into account client resiliency by measuring client strengths. A comparison of changes in each client's ANSA scores before, during, and at the end of treatment will be tracked and presented in a 3-Tier Analysis.

Service Utilization before Eating Disorder Collaborative Engagement Compared to after Eating Disorder Collaborative Engagement (3-Tier Utilization Analysis)

The 3-tiered utilization methodology will be used to compare and analyze the number of psychiatric hospitalizations and bed days as well as the number of outpatient services in the pre and post EDC treatment time periods.



Focus Groups

The Eating Disorder Collaborative will engage clients and staff in active participation of discussions, interviews, and surveys. These focus groups will provide both quantitative and qualitative feedback to be used in the analysis of project outcomes.

Next Steps: Implementation Timeline

Months 1-6: Reaching Out and Implementation

During this phase, SBC-DBH will be working with Community Colleges within the County for collaboration opportunities. SBC-DBH will also share the project concept with local managed care agencies and solicit input and collaborative opportunities. A steering committee will be implemented and preliminary project planning meetings will be scheduled to begin shaping the project. SBD-DBH will work with County Human Resources to create a special recruitment for the positions needed to staff the multidisciplinary team.

Months 3-12: Team Development and Logistics

The multi-disciplinary teams will begin working on creating and documenting business practices. SBC-DBH will begin and manage the process for working with an external agency to create and develop the public information campaign and training.

Months 6-18: Business Practices, Contracts, and Evaluation Metrics

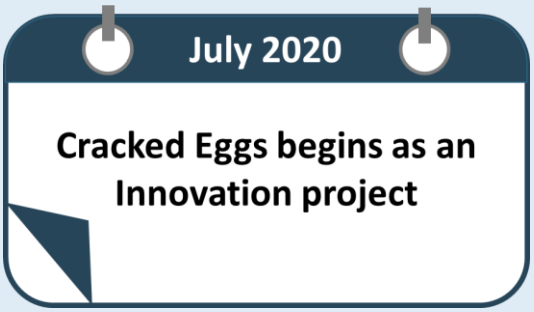
This phase will consist of the finalizing any required contracts, as needed. Complete hiring of new staff, as appropriate. Assessment tool will be introduced to select locations for trial and analysis.

Months 6-54: Full Implementation

Multidisciplinary teams will be working in the field and with local service providers. Work with community colleges and local physician associations will help to influence the materials developed. The assessment will be shared with providers interested in participating and providing feedback.

Innovation

Cracked Eggs (INN-*)



Cracked Eggs is scheduled to be on the California's Mental Health Services Oversight and Accountability Commission (MHSOAC) agenda for March 2020. If approved by the MHSOAC this project will be presented to the San Bernardino County's Board of Supervisors in April 2020. Cracked Eggs primary focus will be to explore the ways in which SBC-DBH's larger system of care can be enhanced and modified to create an empowered environment for individuals with lived-experience. To begin to learn and understand the best ways to accomplish this, DBH will provide funding and administrative support. The project will:

- Incorporate a peer-designed art workshop entitled "Cracked Eggs" into DBH's larger system of care.
- Determine if DBH can use different funding structures to provide the flexibility in billing that is needed by smaller non-profits and community groups without working capital, of which, may be peer-owned and operated.

This workshop series is 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 Journal of Clinical Psychology notes that using art to communicate a mental state and past trauma "complements the biomedical view by focusing on not only sickness and symptoms themselves but the holistic nature of the person."

The Cracked Eggs workshop is run by a peer-owned and operated production company: Bezerk Productions. The workshops are a multi-session process that results in a participant-designed art exhibition and/or performance. Workshops will focus on performance, writing, and art, using a series of techniques that include the use of symptoms associated with mental illness as a method of expression.

Participants focus on the creative process rather than the final "creative" product. Focusing on the creative process allows the workshop facilitator to create an environment that empowers the participants to:

- Give voice to experiences and feelings not easily expressed in words
- Develop self-awareness and self-esteem
- Work on social skills

- Explore experiences and feelings through the lens of spirituality and religious iconography
- Explore other means to manage behaviors and/or symptoms
- Gain different perspectives to assist in problem solving

Workshop facilitators will guide the workgroup participants through exercises designed to use the symptoms from mental illness as art-making tools and techniques. Focus is given to understanding and identifying individual thoughts and feelings and helping workshop participants cope with difficulties and stress in an effort to help with the recovery process.

The Cracked Eggs project was created to address a priority for the County in response to suggestions from consumers on how to encourage more peer participation in DBH's system of care.

Empowering the Consumer

Since the implementation of the Mental Health Services Act in 2005, California has made it a priority to have Peer Advisors, individuals with lived-experience, included into the larger behavioral health workforce. These Peer Advisors, also called peer/family advocates or navigators depending on their role within the organization, are pivotal members of the workforce that provide a unique perspective that enhances the overall relevance and value of the care provided (Wells, C., Axis Group I. The Roles of Consumers with Lived Experience in Mental Health Workforce Development. 2011). Peer Advisors have the important role of bridging the gap between those in the workplace that lack first-hand experience with recovery-oriented treatment practices and those clients that ultimately benefit from recovery-oriented treatment that emphasizes collaborative relationships and shared-decision making concerning treatment options (i.e., a client-informed behavioral health system).

Peer advisors, consumers of behavioral health services, and other stakeholders with lived experience have the potential to improve, expand, and innovate services because of their innate ability to understand and support others impacted by mental illness. By bringing the expertise of those with lived experience to the field as employees and/or contract providers, services may be enhanced for those receiving behavioral health care.

Employing persons with lived experience provides a number of benefits for consumers, communities, and public behavioral health organizations that can include:

- Serving as recovery role models for other consumers

- Representing consumers' needs in the service system through the lens of lived experience
- Broadening the capacity of the system to be client-driven and culturally competent
- Providing information and motivation for staff and peers
- Filling gaps and augmenting services for consumer
- Serving as liaisons between consumer and staff populations
- Refuting biases and stigmas regarding the ability of persons with lived experience to lead independent lives

Having behavioral health programming that includes peer supports has been shown to reduce hospital readmissions, reduce the symptoms of depression, and has shown success in providing information, skills and support needed by individuals with serious mental illness to be more engaged in their care (Purington, Kitty. *Using Peers to Support Physical and Mental Health Integration for Adults with Serious Mental Illness.* National Academy for State Health Policy. January 2016).

Even with this support, behavioral health programs continue to lack programming ***designed*** by peers. By supporting programs designed by and for peers, and integrating these programs into the larger system of care, the overall system will benefit from a decrease in stigma and discrimination.

Target Population

The target population for this project are individuals living with mental illness that are:

- Transitional-Aged Youth (16-25 yrs. old), or
- Adults over the age of 25 years.

Number of Consumers Served by Fiscal Year:

Fiscal Years	Projected No. of Consumers Served
2020 – 21	30
2021 – 22	30
2022 – 23	30
2023 – 24	30
Total	120

Learning Goals

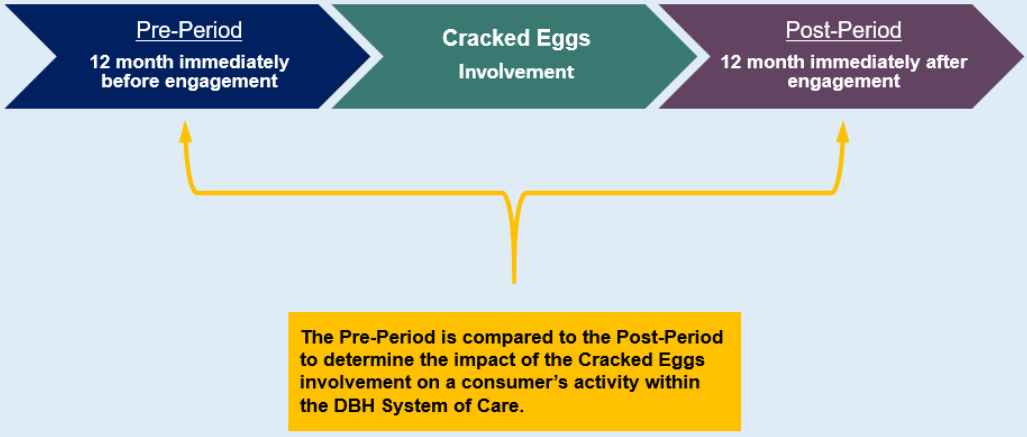
Since the goal of every Innovation project is learning, each Innovation project establishes learning goals as part of the project design. The learning goals for the Cracked Eggs project are:

Learning Goals		
	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 clients' goals.
	2	Examine if participation in Cracked Eggs leads to improved client outcomes.
	3	Examine the challenges and opportunities in scaling-up Cracked Eggs, including developing a train-the-trainer model/curriculum/toolkit.
	4	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 clients and community participants.
	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?

Methodology for Evaluating the Learning Goals

Service Utilization before Cracked Eggs Engagement Compared to after Cracked Eggs Engagement (3-Tier Utilization Analysis)

The 3-tiered utilization methodology analyzes hospitalizations as well as crisis and outpatient services in the pre and post Cracked Eggs involvement time period.



Focus Groups

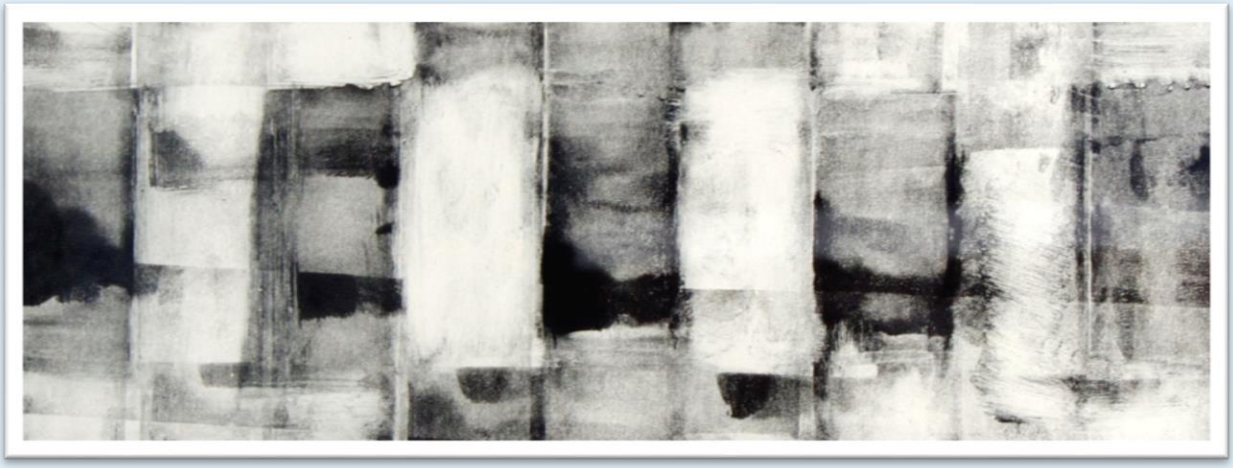
As part of the evaluation process Cracked Eggs consumers, and staff will be assembled to participate in a guided discussion about Cracked Eggs. The discussion questions and topics included effective use of art as a form of expression, using art as an engagement strategy, and use of peers in the system of care.

Surveys

Surveys will be used to collect self-reported data from Cracked Eggs participants. Survey questions will focus on Cracked Eggs participants with this new engagement method as compared to prior experiences.

Next Steps: Implementation Timeline Development

Once approved, SBC-DBH Innovation staff will be meeting with the peer contractor to develop an implementation timeline. The additional time this will require was accounted for and is the reason behind an anticipated with an MHSOAC and BOS approval date of April 2020 and a project start date of July 2020.



Artwork by Froukje Schaafsma-Smith

Multi-County Full Service Partnership Initiative (INN-*)

The Multi-County Full Service Partnership (FSP) Initiative is scheduled to be on the California's Mental Health Services Oversight and Accountability Commission (MHSOAC) agenda in the spring of 2020. This project will be presented to the San Bernardino County's Board of Supervisors after MHSOAC approval. The primary purpose of this innovation project is to increase the quality of mental health services, including measurable outcomes by promoting interagency collaboration and community collaboration related to mental health services, supports, and outcomes.

Through participation in this Multi-county Innovation Project, San Bernardino County will work with Third Sector, a contracted agency working with the MHSOAC and counties to implement this statewide project. This project will implement new data-informed strategies to guide program redesign and facilitate continuous improvement of Adult FSP programs, supported by county-specific implementation and evaluation. The overall purpose and goals of the Innovation Project are to:

- Improve how counties define and track priority outcomes
- Develop new and/or strengthen existing processes for continuous improvement
- Develop a clear strategy for how outcomes and performance measures can best be tracked and streamlined
- Develop a shared understanding and more consistent interpretation of the core FSP components
- Increase the clarity and consistency of enrollment criteria, referral, and graduation processes

Using Data to Enhance Programming

San Bernardino County has eight (8) FSP programs serving an estimated three thousand-four hundred-fifty-eight (3,458) individuals annually. These FSP programs target specific populations with serious mental illness:

- 2 FSP programs assisting underserved children and youth
- 1 FSP program serving Transitional Age Youth (TAY)
- 4 FSP programs serving adults
- 1 FSP program serving older adults

In addition to San Bernardino County FSP programs targeting specific age ranges, the programs are designed to serve unique populations such as those experiencing

homelessness, who may be involved in criminal or juvenile justice, individuals transitioning from institutional care facilities, and high frequency users of emergency psychiatric services and hospitalizations, however all programs provide full wraparound services to the client. Full Service Partnership (FSP) programs are designed to apply a "whatever it takes" approach to serving and partnering with individuals living with severe mental illness.

Variation in FSP populations, needs, and local context has presented a challenge: FSP programs frequently apply different approaches to program design, outcomes measurement, and overall implementation. As a result, San Bernardino County and other counties across California do not have consensus about the best way to maximize impact for FSP participants, and many would like to understand which core components of FSP drive better outcomes. Information flows often feel one-directional, as county staff and providers report data up to the state but struggle to interpret and analyze the data they receive back to examine outcomes or inform future decisions. Additionally, current state-required metrics are difficult to compare across programs, providers, and geographies. In practice, for county staff, providers, and community members, these challenges have meant that state-required performance measures do not fully capture how FSP clients are faring as whole people. Current metrics are limited: they do not prioritize what individuals need most, and in some cases, they fail to capture exactly how much improvement an FSP consumer has made. Additionally, processes for enrolling, discharging, and graduating consumers from FSP programs are either inconsistent or not optimally informed by available data.

Target Population

This Multi-County Full Service Partnership Initiative project focuses on transforming the data and processes counties use to manage their FSP programs to improve performance at scale; it does not entail direct services for FSP clients. San Bernardino County will focus on Adult FSPs. Accordingly, we have not estimated the number of individuals that will be served or identified specific subpopulations of focus. This project will build outcomes-focused approaches across a variety of age-specific and population-specific FSP programs statewide, exploring and identifying key commonalities and relevant differences by population of focus, and building a flexible, scalable set of strategies that can be further implemented statewide.

Learning Goals

Since the goal of every Innovation project is learning, each Innovation project establishes learning goals as part of the project design. The Multi-County Full Service Partnership Initiative project learning goals are:

Learning Goals	1	What was the process that San Bernardino County and Third Sector took to identify and refine FSP program practices?
	2	What changes were made and piloted?
	3	What impacts did they generate following implementation, both for partners (clients) and FSP program providers? a. Compared to current FSP program practices, do practices developed by this project streamline, simplify, and/or improve the overall usefulness of data collection and reporting for FSP programs? b. To what extent has this project helped to streamline data collection/reporting within participating counties (e.g. improved satisfaction with reporting forms; reduced paperwork)? Has this project improved how data is shared and used to inform discussions on FSP program performance and strategies for continuous improvement? c. What impacts has this project and related changes create for clients' outcomes and clients' experiences in FSP?
	4	What broader learning did the project produce? a. How have staff learnings through participation in this FSP-focused project led to shared learning across other programs and services within San Bernardino County? b. How has the statewide FSP Learning Community helped to drive collective learning and fostered a unified county voice for potential state-level change? Specifically, which types of forums and topics have yielded the greatest value for county participants?

Methodology for Evaluating the Learning Goals

This Innovation Project includes a significant learning and evaluation component. DBH, in partnership with other project counties and Third Sector, will identify, procure, and establish an ongoing structure for partnering with the third-party evaluator that will provide an assessment of the project's impacts learning goals via a post-implementation evaluation. The post-implementation evaluation will aim to assess two types of impacts: (A) the overall impact and influence of the project activities and intended changes to

FSP practices and program administration, and (B) the overall improvements for FSP client outcomes. These two types of measures will help determine whether the practices developed by this project effectively simplify and improve the usefulness of data collection and management, and whether these practices supported the project's ultimate goal of improving FSP client outcomes.

Next Steps: Implementation Timeline

Phase 1: Learning Phase

The Learning Phase will act as a ramp-up period and an opportunity for Third Sector to learn about San Bernardino County's context in further detail, including local community assets, resources, and opportunities, existing FSP program practices, and performance on existing outcomes measures. Third Sector will work with staff to lead working groups and interviews, analyze county data, and facilitate meetings with local stakeholders to identify opportunities for improvement. Staff will share data and documents with Third Sector and provide guidance on local priorities and past experiences. By the end of this phase, San Bernardino County will have an understanding of the current state of its FSP programs, customized recommendations to create a more data-driven, outcomes-oriented FSP program, and a realistic work plan for piloting new improvements during the Implementation phase.

Phase 2: Implementation

Third Sector will provide individualized guidance and support to San Bernardino County and other participating counties through the Implementation process, piloting new strategies that were developed. Understanding limitations on staff capacity, Third Sector will support staff by preparing materials, analyzing and benchmarking performance data, helping execute on data-sharing agreements, and leading working group or Steering Committee meetings. Staff will assist with local and internal coordination in order to meet project milestones. Additional activities in Phase 2 may include the following: improving coordination across county agencies to create a human-centered approach to client handoffs and transfers, completing data feedback loops, and developing new referral approaches for equitable access across client FSP populations. As a result of this phase, San Bernardino will have piloted and begun implementing new outcomes-oriented, data-driven strategies.

A third-party evaluator will be selected during this phase. Third Sector, participating counties, and the evaluator will develop a scope of work detailing the exact deliverables and activities that the evaluator will lead as part of the post-implementation evaluation.

PHASE 3: SUSTAINABILITY PLANNING

Third Sector will work with participating counties to understand the success of the changes to-date and develop strategies to sustain and build on these new data-driven approaches. Third Sector will work closely with San Bernardino County to ensure that there is a transition plan in place and staff have the capacity to continue these new strategies. Once sustainability planning has been completed, San Bernardino County will have a clear path forward to continue building on the accomplishments of the project.

Artwork by Carlos Casanova

Innovation

Integrated Behavioral Health Care Innovation Project (INN-*)

The Integrated Care Innovation project is currently in development. It is anticipated that this project will be presented to the Mental Health Services Oversight and Accountability Commission (MHSOAC) and San Bernardino County 's Board of Supervisors (BOS) during Summer 2020.

Proposed Project Concept

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 death decades earlier than necessary, often from easily treatable health 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 this challenge by partnering with the Inland Empire Health Plan (IEHP) to create and deliver integrated behavioral and physical health services to Medi-Cal enrollees at two pilot clinic sites. The integration model that SBC-DBH seeks to create is one where the delivery, coordination, and payment for care related to the full continuum of an individual's physical and behavioral health needs is managed by a single accountable entity. This integration will be more than the common practice of "co-locating" either physical or behavioral health staff in the same location. The pilot clinics will incorporate a full range of outpatient mental health and substance use disorder services alongside primary care services that will:

- Share access to medical information (with appropriate permissions),
- Meet and confer about individual cases, and
- Develop procedures and practices to ensure the delivery of all needed care.

To minimize the dislocation caused when an individual steps down to mild-to-moderate behavioral health services, mental health providers at the two clinic sites will be credentialed with IEHP and authorized not only to provide specialty mental health services, but mild-moderate mental health services as well. This is an option available nowhere else in the county. Traditional services for Medi-Cal enrollees offered through

SBC-DBH or IEHP do not have the option for a single provider to deliver both specialty mental health services and mild-to-moderate mental health services.

Other important components of this Innovation project will include:

- Care management teams built upon the infrastructure and practices, established by the Department of Health Care Services, for the Health Homes Program designed to serve eligible Medi-Cal enrollees with complex medical needs.
- The creation of a shared financial model where IEHP, while under contract with SBC-DBH, will have financial responsibility for needed inpatient and outpatient medical and behavioral health services for the pilot population.

Artwork by Betsy Pruitt

Workforce Education and Training

Workforce Education and Training (WET)

The passage of the Mental Health Services Act (MHSA) in November 2004, provided a unique opportunity to increase staffing and other resources to support public behavioral health programs. MHSA funds increased access to much needed services, and progress toward statewide goals for serving children, Transitional Age Youth (TAY), adults, older adults, and their families.

California's public behavioral health system has suffered from a shortage of behavioral health workers, changes in mental health occupational classifications, and underrepresentation of diversity of professionals with consumer and family member experience. To address challenges faced by the public behavioral health workforce, the MHSA included a component for Mental Health Workforce Education and Training (WET) programs.

WET is a program that provides various training opportunities to the Department of Behavioral Health's (DBH) staff and contract agency staff, promotes the hiring of a culturally diverse workforce, offers financial incentives to recruit and retain staff, recruits volunteers for the department, facilitates clinical intern programs, supports the inclusion and incorporation of consumers and their family members into the behavioral health workforce, and is committed to addressing workforce shortage within San Bernardino County through utilization of various strategies to recruit and retain qualified behavioral health employees.

WET carries forth the vision of the MHSA to create a transformed, culturally-competent system that promotes wellness, recovery, and resilience across the lifespan of all age groups and all cultural backgrounds.

"Thank you for the opportunity and I felt welcome in this community-office filled with hardworking staff."

High school student

"Thank you for the wonderful internship. I have learned so much and enjoyed every second of it. I appreciate everything that DBH does for the community members of San Bernardino County."

– Graduate student

MHSA Legislative Goals

Address workforce shortages and deficits identified in the workforce needs assessment:

- Increase in the number of employees hired in identified needs assessment areas
- Increase in pre-licensed to licensed baseline statistics
- Increase in the number of qualified applications received for clinical positions
- Increase in DBH pre-licensed clinicians hired (interns vs. non-interns)

Designate a WET Coordinator:

- WET Coordinator designated

Educate the workforce on incorporating the general standards:

- Training documented addressing these standards
- TRM survey and report
- Training evaluations

Increase the number of clients and family members of clients employed in the public mental health system:

- Increased number of peer and family advocates (PFAs) hired

Conduct focused outreach and recruitment to provide equal employment opportunities in the public mental health system for individuals who share the racial/ethnic, cultural, and/or linguistic characteristics of clients, family members of clients, and others in the community who have serious mental illness and/or serious emotional disturbance:

- Documented efforts that target the identified population
- Documented career fairs including locations

Recruit, employ, and support the employment of individuals in the public mental health system who are culturally and linguistically competent, or at a minimum, are educated and trained in cultural competence:

- Documented efforts that target the identified populations
- Adherence to cultural competency training requirement
- Increase in hiring of culturally competent staff
- Increase in the number of bilingual staff, bilingual applicants, and bilingual interns

Provide financial incentives to recruit or retain employees within the public mental health system:

- Financial incentives implemented
- Tracking for employee scholarship applicants
- License Exam Prep Program statistics

Incorporate the input of clients and family members of clients, and when possible utilize them as trainers and consultants in public mental health WET programs and/or activities:

- Documented meetings with clients and family members
- Documented trainings facilitated by clients and family members

Incorporate the input of diverse racial/ethnic populations that reflect California's general population into WET programs and/or activities:

- Documented meetings with diverse racial/ethnic populations

Establish regional partnerships:

- Participate in meetings

Positive Results

To meet the legislative goal, *Address workforce shortages and deficits identified in the workforce needs assessment*, a needs assessment was completed in 2008. Psychiatrists, child psychiatrists, licensed clinical therapists, and internists were identified as hard-to-retain and hard-to-recruit positions in the County. A new needs assessment was completed in July 2013 again identifying child psychiatrists and psychiatrists as hard-to-fill and hard-to-retain positions.

The progress made in San Bernardino County in the occupational shortage areas and in other clinical positions is a credit to the various WET programs in place. DBH has been successful in increasing the number of applications received for qualified licensed staff. This is imperative in order to adequately equip the DBH workforce to serve an ever growing and diverse population within San Bernardino County. More progress is needed as there are still occupational shortages.

As seen in the **Table 1**, the WET program has received a slight decrease in overall applications for licensed positions in Fiscal Year 2018/19. However, as a result of the department's year round recruitment, there was an increase in the number of qualified applicants for Clinic Supervisor, Clinical Therapist II, Mental Health Nurse II, Nurse Supervisor, Pre-Licensed Clinical Therapists, Licensed Clinical Social Workers, Licensed Marriage and Family Therapists, and Psychiatric Technician I's.

Table 1:

Number of Qualified Applications Received for DBH Positions Per Fiscal Year											
Job Title	FY 08/09	FY 09/10	FY 10/11	FY 11/12	FY 12/13	FY 13/14	FY 14/15	FY 15/16	FY 16/17	FY 17/18	FY 18/19
Alcohol and Drug Counselor	N/A	N/A	43	44	27	N/A	39	45	32	117	83
Child Psychiatrist	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	6	8	5
Clinic Assistant	N/A	N/A	N/A	N/A	N/A	N/A	47	239	116	103	0
Clinic Supervisor	14	10	57	N/A	N/A	30	37	64	44	25	37
Clinical Therapist, LCSW	N/A	3	5	12	3	6	3	4	11	7	11
Clinical Therapist, MFT	N/A	6	5	12	10	8	9	14	18	16	25
Clinical Therapist, Psychology	N/A	1	3	5	1	N/A	1	4	8	0	1
Clinical Therapist II	N/A	8	12	32	N/A	54	44	39	48	35	58
Licensed Vocational Nurse	N/A	N/A	N/A	N/A	N/A	N/A	N/A	53	30	160	26
Mental Health Education Consultant	N/A	N/A	24	20	N/A	N/A	77	N/A	27	45	0
Mental Health Nurse II	2	8	4	7	N/A	29	32	47	31	24	62
Mental Health Specialist	72	15	13	120	N/A	90	70	226	370	430	10
Nurse Manager	N/A	N/A	N/A	N/A	N/A	N/A	6	N/A	N/A	N/A	N/A
Nurse Supervisor	4	6	N/A	10	N/A	N/A	N/A	9	11	5	13
Peer and Family Advocate I	N/A	N/A	N/A	96	279	187	141	196	201	146	0
Peer and Family Advocate II	N/A	N/A	N/A	32	0	52	35	66	68	66	41
Peer and Family Advocate III	N/A	N/A	N/A	N/A	0	53	31	42	44	48	N/A
Pre-Licensed Clinical Therapist, LCSW	37	50	65	92	81	105	69	223	165	152	164
Pre-Licensed Clinical Therapist, MFT	92	82	86	109	112	128	90	375	233	201	235
Pre-Licensed Clinical Therapist, Psychology	27	22	21	23	21	20	43	50	43	50	11
Pre-Licensed Clinical Therapist, LPCC	N/A	N/A	N/A	N/A	14	2	17	49	31	39	44
Program Manager I	75	N/A	N/A	38	N/A	20	38	38	64	13	4
Program Manager II	6	11	8	6	N/A	6	18	16	31	5	7
Psychiatric Technician I	N/A	43	54	66	59	N/A	46	106	94	24	56
Psychiatrist	N/A	N/A	N/A	1	6	9	8	5	16	14	14
Research and Planning Psychologist	N/A	N/A	N/A	3	N/A	N/A	N/A	N/A	1	2	N/A

Another program that WET oversees is the License Exam Prep Program (LEPP). LEPP was created to help pre-licensed clinicians become licensed. **Table 2** illustrates the progress that LEPP has had to help staff obtain licensure for their discipline.

Table 2:

Program	Fiscal Year	# of Applicants	# of those Applicants who became licensed	% Licensed
LEPP 1	July 2009*	60	41	68%
LEPP 2	January 2011*	38	24	63%
LEPP 3	January 2012*	32	19	59%
LEPP 4	2013/14	18	14	78%
LEPP 5	2014/15	41	37	90%
LEPP 6	2015/16	59	48	81%
LEPP 7	2016/17	65	47	72%
LEPP 8	2017/18	47	27	57%
LEPP 9	2018/19	41	11	27%
Grand Total		**401**	**268**	**67%**

*Prior to Fiscal Year 2013/14, applications were only taken one date per year.

As seen in **Table 2** above, for LEPP 1-8, there has been, on average, 67% licensure rate among the participants. DBH expects the percentage of pre-licensed to licensed clinicians to continue to increase with the benefit of LEPP (**Table 3**).

Table 3:

Through 8 Cohorts of LEPP, Prior to Implementation of Revised LEPP*			
	Clinical Therapist I	**Clinical Therapist I – Psychologist**	**Total**
Licensed	63	4	67
Pre-Licensed	104	7	111
Total	167	11	178
% Licensed	**37.7%**	**36.4%**	**37.6%**

*DBH has seen a slight increase of 2.6% in the percentage of licensed staff since Fiscal Year 2017/18.

With the passage of the MHSA and the creation of WET, DBH was able to 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, students participate in the Internship Program for 12 to 18 months. During this time, they learn to provide clinical services in a public community behavioral health setting. In Fiscal Year 2018/19, there were 38 interns in the intern program across the three disciplines. Additionally, the MFT program expanded to include one doctoral MFT Graduate Student intern (students of other doctoral disciplines can also apply for this internship opportunity).

The program continues to grow and receive positive feedback from participants who report that they received comprehensive training and a valuable experience during their time at DBH. It is hoped that integrating psychiatric residents into the clinical staff and supporting their understanding of the therapeutic process, as well as increasing their clinical skills, will lead to an increase in the retention and hiring of psychiatrists who complete their residency at DBH. DBH is committed to hiring applicants that were previously interns. As seen in **Table 4**, 28% of clinical hires in Fiscal Year 2018/19 were DBH interns. These 13 DBH interns were hired as pre-licensed Clinicians with the department in Fiscal Year 2018/19.

Table 4:

Pre-Licensed Clinicians Hired	FY 11/12	FY 12/13	FY 13/14	FY 14/15	FY 15/16	FY 16/17	FY 17/18	FY 18/19
Total Number of Interns Hired	13	18	13	18	13	20	15	13
Total Number of Non-Interns Hired	11	9	16	19	33	22	30	33
% of Interns Hired	**54%**	**67%**	**45%**	**49%**	**28%**	**48%**	**33%**	**28%**

In 1995, the Board of Supervisors created the MSW Assist Program, which later became known as the DBH Employee Educational Internship Program. This program was created to support current DBH staff in pursuing their Master of Social Work (MSW) or Marriage and Family Therapy (MFT) degrees, by allowing them to intern for up to 20 hours per week in a DBH program as part of their degree program requirements. The program was created to support the WET initiative of building a more skilled workforce by "growing our own" qualified staff to fulfill the identified clinical shortages within the department, in order to serve the community and offer quality services to consumers seeking services within our county. It has increased in popularity since its implementation, and in April 2015, the program was expanded by adding Alcohol and Drug Counselor (AOD) and Bachelor of Social Work (BSW) as additional intern career path options.

Also in Fiscal Year 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 in DBH clinics. WET foresees the number of NPs completing rotations with the department increasing in the future to support the growth of more Behavioral Health Nurse Practitioners in our community.

To meet the Legislative Goal of *Educate the Workforce on Incorporating the General Standards*, DBH continues to incorporate Wellness, Recovery, and Resilience Model in trainings. The General Standards set by the Mental Health Services Act (MHSA) are wellness, recovery, and a resilience model that is culturally competent, supports the philosophy of a consumer/family driven behavioral health system, integrates services, and includes community collaboration. Among the trainings provided in Fiscal Year 2018/19, the following trainings are some of the trainings that incorporate the General Standards set by MHSA:

- Bridges Out of Poverty
- Celebrating Our Cultures
- Hearing Voices
- Hoarding Disorders
- Homeless Outreach and Engagement
- Mental Health First Aid
- Moral Reconation Therapy

The table below provides additional information regarding trainings provided by WET in Fiscal Year 2018/19.

Fiscal Year	Attendance	Classes	CEUs	Evaluation (Avg.)
2013/14	3,095	136	989.45	4.6
2014/15	3,524	108	703	4.6
2015/16	3,867	120	391	4.6
2016/17	4,296	234	494.5	4.6
2017/18	4,477	231	281.5	4.7
2018/19	4,371	283	567.5	4.74

Table 5 indicates that the evaluation average of the trainings in Fiscal Year 2018/19 is 4.74 out of 5. WET has maintained a consistent high volume of offered courses across the last three consecutive fiscal years.

In June 2019, WET was pleased to bring to DBH staff the LEAP® Course, which is a one-day facilitator-led training workshop designed to provide participants the critical research and skillset required to create a therapeutic alliance and build a collaborative relationship with persons who have severe mental illness, that lead to the acceptance of treatment and services. The training was very successful, as evidenced by the considerable volume of positive trainee feedback.

Peer and Family Advocates (PFAs) are behavioral health consumers or family members of behavioral health consumers who provide crisis response services, peer counseling, linkages to services, and support for consumers of DBH services. They also assist with the implementation, facilitation, and on-going coordination of activities of the Community Services and Supports (CSS) plan in compliance with MHSA requirements and perform related duties as required. The Peer and Family Advocate position also fulfills the MHSA Workforce Education and Training legislative goal to *Increase the Number of Clients and Family Members of Clients Employed in the Public Mental Health System*.

As seen in **Table 6**, 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 resulting from the inclusion of Peer and Family Advocates in many DBH programs and the positive outcomes it has yielded on the consumers served by these programs. DBH strives to continue to increase the number of PFAs being hired and maintained on staff in DBH programs and hosts an open recruitment for PFA levels I, II, and III annually. The recruitment, which includes advertising on social media, flyers, and emails circulated throughout the community, and posting on Jobinsocal.com, is widely popular amongst members of the community and garners between 150 to 200 applications annually. By utilizing different outlets to advertise for the PFA positions,

especially social media and word of mouth through current DBH employees, the department increases the public's knowledge of the Peer and Family Advocate position, as well as increases the number of qualified applicants applying for these vacancies each year.

Table 6:

Fiscal Year	Total PFAs with DBH
2005/06	**4**
2006/07	**19**
2007/08	**24**
2008/09	**24**
2009/10	**21**
2010/11	**20**
2011/12	**24**
2012/13	**25**
2013/14	**23**
2014/15	**29**
2015/16	**28**
2016/17	**26**
2017/18	**36**
2018/19	**28** (plus 10 vacancies)

Once a PFA starts working for DBH, they are encouraged to develop professionally and promote to a higher classification. The following table shows the number of PFAs promoted since 2008.

Table 13:

	FY 07/08	FY 11/12	FY 12/13	FY 13/14	FY 14/15	FY 15/16	FY 16/17	FY 17/18	FY 18/19
PFAs Promoted	**3**	**1**	**1**	**4**	**3**	**4**	**3**	**5**	**6**

The contract agencies that work with DBH are required to employ PFAs as well, although they may be given different working titles. The number of PFAs employed with DBH contract agencies continues to increase as more programs are choosing to utilize the benefits presented by incorporating peer support and advocacy into their practices.

Not all contract agencies use the PFA title. A few other titles they use are:

- Family Partner
- Youth Partner
- Peer Partner
- Parent Partner
- Family Support Partner
- Parent Family Advocate

To meet the Legislative Goal, *Conduct Focused Outreach and Recruitment to Provide Equal Employment Opportunities in the Public Mental Health System for Individuals who Share Racial/Ethnic, Cultural and/or Linguistic Characteristics of Clients and Family Members*, the Volunteer Services Coordinator participates in career fairs throughout the County including remote areas such as Barstow and Morongo Basin. As illustrated in **Table 7**, the coordinator increased the number of participants in outreach efforts every year through Fiscal Year 2017/18. However, the number decreased in 2018/19 due to an increase in Partnerships with Pilot Programs for High School Students which caused the Volunteer Services Coordinator to attend less outreach events then previous years.

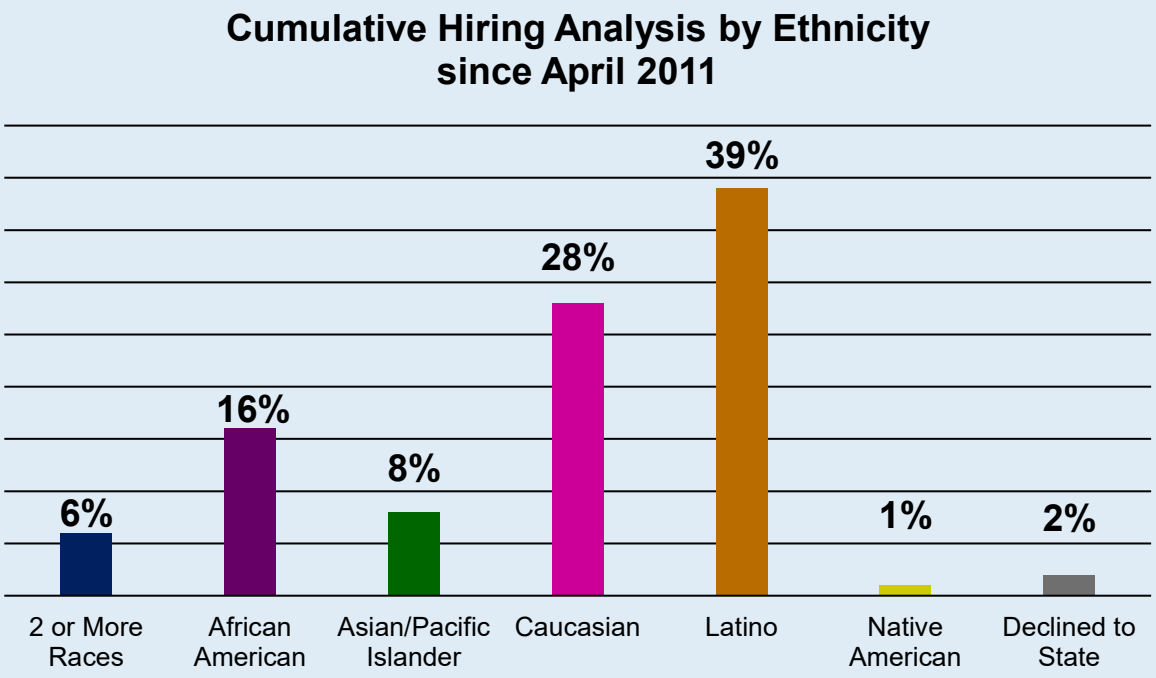
Table 7:

	FY 11/12	FY 12/13	FY 13/14	FY 14/15	FY 15/16	FY 16/17	FY 17/18	FY 18/19	Total
Number of Schools Visited	13	16	23	35	35	70	82	63	**337**
Number of Participants	2,470	2,479	1,706	2,770	4,139	6,958	9,303	6,377	**36,202**

To help reach the Spanish speaking community, the coordinator has partnered with a bilingual co-presenter and translated presentations and handouts into Spanish. The co-presenter also helps to explain behavioral health career opportunities to monolingual parents that may not have a full understanding of what kind of career options are available for their children.

To meet the Legislative Goal, *Recruit, Employ and Support the Employment of Individuals in the Public Mental Health System who are Culturally and Linguistically Competent or, at a minimum, are Educated and Trained in Cultural Competence*, DBH strives to have staff that provide culturally and linguistically competent services to consumers. To ensure that measure is met, all staff are required to take either online or live cultural competency trainings (2 hours for non-clinicians and 4 hours for clinicians), annually.

To help ensure DBH provides culturally and linguistically competent services DBH continually recruits new employees that represent the diverse population of San Bernardino County, as can be seen in the chart below.



To help provide culturally and linguistically competent services to consumers, DBH actively recruits applicants who are bilingual and bicultural. As can be seen in **Table 8**, DBH has continued to maintain the number of bilingual staff employed with DBH in Fiscal Year 2018/19. However, it remains a top priority of the department to continue to recruit and retain bilingual staff.

Table 8:

Fiscal Year	Number of Bilingual Staff
2012/13	150
2013/14	165
2014/15	162
2015/16	171
2016/17	171
2017/18	170
2018/19	172
TOTAL	**1,161**

The majority of bilingual staff speak Spanish, but other languages spoken by staff include:

- Tagalog
- Vietnamese
- French
- German

WET has actively recruited bilingual interns to help provide services in other languages. Since Fiscal Year 2008/09, on average 34% of interns are bilingual. In Fiscal Year 2018/19, 38% of interns were bilingual. Of the bilingual interns, 93% are Spanish speakers.

Table 9:

Number of Bilingual Interns per Fiscal Year											
	FY 08/09	FY 09/10	FY 10/11	FY 11/12	FY 12/13	FY 13/14	FY 14/15	FY 15/16	FY 16/17	FY 17/18	FY 18/19
BSW	3	3	2	0	3	3	5	2	2	4	1
MSW	5	3	9	5	5	8	6	11	7	4	9
MFT	6	3	6	2	5	1	2	8	5	2	3
Psychology	2	1	1	1	0	2	3	3	2	0	2
Total – Bilingual	**16**	**10**	**18**	**8**	**13**	**14**	**16**	**24**	**16**	**10**	**15**
Total Interns	**39**	**46**	**41**	**44**	**47**	**51**	**43**	**47**	**39**	**31**	**39**
% that are Bilingual	**41%**	**22%**	**44%**	**18%**	**28%**	**27%**	**37%**	**51%**	**41%**	**32%**	**38%**

To meet the Legislative Goal, *Provide Financial Incentives to Recruit or Retain Employees within the Public Mental Health System*, the Employee Scholarship Program (ESP) was piloted in 2013. $25,000 in funds is budgeted per year to be distributed among the awardees. The funding for ESP has been allocated to provide scholarships designed to pay student tuition (not to include books, travel, or other expenses) for employees who are working to earn a clinical or non-clinical certificate, associate or bachelor's degree, or a non-clinical master's or doctorate degree. This opportunity is expressly designed to promote the development of a strong, stable, and diverse workforce within DBH.

In Fiscal Year 2012/13, twelve (12) ESP awardees were selected, in Fiscal Year 2013/14, eleven (11) awardees were selected, eight (8) in Fiscal Year 2014/15, ten (10) in Fiscal Year 2015/16, nine (9) in Fiscal Year 2016/17, ten (10) in Fiscal Year 2017/18, and three (3) in Fiscal Year 2018/19. **Table 10** below provides a breakdown of which degrees the awardees were pursuing.

Table 10:

Degrees	FY 12/13	FY 13/14	FY 14/15	FY 15/16	FY 16/17	FY 17/18	FY 18/19
Associates	2	0	0	0	1	0	0
Bachelors	5	5	4	5	5	6	2
Masters	5	6	3	4	2	4	1
Certificate	0	0	1	1	1	0	0
Total Recipients	**12**	**11**	**8**	**10**	**9**	**10**	**3**

Additionally, **Table 11** illustrates the number of ESP awardees whom have promoted to new positions.

Table 11:

	FY 12/13	FY 13/14	FY 14/15	FY 15/16	FY 16/17	FY 17/18	FY 18/19
Awardees Promoted	**1**	**2**	**2**	**0**	**1**	**3**	**10**

As seen in the License Exam Prep Program (LEPP) table, there have been 401 total LEPP participants, with approximately 67% of the participants completing licensure in their discipline (as previously seen in **Table 2**).

To meet the Legislative Goal, *Incorporate the Input of Clients and Family Members of Clients, and When Possible Utilize Them as Trainers and Consultants in Public Mental Health WET Programs and/or Activities*, the Office of Consumer and Family Affairs (OCFA) is invited to the Workforce Development Discussion (WDD) meeting, to provide input on the implementation of the MHSA WET Plan component. OCFA is a Peer and Family Advocate office that provides advocacy and support to consumers and family members.

Peer and Family Advocates (PFAs) train in collaboration with the Training and Development Specialists (TDS) at WET. As part of the Crisis Intervention Training (CIT), PFAs also conduct the Shaken Tree training. The training is an award-winning documentary film that illuminates, through a collection of stories, the journey families experience when one of its members has chronic, persistent mental illness. The film addresses their journey of pain, grief, feelings of helplessness, despair, and stigma associated with mental illness, while giving the viewer hope and ways to survive and live life fully while sharing it with someone who has a mental illness.

After the documentary is viewed, the PFA leads a discussion regarding the film, and connects their own experiences with mental illness as a person in recovery and/or as a family member of someone with a mental illness.

As of Fiscal Year 2014/15, the Shaken Tree training is shown in DBH New Employee Orientation in order to familiarize all new staff with the perspective of family members of consumers battling mental illness. PFAs also participated in the "Get Psyched" conference in November 2018 to encourage youth to consider careers in the behavioral health field.

To meet the Legislative Goal, *Incorporate the Input of Diverse Racial/Ethnic Populations that Reflect California's General Population into WET Programs and/or Activities*, DBH uses multiple methods. DBH uses the Workforce Development Discussion (WDD) meeting and partners with the Office of Cultural Competency and Ethnic Services (OCCES) to help maximize the ability of the existing and potential workforce, contract agencies, and fee-for-service providers, to provide culturally and linguistically appropriate services to County residents by:

- Providing Cultural Competence training to all staff
- Developing policies that clarify the usage of bilingual staff for interpretation services, as well as provide guidelines on providing appropriate services for diverse cultural groups
- Providing interpreter training to all bilingual staff
- Recruiting and retaining multilingual and multicultural staff
- Working with the communities we serve to address the cultural needs of the community
- Cultural Competency Advisory Committee and thirteen (13) Culture-Specific Awareness Subcommittees

OCCES also works closely with the Workforce Development Discussion (WDD) committee to ensure the needs of the diverse racial/ethnic populations of San Bernardino County are being met.

To meet the Legislative Goal, *Establish Regional Partnerships*, the Southern Counties Regional Partnership (SCRP) was created in 2009. SCRP is a collaborative effort between ten Southern California counties. The Partnership's goals are to coordinate regional education programs, disseminate information and strategies throughout the region, develop common training opportunities and share programs that increase diversity of the public behavioral health system workforce when those programs are more easily coordinated at a regional level. The ten counties include:

- Kern
- Imperial
- Orange
- Riverside
- San Bernardino
- San Diego
- San Luis Obispo
- Santa Barbara
- Tri Cities
- Ventura

San Bernardino County was the fiscal agent of SCRP until June 30, 2014. Santa Barbara County assumed responsibility as the fiscal agent during Fiscal Year 2014/15. San Bernardino County continues to participate in SCRP as a member county.

To meet the Legislative Goal, *Coordinate WET Programs and/or Activities*, the WET staff continues to coordinate all WET programs/activities.

Workforce Education and Training (WET) continues to conduct outreach and engagement activities throughout San Bernardino County.

Artwork by Tskandar Iskander

Outreach and Engagement

In Fiscal Year 2018/19, Workforce Education and Training (WET) organized and/or participated in the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
School College & Career Fairs (Elementary/Middle/High Schools)	23	1,590
College Career Fairs	8	443
Classroom Presentations	31	4,266
Get Psyched Seminar – Inland Coalition/Riverside County/San Bernardino County	1	78
Total	**63**	**6,377**

Challenges

The Department continues to have difficulty retaining licensed clinical staff due to challenges presented by the Memorandum of Understanding (MOU) for the Professional bargaining unit. Although the new MOU has increased compensation for clinical staff, one of the remaining challenges is other employers that can offer higher wages and/or better benefits. Additionally, the Department has encounter the following challenges:

- High vacancy rate of hard to fill positions like Alcohol and Other Drug (AOD) counselor,
- Lack of clinical supervisors for all three internship programs,
- Unclear line of succession for the PFA position,
- Lack of DBH volunteer sites.

Solutions in Progress

The Department continues to work closely with County Human Resources to develop creative solutions to address the issue of retaining qualified licensed clinicians. DBH is working to continue implementing creative strategies to retain staff in clinical positions, and is working diligently through outreach efforts to increase the interest of students and community members.

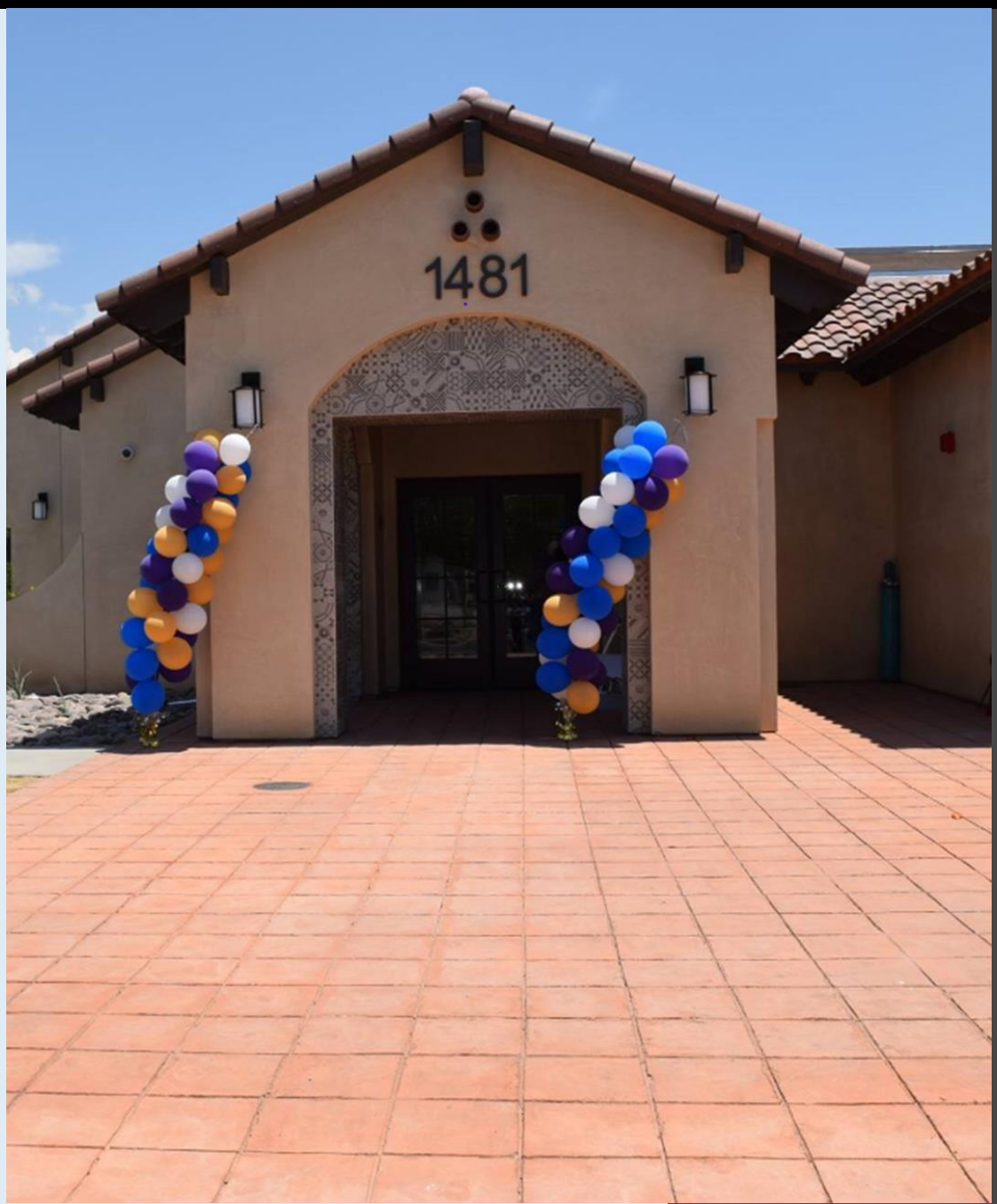
Additionally, the Department has taken the following actions to address the challenges:

- Held a hiring fair to address the AOD counselor positions,
- Developed a plan to implement Incentives for clinical supervisors,
- Updated the succession plan for PFA positions,
- Increased capacity building efforts of potential DBH sites for volunteers.

Collaborative Partners

- Alder School of Professional Psychology
- American Career College
- American University of Antigua
- Argosy University
- Arrowhead Regional Medical Center (ARMC)
- Azusa Pacific University
- Brandman University
- Cajon High School, San Bernardino - MIND Program (Moving In New Directions)
- 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)
- Loma Linda University Medical Center (LLUMC)
- Loma Linda University School of Medicine (LLUSM)
- Pomona Valley Hospital Medical Center (PVHMC)
- Reach Out
- San Bernardino City Unified School District
- Serrano High School, Phelan - Get Psyched
- Touro University College of Osteopathic Medicine (TUCOM)
- University of San Diego
- Western University of Health (WUH)
- Workforce Development Department - Generation Go Student Interns

Capital Facilities and Technological Needs



Capital Facilities and Technological Needs (CFTN)

Each county's Capital Facilities and Technological Needs Component must support the goals of the Mental Health Services Act (MHSA) and the provision of MHSA services. The planned use of the Capital Facilities and Technological Needs' funds produce long-term impacts with lasting benefits that support the behavioral health system's movement towards the recovery, resiliency, cultural competence, a help first model, and expansion of opportunities for accessible community-based services for consumers and their families. These efforts include the development of a variety of technology uses and strategies and/or community-based facilities that support integrated service experiences that are culturally and linguistically appropriate. Funds may also be used to support an increase in:

- Peer-support and consumer-run facilities,
- Development of community-based, less restrictive settings that will reduce the need for incarceration or institutionalization, and
- The development of technological infrastructure for the public behavioral health system to facilitate high quality, cost-effective services and supports for consumers and their families.

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

MHSA Legislative Goals and Related Key Outcomes

Expansion of the capacity and access of existing services or the provision of new services:

- Increased capacity
- Increased access to services
- Increased provision of new services

Increase the county mental health infrastructure on a permanent basis:

- Permanent capital asset obtained
- Modernize and transform clinical and administrative information systems to ensure quality of care, parity, operational efficiency and cost effectiveness
- Implement, maintain, and improve Electronic Health Record (EHR)
- Maintain and utilize data warehouse

Capital Facilities

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

The Crisis Residential Treatment (CRT) Program

The new Crisis Residential Treatment (CRT) facilities are modeled after DBH's and are voluntary, short-term crisis residential programs for San Bernardino residents ages 18 to 59 specialized in providing 24-hour crisis residential treatment to individuals experiencing an acute psychiatric episode or crisis. The CRTs provide 24-hours a day, seven days a week care.

The programs supported under the Community Services and Supports component, provide structured recovery-based, enriched treatment services and activities. Services for these facilities include, but are not limited to:

- Assessments
- Treatment plan development
- Collateral services
- Crisis intervention
- Medication support services
- Individual and group therapy
- Case management

The Crisis Stabilization Unit (CSU)

The Crisis Stabilization Units (CSUs) are voluntary and unlocked, 23-hour psychiatric urgent care centers that are open 24 hours per day, seven days a week that provide a positive, safe, quiet, and calm home-like environment. Individuals experiencing a mental health crisis can be assessed for stabilization services, including a medication evaluation, or can be assessed for hospitalization, if necessary. The CSUs provide the same services as the Crisis Walk-In Centers (CWICs). Both CSUs have 20 spaces to serve, 16 adults ages 18 and older and four adolescent spaces for individuals aged 13 to 17.

Technological Needs

The overarching goal of the technological needs portion of the Capital Facilities and Technological Needs component is to support the modernization of information systems and to increase consumer/family empowerment by providing the tools for secure access to health and wellness information. These projects will result in improvements in the quality of care, operational efficiency, coordination of care, and cost effectiveness across the Department.

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

DBH is in the implementation phase of a Behavioral Health Management Information System (BHMIS) that will support secure access and exchange of health information by providers. Replacement of the Department of Behavioral Health's (DBH) 25 year old information system that is used to track clients as they progress through the treatment system will consist of implementing a new integrated BHMIS that incorporates an Electronic Health Record (EHR). This will improve technological efficiencies, allowing DBH to meet modern State and Federal expectations.

The purpose of the EHR is to provide an efficient system to support better capturing of information, allowing providers to fully document care in a manner that fosters client and family interactions, enables highly functional reporting and data aggregation, as well as enhances coordination of care between internal and external providers.

Behavioral Health has entered into a contract for the implementation of a new integrated billing system and EHR solution that will be implemented in two phases. DBH began the first phase of this project in April of 2017 through the initiation of the implementation phase of the billing system and full self-hosted hardware infrastructure. This includes all elements required to submit claims to the Department of Health Care Services (DHCS), Medicare, and other health insurances, and the ability to upload service and other required data to state and local systems, including but not limited to: Client and Service Information (CSI) and (California Outcomes Measurement System) (CalOMS) reporting. Phase I is currently working to determine when go-live can occur based on outstanding tasks and will include a new electronic prescription solution that will replace Dr. First®.

The implementation of the second phase is a parallel process being developed simultaneously with Phase I, which will culminate to result in the implementation of the full EHR solution. This includes implementing all remaining functionality such as electronic treatment plans, assessments, progress notes, telehealth, etc. The EHR includes all medical record elements required by Federal and State regulations, Medi-Cal and Medicare chart documentation requirements as well as DBH chart documentation standards.

As DBH transitions to the new BHMIS, staff will be trained to use a new electronic prescribing solution, Order Connect, a component of the new system that will replace

Dr.First®. DBH has gained a great deal of knowledge from the implementation of DrFirst®, enabling staff to provide valuable feedback and guidance regarding configuration and implementation.

Data Warehouse

The purpose of a data warehouse is to bring information together from different sources so services and trends can be analyzed to help improve overall service delivery. The data warehouse is a repository of information collected from a variety of data systems, including DBH's current billing system, the hospitalization tracking system, the Full Service Partnership Data Collection and Reporting (DCR) system and performance outcomes information from the Children's Assessment of Needs and Strengths (CANS) and Adult Needs and Strengths Assessment (ANSA). This data will expand to include full pharmacy data from Dr. First® and select clinical information from the upcoming Electronic Health Record.

The data warehouse has been updated with CANS and ANSA data to allow for a more robust and efficient data analysis, focused on improving service delivery to consumers and family members. The warehouse also prepares data collected through Select Survey, an online survey application, to maintain updated service provider information for the department's provider directory and to meet state network adequacy requirements. The data warehouse is built on an agnostic platform to allow for the acceptance of new data, from virtually any source and allows DBH to better analyze the efficiency and effectiveness of services across multiple domains.

Reports generated from data in the warehouse have helped drive evaluation of, and decision making around, program planning across the system of care. The data and information generated through the data warehouse is necessary in the application process when the County seeks to secure additional funds for the expansion of behavioral health services, plays a key role in ongoing conversations about MHSA program development, Innovation program goals and analysis, and behavioral health reforms outlined in Cal-Aim.

Program Updates

Capital Facilities

The Crisis Residential Treatment (CRT) Program

DBH has four Capital Facilities projects to support the expansion of crisis services. All of the projects are part of DBH's grant application to the California Health Facilities Financing Authority (CHFFA), for capital funding for the construction of Crisis Residential Treatment (CRT). Each CRT contains 16 beds.

The Crisis Residential Treatment facilities provides a home-like setting designed to provide an additional access point for individuals experiencing a serious psychiatric crisis. These centers serve adults aged 18-59, 24 hours a day, seven days a week.

The Desert Hill Center CRT is located at 16552 Sunhill Drive, in the city of Victorville and opened on September 5, 2018.

Desert Hill Center CRT

The Wellspring Center CRT is located at 15217 San Bernardino Avenue, in the city of Fontana and opened on October 8, 2018.

Wellspring Center Crisis Center CRT

The Morongo Oasis Center CRT is located at 60805 29 Palms Highway, in the city of Joshua Tree and opened on October 3, 2018.

Morongo Oasis Center CRT

Crisis Stabilization Unit (CSU)

DBH has two additional Capital Facilities projects for the expansion of crisis services. All of the projects are part of DBH's grant application to the California Health Facilities Financing Authority (CHFFA), for capital funding for the construction of Crisis Stabilization Units (CSUs).

The Crisis Stabilization Unit provides voluntary urgent care services for adults and adolescents in a safe, quiet, and calm environment where staff will seek to stabilize an individual's symptoms for safety and take the steps necessary to prepare the individual for their recovery. The CSUs will provide services 24 hours a day, seven days a week to serve adolescents (13-17) and adults, 18 and older.

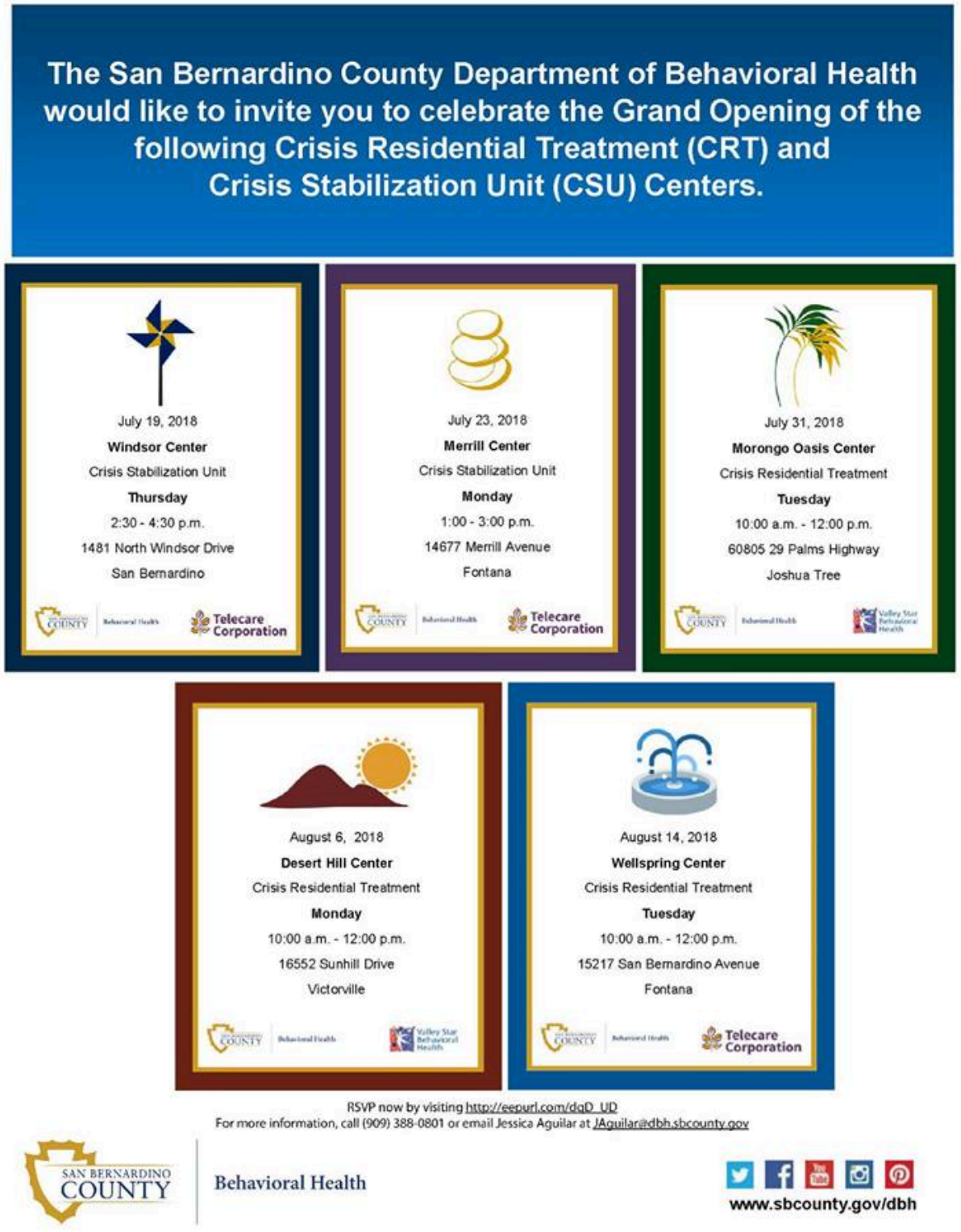
The Windsor Center CSU located at 1481 N. Windsor Drive in the City of San Bernardino and opened on August 25, 2018.

Windsor Center CSU

Ribbon Cutting at Windsor Center CSU

The Merrill Center CSU is located at 14677 Merrill Avenue in the City of Fontana and opened on August 25, 2018.

Merrill Center CSU


The San Bernardino County Department of Behavioral Health would like to invite you to celebrate the Grand Opening of the following Crisis Residential Treatment (CRT) and Crisis Stabilization Unit (CSU) Centers.
July 19, 2018
Windsor Center
Crisis Stabilization Unit
Thursday
2:30 - 4:30 p.m.
1481 North Windsor Drive
San Bernardino
Telecare Corporation
July 23, 2018
Merrill Center
Crisis Stabilization Unit
Monday
1:00 - 3:00 p.m.
14677 Merrill Avenue
Fontana
Telecare Corporation
July 31, 2018
Morongo Oasis Center
Crisis Residential Treatment
Tuesday
10:00 a.m. - 12:00 p.m.
60805 29 Palms Highway
Joshua Tree
August 6, 2018
Desert Hill Center
Crisis Residential Treatment
Monday
10:00 a.m. - 12:00 p.m.
16552 Sunhill Drive
Victorville
August 14, 2018
Wellspring Center
Crisis Residential Treatment
Tuesday
10:00 a.m. - 12:00 p.m.
15217 San Bernardino Avenue
Fontana
Telecare Corporation
RSVP now by visiting http://eepurl.com/dqD_UD
For more information, call (909) 388-0801 or email Jessica Aguilar at JAguilar@dbh.sbcounty.gov
SAN BERNARDINO COUNTY
Behavioral Health
www.sbcounty.gov/dbh

Positive Results

Electronic Health Record

- Standardization of workflow and documentation and availability of client information electronically throughout the organization will promote access by providers with current consumer information and treatment notes.
- Increased network infrastructure to support the BHMIS project
- Implemented system infrastructure hardware enhancements/upgrades in support of the BHMIS project.
- Updated and analyzed the business process to ensure that BHMIS implementation is successful.
- Phase I is currently working on remaining outstanding tasks and configuration changes, due to current reporting requirements.
- Phase II continues to be scheduled for implementation approximately one quarter after a Phase I go-live evaluation has been completed.

Data Warehouse

- The use of the data warehouse has enhanced decision support in regard to quality of care, access to services, performance outcomes, and effectiveness of services.
- Performs analysis of the program outcomes to determine the impact of the MHSA three year plan. Information is used to advocate for policies affecting consumers, department, and county.
- Reports on communities served, timely access to services, service types, and utilization providing comparisons and opportunities for improvement between programs and clinics serving similar populations.
- Analyze data for better coordination of care within the Children's and Family Services, Arrowhead Regional Medical Center, Department of Public Health, Community Development and Housing Agency, and Transitional Assistance Department. The reports that were previously generated manually have been automated.

Dr. First®

- Successful full implementation of the system into standard business operations
- Helped prevent prescription drug errors
- Automated clinical support
- Increased medication reconciliation
- Instant notification of allergies and drug interactions
- Reduced risk of readmissions

Challenges

Electronic Health Record (EHR)

Sufficient staffing to assist in the migration of data currently maintained in several legacy and supporting systems where data is stored present challenges. The transfer of data from the legacy and supporting systems into the new system is also challenging due to the difference in configuration and compatibility between systems.

Recruitment of staff with specialized skills needed to support the complexity of healthcare systems is a challenge.

DBH continues to face challenges meeting implementation milestones and goals due to the continuous changes of enhancements to the BHMIS system at the state and federal level while the data in the new system is being configured. These changes pertain to the requirements for billing and claiming and continue to impact and affect the current business processes which continue to change and evolve while we are still in the development and implementation.

Data Warehouse

The continued development, improvement, and expansion of self-serve dashboards, visual analytics, and statistics to provide real-time decision support tools for both clinical as well as managerial purposes.

The integration of future Electronic Health Records and additional clinical outcomes measures and other data sources to provide a richer data environment for outcomes measurements and information development, data governance to address continued data quality improvement, and converting existing active dashboards to Visual Analytics, allowing greater access, use and security for the sharing of data with programs.

Dr. First®

Training both existing and new staff continues to be time intensive. Staff turnover is a continuous challenge. Another barrier in utilizing Dr. First® is the time constraint felt by staff, in large part due to low and inconsistent staffing for the number of patients seen. Additional challenges continue to include system security requirements and logistics related to day to day operations.

Solutions in Progress

Electronic Health Record

The Behavioral Health Management Information System (BHMIS) integrated solutions infrastructure has been established. Continue to configure new BHMIS base software, data conversion testing and validation, Managed Services Organization (MSO) configuration and initiate the Data Warehouse interface. Review of business processes and workflows for incorporation into the new BHMIS. Staff is being trained to use the Netsmarts California Billing and Claims module, Avatar CalPM. Establishing work groups and sub-project teams across professional disciplines to foster collaborative solutions and to design efficient workflows to be incorporated into the BHMIS.

Data Warehouse

Mapping and programming has continued for continuity to bring data to the new Behavioral Health Management Information Systems (BHMIS) to the Data Warehouse providing compatibility of data between the old system and the new system.

Dr. First®

The department has standardized the utilization of the deployment process of the e-prescribing, Dr. First®, system. Staff training has been incorporated into the onboarding process for all newly hired medical staff, as well as cross-training of support staff.

Program Updates

Electronic Health Record (EHR)

BHMIS system will incorporate an Electronic Health Record (EHR) making this system more effective and efficient in the delivery and analysis of services and will be current with Federal and State regulations and expectations. The department is nearing completion of remaining tasks and modifications to meet the need of the new reporting requirements. Configuration and training is being finalized to prepare staff for the changes to the business processes utilizing new workflows based on analysis and BHMIS processes.

TeleMed

TeleMed will be utilized as the vehicle with which telehealth will be delivered. TeleMed is a separate communications network that will be strictly used to support telehealth services including consultation, collaboration and training as needed to providers.

A separate communication network is necessary to ensure real-time video sessions between the doctors and the consumers. TeleMed will operate parallel to the data network that supports the Integrated Billing-Claims and EHR system to avoid performance issues and increase flexibility.

Data Warehouse

The Data Warehouse has been used to respond to various aspects of the special terms and conditions related to the 1115 Waiver Medi-Cal Program (Medi-Cal 2020), including mapping time and distances for Medi-Cal clients to evaluate contract performance, expanding and modifying the existing children's program report called the Specialized Programs Report for Outcomes Utilization and Treatment (SPROUT) to cover and fit screenings implemented at DBH mental health clinics, the development of contract monitoring tools to provide early warning when service levels are not being met or are being exceeded, and automating and streamlining the processing of shared data for continued care reform. The program was expanded to now include adults and older adults.

Dr. First®

The Dr. First® system was successfully implemented into the standard business operations and is now a current business practice.

Collaborative Partners

- San Bernardino County, County Administrative Office (CAO)
- San Bernardino County, Arrowhead Regional Medical Center (ARMC)
- San Bernardino County, Children and Family Services (CFS)
- San Bernardino County, County Counsel
- San Bernardino County, DBH, contracted service providers and vendors
- San Bernardino County, Human Services (HS)
- San Bernardino County, Information Services Department (ISD)
- San Bernardino County, Information Technology and Support Division (ITSD)
- San Bernardino County, Public Health (DPH)
- San Bernardino County, Purchasing
- San Bernardino County, Sheriff's Department
- Environmental System Research Institute (Esri)
- Inland Empire Health Plan (IEHP)
- Molina Health Care (MHC)
- Statistical Analysis System (SAS)

FISCAL

Artwork by Unknown

Estimated Cost Per Client Fiscal Year 2020/21
County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Three Year Plan FY 2020/21 - FY 2022/23

PREVENTION AND EARLY INTERVENTION

Program Name			Abbreviation	Estimated Total Mental Health Expenditures	Estimated Clients Served by Age Group				Estimated Number of Clients	Estimated Cost Per Client
					Children/ Youth (0-15)	TAY (16-25)	Adult (26-59)	Older Adult (60+)		
Stigma and Discrimination Reduction	Native American Resource Center	PEI-CI-3	NARC	$ 415,376	542	509	538	162	1,751	$ 237
Outreach for Increasing Recognition of Early Signs of Mental Illness	Promotores de Salud / Community Health Worker	PEI CI-1	PdS / CHW	$ 850,424	650	2,300	25,680	1,900	30,530	$ 28
	Behavioral Health Ministries Pilot Project	PEI CI-4	BHMPP	$ 100,000	7	27	285	21	340	$ 294
Access and Linkage to Treatment	Child and Youth Connection	PEI SE-2	CYC	$ 18,765,742	6,992	552	1,656	0	9,200	$ 2,040
Prevention	Preschool PEI Program	PEI SI-2	PPP	$ 478,378	924	42	542	0	1,508	$ 317
	Resilience Promotion in African American Children	PEI SI-3	RPIAAC	$ 938,683	2,400	500	1,000	0	3,900	$ 241
	Older Adult Community Services	PEI SE-1	OACS	$ 857,807	0	0	0	6,339	6,339	$ 135
	LIFT	PEI SE-5	LIFT	$ 299,359	60	30	30	0	120	$ 2,495
	Coalition Against Sexual Exploitation	PEI SE-6	CASE	$ 183,728	10	75	3,000	0	3,085	$ 60
Prevention and Early Intervention	Family Resource Center	PEI CI-2	FRC	$ 3,775,696	7,000	4,000	13,245	2,700	26,945	$ 140
	Community Wholeness and Enrichment	PEI SE-3	CWE	$ 2,767,584	0	2,990	1,013	0	4,003	$ 691
	Military Services and Family Support	PEI SE-4	MSFS	$ 725,000	84	113	812	73	1,082	$ 670
	Student Assistance Program	PEI SI-1	SAP	$ 3,539,592	21,250	2,750	3,500	0	27,500	$ 129
Early Intervention	Early Psychosis Program	PEI SE-7	EPP	$ 1,000,000	0	105	0	0	105	$ 9,524
			Total Program Costs	$ 34,697,368					116,408	$ 298
			PEI Administration	$ 2,628,696						
			PEI Assigned Funds	$ 561,894						
			PEI Total	$ 37,887,958						

Total clients served = 116,408 or $298 per person

Estimated Cost Per Client Fiscal Year 2021/22
County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Three Year Plan FY 2020/21 - FY 2022/23

PREVENTION AND EARLY INTERVENTION

Program Name			Abbreviation	Estimated Total Mental Health Expenditures	Estimated Clients Served by Age Group				Estimated Number of Clients	Estimated Cost Per Client
					Children/ Youth (0-15)	TAY (16-25)	Adult (26-59)	Older Adult (60+)		
Stigma and Discrimination Reduction	Native American Resource Center	PEI-CI-3	NARC	$ 415,376	542	509	538	162	1,751	$ 237
Outreach for Increasing Recognition of Early Signs of Mental Illness	Promotores de Salud / Community Health Worker	PEI CI-1	PdS / CHW	$ 853,474	650	2,300	25,680	1,900	30,530	$ 28
	Behavioral Health Minitries Pilot Project	PEI CI-4	BHMPP	$ 100,000	7	27	285	21	340	$ 294
Access and Linkage to Treatment	Child and Youth Connection	PEI SE-2	CYC	$ 18,827,471	6,992	552	1,656	0	9,200	$ 2,046
Prevention	Preschool PEI Program	PEI SI-2	PPP	$ 478,378	924	42	542	0	1,508	$ 317
	Resilience Promotion in African American Children	PEI SI-3	RPIAAC	$ 938,683	2,400	500	1,000	0	3,900	$ 241
	Older Adult Community Services	PEI SE-1	OACS	$ 862,541	0	0	0	6,339	6,339	$ 136
	LIFT	PEI SE-5	LIFT	$ 308,340	60	30	30	0	120	$ 2,570
	Coalition Against Sexual Exploitation	PEI SE-6	CASE	$ 189,240	10	75	3,000	0	3,085	$ 61
Prevention and Early Intervention	Family Resource Center	PEI CI-2	FRC	$ 3,781,789	7,000	4,000	13,245	2,700	26,945	$ 140
	Community Wholeness and Enrichment	PEI SE-3	CWE	$ 2,825,565	0	2,990	1,013	0	4,003	$ 706
	Military Services and Family Support	PEI SE-4	MSFS	$ 725,000	84	113	812	73	1,082	$ 670
	Student Assistance Program	PEI SI-1	SAP	$ 3,539,592	21,250	2,750	3,500	0	27,500	$ 129
Early Intervention	Early Psychosis Program	PEI SE-7	EPP	$ 1,000,000	0	105	0	0	105	$ 9,524
			Total Program Costs	$ 34,845,449					116,408	$ 299
			PEI Administration	$ 2,707,556						
			PEI Assigned Funds	$ 561,894						
			PEI Total	$ 38,114,899						

Total clients served = 116,408 or $299 per person

Estimated Cost Per Client Fiscal Year 2022/23
County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Three Year Plan FY 2020/21 - FY 2022/23

PREVENTION AND EARLY INTERVENTION

Program Name			Abbreviation	Estimated Total Mental Health Expenditures	Estimated Clients Served by Age Group				Estimated Number of Clients	Estimated Cost Per Client
					Children/ Youth (0-15)	TAY (16-25)	Adult (26-59)	Older Adult (60+)		
Stigma and Discrimination Reduction	Native American Resource Center	PEI-CI-3	NARC	$ 415,376	542	509	538	162	1,751	$ 237.22
Outreach for Increasing Recognition of Early Signs of Mental Illness	Promotores de Salud / Community Health Worker	PEI CI-1	PdS / CHW	$ 856,615	650	2,300	25,680	1,900	30,530	$ 28.06
	Behavioral Health Ministries Pilot Project	PEI CI-4	BHMPP	$ 100,000	7	27	285	21	340	$ 294.12
Access and Linkage to Treatment	Child and Youth Connection	PEI SE-2	CYC	$ 18,891,052	6,992	552	1,656	0	9,200	$ 2,053.38
Prevention	Preschool PEI Program	PEI SI-2	PPP	$ 478,378	924	42	542	0	1,508	$ 317.23
	Resilience Promotion in African American Children	PEI SI-3	RPIAAC	$ 938,683	2,400	500	1,000	0	3,900	$ 240.69
	Older Adult Community Services	PEI SE-1	OACS	$ 867,417	0	0	0	6,339	6,339	$ 136.84
	LIFT	PEI SE-5	LIFT	$ 317,590	60	30	30	0	120	$ 2,646.58
	Coalition Against Sexual Exploitation	PEI SE-6	CASE	$ 194,917	10	75	3,000	0	3,085	$ 63.18
Prevention and Early Intervention	Family Resource Center	PEI CI-2	FRC	$ 3,788,065	7,000	4,000	13,245	2,700	26,945	$ 140.59
	Community Wholeness and Enrichment	PEI SE-3	CWE	$ 2,885,286	0	2,990	1,013	0	4,003	$ 720.78
	Military Services and Family Support	PEI SE-4	MSFS	$ 725,000	84	113	812	73	1,082	$ 670.06
	Student Assistance Program	PEI SI-1	SAP	$ 3,539,592	21,250	2,750	3,500	0	27,500	$ 128.71
Early Intervention	Early Psychosis Program	PEI SE-7	EPP	$ 1,000,000	0	105	0	0	105	$ 9,523.81
			Total Program Costs	$ 34,997,971					116,408	$ 300.65
			PEI Administration	$ 2,788,783						
			PEI Assigned Funds	$ 561,894						
			PEI Total	$ 38,348,648						

Total clients served = 116,408 or $301 per person

Estimated Total Mental Health Expenditures FY 2020/21
County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Three Year Plan FY 2020/21 - FY 2022/23

COMMUNITY SERVICES AND SUPPORTS (CSS) FUNDING

	Estimated CSS Funding					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Non-FSP Programs						
Crisis System of Care Programs						
1. A-5 Diversion Programs	$ 5,383,527	$ 4,273,898	$ 405,837	$ -	$ 435,867	$ 267,925
2. A-6 Community Crisis Response Team	$ 9,442,387	$ 3,045,029	$ 2,173,846	$ -	$ 4,223,511	$ -
Crisis Stabilization Continuum of Care						
1. A-4 Crisis Walk-In Center/Crisis Stabilization Unit	$ 15,077,489	$ 3,303,390	$ 10,822,593	$ -	$ 951,506	$ -
2. A-10 Crisis Residential Treatment Program	$ 13,100,000	$ 2,897,316	$ 7,837,050	$ -	$ 713,438	$ 1,652,196
Peer Support Programs						
1. A-1 Clubhouse Expansion Program	$ 3,104,732	$ 3,104,732	$ -	$ -		$ -
Outreach, Access and Engagement Programs						
1. A-9 Access, Coordination & Enhancement of Quality Behavioral Health Services	$ 8,129,292	$ 8,129,292	$ -	$ -		$ -
2. A-15 Recovery Based Engagement Support Teams (RBEST)	$ 2,257,120	$ 2,235,624	$ 20,620	$ -	$ 876	$ -
FSP Programs						
1. C-1 Comprehensive Children and Family Support Services	$ 39,165,588	$ 8,336,543	$ 16,931,877	$ -	$ 13,397,168	$ 500,000
2. C-2 Integrated New Family Opportunities	$ 1,281,018	$ 797,507	$ 104,974	$ -	$ 378,536	$ -
3. TAY-1 Transitional Age Youth One Stop Centers	$ 8,325,105	$ 5,200,585	$ 2,550,382	$ -	$ 574,138	$ -
4. A-2 Adult Criminal Justice Continuum of Care	$ 7,911,200	$ 4,533,040	$ 2,609,604	$ -	$ 35,323	$ 733,233
5. A-3 Assertive Community Treatment Programs	$ 2,392,641	$ 1,152,932	$ 1,239,709	$ -		
6. A-11 Regional Adult Full Service Partnerships (RAFSP)	$ 6,644,809	$ 1,332,556	$ 5,222,616	$ -	$ 89,637	$ -
7. OA-1 Age Wise	$ 1,869,779	$ 1,519,056	$ 350,723	$ -		
Homeless Services, Long-Term Supports, and Transitional Care Programs						
1. A-7 Housing and Homeless Services Continuum of Care	$ 9,583,403	$ 7,683,640	$ 1,042,653	$ -		$ 857,110
2. A-13 Adult Transitional Care Programs	$ 8,213,042	$ 6,415,049	$ 1,797,993			
CSS Programs	$ 141,881,132	$ 63,960,189	$ 53,110,479	$ -	$ 20,800,000	$ 4,010,464
CSS Administration	$ 14,368,376	$ 13,757,852	$ 610,524			
CSS MHSA Housing Program Assigned Funds	$ -					
Total CSS Program Estimated Expenditures	$ 156,249,508	$ 77,718,041	$ 53,721,003	$ -	$ 20,800,000	$ 4,010,464
FSP Programs as Percent of Total	54.6%					

Estimated Cost Per Client Fiscal Year 2021/22
County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Three Year Plan FY 2020/21 - FY 2022/23

COMMUNITY SERVICES AND SUPPORTS

Programs			Abbreviation	Estimated Total Mental Health Expenditures	Estimated Clients Served by Age Group				Estimated Number of Clients	Estimated Cost Per Client
					Children/Youth (0-15)	TAY (16-25)	Adult (26-59)	Older Adult (60+)		
Crisis System of Care	A-5	Diversion Programs	TTS TEST	$ 5,545,033	300	740	196	400	1,636	$ 3,389
	A-6	Community Crisis Response Team Crisis Intervention Training	CCRT CIT	$ 9,725,658	1,800	2,850	3,250	400	8,300	$ 1,172
Crisis Stabilization Continuum of Care	A-4	Crisis Walk-In Centers Crisis Stabilization Units	CWIC CSU	$ 15,164,304	531	1,296	3,462	256	5,545	$ 2,735
	A-10	Crisis Residential Treatment	CRT STAY	$ 13,414,999		88	438		526	$ 25,504
Peer Support Programs	A-1	Clubhouse Expansion Program		$ 3,169,361			33,352		33,352	$ 95
Outreach, Access and Engagement Programs	A-9	Access, Coordination and Enhancement of Quality Behavioral Health Services	ACE	$ 8,365,080	250	250	4,352	50	4,902	$ 1,706
	A-12	Recovery Based Engagement Support Team	RBEST	$ 2,309,834			420		420	$ 5,500
Full Service Partnerships	C-1	Comprehensive Children and Family Support Services	CCFSS	$ 39,604,891	5,342	1,296			6,638	$ 5,966
	C-2	Integrated New Family Opportunities	INFO	$ 1,319,448	85	167			252	$ 5,236
	TAY-1	Transitional Age Youth One Stop Centers		$ 8,441,081		6,180			6,180	$ 1,366
	A-2	Adult Criminal Justice Continuum of Care	CTASC CHOICE FACT CFACT STAR	$ 8,095,826			622	25	647	$ 12,513
	A-3	Assertive Community Treatment Programs	MAPS ACT	$ 2,464,421			285		285	$ 8,647
	A-11	Regional Adult Full Service Partnerships	RAFSP	$ 6,734,190			930		930	$ 7,241
	OA-1	Age Wise		$ 1,925,873				1,220	1,220	$ 1,579
Housing, Long-Term Supports and Transitional Care Programs	A-7	Housing and Homeless Services Continuum of Care Program		$ 9,850,969		120	1,276	189	1,585	$ 6,215
	A-13	Adult Transitional Care Programs		$ 8,297,374		45	668	10	723	$ 11,476
			Total Program Costs	$ 144,428,342					73,141	$ 1,975
			CSS Administration	$ 14,799,427						
			CSS MHSA Housing Program Assigned Funds	$ -						
			CSS Total	$ 159,227,769						

Total clients served = 73,141 or $ 1,975 per person.

Estimated Cost Per Client Fiscal Year 2022/23
County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Three Year Plan FY 2020/21 - FY 2022/23

COMMUNITY SERVICES AND SUPPORTS

Programs			Abbreviation	Estimated Total Mental Health Expenditures	Estimated Clients Served by Age Group				Estimated Number of Clients	Estimated Cost Per Client
					Children/Youth (0-15)	TAY (16-25)	Adult (26-59)	Older Adult (60+)		
Crisis System of Care	A-5	Diversion Programs	TTS TEST	$ 5,711,384	300	740	196	400	1,636	$ 3,491
	A-6	Community Crisis Response Team Crisis Intervention Training	CCRT CIT	$ 10,017,428	1,800	2,850	3,250	400	8,300	$ 1,207
Crisis Stabilization Continuum of Care	A-4	Crisis Walk-In Centers Crisis Stabilization Units	CWIC CSU	$ 15,253,723	531	1,296	3,462	256	5,545	$ 2,751
	A-10	Crisis Residential Treatment	CRT	$ 13,739,450		88	438		526	$ 26,121
Peer Support Programs	A-1	Clubhouse Expansion Program		$ 3,235,928			33,352		33,352	$ 97
Outreach, Access and Engagement Programs	A-9	Access, Coordination and Enhancement of Quality Behavioral Health Services	ACE	$ 8,607,943	250	250	4,352	50	4,902	$ 1,756
	A-12	Recovery Based Engagement Support Team	RBEST	$ 2,364,129			420		420	$ 5,629
Full Service Partnerships	C-1	Comprehensive Children and Family Support Services	CCFSS	$ 40,057,374	5,342	1,296			6,638	$ 6,035
	C-2	Integrated New Family Opportunities	INFO	$ 1,359,031	89	175			264	$ 5,148
	TAY-1	Transitional Age Youth One Stop Centers		$ 8,560,536		6,180			6,180	$ 1,385
	A-2	Adult Criminal Justice Continuum of Care	CTASC CHOICE FACT CFACT STAR	$ 8,285,990			677	25	702	$ 11,803
	A-3	Assertive Community Treatment Programs	MAPS ACT	$ 2,538,353			285		285	$ 8,907
	A-11	Regional Adult Full Service Partnerships	RAFSP	$ 6,826,252			930		930	$ 7,340
	OA-1	Age Wise		$ 1,983,649				1,220	1,220	$ 1,626
Housing, Long-Term Supports and Transitional Care Programs	A-7	Housing and Homeless Services Continuum of Care Program		$ 9,749,710		120	1,289	189	1,598	$ 6,101
	A-13	Adult Transitional Care Programs		$ 8,384,237		45	668	10	723	$ 11,596
			Total Program Costs	$ 146,675,117					73,221	$ 2,003
			CSS Administration	$ 15,243,410						
			CSS MHSA Housing Program Assigned Funds	$ -						
			CSS Total	$ 161,918,527						

Total clients served = 73,221 or $ 2,003 per person.

Estimated Cost Per Client Fiscal Year 2020/21
County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Three Year Plan FY 2020/21 - FY 2022/23

INNOVATION

Program Name		Abbreviation	Estimated Total Mental Health Expenditures	Estimated Clients Served by Age Group				Estimated Number of Clients	Estimated Cost Per Client
				Children/Youth	TAY	Adult	Older Adult		
				(0-15)	(16-25)	(26-59)	(60+)		
INN-08	Innovative Remote Onsite Assistance Delivery	InnROADs	$ 4,168,899			280		280	$ 14,889
INN-09	Eating Disorder Collaborative	EDC	$ 2,263,310			830		830	$ 2,727
INN-10	Multi-County Full Service Partnership (FSP) Data Learning Collaborative		$ 442,614					0	$ -
INN-11	Cracked Eggs		$ 289,374			30		30	$ 9,646
INN-12	Integrated Behavioral Health Project		$ 636,605					TBD	
Total Program Costs			$ 7,800,802					1140	$ 6,843
INN Administration			$ 743,471						
INN Total			$ 8,544,273						

Total clients served = 1,140 or $6,843 per person

Estimated Cost Per Client Fiscal Year 2021/22
County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Three Year Plan FY 2020/21 - FY 2022/23

INNOVATION

Program Name		Abbreviation	Estimated Total Mental Health Expenditures	Estimated Clients Served by Age Group				Estimated Number of Clients	Estimated Cost Per Client
				Children/Youth	TAY	Adult	Older Adult		
				(0-15)	(16-25)	(26-59)	(60+)		
INN-08	Innovative Remote Onsite Assistance Delivery	InnROADs	$ 4,293,966			280		280	$ 15,336
INN-09	Eating Disorder Collaborative	EDC	$ 2,402,812			835		835	$ 2,878
INN-10	Multi-County Full Service Partnership (FSP) Data Learning Collaborative		$ 212,183					0	$ -
INN-11	Cracked Eggs		$ 254,153			30		30	$ 8,472
INN-12	Integrated Behavioral Health Project		$ 659,367					TBD	
Total Program Costs			$ 7,822,481					1145	$ 6,832
INN Administration			$ 765,775						
INN Total			$ 8,588,256						

Total clients served = 1,145 or $6,832 per person

Estimated Cost Per Client Fiscal Year 2022/23
County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Three Year Plan FY 2020/21 - FY 2022/23

INNOVATION

Program Name		Abbreviation	Estimated Total Mental Health Expenditures	Estimated Clients Served by Age Group				Estimated Number of Clients	Estimated Cost Per Client
				Children/Youth	TAY	Adult	Older Adult		
				(0-15)	(16-25)	(26-59)	(60+)		
INN-08	Innovative Remote Onsite Assistance Delivery	InnROADs	$ 4,422,785			280		280	$ 15,796
INN-09	Eating Disorder Collaborative	EDC	$ 2,647,540			840		840	$ 3,152
INN-10	Multi-County Full Service Partnership (FSP) Data Learning Collaborative		$ 90,632					0	$ -
INN-10	Cracked Eggs		$ 261,774			30		30	$ 8,726
INN-11	Integrated Behavioral Health Project		$ 338,307					TBD	$ -
Total Program Costs			$ 7,761,038					1150	$ 6,749
INN Administration			$ 788,748						
INN Total			$ 8,549,786						

Total clients served = 1,150 or $6,749 per person

Funding Summary FY 2020/21
County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Three Year Plan FY 2020/21 - FY 2022/23

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2020/21 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	$ 63,064,750	$ 19,009,303	$ 11,196,200	$ 2,071,529		
2. Estimated New FY 2020/21 Funding	$ 90,000,000	$ 22,500,000	$ 5,900,000			
3. Transfer in FY 2020/21[1]	$ (10,865,564)			$ 2,180,392	$ 8,685,172	
4. Access Local Prudent Reserve in FY 2020/21						
5. Estimated Available Funding for FY 2020/21	$ 142,199,186	$ 41,509,303	$ 17,096,200	$ 4,251,921	$ 8,685,172	$ -
B. Estimated FY 2020/21 MHSA Expenditures	$ 77,718,041	$ 22,400,145	$ 8,348,583	$ 4,251,921	$ 8,685,172	
G. Estimated FY 2020/21 Unspent Fund Balance	$ 64,481,145	$ 19,109,158	$ 8,747,617	$ -		$ -

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2020	$ 21,655,429
2. Contributions to the Local Prudent Reserve in FY 2020/21	
3. Distributions from the Local Prudent Reserve in FY 2020/21	
4. Estimated Local Prudent Reserve Balance on June 30, 2021	$ 21,655,429

[1]Pursuant to Welfare and Institutions Code Section 5895(b), Counties may use a portion of their CSS funds for WET, CFTN and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

Estimated Total Mental Health Expenditures FY 2020/21
County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Three Year Plan FY 2020/21 - FY 2022/23

PREVENTION AND EARLY INTERVENTION

PEI State and County Programs	Estimated PEI Funding					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Stigma and Discrimination Reduction						
1. PEI CI-3 Native American Resource Center	$ 415,376	$ 415,376				
Outreach for Increasing Recognition of Early Signs of Mental Illness						
1. PEI CI-1 Promotores de Salud / Community Health Worker	$ 850,424	$ 850,424				
2. PEI CI-4 Behavioral Health Ministries Pilot Project	$ 100,000	$ 100,000				
Access and Linkage to Treatment						
1. PEI SE-2 Child and Youth Connection	$ 18,765,742	$ 4,606,046	$ 8,957,527			$ 5,202,169
Prevention						
1. PEI SI-2 Preschool PEI Program	$ 478,378	$ 478,378				
2. PEI SI-3 Resilience Promotion in African American Children	$ 938,683	$ 938,683				
3. PEI SE-1 Older Adult Community Services	$ 857,807	$ 857,807				
4. PEI SE-5 LIFT	$ 299,359	$ 299,359				
5. PEI SE-6 Coalition Against Sexual Exploitation	$ 183,728	$ 183,728				
Prevention and Early Intervention						
1. PEI CI-2 Family Resource Centers	$ 3,775,696	$ 3,775,696				
2. PEI SE-3 Community Wholeness and Enrichment	$ 2,767,584	$ 2,378,154	$ 389,430			
3. PEI SE-4 Military Services and Family Support	$ 725,000	$ 725,000				
4. PEI SI-1 Student Assistance Program	$ 3,539,592	$ 2,600,905	$ 938,687			
Early Intervention						
1. PEI SE-7 Early Psychosis Program	$ 1,000,000	$ 1,000,000				
PEI Programs	**$ 34,697,368**	**$ 19,209,555**	**$ 10,285,644**	**$ -**	**$ -**	**$ 5,202,169**
PEI Administration	**$ 2,628,696**	$ 2,628,696				
PEI Assigned Funds	**$ 561,894**	$ 561,894				
Total PEI Program Estimated Expenditures	**$ 37,887,958**	**$ 22,400,145**	**$ 10,285,644**	**$ -**	**$ -**	**$ 5,202,169**

Estimated Cost Per Client Fiscal Year 2020/21
County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Three Year Plan FY 2020/21 - FY 2022/23

COMMUNITY SERVICES AND SUPPORTS

Programs			Abbreviation	Estimated Total Mental Health Expenditures	Estimated Clients Served by Age Group				Estimated Number of Clients	Estimated Cost Per Client
					Children/Youth (0-15)	TAY (16-25)	Adult (26-59)	Older Adult (60+)		
Crisis System of Care	A-5	Diversion Programs	TTS TEST	$5,383,527	300	740	1,960	400	3,400	$ 1,583
	A-6	Community Crisis Response Team Crisis Intervention Training	CCRT CIT	$ 9,442,386	1,800	2,850	3,250	400	8,300	$ 1,138
Crisis Stabilization Continuum of Care	A-4	Crisis Walk-In Centers Crisis Stabilization Units	CWIC CSU	$ 15,077,489	531	1,296	3,462	256	5,545	$ 2,719
	A-10	Crisis Residential Treatment	CRT STAY	$ 13,099,999		88	438		526	$ 24,905
Peer Support Programs	A-1	Clubhouse Expansion Program		$ 3,104,732			30,352		30,352	$ 102
Outreach, Access and Engagement Programs	A-9	Access, Coordination and Enhancement of Quality Behavioral Health Services	ACE	$ 8,129,292	250	250	4,352	50	4,902	$ 1,658
	A-12	Recovery Based Engagement Support Team	RBEST	$ 2,257,120			420		420	$ 5,374
Full Service Partnerships	C-1	Comprehensive Children and Family Support Services	CCFSS	$ 39,165,588	5,342	1,296			6,638	$ 5,900
	C-2	Integrated New Family Opportunities	INFO	$ 1,281,017	81	159			240	$ 5,338
	TAY-1	Transitional Age Youth One Stop Centers		$ 8,325,105		6,180			6,180	$ 1,347
	A-2	Adult Criminal Justice Continuum of Care	CTASC CHOICE FACT CFACT STAR	$ 7,911,200			592	25	617	$ 12,822
	A-3	Assertive Community Treatment Programs	MAPS ACT	$ 2,392,641			285		285	$ 8,395
	A-11	Regional Adult Full Service Partnerships	RAFSP	$ 6,644,809			930		930	$ 7,145
	OA-1	Age Wise		$ 1,869,779				1,220	1,220	$ 1,533
Housing, Long-Term Supports and Transitional Care Programs	A-7	Housing and Homeless Services Continuum of Care Program		$ 9,583,403		120	1,243	189	1,552	$ 6,175
	A-13	Adult Transitional Care Programs		$ 8,213,042		45	668	10	723	$ 11,360
			Total Program Costs	$ 141,881,129					71,830	$ 1,975
			CSS Administration	$ 14,368,376						
			CSS MHSA Housing Program Assigned Funds	$ -						
			CSS Total	$ 156,249,505						

Total clients served = 71,830 or $ 1,975 per person.

Estimated Total Mental Health Expenditures FY 2020/21
County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Three Year Plan FY 2020/21 - FY 2022/23

INNOVATION (INN) FUNDING

			Estimated Innovation 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
INN Programs								
1	INN-08	Innovative Remote Onsite Assistance Delivery	$ 6,432,209	$ 3,973,209	$ 195,690			
2	INN-09	Eating Disorder Collaborative	$ 2,263,310	$ 2,263,310				
3	INN-10	Multi-County Full Service Partnership (FSP) Data Learning Collaborative	$ 442,614	$ 442,614				
4	INN-11	Cracked Eggs	$ 289,374	$ 289,374				
5	INN-12	Integrated Behavioral Health Project	$ 636,605	$ 636,605				
		INN Programs	$ 7,800,802	$ 7,605,112	$ 195,690	$ -	$ -	$ -
		INN Administration	$ 743,471	$ 743,471				
		Total INN Program Estimated Expenditures	$ 8,544,273	$ 8,348,583	$ 195,690	$ -	$ -	$ -

Estimated Total Mental Health Expenditures FY 2020/21
County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Three Year Plan FY 2020/21 - FY 2022/23

Workforce, Education and Training (WET) FUNDING

	Estimated Innovation 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 Programs						
1. Training and Technical Support	$ 261,879	$ 261,879				
2. Leadership Development	$ 10,000	$ 10,000				
3. Internship Program	$ 1,188,891	$ 1,188,891				
4. Psychiatric Residency Program	$ 603,798	$ 603,798				
5. Financial Incentive Program	$ 50,000	$ 50,000				
WET Programs	$ 2,114,568	$ 2,114,568	$ -	$ -	$ -	$ -
WET Statewide Contribution	$ 697,717	$ 697,717				
WET Administration	$ 1,439,636	$ 1,439,636				
Total WET Program Estimated Expenditures	$ 4,251,921	$ 4,251,921	$ -	$ -	$ -	$ -

Estimated Total Mental Health Expenditures FY 2020/21
County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
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Capital Facilities/Technological Needs (CFTN) FUNDING

	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 Facilities Projects						
1. Remaining CHFFA Cost	$ -					
CFTN Programs - Technological Needs Projects						
1. Behavioral Health Management Information Systems	$ 5,644,593	$ 5,644,593				
2 SAS Data Warehouse	$ 1,000,926	$ 1,000,926				
CFTN Programs	$ 6,645,519	$ 6,645,519	$ -	$ -	$ -	$ -
CFTN Administration	$ 2,039,653	$ 2,039,653				
Total CFTN Program Estimated Expenditures	$ 8,685,172	$ 8,685,172	$ -	$ -	$ -	$ -

Funding Summary FY 2021/22

County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Three Year Plan FY 2020/21 - FY 2022/23

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2021/22 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	$ 64,481,145	$ 19,109,158	$ 8,747,617	$ -	$ -	$ -
2. Estimated New FY 2021/22 Funding	$ 90,700,000	$ 22,700,000	$ 6,000,000			
3. Transfer in FY 2021/22[1]	$ (13,302,770)			$ 4,357,046	$ 8,945,724	
4. Access Local Prudent Reserve in FY 2021/22						
5. Estimated Available Funding for FY 2021/22	$ 141,878,375	$ 41,809,158	$ 14,747,617	$ 4,357,046	$ 8,945,724	
B. Estimated FY 2021/22 MHSA Expenditures	$ 79,832,763	$ 22,597,144	$ 8,385,888	$ 3,659,329	$ 8,945,724	
G. Estimated FY 2021/22 Unspent Fund Balance	$ 62,045,612	$ 19,212,014	$ 6,361,729	$ 697,717	$ -	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2021	$ 21,655,429
2. Contributions to the Local Prudent Reserve in FY 2021/22	
3. Distributions from the Local Prudent Reserve in FY 2021/22	
4. Estimated Local Prudent Reserve Balance on June 30, 2022	$ 21,655,429

[1]Pursuant to Welfare and Institutions Code Section 5895(b), Counties may use a portion of their CSS funds for WET, CFTN and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

Estimated Total Mental Health Expenditures FY 2021/22
County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Three Year Plan FY 2020/21 - FY 2022/23

PREVENTION AND EARLY INTERVENTION

PEI State and County Programs	Estimated PEI Funding					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Stigma and Discrimination Reduction						
1. PEI CI-3 Native American Resource Center	$ 415,376	$ 415,376				
Outreach for Increasing Recognition of Early Signs of Mental Illness						
1. PEI CI-1 Promotores de Salud / Community Health Worker	$ 853,474	$ 853,474				
2. PEI CI-4 Behavioral Health Ministires Pilot Project	$ 100,000	$ 100,000				
Access and Linkage to Treatment						
1. PEI SE-2 Child and Youth Connection	$ 18,827,471	$ 4,641,699	$ 8,983,603			$ 5,202,169
Prevention						
1. PEI SI-2 Preschool PEI Program	$ 478,378	$ 478,378				
2. PEI SI-3 Resilience Promotion in African American Children	$ 938,683	$ 938,683				
3. PEI SE-1 Older Adult Community Services	$ 862,541	$ 862,541				
4. PEI SE-5 LIFT	$ 308,340	$ 308,340				
5. PEI SE-6 Coalition Against Sexual Exploitation	$ 189,240	$ 189,240				
Prevention and Early Intervention						
1. PEI CI-2 Family Resource Centers	$ 3,781,789	$ 3,781,789				
2. PEI SE-3 Community Wholeness and Enrichment	$ 2,825,565	$ 2,435,002	$ 390,563			
3. PEI SE-4 Military Services and Family Support	$ 725,000	$ 725,000				
4. PEI SI-1 Student Assistance Program	$ 3,539,592	$ 2,598,172	$ 941,420			
Early Intervention						
1. PEI SE-7 Early Psychosis Program	$ 1,000,000	$ 1,000,000				
PEI Programs	**$ 34,845,449**	**$ 19,327,694**	**$ 10,315,586**	**$ -**	**$ -**	**$ 5,202,169**
PEI Administration	**$ 2,707,556**	$ 2,707,556				
PEI Assigned Funds	**$ 561,894**	$ 561,894				
Total PEI Program Estimated Expenditures	**$ 38,114,899**	**$ 22,597,144**	**$ 10,315,586**	**$ -**	**$ -**	**$ 5,202,169**

Estimated Total Mental Health Expenditures FY 2021/22
County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Three Year Plan FY 2020/21 - FY 2022/23

COMMUNITY SERVICES AND SUPPORTS (CSS) FUNDING

	Estimated CSS Funding					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Non-FSP Programs						
Crisis System of Care Programs						
1. A-5 Diversion Programs	$ 5,545,033	$ 4,432,035	$ 409,206	$ -	$ 435,867	$ 267,925
2. A-6 Community Crisis Response Team	$ 9,725,658	$ 3,310,256	$ 2,191,891	$ -	$ 4,223,511	$ -
Crisis Stabilization Continuum of Care						
1. A-4 Crisis Walk-In Center/Crisis Stabilization Unit	$ 15,164,304	$ 4,014,967	$ 10,197,831	$ -	$ 951,506	$ -
2. A-10 Crisis Residential Treatment Program	$ 13,415,000	$ 2,027,764	$ 9,021,601	$ -	$ 713,438	$ 1,652,196
Peer Support Programs						
1. A-1 Clubhouse Expansion Program	$ 3,169,361	$ 3,169,361	$ -	$ -		$ -
Outreach, Access, and Engagement Programs						
1. A-9 Access, Coordination & Enhancement of Quality Behavioral Health Services	$ 8,365,080	$ 8,365,080	$ -	$ -		$ -
2. A-15 Recovery Based Engagement Support Teams (RBEST)	$ 2,309,834	$ 2,287,853	$ 21,105	$ -	$ 876	$ -
FSP Programs						
1. C-1 Comprehensive Children and Family Support Services	$ 39,604,892	$ 8,635,299	$ 17,072,424	$ -	$ 13,397,168	$ 500,000
2. C-2 Integrated New Family Opportunities	$ 1,319,448	$ 835,066	$ 105,846	$ -	$ 378,536	$ -
3. TAY-1 Transitional Age Youth One Stop Centers	$ 8,441,081	$ 5,295,390	$ 2,571,553	$ -	$ 574,138	$ -
4. A-2 Adult Criminal Justice Continuum of Care	$ 8,095,826	$ 4,696,004	$ 2,631,266	$ -	$ 35,323	$ 733,233
5. A-3 Assertive Community Treatment Programs	$ 2,464,421	$ 1,214,421	$ 1,250,000	$ -		
6. A-11 Regional Adult Full Service Partnerships (RAFSP)	$ 6,734,190	$ 1,378,585	$ 5,265,968	$ -	$ 89,637	$ -
7. OA-1 Age Wise	$ 1,925,873	$ 1,572,239	$ 353,634	$ -		
Homeless Services, Long-Term Supports and Transitional Care Programs						
1. A-7 Housing and Homeless Services Continuum of Care	$ 9,850,969	$ 8,066,960	$ 926,899	$ -		$ 857,110
2. A-13 Adult Transitional Care Programs	$ 8,297,374	$ 6,360,361	$ 1,937,013			
CSS Programs	$ 144,428,342	$ 65,661,643	$ 53,956,235	$ -	$ 20,800,000	$ 4,010,464
CSS Administration	$ 14,799,427	$ 14,171,120	$ 628,307			
CSS MHSA Housing Program Assigned Funds	$ -					
Total CSS Program Estimated Expenditures	$ 159,227,769	$ 79,832,763	$ 54,584,542	$ -	$ 20,800,000	$ 4,010,464
FSP Programs as Percent of Total	54.5%					

Estimated Total Mental Health Expenditures FY 2021/22
County of San Bernardino
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Mental Health Services Act (MHSA)
MHSA Three Year Plan FY 2020/21 - FY 2022/23

INNOVATION (INN) FUNDING

	Estimated Innovation 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
INN Programs						
1. INN-08 Innovative Remote Onsite Assistance Delivery	$ 4,293,966	$ 4,091,598	$ 202,368			
2. INN-09 Eating Disorder Collaborative	$ 2,402,812	$ 2,402,812				
3 INN-10 Multi-County Full Service Partnership (FSP) Data Learning Collaborative	$ 212,183	$ 212,183				
4 INN-11 Cracked Eggs	$ 254,153	$ 254,153				
5 INN-12 Integrated Behavioral Health Project	$ 636,605	$ 659,367				
INN Programs	$ 7,822,481	$ 7,620,113	$ 202,368	$ -	$ -	$ -
INN Administration	$ 765,775	$ 765,775				
Total INN Program Estimated Expenditures	$ 8,588,256	$ 8,385,888	$ 202,368	$ -	$ -	$ -

Estimated Total Mental Health Expenditures FY 2021/22
County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
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Workforce, Education and Training (WET) FUNDING

	Estimated Innovation 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 Programs						
1. Training and Technical Support	$ 269,735	$ 269,735				
2. Leadership Development	$ 10,300	$ 10,300				
3. Internship Program	$ 1,224,558	$ 1,224,558				
4. Psychiatric Residency Program	$ 621,912	$ 621,912				
5. Financial Incentive Program	$ 50,000	$ 50,000				
	$ -					
WET Programs	$ 2,176,505	$ 2,176,505	$ -	$ -	$ -	$ -
WET Statewide Contribution						
WET Administration	$ 1,482,824	$ 1,482,824				
Total WET Program Estimated Expenditures	$ 3,659,329	$ 3,659,329	$ -	$ -	$ -	$ -

Estimated Total Mental Health Expenditures FY 2021/22
County of San Bernardino
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Capital Facilities/Technological Needs (CFTN) FUNDING

	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 Facilities Projects						
1. Remaining CHFFA Cost	$ -					
CFTN Programs - Technological Needs Projects						
1. Behavioral Health Management Information Systems	$ 5,813,931	$ 5,813,931				
2 SAS Data Warehouse	$ 1,030,953	$ 1,030,953				
CFTN Programs	$ 6,844,884	$ 6,844,884	$ -	$ -	$ -	$ -
CFTN Administration	$ 2,100,840	$ 2,100,840				
Total CFTN Program Estimated Expenditures	$ 8,945,724	$ 8,945,724	$ -	$ -	$ -	$ -

Funding Summary FY 2022/23
County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
MHSA Three Year Plan FY 2020/21 - FY 2022/23

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2022/23 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	$ 62,045,612	$ 19,212,014	$ 6,361,729	$ 697,717	$ -	$ -
2. Estimated New FY 2022/23 Funding	$ 90,700,000	$ 22,700,000	$ 6,000,000			
3. Transfer in FY 2022/23[1]	$ (13,679,425)			$ 4,465,325	$ 9,214,100	
4. Access Local Prudent Reserve in FY 2022/23						
5. Estimated Available Funding for FY 2022/23	$ 139,066,187	$ 41,912,014	$ 12,361,729	$ 5,163,042	$ 9,214,100	
B. Estimated FY 2022/23 MHSA Expenditures	$ 81,397,864	$ 22,848,842	$ 8,335,824	$ 3,767,608	$ 9,214,100	
G. Estimated FY 2022/23 Unspent Fund Balance	$ 57,668,323	$ 19,063,172	$ 4,025,905	$ 1,395,434	$ -	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2022	$ 21,655,429
2. Contributions to the Local Prudent Reserve in FY 2022/23	
3. Distributions from the Local Prudent Reserve in FY 2022/23	
4. Estimated Local Prudent Reserve Balance on June 30, 2023	$ 21,655,429

[1]Pursuant to Welfare and Institutions Code Section 5895(b), Counties may use a portion of their CSS funds for WET, CFTN and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

Estimated Total Mental Health Expenditures FY 2022/23
County of San Bernardino
Department of Behavioral Health
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PREVENTION AND EARLY INTERVENTION

PEI State and County Programs	Estimated PEI Funding					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Stigma and Discrimination Reduction						
1. PEI CI-3 Native American Resource Center	$ 415,376	$ 415,376				
Outreach for Increasing Recognition of Early Signs of Mental Illness						
1. PEI CI-1 Promotores de Salud / Community Health Workers	$ 856,615	$ 856,615				
2. PEI CI-4 Behavioral Health Ministries Pilot Project	$ 100,000	$ 100,000				
Access and Linkage to Treatment						
1. PEI SE-2 Child and Youth Connection	$ 18,891,052	$ 4,727,211	$ 8,961,672			$ 5,202,169
Prevention						
1. PEI SI-2 Preschool PEI Program	$ 478,378	$ 478,378				
2. PEI SI-3 Resilience Promotion in African American Children	$ 938,683	$ 938,683				
3. PEI SE-1 Older Adult Community Services	$ 867,417	$ 867,417				
4. PEI SE-5 LIFT	$ 317,590	$ 317,590				
5. PEI SE-6 Coalition Against Sexual Exploitation	$ 194,917	$ 194,917				
Prevention and Early Intervention						
1. PEI CI-2 Family Resource Centers	$ 3,788,065	$ 3,788,065				
2. PEI SE-3 Community Wholeness and Enrichment	$ 2,885,286	$ 2,493,555	$ 391,731			
3. PEI SE-4 Military Services and Family Support	$ 725,000	$ 725,000				
4. PEI SI-1 Student Assistance Program	$ 3,539,592	$ 2,595,358	$ 944,234			
Early Intervention						
1. PEI SE-7 Early Psychosis Program	$ 1,000,000	$ 1,000,000				
PEI Programs	**$ 34,997,971**	**$ 19,498,165**	**$ 10,297,637**	**$ -**	**$ -**	**$ 5,202,169**
PEI Administration	**$ 2,788,783**	$ 2,788,783				
PEI Assigned Funds	**$ 561,894**	$ 561,894				
Total PEI Program Estimated Expenditures	**$ 38,348,648**	**$ 22,848,842**	**$ 10,297,637**	**$ -**	**$ -**	**$ 5,202,169**

Estimated Total Mental Health Expenditures FY 2022/23
County of San Bernardino
Department of Behavioral Health
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COMMUNITY SERVICES AND SUPPORTS (CSS) FUNDING

			Estimated CSS Funding					
			A	B	C	D	E	F
			Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Non-FSP Programs								
Crisis System of Care Programs								
1.	A-5	Diversion Programs	$ 5,711,384	$ 4,592,133	$ 415,459	$ -	$ 435,867	$ 267,925
2.	A-6	Community Crisis Response Team	$ 10,017,428	$ 3,568,534	$ 2,225,383	$ -	$ 4,223,511	$ -
Crisis Stabilization Continuum of Care								
1.	A-4	Crisis Walk-In Center/Crisis Stabilization Unit	$ 15,253,723	$ 4,008,289	$ 10,293,928	$ -	$ 951,506	$ -
2.	A-10	Crisis Residential Treatment Program	$ 13,739,450	$ 1,871,729	$ 9,502,087	$ -	$ 713,438	$ 1,652,196
Peer Support Programs								
1.	A-1	Clubhouse Expansion Program	$ 3,235,928	$ 3,235,928	$ -	$ -		$ -
Outreach, Access and Engagement Programs								
1.	A-9	Access, Coordination & Enhancement of Quality Behavioral Health Services	$ 8,607,943	$ 8,607,943	$ -	$ -		$ -
2.	A-15	Recovery Based Engagement Support Teams (RBEST)	$ 2,364,129	$ 2,341,651	$ 21,602	$ -	$ 876	$ -
FSP Programs								
1.	C-1	Comprehensive Child and Family Support Services	$ 40,057,375	$ 8,826,918	$ 17,333,288	$ -	$ 13,397,168	$ 500,000
2.	C-2	Integrated New Family Opportunities	$ 1,359,031	$ 873,032	$ 107,463	$ -	$ 378,536	$ -
3.	TAY-1	Transitional Age Youth One Stop Centers	$ 8,560,535	$ 5,375,552	$ 2,610,846	$ -	$ 574,138	$ -
4.	A-2	Adult Criminal Justice Continuum of Care	$ 8,285,990	$ 4,845,963	$ 2,671,471	$ -	$ 35,323	$ 733,233
5.	A-3	Assertive Community Treatment Programs	$ 2,538,353	$ 1,269,254	$ 1,269,099	$ -		
6.	A-11	Regional Adult Full Service Partnerships (RAFSP)	$ 6,826,252	$ 1,390,184	$ 5,346,431	$ -	$ 89,637	$ -
7.	OA-1	Age Wise	$ 1,983,649	$ 1,624,612	$ 359,037	$ -		
Homeless Services, Long-Term Supports and Transitional Care Programs								
1.	A-7	Housing and Homeless Services Continuum of Care	$ 9,749,710	$ 7,952,269	$ 940,331	$ -		$ 857,110
2.	A-13	Adult Transitional Care Programs	$ 8,384,237	$ 6,417,070	$ 1,967,167			
		CSS Programs	$ 146,675,117	$ 66,801,061	$ 55,063,591	$ -	$ 20,800,000	$ 4,010,464
		CSS Administration	$ 15,243,410	$ 14,596,803	$ 646,607			
		CSS MHSA Housing Program Assigned Funds	$ -					
		Total CSS Program Estimated Expenditures	$ 161,918,527	$ 81,397,864	$ 55,710,198	$ -	$ 20,800,000	$ 4,010,464
		FSP Programs as Percent of Total	54.2%					

Estimated Total Mental Health Expenditures FY 2022/23
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INNOVATION (INN) FUNDING

			Estimated Innovation 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
INN Programs								
1	INN-08	Innovative Remote Onsite Assistance Delivery	$ 4,422,785	$ 4,208,823	$ 213,962			
2	INN-09	Eating Disorder Collaborative	$ 2,647,540	$ 2,647,540				
3	INN-10	Multi-County Full Service Partnership (FSP) Data Learning Collaborative	$ 90,632	$ 90,632				
4	INN-11	Cracked Eggs	$ 261,774	$ 261,774				
5	INN-12	Integrated Behavioral Health Project	$ 338,307	$ 338,307				
		INN Programs	$ 7,761,038	$ 7,547,076	$ 213,962	$ -	$ -	$ -
		INN Administration	$ 788,748	$ 788,748				
		Total INN Program Estimated Expenditures	$ 8,549,786	$ 8,335,824	$ 213,962	$ -	$ -	$ -

Estimated Total Mental Health Expenditures FY 2022/23
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Workforce, Education and Training (WET) FUNDING

	Estimated Innovation 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 Programs						
1. Training and Technical Support	$ 277,827	$ 277,827				
2. Leadership Development	$ 10,609	$ 10,609				
3. Internship Program	$ 1,261,294	$ 1,261,294				
4. Psychiatric Residency Program	$ 640,569	$ 640,569				
5. Financial Incentive Program	$ 50,000	$ 50,000				
WET Programs	$ 2,240,299	$ 2,240,299	$ -	$ -	$ -	$ -
WET Statewide Contribution						
WET Administration	$ 1,527,309	$ 1,527,309				
Total WET Program Estimated Expenditures	$ 3,767,608	$ 3,767,608	$ -	$ -	$ -	$ -

Estimated Total Mental Health Expenditures FY 2022.23
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Capital Facilities/Technological Needs (CFTN) FUNDING

	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 Facilities Projects						
1. Remaining CHFFA Cost	$ -					
CFTN Programs - Technological Needs Projects						
1. Behavioral Health Management Information Systems	$ 5,988,349	$ 5,988,349				
2 SAS Data Warehouse	$ 1,061,882	$ 1,061,882				
CFTN Programs	$ 7,050,231	$ 7,050,231	$ -	$ -	$ -	$ -
CFTN Administration	$ 2,163,869	$ 2,163,869				
Total CFTN Program Estimated Expenditures	$ 9,214,100	$ 9,214,100	$ -	$ -	$ -	$ -