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SAN BERNARDINO COUNTY

**Contract Number**

**23-503 A-2**

**SAP Number**

# Department of Behavioral Health

| | |
|---|---|
| **Department Contract Representative** | Misty May |
| **Telephone Number** | 909-421-9381 |
| **Contractor** | California Department of Health Care Services |
| **Contractor Representative** | Mental Health Services Division |
| **Telephone Number** | 916-552-9536 |
| **Contract Term** | July 1, 2023 through June 30, 2026 |
| **Original Contract Amount** | $550,758,995 |
| **Amendment Amount** | $14,118,257 |
| **Total Contract Amount** | $564,877,252 |
| **Cost Center** | Various |

**Briefly describe the general nature of the contract:**
Approve Amendment No. 2 to the Mental Health Services Act Three-Year Integrated Plan Contract No. 23-503, which includes the Mental Health Services Act County Compliance Certification, County Fiscal Accountability Certification, for an Annual Plan Update for 2025-26, including an increase in expenditures of $10,089,184, from $184,391,988 to $194,481,172, for the period of July 1, 2025 through June 30, 2026.

**FOR COUNTY USE ONLY**

| Approved as to Legal Form | Reviewed for Contract Compliance | Reviewed/Approved by Department |
|---|---|---|
| Signed by: Dawn Martin 8FD744A7697047B... | Signed by: Michael Shin 6060C011AC3C487... | DocuSigned by: Georgina Yoshioka 7DF8977EFA674B2... |
| Dawn Martin, Deputy County Counsel | Michael Shin, Contracts Manager | Georgina Yoshioka, Interim Director |
| Date 5/12/2025 | Date 5/12/2025 | Date 5/12/2025 |

Revised 04/10/19

SAN BERNARDINO COUNTY

Behavioral Health



Artwork by Luz Gutierrez

Mental Health Services Act

# Annual Update for Fiscal Year 2025/2026

# Message from the Director

## Welcome

On behalf of the Department of Behavioral Health (DBH) staff, community partners, providers, and stakeholders, thank you for your interest in the Mental Health Services Act (MHSA) Annual Update for Fiscal Year (FY) 2025/26. The Annual Update provides the opportunity to highlight the achievements of DBH and contracted partner programs during the previous fiscal year (FY 2023/24). This Update demonstrates how community input has shaped DBH programming and implementation and provides updates to existing MHSA programs. Program expansion has created more places for people to connect with mental health and substance use disorder services, enhanced collaboration for the coordination of treatment, continued the growth of the Office of Suicide Prevention, increased the availability of behavioral health crisis services, and implemented successful innovative practices across the continuum of care.

On March 5, 2024, California voters passed Proposition 1, Behavioral Health Services Program and Bond Measure. Proposition 1 amended California's Mental Health Services Act and created a $6.38 billion general obligation bond. For San Bernardino County, Proposition 1 will impact core outpatient, crisis, recovery-oriented and outreach and engagement services, including an impact on workforce initiatives.

Proposition 1 aims to support Californians who are most affected by severe behavioral health conditions and homelessness. The amendment:

- Renames the Mental Health Services Act to the Behavioral Health Services Act (BHSA),
- Changes how revenue from the 1% tax on income above $1 million is spent under the law,
- Increases the community planning process, outcome, and reporting requirements to include the entire county behavioral health system, not only BHSA-funded programs and services.

San Bernardino County has been developing a mitigation plan to address these amendments under the direction and support of the California Behavioral Health Directors Association (CBHDA).

For more information on Proposition 1, please attend the DBH monthly Community Policy Advisory Committee Meetings – See at a glance flyer for dates.

Thank you for your interest, patience and understanding during this transition.

Sincerely,



Georgina Yoshioka, DSW, LCSW, MBA
Director
San Bernardino County, Department of Behavioral Health

# Mensaje de la Directora

## Bienvenidos

En nombre del personal del Departamento de Salud Mental (DBH por sus siglas en inglés), los socios de la comunidad, los proveedores y las partes interesadas, le agradecemos su interés en la Actualización Anual de la Ley de Servicios de Salud Mental (MHSA por sus siglas en inglés) para el Año Fiscal 2025/26. La Actualización Anual ofrece la oportunidad para destacar los logros de los programas de DBH y de los socios contratados durante el año fiscal anterior 2023/24. Esta actualización demuestra cómo las aportaciones de la comunidad han dado forma a la programación y ejecución de DBH y proporciona actualizaciones de los programas MHSA existentes. La expansión del programa ha creado más espacios para que las personas se conecten con los servicios de salud mental y trastornos por consumo de sustancias, ha mejorado la colaboración para la coordinación del tratamiento, ha continuado el crecimiento de la Oficina de Prevención de Suicidio, ha aumentado la disponibilidad de servicios de crisis de salud mental y ha implementado practicas innovadoras exitosas a lo largo del continuo de atención.

El 5 de marzo de 2024, los votantes de California aprobaron la Proposición 1, Programa de Servicios de Salud Mental y Medida de Bonos. La Proposición 1 modificó la Ley de Servicios de Salud Mental de California y creó un bono de obligación general de 6.38 millones de dólares. Para el condado de San Bernardino, la Proposición 1 tendrá un impacto en los servicios ambulatorios de crisis, servicios orientados a la recuperación y de extensión y participación, incluyendo un impacto en las iniciativas de la fuerza laboral.

La Proposición 1 tiene como objetivo apoyar a los californianos más afectados por problemas graves de salud mental y por falta de vivienda. La modificación:

- Cambia el nombre de la Ley de Servicios de Salud Mental en inglés, Mental Health Services Act por inglés, Behavioral Health Services Act (BHSA por sus siglas en inglés)
- Cambia la forma en que se gastan los ingresos del impuesto de 1% sobre los ingresos superiores a $1 millón según la ley
- Aumenta el proceso de planificación comunitaria, los resultados y los requisitos de información para incluir todo el sistema de salud conductual del condado, no sólo los programas y servicios financiados por la BHSA.

# Mensaje de la Directora

El condado de San Bernardino ha estado desarrollando un plan de mitigación para abordar estas modificaciones bajo la dirección y el apoyo de la Asociación de directores de Salud Mental de California (CBHDA por sus siglas en inglés). Para obtener más información sobre la Propuesta 1, asista a las reuniones mensuales del Comité Asesor de Políticas Comunitarias de la DBH – Vea el folleto de Horarios para las fechas.

Gracias por su interés, paciencia y compresión durante esta transición.



Artwork by Rey French

Atentamente,



Georgina Yoshioka, DSW, LCSW, MBA
Directora
Condado de San Bernardino, Departamento de Salud Mental

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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: Georgina Yoshioka, DSW, MBA, LCSW | Name: Dr. Rebecca Scott Young |
| Telephone Number: (909) 252-5142 | Telephone Number: (909) 252-4046 |
| E-mail: Georgina.Yoshioka@dbh.sbcounty.gov | E-mail: MHSA@dbh.sbcounty.gov |
| Local Mental Health Mailing Address: | Department of Behavioral Health<br>303 East Vanderbilt Way<br>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.

Dr. Georgina Yoshioka
Local Mental Health Director (PRINT)

DocuSigned by:
Georgina Yoshioka 6/18/2025
7DF8077EFA674B2...
Signature Date

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**Enclosure 1**

# MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: San Bernardino

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

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

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

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

Dr. Georgina Yoshioka
Local Mental Health Director (PRINT)

DocuSigned by: Georgina Yoshioka 6/18/2025
70F807EFA874B2...
Signature Date

I hereby certify that for the fiscal year ended June 30, 2024, 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 January 24, 2025 for the fiscal year ended June 30, 2024. I further certify that for the fiscal year ended June 30, 2024, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

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

Ensen Mason
County Auditor Controller / City Financial Officer (PRINT)

Signature 6/18/25
Date

[1] Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)

SAN BERNARDINO COUNTY
Behavioral Health

# MHSA Annual Update for FY 25/26: Community Program Planning

## Overview of San Bernardino County

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

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

According to the United States Census Bureau, the estimated population is 2,193,656 (*Source*: US Census -2022). Approximately half of the county's population resides in the West Valley (32%) and East Valley (23%) region, accounting for only 2.5% of the land. The remaining population resides in the Central Valley (20%) and Desert or Mountain regions (25%).

The residents of San Bernardino County fall into the following age groups: 45% are adults between the ages of 26 and 59 years old, 22% are children under the age of 15, 18% are older adults (age 60 and over), and the remaining 15% are between the ages of 16 and 25 years old.

San Bernardino County is the fifth largest county in California in terms of population and ethnic diversity. The largest ethnic population in the county is Latinx/Hispanic (56%), followed by Caucasian (24%), Asian/Pacific Islander (9%), African American/Black (7%), and Native American (0.2%). The remaining 4% is unknown.

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

| Geographic Region | |
|---|---|
| **20%** Central Valley | **23%** East Valley |
| **25%** Desert/Mountain | **32%** West Valley |

| Age | |
|---|---|
| **22%** Children (0-15) | **45%** Adults (26-59) |
| **15%** TAY (16-25) | **18%** Older Adults (60+) |

| Race/Ethnicity | |
|---|---|
| **7%** African American/Black | **56%** Latinx/Hispanic |
| **9%** Asian/Pacific Islander | **<1%** Native American |
| **24%** Caucasian/White | **4%** Other/Unknown |

| Gender Identity | |
|---|---|
| **50%** Female | **50%** Male |

**N**=2,193,656

**Source:** U.S. Census - 2022: ACS 1-Year Estimates Data Profiles

# Community Program Planning

## Introduction

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

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

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

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

# Community Program Planning

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

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

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

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

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

- Behavioral Health Commission (BHC): 10 annual meetings held monthly
- District Advisory Committee meetings: 5 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 monthly meetings
- Cultural Competency Advisory Committee (CCAC), along with 14 separate cultural specific subcommittees: 15 monthly meetings
- Transitional Age Youth (TAY) Advisory Boards
- MHSA Executive Committee meetings

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

Additional regular stakeholder engagement and education meetings include:

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

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

## Cultural Competency

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

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

Language regarding cultural competence is included in all department contracts with community-based organizations and individual providers to ensure contract services are provided in a culturally competent manner. Additionally, cultural competence is assessed in each DBH employee's annual Work Performance Evaluation (WPE).

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

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

## Public Relations and Outreach

The Public Relations and Outreach (PRO) division promotes services to people who have experienced mental illness or substance use disorders. PRO works to reduce stigma through education, awareness, and outreach. Utilizing strategic communication and community engagement, they advocate for all people to enjoy optimum wellness. PRO provides employee wellness events and events to the community at no cost.

PRO collaborates with many local nonprofit organizations to share information and resources to fulfill shared vision and goals, such as PRO's collaboration with Department of Aging and Adult Services (DAAS) to organize the Evening with the Stars and Summer Wellness Extravaganza event. PRO's activities and events are family driven and incorporate educational opportunities for anyone to attend and learn. When planning events, PRO focuses on DBH's vision of a county that promotes mental health for the community and empowers personal growth. During PRO's events, flyers are shared with the community so they can learn about all the services DBH offers.

During Fiscal Year 2023/24, PRO participated in a total of 257 resource fairs and tabling events. In addition, PRO had 37 trainings on mental health and substance use disorders and 294 outreach events. These events were held throughout San Bernardino County to reach as many people as possible. Targeted populations include African American/Black, Latinx/Hispanic, faith-based, youth, TAY, LGBTQ+, reentry, and unhoused populations.

PRO collaborated with the Second District of San Bernardino County and County Supervisor Jesse Armendarez for the Office of Suicide Prevention Telephone Townhall "Promote Hope, Let's Talk" on March 12, 2024, to bring a conversation about suicide prevention. There were over 49,000 total calls dialed in with 1,357 accepted calls for the townhall, including 59 Spanish participants. This conversation was broadcasted and uploaded on YouTube to make it available for anyone who was interested in hearing what DBH and the Second District are doing to open the conversation regarding suicide prevention.

## Public Relations and Outreach, cont.

The outreach team encountered difficulties during FY 2023/24 in effectively sharing information about services with unhoused communities, as resources often include phone numbers and hotline information that necessitate access to a phone or the ability to travel. To address these difficulties, PRO has enlisted subject matter experts from the Homeless Support and Outreach Services unit to enhance their outreach and engagement strategies with the unhoused community.

Additionally, reaching the high desert region has proven challenging due to the limited number of events in these areas. PRO is exploring an expansion project aimed at forging connections with community-based organizations in the high desert region, thereby increasing their presence at local events and spaces to promote DBH programs and services.

The PRO division also faced obstacles in distributing comprehensive printed materials covering all mental health topics of public interest. To address the need for a more comprehensive catalog of printed materials, the public relations team is revamping their resources. They are developing more targeted, easily accessible informational pamphlets and digital resources that address frequently asked questions and key mental health topics, informed by community feedback.

In addition to the resource fairs and tabling events, PRO conducted the following outreach and engagement activities during FY 2023/24:

| Activity Type | Number of Activity Type | Total Number of Participants |
|---|---|---|
| **Meet the Artist Exhibition** | 1 | 200 |
| **Evening with the Stars** | 1 | 300 |
| **Directing Change** | 1 | 100 |
| **Recovery Happens** | 1 | 1,600 |
| **Annual Commission Award Ceremony** | 1 | 200 |
| **Office of Suicide Prevention Telephone Townhall** | 1 | 1,357 |
| **Sound of Recovery** | 1 | 150 |
| **Total** | **7** | **3,907** |

## Public Relations and Outreach, cont.

"I have a brother who has major mental illness issues, I am his social security payee, so finding this wonderful art show was an amazing gift last year! I got to meet so many people like me who have family members with mental illness, it was so helpful sharing stories and just knowing that there are others like me and thank you for all you and your coworkers do for the mentally ill community. They need so much support, and I am thankful you and others are available and have programs for them."

-Community Member

"I was a foster child myself, and when I aged out of the system, I received services from the Department of Behavioral Health. Working with you guys in this way was the reason I felt inspired to pursue work in this field, and currently why I have a stable job - so very full circle. Thank you for the work you do".

-Community Member

## MHSA Annual Update: Community Program Planning Process

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

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

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

### MHSA Annual Update CPP Demographics

**Age**



**0%** 0-15
**7%** 16-25
**80%** 26-59
**12%** 60+
**<1%** Prefer not to answer

**Gender Identity**

**29%** Male
**68%** Female
**3%** Other

**Race/Ethnicity**

**20%** African American/Black
**27%** Caucasian/White
**4%** American Indian/Alaskan Native
**5%** Asian/Pacific Islander
**41%** Latinx/Hispanic
**19%** Other/Unknown

**N**=360 **Note:** Not every participant answered all questions. Not all numbers add to 100 due to rounding or multiple responses.

# Community Program Planning

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

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

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

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

## MHSA Annual Update CPP Demographics

### Primary Language



**91%** English

**11%** Spanish

**3%** Other

### Region



**12%** Central Valley

**21%** East Valley

**20%** Desert/Mountain

**26%** West Valley

**0%** Out of county

**21%** Prefer not to answer

**N**=360 **Note:** Not every participant answered all questions. Not all numbers add to 100 due to rounding or multiple responses.

# Community Program Planning

To increase participation opportunities across the county, the department hosted additional online sessions on January 21, 2025, from 10 to 11 a.m. and from 5 to 6 p.m. These sessions provided additional opportunities for individuals unable to attend one of the regularly scheduled meetings to participate via computer, smartphone, and other technological devices.

At the end of the presentations, the facilitator opened the presentation to encourage discussion, allow stakeholders to have questions answered, and provide input. Once the question-and-answer session concluded, participants were advised about additional opportunities to provide feedback. The link to the survey was provided in the presentation, and participants were also provided information for alternative methods to provide input and feedback, including the email address, phone number for the MHSA Administration staff, and a link to the MHSA Issue Resolution that can be accessed at: https://wp.sbcounty.gov/dbh/wp-content/uploads/sites/121/2021/08/COM0947.pdf?x62087

The MHSA Annual Update was presented at the Cultural Competency Advisory Committee on Thursday, January 16, 2025, to ensure additional opportunities to stakeholders to interact with decision making staff.

To further support this Community Planning Process effort, a special Community Policy Advisory Committee (CPAC) session was hosted on Thursday, February 20, 2025.

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

## MHSA Annual Update CPP Demographics

**Groups Represented**

| | | |
|---|---|---|
| **1%** Law Enforcement | **1%** Veterans Organizations | **7%** Faith-Based Organization |
| **39%** Education/Students | **52%** Family Member or Loved One | **49%** Consumer of Mental Health Services |
| **12%** Social or Human Service Program/Agency | **30%** Federal, State, County, or City Government | **7%** Consumer of Substance Use Disorder Services |
| **39%** Healthcare – Behavioral/Mental Health and Physical Health | **6%** Alcohol and Drug Service Program Providers | **5%** Youth or Youth Mental Health/ Substance Use Disorder Organization |
| **12%** Non-Profit Organization | **4%** Veterans | **21%** Community-Based Organizations |
| **4%** Area Agencies on Aging | **4%** Managed Care Plans (MCPs) | **37%** Self Employed/Not Employed/Other |

**N**=360 **Note:** Total does not equal 100% since some respondents represent multiple groups.

# Community Program Planning

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

A total of **769** stakeholders attended this year's Community Program Planning stakeholder sessions, and DBH received **360** completed stakeholder comment forms as a result of those who attended the CPP stakeholder sessions or submitted a form during the 30-Day Public Review and Comment period. Of the those who completed a survey, **90%** were either satisfied or very satisfied with the CPP meeting and its goals.

Really impressed by the system in place to collect stakeholder input in an ongoing basis, how feedback is shared monthly, and really being utilized when making program improvement decisions, as well as amount of what the community needs are. It really keeps it current & relevant. Great Job! Great presentation on the update, plain language, engaging and relatable.

**Stakeholder Comments**

The Annual Plan was well written and well put together. I thank all involved with putting it together.

Very comprehensive and well put together in terms of discussing roadmaps and improvements over a period of time over the Fiscal years.

I learned that the program has abundant community resources for mental Health. It serves communities with youth, adults, and homeless.

This was a good update - so nice to hear that you take input very seriously.

# Community Program Planning

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



SAN BERNARDINO COUNTY | Behavioral Health

MHSA Annual Update FY 2025/2026

## Planning Meetings

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

Event will be held in-person

**January 2025**

**08 — 10 a.m.** — Mental Health and Substance Use Awareness Subcommittee
Call-In: 1-415-655-0002
WebEx Meeting Number: 961 777 142
Join Meeting

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

**09 — 1 p.m.** — PEI Quarterly Provider Meeting
Call-In: 1-415-655-0002
WebEx Meeting Number: 2485 096 9219
Join Meeting

**09 — 10 a.m.** — Disabilities Awareness Subcommittee
Call-In: 1-415-655-0002
WebEx Meeting Number: 146 434 2208
Join Meeting

**09 — 3:30 p.m.** — Second District Advisory Committee
Call-In: 1-415-655-0002
WebEx Meeting Number: 2483 823 7369
Password: pxYctfry353
Join Meeting

**10 — 10 a.m.** — Asian Pacific Islander Awareness Subcommittee
Call-In: 1-415-655-0002
WebEx Meeting Number: 968 187 539
Join Meeting

**13 — 10 a.m.** — Suicide Prevention Awareness Subcommittee
Call-In: 1-415-655-0002
WebEx Meeting Number: 146 264 6760
Join Meeting

**13 — 10 a.m.** — Victor Community Support Services
Call-In: 1-669-444-9171
Zoom Meeting ID: 237 481 4005 Passcode: 865178
Join Meeting

**13 — 2 p.m.** — African American Awareness Subcommittee
Call-In: 1-415-655-0002
WebEx Meeting Number: 146 893 8322
Join Meeting

**14 — 1 p.m.** — Spirituality Awareness Subcommittee
Call-In: 1-415-655-0002
WebEx Meeting Number: 961 357 009
Join Meeting

**14 — 10:30 a.m.** — Desert Stars Clubhouse
1841 E. Main St., Barstow

**15 — 11 a.m.** — Pathways to Recovery Clubhouse
17053 E. Foothill Blvd. Suite B, Fontana

**15 — 2 p.m.** — Transitional Age Youth (TAY) Awareness Subcommittee
Call-In: 1-415-655-0002
WebEx Meeting Number: 960 523 715
Join Meeting

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

**15 — 6 p.m.** — Fourth District Advisory Committee
Call-In: 1-415-655-0002
WebEx Meeting Number: 2495 776 5577
Password: fBw5HAvQH23
Join Meeting

**15 — 11 a.m.** — First District Advisory Committee
Call-In: 1-415-655-0002
WebEx Meeting Number: 187 662 3366
Join Meeting

**16 — 1 p.m.** — Cultural Competency Advisory Committee (CCAC)
Call-In: 1-415-655-0002
WebEx Meeting Number: 969 101 891
Join Meeting

**21 — 11 a.m.** — Amazing Place Clubhouse
2940 Inland Empire Blvd., Ontario

**21 — 2 p.m.** — Native American Awareness Subcommittee
Call-In: 1-415-655-0002
WebEx Meeting Number: 146 996 4635
Join Meeting

**21 — 10 a.m.** — MHSA Administration
Call-In: 1-415-655-0002
WebEx Meeting Number: 2498 681 4350
Join Meeting

**21 — 5 p.m.** — MHSA Administration
Call-In: 1-415-655-0002
WebEx Meeting Number: 2495 495 7647
Join Meeting

**22 — 11 a.m.** — Serenity Clubhouse
12625 Hesperia Rd. Suite B, Victorville

**22 — 1 p.m.** — Women's Awareness Subcommittee
Call-In: +1-415-655-0002
WebEx Meeting Number: 967 920 279
Join Meeting

**23 — 10 a.m.** — Older Adults Awareness Subcommittee
Call-In: 1-415-655-0002
WebEx Meeting Number: 961 983 483
Join Meeting

**23 — 10 a.m.** — Latino Awareness Subcommittee
Call-In: +1-415-655-0002 - Spanish Only
WebEx Meeting Number: 966 009 041
Join Meeting

**24 — 12:30 p.m.** — Pacific Clinics Family Resource Center
58457 Twenty Nine Palms Hwy, Suite 102, Yucca Valley

**27 — 11 a.m.** — Consumer and Family Members Awareness Subcommittee
Call-In: +1-415-655-0002
WebEx Meeting Number: 2495 614 6844
Join Meeting

**28 — 11 a.m.** — TEAM House Clubhouse
201 W. Mill Street, San Bernardino

**28 — 11:30 a.m.** — Central Valley Fun Clubhouse
1501 S. Riverside Ave., Rialto

**28 — 12:30 p.m.** — LGBTQ Awareness Subcommittee
Call-In: +1-415-655-0002
WebEx Meeting Number: 960 570 704
Join Meeting

**28 — 5 p.m.** — Fifth District Advisory Committee
Call-In: 1-415-655-0002
WebEx Meeting Number: 187 027 1608
Join Meeting

**29 — 11:30 a.m.** — Santa Fe Wellness Club Clubhouse
56020 Santa Fe Trail, Suite M, Yucca Valley

**30 — 11:30 a.m.** — A Place to Go Clubhouse
32770 Old Woman Springs Rd. Suite B, Lucerne Valley

**February 2025**

**3 — 3 p.m.** — Veterans Awareness Subcommittee
Call-In: 1-415-655-0002
WebEx Meeting Number: 2482 788 1413
Join Meeting

**6 — 9 a.m.** — Rim Family Services
Zoom Meeting ID: 825 7790 5597 Passcode: 1800
Join Meeting

**12 — 10 a.m.** — Victor Community Support Services (San Bernardino)
600 N. Arrowhead Ave. Suite 300, San Bernardino

**12 — 11 a.m.** — Third District Advisory Committee
Call-In: 1-415-655-0002
WebEx Meeting Number: 146 962 9460
Join Meeting

**19 — 1 p.m.** — Senior Affairs Commission
784 E. Hospitality Lane, San Bernardino

**20 — 10 a.m.** — Community Policy Advisory Committee
720 E. Carnegie Dr. Suite 150, San Bernardino

Event will be held in-person

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

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

San Bernardino County Department of Behavioral Health

# Community Program Planning

SAN BERNARDINO COUNTY | Behavioral Health

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

## Reunión de Planificación

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

El evento se llevará a cabo en persona

### Enero 2025

**08 — 10 a.m.**
**Subcomité de Concientización sobre la Salud Mental y el Uso de Sustancias**
**Llamada telefónica:** 1-415-655-0002
**Número de reunión de WebEx:** 961 777 142
Ingresar a la reunión

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

**09 — 1 p.m.**
**Reunión Trimestral de Proveedores de PEI**
**Llamada telefónica:** 1-415-655-0002
**Número de reunión de WebEx:** 2485 096 9219
Ingresar a la reunión

**09 — 10 a.m.**
**Subcomité de Concientización de Discapacidades**
**Llamada telefónica:** 1-415-655-0002
**Número de reunión de WebEx:** 146 434 2208
Ingresar a la reunión

**09 — 3:30 p.m.**
**Comité Asesor del Segundo Distrito**
**Llamada telefónica:** 1-415-655-0002
**Número de reunión de WebEx:** 2483 823 7369
**Código de acceso:** pxYctfry353
Ingresar a la reunión

**10 — 10 a.m.**
**Subcomité de Concientización de Asiáticos/Isleños del Pacífico**
**Llamada telefónica:** 1-415-655-0002
**Número de reunión de WebEx:** 968 187 539
Ingresar a la reunión

**13 — 10 a.m.**
**Subcomité de Concientización de Prevención del Suicidio**
**Llamada telefónica:** 1-415-655-0002
**Número de reunión de WebEx:** 146 264 6760
Ingresar a la reunión

**13 — 10 a.m.**
**Servicios de Apoyo Comunitario de Victor**
**Llamada telefónica:** 1-669-444-9171
**Zoom Meeting ID:** 237 481 4005
**Código de acceso:** 865178
Ingresar a la reunión

**13 — 2 p.m.**
**Subcomité de Concientización de Afroamericanos**
**Llamada telefónica:** 1-415-655-0002
**Número de reunión de WebEx:** 146 893 8322
Ingresar a la reunión

**14 — 1 p.m.**
**Subcomité de Concientización de Espiritualidad**
**Llamada telefónica:** 1-415-655-0002
**Número de reunión de WebEx:** 961 357 009
Ingresar a la reunión

**14 — 10:30 a.m.**
**Casa Club Desert Stars**
1841 E. Main St., Barstow

**15 — 11 a.m.**
**Casa Club Pathways to Recovery**
17053 E. Foothill Blvd. Suite B, Fontana

**15 — 2 p.m.**
**Subcomité de Concientización de Jóvenes en Edad de Transición (TAY)**
**Llamada telefónica:** 1-415-655-0002
**Número de reunión de WebEx:** 960 523 715
Ingresar a la reunión

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

**15 — 6 p.m.**
**Comité Asesor del Cuarto Distrito**
**Llamada telefónica:** 1-415-655-0002
**Número de reunión de WebEx:** 2495 776 5577
**Código de acceso:** fBw5HAvQH23
Ingresar a la reunión

**15 — 11 a.m.**
**Comité Asesor del Primer Distrito**
**Llamada telefónica:** 1-415-655-0002
**Número de reunión de WebEx:** 187 662 3366
Ingresar a la reunión

**16 — 1 p.m.**
**Comité Consultivo de Competencia Cultural (CCAC)**
**Llamada telefónica:** 1-415-655-0002
**Número de reunión de WebEx:** 969 101 891
Ingresar a la reunión

**21 — 11 a.m.**
**Casa Club Amazing Place**
2940 Inland Empire Blvd., Ontario

**21 — 2 p.m.**
**Subcomité de Concientización de Nativos Americanos**
**Llamada telefónica:** 1-415-655-0002
**Número de reunión de WebEx:** 146 996 4635
Ingresar a la reunión

**21 — 10 a.m.**
**Administración de MHSA**
**Llamada telefónica:** 1-415-655-0002
**Número de reunión de WebEx:** 2498 681 4350
Ingresar a la reunión

**21 — 5 p.m.**
**Administración de MHSA**
**Llamada telefónica:** 1-415-655-0002
**Número de reunión de WebEx:** 2495 495 7647
Ingresar a la reunión

**22 — 11 a.m.**
**Casa Club Serenity**
12625 Hesperia Rd. Suite B, Victorville

**22 — 1 p.m.**
**Subcomité de Concientización de Mujeres**
**Llamada telefónica:** +1-415-655-0002
**Número de reunión de WebEx:** 967 920 279
Ingresar a la reunión

**23 — 10 a.m.**
**Comisión de Asuntos para Adultos Mayores**
**Llamada telefónica:** 1-415-655-0002
**Número de reunión de WebEx:** 961 983 483
Ingresar a la reunión

**23 — 10 a.m.**
**Subcomité de Concientización de Latinos**
**Llamada telefónica:** +1-415-655-0002 - En español
**Número de reunión de WebEx:** 966 009 041
Ingresar a la reunión

**24 — 12:30 p.m.**
**Centro de Recursos Familiares de las Clínicas del Pacífico**
58457 Twenty Nine Palms Hwy, Suite 102, Yucca Valley

**27 — 11 a.m.**
**Subcomité de Concientización de Consumidores y Miembros de Familias**
**Llamada telefónica:** +1-415-655-0002
**Número de reunión de WebEx:** 2495 614 6844
Ingresar a la reunión

**28 — 11 a.m.**
**Casa Club TEAM house**
201 W. Mill Street, San Bernardino

**28 — 11:30 a.m.**
**Casa Club del Valle Central**
1501 S. Riverside Ave., Rialto

**28 — 12:30 p.m.**
**Subcomité de Concientización de LGBTQ**
**Llamada telefónica:** +1-415-655-0002
**Número de reunión de WebEx:** 960 570 704
Ingresar a la reunión

**28 — 5 p.m.**
**Comité Asesor del Quinto Distrito**
**Llamada telefónica:** 1-415-655-0002
**Número de reunión de WebEx:** 187 027 1608
Ingresar a la reunión

**29 — 11:30 a.m.**
**Casa Club del Bienestar de Santa Fe**
56020 Santa Fe Trail, Suite M, Yucca Valley

**30 — 11:30 a.m.**
**Casa Club A Place To Go**
32770 Old Woman Springs Rd. Suite B, Lucerne Valley

### Febrero 2025

**3 — 3 p.m.**
**Subcomité de Concientización de Veteranos**
**Llamada telefónica:** 1-415-655-0002
**Número de reunión de WebEx:** 2482 788 1413
Ingresar a la reunión

**6 — 9 a.m.**
**Servicios Familiares de RIM**
**Zoom Meeting ID:** 825 7790 5597
**Código de acceso:** 1800
Ingresar a la reunión

**12 — 10 a.m.**
**Servicios de Apoyo Comunitario de Victor (San Bernardino)**
600 N. Arrowhead Ave. Suite 300, San Bernardino

**12 — 11 a.m.**
**Comité Asesor del Tercer Distrito**
**Llamada telefónica:** 1-415-655-0002
**Número de reunión de WebEx:** 146 962 9460
Ingresar a la reunión

**19 — 1 p.m.**
**Comisión de Asuntos para Adultos Mayores**
784 E. Hospitality Lane, San Bernardino

**20 — 10 a.m.**
**Comité Comunitario Consultivo de Políticas**
720 E. Carnegie Dr. Suite 150, San Bernardino

El evento se llevará a cabo en persona

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

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

San Bernardino County Department of Behavioral Health

## Community Program Planning Process Evaluation & Behavioral Health Needs Assessment

In November 2023, DBH partnered with Health Management Associates (HMA), an independent national research and consulting firm in the healthcare industry, to complete an assessment of DBH's Community Program Planning (CPP) process for developing the MHSA Three-Year Integrated Plan and Annual Plan Updates and a behavioral health needs and capacity assessment. The project extended from November 2023 to August 2024.

Administrative Managers, Program Managers, Program Specialists, Peer and Family Advocates, and an Addiction Medicine Physician from the mental health and Substance Use Disorder and Recovery Services divisions made up a project management team, core team, and community advisory group that worked alongside the consultant to provide feedback on data collection, priorities, and recommendations.

Data informed stakeholder engagement, and engagement with populations with disparities and barriers to services was prioritized. The scope of work included but was not limited to utilization data and other available data on access, outcomes, and health measures.

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

Health Management Associates (HMA) conducted a population assessment of behavioral health needs to identify the cultural and linguistic needs of served and unserved county residents, in accordance with 9 CCR § 1810.410, and conducted a workforce needs assessment focusing on linguistic capability, provider diversity, and education and training needs in accordance with 9 CCR § 1810.410 and 9 CCR § 3830.

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

HMA used a combination of data analysis, document review, and community engagement throughout the project to conduct the assessments.

The next few pages provide a summary of the strategies used during the assessment, key findings and areas of opportunities,

and current actions taken. The final report identifies strengths, challenges, and recommendations for areas of opportunity within the Mental Health Services Act (MHSA) programming in San Bernardino County and can be found in the Attachments section on page 426.

Some strategies used for qualitative and quantitative data collection included:

- Collected and analyzed available data on consumer services, demographics, capacity data, and workforce needs.
- Conducted interviews with outpatient and residential behavioral health providers, culturally specific organizations, social service agencies, and school district representatives, amongst others, to solicit their input on system strengths and areas for improvement.
- Facilitated focus groups with 200+ participants, where the groups included individuals with lived experiences.
- Administered a community survey that received 232 responses regarding system strengths, barriers, and unmet needs, as well as awareness and participation in the CPP.
- Convened townhalls as a forum to hear additional input from community members.
- Observed several DBH-run meetings that are a part of the CPP.

<u>Behavioral Health Needs and Capacity Assessment</u>

Key findings of the behavioral health needs and capacity assessment were broken down by the strengths and opportunities for improvement/unmet needs. The qualitative feedback key findings are organized in the categories below:

Strengths:

- Provider Collaboration
- Service Availability and Accessibility
- County Engagement Efforts
- Effectiveness of Services

Opportunities for Improvement and Unmet Needs:

- Access and Service Availability
- Cultural Responsiveness and Disparity Reduction
- Workforce Recruitment and Retention
- Implementation of New Initiatives
- Internal and External Collaboration
- Operations
- Community Engagement

HMA provided recommendations that could have a significant impact on behavioral healthcare delivery in San Bernardino County. These are categorized into the five areas below:

1. Expand Access to High-Quality Services
2. Improve Service Integration and Coordination
3. Enhance External Communication and Engagement
4. Strengthen Administrative and Operational Processes
5. Address Workforce Challenges

# Community Program Planning

DBH is reviewing the recommendations and developing strategies to help improve behavioral healthcare delivery in our county. This is a continuous process, and updates will be shared in future meetings.

Community Program Planning (CPP) Process Assessment

Some key findings related to the observations of the Community Program Planning (CPP) process are listed below by strengths and opportunities for improvement:

Strengths:

- Meetings were well attended, there were plenty of opportunities for constituent questions and feedback, and participants were engaged.
- A wide array of special population meetings were held.
- Information shared met Culturally and Linguistically Appropriate Services Standards.

Opportunities for Improvement:

- There was a disconnect among constituents regarding the context and goal of the meetings and the connection between the Mental Health Services Act (MHSA) and the CPP.
- The process of submitting comments could be streamlined.
- San Bernardino County could leverage online tools to improve interactions and engagement during meetings.

Some key findings related to the feedback on the Community Program Planning (CPP) process are listed below by strengths and opportunities for improvement:

Strengths:

- The County has tested multiple strategies for outreach, including partnering with organizations to host meetings, virtual forums, surveys, etc.
- The intent behind the process and sub-committees is good, even if they are not always as effective and well-attended as participants would like.
- The County promotes the sessions to providers and the community and is generally good about receiving feedback.

Opportunities for Improvement:

- Stakeholders have many competing requirements for their time and resources and want clearly defined goals, objectives, and action items for meetings with a stronger focus on operational application rather than statistics.
- There is a need for clearer communication on the objective of the CPP process.
- There is a desire to increase participation from individuals who have not traditionally been a part of the process, such as those who may have behavioral health needs but do not access services for one reason or another.

HMA found that San Bernardino County has a very successful Community Program Planning Process and a strong foundation on which focused enhancements could

be implemented to improve planning and engagement efforts. Some of the HMA recommendations for enhancing external communication and engagement to help build awareness of the CPP process and support meaningful engagement with consumers and the community include:

- Building awareness of the Community Program Planning (CPP) process
- Improving CPP progress and outcomes tracking
- Leveraging trusted partners to support information sharing
- Improving connections with marginalized communities
- Offering engagement opportunities in community settings
- Leveraging technology to support engagement

DBH is taking the following steps to address the assessment recommendations:

- Providing more context about MHSA and the CPP process during meetings to help educate stakeholders on the planning process and how their engagement and feedback helps to guide DBH programs.
- Expanding stakeholder groups to include more unserved/underserved populations, community members, service partners, faith-based organizations, children and youth groups, etc., to increase community engagement and feedback and to involve more service partners to increase information sharing with the community.
- Coordinating with other departments and organizations to participate in their community/patient needs assessments to identify the needs of the county and expand access and services to meet those needs.
- Holding the monthly Community Policy Advisory Committee (CPAC) meetings in more locations throughout the county to engage with stakeholders in community settings.

DBH leadership is working on identifying additional opportunities for improvement and continues to encourage stakeholder engagement and feedback to guide its programs and services.



## Public Review and Comment Period

The MHSA Annual Update was posted on the department's website for stakeholder review and comment from February 14, 2025, through March 17, 2025, at https://wp.sbcounty.gov/dbh/programs/mhsa/, per Welfare and Institutions Code 5848. Stakeholder comment forms and directions were posted with the draft MHSA Annual Update on the department's website.

Stakeholders were also informed that they could submit comments/recommendations via email to the DBH MHSA email box at MHSA@dbh.sbcounty.gov during the time the MHSA Annual Update draft was posted for public comment. Stakeholders were informed that comments can be received anytime throughout the year but will not be included in the final MHSA Annual Update unless provided during the 30-day comment period.

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

DBH would like to thank everyone who reviewed the plan and/or submitted a comment. There were no substantive comments received during the 30-day public review and comment period. DBH encourages and supports community collaboration, particularly involvement of stakeholders, in all aspects of the MHSA.

## Summary and Analysis of Stakeholder Comments

During the Community Program Planning meetings and the 30-day public review and comment period, DBH received several inquiries on the stakeholder comment forms asking: what services are available in their region, how to access additional information on available behavioral health services in San Bernardino County, and where to find out more information on Substance Use Disorder and Recovery Services (SUDRS). Please see below for additional information on services and programs.

Services and programs by region

The DBH Services Guide is located at https://wp.sbcounty.gov/dbh/resources/, under the Services Guide, Handbooks, and Provider Directories section, and includes service providers in the East Valley, West Valley, Desert/Mountain, and Morongo Basin. It is available in English, Spanish, Mandarin, and Vietnamese. The DBH Services Guide is a summary of DBH and DBH contract provider services and is not inclusive of all services and/or providers.

## Summary and Analysis of Stakeholder Comments, cont.

Organizations that provide services

DBH's Provider Directories, which include each licensed, waivered, or registered mental health provider and licensed substance use disorder services provider employed with or contracted by DBH to deliver Medi-Cal services, may be viewed at https://wp.sbcounty.gov/dbh/resources/ under the Services Guide, Handbooks, and Provider Directories section.

Substance Use Disorder and Recovery Services (SUDRS) Resources

The DBH SUDRS providers can be found in the DBH Services Guide, and additional SUDRS resources can be found at https://wp.sbcounty.gov/dbh/resources/#SUDRSresources.

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

Community Program Planning Meetings

Throughout the year, regular stakeholder meetings include:

- Behavioral Health Commission (BHC)
- District Advisory Committee (DAC)
- Community Policy Advisory Committee (CPAC)
- Cultural Competency Advisory Committee (CCAC), along with 14 Culturally Specific Subcommittees
- Association of Community Based Organizations (ACBO)
- Prevention and Early Intervention (PEI) Provider Network

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

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

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 to the use of MHSA funds, non-compliance with MHSA general standards, inconsistency between the approved MHSA

## Summary and Analysis of Stakeholder Comments, cont.

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

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

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

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

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

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

## Summary and Analysis of Stakeholder Comments, cont.

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

During stakeholder meetings, community members asked how they will be informed about the Behavioral Health Services Act (BHSA) regulatory changes and how it might potentially affect their programs.

Community Program Planning Meetings
Throughout the year, as DBH is apprised on BHSA updates, they will share this information with stakeholders through the Community Program Planning meetings.

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

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

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

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

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

**Assistance for Disabled Individuals**

For individuals with developmental disabilities and intellectual disabilities, DBH collaborates and works with First 5 (https://first5sanbernardino.org/initatives/early-learning/) and the Inland Regional Center (https://www.inlandrc.org/). Both programs specifically work with this population (Developmental Disabilities and

## Summary and Analysis of Stakeholder Comments, cont.

Intellectual Disabilities) and ensure that the individual and families are referred to the appropriate resources (i.e., Early Head Start/Head Start).

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

**Reduction of Discrimination and Stigma**

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

**Support for Parents and Caregivers**

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

**Crisis Services**

The Crisis Walk-In Center (CWIC) programs are staffed with available nurses, and services are available to the community 24 hours per day, 365 days a year. Further, the DBH Crisis Contact Center (CCC) operates 24 hours per day, 365 days a year, offering text message, telephone, and telehealth support countywide to individuals in crisis. The CCC is able to dispatch mobile crisis response services 24 hours per day, 365 days a year, when safe and appropriate, to the West Valley, East Valley, and High Desert regions.

## Summary and Analysis of Stakeholder Comments, cont.

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

**Shelter Beds and Homeless Assistance**

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

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

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

These programs are intended to reduce:

- Incidents of acute involuntary psychiatric hospitalization
- The number of calls to law enforcement for psychiatric emergencies
- The number of psychiatric emergencies in hospital emergency departments
- The number of consumers seeking emergency psychiatric services from hospital emergency departments
- The amount of time a consumer with a psychiatric emergency spends in hospital emergency departments and increase consumer access to services

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

## Summary of Program Changes

DBH has made a practice of planning for sustainable growth in the development and implementation of MHSA and its system of care services. This MHSA Annual Update reflects program changes under Prevention and Early Intervention (PEI) and Community Services and Supports (CSS) components. There are no planned program changes under the Innovation (INN) component.

The following are proposed changes in programs and components:

**Prevention and Early Intervention**

Child and Youth Connection – Budget Increase

The Children's Assessment Center (CAC), administered by Loma Linda University Children's Hospital (LLUCH) under the Child and Youth Connection (CYC) program, will increase funding from $62,000 to $165,000 per year. This funding change will increase early access and linkage to medically necessary care and treatment. It connects children and youth with severe mental health conditions to care as early in the onset of these conditions as practicable, to medically necessary care and treatment. It includes, but is not limited to, care provided by county mental health programs.

Goals of the project:

- Pre-forensic examination counseling services to help minimize the children's/youths' trauma from the examination and decrease the psychological distress associated with child abuse allegations.
- Provide pre-forensic examination counseling services to an estimated 900 unduplicated children and adolescents.

This program serves consumers ages 0-18 years old throughout San Bernardino County.

Family Resource Center (FRC) – Expansion Update

Department of Behavioral Health, Prevention and Early Intervention (PEI) Family Resource Center is expanding their services to include a Family Wellness Center (FWC). The FWC expansion will include prevention and early intervention services as well as specialty mental health services for children, youth, and adults with mental health concerns. This expansion will increase the annual FRC budget by $1,500,000 from $2,774,774 to $4,274,774, previously budgeted increase in the MHSA Annual Plan Update for FY 2022/23. This expansion will enable DBH to broaden its scope of services by providing a comprehensive approach to family wellness while continuing to offer essential services to promote wellness, recovery, and resiliency for its clients.

FRC programs offer:

- Services tailored to individualized communities' specific needs and cultural requirements.
- Services and activities at non-traditional locations, such as community centers, where other collateral services are also provided.

## Summary of Program Changes, cont.

- A reduction in stigma associated with seeking mental health services, increasing the likelihood that community members will use the services.

Population served will be children and their families throughout San Bernardino County.

Preschool PEI Program (PPP) and Lift Program
The Prevention and Early Intervention Preschool PEI and Lift programs are being evaluated for transition to early intervention programs for children ages 0-5.

**Community Services and Supports**

Housing and Homeless Services Continuum of Care Program – Position Transfer
The Homeless Outreach Support Team (HOST) under the Housing and Homeless Services Continuum of Care Program is transferring a Clinical Therapist I Psychologist position to the Choosing Healthy Options to Instill Change and Empowerment (CHOICE) program under the Forensic Services Continuum of Care program.

- This change will allow the CHOICE program to provide psychiatric services directly to consumers enrolled in the CHOICE Mental Health Outpatient program at the Probation Department Day Reporting Centers rather than referring them to another clinic.

This position will be funded under the AB109 Realignment.

**Innovation**

Eating Disorder Collaborative – Project Sunset
Eating Disorder Collaborative (EDC) is scheduled to sunset in December 2025. DBH is in the process of reviewing project data and outcomes to determine continuation of the project. DBH is considering options to continue the project or project services under Community Services and Supports (CSS) Full Service Partnership (FSP) program and/or other opportunities with Managed Care Plans (MCPs) to continue to provide project services where appropriate.

Cracked Eggs – Project Sunset
The contract for Cracked Eggs ends June 2026 and will not continue as a standalone program. Low enrollment rates combined with the substantial operational costs have rendered it unsustainable. However, the project highlighted that art can be a therapeutic tool. DBH will explore ways to incorporate some of the artistic strategies learned during this Innovation project to include in our system of care where appropriate. The final report will be released in FY 2026/27.

## Public Hearing

The Public Hearing was conducted at the San Bernardino County Behavioral Health Commission general session on April 3, 2025, at County of San Bernardino Health Services Building Auditorium located at 850 E. Foothill Blvd., Rialto, CA 92376. Satellite locations were also available at the Department of Behavioral Health Apple Valley Community Clinic located at 18818 Highway 18, Apple Valley, CA, 92307, and at the Family Resource Center located at 58945 Business Center Drive, Yucca Valley, CA, 92284. The agenda, meeting regulations of MHSA public hearings, and a copy of the MHSA Public Hearing presentation were verbally and/or electronically accessible for all attendees during the meeting. As with all public meetings, interpretation services and materials in other languages were available upon request.

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

The Behavioral Health Commission affirmed that the DBH adhered to the MHSA CPP process and supported the submission of the MHSA Annual Update for Fiscal Year 2025/26 to the San Bernardino County Board of Supervisors scheduled for approval in a May 2025 meeting and the subsequent submission to the Department of Health Care Services and Mental Health Services Oversight and Accountability Commission.

## Improvements in Progress

Stakeholder feedback received during the continuous Community Program Planning (CPP) process indicated that stakeholders want to receive more information on the Behavioral Health Services Act (BHSA) and how it might affect programs.

In March 2024, voters approved Proposition 1 to reform the Mental Health Services Act (MHSA) to the Behavioral Health Services Act (BHSA) and fund needed behavioral health facility infrastructure through a general obligation bond. The efforts to implement Proposition 1 are referred to as Behavioral Health Transformation (BHT).

The Department of Health Care Services (DHCS) is enacting changes resulting from Proposition 1 through the Behavioral Health Transformation project and are providing guidance to counties. As the Department of Behavioral Health (DBH) is apprised on BHSA updates, they will share this information with stakeholders through the Community Policy Advisory Committee (CPAC) meetings throughout the next fiscal year.

The current MHSA programs and services will continue as approved through June 30, 2026. The first BHSA Integrated Plan for FY 2026/27 through FY 2028/29 is due by June 30, 2026, and will be effective on July 1, 2026. The Integrated Plan is currently being developed, and DBH will continue to engage stakeholders and obtain feedback through the Community Program Planning (CPP) process during development of the Plan over the next fiscal year.

To ensure as smooth a transition from MHSA to BHSA as possible, DBH is currently engaged in the following activities:

- Expanding stakeholder engagement by identifying and connecting with new partners to ensure inclusive participation in the CPP process and program planning.
- Educating stakeholders on Proposition 1, discussing its program impacts, and soliciting actionable feedback to address community needs and guide future planning during monthly CPAC meetings.
- Continuing to meet with county partners and discuss program impacts.
- Developing mitigation plans to ensure a smooth transition to funding structures and service models.
- Maintaining a proactive role in the BHSA transition, engaging in Behavioral Health Transformation (BHT) listening sessions led by the state, and staying up-to-date on evolving policies and regulations to ensure informed decision-making and community alignment.

Additional information on stakeholder engagement can be found on the Department of Health Care Services (DHCS) website using the following link: Stakeholder-Engagement.

SAN BERNARDINO COUNTY
Behavioral Health

# MHSA Annual Update for FY 25/26: PEI Component including Annual Prevention and Early Intervention Report

# Prevention and Early Intervention

## Introduction

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

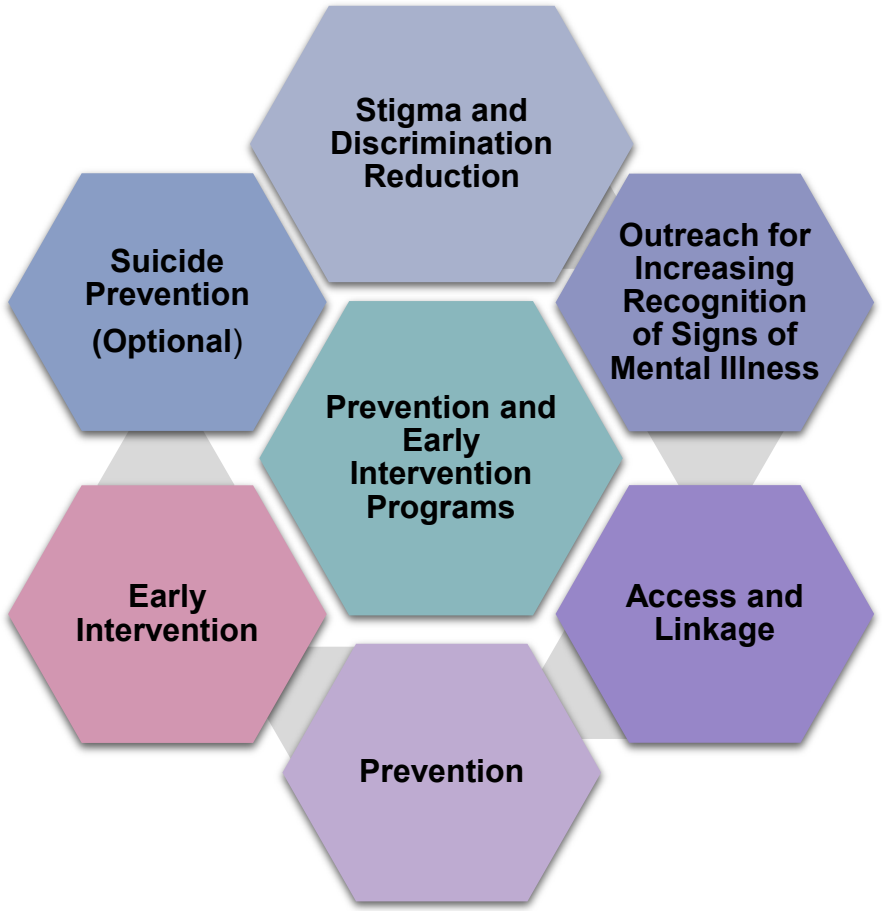
Strategies and activities are applied early on to avert the onset or relapse of mental health conditions among individuals. The component also seeks to change community conditions known to contribute to behavioral health concerns.

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

PEI initiatives are dedicated to addressing the priority needs identified by diverse local community stakeholders, fulfilling the critical community and priority population needs delineated in the Mental Health Services Act (MHSA), and effecting transformation within the public mental health system.

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

**State-Defined Prevention and Early Intervention Programs**



## Introduction, cont.

**Local PEI Construct**

County PEI programs operate under the State-Defined Prevention and Early Intervention reporting construct as illustrated in the following table.

**Stigma and Discrimination Reduction**

- Native American Resource Center (NARC)

**Outreach for Increasing Recognition of Signs of Mental Illness**

- *Promotores de Salud* (PdS)
- Community Health Workers (CHW)
- Substance Use Prevention & Pathways to Outreach and Treatment (SUPPOrT)

**Access and Linkage to Treatment**

- Child and Youth Connection (CYC)




**Prevention**

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

**Early Intervention**

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

**Suicide Prevention (Optional)**

- Office of Suicide Prevention (OSP)

## Introduction, cont.

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

| Acronym | Program | Acronym | Program |
|---|---|---|---|
| NARC | Native American Resource Center | CYC | Child and Youth Connection |
| SAP | Student Assistance Program | PPP | Preschool PEI Program |
| CHW | Community Health Workers | LP | Lift Program |
| OSP | Office of Suicide Prevention | OACS | Older Adult Community Services |
| MSFS | Military Services and Family Support | | |

## Introduction, cont.

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

| Acronym | Program | Acronym | Program |
|---|---|---|---|
| NARC | Native American Resource Center | CYC | Child and Youth Connection |
| PdS | Promotores de Salud | PPP | Preschool PEI Program |
| CHW | Community Health Workers | LP | Lift Program |
| SUPPOrT | Substance Use Prevention & Pathways to Outreach and Treatment | RPiAAC | Resilience Promotion in African American Children |
| CASE | Coalition Against Sexual Exploitation | OACS | Older Adult Community Services |
| OSP | Office of Suicide Prevention | FRC | Family Resource Center |
| MSFS | Military Services and Family Support | CWE | Community Wholeness and Enrichment |
| SAP | Student Assistance Program | IDEA | Improving Detection and Early Access |

## Introduction, cont.

SB 1004 PEI Program Priority Areas
All PEI programs are required to comply with WIC Section 5840.7 enacted by Senate Bill 1004, which requires counties to specify how they are incorporating the following six program-identified priorities in the FY 24/25 MHSA plan:

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

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

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

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

## Introduction, cont.

| PEI Component | Local Program Name | SB 1004 Priority Category | | | | | |
|---|---|---|---|---|---|---|---|
| | | 1 Child Trauma | 2 Early Psychosis | 3 Youth Outreach | 4 Cultural Comp | 5 Older Adults | 6 Early ID |
| **Stigma and Discrimination Reduction** | PEI-CI-3: Native American Resource Center | | | | x | | |
| **Outreach for increasing recognition for early signs of Mental Illness** | PEI CI-1: Promotores de Salud/Community Health Worker | | | | x | | |
| | PEI CI-5: Substance Use Prevention & Pathways to Outreach and Treatment (SUPPOrT) | | | | | | x |
| **Access and linkage to treatment** | PEI SE-2: Child and Youth Connection | x | | | | | |

## Introduction, cont.

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

## Introduction, cont.

**PEI Community Program Planning**

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

A series of District Advisory Committee (DAC) meetings were held in in FY 23/24. There are five distinct districts within San Bernardino County, each very unique and different. PEI met with each district during their DAC meetings to share specific district information about MHSA including PEI. Each engagement was a two-hour presentation via Webex in order to reach a greater audience.

- District 1 – November 15, 2023
- District 2 – January 11, 2024
- District 3 – February 14, 2024
- District 4 – February 21, 2024
- District 5 – January 23, 2024

In addition to the District Advisory Committee meetings, PEI completed a presentation in the Community Policy Advisory Committee (CPAC) on October 18, 2023, where we presented a complete overview of the PEI programs.

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

Committee meetings were advertised on all DBH social media platforms, including Facebook, Instagram, and X.

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

The top three priorities for PEI efforts within our community:

- Childhood trauma early intervention to address early origins of mental health and substance use disorder needs.
- Strategies targeting mental health and substance use disorder needs of older adults.
- Strategies addressing needs of individuals at high risk of crisis.

Some of the PEI priorities within our community that are already being met:

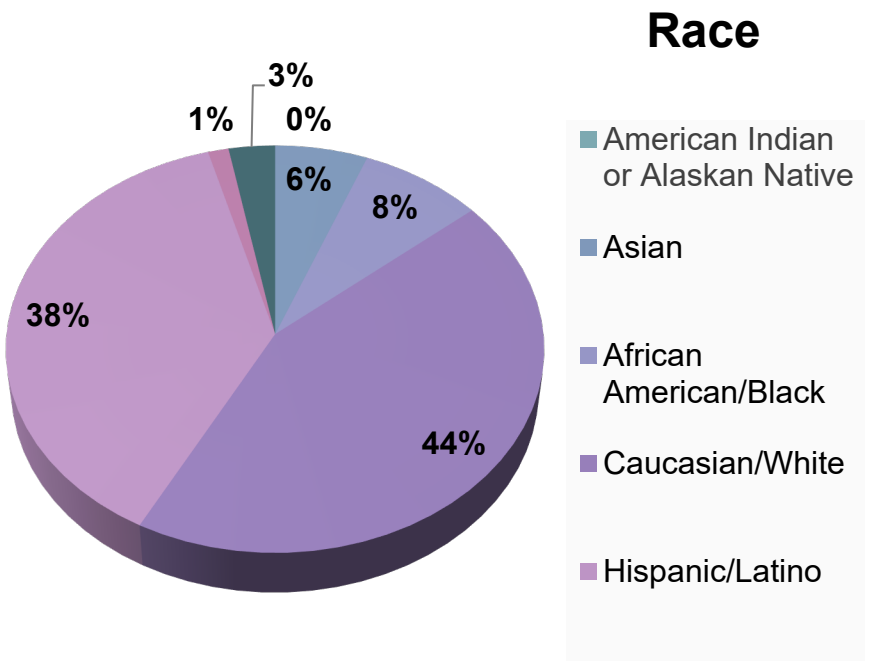
- Culturally competent and linguistically appropriate.
- Strategies targeting mental health needs of older adults.
- Childhood trauma early intervention to deal with early origins of mental health and substance use disorder needs.
- Early psychosis and mood disorder detection and intervention and mood disorder programming across the lifespan.

## Introduction, cont.

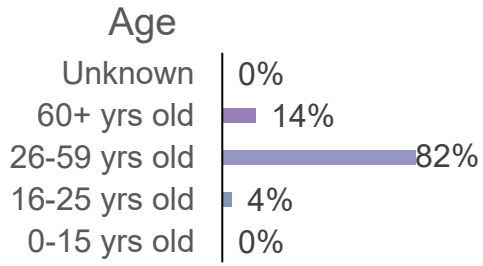
**PEI Community Program Planning, cont.**

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

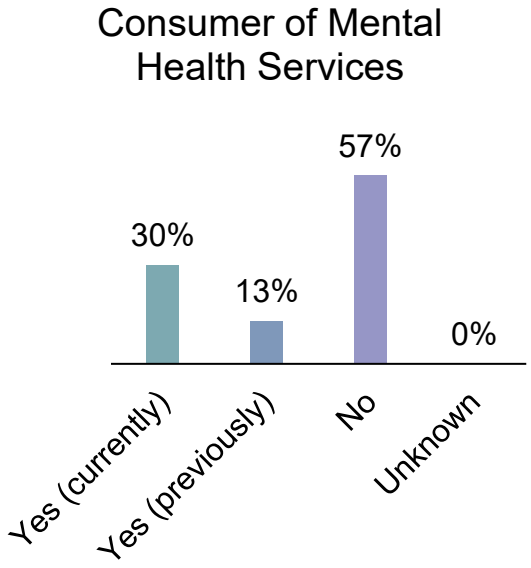
The rich racial diversity of San Bernardino County was reflected in the demographic data of the participants, with 8% identifying as African American/Black, 6% Asian, 44% Caucasian, 38% Latinx/Hispanic, and 1% Native Hawaiian/Pacific Islander. In addition, 3% of participants indicated that they identify with more than one race.

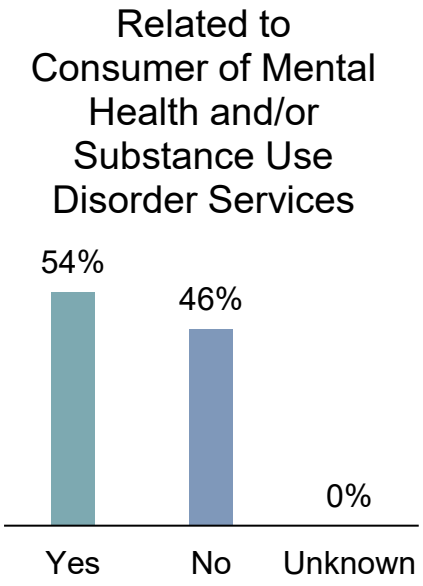



The majority of participants were adults, with 82% reporting that they were between 26-59 years old, 14% were older adults over 60, and 4% TAY aged youth (16-25).




Participants comprised of a mix of individuals with 43% reporting that they are either a current or previous consumer of mental health services and 54% reporting that the are related to a consumer of either mental health or substance use disorder services.



## Introduction, cont.

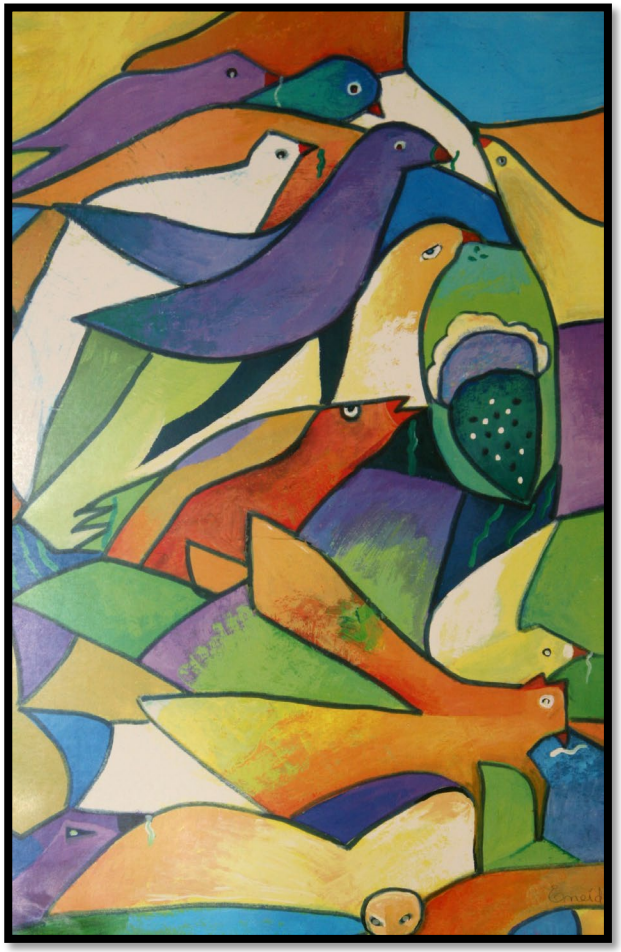
### PEI Data Collection

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

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

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

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



Artwork by Eneida Reboucas

## Introduction, cont.

**PEI Statewide Projects**

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

The three (3) statewide projects include:

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

These projects are administered by CalMHSA and are represented under the Take Action for Mental Health project. Strategies for FY 2023/24 included:

- Distribution of the Take Action for Mental Health campaign's materials and messages,
- Technical assistance and outreach to members contributing to the PEI Program,
- Mental health and suicide prevention training to diverse audiences, and
- Engaging youth through the Directing Change program.

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



## Introduction, cont.

**San Bernardino County Local Impact**

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

Two hundred and nine participants submitted a total of 70 films. Entries were submitted by filmmakers from twelve San Bernardino County schools: Apple Valley High School, Silverado High School, Upland High School, Entrepreneur High School, Encore High School, Cajon High School, Jurupa Hills High School, San Andreas High School, University Preparatory, Fontana High School, Rim of the World High School, and Hesperia High School. San Bernardino County filmmakers whose entries competed in the categories of Mental Health Matters, Suicide Prevention, Animated Short, Walk in Our Shoes and Through the Lens of Culture.

San Bernardino County hosted a Directing Change Award Ceremony at the Harkins Movie Theater in Redlands on May 11, 2024, to honor the San Bernardino County filmmakers.




NOTE: The annual budget shown is the amount of the MHSA PEI funding which has been allocated to these programs. It may differ from the amounts in the Fiscal section as those account for anticipated utilization values.

## Introduction, cont.

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

## Number of Consumers to be Served

The tables below demonstrate the number of consumers to be served by program name for Fiscal Year 2025/26:

| Program Name | Fiscal Year 2025/26 Total |
|---|---|
| Child and Youth Connection | 6,529 |
| Coalition Against Sexual Exploitation | 1,500 |
| Community Wholeness and Enrichment | 5,914 |
| Early Psychosis Program/Improving Detection and Early Access | 26 |
| Family Resource Center | 26,945 |
| Lift Progam | 120 |
| Military Services and Family Support | 3,878 |

| Program Name | Fiscal Year 2025/26 Total |
|---|---|
| Native American Resource Center | 1,751 |
| Older Adult Community Services | 3,166 |
| Preschool PEI | 1,508 |
| *Promotores de Salud*/Community Health Worker | 30,687 |
| Resilience Promotion in African American Children | 4,753 |
| Student Assistance Program | 15,126 |
| Substance Use Prevention & Pathways to Outreach and Treatment | 3,400 |

# Native American Resource Center (NARC)

## Program Description and Target Population

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

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

The tables below provide an overview of the program's target population, service locations, annual budget allocation, and the types of services offered. The NARC program continually assesses the needs of its participants and responds by updating the services they offer.

| | |
|---|---|
| **Program Serves** | **Children**<br>**TAY (16-25)**<br>**Adults**<br>**Older Adults (60+)** |
| **Location of Services** | Counseling Centers |
| **Annual Budget FY 25/26** | $500,000 |
| **Cost Per Client FY 25/26** | $285 |

| | |
|---|---|
| **Services Offered** | • **Talking Circles**<br>• **Wellness Circles**<br>• **Drumming Circles**<br>• **Daughters of Tradition**<br>• **Cultural education and awareness**<br>• **Cultural arts therapy**<br>• **Cognitive therapy groups** |

# Native American Resource Center (NARC), cont.

## State Program Positive Results

NARC provides a variety of activities rooted in tradition. The program aims to reduce stigma around mental illness and accessing behavioral health services by emphasizing culturally-focused preventative measures. For instance, using Talking Circles in place of traditional group therapy helps alleviate the stigma associated with engaging in behavioral health activities. Additionally, incorporating traditional Native practices such as beading, art, and storytelling demonstrates how cultural norms can be seamlessly integrated with therapeutic approaches.

## Stigma & Discrimination Reduction

Recognizing and acknowledging the behaviors and actions that have caused emotional harm to the Native American community is a crucial first step towards healing and transformation. Educating the community about historical and intergenerational trauma helps in addressing the unique needs of this underserved group.

To assess progress in reducing stigma and discrimination, NARC measures changes in attitudes, knowledge, and behaviors. This is done through surveys that evaluate how participants' perceptions of mental illness have evolved as a result of the activities or presentations they engaged in.

NARC saw a decrease in the utilization of behavioral health services FY 2022/23 to FY 2023/24.

However, as a result of the culturally-based mental wellness activities offered by NARC, the total number of individuals participating in NARC activities exceeded their projected targets for a third consecutive year. The high participation numbers highlight the continued need for support in addressing behavioral health issues within Native American communities in San Bernardino County.

**Number of Participants / Number of Services Projected vs Actual**

| | Projected | Actual | | |
|---|---|---|---|---|
| | | FY 21/22 | FY 22/23 | FY 23/24 |
| **Unduplicated Participants** | 1,751 | 4,138 | 5,566 | 3,334 |
| **Number of Services** | 2,544 | 5,200 | 5,972 | 4,153 |

# Native American Resource Center (NARC), cont.

**State Program Positive Results, cont.**

**Access & Linkage to Services**

NARC provides access and linkage to additional services and higher levels of care for participants who need treatment beyond early intervention. Participants needing higher levels of care receive referrals to providers who can appropriately meet their needs.

NARC works closely with Riverside San Bernardino County Indian Health, Inc. (RSBCIHI). RSBCIHI supports NARC with linkage to RSBCIHI's Behavioral Health Services Department or to an outside agency.

FY 2023/24 saw a significant increase in referrals. This rise in referrals is linked to a growing demand for mental health services that exceed basic care, stemming from the after-effects of the pandemic.

The adjacent table shows the number of participants who were linked to referrals during the three previous fiscal years.

**Access and Linkage to Services Referrals**

| | FY 21/22 | FY 22/23 | FY 23/24 |
|---|---|---|---|
| Number of Referrals Provided | 5 | 4 | 20 |
| Number of referrals to county-funded / administered programs | 0 | 0 | 0 |
| Number of referrals to other programs | 4 | 4 | 20 |
| Number of participants who followed through and engaged in services at a county-funded / administered program at least once | 0* | 0* | 0* |

* All participants engaged in treatment with the non-county administered service providers to whom they were referred.

# Native American Resource Center (NARC), cont.

**State Program Positive Results, cont.**

**Improving Timely Access**

NARC enhances timely access to behavioral health services for members of historically underserved populations. They facilitate referrals to appropriate prevention, early intervention, and higher-level care services. This includes individuals who are unserved, underserved, or inadequately served within the care system, who face higher risks of homelessness, institutionalization, incarceration, or out-of-home placements.

NARC also serves ethnic, racial, cultural, and linguistic groups lacking access to mental health programs. Barriers such as misidentification of mental health needs, insufficient engagement and outreach, limited language access, and a lack of culturally competent services make it challenging for these individuals to obtain care.

NARC actively identifies and engages with individuals to assess their needs and provides culturally relevant referrals to meet their behavioral health care requirements.

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

The improvement in Timely Access is due to NARC's use of the Screendox electronic health record system, which tracks risk factors related to substance use, mental health, domestic violence, and gambling. This system has enhanced NARC’s ability to collect Timely Access data more accurately.

| Improving Timely Access Referrals | | | |
|---|---|---|---|
| | FY 21/22 | FY 22/23 | FY 23/24 |
| Number of Referrals Provided | 294 | 247 | 313 |

## Native American Resource Center (NARC), cont.

### Demographics

| Fiscal Year | Age (yrs. old) | | | | |
|---|---|---|---|---|---|
| | 0-15 | 16-25 | 26-59 | 60+ | UNK |
| FY 21/22 | 2% | 2% | 3% | 1% | 91% |
| FY 22/23 | 3% | 6% | 12% | 3% | 76% |
| FY 23/24 | 9% | 8% | 34% | 9% | 40% |

| Fiscal Year | Sexual Orientation |
|---|---|
| % of consumers who identified as LGBTQ+ | |
| FY 21/22 | 0% |
| FY 22/23 | <1% |
| FY 23/24 | 0% |

| Fiscal Year | Gender Identity | | | |
|---|---|---|---|---|
| | ♂ | ♀ | ⚧ | UNK |
| FY 21/22 | 11% | 26% | 0% | 64% |
| FY 22/23 | 8% | 17% | <1% | 75% |
| FY 23/24 | 15% | 49% | 0% | 36% |

| Fiscal Year | Veteran Status |
|---|---|
| % of consumers who identified as a veteran | |
| FY 21/22 | 0% |
| FY 22/23 | 1% |
| FY 23/24 | 2% |

| Fiscal Year | Disability |
|---|---|
| % of consumers who identified a physical disability | |
| FY 21/22 | 1% |
| FY 22/23 | 3% |
| FY 23/24 | 6% |

| Fiscal Year | Primary Language | | | |
|---|---|---|---|---|
| | ENG | SPAN | OTH | UNK |
| FY 21/22 | 97% | 0% | 0% | 3% |
| FY 22/23 | 14% | <1% | <1% | 86% |
| FY 23/24 | 59% | 2% | <1% | 39% |

# Native American Resource Center (NARC), cont.

**Demographics, cont.**

### Demographic Observations

- NARC continues to provide culturally appropriate services to the Native American community.
- Due to the increased number of in-person activities, participants were again offered the opportunity to complete paper surveys instead of only electronic surveys.
- With the increase of surveys completed, NARC was able to more accurately identify communities participating in their activities.

| | Race/Ethnicity | FY 21/22 | FY 22/23 | FY 23/24 |
|---|---|---|---|---|
| Race | African-American/Black | 1% | 2% | 8% |
| | American-Indian/Alaska Native | 6% | 10% | 21% |
| | Asian | 1% | 1% | 2% |
| | Hispanic/Latinx | 0% | 7% | 8% |
| | Native Hawaiian or Pacific Islander | 0% | <1% | <1% |
| | Caucasian/White | <1% | 3% | 4% |
| | More than One Race | 1% | 0% | 6% |
| | Other Race | 3% | 10% | 24% |
| | Declined to Answer | 87% | 67% | 35% |

## Native American Resource Center (NARC), cont.

**Demographics, cont.**

| | Race/Ethnicity | FY 21/22 | FY 22/23 | FY 23/24 |
|---|---|---|---|---|
| Ethnicity | African | 0% | 0% | 0% |
| | Asian Indian/South Asian | 0% | 0% | 0% |
| | Cambodian | 0% | 0% | 0% |
| | Chinese | 0% | 0% | 0% |
| | Eastern European | 0% | 0% | 0% |
| | European | 0% | 0% | 0% |
| | Hispanic/Latino | 1% | 7% | 0% |
| | Filipino | 0% | 0% | 0% |
| | Japanese | 0% | 0% | 0% |
| | Korean | 0% | 0% | 0% |
| | Middle Eastern | 0% | 0% | 0% |
| | Vietnamese | 0% | 0% | 0% |
| | Other | 1% | 0% | 0% |
| | More than one ethnicity | 0% | 0% | 0% |
| | Declined to Answer | 98% | 93% | 100% |

# Native American Resource Center (NARC), cont.

## Program Goals

The goals of the Native American Resource Center are to:

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

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

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

## Program Outcomes

| Method used to collect outcome | Description of method | Frequency of use | Number Completed |
|---|---|---|---|
| Historical Trauma Survey | Mixed-use survey designed to measure changes in attitudes, knowledge, and behavior through a combination of survey questions, storytelling, and artistic expression. | Post-activity | FY 21/22: 5<br>FY 22/23: 0*<br>FY 23/24: 0* |
| Stigma Reduction Questionnaire (SRQ) Survey | Survey to measure changes in attitudes, knowledge and behavior related to mental health services. | Post-activity | FY 21/22: 8<br>FY 22/23: 147*<br>FY 23/24: 1,757 |

*Shows areas for improvement in survey distribution.

# Native American Resource Center (NARC), cont.

## Outcome Discussion

### Historical Trauma and Reduction of Stigma

Historical trauma is the cumulative, multigenerational, collective experience of emotional and psychological injury in communities and in descendants. Historical trauma responses are the biological, societal, and psychological symptoms which include changes in the traditional ways of child rearing, family structure, and relationships. These learned behaviors, coping skills, and general mistrust of outside agencies effects help seeking of mental health services. Intergenerational trauma is the transference of emotional, physical, or social pain from one person to their descendants. Survivors of trauma may hold stereotypes about mental health treatment and may be unfamiliar with mental health services which can minimize the need for services. As a result of historical trauma and policies of governmental agencies, Native Americans report fears of removal of their children, forced hospitalization in mental health institutions, and general mistrust.

Stigmatizing ideas stemming from historical trauma are reduced through providing education regarding trauma and the effects on individual, family, and the community which allows for the process of healing unresolved grief and the loss of cultural identity. Through increased awareness of and returning to traditional laws, principles and values are preventative measures for at risk behaviors.

NARC program participated in Cultural Competency Trainings which discussed how historical and intergenerational trauma effects the family systems and how those families navigate through systems of care. Events such as, Native American Heritage Month celebrations have also been a way to share about historical trauma.

# Native American Resource Center (NARC), cont.

## Outcome Discussion, cont.

### Stigma Reduction Surveys

In FY 2023/24, NARC began collecting data on stigma-related outcomes through its independent data system, Screendox. The transition to Screendox has led to a rise in the number of identified respondents. NARC observed that the increasing demand for mental health services suggests a decline in the stigma associated with mental health.

While the transition to Screendox resulted in the exclusion of certain questions from the current data set, PEI and NARC are collaborating to create a more effective data collection method that will fully capture the information outlined in the table below.

| Percentage of participants who agreed that they would be more likely to engage or support someone living with a mental health challenge | | | |
|---|---|---|---|
| | **FY 21/22 N=8*** | **FY 22/23 N=147*** | **FY 23/24 N=1,757** |
| More likely to seek mental health support if needed | 100% | 87% | 100% |
| More likely to talk to a friend or family member about mental health needs | 100% | 84% | 0* |
| More likely to take action to prevent mental health discrimination | 88% | 83% | 0* |
| More likely to actively and compassionately listen to someone in distress | 100% | 89% | 0* |

*Shows areas for improvement in survey distribution.

## Native American Resource Center (NARC), cont.

### Challenges/Solutions

NARC current challenge is to replace an employee who was providing services for the NARC program. NARC has put out recruitment request and should be filled within the first month of the new fiscal year.

NARC coordinator is working with its Human Resource Director regarding the recruitment process to hire a new prevention educator. In the meantime, other staff from other programs are assisting in collaborating events.

### Success Story

**Navajo Language Class-** In April NARC attended and assisted with Navajo Language Classes located at the Barstow RSBCIHI location. This course is designed to teach participants how to introduce themselves in Navajo along with the cultural significance behind it. Learning a Native language creates a space for a person to connect with others, to feel more comfortable to go to new places, and creates feelings of inspiration and community. After the end of one of the classes a participant expressed her gratitude towards the facilitators stating she "was not able to learn the language growing up, even though my family knows how to speak Navajo. My entire family is from Arizona but I was born here in Barstow, I always felt left out but now I feel more confident in myself'.

### Program Updates

There are no planned program updates for Fiscal Year 2025/26.

# *Promotores de Sal*ud/Community Health Worker (PdS/CHW)

**Program Description and Target Population**

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

The program provides field-based outreach and education to all age groups in many areas of the county. The chart below provides an overview of the program services.

| | |
|---|---|
| **Services Offered** | • Mental Health and Substance Use Screenings and Assessments<br>• Mental Health Educational Presentations<br>• Case Management<br>• Resource Referrals<br>• Peer Counseling |

| | |
|---|---|
| **Program Serves** | **Children**<br>**TAY (16-25)**<br>**Adults**<br>**Older Adults (60+)** |
| **Location of Services** | Community based |
| **Annual Budget FY 25/26** | $1,264,429 |
| **Cost Per Client FY 25/26** | $41 |

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

## State Program Positive Results

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

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

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

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

**Number of CHW Individuals / Number of Services Projected vs Actual**

| | Projected | Actual | | |
|---|---|---|---|---|
| | | FY 21/22 | FY 22/23 | FY 23/24 |
| Unduplicated Individuals | 15,568 | 12,820 | 24,083 | 37,584 |
| Number of Services | 24,764 | 13,851 | 24,764 | 37,755 |

**Number of PdS Individuals / Number of Services Projected vs Actual**

| | Projected | Actual | | |
|---|---|---|---|---|
| | | FY 21/22 | FY 22/23 | FY 23/24 |
| Unduplicated Individuals | 15,119 | 49,875 | 40,570 | 36,949 |
| Number of Services | 15,119 | 58,519 | 47,925 | 45,833 |

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

**State Program Positive Results, cont.**

**Outreach**

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

During the last three fiscal years, the PdS/CHW program has served 201,881 unduplicated individuals. This figure includes potential responders in the community, these are people in the community who can identify early signs of mental illness and refer individuals to behavioral health services.

The PdS/CHW program continues to exceed their annual total of projected unduplicated individuals. Community members are requesting more in-person services and presentations from PdS/CHW's. While virtual presentations are still common, potential responders do prefer field-based outreach to participate in activities and trainings.

The PdS/CHW program captures information on the number of potential responders trained each year. This enables tracking the increase in mental health awareness in the community. Between FY 2021/22 and FY 2023/24, the program engaged an average of 60,362 potential responders per year.

| Potential Responders | | | |
|---|---|---|---|
| | Number of Potential Responders | | |
| | *PdS* | *CHW* | *Total* |
| FY 2021/22 | 48,753 | 12,610 | 61,363 |
| FY 2022/23 | 34,426 | 23,800 | 58,226 |
| FY 2023/24 | 24,279 | 37,218 | 61,497 |



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

**State Program Positive Results, cont.**

**Outreach, cont.**

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

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

*Promotores de Salud* and Community Health Workers naturally become trusted and reliable members of their communities. These relationships enable them to serve as community liaisons and contribute to the successful delivery of culturally appropriate services. As cultural brokers in the community, they may also serve as advocates, educators, mentors, and interpreters.

PdS/CHWs engage individuals in both traditional and non-traditional settings to build trust and reduce stigma in their targeted populations. The list below displays the most prevalent types of settings used to engage potential responders during the 2023/24 fiscal year.

| Types of Settings | |
|---|---|
| • Cultural Organization<br>• Virtual Platforms<br>• Community Event<br>• Community-Based Organization<br>• Church<br>• School | • Residence<br>• Family Resource Center<br>• Recreation Center<br>• Behavioral Health Clinic<br>• Faith-Based Organizations |

PdS/CHWs are engaging with individuals in a variety of cultural and community spaces that range from schools, homes, to hair salons. PdS/CHWs are constantly discovering new ways to connect with potential responders and community members in their own environments.

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

**State Program Positive Results, cont.**

**Improving Timely Access to Underserved Populations**

An additional PdS/CHW program strategy is to improve timely access to services. PdS/CHWs are trained and equipped with the necessary resources to link individuals to possible mental health services as soon as possible and provide support.

Improved data collection efforts have allowed the program to better track referrals to other services. The PdS/CHW program successfully connects underserved populations to timely services. PdS/CHW program providers have improved their efforts in increasing and tracking referrals to prevention, early intervention, and treatment beyond early onset of serious mental illness. The program made over 9,004 referrals this last fiscal year.




| Improving Timely Access Referrals | | | |
|---|---|---|---|
| | FY 2021/22 | FY 2022/23 | FY 2023/24 |
| # of Referrals Provided | 205 | 15,006 | 9,004 |
| Referred To | • Prevention<br>• Early Intervention<br>• Treatment Beyond Early Onset | | |

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

- African American
- Asian and Pacific Islander
- Children and Youth at risk of school failure
- Individuals experiencing onset of serious psychiatric illness
- Latinx/Hispanic
- LGBTQ+
- Native American
- Trauma-exposed

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

### Demographics

| Fiscal Year | CHW Age (yrs. old) | | | | |
|---|---|---|---|---|---|
| | 0-15 | 16-25 | 26-59 | 60+ | UNK |
| FY 21/22 | 1% | 2% | 1% | 2% | 94% |
| FY 22/23 | 2% | 3% | 5% | 2% | 88% |
| FY 23/24 | 2% | 3% | 7% | 2% | 85% |

| Fiscal Year | PdS Age (yrs. old) | | | | |
|---|---|---|---|---|---|
| | 0-15 | 16-25 | 26-59 | 60+ | UNK |
| FY 21/22 | 12% | 20% | 56% | 7% | 6% |
| FY 22/23 | 8% | 16% | 63% | 10% | 3% |
| FY 23/24 | 7% | 13% | 64% | 11% | 4% |

| Fiscal Year | CHW Sexual Orientation |
|---|---|
| % of consumers who identified as LGBTQ+ | |
| FY 21/22 | <1% |
| FY 22/23 | <1% |
| FY 23/24 | <1% |

| Fiscal Year | PdS Sexual Orientation |
|---|---|
| % of consumers who identified as LGBTQ+ | |
| FY 21/22 | <1% |
| FY 22/23 | <1% |
| FY 23/24 | <1% |

| Fiscal Year | CHW Gender Identity | | | |
|---|---|---|---|---|
| | ♂ | ♀ | ⚧ | UNK |
| FY 21/22 | 4% | 7% | <1% | 90% |
| FY 22/23 | 3% | 7% | <1% | 90% |
| FY 23/24 | 5% | 10% | <1% | 85% |

| Fiscal Year | PdS Gender Identity | | | |
|---|---|---|---|---|
| | ♂ | ♀ | ⚧ | UNK |
| FY 21/22 | 5% | 89% | 0% | 6% |
| FY 22/23 | 3% | 93% | <1% | 4% |
| FY 23/24 | 14% | 22% | <1% | 65% |

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

**Demographics, cont.**

| Fiscal Year | CHW Veteran Status |
|---|---|
| % of consumers who identified as a veteran | |
| FY 21/22 | <1% |
| FY 22/23 | <1% |
| FY 23/24 | <1% |

| Fiscal Year | PdS Veteran Status |
|---|---|
| % of consumers who identified as a veteran | |
| FY 21/22 | <1% |
| FY 22/23 | <1% |
| FY 23/24 | <1% |

| Fiscal Year | CHW Disability |
|---|---|
| % of consumers who identified a physical disability | |
| FY 21/22 | <1% |
| FY 22/23 | <1% |
| FY 23/24 | 1% |

| Fiscal Year | PdS Disability |
|---|---|
| % of consumers who identified a physical disability | |
| FY 21/22 | <1% |
| FY 22/23 | <1% |
| FY 23/24 | 1% |

| Fiscal Year | CHW Primary Language | | | |
|---|---|---|---|---|
| | ENG | SPAN | OTH | UNK |
| FY 21/22 | 46% | 0% | 2% | 52% |
| FY 22/23 | 6% | <1% | 1% | 92% |
| FY 23/24 | 15% | <1% | 1% | 84% |

| Fiscal Year | PdS Primary Language | | | |
|---|---|---|---|---|
| | ENG | SPAN | OTH | UNK |
| FY 21/22 | 5% | 89% | 0% | 6% |
| FY 22/23 | 3% | 93% | <1% | 4% |
| FY 23/24 | 2% | 94% | <1% | 3% |

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

**Demographics, cont.**

## CHW Demographic Observations

- CHW demographic data includes all target population programs for the African American/Black, Latinx/Hispanic, Asian Pacific Islander, LGBTQ+, and Native American communities.
- CHWs continue their efforts to reach additional members of the African American/Black community.
- There is an upward trend in the response rate for collecting data over the last three years. CHWs continue to discover creative strategies and opportunities for improvement when engaging with members of all the target communities served.

| | CHW Race | FY 21/22 | FY 22/23 | FY 23/24 |
|---|---|---|---|---|
| Race | African-American/Black | <1% | 27% | 2% |
| | American-Indian/Alaska Native | 2% | 1% | 2% |
| | Asian | 2% | 1% | 1% |
| | Latinx/Hispanic | <1% | 3% | 2% |
| | Native Hawaiian or Pacific Islander | <1% | <1% | <1% |
| | Caucasian/White | 0% | 1% | 4% |
| | More than One Race | 0% | 1% | 1% |
| | Other Race | <1% | 3% | 2% |
| | Declined to Answer | 96% | 63% | 85% |

| | CHW Ethnicity | FY 21/22 | FY 22/23 | FY 23/24 |
|---|---|---|---|---|
| Ethnicity | African | <1% | <1% | 0% |
| | Asian Indian/South Asian | <1% | <1% | 0% |
| | Cambodian | 0% | <1% | 0% |
| | Chinese | 2% | 4% | 6% |
| | Eastern European | 0% | 0% | 0% |
| | European | 0% | <1% | <1% |
| | Hispanic/Latino | <1% | 1% | 21% |
| | Filipino | <1% | <1% | <1% |
| | Japanese | 0% | <1% | 0% |
| | Korean | <1% | <1% | <1% |
| | Middle Eastern | 0% | <1% | 0% |
| | Vietnamese | 0% | 2% | 3% |
| | Other | <1% | <1% | <1% |
| | More than one ethnicity | 0% | <1% | <1% |
| | Declined to Answer | 98% | 92% | 64% |

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

**Demographics, cont.**

### PdS Demographic Observations

- The PdS component of the program continues to successfully capture demographic data. This is in part due to the relationships and trust built within the community.
- Most individuals served in FY 23/24 were female, Spanish speaking adults aged 26-59.

| | PdS Race | FY 21/22 | FY 22/23 | FY 23/24 |
|---|---|---|---|---|
| Race | African-American/Black | <1% | <1% | <1% |
| | American-Indian/Alaska Native | <1% | <1% | 0% |
| | Asian | <1% | <1% | 0% |
| | Latinx/Hispanic | 92% | 39% | 62% |
| | Native Hawaiian or Pacific Islander | <1% | <1% | 0% |
| | Caucasian/White | 47% | 36% | 1% |
| | More than One Race | 6% | 1% | <1% |
| | Other Race | 6% | 8% | 7% |
| | Declined to Answer | 40% | 16% | 29% |

| | PdS Ethnicity | FY 21/22 | FY 22/23 | FY 23/24 |
|---|---|---|---|---|
| Ethnicity | African | <1% | 0% | <1% |
| | Asian Indian/South Asian | <1% | 0% | 0% |
| | Cambodian | 0% | 0% | 0% |
| | Chinese | 0% | 0% | 0% |
| | Eastern European | 0% | 0% | 0% |
| | European | <1% | 0% | 0% |
| | Hispanic/Latino | 92% | 39% | 68% |
| | Filipino | 0% | 0% | 0% |
| | Japanese | 0% | 0% | 0% |
| | Korean | 0% | 0% | <1% |
| | Middle Eastern | <1% | 0% | 0% |
| | Vietnamese | <1% | 0% | 0% |
| | Other | 21% | 68% | 12% |
| | More than one ethnicity | <1% | 0% | 0% |
| | Declined to Answer | 78% | 32% | 20% |

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

**Program Goals**

The goals of the PdS/CHW program are to:

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

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

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

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

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

### Program Outcomes

| Method use to collect outcome | Description of method | Frequency of use | Number Completed |
|---|---|---|---|
| Stigma Discrimination Reduction Surveys | Refers to a compilation of surveys used by the Department of Behavioral Health – PEI programs designed to capture outcomes from Stigma and Discrimination Reduction activities. Examples of surveys used by PdS/CHW programs are the Modular presentation Survey, Measures, Outcomes, and Quality Assessment (MOQA) Survey, and the Stigma Reduction Questionnaire (SRQ). | Post – after each Stigma Reduction presentation | FY 21/22: 4,277<br>FY 22/23: 828<br>FY 23/24: 102 |
| PEI Outreach Survey | The PEI Outreach Survey has 13 questions. The first 9 collect PEI demographic information, and the last 4 gather information on individuals' confidence in recognizing potential mental health challenges and seeking services if needed. | Pre and Post each educational Outreach activity | FY 21/22: 430<br>FY 22/23: 1,571<br>FY 23/24: 6,759 |

### Outcome Discussion

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

Strategies for engagement vary between cultural groups. Some cultural groups are comfortable with utilizing technological tools, while others prefer traditional in-person strategies. Not all cultures experience the same level of comfort with the same approaches. The program continues to explore the most effective methods for delivering culturally appropriate services in their communities and maximizing engagement efforts.

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

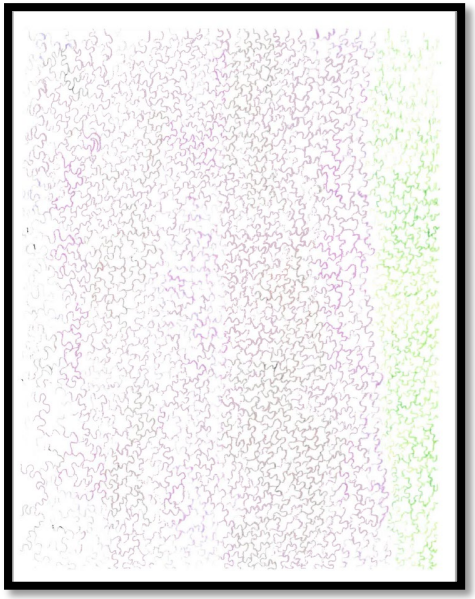
**Outcome Discussion, cont.**

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

The program evaluates success by administering surveys and questionnaires that capture changes in learning, perception and help seeking behaviors. To measure stigma reduction following engagement, PdS/CHWs utilize the Stigma Reduction Questionnaire (SRQ) to capture individual changes in how they feel after participating in an event or activity. Sample questions include:

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

- Socialize with someone who had a serious mental health condition.
- Take action to prevent discrimination against people with mental health conditions.
- Actively and compassionately listen to someone in distress.
- Seek support from a mental health professional if I thought I needed it.
- Talk to a friend or a family member if I am experiencing emotional distress.



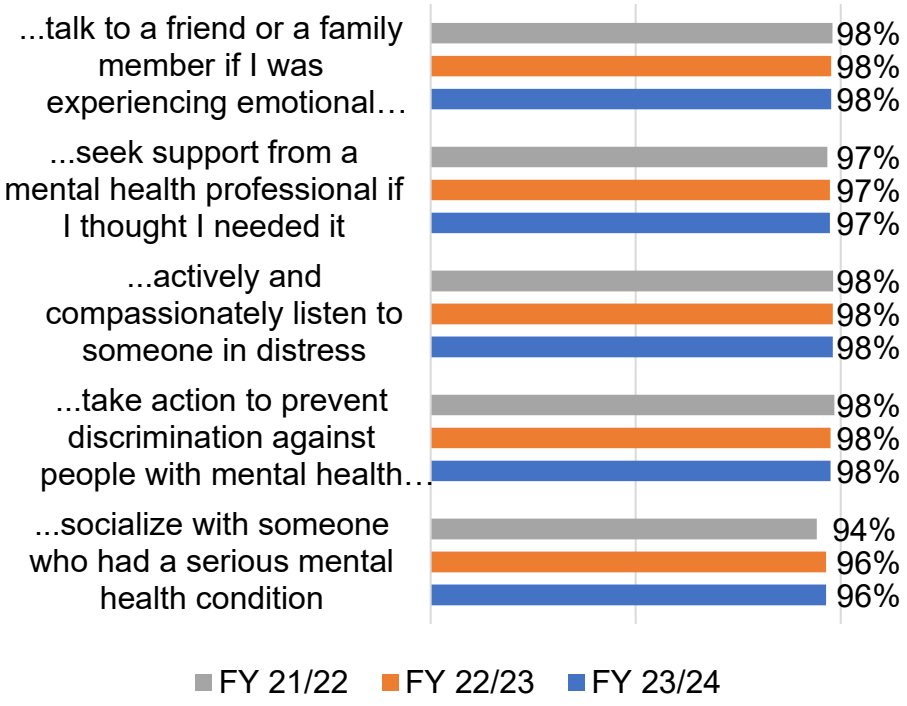
Artwork by Michael Moreno

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

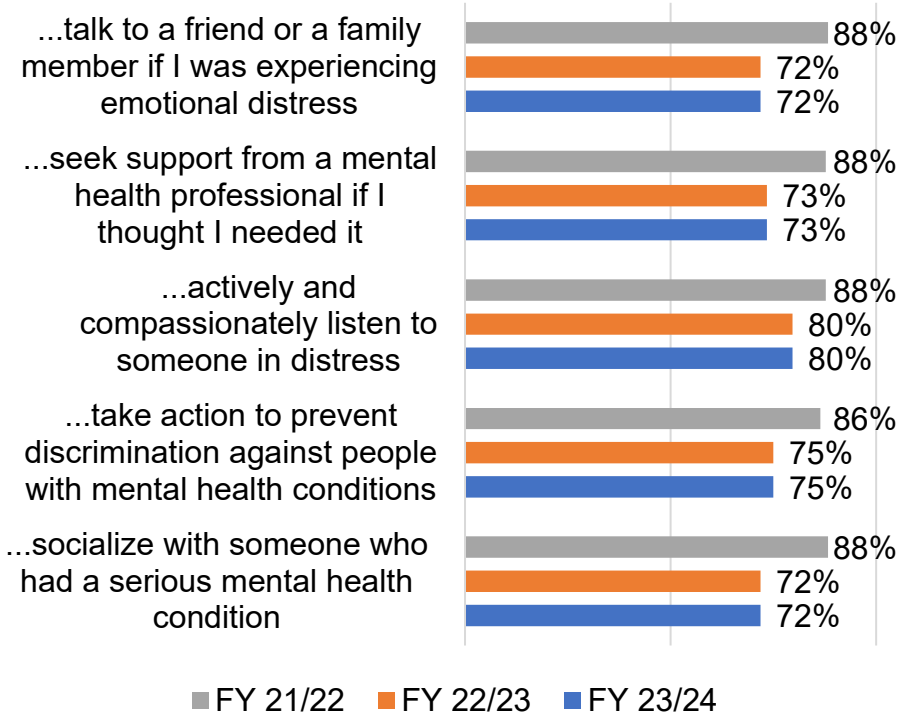
**Outcome Discussion, cont.**

In FY 23/24, survey data shows that 84% of individuals agree or strongly agree with the stigma survey questions after attending an event or activity, which is represented in the charts below. The findings gathered this fiscal year show that PdS/CHWs' initiatives continue to assist reduce stigma in their target populations.

**(PdS)**
**As a direct result of this training I am MORE likely to...**




**(CHW)**
**As a direct result of this training I am MORE likely to...**

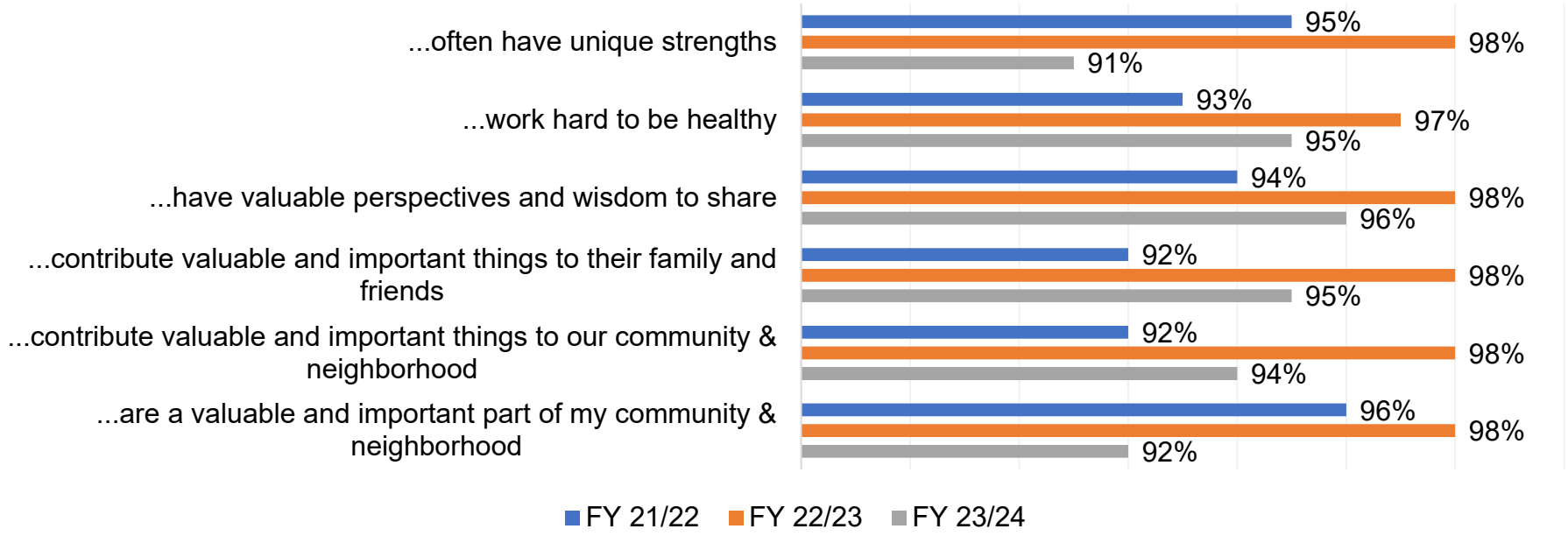


## *Promotores de Salud*/Community Health Worker (PdS/CHW), cont.

**Outcome Discussion, cont.**

Additional stigma survey results below demonstrate a change in attitude of the individuals who received a stigma-reduction activity. FY 23/24 data shows that as a direct result of PdS activities, 94% of individuals agree or strongly agree that they are likely to feel and view people experiencing mental health challenges in a positive light. PdS's have successfully engaged with community members and provided responders with the resources and the ability to assist friends, family, and community members facing mental health challenges.

**_Promotores de Salud_: As a direct result of this training I agree I am MORE likely to feel that people experiencing mental health challenges...**



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

### Challenges/Solutions

While the PdS/CHW program repeatedly exceeds in serving the number of projected individuals, it still encounters its own challenges.

For instance, program providers experience difficulty making the most out of their engagement efforts with potential responders at outreach events. While at busy outreach events, it is a challenge to build rapport and trust with individuals in a limited amount of time. This in turn creates an unwillingness for some individuals to complete surveys or provide feedback.

The stigma attached to mental health and illness in the Asian and Pacific Islander (API) community remains one of the primary challenges faced. CHWs in the API community are building creative engagement efforts within the community so that they can reduce the stigma associated with mental health while also recruiting community partners to assist in CHW efforts.

While not as severe as the historic 2023 winter storms, the San Bernardino County mountain communities faced heavy winter storms in 2024 that again provided barriers to service. At times, PdS/CHW's relied on providing services virtually due to challenges in road transportation.

For PdS/CHWs in remote geographical regions within the county, there are challenges in attending and curating culturally specific events. Additionally, it is also a challenge to sufficiently recruit and retain staff to carry out the goals of the program.

As a result, PdS/CHWs continue to provide incentives as motivation for participation. These incentives consist of resources to help with unmet needs such as school and office supplies, food, rental, and utility assistance.

The program strives to foster open communication and strengthen ties with community partners as it is crucial for overcoming future obstacles and ensuring that CHW's effectively identify new upcoming opportunities to engage in future community events.

Lastly, PdS/CHWs continue to engage with individuals, agencies, and schools regarding the importance of collecting demographic data. Also, finding improved methods of gathering demographic data, which include creating the most ideal survey presentation that will collect the most information and prevent survey fatigue.

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

### Lessons Learned

PdS/CHW providers continue to cultivate a proactive approach to build trust with organizational partners by ensuring clear communication and collaborative problem solving to encourage stronger results. The process of recruiting and retaining PdS/CHWs and peer providers in a competitive job market requires creative strategies. Building ideal, culturally appropriate surveys, improve the quality of data received from the program's individuals served. This coupled with survey education, allows for PdS/CHWs to improve and provide access to individual demographic data.

### Success Story

"*Promotora* referred a client for services due to having relationship problems with her daughter and experiencing low self-esteem. The client shared with *Promotora* that after she received individual and family therapy, she gained effective communication and coping skills that helped her strengthen her relationship with her daughter. In addition, she shared that she was feeling better about herself and decided to enroll in school."

### Program Updates

There are no planned program updates for Fiscal Year 2025/26.

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

## Program Description and Target Population

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

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

| | |
|---|---|
| **Services Offered** | • **Medication Assisted Treatment (MAT) Referrals**<br>• **Substance Use Disorder Services Referrals**<br>• **Behavioral Health Services Referrals**<br>• **Community Education and Awareness** |

| | |
|---|---|
| **Program Serves** | **Children**<br>**TAY (16-25)**<br>**Adults**<br>**Older Adults (60+)** |
| **Location of Services** | School Campuses, Behavioral Health Clinics, In-home |
| **Annual Budget FY 25/26** | $417,500 |
| **Cost Per Client FY 25/26** | $122 |

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

## State Program Positive Results

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

In FY 23/24, the program increased its outreach efforts to raise awareness and provide substance use and mental health resources at community fairs, workshops, and conferences. The table on the right shows that SUPPOrT engaged 3,662 unduplicated participants at 110 community health fairs.

The SUPPOrT program outreach efforts reached out to 1,609 potential responders in the community. Potential responders are people in the community who can identify early signs of mental illness and refer individuals to Behavioral Health services. Examples of potential responders include community service providers and school personnel.

SUPPOrT program has successfully distributed the following: 1,232 Naloxone Medication, 1,524 Deterra Medication disposal pouch, and 1,677 Fentanyl Test strips. Out of the naloxone distribution, one report was submitted of an overdose reversal due to participant receiving training on how to administer Naloxone and save someone's life.

| Number of Participants / Number of Services Projected vs Actual | | | | |
|---|---|---|---|---|
| | Projected | Actual | | |
| | | FY 21/22 | FY 22/23 | FY 23/24 |
| Unduplicated Participants | 3,400 | N/A | 212 | 3,662 |
| Number of Services | 3,400 | N/A | 216 | 4,333 |

| Number of Potential Responders | | |
|---|---|---|
| FY 21/22 | FY 22/23 | FY 23/24 |
| N/A | 212 | 3,338 |

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

## Demographics

| Fiscal Year | Age (yrs. old) | | | | |
|---|---|---|---|---|---|
| | 0-15 | 16-25 | 26-59 | 60+ | UNK |
| FY 21/22 | N/A | N/A | N/A | N/A | N/A |
| FY 22/23 | 0% | 19% | 10% | 1% | 70% |
| FY 23/24 | 1% | 8% | 24% | 3% | 64% |

| Fiscal Year | Veteran Status |
|---|---|
| | % of consumers who identified as a veteran |
| FY 21/22 | N/A |
| FY 22/23 | <1% |
| FY 23/24 | 2% |

| Fiscal Year | Sexual Orientation |
|---|---|
| | % of consumers who identified as LGBTQ+ |
| FY 21/22 | N/A |
| FY 22/23 | 7% |
| FY 23/24 | 3% |

| Fiscal Year | Disability |
|---|---|
| | % of consumers who identified a physical disability |
| FY 21/22 | N/A |
| FY 22/23 | 8% |
| FY 23/24 | 6% |

| Fiscal Year | Gender Identity | | | |
|---|---|---|---|---|
| | ♂ | ♀ | ⚧ | UNK |
| FY 21/22 | N/A | N/A | N/A | N/A |
| FY 22/23 | 7% | 22% | 1% | 70% |
| FY 23/24 | 12% | 24% | 0% | 64% |

| Fiscal Year | Primary Language | | | |
|---|---|---|---|---|
| | ENG | SPAN | OTH | UNK |
| FY 21/22 | N/A | N/A | N/A | N/A |
| FY 22/23 | 30% | <1% | 0% | 70% |
| FY 23/24 | 33% | 3% | <1% | 64% |

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

**Demographics, cont.**

| | Race/Ethnicity | FY 21/22 | FY 22/23 | FY 23/24 |
|---|---|---|---|---|
| Race | African American/Black | N/A | 2% | 6% |
| | American-Indian/Alaska Native | N/A | 0% | 1% |
| | Asian | N/A | 1% | 6% |
| | Latinx/Hispanic | N/A | 24% | 18% |
| | Native Hawaiian or Pacific Islander | N/A | <1% | 1% |
| | Caucasian/White | N/A | 3% | 10% |
| | More than One Race | N/A | 1% | 1% |
| | Other Race | N/A | 1% | 1% |
| | Declined to Answer | N/A | 69% | 56% |

| | Race/Ethnicity | FY 21/22 | FY 22/23 | FY 23/24 |
|---|---|---|---|---|
| Ethnicity | African | N/A | 2% | 6% |
| | Asian Indian/South Asian | N/A | 1% | 1% |
| | Cambodian | N/A | 1% | <1% |
| | Chinese | N/A | 0% | <1% |
| | Eastern European | N/A | 1% | <1% |
| | European | N/A | 2% | 7% |
| | Latinx/Hispanic | N/A | 22% | 19% |
| | Filipino | N/A | 1% | 1% |
| | Japanese | N/A | 0% | 0% |
| | Korean | N/A | 0% | 1% |
| | Middle Eastern | N/A | 1% | <1% |
| | Vietnamese | N/A | 0% | <1% |
| | Other | N/A | 2% | 5% |
| | More than one ethnicity | N/A | 2% | 2% |
| | Declined to Answer | N/A | 65% | 54% |

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

### Program Goals

- Reduce prolonged suffering associated with untreated mental illness:
  - Reduce risk factors
  - Reduce indicators
  - Increase protective factors that may improve mental, emotional, and relational functioning.
- Reduce stigma and discrimination associated with mental illness:
  - Reduce negative feelings, attitudes, beliefs, perceptions, stereotypes, and/or discrimination related to having a mental illness, being diagnosed, or seeking services.
  - Increase acceptance, dignity, inclusion, and equity for individuals with mental illness and members of families.
- Increase recognition of early signs of mental illness:
  - Potential Responders:
    - Identify early signs of potentially severe and disabling mental illness.
    - Provide support to individuals with mental illness.
    - Refer individuals who need treatment or other mental health services.
  - Individuals:
    - Recognize your own symptoms.
    - Respond to symptoms.

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

### Program Outcomes

| Method use to collect outcome | Description of method | Frequency of use | Number Completed |
|---|---|---|---|
| Outreach Survey | The Outreach Survey has13 questions. The first 9 are used to collect PEI demographic information, and the last 4 are used to gather information on participants' confidence in recognizing potential mental health challenges and seeking services if needed. | After each outreach activity | FY 21/22: N/A<br>FY 22/23: 68<br>FY 23/24: 1580 |

### Outcome Discussion

The Department of Behavioral Health's Office of PEI, SUPPOrT and Research and Evaluation teams collaborated in creating an outreach survey that gathers information on participant's knowledge of substance use disorders following an engagement activity. Sample outreach survey questions include:

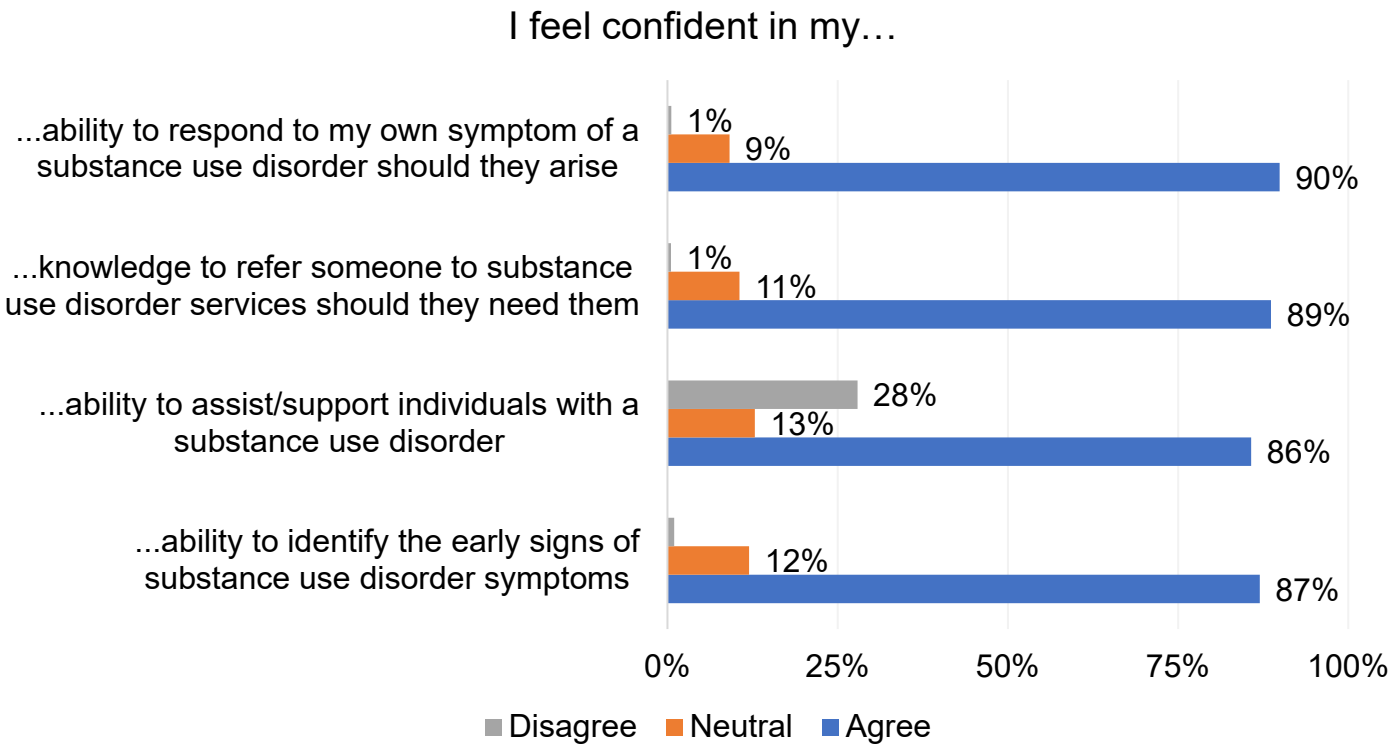
I feel confident in my…

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

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

### Outcome Discussion, cont.

Outreach survey data illustrates that 90% of participants who completed the survey agree that they successfully increased their ability to respond to their symptoms of a substance use disorder, should they arise. Also, following their activities, 87% of participants agreed that they were more confident in their ability to identify early signs of substance use disorder symptoms and, in their knowledge, to complete a referral for substance use disorder service. The overall outcomes demonstrate that SUPPOrT outreach and educational activities are successfully meeting the intended goals of the program.



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

### Challenges/Solutions

Staffing was one of the most significant issues for the SUPPOrT program in Fiscal Year 2023/24. The program has received increased requests to provide outreach and educational activities, requiring more staff to assist with outreach events to provide information on substance use disorder to raise awareness.

As a result, the program will engage in efforts to recruit additional staff in the near future. In addition to this, SUPPOrT will collaborate with DBH's Public Relations and Outreach team for substance use disorder outreach efforts.

### Lessons Learned

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

### Success Story

SUPPOrT is centrally located in San Bernardino County, and staff have the capacity to mobilize to any region in the county. With the implementation of the new San Bernardino County Overdose Dashboard (ODASH), the SUPPOrT team can identify hot spots and target those areas in greater need of harm reduction, prevention, and education.

### Program Updates

There are no planned program updates for Fiscal Year 2025/26.

# Child and Youth Connection (CYC)

## Program Description and Target Population

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

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

| | |
|---|---|
| **SART and EIIS Services Offered** | • **Assessments**<br>• **Comprehensive Treatment Services**<br>• **Case Management Services**<br>• **Mental Health Education** |

| | |
|---|---|
| **The SART and EIIS Programs Serve** | **Children** |
| **Location of Services** | Desert/Mountain, East Valley, Central Valley, West Valley |
| **Annual Budget FY 25/26** | $29,339,303 |
| **Cost Per Consumer FY 25/26** | $4,493 |

# Child and Youth Connection (CYC), cont.

## Program Description and Target Population, cont.

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

## Program Highlights

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

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

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

**Number of Participants / Number of Services Projected vs Actual**

| | Projected | Actual | | |
|---|---|---|---|---|
| | | FY 21/22 | FY 22/23 | FY 23/24 |
| Unduplicated Participants | 6,529 | 9,633 | 7,111 | 8,325 |
| Number of Services | 70,969 | 87,867 | 86,701 | 103,926 |

**Prevention:**

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

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

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

## Child and Youth Connection (CYC), cont.

**Program Highlights, cont.**

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

| Prevention | FY 21/22 | FY 22/23 | FY 23/24 |
|---|---|---|---|
| Unduplicated Participants | 3,231 | 2,349 | 5,079 |
| Total Services | 2,965 | 3,262 | 4,028 |

**Early Intervention:**

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

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

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

| Treatment Success by Fiscal Year | | | |
|---|---|---|---|
| | Total Episodes | Closed Episodes | % Met Goals |
| FY 21/22 | 2,286 | 2,141 | 39% |
| FY 22/23 | 2,538 | 2,042 | 23% |
| FY 23/24 | 2,408 | 2,044 | 39% |

## Child and Youth Connection (CYC), cont.

**Program Highlights, cont.**

**Outreach:**

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

| Potential Responders Reached | | | |
|---|---|---|---|
| | FY 21/22 | FY 22/23 | FY 23/24 |
| Potential Responders | 917 | 1,037 | 1,231 |

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

## Child and Youth Connection (CYC), cont.

**Program Highlights, cont.**

**Access and Linkage to Treatment:**

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

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

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

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

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

The Healthy Homes Program, a clinical unit with JCBHS, has clinicians who are co-located at the Children and Family Services (CFS) offices throughout the county. The Healthy Homes clinicians conduct assessments for children involved with CFS.

If these children and youth need ongoing services, they are referred to local service providers and programs.

Sometimes, these clinicians will provide short-term mental health services to prevent involvement in a long-term program.

# Child and Youth Connection (CYC), cont.

**Program Highlights, cont.**

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

| Access and Linkage to Services Referrals | | | |
|---|---|---|---|
| | FY 21/22 | FY 22/23 | FY 23/24 |
| Number of Referrals | 2,053 | 1,919 | 2,408 |
| County-funded | 2,053 | 1,919 | 2,408 |
| Non-County Funded | 0 | 0 | 0 |
| Participants Engaged | 1,686 | 1,919 | 2,044 |

**Improve Timely Access to Treatment:**

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

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

The table below shows the number of referrals to prevention, early intervention, or treatment beyond early onset service over the last three fiscal years. There was a significant increase in Fiscal Year 2023/24. Most issues with the data have been identified, and we are actively working on solution to address them.

| Improving Timely Access Referrals | | | |
|---|---|---|---|
| | FY 21/22 | FY 22/23 | FY 23/24 |
| Number of Referrals Provided | 3,010 | 1,919 | 2,408 |

## Child and Youth Connection (CYC), cont.

### Demographics

| Fiscal Year | Age (yrs. old) | | | | |
|---|---|---|---|---|---|
| | 0-15 | 16-25 | 26-50 | 60+ | UNK |
| FY 21/22 | 27% | <1% | 4% | <1% | 68% |
| FY 22/23 | 36% | 3% | 26% | 1% | 34% |
| FY 23/24 | 83% | 11% | 5% | <1% | 1% |

| Fiscal Year | Veteran Status |
|---|---|
| | % of consumers who identified as a veteran |
| FY 21/22 | 0% |
| FY 22/23 | 0% |
| FY 23/24 | 0% |

| Fiscal Year | Sexual Orientation |
|---|---|
| | % of consumers who identified as LGBTQ+ |
| FY 21/22 | 0% |
| FY 22/23 | 0% |
| FY 23/24 | 0% |

| Fiscal Year | Disability |
|---|---|
| | % of consumers who identified a physical disability |
| FY 21/22 | 0% |
| FY 22/23 | 0% |
| FY 23/24 | <1% |

| Fiscal Year | Gender Identity | | | |
|---|---|---|---|---|
| | ♂ | ♀ | ⚧ | UNK |
| FY 21/22 | <1% | 1% | 0% | 97% |
| FY 22/23 | 1% | 8% | 0% | 90% |
| FY 23/24 | 46% | 54% | 0% | 0% |

| Fiscal Year | Primary Language | | | |
|---|---|---|---|---|
| | ENG | SPAN | OTH | UNK |
| FY 21/22 | <1% | 1% | 0% | 97% |
| FY 22/23 | 1% | 8% | 0% | 90% |
| FY 23/24 | 46% | 54% | 0% | 0% |

# Child and Youth Connection (CYC), cont.

**Demographics, cont.**

### Demographic Observations

The CYC program successfully reached the largest proportion of children, effectively targeting the intended age group. However, in certain categories a significant number of participants chose not to answer. This is often due to the questions being considered inappropriate for that particular age group.

| | Race | FY 21/22 | FY 22/23 | FY 23/24 |
|---|---|---|---|---|
| Race | African American/Black | 14% | 16% | 34% |
| | American-Indian/Alaska Native | 1% | <1% | <1% |
| | Asian | 1% | <1% | 2% |
| | Latinx/Hispanic | 20% | 39% | 31% |
| | Native Hawaiian/Pacific Islander | <1% | 0% | <1% |
| | Caucasian/White | 15% | 12% | 27% |
| | More Than One Race | 2% | 1% | 6% |
| | Other Race | 1% | 3% | 1% |
| | Declined to Answer | 66% | 28% | 1% |

| | Ethnicity | FY 21/22 | FY 22/23 | FY 23/24 |
|---|---|---|---|---|
| Ethnicity | African | 1% | 1% | 6% |
| | Asian Indian/South Asian | 0% | 0% | 0% |
| | Cambodian | 0% | 0% | 0% |
| | Chinese | 0% | 0% | 0% |
| | Eastern European | 0% | 0% | 0% |
| | European | 0% | 0% | 0% |
| | Hispanic/Latino | 4% | 9% | 69% |
| | Filipino | 0% | 0% | <1% |
| | Japanese | 0% | 0% | 0% |
| | Korean | 0% | 0% | 0% |
| | Middle Eastern | 0% | 0% | <1% |
| | Vietnamese | 0% | 0% | <1% |
| | Other | 1% | 4% | 25% |
| | More Than One Ethnicity | 1% | 0% | 0% |
| | Declined to Answer | 59% | 9% | 0% |

## Child and Youth Connection (CYC), cont.

### Program Goals

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

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

Improve timely access to services for underserved populations:

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

Reduce prolonged suffering:

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

Reduce stigma and discrimination associated with mental illness:

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

# Child and Youth Connection (CYC), cont.

### Program Outcomes

| Method use to collect outcome | Description of method | Frequency of use | Number Completed |
|---|---|---|---|
| Children and Adolescent Needs and Strengths Assessment (CANS) | CANS is a multi-purpose tool developed for children's services to support decision making, including level of care and service planning. | Intake, 6 months, Discharge, Significant life events | FY 21/22: 1,020<br>FY 22/23: 1,045<br>FY 23/24: 1,339 |

### Outcome Discussion

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

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

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

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

## Child and Youth Connection (CYC), cont.

**Outcome Discussion, cont.**

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

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

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

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

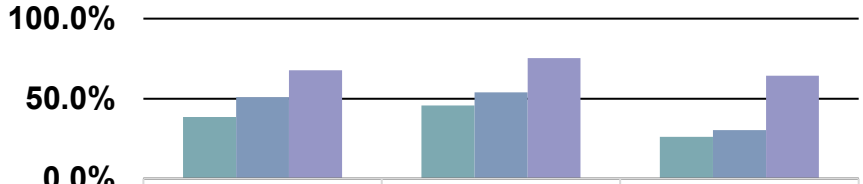
The Ages 0-5 Early Childhood module rates the same sub-domains as the Life Functioning Domain; however, these sub-domains are rated through a lens more focused on the stages of development from ages 0-5 rather than the participant's overall life functioning.

## Child and Youth Connection (CYC), cont.

### Outcome Discussion, cont.

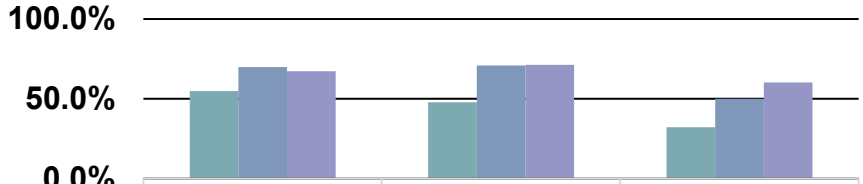
These graphs demonstrate global improvement in life functioning, behavioral/emotional needs, and ages 0-5 early childhood for both EIIS and SART participants of the CYC program. Both programs have maintained an average of 46% improvement in the life functioning domain, 50% improvement in the behavioral/emotional needs domain, and 28% in the ages 0-5 early childhood domain.

**CYC SART % Improved by Fiscal Year**




| | Life Functioning | Behavioral/ Emotional Needs | Ages 0-5 Early Childhood |
|---|---|---|---|
| FY 20/21 | 38.6% | 45.7% | 26.1% |
| FY 21/22 | 51.0% | 53.9% | 30.4% |
| FY 23/24 | 67.8% | 75.3% | 64.3% |

**CYC EIIS % Improved by Fiscal Year**

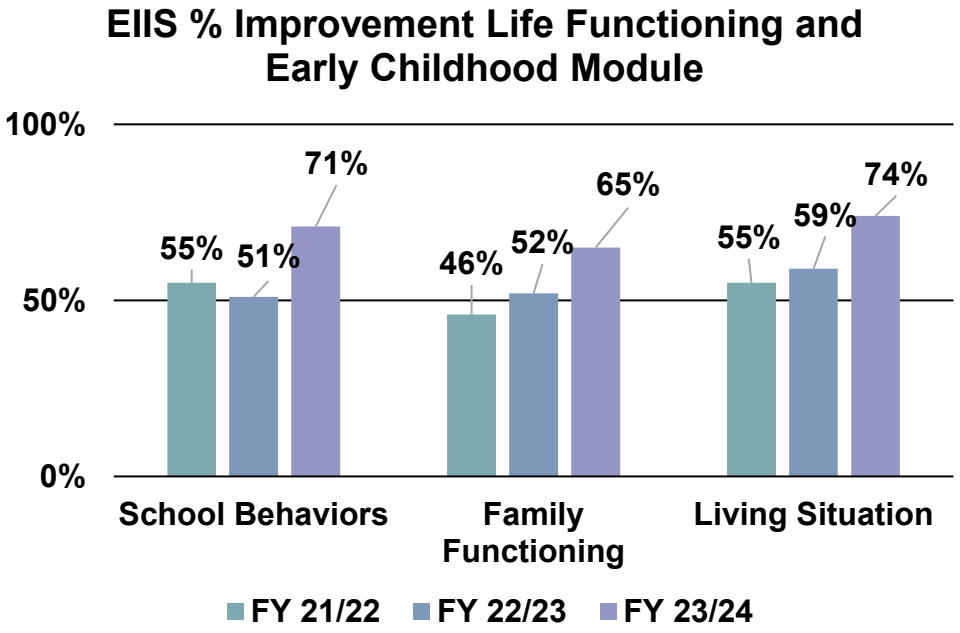


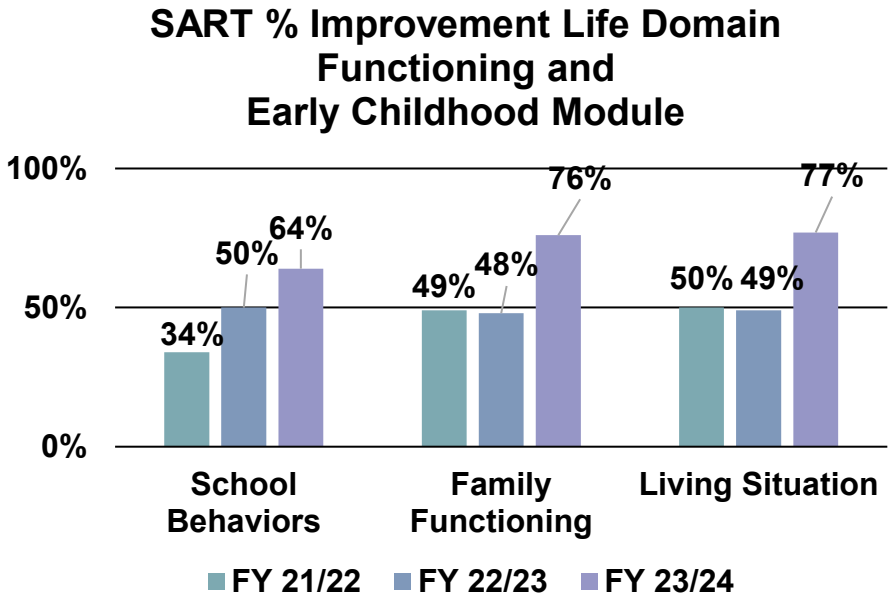

| | Life Functioning | Behavioral/ Emotional Needs | Ages 0-5 Early Childhood |
|---|---|---|---|
| FY 21/22 | 54.9% | 47.9% | 32.2% |
| FY 22/23 | 70.0% | 71.0% | 50.0% |
| FY 23/24 | 67.3% | 71.3% | 60.2% |

## Child and Youth Connection (CYC), cont.

### Outcome Discussion, cont.

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

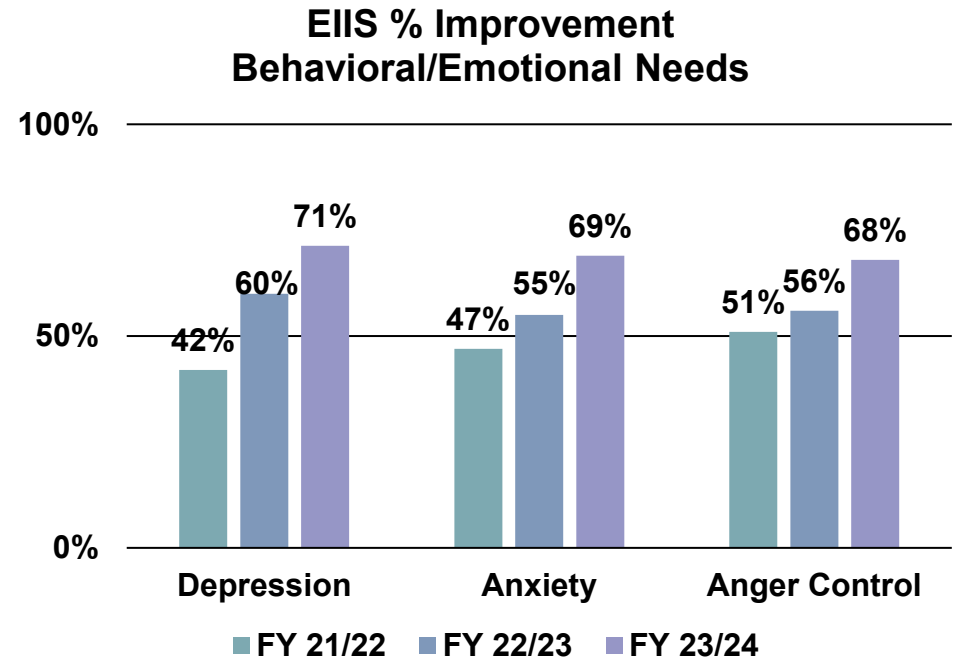


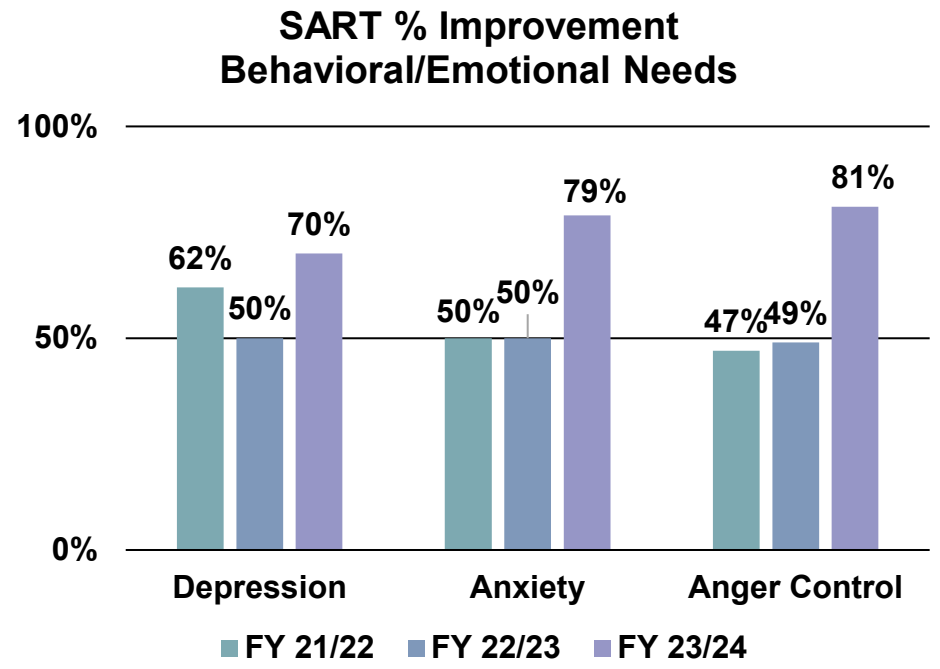



## Child and Youth Connection (CYC), cont.

### Outcome Discussion, cont.

Depression can be a significant barrier to child development. Both programs have been successful in maintaining an average of 53% improvement in depression. Children who were referred and presented difficulties with regulating anger showed an average improvement of 69%. Reducing anxiety leads to improved behavioral and emotional functioning. The program maintains an average improvement of over 50% over the three-year review period.



## Child and Youth Connection (CYC), cont.

### Challenges/Solutions

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

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

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

### Lessons Learned

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

## Child and Youth Connection (CYC), cont.

### Success Story

A 7-year-old male was referred to West End Family Counseling Services due to symptoms of depression, anger, anxiety, and problematic peer interactions, which affected his ability to maintain social connections and daily routines. Living with his mother, aunt, cousins, and grandmother, his behavior was disruptive at home and put his school placement at risk.

He went through a comprehensive evaluation by a transdisciplinary SART team and received intensive play therapy to improve coping skills, process family dynamics, boost confidence, and reduce anxiety and anger. His mother collaborated with the team, following recommendations, including implementing a 504 plan to address school behaviors.

The clinical staff worked closely with the child and mother, improving their bond, communication, and interaction. The child showed significant progress over a year of treatment in his daily routine, social interactions, and overall mood. His relationship with his family improved, and he demonstrated increased persistence in challenging tasks. Due to his positive behavior, the 504 plan was not needed this school year.

The child's mother actively supported the treatment process, helping the child use coping strategies and improve confidence. Their connection has strengthened, and the child now responds positively to praise, smiling and hugging his mother when acknowledged for his efforts.

### Program Updates

The Children's Assessment Center (CAC) by Loma Linda University Children's Hospital (LLUCH), under this program will have an increase in funding from $62,000 to $165,000 per year. The funding will increase early access and linkage to medically necessary care and treatment by connecting children and youth with severe mental health conditions.

# Preschool PEI Program (PPP)

## Program Description and Target Population

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

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



| | |
|---|---|
| **Program Serves** | **Children, TAY (16-25), Adults, Older Adults (60+)** |
| **Location of Services** | Preschool, In Home, and Counseling Centers |
| **Annual Budget FY 25/26** | $425,000 |
| **Cost Per Client FY 25/26** | $281 |

| | |
|---|---|
| **Services Offered** | • **Social-emotional development**<br>• **Screenings & assessments**<br>• **Trauma support**<br>• **Resources and referrals**<br>• **Behavioral health plan development**<br>• **Family support** |

# Preschool PEI Program (PPP), cont.

## Program Highlights

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

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

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

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

The PPP seeks to reduce these risk factors by:

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

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

| Number of Participants / Number of Services Projected vs Actual | | | | |
|---|---|---|---|---|
| | Projected | Actual | | |
| | | FY 21/22 | FY 22/23 | FY 23/24 |
| Unduplicated Participants | 1,508 | 697 | 409 | 354 |
| Number of Services | 3,545 | 3,183 | 1,358 | 1,075 |

# Preschool PEI Program (PPP), cont.

### Program Highlights, cont.

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

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

### Teacher Training

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

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

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

In Fiscal Year 2022/23, an emerging trend indicated a decrease in self-regulation among preschoolers. In response, PSD Class Teacher Coaches were utilized to address intervention strategies and provide Second Step curriculum training to teachers and Behavioral Health Specialists received training on the Teaching Pyramid curriculum.

Fiscal Year 2023/24 saw the continued support for Second Step and the Teaching Pyramid curriculums by adding additional guidance through training and integrated coaching.

# Preschool PEI Program (PPP), cont.

## Program Highlights, cont.

### Bereavement and Loss

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

This may include a parent, grandparent, or other person close to the child. The loss may be due to death, divorce, separation, foster care, military deployment, homelessness, or parent incarceration.

In previous years, PPP utilized the Trauma, Loss, and Compassion (TLC) model to improve child/family outcomes. The TLC activities help children self-regulate, practice social behavior in a safe space, and to develop healthy coping skills, which decrease aggressive, internalizing, self-isolation, and other self-harming behaviors.

In Fiscal Year 2023/24, PPP transitioned to a new program to address loss. The Living in Grief Healing Together (LIGHT) Program is an eight-week workshop for enrolled PSD children, facilitated by MFT Interns and supervised by a Clinical Supervisor. The LIGHT team focuses on discussing loss, fostering hope, and understanding emotions. The program works with children who have experienced trauma, especially grief and loss.

| Number of Children Participating in the TLC Group | | |
|---|---|---|
| FY 2021/22 | FY 2022/23 | FY 2023/24 |
| 18 | 76 | 0 |

| Number of Children Participating in the L.I.G.H.T. Program | | |
|---|---|---|
| FY 2021/22 | FY 2022/23 | FY 2023/24 |
| 0 | 0 | 43 |

# Preschool PEI Program (PPP), cont.

## Program Highlights, cont.

### Access & Linkage to Services

Behavioral Health Specialists within the San Bernardino County Preschool Services Department identify children struggling with learning, behavioral or emotional challenges, and refer their families to SART (Screening Assessment Referral Treatment) centers and psychological treatment centers to access additional services to support the child and their caregivers.

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

### Needs Assessment

PPP, PSD, and their partnering agencies collaboratively identify children ages 0-5 enrolled in preschool classrooms where there are concerns related to self-regulation and social-emotional challenges.

To assess and evaluate at-risk children, the tools Ages and Stages Questionnaire-Social Emotional 2 (ASQ-SE2) and the Desired Results Developmental Profile (DRDP) are used. These assessment tools provide valuable data that helps in identifying children who may need additional support. The data-driven approach ensures that interventions are both relevant and effective.

The partnering agencies lend support by offering direct home and classroom assistance for the children and their families. These partnerships enable PPP to reach a broader segment of the population, particularly those who may not have had access to resources otherwise.

# Preschool PEI Program (PPP), cont.

## Demographics

| Fiscal Year | Age (yrs. old) | | | | |
|---|---|---|---|---|---|
| | 0-15 | 16-25 | 26-59 | 60+ | UNK |
| FY 21/22 | 53% | 45% | 30% | 1% | 4% |
| FY 22/23 | 51% | 4% | 26% | 1% | 18% |
| FY 23/24 | 54% | 5% | 33% | 1% | 7% |

| Fiscal Year | Veteran Status |
|---|---|
| % of consumers who identified as a veteran | |
| FY 21/22 | 0% |
| FY 22/23 | 0% |
| FY 23/24 | 0% |

| Fiscal Year | Sexual Orientation |
|---|---|
| % of consumers who identified as LGBTQ+ | |
| FY 21/22 | 0% |
| FY 22/23 | 0% |
| FY 23/24 | <1% |

| Fiscal Year | Disability |
|---|---|
| % of consumers who identified a physical disability | |
| FY 21/22 | 3% |
| FY 22/23 | 5% |
| FY 23/24 | 4% |

| Fiscal Year | Gender Identity | | | |
|---|---|---|---|---|
| | ♂ | ♀ | ⚧ | UNK |
| FY 21/22 | 28% | 44% | 0% | 26% |
| FY 22/23 | 32% | 38% | 0% | 30% |
| FY 23/24 | 19% | 34% | <1% | 46% |

| Fiscal Year | Primary Language | | | |
|---|---|---|---|---|
| | ENG | SPAN | OTH | UNK |
| FY 21/22 | 84% | 7% | 2% | 0% |
| FY 22/23 | 79% | 7% | 1% | 0% |
| FY 23/24 | 84% | 6% | 1% | 9% |

# Preschool PEI Program (PPP), cont.

**Demographics, cont.**

| | Race/Ethnicity | FY 21/22 | FY 22/23 | FY 23/24 |
|---|---|---|---|---|
| Race | African-American/Black | 20% | 21% | 24% |
| | American-Indian/Alaska Native | 2% | <1% | 1% |
| | Asian | 0% | 2% | 0% |
| | Hispanic/Latinx | 0% | 1% | <1% |
| | Native Hawaiian or Pacific Islander | 0% | 1% | 1% |
| | Caucasian/White | 33% | 31% | 27% |
| | More than One Race | 5% | 0% | 6% |
| | Other Race | 1% | 7% | 40% |
| | Declined to Answer | 35% | 37% | 34% |

| | Race/Ethnicity | FY 21/22 | FY 22/23 | FY 23/24 |
|---|---|---|---|---|
| Ethnicity | African | 0% | 2% | <1% |
| | Asian Indian/South Asian | 0% | 0% | 0% |
| | Cambodian | 0% | 0% | 0% |
| | Chinese | 0% | 3% | 0% |
| | Eastern European | 0% | 0% | 0% |
| | European | 0% | 2% | 0% |
| | Hispanic/Latinx | 42% | 88% | 18% |
| | Filipino | 0% | 0% | 0% |
| | Japanese | 0% | 0% | 0% |
| | Korean | 0% | 0% | 0% |
| | Middle Eastern | 1% | 1% | 1% |
| | Vietnamese | 0% | 0% | 0% |
| | Other | 0% | 3% | 9% |
| | More than one ethnicity | 1% | 3% | 0% |
| | Declined to Answer | 58% | 3% | 52% |

# Preschool PEI Program (PPP), cont.

**Demographics, cont.**

**Demographic Observations**

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

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

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

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

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

# Preschool PEI Program (PPP), cont.

## Program Goals

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

## Program Outcomes

The instrument employed to assess outcomes within the PPP is the Desired Results Developmental Profile (DRDP). This tool is designed to evaluate various developmental domains, providing valuable insights into the progress of students. By systematically measuring outcomes, the DRDP tracks growth over time and enables PPP to identify areas for improvement.

### The Desired Results Development Profile

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

| Method use to collect outcome | Description of method | Frequency of use | Number Completed |
|---|---|---|---|
| The Desired Results Developmental Profile (DRDP) | Designed for teachers to observe, document, and reflect on the learning, development, and progress of children who are enrolled in early care and education programs and before-and after-school programs. | Fall, Winter, and Spring | FY 21/22: 2,451<br>FY 22/23: 1,290<br>FY 23/24: 1,219 |

# Preschool PEI Program (PPP), cont.

## Outcome Discussion

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

| Desired Results Developmental Profile | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Social-Emotional Development Domain | FY 2021/22 | | | FY 2022/23 | | | FY 2023/24 | | |
| | Pre | Post | Increase | Pre | Post | Increase | Pre | Post | Increase |
| Identity of Self in Relation to Others | 49% | 65% | 16% | 48% | 70% | 76% | 52% | 79% | 66% |
| Social and Emotional Understanding | 46% | 62% | 16% | 48% | 67% | 75% | 48% | 75% | 67% |
| Relationships and Social Interactions with Familiar Adults | 48% | 68% | 20% | 52% | 70% | 80% | 54% | 81% | 67% |
| Relationships and Social Interactions with Peers | 53% | 72% | 19% | 58% | 76% | 82% | 59% | 84% | 70% |
| Symbolic and Sociodramatic Play | 29% | 44% | 15% | 33% | 44% | 59% | * | * | * |

*Not included in FY 2023/24 DRDP assessment

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

# Preschool PEI Program (PPP), cont.

### Challenges/Solutions

Children enrolling in preschool after COVID-19 have demonstrated serious self-regulation concerns. An increasing number of preschool-age children are entering the classroom and consistently posing a safety threat to themselves and other children. Additionally, the PPP encountered barriers of low participation in Theraplay, a form of structured therapy to address building adult-child relationships. Interactive, physical, and fun activities are used to create healthy caregiver-child attachment.

To support increased usage of Theraplay, PSD has incorporated nine trainings in the program year, with five days exclusively set for Teaching Pyramid modules. An additional support of coaching is integrated to assist staff with implementation of Theraplay interventions. Theraplay groups are now being offered with increased fidelity and support.

### Lessons Learned

Parents or caregivers and preschool teaching staff can lack the training necessary to understand and provide effective intervention strategies for preschool children. PSD continues to engage various mental health professionals to evaluate DRDP and background data to identify areas of need.

**Program Updates**

This program is being evaluated for transition to early intervention program for children ages 0-5.

# Preschool PEI Program (PPP), cont.

## Collaborative Partners

- Fatherhood FIRE Program
- 211 Inland SoCal United Way- PSD 211 Specialist
- Cal Baptist University MFT Intern Program
- County Library
- First 5
- Transitional Assistance Department
- Children's Fund
- Victor Community Support Services
- Christian Counseling Services
- Desert Mountain
- Lutheran Social Services
- Foster & Kinship CARE Education
- Childcare Resource Center
- Inland Regional Center
- Dr. Bergin
- Fontana Unified School District
- Colton Bloomington School District
- Needles School District
- West Valley SART

## Success Stories

"[The student] has now made his transition over to TK. In our time together, we focused on engagement and better communication with mom. [The student] is now more confident with expressing his feelings and sharing why something made him upset or why he reacted the way he did when he was asked about it. He has improved in using his words instead of just screaming or crying loudly at mom. He is also more redirectable compared to when we first started. Overall, his mom feels that improvements have been made and that she's appreciative of the services that were given to [The student]."

-MFT Intern #1

"In our time together with [The student] and their family, we focused on structure and nurture between them and mom. With each home session, [The student] was easily able to redirect their attention and efforts back to the activity. Their listening skills improved with both mom and therapist interns. Lastly, [The student] improved on their communication. For example, they would ask rather than demand for something… and they are more able to acknowledge their emotions when asked about it. We also saw mom and [The student's] bond become closer throughout each session. Once again, mom feels that [The student has] made major improvements and is also appreciative of the services that were provided."

-MFT Intern #2

# Resilience Promotion in African American Children (RPiAAC)

## Program Description and Target Population

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

| | |
|---|---|
| **Services Offered** | • Cultural awareness and empowerment workshops<br>• Professional development presentations<br>• Mental health/SUD screenings<br>• Mental health/SUD education<br>• Counseling services<br>• Case management<br>• Homework assistance<br>• Parenting Workshops |

| | |
|---|---|
| **Program Serves** | **Children**<br>**TAY (16-25)**<br>**Adults** |
| **Location of Services** | School campuses, Family Resource Centers, Community organizations |
| **Annual Budget FY 25/26** | $1,700,688 |
| **Cost Per Client FY 25/26** | $358 |

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

## State Program Positive Results

The RPiAAC program works in collaboration with local schools to provide programming and activities at school sites that are convenient for students and their families. Individuals undergo screening for risk factors that may result in mental health symptoms and the likelihood of developing an early-onset mental illness. The concerns of impairment and safety are further evaluated to establish the degree of the individual's need of additional services.

RPiAAC providers involve students and parents in planning culturally appropriate and engaging activities for the target audience. Trends from screening tools and survey feedback determine the offered activities.

The RPiAAC program is categorized as a State Prevention and Early Intervention program. The program aims to reduce risk factors such as school failure, dropout, and juvenile justice involvement. It increases protective factors such as positive coping skills, increased knowledge, access to services, and positive self-image. RPiAAC provides a variety of prevention activities and social skill groups through evidence-based curriculums, Peacemakers, and National Curriculum and Training Institute (NCTI) Youth Crossroads.

Services are intended for children who are identified as struggling with behavior in class, maintaining passing grades, absenteeism, and tardiness.

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

**Number of Individuals / Number of Services Projected vs Actual**

| | Projected | Actual | | |
|---|---|---|---|---|
| | | FY 21/22 | FY 22/23 | FY 23/24 |
| **Unduplicated Individuals** | 4,753 | 1,078 | 1,076 | 1,464 |
| **Number of Services** | 8,339 | 5,962 | 7,474 | 9,136 |

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

**State Program Positive Results, cont.**

**Prevention**

The RPiAAC program implements a variety of prevention services and social skill groups through evidence-based curriculums and activities, such as:

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

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

Through the Meet A Pro activities, African American/Black professionals talk with students about their careers, personal experience of racism and discrimination, and how they overcame obstacles to succeed. These activities are intended to influence favorable perceptions of professional accomplishment for African American/Black children and TAY and encourage them to follow their desired career pathways.

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



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

**State Program Positive Results, cont.**

**Early Intervention**

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

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

The program also uses the Pediatric Symptom Checklist (PSC) at intake to assess emotional and behavioral problems in children. The tool assists in recognizing cognitive, emotional, and behavioral problems so that program staff can initiate the appropriate interventions.

The adjacent chart shows the number of early intervention services as reported by the RPiAAC program.

| Early Intervention Individuals / Services | | | |
|---|---|---|---|
| | FY 2021/22 | FY 2022/23 | FY 2023/24 |
| Unduplicated Individuals | 41 | 42 | 75 |
| Number of Services | 239 | 908 | 1,950 |



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

**State Program Positive Results, cont.**

**Early Intervention, cont.**

RPiAAC providers established relationships with school districts to resume on campus services. Services are initiated via referral from school staff. The program continues to expand its services to the high desert region of the county.

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

| Treatment Success by Fiscal Year | | | |
|---|---|---|---|
| | Total Episodes | Closed Episodes | % Met Goals |
| FY 2021/22 | 335 | 122 | 38% |
| FY 2022/23 | 335 | 51 | 38% |
| FY 2023/24 | 467 | 5 | 73% |

**Outreach**

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

**Outreach Settings**



- Schools
- Community events
- Community based organization facility

**Types of Potential Responders**



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

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

**State Program Positive Results, cont.**

**Outreach, cont.**

Collaborations with different agencies and stakeholders have allowed the program to identify and target the at-risk African American/Black population. One of the largest barriers faced was the decrease in in-person participation and change in engagement due to the virtual platform presented to students. The table below illustrates the number of potential responders reached during each of the three previous fiscal years.

| Potential Responders Reached | | | |
|---|---|---|---|
| | FY 2021/22 | FY 2022/23 | FY 2023/24 |
| Potential Responders | 977 | 992 | 932 |



Artwork by Lana Manzo

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

## Demographics

| Fiscal Year | Age (yrs. old) | | | | |
|---|---|---|---|---|---|
| | 0-15 | 16-25 | 26-59 | 60+ | UNK |
| FY 21/22 | 13% | 4% | 0% | 0% | 83% |
| FY 22/23 | 12% | 6% | 0% | 0% | 83% |
| FY 23/24 | 40% | 15% | 17% | 6% | 22% |

| Fiscal Year | Veteran Status |
|---|---|
| | % of consumers who identified as a veteran |
| FY 21/22 | 0% |
| FY 22/23 | 0% |
| FY 23/24 | <1% |

| Fiscal Year | Sexual Orientation |
|---|---|
| | % of consumers who identified as LGBTQ+ |
| FY 21/22 | 0% |
| FY 22/23 | <1% |
| FY 23/24 | <1% |

| Fiscal Year | Disability |
|---|---|
| | % of consumers who identified a physical disability |
| FY 21/22 | 0% |
| FY 22/23 | 0% |
| FY 23/24 | 6% |

| Fiscal Year | Gender Identity | | | |
|---|---|---|---|---|
| | ♂ | ♀ | ⚧ | UNK |
| FY 21/22 | 34% | 51% | 0% | 15% |
| FY 22/23 | 30% | 46% | 0% | 22% |
| FY 23/24 | 34% | 52% | <1% | 14% |

| Fiscal Year | Primary Language | | | |
|---|---|---|---|---|
| | ENG | SPAN | OTH | UNK |
| FY 21/22 | 88% | 0% | 12% | 0% |
| FY 22/23 | 89% | 1% | <1% | 10% |
| FY 23/24 | 76% | 5% | <1% | 19% |

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

**Demographics, cont.**

## Demographic Observations

- The RPiAAC program has consistently served the target population over the last three fiscal years, with 55% of the individuals served being children and TAY aged 0-25 years old. This aligns with the program's target population.
- Although the program focuses on African American/Black students, RPiAAC continues to successfully reach individuals who identify as Latinx/Hispanic.
- There is an increase in adults aged 26-59, showing that more parents are engaged by the program.

| | Race | FY 21/22 | FY 22/23 | FY 23/24 |
|---|---|---|---|---|
| Race | African-American/Black | 77% | 70% | 59% |
| | American-Indian/Alaska Native | 0% | 0% | 0% |
| | Asian | 0% | <1% | <1% |
| | Latinx/Hispanic | 18% | 25% | 12% |
| | Native Hawaiian or Pacific Islander | 0% | <1% | <1% |
| | Caucasian/White | 4% | 6% | 17% |
| | More than One Race | 4% | 2% | 2% |
| | Other Race | 1% | 6% | 5% |
| | Declined to Answer | 3% | 6% | 5% |

| | Ethnicity | FY 21/22 | FY 22/23 | FY 23/24 |
|---|---|---|---|---|
| Ethnicity | African | 82% | 74% | 41% |
| | Asian Indian/South Asian | 0% | <1 | <1% |
| | Cambodian | 0% | 0% | <1% |
| | Chinese | 0% | 0% | 0% |
| | Eastern European | 1% | 7% | 1% |
| | European | 3% | 0% | 6% |
| | Hispanic/Latino | 18% | 25% | 39% |
| | Filipino | 0% | 1% | 0% |
| | Japanese | 0% | 0% | 0% |
| | Korean | 0% | 0% | 0% |
| | Middle Eastern | 0% | <1% | 0% |
| | Vietnamese | 0% | 0% | <1% |
| | Other | 6% | 4% | 9% |
| | More than one ethnicity | 4% | 7% | 3% |
| | Declined to Answer | 2% | 6% | 1% |

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

## Program Goals

Reduce prolonged suffering associated with untreated mental illness by:

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

Reduce stigma and discrimination associated with mental illness by:

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

## Program Outcomes

| Method use to collect outcome | Description of method | Frequency of use | Number Completed |
|---|---|---|---|
| Children and Adolescent Needs and Strengths Assessment (CANS) | CANS is a multi-purpose tool developed for children's services to support decision making, including level of care and service planning. | Intake, 3 - 6 months, Discharge, Significant life events | FY 21/22: 31<br>FY 22/23: 32<br>FY 23/24: 80 |
| National Curriculum & Training Institute (NCTI) | A complete behavioral change system delivered in a group format, following a precise sequence that leads individuals from a general level of discussion to a specific behavioral commitment. | 2 times Initial & completion | FY 21/22: 305<br>FY 22/23: 377<br>FY 23/24: 689 |

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

## Outcome Discussion

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

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

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

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

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

On average, youth exhibited an improvement of 11% in their cognitive life skills and skills managing substance and alcohol use and anger management.

| NCTI Youth Crossroads | | | |
|---|---|---|---|
| **Curriculum** | **Average Pre-Test** | **Average Post-Test** | **Percent Improvement** |
| Cognitive Life Skills | 4.65 | 5.71 | 11% |
| Alcohol and Substance Use | 3.70 | 3.80 | 2% |
| Anger Management | 3.57 | 3.83 | 5% |

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

### Challenges/Solutions

In today's competitive job market, the RPiAAC program faces challenges with recruitment and retention for some of the programs staff positions. Some of the program's positions are filled by intern staff through a collaboration with local colleges and universities.

The program continues to explore the best paths to access of information management systems and data collection methods to report outcomes. DBH continues it's collaboration efforts with RPiAAC providers to create streamlined access to all reporting databases.

### Lessons Learned

In FY 2023/24, the RPiAAC has been successful in building relationships with schools in the high desert region, which has helped the program improve access and linkage to services for at-risk youth.

### Success Stories

"This program has taught us how to confront our emotions in everyday life as teens in real life situations and as a result, make ourselves better."

### Program Updates

There are no planned program updates for Fiscal Year 2025/26.

# Older Adult Community Services (OACS)

## Program Description and Target Population

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

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

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

| | |
|---|---|
| **Services Offered** | • Mental Health Education<br>• Mental Health/SUD Screenings<br>• Case Management Services<br>• Home Safety Screenings<br>• Transportation Assistance for High Desert Residents<br>• Counseling Services<br>• Physical Fitness/Wellness Activities<br>• Suicide Prevention |

| | |
|---|---|
| **Program Serves** | **Older Adults (60+)** |
| **Location of Services** | In-home, Senior Centers, Mobile Services, Mental Health Care Facilities |
| **Annual Budget FY 25/26** | $963,818 |
| **Cost Per Consumer FY 25/26** | $227 |

# Older Adult Community Services (OACS), cont.

## Program Highlights

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

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

OACS providers collaborate closely with service coordinators at local senior centers and apartment complexes to design and implement presentations, workshops, and/or groups aimed at addressing the mental health symptom prevention needs within the community.

Participants are screened for mental health symptoms and early onset diagnosis possibility. Impairment and safety issues are evaluated to determine the participant's need severity.

OACS providers, in collaboration with their peer family advocates and program participants, utilize a variety of methods such as suggestion boxes, polling, and analysis of screening tools to assess and determine the activities to be offered.

The table provided below offers an overview of the planned service objectives and the actual services rendered by the OACS program over the past three fiscal years.

The implementation of virtual services has notably mitigated transportation-related obstacles. Furthermore, the program consistently surpasses the projected participation targets, aligning with the prevailing trends in mental health services

**Number of Participants / Number of Services Projected vs Actual**

| | Projected | Actual | | |
|---|---|---|---|---|
| | | FY 21/22 | FY 22/23 | FY 23/24 |
| **Unduplicated Participants** | 4,240 | 11,438 | 8,957 | 8,534 |
| **Number of Services** | 6,126 | 4,181 | 5,755 | 4,443 |

# Older Adult Community Services (OACS), cont.

**Program Highlights, cont.**

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

## Older Adult Community Services (OACS), cont.

**Program Highlights, cont.**

| Prevention Activity | Description | Risk Factors Addressed | Protective Factors Addressed |
|---|---|---|---|
| Tai Chi for Arthritis | • To help seniors improve mental and physical balance, reduce accidental falls, and increase strength, mobility, and heart/lung/muscle function. Reducing pain and stiffness, protecting joints, and improving relaxation, vitality, posture, and immunity. | • Reducing mental illness factors<br>• Access to physical and mental health care<br>• Depression<br>• Chronic physical health conditions | • Screenings for mental health and substance use<br>• Knowledge and access to services<br>• Socialization<br>• Positive coping skills |
| Transportation Reimbursement Escort Program (TREP) | • Transportation reimbursement program provided to seniors in the High Desert communities for their medical appts, medication pick-ups, and errands. | • Prolonged isolation<br>• Access to physical and mental health care | • Transportation assistance<br>• Socialization<br>• Knowledge and access to services |
| Home Safety Program | • To assist seniors in maintaining personal and home safety through education and services covering personal safety, home safety, fall prevention, and medication management assistance. | • Poverty - Insufficient food, shelter, healthcare<br>• Ongoing stress<br>• Preventive measures | • Access to mental and physical health care<br>• Knowledge and access to services |

# Older Adult Community Services (OACS), cont.

## Program Highlights, cont.

### Outreach

Outreach is a primary strategy in the OACS program for increasing recognition of early signs and symptoms of mental illness. As a result of successful outreach efforts, OACS has reached over 20,000 participants, also known as potential responders, across FYs 2021/22, 2022/23, and 2023/24.

| Potential Responders Reached | | | |
|---|---|---|---|
| | FY 21/22 | FY 22/23 | FY 23/24 |
| Potential Responders | 9,911 | 8,988 | 8,534 |

Potential participants in this program are involved in various activities. They attend educational presentations to learn about the signs and symptoms of mental illness and age-related difficulties. They also work in multidisciplinary teams with responders/providers from different fields to enhance the team's capabilities. Through collaboration, they gain a better understanding of age-related difficulties, mental health issues, and other challenges affecting older adults.

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

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

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

# Older Adult Community Services (OACS), cont.

**Program Highlights, cont.**

The early intervention services provided by the OACS program offer a comprehensive approach to supporting older adults with emerging mental health concerns. These services are designed to identify mental health issues early and provide timely interventions to prevent the escalation of symptoms. The core components of EIS include:

- Mental Health Screenings and Assessments: Screenings are the first step in identifying potential behavioral health concerns. Licensed professionals conduct thorough evaluations for symptoms of anxiety, depression, and other behavioral health conditions.
- Individual Therapy: One-on-one therapy sessions provide a safe, confidential space for individuals to explore their emotions, challenges, and mental health concerns. Therapy is personalized to meet the emotional and psychological needs of each older adult.
- Group Therapy: Group therapy provides individuals the opportunity to connect with others facing similar challenges. These sessions promote peer support, and open communication, and help reduce feelings of isolation.
- Case Management: OACS case managers offer holistic support, coordinating care, making referrals to mental health providers or community resources, and assisting with logistical needs such as transportation or medication access.
- The data on the following pages illustrates the impact of these services over the past three fiscal years, highlighting trends such as the number of individuals served, types of services utilized, and the success rates of early intervention efforts. This information is critical for evaluating program effectiveness and identifying areas for improvement.

# Older Adult Community Services (OACS), cont.

## Program Highlights, cont.

### Early Intervention Services

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

| Number of Open Episodes by Fiscal Year | | | |
|---|---|---|---|
| | FY 21/22 | FY 22/23 | FY 23/24 |
| Open Episodes at any time during the fiscal year | 21 | 33* | 22 |

*FY 22/23 reported numbers were incorrect, actual numbers have been updated

Early intervention services for homebound elders primarily shifted to virtual due to COVID-19's long-term effects. However, telehealth isn't favored among older adults due to limited resources and unfamiliarity with technology. Many lack access to computers or smartphones. Early intervention services have increased since providers returned to in-person services and seniors become more comfortable with technology.

# Older Adult Community Services (OACS), cont.

## Program Highlights, cont.

### Early Intervention Services

| Treatment Success by Fiscal Year | | | |
|---|---|---|---|
| | FY 21/22 | FY 22/23 | FY 23/24 |
| Treatment Successful | 33% | 15% | 32% |
| Treatment Partially Successful | 22% | 33% | 29% |
| Treatment Not Successful | 38% | 44% | 36% |
| Missing or Other | 14% | 7% | 7% |

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

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

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

# Older Adult Community Services (OACS), cont.

## Demographics

| Fiscal Year | Age (yrs. old) | | | | |
|---|---|---|---|---|---|
| | 0-15 | 16-25 | 26-59 | 60+ | UNK |
| FY 21/22 | 0% | 0% | <1% | 27% | 72% |
| FY 22/23 | 0% | 0% | <1% | 29% | 71% |
| FY 23/24 | 1% | 0% | <1% | 20% | 73% |

| Fiscal Year | Veteran Status |
|---|---|
| | % of consumers who identified as a veteran |
| FY 21/22 | <1% |
| FY 22/23 | <2% |
| FY 23/24 | <1% |

| Fiscal Year | Sexual Orientation |
|---|---|
| | % of consumers who identified as LGBTQ+ |
| FY 21/22 | <1% |
| FY 22/23 | <1% |
| FY 23/24 | 5% |

| Fiscal Year | Disability |
|---|---|
| | % of consumers who identified a physical disability |
| FY 21/22 | 3% |
| FY 22/23 | 3% |
| FY 23/24 | 26% |

| Fiscal Year | Gender Identity | | | |
|---|---|---|---|---|
| | ♂ | ♀ | ⚧ | UNK |
| FY 21/22 | 18% | 51% | 0% | 31% |
| FY 22/23 | 13% | 35% | 0% | 52% |
| FY 23/24 | 18% | 50% | 0% | 32% |

| Fiscal Year | Primary Language | | | |
|---|---|---|---|---|
| | ENG | SPAN | OTH | UNK |
| FY 21/22 | 10% | 2% | 0% | 88% |
| FY 22/23 | 12% | 3% | <1% | 85% |
| FY 23/24 | 27% | 3% | <1% | 70% |

# Older Adult Community Services (OACS), cont.

**Demographics, cont.**

### Demographic Observations

Historically, older adults have been hesitant to engage in services and share personal information. This reluctance is often rooted in experiences from past eras when government and institutional practices were harmful toward individuals with mental health challenges, members of the LGBTQ+ community, and people from ethnic and minority groups.

This deep-seated mistrust has made capturing accurate demographic data more challenging. In recent years, there has been a decline in participants identifying as male. There has also been an increase in individuals choosing not to answer gender-related questions, reflecting evolving attitudes toward gender identity and privacy.

This trend is particularly concerning given that research shows older adult males, specifically Caucasian and Native American men, have some of the highest rates of suicide attempts and deaths. Engaging this demographic remains a priority for the OACS program, which will continue to monitor these trends in the coming years and adapt outreach efforts accordingly.

Additionally, there has been a noticeable decrease in participants identifying as having a physical disability. This decline may be linked to the expansion of telehealth services, which allowed many individuals to receive care from home.

All current OACS providers are committed to continuing the offering of telehealth services, ensuring that participants who require technological assistance receive the support they need to access these services effectively.

# Older Adult Community Services (OACS), cont.

**Demographics, cont.**

| | Ethnicity/Race | FY 21/22 | FY 22/23 | FY 23/24 |
|---|---|---|---|---|
| Race | African American/Black | 1% | <1% | <1% |
| | Native American or Alaskan Native | <1% | <1% | <1% |
| | Asian | <1% | <1% | <1% |
| | Latinx/Hispanic | 3% | 4% | <1% |
| | Native Hawaiian/Pacific Islander | 0% | 0% | <1% |
| | Caucasian/White | 6% | 8% | 12% |
| | More than One Race | <1% | <1% | <1% |
| | Other | <1% | 1% | 1% |
| | Declined to Answer | 67% | 84% | 82% |

## Older Adult Community Services (OACS), cont.

**Demographics, cont.**

| | Ethnicity/Race | FY 21/22 | FY 22/23 | FY 23/24 |
|---|---|---|---|---|
| Ethnicity | African | 2% | <1% | <1% |
| | Asian Indian/South Asian | 1% | 0% | <1% |
| | Cambodian | 0% | 0% | 0% |
| | Chinese | 1% | <1% | <1% |
| | Eastern European | 0% | 0% | 0% |
| | European | 30% | 20% | 18% |
| | Hispanic/Latino | 3% | 4% | 1% |
| | Filipino | 1% | <1% | <1% |
| | Japanese | 0% | 0% | 0% |
| | Korean | 0% | 0% | <1% |
| | Middle Eastern | 0% | 0% | 0% |
| | Vietnamese | 0% | 0% | 0% |
| | Other | 5% | 2% | 1% |
| | More than One Ethnicity | 2% | 1% | 3% |
| | Declined to Answer | 57% | 75% | 75% |

# Older Adult Community Services (OACS), cont.

### Program Goals

The Prevention Program aims to alleviate prolonged suffering from untreated mental health issues. This is achieved by:

- Reducing risk factors and early indicators of mental illness.
- Enhancing protective factors that promote better mental, emotional, and relational health.
- Promoting healthy aging through prevention programing.

The OACS program serves adults aged 60 and above, aiming to foster a healthy aging process through the following initiatives:

- Facilitating access to activities that encourage connections among older adults.
- Providing education and promoting participation in behavioral and physical wellness activities.
- Enhancing personal safety, home safety, and fall prevention measures, while supporting medication management.
- Encouraging older adults to participate in suicide and depression screenings.
- Expanding access to therapy services and promoting early engagement in treatment for mental health conditions.



Artwork by Peter Millar

# Older Adult Community Services (OACS), cont.

### Program Outcomes

| Method Used to Collect Outcomes | Description of Method | Frequency of Use | Number Completed |
|---|---|---|---|
| Adult Needs and Strengths Assessment (ANSA) | A comprehensive assessment of psychological and social factors used for treatment planning. This assessment measures functioning in several important life domains and helps to support decision-making and level of care and service planning, and ensure projected goals are being met. | • Intake<br>• 3 Months<br>• Discharge<br>• Significant Life Events | FY 21/22: 65<br>FY 22/23: 35<br>FY 23/24: 21 |
| Satisfaction Survey | Survey that reflects on the usefulness of the service/presentation and the speaker's ability to deliver information. An additional space was provided for narrative feedback. | • Post Service and/or Presentation | FY 21/22: 255<br>FY 22/23: 42<br>FY 23/24: 828 |
| Outreach Questionnaires | A seven-item questionnaire that assesses a participant's improved knowledge of signs and symptoms that can lead to a potentially serious mental illness. | • Pre/Post Mental Health Education Presentation and/or Activity | FY 21/22: 52<br>FY 22/23: 73<br>FY 23/24: 347 |
| PHQ-9 | Nine-question instrument given to patients in a healthcare setting to screen for the presence and severity of depression. | • Intake<br>• 6 Months | FY 21/22: 25<br>FY 22/23: 30<br>FY 23/24: 37 |

# Older Adult Community Services (OACS), cont.

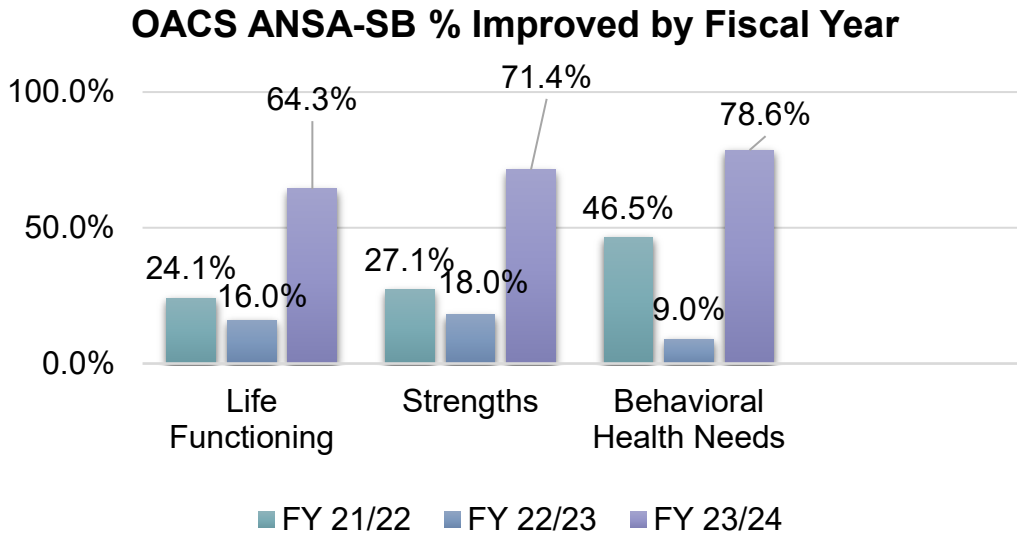
## Outcome Discussion

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

The data shows that individuals in early intervention services saw improvements in Life Functioning, Strengths, and Behavioral Health Needs. However, in FY 23/24, all three areas saw a significant improvement, since COVID-19. Providers are working on innovative strategies to engage older adults and continue to improve outcomes.

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

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



# Older Adult Community Services (OACS), cont.

**Outcome Discussion, cont.**

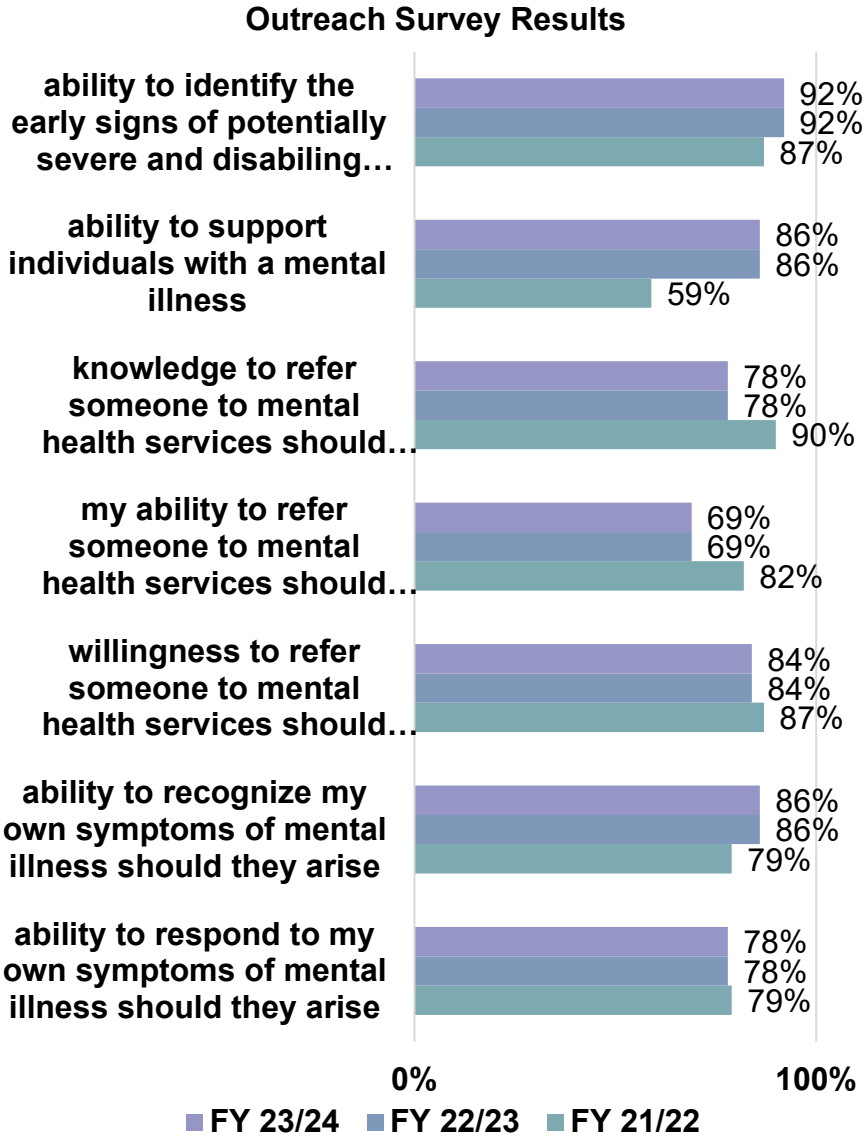
Outreach Survey Results

The OACS program conducts various outreach activities, including:

- Educational sessions for the community to learn more about mental health and wellness.
- Information dissemination events focused on the signs and symptoms of mental illness, as well as age-related challenges.
- Participants in mental health information events complete a survey to evaluate their understanding, comfort level in assisting others, and post-event feelings. The graph on this page displays survey questions and responses from the past three years.

Key findings include:

- Increased confidence: In FY 23/24, 88% of survey respondents felt confident in recognizing and assisting individuals with mental illness.
- Improved referral knowledge: The survey results show an overall improvement in participants' understanding of the mental health referral process and their intent to seek mental health services if needed.
- These results underscore the success of education and behavioral health promotion strategies in increasing community awareness of mental health issues and available resources.



# Older Adult Community Services (OACS), cont.

## Outcome Discussion, cont.

Consumer Satisfaction Surveys

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



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

**74%** stated that the program helped improve their mental health.
**83%** stated that they would continue walking due to the effects on their physical health.
**65%** stated improvements in quality time spent with friends and family.



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

**100%** of OACS participants agreed or totally agreed that participants improved their knowledge of mental health and stigma reduction.
**100%** of OACS Wellness presentation participants agreed that the presentations were useful and the speaker delivered information.



OACS Mobile Outreach and Health Screenings – Designed to decrease transportation barriers and increase access to services by providing on-site assessments and screenings for OACS participants.

**98%** of participants said they learned something new at the Mobile Outreach or Health screening event.
**100%** of participants found value in having services delivered in mobile settings.

# Older Adult Community Services (OACS), cont.

**OACS Program: Addressing Service Access Challenges**

The OACS providers continue to face challenges in connecting participants to timely Early Intervention and Psychiatric services, particularly for those with private insurance or requiring a higher level of care. These challenges are especially pronounced in the mountain communities, where there is a shortage of mental health service providers. This shortage creates significant transportation difficulties for older adults, who often must travel long distances to access necessary services.

Another ongoing challenge for the OACS program is identifying and providing services to homebound or isolated seniors, especially during the winter months in remote areas of the county. The mountain regions, in particular, are impacted by harsh weather conditions, making it difficult for seniors to receive in-person support. To combat isolation issues, OACS providers increase the frequency of safety calls to participants, especially during severe weather. Additionally, they offer a range of seminars and workshops focused on topics such as:

- The benefits of socialization.
- Stress reduction strategies.
- Locating and accessing local resources.

The OACS program focuses on activities tailored specifically to older adult men, a group that is often less engaged in traditional wellness programs. These activities include male-centric workshops, fitness classes, and peer-led support groups to foster camaraderie and encourage participation in mental and physical health initiatives. Additionally, the program addresses transportation challenges faced by seniors, especially in rural areas, by partnering with health insurance providers to offer free or subsidized transportation to medical appointments. The OACS provides workshops to help seniors navigate public transit, enhancing their mobility and access to essential services and community activities.

# Older Adult Community Services (OACS), cont.

### Lessons Learned

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

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

### Program Updates

There are no planned program updates for Fiscal Year 2025/26.

### Success Story

An 83-year-old Caucasian male self-referred to the early intervention services program, seeking support for symptoms of anxiety and mild depression. He had recently been diagnosed with Parkinson's disease, a life-altering condition that significantly impacted his daily functioning and life skills. Compounding his struggles, he had also experienced the sudden death of his son about a year prior, leaving him grappling with grief.

Through his participation in EIS, the individual was able to address both his grief and the emotional impact of his declining health. With the guidance of the program, he learned to reframe his losses, shifting his focus from what he could no longer do to what he could still achieve, He also worked on strengthening his family relationships and finding renewed meaning and support through his connections with loved ones.

Over time, the individual felt he had made significant progress. He reported that he was now grieving more healthily and had gained a more positive outlook on his abilities, with strong family support. He ultimately decided to conclude his time in the program, feeling confident that he had met his personal goals and was ready to move forward.

# Lift Program

## Program Description and Target Population

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

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

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

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

| | |
|---|---|
| **Services Offered** | • **Parent education and support**<br>• **Post-natal depression screenings**<br>• **Nurturing activities to increase maternal attachment**<br>• **Developmental milestones education**<br>• **Life and employment skills development**<br>• **Community referrals** |

| | |
|---|---|
| **Program Serves** | **Children, Youth, TAY, Older Adults** |
| **Location of Services** | In-home |
| **Annual Budget FY 25/26** | $396,000 |
| **Cost Per Client FY 25/26** | $3,300 |

# Lift Program, cont.

## Program Positive Results

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

- Edinburgh Postnatal Depression Scale
- Fagerstrom Test for Nicotine Dependency
- Maternal Fetal Attachment Scale
- Life Skills Progression
- Father Skills Assessment
- Teeth for Two

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

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

| Number of Participants / Number of Services Projected vs Actual | | | | |
|---|---|---|---|---|
| | Projected | Actual | | |
| | | FY 21/22 | FY 22/23 | FY 23/24 |
| Unduplicated Participants | 120 | 154 | 52 | 65 |
| Number of Services | 1,728 | 759 | 360 | 511 |

# Lift Program, cont.

## Program Positive Results, cont.

Edinburgh Postnatal Depression Scale

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

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

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



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

The chart below presents data from the past three years. In the most recent fiscal year, 65 mothers were screened for signs of depression, highlighting an increased need for support to prevent depression from becoming severe or disabling. Lift nurses continue to provide support and monitor all participants in the program, regardless of their engagement with the program or any other mental health services.

**Identification of Depression Related Mental Health Needs**

| | FY 2021/22 (N=46) | FY 2022/23 (N=52) | FY 2023/24 (N=65) |
|---|---|---|---|
| Exhibited signs of depression | 1 | 6 | 22 |
| Received mental health supportive services | 1 | 6 | 6 |
| Required clinical intervention | 1 | 4 | 0 |

# Lift Program, cont.

## Demographics

| Fiscal Year | Age (yrs. old) | | | | |
|---|---|---|---|---|---|
| | 0-15 | 16-25 | 26-50 | 60+ | UNK |
| FY 21/22 | 39% | 18% | 27% | 0% | 4% |
| FY 22/23 | 63% | 0% | 37% | 0% | 0% |
| FY 23/24 | 0% | 8% | 32% | 0% | 60% |

| Fiscal Year | Veteran Status |
|---|---|
| | % of consumers who identified as a veteran |
| FY 21/22 | 0% |
| FY 22/23 | 0% |
| FY 23/24 | 0% |

| Fiscal Year | Sexual Orientation |
|---|---|
| | % of consumers who identified as LGBTQ+ |
| FY 21/22 | 1% |
| FY 22/23 | 2% |
| FY 23/24 | 6% |

| Fiscal Year | Disability |
|---|---|
| | % of consumers who identified a physical disability |
| FY 21/22 | 2% |
| FY 22/23 | 6% |
| FY 23/24 | 3% |

| Fiscal Year | Gender Identity | | | |
|---|---|---|---|---|
| | ♂ | ♀ | ⚧ | UNK |
| FY 21/22 | 21% | 69% | 0% | 9% |
| FY 22/23 | 20% | 69% | 0% | 11% |
| FY 23/24 | 0% | 74% | 0% | 26% |

| Fiscal Year | Primary Language | | | |
|---|---|---|---|---|
| | ENG | SPAN | OTH | UNK |
| FY 21/22 | 74% | 8% | 7% | 8% |
| FY 22/23 | 78% | 9% | 10% | 4% |
| FY 23/24 | 74% | 5% | 6% | 15% |

# Lift Program, cont.

**Demographics, cont.**

**Demographic Observations**

The Lift program primarily targets first-time pregnant women, new mothers, and with their families. Most participants are TAY and adult women. However, there is a small percentage of male participants, which reflects services provided to fathers who are participating in the family services program.

The ethnic/racial diversity of the participants generally reflects the diversity of the population of San Bernardino County. However, members of the Asian and Native Hawaiian and Pacific Islander communities are not currently participating in the Lift program. Efforts will be made in the upcoming program years to engage this community.

# Lift Program, cont.

**Demographics, cont.**

| | Race/Ethnicity | FY 21/22 | FY 22/23 | FY 23/24 |
|---|---|---|---|---|
| Race | African-American/Black | 22% | 27% | 21% |
| | American-Indian/Alaska Native | 2% | 3% | 3% |
| | Asian | 0% | 0% | 0% |
| | Hispanic/Latinx | 4% | 0% | 7% |
| | Native Hawaiian or Pacific Islander | 0% | 0% | 0% |
| | Caucasian/White | 27% | 10% | 34% |
| | More than One Race | 8% | 0% | 0% |
| | Other Race | 10% | 26% | 3% |
| | Decline to Answer | 27% | 34% | 30% |

| | Race/Ethnicity | FY 21/22 | FY 22/23 | FY 23/24 |
|---|---|---|---|---|
| Ethnicity | African | 5% | 9% | 3% |
| | Asian Indian/South Asian | 0% | 0% | 0% |
| | Cambodian | 0% | 0% | 0% |
| | Chinese | 0% | 0% | 0% |
| | Eastern European | 0% | 0% | 0% |
| | European | 0% | 0% | 0% |
| | Hispanic/Latino | 71% | 52% | 39% |
| | Filipino | 1% | 0% | 0% |
| | Japanese | 0% | 0% | 0% |
| | Korean | 0% | 0% | 0% |
| | Middle Eastern | 0% | 0% | 6% |
| | Vietnamese | 0% | 0% | 0% |
| | Other | 0% | 3% | 9% |
| | More than one ethnicity | 10% | 11% | 0% |
| | Decline to Answer | 59% | 25% | 29% |

# Lift Program, cont.

### Program Goals

The goal of the Lift Program is to promote healthy outcomes for at risk mothers and their infants though providing home visitation services. Registered nurses provide education and resources to reduce risk factors and promote protective factors.

The goals of the Lift program are as follows:

- Improve pregnancy outcomes by helping participants obtain prenatal care from their physician and reduce cigarette, alcohol, and illegal drug use.
- Teach participants about healthy nutrition during pregnancy to improve overall mental health outcomes for mother and child.
- Improve child health and development by helping parents provide appropriate care of their children in the first two years of life.
- Guide parents on caring for and nurturing their children and provide safe and consistent child discipline practices.
- Improve maternal development by helping mothers to develop a vision and plan for their future, make reasoned choices about the partners, family, and friends involved with their child, plan future pregnancies, reach their educational goals, and find employment.

### Program Outcomes

| Method use to collect outcome | Description of method | Frequency of use | Number Completed |
|---|---|---|---|
| Maternal Fetal Attachment Scale | The Maternal Fetal Attachment Scale is a tool used to determine the attachment between a mother and her unborn child. | 1x at the beginning of services | FY 21/22: 46<br>FY 22/23: 52<br>FY 23/24: 65 |
| Life Skills Progression Tool | The Life Skills Progression is a tool used to monitor participants' strengths and needs. | 1x at the beginning of services | FY 21/22: 40<br>FY 22/23: 52<br>FY 23/24: 65 |

# Lift Program, cont.

## Outcome Discussion

Maternal Fetal Attachment Scale (MFA)

The MFA Scale is a questionnaire that assesses the bond between expectant mothers and their unborn child, with higher scores indicating stronger prenatal attachment. The MFA is administered to participants in the Lift program, and the results help identify their unique needs.

Addressing early indicators of maternal-fetal attachment enhances protective factors for both mother and baby, fostering bonding, strengthening family support, and promoting a stable, healthy home environment—all of which contribute to positive child outcomes.

Lift nurses provide individualized support based on MFA findings, focusing on areas such as mothers' willingness to forgo harmful activities, body image, future hopefulness, and reading to their unborn child. Support may include education, nurturing activities, and family counseling, which help develop more positive relationships.



Artwork by Tracey Garcia

# Lift Program, cont.

## Outcome Discussion, cont.

| Nurturing & Attachment | | | |
|---|---|---|---|
| | FY 2021/22 | FY 2022/23 | FY 2023/24 |
| I desire this baby / I'm not sorry I became pregnant | 100% | 100% | 90% |
| I am willing to give up certain things to protect my baby | 67% | 94% | 85% |
| I read to my baby / unborn child | 50% | 53% | 48% |

| Family Supports | | | |
|---|---|---|---|
| | FY 2021/22 | FY 2022/23 | FY 2023/24 |
| My mate wants this pregnancy | 0% No | 0% No | 17% No |
| My pregnancy interferes with my relationship with my mate | 33% Yes | 22% Yes | 20% Yes |
| My family supports my pregnancy | 72% Yes | 63% Yes | 77% Yes |
| My family will help in caring for my baby | 65% Yes | 82% Yes | 77% Yes |

Family support is a valuable protective factor. A new mother or expectant mother relies heavily on the support received from close family and friends during pregnancy and in the early years of the newborn's life.

The Family Supports chart indicates that over the past three years, there has been an increase in respondents reporting that their partner did not want the pregnancy, but there was a slight decrease in those who felt that their pregnancy interfered with their relationship. Participants expressing these feelings are offered family counseling to help address and reconcile them.

Feelings of family support for the pregnancy have risen during this three-year review. Involving all family members in the Lift program interventions strengthens the support system for expectant mothers throughout their pregnancy.

# Lift Program, cont.

## Outcome Discussion, cont.

### Life Skills Progression (LSP) Tool

The LSP tool captures a portrait of the behaviors, attitudes, and skills of mothers enrolled in the Lift program. It helps to establish a baseline of participant profile, identify strengths and needs, plan interventions, and monitors outcomes to show that interventions are working.

In the Lift program, the LSP is used to assess needs related to education and employment. As seen in the table below, there is a strong correlation between the education level and stable employment. In FY 2023/24, the percentage of participants with less than a high school education significantly increased from the past year which is reflected in the decrease of stable employment.

Stable employment lowers risk factors associated with poverty and unemployment while enhancing protective factors related to economic security. The Lift program supports participants by providing referrals to high school diploma completion programs. Earning a diploma boosts protective factors, including future opportunities, and increased self-esteem through accomplishment.

Additionally, the program offers referrals to the Preschool Services Department Apprenticeship program and other career training options. By securing stable employment, families improve self-esteem, self-efficacy, and overall economic security.

**Participant Education Level and Employment Stability**

| | FY 2021/22 | FY 2022/23 | FY 2023/24 |
|---|---|---|---|
| Less than high school education | 1% | 2% | 17% |
| Unemployed / work occasionally | 61% | 69% | 72% |
| Some college | 26% | 46% | 34% |
| Stable employment | 26% | 31% | 17% |

# Lift Program, cont.

### Challenges/Solutions

The LIFT team consists of 1 Supervising Nurse case manager (Vacant since August 2022) and 3 Home Visiting Registered Nurses (RN). This year LIFT had the challenges of the ongoing staffing issues where two of the three RN staff were out for extensive periods of time. This had a direct impact on recruitment efforts and put a strain on the remaining staff to manage the existing caseload.

### Lessons Learned

Despite the challenges the department learned to prioritize caseloads to continue the delivery of services to existing clients and reduced the effort of recruiting new clients as referrals continued to come in from our partnerships.

### Program Updates

This program is being evaluated for transition to early intervention program for children ages 0-5.

### Success Story

"My experience with the Lift program is good, because it came into my life when I really needed it. It gave me very valuable information that was essential at that time. Like the stages I was going through in my pregnancy, how I was preparing for the arrival of a new baby, information on good nutrition, caring for the new baby and how I should also take care of myself. Another thing I am grateful for is the financial help with some essential and safe products for the baby. I recommend this program to all pregnant mothers because it will help them gain knowledge about this new stage of their life and it will also help them financially to have the basics for the arrival of their new baby. Coni was not only [my baby's] and my nurse, she also managed to do something more for me and my [other] children because she was always there to support us."

- Participant

# Coalition Against Sexual Exploitation (CASE)

## Program Description and Target Population

CASE of San Bernardino County is a county-wide partnership dedicated to combating the commercial sexual exploitation of children (CSEC). The coalition works to educate the community, intervene with at-risk youth, and provide vital services and support to children and teens who are victims of commercial sexual exploitation. Through education and training, CASE helps raise awareness of the issue, teaches how to recognize the signs of exploitation, and ensures direct access to resources and treatment for affected youth.

The CASE team is a multidisciplinary group that includes CFS, the Public Defender's Office, and Behavioral Health, as well as attorneys from the District Attorney's Office and Public Defender's Office. In addition, probation officers, public health nurses, advocates from Court Appointed Special Advocates (CASA) and Open Door are part of the collaborative effort. Together, these professionals work to provide comprehensive services to youth who have been identified as commercially sexually exploited.

CASE's primary aim is to reduce both the number of youth who are exploited and the risk factors that contribute to exploitation. By focusing on prevention, the coalition strives to decrease these risks while strengthening protective factors for vulnerable children and teens. This multi-agency model supports state-level prevention initiatives designed to protect at-risk youth and ultimately prevent commercial sexual exploitation.

| | |
|---|---|
| **Services Offered** | • **Mental health assessments**<br>• **Crisis Intervention**<br>• **Case Management including linkage and referrals**<br>• **School enrollment assistance**<br>• **Therapeutic interventions**<br>• **Transportation assistance**<br>• **Placement consultation**<br>• **Outreach and community awareness training** |

| | |
|---|---|
| **Program Serves** | **Children, Youth, TAY** |
| **Location of Services** | Foster care placements, hospitals, schools, community settings |
| **Annual Budget FY 25/26** | $255,266 |
| **Cost Per Client FY 25/26** | $170 |

# Coalition Against Sexual Exploitation (CASE), cont.

## State Program Positive Results

The CASE program works to reduce prolonged suffering associated with untreated mental illness by recognizing signs of CSEC involvement and providing access to services early, thereby addressing risk factors and promoting protective factors. Their goals are as follows:

- Train agency staff on identifying and recognizing signs of commercial sexual exploitation of children (CSEC).
- Raise public awareness of CSEC issues.
- Raise knowledge of available community resources.
- Identify youth who are potential CSEC victims and provide access to needed resources and treatment.

Risk factors identified for CASE participants are running away, trauma exposure (e.g., history of sexual abuse and child welfare or probation system involvement), school failure/chronic absenteeism, poverty, substance use, and violence.

Protective factors for CASE participants include positive adult interactions, school/community involvement, resourcefulness, resiliency, peer relationships, optimism, leadership, and life skills. CASE prevention activities seek to address the risk factors and protective factors with the following services:

- Placement assistance, advocacy, safety planning, and CASE Youth Resource cards to help reduce the risk factors for homeless/runaway youth.
- Support, consultations, and advocacy from the San Bernardino Superintendent of Schools, Probation, and the District Attorney's office to help reduce risk factors for youth with a history of violations with truancy, curfew, and/or involvement with the juvenile justice system.
- Creation of safety plans, CFS Social Worker assignment, Child Family Team (CFT) meetings, mentor assignment, Public Health, and therapeutic services are available to youth that face sexual abuse, physical abuse, and neglect risk factors.

**Number of Participants / Number of Services Projected vs Actual**

| | Projected | Actual | | |
|---|---|---|---|---|
| | | FY 21/22 | FY 22/23 | FY 23/24 |
| Unduplicated Participants | 1,500 | 1,398 | 1,661 | 1,626 |
| Number of Services | 1,500 | 1,920 | 2,044 | 1,971 |

# Coalition Against Sexual Exploitation (CASE), cont.

### State Program Positive Results, cont.

Prevention activities include ongoing, individualized engagement between the CSEC youth and the multidisciplinary team. There were forty-two total CASE participants in FY 2023/24. The total number of participants is higher than the previous year but remains lower than the high of 58 from FY 2021/22 as shown in the table below.

| Number of Prevention Participants | | | |
|---|---|---|---|
| | FY 21/22 | FY 22/23 | FY 23/24 |
| **Unduplicated Participants** | 58 | 35 | 42 |
| **Number of participants continuing from previous year** | 40 | 24 | 25 |
| **Percentage of continuing participants** | 69% | 69% | 60% |

### Girls' Court

A prevention activity for CASE is Girls' Court, a program for at-risk females between the ages of 12 and 17 who are involved in the legal system. Girl's Court focuses on self-esteem-building and empowerment components for young women. If they complete the program successfully, their criminal records are sealed before turning 18 to alleviate further stigmatization of having prior juvenile justice involvement.

Graduation from Girls' Court requires participants to show progress in the program, meet benchmarks, and obtain supervision goals. The youth's changes demonstrate healthy lifestyle choices, self-empowerment, pro-social behavior, educational pursuits, and well being. Participation in Girls' Court reduces negative outcomes by encouraging participants to remain enrolled in school, fostering academic achievement, reducing school dropout rates and attempts to reduce recidivism and incarceration rates by the participants' commitment to healthy lifestyle choices and pro-social behavior.

| Girls' Court Completion Rate | | | |
|---|---|---|---|
| | FY 21/22 | FY 22/23 | FY 23/24 |
| **Completion Rate** | 20% | 41% | 26% |

# Coalition Against Sexual Exploitation (CASE), cont.

**State Program Positive Results, cont.**

**Outreach for Increasing Recognition of Early Signs and Symptoms of Mental Illness**

CASE uses the state strategy, outreach for increasing recognition of Early Signs and Symptoms of Mental Illness, as a way to involve child-serving agencies and the community in identifying children who may be at risk of sexual exploitation and provide information and resources on how to keep children safe.

Outreach and education efforts focus on training agency staff on identifying and recognizing signs of commercial sexual exploitation (CSE) in youth, raising public awareness of commercial sexual exploitation of children (CSEC) issues, raising knowledge of available community resources, and increasing the ability to identify youth who are potential CSE victims and provide access to needed resources and treatment.

During FY 2023/24, the CASE program provided educational outreach to 1,971 potential responders, including staff from law enforcement agencies, probation department, attorneys, school personnel, health care providers, and local area community service providers.



Artwork by Sonia Stockton

# Coalition Against Sexual Exploitation (CASE), cont.

## State Program Positive Results, cont.

In terms of being able to identify youth who are potential CSEC victims, 88% reported that they can recognize key terms relating to CSEC victims and the subculture of trafficking, and 93% now have an increased understanding of trauma bonds and identifying signs of CSEC involvement, as shown in the table below:

| Program Goals | |
|---|---|
| **Goal: Raise awareness of CSEC issues** | |
| Ability to define / describe human trafficking | 95% |
| Increased knowledge and awareness of recruiting tactics and locations | 93% |
| **Goal: Raise knowledge of available community resources** | |
| Knowledgeable about available resources for CSEC youth | 75% |
| **Goal: Identify youth who are potential CSEC victims** | |
| Able to recognize key terms relating to CSEC victims and the subculture of trafficking | 88% |
| Understanding trauma bonds / identifying signs of CSEC involvement<br><br>**N**=275 | 92% |

Early Intervention services are available to CASE participants. However, the CASE team members do not directly provide these services. The multidisciplinary team assesses, refers, and links children identified as needing early intervention support.

# Coalition Against Sexual Exploitation (CASE), cont.

## Demographics

| Fiscal Year | Age (yrs. old) | | | | |
|---|---|---|---|---|---|
| | 0-15 | 16-25 | 26-59 | 60+ | UNK |
| FY 21/22 | 0% | 11% | 20% | 1% | 68% |
| FY 22/23 | 4% | 24% | 56% | 4% | 12% |
| FY 23/24 | 3% | 27% | 52% | 2% | 3% |

| Fiscal Year | Veteran Status |
|---|---|
| | % of consumers who identified as a veteran |
| FY 21/22 | 0% |
| FY 22/23 | 3% |
| FY 23/24 | 2% |

| Fiscal Year | Sexual Orientation |
|---|---|
| | % of consumers who identified as LGBTQ+ |
| FY 21/22 | 1% |
| FY 22/23 | 4% |
| FY 23/24 | 3% |

| Fiscal Year | Disability |
|---|---|
| | % of consumers who identified a physical disability |
| FY 21/22 | 0% |
| FY 22/23 | 4% |
| FY 23/24 | 4% |

| Fiscal Year | Gender Identity | | | |
|---|---|---|---|---|
| | ♂ | ♀ | ⚧ | UNK |
| FY 21/22 | 10% | 23% | 0% | 60% |
| FY 22/23 | 16% | 33% | 1% | 50% |
| FY 23/24 | 14% | 28% | 0% | 58% |

| Fiscal Year | Primary Language | | | |
|---|---|---|---|---|
| | ENG | SPAN | OTH | UNK |
| FY 21/22 | 100% | 0% | 0% | 0% |
| FY 22/23 | 100% | 0% | 0% | 0% |
| FY 23/24 | 48% | 2% | 1% | 49% |

# Coalition Against Sexual Exploitation (CASE), cont.

**Demographics, cont.**

| | Race/Ethnicity | FY 21/22 | FY 22/23 | FY 23/24 |
|---|---|---|---|---|
| Ethnicity | African | 0% | 0% | 0% |
| | Asian Indian/South Asian | 2% | 0% | 2% |
| | Cambodian | 0% | 0% | 0% |
| | Chinese | 0% | 6% | 1% |
| | Eastern European | 0% | 0% | 1% |
| | European | 0% | 0% | 0% |
| | Hispanic/Latino | 43% | 88% | 41% |
| | Filipino | 2% | 0% | <1% |
| | Japanese | 0% | 1% | 0% |
| | Korean | 0% | 0% | 0% |
| | Middle Eastern | 0% | 1% | 0% |
| | Vietnamese | 0% | 0% | <1% |
| | Other | 0% | 3% | 58% |
| | More than one ethnicity | 0% | 1% | <1% |
| | Declined to Answer | 51% | 5% | 1% |

**Demographic Observations**

- CASE has consistently served the targeted demographics over the last three fiscal years. Females between 16 - 50 are among the highest recipients of CASE services. The demographic totals represent both Prevention and Outreach service demographics.
- Creation of the "CASE Database" enabled CASE to enter client information on a monthly basis from the beginning of Fiscal Year 2023/24.

| | Race/Ethnicity | FY 21/22 | FY 22/23 | FY 23/24 |
|---|---|---|---|---|
| Race | African-American/Black | 3% | 13% | 12% |
| | American-Indian/Alaska Native | 0% | 1% | <1% |
| | Asian | 3% | 4% | 3% |
| | Hispanic/Latinx | 2% | 10% | 0% |
| | Native Hawaiian or Pacific Islander | 0% | <1% | <1% |
| | Caucasian/White | 9% | 20% | 12% |
| | More than One Race | 0% | 0% | 7% |
| | Other Race | 0% | 6% | 2% |
| | Declined to Answer | 83% | 46% | 63% |

# Coalition Against Sexual Exploitation (CASE), cont.

## Program Goals

Reduce prolonged suffering associated with untreated mental illness:

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

Increase recognition of early signs and symptoms of mental illness:

- Raise public awareness of CSEC issues,
- Raise knowledge of available community resources, and
- Identify youth who are potential CSEC victims.

## Program Outcomes

| Method use to collect outcome | Description of method | Frequency of use | Number Completed |
|---|---|---|---|
| Continuing Engagement | Determine percentage of CSEC youth remain active on the CASE MDT roster from one year to another, demonstrating continuing engagement in the program. | 1x at beginning of new year | FY 21/22: 40<br>FY 22/23: 24<br>FY 23/24: 25 |
| Girl's Court | Girls' Court completion requires meeting program requirements including demonstration of healthy lifestyle choices, self-empowerment, pro-social behavior, educational pursuit, and well being. | 1x at completion of Girls' Court program | FY 21/22: 40%<br>FY 22/23: 21%<br>FY 23/24: 26% |
| Outreach Survey | Use survey to gauge effectiveness of educational outreach events designed to increase recognition of indicators of CSEC involvement, including understanding and awareness of trauma bonds and the effect on mental health | 1x Completed at educational outreach events | FY 21/22: 214<br>FY 22/23: 335<br>FY 23/24: 275 |

# Coalition Against Sexual Exploitation (CASE), cont.

## Outcome Discussion

### Continuing Engagement

One of the challenges associated with CSEC youth is maintaining continuing engagement. A key indicator of success is building trust and rapport with the youth and allowing them to continue to engage in needed services. One measure of success is continued participation in the CASE program. The percentage of continuing participants in FY 21/22 increased to 69% with 40 of the 58 active participants returning. In FY 22/23, although the total number of participants declined, the percentage of those who continued stayed steady, with 24 of 35 participants (69%) continuing their CASE services. In FY 23/24 the percentage of participants continuing decreased to 60%.

### Girls' Court

Girls' Court measures successful completion of program by successfully meeting goals, demonstrating healthy lifestyle choices, self-empowerment, pro-social behavior, educational pursuit, and well being. During FY 21/22, 40% of the Girls' Court participants graduated from the program, 21% during FY 22/23 and 26% in FY 23/24.

### Outreach Surveys

Outreach surveys designed to measure the effect of meeting the educational goals of the outreach presentations were implemented in FY 23/24. These surveys measure whether participants gained knowledge and awareness about key topics discussed during the presentation, including increased awareness of CSEC issues, identifying and recognizing signs of CSE in youth, raising understanding of available community resources, and improving the ability to identify youth who are potential CSE victims and provide access to needed resources and treatment. In FY 21/22, 214 surveys were completed, and 335 surveys were completed in FY 22/23 presentations with 275 being completed in FY 23/24.

# Coalition Against Sexual Exploitation (CASE), cont.

## Challenges/Solutions

Historically, CASE faces the challenge of data collection and tracking of the multitude of services each CASE client receives. Over this fiscal year, the creation of the “CASE Database” has been completed and is ready to begin tracking. As of July 1, 2023, CASE will begin to enter client information on a monthly basis.

The referral process has also been a challenge with staff changes and onboarding processes. During the recent CASE Steering Committee, the lack of new client referrals has been down, meaning one of two scenarios: 1) victimization is down and youth aren’t being exploited in San Bernardino County or 2) Appropriate evaluation/screenings of the youth coming in and out of our providers offices are not being evaluated properly resulting in low number of referrals. Ultimately, resulting in victims or potential victims not getting access to appropriate services.

## Lessons Learned

When CSEC youth are placed in single-family homes instead of group homes, they tend to stay engaged with services longer, attend school more regularly, and experience greater overall stability. The supportive environment of a single-family home seems to help these youth feel safer and more secure, leading to better outcomes in both their education and personal well-being.



Artwork by Dani Farmer

## Coalition Against Sexual Exploitation (CASE), cont.

### Success Story

This past June, a client successfully graduated high school. She graduated with A's and as the class vice president. She continues to attend Santiago College focusing on Forensic Nursing. She recently graduated from the Run 2 Rescue program and was gifted with her first car. She also secured her first job with Run 2 Rescue in which her job entails various tasks and duties. Since graduating from the program, she has been given the privilege to have a phone and learning how to set boundaries and runs the Run 2 Rescue social media page. She is looking to apply to Chapman University and is planning to live on campus next year. Run 2 Rescue and the Public Defender's office continues to be of support to this youth.

### Program Updates

There are no planned program updates for Fiscal Year 2025/26.

# Family Resource Center (FRC)

## Program Description and Target Population

Family Resource Centers (FRCs) offer a variety of Prevention and Early Intervention services supporting the health and wellness of individuals and families. FRC locations allow services to be tailored to individualized communities' specific needs and cultural requirements. Services and activities are offered at non-traditional locations, such as community centers, where other collateral services are also provided. This reduces the stigma associated with seeking mental health services, increasing the likelihood that community members will use the services.

The earlier people seek mental health intervention, the less intense treatment will be needed. People who receive early intervention learn to apply healthy coping skills and avoid reliance on unhealthy and sometimes dangerous coping mechanisms.

Family Resource Centers offer participants options to participate in activities that foster mental health, such as: raising self-awareness and practicing healthy coping skills in prevention activities; learning about signs and symptoms of mental illness to self-identify early signs; offering individual and family counseling sessions to work on problems and challenges; allowing recovery to be less difficult and time-consuming.

| Services Offered |
|---|
| • After school youth projects and activities<br>• Behavioral health education workshops<br>• Maternal mental health<br>• Personal development<br>• Skills-based education for adults<br>• Family counseling<br>• Individual therapy |

| | |
|---|---|
| **Program Serves** | **Children**<br>**TAY (16-25)**<br>**Adults**<br>**Older Adults (60+)** |
| **Location of Services** | Community |
| **Annual Budget FY 25/26** | $5,100,000 |
| **Cost Per Client FY 25/26** | $189 |

# Family Resource Center (FRC), cont.

### State Program Positive Results

FRCs provide a mix of Prevention and Early Intervention activities to promote mental wellness.

Prevention activities focus on reducing risk factors and building protective factors. FRCs offer parenting classes, NCTI Crossroads© workshops, art programs, computer skills training, resume and job search assistance, and help with accessing basic needs. These programs aim to strengthen relationships, foster community engagement, develop coping skills, and promote healthy lifestyles, all contributing to resilience and self-sufficiency.

Outreach services educate community stakeholders—such as service providers, families, law enforcement, healthcare providers, and school staff—on recognizing early signs of mental illness. Initiatives like community film screenings and expert Q&A sessions help raise awareness of mental health issues.

Early Intervention activities focus on recovery through therapeutic services, including individual counseling, family counseling, group therapy, and relapse prevention. The tables to the right outline projected and actual participant numbers and services provided annually.

**Number of Participants / Number of Services Projected vs Actual**

| | Projected | Actual | | |
|---|---|---|---|---|
| | | FY 21/22 | FY 22/23 | FY 23/24 |
| **Unduplicated Participants** | 26,945 | 28,355 | 36,383 | 43,992 |
| **Number of Services** | 51,011 | 39,861 | 47,207 | 35,971 |

**Potential Responders Reached**

| | FY 2021/22 | FY 2022/23 | FY 2023/24 |
|---|---|---|---|
| Number of Potential Responders Reached | 17,714 | 16,927 | 8,795 |

# Family Resource Center (FRC), cont.

### State Program Positive Results, cont.

### Access & Linkage to Services

FRCs offer access to and connections with services for participants requiring treatment beyond early intervention. Those needing more intensive care are referred to appropriate service providers that can address their needs. Many FRCs facilitate “warm hand-offs” to higher-level providers by making advance calls or providing in-person introductions, ensuring participants can easily connect with their referral partners.

FY 23/24 saw a significant increase in referrals. This rise is linked to a growing demand for mental health services that exceed basic care, with many providers pointing to the need arising from the after-effects of the pandemic. The table below shows the number of participants who received access and linkage referrals in the past three fiscal years.

| Access and Linkage to Services Referrals | | | |
|---|---|---|---|
| | FY 2021/22 | FY 2022/23 | FY 2023/24 |
| Number of Referrals Provided | 52 | 46 | 162 |
| Number of referrals to County-funded / administered programs | 7 | 8 | 117 |
| Number of referrals to other programs | 45 | 38 | 45 |
| Number of participants who followed through and engaged in services at a County-funded / administered program at least once | 42 | 18 | 66 |

# Family Resource Center (FRC), cont.

## State Program Positive Results, cont.

### Improving Timely Access

FRCs work to improve timely access to mental health services for members of historically underserved populations by providing referrals to appropriate prevention, early intervention, and/or higher-level care services as needed. Members of historically underserved populations include individuals who are so poorly served that they are at risk of homelessness, institutionalization, incarceration, out-of-home placement, as well as members of ethnic/racial, cultural, and linguistic populations that to not have access to mental health programs due to barriers such as poor identification of their mental health needs, poor engagement and outreach, limited language access, and lack of culturally competent services. FRCs actively work to identify and engage individuals in need and provide referrals that meet their mental health care needs in a culturally relevant manner.

In FY 22/23, a FRC service provider identified and implemented an alternate method for collecting information. This adjustment significantly contributed to the surge in number of referrals aimed at improving timely access. Continuing this method of data gathering into FY 23/24 has yielded more accurate results and indicated an increase in the number of referrals provided. PEI is currently collaborating with other providers to explore avenues for integrating comparable modifications, with the objective of optimizing the capture of such referrals.

| Improving Timely Access Referrals | | | |
|---|---|---|---|
| | FY 2021/22 | FY 2022/23 | FY 2023/24 |
| Number of Referrals Provided | 209 | 1,318 | 1,635 |

## Family Resource Center (FRC), cont.

### Demographics

| Fiscal Year | Age (yrs. old) | | | | |
|---|---|---|---|---|---|
| | 0-15 | 16-25 | 26-59 | 60+ | UNK |
| FY 21/22 | 9% | 4% | 19% | 1% | 67% |
| FY 22/23 | 21% | 7% | 35% | 3% | 95% |
| FY 23/24 | 17% | 8% | 27% | 7% | 41% |

| Fiscal Year | Veteran Status |
|---|---|
| | % of consumers who identified as a veteran |
| FY 21/22 | <1% |
| FY 22/23 | <1% |
| FY 23/24 | <1% |

| Fiscal Year | Sexual Orientation |
|---|---|
| | % of consumers who identified as LGBTQ+ |
| FY 21/22 | <1% |
| FY 22/23 | <1% |
| FY 23/24 | <1% |

| Fiscal Year | Disability |
|---|---|
| | % of consumers who identified a physical disability |
| FY 21/22 | 2% |
| FY 22/23 | 2% |
| FY 23/24 | 3% |

| Fiscal Year | Gender Identity | | | |
|---|---|---|---|---|
| | ♂ | ♀ | ⚧ | UNK |
| FY 21/22 | 12% | 30% | <1% | 57% |
| FY 22/23 | 17% | 31% | <1% | 52% |
| FY 23/24 | 18% | 33% | <1% | 49% |

| Fiscal Year | Primary Language | | | |
|---|---|---|---|---|
| | ENG | SPAN | OTH | UNK |
| FY 21/22 | 71% | 16% | 11% | 2% |
| FY 22/23 | 65% | 18% | <1% | 17% |
| FY 23/24 | 68% | 11% | <1% | 28% |

## Family Resource Center (FRC), cont.

**Demographics, cont.**

| | Race/Ethnicity | FY 21/22 | FY 22/23 | FY 23/24 |
|---|---|---|---|---|
| Race | African-American/Black | 3% | 7% | 6% |
| | American-Indian/Alaska Native | 3% | 2% | 1% |
| | Asian | 1% | 2% | 1% |
| | Hispanic/Latinx | 12% | 31% | 28% |
| | Native Hawaiian or Pacific Islander | 0% | <1% | <1% |
| | Caucasian/White | 4% | 3% | 21% |
| | More than One Race | 4% | 19% | 4% |
| | Other Race | 14% | 12% | 6% |
| | Declined to Answer | 19% | 42% | 33% |

| | Race/Ethnicity | FY 21/22 | FY 22/23 | FY 23/24 |
|---|---|---|---|---|
| Ethnicity | African | 1% | 3% | 2% |
| | Asian Indian/South Asian | 0% | 1% | <1% |
| | Cambodian | 0% | 0% | <1% |
| | Chinese | 0% | <1% | <1% |
| | Eastern European | 0% | <1% | <1% |
| | European | 9% | 10% | 9% |
| | Hispanic/Latinx | 38% | 31% | 10% |
| | Filipino | 0% | <1% | <1% |
| | Japanese | 0% | <1% | <1% |
| | Korean | 0% | <1% | <1% |
| | Middle Eastern | 0% | <1% | <1% |
| | Vietnamese | 0% | <1% | <1% |
| | Other | 18% | 30% | 14% |
| | More than one ethnicity | 5% | 4% | 2% |
| | Declined to Answer | 66% | 20% | 53% |

**Demographic Observations**

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

# Family Resource Center (FRC), cont.

## Program Goals

The goal of the FRC program is to alleviate prolonged suffering from untreated mental illness. Prevention efforts focus on identifying risk factors, lowering indicators, and enhancing protective factors to improve mental, emotional, and relational functioning. Early intervention provides counseling and treatment that reduces symptoms and supports recovery. Additional objectives include reducing stigma around mental illness and enhancing access to services by connecting participants with severe mental health needs to necessary care, particularly for historically underserved populations.

| Method use to collect outcome | Description of method | Frequency of use | Number Completed |
|---|---|---|---|
| Children and Adolescent Needs and Strengths Assessment (CANS) | CANS is a multi-purpose tool developed for children's services to support decision-making, including level of care and service planning. | Intake, 3 months, Discharge, Significant life events | FY 21/22: 211<br>FY 22/23: 312<br>FY 23/24: 348 |
| Adult Needs and Strengths Assessment (ANSA) | A comprehensive assessment of psychological and social factors used for treatment planning. This assessment measures functioning in several important life domains and helps to support decision making and level of care and service planning, and ensure projected goals are being met. | Intake, 3 months, Discharge, Significant life events | FY 21/22: 130<br>FY 22/23: 237<br>FY 23/24: 241 |
| NCTI Crossroads © | A complete behavioral change system delivered in a group format, following a precise sequence that leads participants from a general level of discussion to a specific behavioral commitment. | 2 times Initial & completion | FY 21/22: 98<br>FY 22/23: n/a*<br>FY 23/24: 102 |
| Life Skills Progression (LSP) | Assesses the strengths and needs of families participating in the Family Support program. The LSP measures 35 parental skills in areas such as relationships, resources, medical health, mental health, and basic essentials. | 2 times Initial & completion | FY 21/22: 154<br>FY 22/23: 193<br>FY 23/24: 228 |

* Due to licensing issues, no data is available for FY 2022/23.

# Family Resource Center (FRC), cont.

### Outcome Discussion

Early Intervention activities such as individual and family counseling offer therapeutic services such as cognitive behavioral therapy and solution-focused therapy. Outcomes are measured using the Child and Adolescent Needs and Strengths – San Bernardino (CANS-SB) Assessments and Adult Needs and Strengths Assessments – San Bernardino County (ANSA-SB).

### Child and Adolescent Needs and Strengths Assessment (CANS)

The Child and Adolescent Needs and Strengths (CANS) assessment is an evidence-based, multi-purpose tool that helps develop the level of care and service planning and allows for the monitoring of outcomes of services. The table below shows that children and youth participating in FRCs early intervention activities have made improvements in these domains.

Children and youth availing of FRC resources a face a variety of challenges. The following tables show some of the most prevalent subdomains and the corresponding rates of improvement. In FY 2023/24, the Strengths Domains saw slight decline from the previous years, whereas the Life Functioning and Behavioral Health Domains both saw increases in comparison to results from previous years.

| Child and Adolescent Needs and Strengths<br>Improvement in Primary Domains | | | |
|---|---|---|---|
| | FY 21/22 | FY 22/23 | FY 23/24 |
| Life Functioning Domain | 45.5% | 43.1% | 44.2% |
| Strengths Domain | 84% | 79.1% | 78.9% |
| Behavioral Health Needs Domain | 42.3% | 37.4% | 43.9% |

# Family Resource Center (FRC), cont.

## Outcome Discussion, cont.

### Child and Adolescent Needs and Strengths Assessment (CANS), cont.

| Child and Adolescent Needs and Strengths Improvement in Subdomains | | | |
|---|---|---|---|
| | FY 21/22 | FY 22/23 | FY 23/24 |
| Life Functioning Domain | | | |
| Family Functioning | 76% | 61% | 74% |
| Social Functioning | 75% | 80% | 80% |
| School Achievement | 61% | 72% | 61% |
| Strengths Domain | | | |
| Family Strengths | 70% | 59% | 50% |
| Interpersonal | 70% | 69% | 63% |
| Resiliency | 70% | 76% | 68% |
| Resourcefulness | 69% | 61% | 64% |
| Behavioral Health Needs | | | |
| Depression | 83% | 74% | 70% |
| Anxiety | 71% | 68% | 77% |
| Anger Control | 71% | 63% | 71% |
| Risk Behaviors | | | |
| Suicide Risk | 85% | 71% | 86% |
| Non-Suicidal, Self-Injurious Behavior | 72% | 72% | 75% |

### Adult Needs and Strengths Assessment (ANSA)

The ANSA is a multi-purpose tool developed for adult behavioral health services to support decision-making, including the level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. The ANSA helps care providers decide which of an individual's needs are the most important to address in a treatment plan. The ANSA also helps to identify strengths.

Overall, adults participating in the FRCs' early intervention activities whose treatment sessions opened and closed within the same fiscal year made improvements. The chart below shows that there has been a steady increase across all three domains with FY 23/24 showing the highest improved percentages.

| Adult Needs and Strengths Improvement in Primary Domains | | | |
|---|---|---|---|
| | FY 21/22 | FY 22/23 | FY 23/24 |
| Life Functioning Domain | 62.9% | 76.8% | 83.4% |
| Strengths Domain | 59.3% | 74.2% | 80% |
| Behavioral Health Needs Domain | 61.1% | 73.2% | 79.4% |

# Family Resource Center (FRC), cont.

## Outcome Discussion, cont.

### Adult Needs and Strengths Assessment (ANSA), cont.

In FY 2023/24, struggles with decision-making and judgement were common issues among adults. Out of 83 individuals with these concerns, 90% showed improvement in this skill.

**Adult Needs and Strengths Improvement in Subdomains**

| | FY 21/22 | FY 22/23 | FY 23/24 |
|---|---|---|---|
| Life Functioning Domain | | | |
| Family Functioning | 59% | 71% | 81% |
| Social Functioning | 64% | 77% | 85% |
| Decision-Making/Judgment | 76% | 89% | 90% |
| Parenting Roles | 63% | 83% | 88% |
| Strengths Domain | | | |
| Family Strengths/Family Support | 55% | 66% | 60% |
| Community Connection | 42% | 76% | 85% |
| Natural Supports | 37% | 73% | 78% |
| Resiliency | 70% | 79% | 84% |
| Resourcefulness | 64% | 77% | 89% |
| Behavioral Health Needs Domain | | | |
| Depression | 69% | 84% | 91% |
| Anxiety | 60% | 80% | 86% |
| Adjustment to Trauma | 58% | 82% | 88% |
| Eating Disturbances | 68% | 89% | 91% |

### National Curriculum and Training Institute (NCTI)

Participants engaged in a variety of NCTI courses with topics including anger management, cognitive life skills, substance use and alcohol, and parenting.

The knowledge gained in courses such as cognitive life skills and parenting intends to improve communication and family relationships, which results in increased protective factors.

The knowledge gained in the alcohol and substance use courses intends to reduce use and dependence on substances, resulting in a reduction of risk factors.

**NCTI Percent Improvement All Courses**

| | Average Pre-Test | Average Post-Test | Percent Improvement |
|---|---|---|---|
| **FY 21/22** | 5.73 | 9.46 | 65% |
| **FY 22/23** | n/a* | n/a* | n/a* |
| **FY 23/24** | 5.11 | 19.62 | 41.46% |

* Due to licensing issues, no data is available for FY 22/23.

# Family Resource Center (FRC), cont.

### Outcome Discussion, cont.

#### Life Skills Progression (LSP)

LPS surveys gather detailed family information through interviews and observations. They're completed at intake to assess family strengths and needs and again at the end of services to track progress. LSP measures growth in relationships, resources, medical and mental health, and essentials crucial for mental well-being. The outcomes, indicating average percent increases in these areas over the past three years, are detailed in the table below.

| Life Skills Progression Percent Improvement | | | |
|---|---|---|---|
| | FY 21/22 | FY 22/23 | FY 23/24 |
| Relationships | 13.8% | 13.5% | 23% |
| Resources | 29.0 | 18.1% | 44% |
| Medical | 8.6% | 8.5% | 15% |
| Mental Health | 37.9% | 18.0% | 36% |
| Basic Essentials | 10.9% | 12.8% | 14% |

### Challenges/Solutions

A common challenge faced by the FRCs is inconsistent staffing and training, which can directly effect service delivery and program effectiveness. Frequent turnover and vacancies, along with the extensive training needed by staff to engage in community work, have resulted in delays and a slow start in providing services. The rising demand for mental health support and the limited availability of providers.

To address the challenge of inconsistent staffing and training, the FRCs have increased efforts to hire and quickly onboard new staff in key roles to assist in a continuation of services supporting their communities.

### Lessons Learned

Since the years following the COVID pandemic, there has been an increase in the demand for mental health services. Recognizing this growing need, the FRCs have made concerted efforts to raise awareness of the mental health resources available to the community.

These initiatives include outreach programs aimed at educating the community about the range of services offered and extend their reach by partnering with local schools and organizations.

## Family Resource Center (FRC), cont.

### Success Story

Client sought therapy for grief after the suicide of her grandson whom she was the primary adult caretaker. Client utilized grief group, grief workshops, faith-based women's conferences along with therapy to heal from the pain, find meaning in his suicide, and became trained in a faith-based program for a grief group which she implemented at a local church. Client expanded her world beyond the life and death of her grandson and began to do the things on her bucket list.




### Program Updates

PEI FRC is expanding their services to include a Family Wellness Center (FWC). The FWC expansion will include prevention and early intervention services as well as Specialty Mental Health Services for children, youth, and adults with mental health concerns.

# Community Wholeness and Enrichment (CWE)

### Program Description and Target Population

The CWE program is categorized as a Prevention and Early Intervention program. CWE identifies and helps to manage the early onset of mental health symptoms in transitional age youth (TAY) ages 16-25 and adults ages 26-59 who are experiencing the initial onset of a mental or emotional illness and/or substance use disorder.

The primary goal of the CWE program is to address mental health disorders early in their onset, utilizing the prevention and early intervention services to prevent the onset or reduce the severity of a mental illness. Although prevention and early intervention can be implemented over the lifespan, the benefits are maximized when people are targeted at or around the time of onset of a mental disorder. Utilizing stakeholder feedback and community needs assessments, CWE providers work closely with their communities to understand their needs and ensure they are met. CWE services include screenings, assessments, therapeutic treatment, resources, and education.

TAY, adults, and/or their family members are considered eligible for CWE programs based on risk factors for developing a potentially serious mental illness. CWE providers can evaluate a participant's risk factors using various screenings, including the immediate needs screening tool. The screenings also address experience with mental health, including past services received, to determine the participant's current mental health needs.

| | |
|---|---|
| **Services Offered** | • **Screenings/Assessments**<br>• **Case Management, Linkage and Referrals**<br>• **Support Groups (includes suicide bereavement)**<br>• **Mental Health Education**<br>• **Early Intervention Counseling Services** |

| | |
|---|---|
| **Program Serves** | **TAY (16-25)**<br>**Adults (26-59)** |
| **Location of Services** | Central Valley, Desert/Mountain, East Valley, West Valley |
| **Annual Budget FY 25/26** | $1,075,000 |
| **Cost Per Consumer FY 25/26** | $182 |

# Community Wholeness and Enrichment (CWE), cont.

## Program Highlights

CWE is a program that focuses on prevention and early intervention. In addition to these services, the program provides suicide prevention and outreach education. The program uses strategies to increase and improve linkage and timely access to services to ensure participants are connected to appropriate services. These strategies include assessments and case management.

## Prevention and Early Intervention

Early onset of mental illness can be linked to risk factors such as trauma, stressful life events, and isolation. The CWE program focuses on prevention through supportive groups and offers topics like relapse prevention, depression, anxiety, and suicide bereavement support. Early intervention services include evidence-based treatments, therapies, and relapse prevention services to promote early recovery and functional outcomes for mental illness. The chart below shows the number of participants that received prevention and early intervention services.

| Prevention | Projected | FY 2021/22 | FY 2022/23 | FY 2023/24 |
|---|---|---|---|---|
| Unduplicated Participants | 2,956 | 3,634 | 2,091 | 2,572 |
| Number of Services | 7,809 | 8,306 | 6,052 | 5,668 |

| Early Intervention | Projected | FY 2021/22 | FY 2022/23 | FY 2023/24 |
|---|---|---|---|---|
| Unduplicated Participants | 2.958 | 1,624 | 2,429 | 1,372 |
| Number of Services | 4,824 | 1,186 | 853 | 3,248 |

# Community Wholeness and Enrichment (CWE), cont.

## Program Highlights, cont.

The CWE program seeks continuous solutions, such as telehealth services, to boost the percentage of participants achieving their treatment goals. The table below shows the number of episodes opened and closed, and the proportion of participants who met their treatment goals for each fiscal year.

**Treatment Success by Fiscal Year**

| | Total Episodes | Closed Episodes | % Met Goals |
|---|---|---|---|
| FY 2021/22 | 399 | 264 | 53% |
| FY 2022/23 | 430 | 289 | 67% |
| FY 2023/24 | 352 | 187 | 42% |

### Outreach

The CWE engages new participants and educates potential responders about the signs and symptoms of mental illness, as well as to recognize their symptoms and seek services if needed. These outreach services allow individuals to identify signs and symptoms in their friends, family, and themselves, leading to a greater likelihood of seeking services for behavioral health needs.

The following table illustrates the number of potential responders reached and the types of settings where outreach occurred over the last three fiscal years.

The community is actively adjusting to changing circumstances and while there has been a decrease in engagement, the data for FY 2023/24 presents an opportunity for us to identify areas for improvement and enhance community involvement moving forward.

**Potential Responders Reached**

| | FY 2021/22 | FY 2022/23 | FY 2023/24 |
|---|---|---|---|
| Potential Responders | 1,040 | 1,648 | 1,033 |

**Outreach**
**Types of Responders / Settings**

| Types of Responders | Settings |
|---|---|
| • Community service providers<br>• Families<br>• Employers<br>• Primary health care providers<br>• School personnel<br>• Leaders of faith-based organizations<br>• Peer providers<br>• Consumer family members | • Community events<br>• Community-based organizations<br>• Social media outreach<br>• County facilities<br>• Family resource centers<br>• Faith-based organizations<br>• Schools<br>• Virtual platforms |

# Community Wholeness and Enrichment (CWE), cont.

## Program Highlights, cont.

### Access & Linkage

The CWE program targets those with early-onset behavioral illness. The program is also designed to serve participants with serious mental illness. So, while the program does utilize the Access and Linkage to Treatment strategy, CWE providers need to link individuals to a higher level of care. The CWE program made 10 referrals to treatment beyond early onset over the last three fiscal years. These individuals were engaged in the program.

### Improve Timely Access to Treatment

### Access & Linkage

The CWE program targets those with early-onset behavioral illness. The program is also designed to serve participants with serious mental illness. So, while the program does utilize the Access and Linkage to Treatment strategy, CWE providers need to link individuals to a higher level of care. The CWE program made 10 referrals to treatment beyond early onset over the last three fiscal years. These individuals were engaged in the program.

| Improve Timely Access to Services | | | |
|---|---|---|---|
| | FY 2021/22 | FY 2022/23 | FY 2023/24 |
| Number of Referrals | 1 | 0 | 10 |
| Participants Engaged | 0 | 0 | 10 |
| Average # of Days Participant Engaged | 0 | 0 | 0 |

Within the Improve Timely Access strategy, CWE providers served the following underserved populations:

| Underserved Populations | |
|---|---|
| • Trauma-exposed<br>• Co-occurring<br>• Justice-involved<br>• TAY foster children | • LGBTQ+<br>• Homeless<br>• African American/Black<br>• Latinx/Hispanic |

# Community Wholeness and Enrichment (CWE), cont.

## Program Highlights, cont.

### Suicide Prevention

One primary focus of the CWE program is to provide support for suicide. This includes providing services that are centered around the prevention of suicides. The program distributes information to the community on the signs and symptoms of someone who may be at risk of suicide.

In addition, the program organizes specific educational opportunities to learn more about suicide prevention. They provide access to gatekeeper training such as Applied Suicide Intervention Skills Training (ASIST), SafeTALK, and Question, Persuade, Refer (QPR) to build the communities' capacity to respond to a suicide-related crisis. They also customize suicide prevention training for the specific needs of the community. Community member organizations can reach out to the program and request individualized training for specific communities.

The long-term effects of COVID-19 created challenges in providing suicide prevention training. Providers continue to offer virtual training and utilize curriculums that could be delivered in a virtual platform, such as QPR, to increase participation.

Providers of the CWE program have trained a total of 799 individuals in suicide prevention over the last three fiscal years.

| Suicide Prevention Trainings | | | |
|---|---|---|---|
| | FY 2021/22 | FY 2022/23 | FY 2023/24 |
| Unduplicated Participants | 150 | 304 | 345 |

## Community Wholeness and Enrichment (CWE), cont.

### Demographics

| Fiscal Year | Age (yrs. old) | | | | |
|---|---|---|---|---|---|
| | 0-15 | 16-25 | 26-59 | 60+ | UNK |
| FY 21/22 | <1% | 11% | 28% | <1% | 60% |
| FY 22/23 | <1% | 14% | 40% | <1% | 45% |
| FY 23/24 | <1% | 16% | 55% | <1% | 27% |

| Fiscal Year | Veteran Status |
|---|---|
| | % of consumers who identified as a veteran |
| FY 21/22 | <1% |
| FY 22/23 | <1% |
| FY 23/24 | <1% |

| Fiscal Year | Sexual Orientation |
|---|---|
| | % of consumers who identified as LGBTQ+ |
| FY 21/22 | 0% |
| FY 22/23 | <1% |
| FY 23/24 | <1% |

| Fiscal Year | Disability |
|---|---|
| | % of consumers who identified a physical disability |
| FY 21/22 | 3% |
| FY 22/23 | <1% |
| FY 23/24 | <1% |

| Fiscal Year | Gender Identity | | | |
|---|---|---|---|---|
| | ♂ | ♀ | ⚧ | UNK |
| FY 21/22 | 7% | 18% | 0% | 75% |
| FY 22/23 | 10% | 23% | 1% | 66% |
| FY 23/24 | 17% | 38% | 4% | 41% |

| Fiscal Year | Primary Language | | | |
|---|---|---|---|---|
| | ENG | SPAN | OTH | UNK |
| FY 21/22 | 80% | 17% | 0% | 3% |
| FY 22/23 | 76% | 15% | 0% | 9% |
| FY 23/24 | 68% | 29% | 0% | 3% |

# Community Wholeness and Enrichment (CWE), cont.

**Demographics, cont.**

### Demographic Observations

The CWE program primarily serves Transitional Age Youth (TAY) and adults, aligning with its target population. Mental health concerns are especially prevalent among TAY and young adults, a group facing significant stressors such as new responsibilities, role changes, and financial pressures. Early identification and comprehensive assessments are critical for providing appropriate services and ensuring better outcomes.

In the past three fiscal years, the program has consistently served nearly twice as many females as males, which is in line with research showing that mental illness is more prevalent among females than males. As of 2024, approximately 38% of females experienced mental illness in the previous year, compared to 17% of males. Commonly diagnosed conditions include depression, anxiety, and mood disorders.



Artwork by Carolyn Brown

# Community Wholeness and Enrichment (CWE), cont.

**Demographics, cont.**

| | Ethnicity/Race | FY 21/22 | FY 22/23 | FY 23/24 |
|---|---|---|---|---|
| Race | African American/Black | 5% | 2% | 5% |
| | American-Indian/Alaska Native | <1% | <1% | <1% |
| | Asian | <1% | <1% | <1% |
| | Native Hawaiian/Pacific Islander | <1% | <1% | <1% |
| | Latinx/Hispanic | 29% | 15% | 42% |
| | Caucasian/White | 15% | 12% | 14% |
| | More than One Race | 4% | 2% | 7% |
| | Other | 23% | 3% | 11% |
| | Declined to Answer | 52% | 65% | 36% |

| | Ethnicity/Race | FY 21/22 | FY 22/23 | FY 23/24 |
|---|---|---|---|---|
| Ethnicity | African | 0% | <1% | 3% |
| | Asian Indian/South Asian | <1% | 0% | <1% |
| | Cambodian | 0% | 0% | 0% |
| | Chinese | <1% | 0% | <1% |
| | Eastern European | 0% | <1% | <1% |
| | European | 3% | 10% | 14% |
| | Hispanic/Latino | 29% | 15% | 42% |
| | Filipino | <1% | <1% | <1% |
| | Japanese | 0% | 0% | 0% |
| | Korean | 0% | 0% | 0% |
| | Middle Eastern | <1% | 0% | <1% |
| | Vietnamese | 0% | 0% | <1% |
| | Other | 5% | 3% | 11% |
| | More than One Ethnicity | 1% | 7% | 7% |
| | Declined to Answer | 61% | 79% | 36% |

# Community Wholeness and Enrichment (CWE), cont.

## Program Goals

The primary objective of the CWE program is to address mental health disorders early on in their development by utilizing prevention and early intervention services to avert or lessen the severity of mental disorders.

Prevention and Early intervention throughout a person's lifetime can yield the greatest benefits, particularly when young people are at or near the onset of mental health disorders. To identify and help manage early mental health symptoms, the CWE program uses collaborative approaches and short-term interventions.

The CWE program services reduce and prevent crises by providing support early in the emergence of a mental health concern.

They also provide support and education to the families. These services include information on how to support a family member who is experiencing a mental health crisis.

Respite care is an important element of this program. Family members are provided with information on identifying the signs and symptoms of a potential mental health concern. They have access to services that can help reduce the stressors associated with caring for a loved one suffering from mental disorders.

## Program Outcomes

| Method use to collect outcome | Description of method | Frequency of use | Number Completed |
|---|---|---|---|
| Adult Needs and Strengths Assessment (ANSA) | A comprehensive assessment of psychological and social factors is used for treatment planning. This assessment measures functioning in several important life domains and helps to support decision-making, level of care and service planning, and ensuring projected goals are being met. | • Intake<br>• 3 months<br>• Discharge<br>• Significant life events | FY 21/22: 234<br>FY 22/23: 244<br>FY 23/24: 171 |

# Community Wholeness and Enrichment (CWE), cont.

## Outcome Discussion

The CWE program uses the Adult Needs and Strengths Assessment – San Bernardino County (ANSA-SB) to measure the outcomes of early intervention treatments.

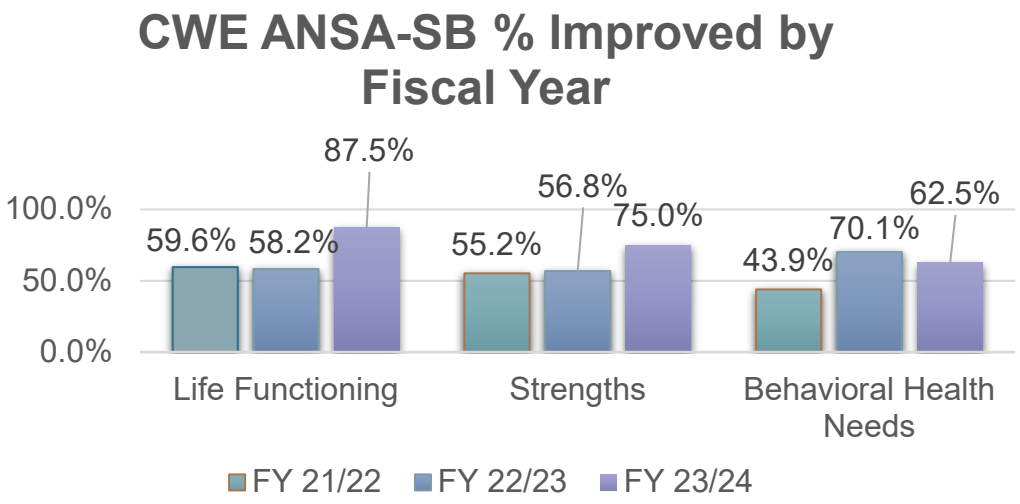
ANSA-SB is an information integration tool for adults with behavioral health challenges. It supports individual case planning and the planning and evaluation of service systems. Each dimension is rated on a four-point scale when the ANSA-SB is administered. It is administered at intake and at three-month intervals until discharge.

The ANSA-SB measures the readiness of early intervention participants to engage in services. CWE focuses on three primary domains:

- The Life Functioning domain evaluates factors like an individual's family relationships, social functioning, decision-making, self-care, and knowledge of illness.
- Strengths domain evaluates factors like family support, optimism, interpersonal, social connectedness, relationship permanence, vocational, and resilience.
- Behavioral Health Needs, which evaluates factors like thought disorders, depression, anxiety, antisocial behavior, adjustment to trauma and substance use.

There was a slight decline in life functioning from FY 21/22 to FY 22/23. However, there was a significant improvement in FY 23/24.
There was a steady improvement in strengths over the three fiscal years, with a notable increase in FY 23/24.
Behavioral health needs increased significantly from FY 21/22 to FY 22/23 and declined in FY 23/24.

The data shows significant advancements in all areas when comparing Fiscal Year 2022/2023 to Fiscal Year 2023/2024. The most notable progress is seen in life functioning and personal strengths, indicating a positive overall well-being and capability trend.



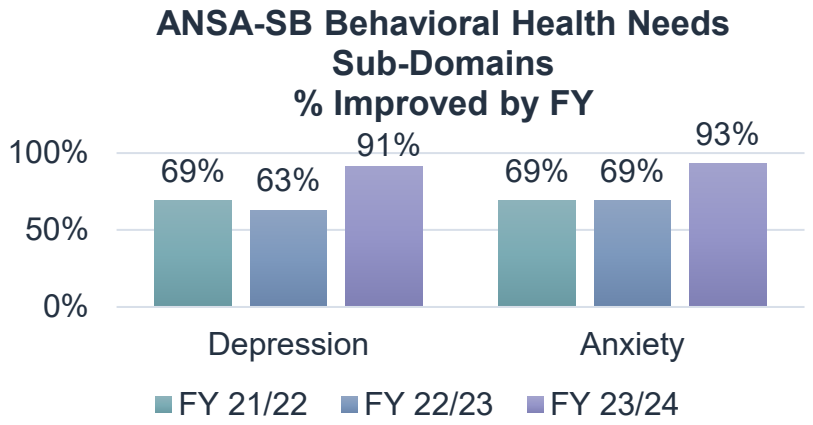
# Community Wholeness and Enrichment (CWE), cont.

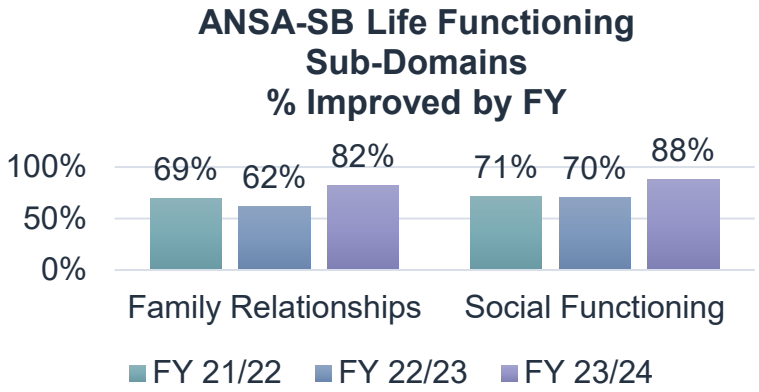
**Outcome Discussion, cont.**

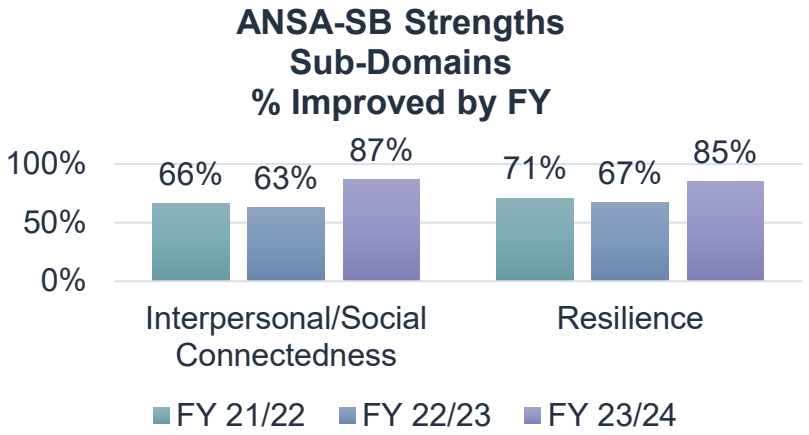
Each domain contains sub-domains that measure:

- Depression,
- Anxiety,
- Family Relationships,
- Social Functioning,
- Interpersonal/Social Connectedness, and
- Resilience.

These subdomains were found to align most closely with the goals of the CWE program. The charts on this page illustrate the percentage of improvement in each domain. The upgrades are indicators that the interventions provided by the program helped to avert or lessen the severity of a mental disorder.



# Community Wholeness and Enrichment (CWE), cont.

## Challenges/Solutions

The primary challenge identified by CWE providers pertains to the stigma associated with seeking mental health services and offering support groups for the loved ones of individuals with a mental health disorder. Engaging family members, particularly in suicide bereavement groups, has proven to be difficult. Stakeholder feedback has indicated that the community perceives group settings as intimidating.

CWE providers are working to strengthen their connections with the community to ensure that people are aware of all the services they offer, including support groups. They are partnering with community organizations and providing education to reduce the stigma surrounding mental health, especially in relation to suicide. The CWE program will continue to advocate for the importance of attending a suicide bereavement group for survivors of those who have lost a loved one to suicide.

## Lessons Learned

PEI has identified that managing CWE data within the agencies over the past three fiscal years has presented challenges regarding retrieval and analysis. Providers are committed to enhancing their data management processes in the future to ensure easier accessibility for themselves and DBH.

### Success Story

The client, a 19-year-old female, had a history of abuse from her father and was struggling with depression following EMDR therapy for PTSD. She exhibited symptoms such as fatigue, loss of interest in activities, hopelessness, and feelings of worthlessness.

During depressive episodes, she isolated herself and frequently cried, expressing frustration over her emotions. She also reported overthinking and engaging in impulsive behaviors like partying and seeking male attention when feeling low. Her goals included reducing isolation and improving boundaries.

Through therapy, she learned to reframe negative thoughts, develop healthier coping strategies, and set better boundaries with family and friends.

### Program Updates

There are no planned program updates for Fiscal Year 2025/26.

# Military Services and Family Support (MSFS)

## Program Description and Target Population

The MSFS program is a Prevention and Early Intervention program that targets active-duty military service members of all branches, veterans, and retired military personnel and their families.

This program addresses the challenges military members and their families face due to circumstances unique to military life. Due to the stigma of mental health discussion in the military community, it can be difficult for those experiencing a mental health concern to seek help as they fear retaliation, loss of job/status, or embarrassment.

Through mental health promotion activities and building relationships with the military communities, the MSFS program can offer and assure confidential services. Services are offered in any setting that makes the individual comfortable, including individual's homes or nearby public places.

MSFS providers utilize stakeholder feedback and community needs assessments to work closely with their communities to understand their needs and ensure they are met.

MSFS services include screenings and assessments, therapeutic treatment, resources and education.

| | |
|---|---|
| **Services Offered** | • Mental Health Education<br>• Mental Health/Substance Use Disorder screenings<br>• Case Management and Referrals<br>• Psychoeducation<br>• Counseling Services<br>• Suicide Prevention |

| | |
|---|---|
| **Program Serves** | **Children**<br>**TAY (16-25)**<br>**Adults**<br>**Older Adults (60+)** |
| **Location of Services** | Central Valley, Desert/Mountain, East Valley |
| **Annual Budget FY 25/26** | $725,000 |
| **Cost Per Client FY 25/26** | $186 |

## Military Services and Family Support (MSFS), cont.

### State Program Positive Results

The MSFS program is categorized as a Prevention and Early Intervention program. In addition to prevention and early intervention services, the program offers outreach education and suicide prevention. The MSFS program utilizes the Access and Linkage and Improve Timely Access strategies to ensure individuals are linked to the necessary services to meet their needs. In the past 3 years, the program has consistently exceeded its goals.

| Number of Individuals / Number of Services Projected vs Actual | | | | |
|---|---|---|---|---|
| | Projected | Actual | | |
| | | FY 21/22 | FY 22/23 | FY 23/24 |
| Unduplicated Individuals | 3,605 | 6,091 | 3,480 | 3,917 |
| Number of Services | 6,990 | 10,168 | 7,118 | 7,701 |

### Prevention

The risk factors associated with military service include experience of trauma, isolation, moral injury, substance use, and stress.

To combat these risk factors, prevention services seek to build protective factors in individuals, including supportive care, inclusion, and services relevant to military experience.

The table shows prevention individuals and services by fiscal year. The program depends on local military bases for access to service members and military families. The program continues to build rapport with new military base leadership.

| Prevention Individuals / Services | | | |
|---|---|---|---|
| | FY 2021/22 | FY 2022/23 | FY 2023/24 |
| Unduplicated Individuals | 292 | 414 | 400 |
| Number of Services | 1,100 | 1,344 | 1,350 |

# Military Services and Family Support (MSFS), cont.

## State Program Positive Results, cont.

### Outreach

The MSFS program provides engaging outreach services that educate and train potential responders to recognize and respond to early signs of potentially severe and disabling mental illness.

Providing outreach services to this at-risk group helps responders recognize signs in themselves and others. Recent leadership changes at military installations restricted access to service areas, resulting in decreased outreach opportunities. MSFS providers continue to find ways to collaborate with all community and military partners. The table below shows the number of potential responders reached.

| Potential Responders Reached | | | |
|---|---|---|---|
| | FY 2021/22 | FY 2022/23 | FY 2023/24 |
| Potential Responders | 5,786 | 2,533 | 2,869 |

The table below shows the types of responders and in which settings those responders were reached.

| Outreach<br>Types of Responders / Settings | |
|---|---|
| Types of Responders | Settings |
| • Community service providers<br>• Military Personnel or Veterans<br>• Peer Providers<br>• School Personnel<br>• Employers<br>• Families<br>• Law Enforcement Personnel<br>• Cultural Brokers | • Community Events<br>• Community-Based Organizations<br>• Faith-Based Organization<br>• Schools<br>• Recreation Center<br>• Virtual Platforms |

### Early Intervention

Early intervention services, treatments, and interventions are aimed at addressing and promoting recovery and related functional outcomes for a mental illness early in its emergence. Services are provided to individuals identified as experiencing the first onset of a serious mental illness. These treatment services include developing a treatment plan with goals that are meaningful to the individual.

# Military Services and Family Support (MSFS), cont.

## State Program Positive Results, cont.

### Early Intervention, cont.

The table below illustrates the total number of early intervention episodes opened in each fiscal year, the number of episodes closed in the fiscal year, and the percentage of individuals who met their treatment goals. FY 2022/23 decreased in overall episodes and the percentage of individuals who met their goals.

The decrease is attributed to many individuals not completing their early intervention treatment plan. Changes in the leadership at the military base limited access to military families engaged in services. There has been progress in reestablishing those relationships to gain access.

**Treatment Success by Fiscal Year**

| | Total Episodes | Closed Episodes | % Met Goals |
|---|---|---|---|
| FY 2021/22 | 335 | 122 | 40% |
| FY 2022/23 | 88 | 51 | 18% |
| FY 2023/24 | 42 | 40 | 65% |

### Access & Linkage to Treatment

Access and Linkage to Treatment services are integrated into the MSFS program to connect individuals and/or their family members with severe mental health concerns to care and treatment that will meet their needs as early as possible in the onset of these conditions.

The below table illustrates the number of referrals made to a higher level of care each fiscal year. It also includes those referred to a county or non-county funded entity and those that were referred and engaged in treatment. MSFS providers can provide referrals to county-funded programs and occasionally to a non-county funded provider, such as a private physician.

**Access and Linkage to Services Referrals**

| | FY 2021/22 | FY 2022/23 | FY 2023/24 |
|---|---|---|---|
| Number of Referrals | 15 | 21 | 30 |
| County-Funded | 15 | 7 | 14 |
| Non-County Funded | 0 | 8 | 11 |
| Individuals Engaged | 15 | 15 | 30 |

# Military Services and Family Support (MSFS), cont.

**State Program Positive Results, cont.**

**Improve Timely Access to Treatment**

The Improve Timely Access to Treatment strategy focuses on providing appropriate services based on accessibility, cultural and language appropriateness, transportation, family focus, available hours, and cost of services to increase access to appropriate mental health services for underserved populations.

The MSFS program services are available in whatever setting is most comfortable to a individual, whether if it is virtual, in a clinical setting, or in-home. The Improve Timely Access to Services strategy aims to refer individuals of underserved populations to prevention, early intervention, or higher level of care services.

The program aims to serve underserved populations which include, active members of the military, recently retired military/veterans, and their families. The adjacent table provides a sample of the underserved populations served this past fiscal year.

Through the last three fiscal years, individuals were engaged, on average, no more than eight days after the date of referral. The Improve Timely Access to Services table illustrates the number of individuals who were given a referral to a prevention, early intervention, or higher level of care service, the number of those referred who engaged in services, and the average number of days from date of referral to date been involved in services. This illustrates the ability of the MSFS program to provide linkage and referrals in a timely manner to individuals with needed services as soon as possible.

| Improve Timely Access to Services | | | |
|---|---|---|---|
| | FY 2021/22 | FY 2022/23 | FY 2023/24 |
| Number of Referrals | 86 | 96 | 53 |
| Individuals Engaged | 10 | 19 | 4 |
| Average # of Days Individual Engaged | 9.5 | 6.89 | 8.7 |

**Underserved Populations**

- Trauma-exposed
- Co-occurring
- At risk children and youth
- Latinx/Hispanic
- LGBTQ+
- African American
- Military/Veterans
- Pacific Islander
- Individuals experiencing onset of serious psychiatric illness

## Military Services and Family Support (MSFS), cont.

### Demographics

| Fiscal Year | Age (yrs. old) | | | | |
|---|---|---|---|---|---|
| | 0-15 | 16-25 | 26-50 | 60+ | UNK |
| FY 21/22 | 3% | 3% | 16% | 3% | 75% |
| FY 22/23 | 12% | 8% | 35% | 6% | 39% |
| FY 23/24 | 18% | 12% | 45% | 14% | 11% |

| Fiscal Year | Veteran Status |
|---|---|
| | % of Individuals who identified as a veteran |
| FY 21/22 | 7% |
| FY 22/23 | 13% |
| FY 23/24 | 14% |

| Fiscal Year | Sexual Orientation |
|---|---|
| | % of Individuals who identified as LGBTQ+ |
| FY 21/22 | 1% |
| FY 22/23 | 2% |
| FY 23/24 | 1% |

| Fiscal Year | Disability |
|---|---|
| | % of Individuals who identified a physical disability |
| FY 21/22 | 0% |
| FY 22/23 | 0% |
| FY 23/24 | 0% |

| Fiscal Year | Gender Identity | | | |
|---|---|---|---|---|
| | ♂ | ♀ | ⚧ | UNK |
| FY 21/22 | 13% | 23% | 0% | 64% |
| FY 22/23 | 30% | 46% | <1% | 24% |
| FY 23/24 | 36% | 54% | <1% | 10% |

| Fiscal Year | Primary Language | | | |
|---|---|---|---|---|
| | ENG | SPAN | OTH | UNK |
| FY 21/22 | 91% | 1% | 0% | 8% |
| FY 22/23 | 98% | <1% | 0% | 2% |
| FY 23/24 | 98% | 1% | <1% | 0% |

# Military Services and Family Support (MSFS), cont.

**Demographics, cont.**

**Demographic Observations**

- The MSFS program is successful in serving children, TAY, and adults at 18%, 12%, and 45% respectively. This aligns with the program's goal of serving those with military service and their families.
- The program was consistent in serving the same number of veterans the past two fiscal years.

| | | FY 21/22 | FY 22/23 | FY 23/24 |
|---|---|---|---|---|
| Race | African-American/Black | 5% | 11% | 13% |
| | American-Indian/Alaska Native | 0% | 1% | <1% |
| | Asian | 1% | 1% | 2% |
| | Latinx/Hispanic | 10% | 10% | 15% |
| | Native Hawaiian or Pacific Islander | 1% | 2% | 1% |
| | Caucasian/White | 18% | 31% | 43% |
| | More than One Race | 4% | 6% | 6% |
| | Other Race | 4% | 10% | 5% |
| | Declined to Answer | 62% | 29% | 13% |

| | | FY 21/22 | FY 22/23 | FY 23/24 |
|---|---|---|---|---|
| Ethnicity | African | 0% | 2% | 4% |
| | Asian Indian/South Asian | 0% | 4% | 1% |
| | Cambodian | 0% | 0% | 1% |
| | Chinese | 0% | 0% | 3% |
| | Eastern European | 0% | <1% | <1% |
| | European | 3% | 3% | 3% |
| | Hispanic/Latino | 10% | 10% | 3% |
| | Filipino | 0% | <1% | 4% |
| | Japanese | 0% | <1% | 2% |
| | Korean | 0% | 0% | 2% |
| | Middle Eastern | 0% | <1% | 6% |
| | Vietnamese | 0% | 0% | 2% |
| | Other | 7% | 34% | 26% |
| | More than one ethnicity | 9% | 17% | 8% |
| | Declined to Answer | 80% | 36% | 34% |

## Military Services and Family Support (MSFS), cont.

**Program Goals**

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

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

Improve timely access to services for underserved populations:

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

Reduce prolonged suffering:

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

Reduce stigma and discrimination associated with mental illness:

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

## Military Services and Family Support (MSFS), cont.

### Program Outcomes

| Method use to collect outcome | Description of method | Frequency of use | Number Completed |
|---|---|---|---|
| Adult Needs and Strengths Assessment (ANSA) | A comprehensive assessment of psychological and social factors used for treatment planning. This assessment measures functioning in several important life domains and helps to support decision making and level of care and service planning, and ensure projected goals are being met. | Intake, 3 months, Discharge, Significant life events | FY 21/22: 42<br>FY 22/23: 36<br>FY 23/24: 27 |
| PTSD Checklist for Active and Veteran Military (PCL-M) | A comprehensive assessment of psychological and social factors used for treatment planning. This assessment measures functioning in several important life domains and helps to support decision-making and level of care and service planning, and ensure projected goals are being met. | Every three months for duration of treatment | FY 21/22: 6<br>FY 22/23: 7<br>FY 23/24: 5 |

### Outcome Discussion

The ANSA-SB is a comprehensive assessment of psychological and social aspects used for treatment planning by MSFS early intervention providers. This assessment assesses functioning in various essential life areas and aids in decision-making, level of care and service planning, and ensuring that planned goals are realized. Based on the individual's response, they receive a rating from 0 to 3, with 0 revealing there is no evidence of needs and 3 requiring immediate and/or intensive action.

The Life Functioning Domain focuses on the different areas of social interaction in a individual's life. This can include how they function individually, within family, peer, school, and community realms.

The Strengths Domain refers to the individual assets a individual can use to advance healthy development. Identifying areas where strengths can be built is a significant element of service planning.

## Military Services and Family Support (MSFS), cont.

**Outcome Discussion, cont.**

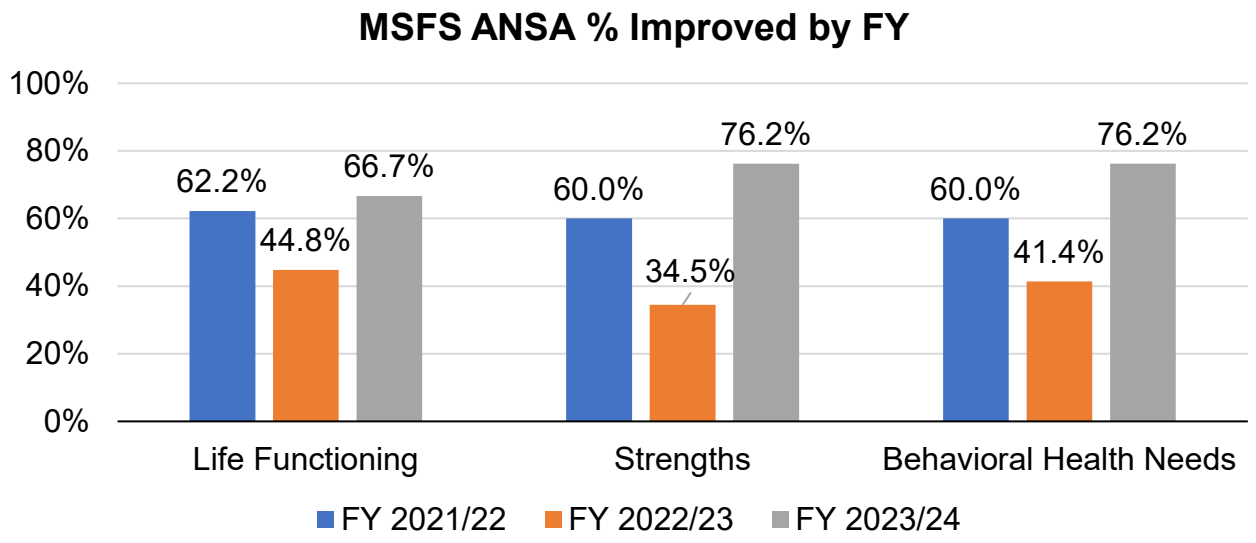
The Behavioral Health Needs Domain identifies the behavioral health needs of a individual.

The table below illustrates the percentage of individual improvement in global areas of Life Functioning, Strengths, and Behavioral Health Needs.

Domain improvement leads to improved recovery including emotional and relational functioning. These improvements reduce the prolonged suffering related to an untreated mental health concern.

These sub-domains are used to measure everyone's specific service needs. During FY 23/24, individuals improved an average of 73% in the Life Functioning, Strengths, and Behavioral Health Needs domains.

The Life Functioning, Strengths, and Behavioral Health Needs Domains saw an average improvement of 58% over the last three fiscal year period.



## Military Services and Family Support (MSFS), cont.

**Outcome Discussion, cont.**

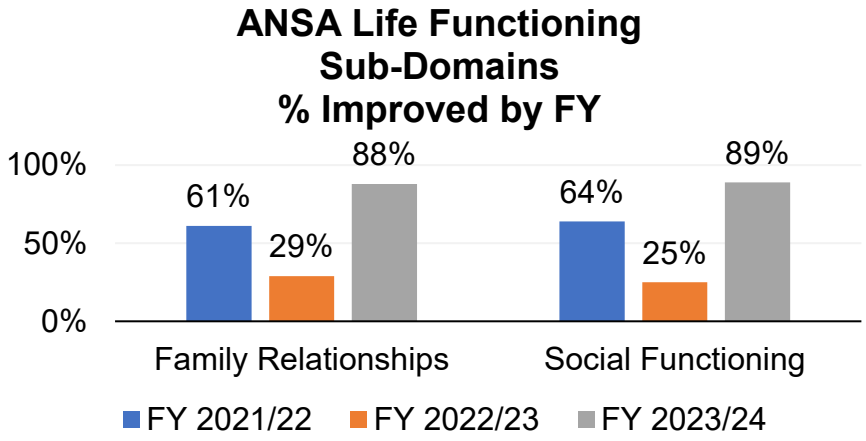
Each domain includes sub-domains that help to evaluate the individual's readiness to participate in early intervention services.

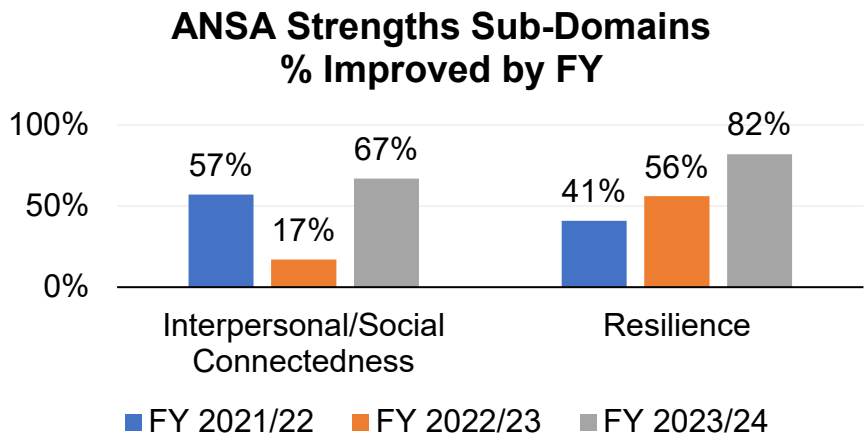
In the domain of Life Functioning, the sub-domain of family relationships evaluates and rates the individual's relationships with their family members: spouse/partner, children, and other family members. The sub-domain of social functioning rates social skills and relationships for a individual.

Individuals saw an average improvement of 88% across the Life Functioning sub-domains of Family Relationships and Social Functioning in FY 23/24.

In the Strengths domain, the interpersonal/social connectedness sub-domain measures a individual's social and relationship. The resilience domain measures a individual's ability to recognize their internal strengths and use them to manage their daily life.

Individuals saw an average improvement of 75% across the Strengths sub-domains of Interpersonal/Social Connectedness and Resilience in FY 23/24. These results demonstrate the effectiveness of early intervention services in improving an individuals' ability to recognize and capitalize on their personal strengths.



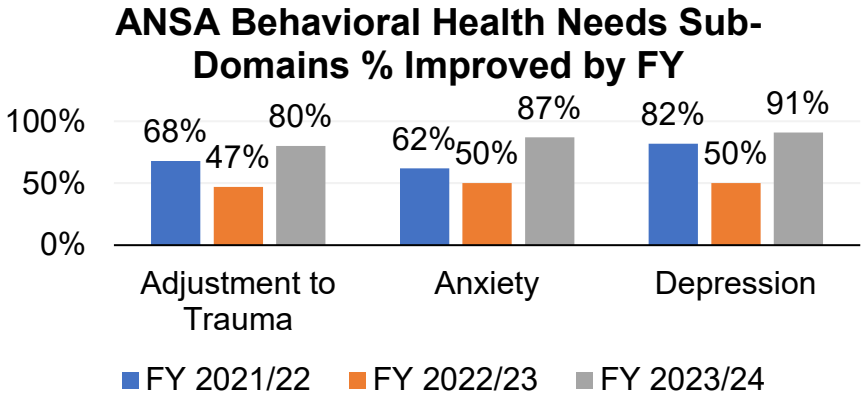



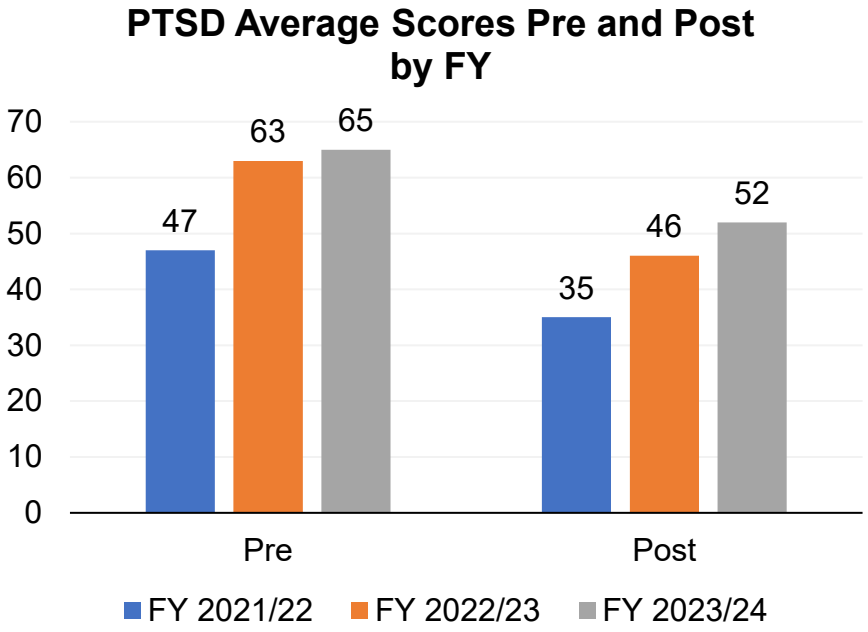
## Military Services and Family Support (MSFS), cont.

### Outcome Discussion, cont.

The Behavioral Health Needs sub-domain of adjustment to trauma is used to help the individual define their difficulties related to a traumatic experience. An improvement in an identified need indicates that a individual has improved a debilitating level of trauma symptoms. The anxiety sub-domain measures improvement in an individual's anxiety symptoms such as excessive fear and anxiety related to behavioral disturbances. Improvement in the depression sub-domain may indicate a decrease in symptoms such as irritable or depressed mood, social withdrawal, and sleep disturbances.

Individuals saw an average improvement of 86% across the Behavioral Health Needs sub-domains of Adjustment to Trauma, Anxiety, and Depression in FY 23/24.




The table above illustrates the comparison of individual pre and post scores on the Post-Traumatic Stress Disorder (PTSD) Checklist for Active and Veteran Military members (PCL-M). The PCL-M uses 17 questions to assess the degree to which individuals experience symptoms of PTSD, such as trouble falling or staying asleep, being "hyper alert" or watchful and on guard, or feeling jumpy and/or easily startled. Higher scores indicate a greater intensity of PTSD symptoms.

## Military Services and Family Support (MSFS), cont.

### Outcome Discussion, cont.

Total Symptom Severity Scores can range anywhere from 17 to 85. A cutoff score of 50 or more suggests the presence of a significant level of symptom severity. Results indicate that MSFS early intervention individuals scored 65 points out of a total of 85 on the PCL-M before receiving treatment. After treatment, MSFS individuals scored 52 points on average, reducing their total symptom severity score by an average of 17 points, indicating a reduction in total symptom severity.

### Challenges/Solutions

Group participation also continues to be a challenge, as individuals prefer individual meetings via videoconferencing or in person rather than group meetings. Individuals have shared that they prefer virtual individual meetings because they help preserve anonymity within their communities and they face stigmas of being involved in mental health services. In more remote service regions, transportation and reliable internet service continue to challenge individuals.

The MSFS program faced difficulties with one of the bases they partner with in Barstow. After a change in command, new limitations were placed on providing group services and access to the base from outside agencies. Even with the challenges presented, the MSFS program has continued to successfully serve the military community by meeting its clients where they are. The program seeks to create groups in a different settings, such as schools, to assist the family of servicemembers.

### Lessons Learned

PEI continues to work with MSFS providers to ensure that the appropriate data is collected and to provide technical assistance for database navigation. MSFS providers can reach a larger population through telehealth services, including individuals outside of their service regions. Program staff can train individuals on how to use virtual meeting platforms, especially those poor internet service areas.

Staff recruitment efforts continue in the Central/East Valley regions to ensure that the program's target population is adequately served.

## Military Services and Family Support (MSFS), cont.

### Success Story

A veteran client with severe PTSD suffering from a lack of familial support initiated at the onset of the pandemic and following loss of business. As treatment progressed, the client created a new support system and began a new job which led to increased anxiety. He used his art, support group, and therapy to cope with thoughts of being useless. After months and near exhaustion of all resources, he was awarded full disability from the Veteran Affairs (VA). Client has renewed hope, financial security, and is now able to focus more time and effort on his art.

### Program Updates

There are no planned program updates for Fiscal Year 2025/26.

# Student Assistance Program (SAP)

## Program Description and Target Population

The Student Assistance Program (SAP) employs a school-based approach to provide targeted services to students in kindergarten through 12th grade who require interventions for substance abuse, mental health, academic, emotional, and/or social issues. SAP links education, programs, and services within and across school and community systems to form a support network for students.

SAP's target population consists of K-12 students and their families who have the following characteristics: Trauma exposure, the onset of serious psychiatric illness for the first time, families in distress, at risk of dropping out of school, and/or becoming involved with the juvenile justice system.

The SAP program prioritizes schools and school districts with high rates of students from underserved ethnic/cultural groups, poverty, low academic achievement, suspension, expulsion, dropouts, children/youth in foster care, at risk of juvenile justice involvement, and/or community violence.

Services are not intended for those who have previously been diagnosed with a mental health condition, as well as students whose needs have been identified and should be met as part of an Individual Education Plan (IEP).

| | |
|---|---|
| **Services Offered** | • **Mental Health and Substance Use Screenings and Assessments**<br>• **Mental Health Educational Presentations**<br>• **Critical Incident Stress Debriefing**<br>• **Individual and Group Counseling**<br>• **Alcohol and Drug Education and Intervention** |

| | |
|---|---|
| **Program Serves** | **Children, Youth, TAY (16-25)** |
| **Location of Services** | School Campuses, Mental Health Clinics, In-home |
| **Annual Budget FY 25/26** | $7,832,596 |
| **Cost Per Consumer FY 25/26** | $518 |

# Student Assistance Program (SAP), cont.

## Program Highlights

SAP uses a school-based approach to provide focused services to students needing interventions for substance use, mental health, academic, emotional, and/or social issues. It is a process that connects students to a network of supports. SAP identifies students in need and links them to services that can fully assess their needs. Once assessed, students are connected with the appropriate level of services and ongoing support.

The SAP falls into the State Prevention and Early Intervention Program reporting structure. The program includes both prevention and early intervention activities to provide students with a comprehensive system of care.

## Prevention

SAP prevention activities offer education, outreach, and support to help students and school staff understand mental wellness.

Prevention activities are readily available to all students and staff. Referrals can be made to additional services such as screening and assessments. These referrals can be made by school counselors, teachers, and/or parents.

SAP delivers presentations at school assemblies and offers after-school group activities. They are provided with useful information on the signs and symptoms of mental illness as well as substance use disorders.

The following includes some of the topics that are presented by the SAP program:

- Substance Use Education and Interventions,
- Conflict Resolution,
- Self-Control/Anger Management,
- Healthy Dating and Relationships,
- Psychoeducational/Social Skill Building,
- Grief Processing/Critical Incident Debriefing, and
- Suicide Prevention.

**Number of Participants / Number of Services Projected vs Actual**

| | Projected | Actual | | |
|---|---|---|---|---|
| | | FY 21/22 | FY 22/23 | FY 23/24 |
| Unduplicated Participants | 15,126 | 13,337 | 50,221* | 56,608 |
| Number of Services | 18,402 | 20,280 | 67,095* | 58,432 |

*FY 22/23: reported numbers were incorrect, actual numbers have been updated.

# Student Assistance Program (SAP), cont.

## Program Highlights, cont.

### Early Intervention

The programs core component consists of professionally trained teams. These teams are comprised of school personnel and staff from community behavioral health agencies.

SAP team members are trained to identify potential learning barriers and make recommendations that will benefit both the student and their families. They work collaboratively to meet the needs of the student in the most effective and practical manner.

The SAP team plans and implements services to improve students well-being. They include ongoing support to ensure the students are successful in their treatment program.

When a student's needs exceed the scope of the program, the SAP team connects the student and their families to additional community resources and services. This would include referrals to a higher level of care.

The following chart includes data on the number of children and youth served by early intervention services.

| Early Intervention Participants / Services | | | |
|---|---|---|---|
| | FY 21/22 | FY 22/23 | FY 23/24 |
| Unduplicated Participants | 836 | 570 | 905 |
| Total Services | 8,188 | 7,958 | 12,384 |

SAP early intervention services rely heavily on school site referrals originating from prevention services. When schools transitioned to distance learning, the prevention services were temporarily suspended but as you can see, there is now an increase in services due to children returning to traditional learning sites.

The chart below provides an overview of client successes. Data shows that their treatment plans dropped slightly over the last three fiscal years. Clients were displaced during the pandemic and moved out of their program service area causing interruptions in services. Some clients did not have adequate technology or space needed for a successful transition to telehealth services.

| Treatment Success by Fiscal Year | | | |
|---|---|---|---|
| | FY 21/22 | FY 22/23 | FY 23/24 |
| Treatment Successful | 38% | 38% | 37% |
| Treatment Partially Successful | 22% | 18% | 28% |
| Treatment Not Successful | 32% | 36% | 23% |
| Missing or Other | 8% | 7% | 12% |

# Student Assistance Program (SAP), cont.

**Program Highlights, cont.**

**Outreach**

The SAP program is intended to minimize barriers to learning, support students in developing academic and personal successes, and shorten the duration of untreated mental illness. To reach potential responders, the SAP program extends information and education in various settings. School staff meetings, community meetings, and schoolwide psychoeducation are used by all providers. The tables are shown to detail the settings in which Outreach is carried out and the types of potential responders who took part in the education activities.

San Bernardino County Superintendent of Schools, in collaboration with the DBH, host a multi-day Southern Region Student Wellness Conference that trains and supports all those who work closely with children and youth. In July 2024, over 900 people attended the conference to learn about positive behavior interventions for the classroom, including identifying behavioral issues and referring to services. Through this partnership, schools also have access to year-round training and support for the implementation of the Positive Behavioral Intervention and Supports (PBIS) model on their school site campuses.

| Outreach Settings |
|---|
| • Schools<br>• Community Events<br>• Health Fairs<br>• Family Resource Center<br>• Community Based Organization Facility<br>• Faith-Based Organizations<br>• Southern Region Student Wellness Conference<br>• Behavioral Health Clinics<br>• Student Attendance Review Board Meetings<br>• Shelters |

| Types of Potential Responders |
|---|
| • Families<br>• Parents<br>• Community Members<br>• School Officials/Staff<br>• Community Service Providers<br>• Law Enforcement<br>• Peer Providers<br>• Student Attendance Review Boards<br>• Mediators<br>• Prevention/Treatment Professionals<br>• Social Service Providers |

## Student Assistance Program (SAP), cont.

### Demographics

| Fiscal Year | Age (yrs. old) | | | | |
|---|---|---|---|---|---|
| | 0-15 | 16-25 | 26-59 | 60+ | UNK |
| FY 21/22 | 51% | 5% | 26% | 1% | 17% |
| FY 22/23 | 55% | 17% | 14% | <1% | 13% |
| FY 23/24 | 29% | 10% | 6% | <1% | 55% |

| Fiscal Year | Veteran Status |
|---|---|
| | % of consumers who identified as a veteran |
| FY 21/22 | <1% |
| FY 22/23 | <1% |
| FY 23/24 | <1% |

| Fiscal Year | Sexual Orientation |
|---|---|
| | % of consumers who identified as LGBTQ+ |
| FY 21/22 | <1% |
| FY 22/23 | <1% |
| FY 23/24 | 2% |

| Fiscal Year | Disability |
|---|---|
| | % of consumers who identified a physical disability |
| FY 21/22 | <1% |
| FY 22/23 | <1% |
| FY 23/24 | <1% |

| Fiscal Year | Gender Identity | | | |
|---|---|---|---|---|
| | ♂ | ♀ | ⚧ | UNK |
| FY 21/22 | 6% | 10% | 0% | 83% |
| FY 22/23 | 5% | 12% | 0% | 83% |
| FY 23/24 | 15% | 22% | 0% | 63% |

| Fiscal Year | Primary Language | | | |
|---|---|---|---|---|
| | ENG | SPAN | OTH | UNK |
| FY 21/22 | 61% | 5% | 0% | 34% |
| FY 22/23 | 71% | 5% | <1% | 24% |
| FY 23/24 | 34% | 2% | <1% | 63% |

# Student Assistance Program (SAP), cont.

**Demographics, cont.**

### Demographic Observations

- The SAP program has consistently served the targeted demographics over the last three fiscal years. Children and Youth are the significant participants.
- The SAP program serves high numbers of adults with the annual Southern Region Student Wellness Conference.
- Family support services also contribute to the number of adults served by the SAP program.
- There has been a significant increase in participants declining to answer demographic questions partly due to the age of participants and some thinking the questions are inappropriate to ask.
- The ethnic and racial participation is consistent with the demographic of the general population of San Bernardino County.

| | Ethnicity/Race | FY 21/22 | FY 22/23 | FY 23/24 |
|---|---|---|---|---|
| Race | African American/Black | 8% | 9% | 5% |
| | American-Indian/Alaska Native | 0% | 0% | <1% |
| | Asian | 2% | 4% | 2% |
| | Native Hawaiian/Pacific Islander | 0% | 1% | <1% |
| | Caucasian/White | 18% | 19% | 7% |
| | Latinx/Hispanic | 16% | 27% | 16% |
| | More than One Race | 3% | 5% | 2% |
| | Other Race | 11% | <1% | <1% |
| | Declined to answer | 42% | 34% | 66% |

## Student Assistance Program (SAP), cont.

**Demographics, cont.**

| | Ethnicity/Race | FY 21/22 | FY 22/23 | FY 23/24 |
|---|---|---|---|---|
| Ethnicity | African | <1% | 1% | 1% |
| | Asian Indian/South Asian | 0% | 0% | <1% |
| | Cambodian | 0% | 0% | 0% |
| | Chinese | 0% | 0% | 0% |
| | Eastern European | 0% | 0% | <1% |
| | European | 1% | 1% | <1% |
| | Hispanic/Latino | 4% | 3% | 1% |
| | Filipino | 0% | 0% | <1% |
| | Japanese | 0% | 0% | 0% |
| | Korean | 0% | 0% | 0% |
| | Middle Eastern | 0% | 0% | <1% |
| | Vietnamese | 0% | 0% | <1% |
| | Other | 5% | 3% | 3% |
| | More than One Ethnicity | 3% | 1% | <1% |
| | Declined to answer | 87% | 91% | 90% |

## Student Assistance Program (SAP), cont.

### Program Goals

The State program's prevention goal is to reduce prolonged suffering associated with untreated mental illness by reducing risk factors and increasing protective factors. The Early Intervention goal is to reduce symptoms and improve recovery, including mental and relational functioning. The SAP program is designed to meet the State's goals by reducing learning hurdles, assisting students in building academic and emotional achievement, and decreasing the period of untreated mental illness. The tools used to measure the effectiveness of the SAP program are listed in the table below.

| Method use to collect outcome | Description of method | Frequency of use | Number Completed |
|---|---|---|---|
| Children and Adolescent Needs and Strengths Assessment (CANS) | CANS is a multi-purpose tool developed for children's services to support decision making, including level of care and service planning. | Intake, 6 months, Discharge, Significant life events | FY 21/22: 393<br>FY 22/23: 465<br>FY 23/24: 595 |
| Pediatric Symptom Checklist (PSC 35) | PSC is a 35-item parent-completed questionnaire that assesses a broad range of emotional and behavioral problems in children. It is used as a screen for psychosocial problems in pediatric well-child visits, school enrollment, and entry into other systems of care for children from 4 to 18 years of age. With repeat administrations, it is also used to assess changes in functioning over time. | Initial, 6 months, discharge | FY 21/22: 485<br>FY 22/23: 737<br>FY 23/24: 466 |
| Measurement Outcomes and Quality Assessment (MOQA_SPP/SDR) | The MOQA surveys are used to gather information regarding the stigma associated with mental health needs. Forms of MOQA used are Stigma and Discrimination Reduction (SDR), Suicide Prevention (SP), and Outreach. | Completion of SDR, SP, or Outreach activity | FY 21/22: 200<br>FY 22/23: 229<br>FY 23/24: 66 |
| Client Satisfaction Survey | Client satisfaction surveys are used to determine whether the participants are gaining useful and valuable information from the program as well as a way to determine whether the participants are engaging in the program in a way that is satisfying and enjoyable. | Completion of Services | FY 21/22: 157<br>FY 22/23: 162<br>FY 23/24: 188 |

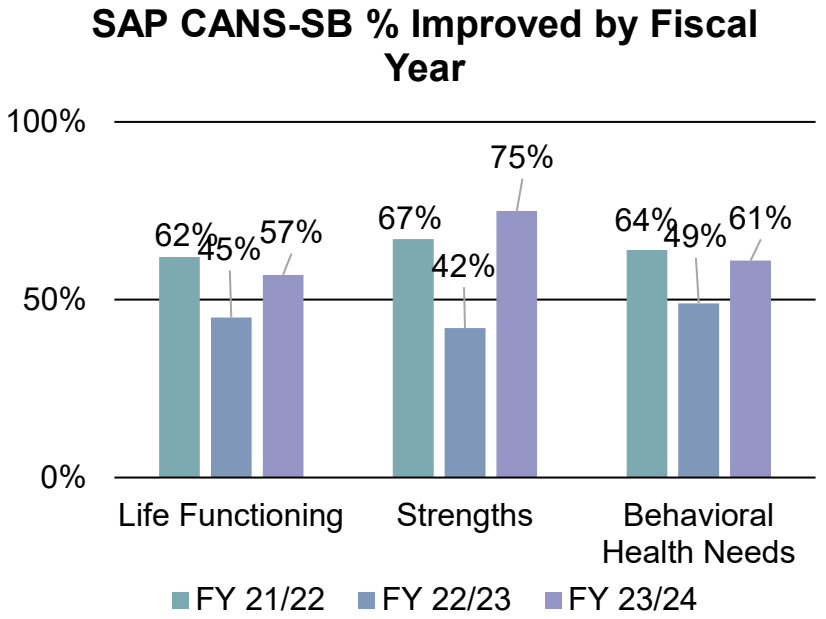
# Student Assistance Program (SAP), cont.

## Outcome Discussion

The SAP program uses the Children and Adolescent Needs and Strengths – San Bernardino (CANS-SB) assessment to measure outcomes of the early intervention treatments, as well as to develop treatment plans and goals. Within the first 30 days of receiving assistance, children and TAY receive the initial CANS-SB assessment. Every three to six months, follow-up assessments are conducted, and a final assessment is completed at the conclusion of services. The CANS-SB includes three primary domains used to evaluate early intervention needs. The domains utilized by the SAP program include:

- Life Functioning addresses various areas of social interaction present in the lives of children, teenagers, and their families. This domain assesses their performance in the areas of self, family, peers, school, and community.
- The Strengths domain describes the assets of the child/youth that can be used to advance healthy development. Addressing a child's strengths while also addressing their behavioral/emotional needs leads to better functioning and better outcomes.
- The Behavioral/Emotional Needs domain identifies the behavioral health needs of the child.

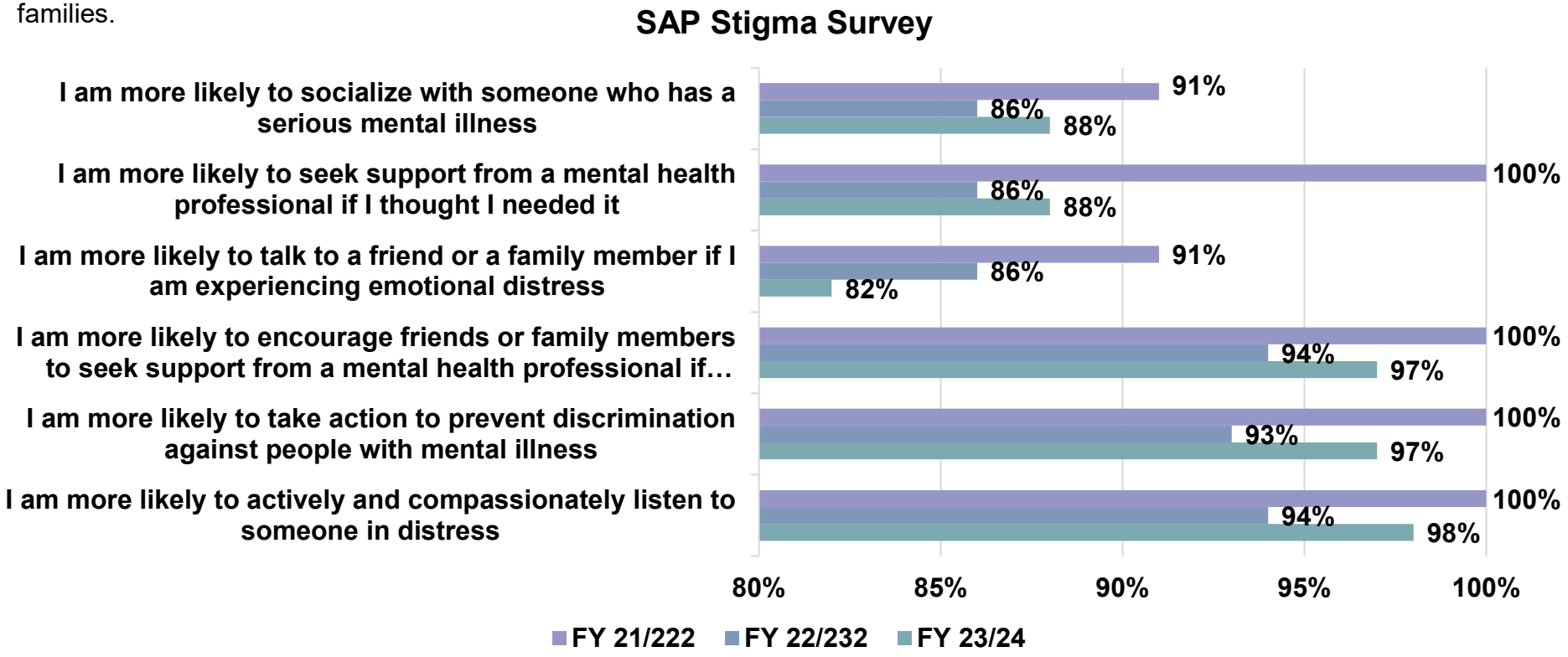
The following graph demonstrates overall improvement in the elements of Life Functioning, Strengths, and Behavioral/Emotional Needs, of participants of the SAP program. The results demonstrate consistent increases in approximately 64% of all three domains. The increase leads to an overall improvement in reducing symptoms and recovery, including mental and relational functioning.



# Student Assistance Program (SAP), cont.

## SAP Stigma Surveys

The stigma surveys are used to examine whether stigma prevention efforts and/or curriculum aimed at youth effect their knowledge, attitudes, and behavior surrounding behavioral health. Stigma surveys are used after any direct activity whose purpose is to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes, and/or discrimination relating to being diagnosed with a mental illness, having a mental illness, or seeking mental health services. As a direct result of these trainings the participants answer the questions below. A Stigma and Discrimination Reduction activity also includes direct activities whose purpose is to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and members of their families.



# Student Assistance Program (SAP), cont.

### Challenges/Solutions

An ongoing challenge for SAP providers is the high staff turnover at both the provider level and school administration level. The departure of experienced staff have led to disruptions in service delivery. Recruiting and training new staff requires considerable time and resources, which temporarily hampers the program's efficiency and effectiveness. Staff turnover also affects team dynamics and morale, impacting the overall productively and job satisfaction of remaining team members. Replacing experienced staff with new hires requires a period of adjustment, during which the quality and consistency of services may fluctuate.

To address this challenge, strategies have been implemented to stabilize the workforce and improve understanding of staffing ratios. This has included hiring experienced staff with Alcohol and Drug Certification to broaden the range of expertise within the programs. Such qualifications are increasingly relevant given the complex needs of many students and their families, particularly those dealing with substance-related issues. Investing in a robust recruitment and retention initiative is also crucial to attracting and retaining skilled staff members. Additionally, providing ongoing training and professional development opportunities can help new hires quickly acclimate to their roles and improve their effectiveness.

Another challenge is the increase in the severity of symptoms among newly referred students. Many of these students require more intensive programs to address their mental health needs. This shift means that fewer students are being assessed withing the SAP program as they are being redirected to the more intense services. Providers are seeking new referral sources via community-based organizations, churches, and community events that can help expand the SAP reach and ensure that more students in need are identified and supported. Engaging with these local entities not only broadens the referral network but also strengthens community ties and fosters a collaborative approach to mental health care.

# Student Assistance Program (SAP), cont.

## Lessons Learned

In FY 2023/24, SAP program providers realized that there were multiple agencies that offer similar services on campus. Although this is good for our community and families, it can limit space and be confusing for the school site. As a result, we recognized the need to clearly explain the differences between all the different campus programs and what each one can offer to the students and families.

### Success Story

With the lifting of restrictions over community events, there has been an increase in the number of outreach events that SAP providers can attend. These community events help funnel referrals to the providers, allowing them to serve the student population even further. As a result, there has been a sharp increase in the outreach numbers, which in turn has increased the number of referrals received for the Early Intervention process.



### Program Updates

There are no planned program updates for Fiscal Year 2025/26.

# Improving Detection and Early Access (IDEA)

## Program Description and Target Population

Psychosis is a serious mental health condition in which thought and emotion are so disrupted that one loses contact with external reality. Early warning signs and symptoms—which can last from a few days to several weeks or even years—often signal the onset of a serious and long-lasting mental condition accompanied by psychotic symptoms. This phase of forewarning is a powerful point at which intervention can help to reduce a worsening of mental symptoms, distress, and functional impairment. People at this early stage are at a Clinical High Risk (CHR) of developing a serious illness.

Most individuals who develop psychosis exhibit symptoms between the ages of 16 and 25. According to existing treatment model research, some people can escape a lifetime of impairment and find fulfillment in their everyday lives with proper and timely intervention.

The goal of the IDEA program, formerly known as the Early Psychosis Care (EPC) program, is to identify youth at clinically high risk of psychosis as early as feasible in the warning phase and to begin treatment as soon as possible during the first episode of psychosis.

The IDEA program aims to serve a total of 26 unduplicated participants annually through the TAY One-Stop Centers.

| | |
|---|---|
| **Services Offered** | • **Mental Health and Substance Use Screenings and Assessments**<br>• **Mental Health Educational Presentations**<br>• **Individual and Group Counseling**<br>• **Case Management**<br>• **Family Education and Support**<br>• **Supported Employment and Education** |

| | |
|---|---|
| **Program Serves** | **TAY (16-25)** |
| **Location of Services** | TAY Centers, Mental Health Clinics, Hospitals |
| **Annual Budget FY 25/26** | $1,000,000 |
| **Cost Per Consumer FY 25/26** | $38,462 |

# Improving Detection and Early Access (IDEA), cont.

## Existing Efforts

The Department of Behavioral Health continues to offer a comprehensive continuum of services, including prevention and early intervention, crisis assistance, and a variety of outpatient and short-term residential treatments that vary in intensity based on the needs of consumers. The continuum of care ensures that individuals obtain care in a variety of ways and provides an existing infrastructure for identifying and treating early episodes of psychosis as well as the precursor signs and symptoms (e.g., Clinical High Risk or prodromal phase). The grant-funded Premier program is part of the continuum. Individuals who have been recognized as having their first episodes of psychosis are currently served through the Premier program. Individuals in the Premier program are often identified and referred from inpatient mental hospitals.

## IDEA Updates

As stated in the previous Annual Update, the original structure and scope of the IDEA program (formerly the Early Psychosis Program (EPC) introduced in the FY 20/21 Three-Year Integrated Plan) has been modified because of funding reductions resulting from COVID-19 restrictions. Program administrators plan to use the existing infrastructure within the continuum of services offered by the Department of Behavioral Health. The adjusted funding for the program will require a phased approach to program implementation.

**A recap of the changes are as follows:**

- The program's annual projected number of participants has been reduced from 105 to 26 per year.
- The IDEA program will shift its program planning and implementation from developing multiple Coordinated Specialty Care (CSC) teams to the establishment of a small unit consisting of a Mental Health Clinic Supervisor, Clinical Therapist I, Program Specialist II, Social Worker II, Mental Health Specialist, Office Assistant III, Peer and Family Advocate, and part-time Adult and Child Psychiatrist.
- This unit will be responsible for providing mental health services including screening and assessments, individual and group counseling, case management, family education and support, as well as supported education and employment.

The IDEA program is currently in process of recruiting for the Clinic Supervisor and Clinical Therapist I positions, which are expected to be filled in the first half of the FY 24/25. As the program currently has no clinical staff, they have provided referral services only for nine individuals to date.

## Improving Detection and Early Access (IDEA), cont.

**The IDEA program will be developed through the following phases:**

**Phase I: Needs Assessment**

- Complete needs assessments to identify training gaps.
- Map existing resources.
- Locate screening tool to be used to identify clinical high risk.

**Phase II: Recruitment of Program Support Staff**

The program staff will coordinate program referrals and serve as a resource hub and centralized access point for mental health providers to facilitate participants' access to timely and appropriate services.

Phase II will consist of the following:

- Recruiting and hiring a program Clinical Therapist I. This position will be utilized to coordinate and provide the delivery of specialized services for Early Psychosis care in order to enhance the current mental health care system.
- Recruiting and hiring a Program Specialist II to assist with program development and outcome reporting.
- Recruit and hire an Office Assistant III to support clinical staff and facilitate access and linkage services.
- Recruit and hire a Social Worker II. This position will provide outreach and education services to the department clinics, community partners, schools/colleges, and other community members as needed. This position will also conduct screenings for eligibility and fit for the program services offered.

**Phase III: Clinical High-Risk Training and Education**

The program coordinator will provide training and workshops to program staff within the DBH infrastructure, as well as community partners, school/college counselors, amongst others.

Training will be provided to:

- Prevention and Early Intervention program providers,
- TAY program administrators,
- DBH Outpatient Clinic staff, and
- Community partners.

# Office of Suicide Prevention (OSP)

### Program Description and Target Population

The Office of Suicide Prevention (OSP) is a new Prevention and Early Intervention (PEI) program, categorized as a stand-alone Suicide Prevention Program.

As legislation evolves and suicide prevention efforts expand across the state, DBH has considered how to meet the changing needs of the communities. Recent community planning supports the need to strengthen the infrastructure surrounding suicide prevention by enhancing our current programming to include staff that can direct their attention to implementing, coordinating, and evaluating suicide prevention efforts in San Bernardino County. This initiative presents an opportunity to be amongst one of the few counties in California to invest in the reduction of suicide by creating a local office dedicated to leading suicide prevention efforts in our county.

The Office of Suicide Prevention consists of full-time staff committed to guiding the continued implementation of a strategic suicide prevention plan for San Bernardino County. As the OSP is still in its infancy of implementation and will have more information to report in future updates.

| | |
|---|---|
| **Services Offered** | • **Suicide Prevention Outreach and Education**<br>• **Critical Incident Stress Debriefing**<br>• **Countywide Strategic Planning Coordination** |

| | |
|---|---|
| **Program Serves** | **Children, Youth, TAY, Adults, Older Adults** |
| **Location of Services** | Countywide |
| **Annual Budget FY 25/26** | $380,504 |
| **Cost Per Client FY 25/26** | $253 |

## Office of Suicide Prevention (OSP), cont.

### State Program Positive Results

In September 2023, DBH launched the Office of Suicide Prevention in San Bernardino County, offering a centralized website with up-to-date information on warning signs, upcoming trainings, conversation tips, and available resources. The site is regularly updated to ensure residents have the latest information for residents seeking support.

The OSP will consist of three primary positions to manage the daily operations.

Program Specialist II- Leads a small support team in suicide prevention efforts, oversees tasks, writing strategic plans, and implementing business processes.

Mental Health Specialist- Conducts community trainings and presentations, builds stakeholder networks for suicide prevention, and facilitates meetings within the suicide prevention network.

Office Assistant III- Provides administrative support for the Office of Suicide Prevention (OSP).

Recruitment for these positions began in July 2023 following program approval. We have hired for the Program Specialist II and Office Assistant III position. OSP is still interviewing for Mental Health Specialist.



SAN BERNARDINO COUNTY
Behavioral Health

# MHSA Annual Update for FY 25/26: Community Services and Supports

# Community Services and Supports

## Introduction

Under the Mental Health Services Act (MHSA), 76% of MHSA funding is mandated to be allocated to the Community Services and Supports (CSS) component. The CSS component provides access to an expanded continuum of care for persons living with a serious mental illness (SMI) and children with serious emotional disturbance (SED).

| Community Services and Supports Goals |
|---|
| • Reduce the subjective suffering from serious mental illness for adults and serious emotional disorders for children and youth. |
| • Reduce homelessness and increase safe and permanent housing. |
| • Increase in self-help and consumer/family involvement. |
| • Increase access to treatment and services for co-occurring problems, substance use, and health. |
| • Reduction in disparities in racial and ethnic populations. |
| • Reduce the number of multiple out-of-home placements for foster care youth. |
| • Reduce criminal and juvenile justice involvement. |
| • Reduce the frequency of emergency room visits and unnecessary hospitalizations. |
| • Increase a network of community support services. |

The CSS section is organized by programs with similar service responsibilities but may serve different target populations. Programs intended to provide interventions or supports during a mental health crisis are described in the Crisis System of Care section of the CSS component. There are nine Full Service Partnership (FSP) programs that provide intensive case management and treatment services for consumers.

The Peer Support Programs section highlights consumer-driven programs that operate from a lived experience perspective. The overarching goal of all CSS programs is to provide the necessary services and supports that help consumers achieve mental health and wellness and recovery goals.



Artwork by Isis Torres

## Introduction, cont.

The table below lists the CSS programs:

| Community Services and Supports Programs |
|---|
| Crisis System of Care<br>• A-5: Triage Transitional Services<br>• A-6: Community Crisis Services<br>• A-16: Crisis Intervention Collaborative Programs |
| Crisis Stabilization Continuum of Care<br>• A-4: Crisis Walk-In Centers (CWICs)/Crisis Stabilization Units (CSUs)<br>• A-10: Crisis Residential Treatment (CRT) |
| Peer Programs<br>• A-1: Peer Programs |
| Outreach, Access, and Engagement Programs<br>• A-9: Access, Coordination, and Enhancement (ACE)<br>• A-15: Recovery Based Engagement Support Teams (RBEST) |
| Full Service Partnerships<br>• C-1: Comprehensive Children and Family Support Services (CCFSS)<br>• C-2: Integrated New Family Opportunities (INFO)<br>• TAY-1: One Stop Transitional Age Youth (TAY) Centers<br>• A-2: Forensic Services Continuum of Care<br>• A-3: Assertive Community Treatment Model Full Service Partnership Services<br>• A-11: Regional Adult Full Service Partnership (RAFSP)<br>• A-20: Collaborative Adult Full Service Partnership Services<br>• OA-1: Age Wise |
| Homeless Services, Long-Term Supports, and Transitional Care<br>• A-7: Housing and Homeless Services Continuum of Care Programs<br>• A-13: Adult Transitional Care Programs |

## CSS Demographics for FY 2023/24

| Age Group | |
|---|---|
| Children (0-15) | 20% |
| TAY (16-25) | 20% |
| Adult (26-59) | 51% |
| Older Adult (60+) | 10% |

| Gender | |
|---|---|
| Female | 48% |
| Male | 52% |
| Other | <1% |

| Race/Ethnicity | | | |
|---|---|---|---|
| African American/Black | 20% | Latinx/Hispanic | 41% |
| Native American or Alaska Native | <1% | Caucasian/White | 29% |
| Asian/Pacific Islander | 2% | Other/Unknown | 7% |

| Primary Language | |
|---|---|
| English | 95% |
| Spanish | 4% |
| Other/Unknown /Not Reported | 2% |

**N**=15,637

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

| Primary Diagnosis | | | |
|---|---|---|---|
| Anxiety disorders | 12% | Psychosis | 25% |
| Bipolar disorders | 9% | Substance related | 4% |
| Depressive disorders | 25% | Neurodevelopmental/ cognitive disorders | 3% |
| Disruptive disorders | 3% | None/Deferred | 2% |
| Other | 16% | | |

| Region | |
|---|---|
| Central Valley | 22% |
| Desert/Mountain | 35% |
| East Valley | 26% |
| West Valley | 12% |
| Out of County | 6% |

## CSS Data Explanation

CSS programs provide data on both consumer demographics and the number of consumers served in each program. The number of consumers served and the number for demographics may differ depending on the level of services received. The number served is inclusive of all providers and includes data for all FSPs within the program. The demographics represent the data for unduplicated consumers seen by the providers within the program, which may result in lower numbers compared to the data for number of consumers served.

## CSS Capacity Assessment

The Community Services and Supports component consists of eighteen (18) programs designed to support a continuum of services that support the mental health needs of diverse Children, TAY, Adults, and Older Adults based on their specific need. In compliance with 9 CCR § 3650, each program was developed through the Community Program Planning process and includes: a description of services, the targeted number of people to be served by age group, demographics of consumers, program outcomes, and includes a summary of challenges and solutions related to program implementation.

The Department of Behavioral Health (DBH) conducted an analysis of available San Bernardino County data to understand the scope of mental health needs among the four age-specific target populations. The data was reviewed and analyzed to determine estimates of the unserved, underserved, and inappropriately served individuals in the county. For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 212-218.

As part of the program implementation, DBH is committed to the ongoing review of community behavioral health needs, the staff capacity, the public behavioral health system, and the implementation of continuous improvement efforts based on qualitative and quantitative data and informatics.

DBH collects, prepares, and presents data and information to its stakeholders. Stakeholders review the information and provide feedback on identifying additional populations, program improvement and design, priorities, and unmet needs.

In November 2023, DBH partnered with an independent national research and consulting firm in the healthcare industry to complete an assessment of the stakeholder process for developing the MHSA Three-Year Integrated Plan and Annual Plan Updates and behavioral health needs and capacity assessment (see page 24).

### Populations for Full Service Partnerships

The CSS section of this Three-Year Plan provides detailed overviews of all Full Service Partnership (FSP) programs, including demographics, numbers projected to be served, goals, and key outcomes. These 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 who:<br>  • Are identified as living with serious emotional disturbances<br>  • Have problems at school or at risk of dropping out<br>  • Are at risk of, or are involved in, the juvenile justice system<br>  • Need crisis intervention and/or are at serious risk of psychiatric hospitalization<br>  • Are at risk of residential treatment or are stepping down from residential treatment<br>  • Are homeless or at risk of homelessness<br>  • Are high users of service; multiple hospitalizations/institutions<br>  • Are at risk due to lack of services because of cultural, linguistic, or economic barriers<br>  • Are at risk due to exposure to domestic violence, physical, emotional, verbal, sexual abuse<br>  • Have co-occurring disorders<br>  • Are at-risk of or experiencing sexual exploitation |

| Transitional Aged Youth |
| --- |
| • Those transitional age youth who:<br>  • Have serious mental illness or serious emotional disturbances<br>  • Have repeatedly used emergency mental health services<br>  • Have co-occurring disorders<br>  • Are homeless or at risk of homelessness<br>  • Are at risk of involuntary hospitalization or institutionalization<br>  • Are involved in the juvenile justice system<br>  • Are in out-of-home placement<br>  • Are aging out of or part of the child welfare system<br>  • Are high utilizers of hospital services |

**Populations for Full Service Partnerships, cont.**

| Adults |
| --- |
| • Those adults who:<br>  • Are living with serious mental illness (SMI)<br>  • Are homeless or at risk of homelessness<br>  • Have co-occurring substance use disorders<br>  • Are involved in the criminal justice system or who are in transitioning/discharged from the criminal justice system<br>  • Have been recently discharged from psychiatric hospitals/higher levels of care<br>  • Are frequently hospitalized or are frequent users of emergency room services for psychiatric problems |

| Older Adults |
| --- |
| • Those older adults who:<br>  • Have serious mental illness (SMI)<br>  • Are homeless or at risk of homelessness<br>  • Are frequent users of emergency room services for psychiatric problems or are frequently hospitalized<br>  • Have reduced personal and/or community functioning due to physical and/or health problems<br>  • Have a co-occurring substance use disorder<br>  • Are isolated and at risk for suicide due to stigma surrounding their mental health problems |

# CSS: Crisis System of Care

## Introduction

The primary goals of the Crisis System of Care (CSOC) programs are to reduce hospital emergency room visits and unnecessary acute psychiatric hospitalizations, improve consumer participation in outpatient services after a crisis, and reduce the percentage of consumers who return for additional crisis services within a short timeframe.

CSOC programs serve MHSA populations by utilizing system development strategies that help enhance the capacity to provide value-driven, evidence-based services. Through system development, counties improve program services and supports for all consumers and families, enhance their service delivery systems, and build transformational programs and services. CSOC consists of a continuum of programs that provide education and support for community partners to divert from unnecessary psychiatric hospitalization when a more appropriate level of care is available.

Programs under the CSOC are:

- A-5 Triage Transitional Services
  - Triage Transitional Services (TTS)
  - Placement After Stabilization (PAS)
- A-6 Community Crisis Services
  - Community Crisis Response Team (CCRT)
- A-16 Crisis Intervention Collaborative Programs
  - Crisis Intervention Training (CIT) Program
  - Community Education Program (CEP)
  - Triage, Engagement, and Support Teams (TEST)

## Target Populations

The table below represents the target population of consumers to be served by programs within the Crisis System of Care.

| Crisis Stabilization Continuum of Care Programs | | | | |
|---|---|---|---|---|
| **Program Name** | **Target Population** | | | |
| | Children | TAY | Adults | Older Adult |
| **Triage Transitional Services (TTS)** | | X | X | X |
| **Community Crisis Response Team (CCRT)** | X | X | X | X |
| **Crisis Intervention Training (CIT)** | | X | X | X |
| **Community Education Program (CEP)** | | X | X | X |
| **Triage, Engagement, and Support Teams (TEST)** | X | X | X | X |

# CSS: Crisis System of Care

**Number of Consumers to be Served**

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

| Program | Ages Served | Service Area* |
|---|---|---|
| Triage Transitional Services | 450 TAY<br>1,450 Adult<br>100 Older Adult | 2,000 GSD |
| | TOTAL = 2,000 | TOTAL = 2,000 |
| Triage, Engagement, and Support Teams | 625 Children<br>1,625 TAY<br>3,100 Adult<br>625 Older Adult | 4,650 GSD<br>1,325 O&E |
| | TOTAL = 5,975 | TOTAL = 5,975 |
| Community Crisis Response Team | 1,900 Children<br>1,620 TAY<br>2,870 Adult<br>200 Older Adult | 1,770 GSD<br>4,820 O&E |
| | TOTAL = 6,590 | TOTAL = 6,590 |
| Crisis Intervention Training | 250 TAY<br>1,500 Adult<br>70 Older Adult | 1,820 O&E |
| | TOTAL = 1,820 | TOTAL = 1,820 |
| Community Education Program | 25 Children<br>300 TAY<br>1,000 Adult<br>100 Older Adult | 1,425 O&E |
| | TOTAL = 1,425 | Total = 1,425 |

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

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

## Triage Transitional Services (TTS)

| Program Name | Actual Number Served FY 2023/24 | Estimated Number to be Served FY 2025/26 | Annual Budgeted Funds FY 2025/26 | Estimated Annual Cost per Person FY 2025/26 |
|---|---|---|---|---|
| Triage Transitional Services | 2,236 | 2,000 | $2,033,100 | $1,017 |

| Program Serves | Symptom Severity | Location of Services | Typical Population Characteristics |
|---|---|---|---|
| Ages 16+ | SMI* | Clinic-based  | Experiencing a behavioral health crisis |

*SMI = serious mental illness

### Program Description and Target Population

Triage Transitional Services (TTS) were designed to assess consumers who voluntarily present to the Arrowhead Regional Medical Center – Behavioral Health Unit (ARMC-BHU). As part of a team, TTS works alongside ARMC-BHU staff to assist in determining if the consumer meets medical necessity for psychiatric inpatient treatment or if their needs can be met in other, less restrictive settings outside of an emergency department or psychiatric inpatient treatment unit.

The Placement After Stabilization (PAS) program, an expansion of TTS, provides discharge planning and serves as a liaison to facilitate appropriate placement upon discharge for each of the five contracted Crisis Residential Treatment (CRT) facilities throughout San Bernardino County in the following areas: San Bernardino (2 sites), Joshua Tree, Victorville, and Fontana. The staff PAS work collaboratively with CRT staff to provide services that are intended to divert and reduce psychiatric inpatient hospitalization, assist consumers to maintain self-sufficiency, increase housing stability, and assist consumers to successfully reintegrate into the community.

### Demographics

**Age**



**0%** Children
**22%** TAY
**74%** Adult
**4%** Older Adult

**Gender Identity**

**65%** Male
**35%** Female
**<1%** Other

**Race/Ethnicity**

**21%** African American/Black
**29%** Caucasian/White
**<1%** American Indian/ Alaska Native
**2%** Asian/Pacific Islander
**45%** Latinx/Hispanic
**3%** Other/Unknown

**Primary Language**



**97%** English
**3%** Spanish
**<1%** Other/ Unknown

**N**=1,138

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

# CSS: Triage Transitional Services (TTS)



## Services Offered

TTS staff are co-located with ARMC-BHU to provide the following services:

- Crisis assessment and intervention
- Case management
- Collateral contacts
- Transportation assistance
- Linkage to housing assistance
- Linkage to outpatient resources and providers
- Referrals to medical and social services agencies
- Family and caretaker education
- Consumer advocacy

PAS Clinical Therapists are co-located at each CRT site to provide the following services:

- Screening for discharge services
- Assessments
- Discharge planning
- Placement assistance
- Transportation

## Positive Results

In FY 2023/24, TTS staff served a total of 1,781 consumers from the ARMC-BHU Triage Unit. Of these, a total of 926 (52%) consumers were diverted from unnecessary hospitalization.

As part of the expanded TTS services, PAS services assisted a total of 455 consumers. Of these consumers, 285 remained in the CRT program long enough to receive linkage to aftercare services, and 100% were successfully placed in safe and sustainable community placements.

All staff received the Listen-Empathize-Agree-Partner (LEAP) training, a set of evidence-based practices to create therapeutic alliance and trusting relationships with consumers to build rapport and create relationships. This has resulted in providing additional ways to engage with consumers and opportunities to provide services.

## Demographics



**N**=1,138

### Primary Diagnosis

| | |
|---|---|
| **3.0%** Anxiety disorders | **43.2%** Psychosis disorders |
| **7.7%** Bipolar disorders | **5.4%** Substance use disorders |
| **26.9%** Depressive disorders | **12.0%** Other |
| **<1%** Disruptive disorders | **1.2%** None/deferred |
| **<1%** Neurodevelopmental/Cognitive | |

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

## Challenges/Solutions

TTS staff experienced challenges with limited resources for placement, including homeless shelters and housing services. To address this challenge, staff are collaborating with community and other DBH programs to identify additional placement services as part of their ongoing duties.

Challenges with unsuccessful placements in Board and Care and Room and Board were addressed by working collaboratively with Room and Board homeowners and house managers to improve customer service and more successful placements.

Staffing challenges led to delays in timely outpatient psychiatric appointments and clinic intakes, which could potentially impact access to needed medication. To ensure access to timely medication, TTS staff informed consumers about the option to obtain medication refills at the Crisis Stabilization Units (CSUs) in the interim.

Another challenge for consumers was the lack of transportation options. DBH staff assisted consumers by providing bus passes or contacting Managed Care Plans to secure transportation services for medical appointments.

Program staff faced challenges placing system-involved and pregnant transitional age youth (TAY) consumers in traditional TAY programs. To address this challenge, TTS staff worked to identify other TAY service providers in the community to assist with placements for this specific population.

## Outreach and Engagement

For FY 2023/24, 20 participants attended a presentation where TTS program staff were available to discuss their program and offer resources.

### Success Story

"Juan" called the program in crisis after a suicide attempt. Due to staff's ability to assess over the phone and adept skills to build a rapport, Juan presented to the hospital and TTS assisted him as a voluntary walk-in. TTS staff provided connection to follow-up outpatient services. Juan thanked staff when it came time for him to be discharged.

**Program Updates**

There are no planned updates for this program.



Artwork by Willie Cotton

**Success Story**

"Kenny" was a socially isolated consumer when he entered the PAS program. He was resistant to mental health treatment and services and experienced emotional dysregulation, which resulted in challenges in employment. PAS staff supported Kenny and consistently worked with him to become medication and mental health treatment compliant. He developed great social skills, hosts group meetings in his community residence, and has obtained employment. Kenny is now pursuing career training goals to become a Peer and Family Advocate.

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 222-225.

## Community Crisis Response Team (CCRT)

| Program Name | Actual Number Served FY 2023/24 | Estimated Number to be Served FY 2025/26 | Annual Budgeted Funds FY 2025/26 | Estimated Annual Cost per Person FY 2025/26 |
|---|---|---|---|---|
| Community Crisis Response Team | 5,474 | 6,590 | $10,501,558 | $1,594 |

| Program Serves | Symptom Severity | Location of Services | Typical Population Characteristics |
|---|---|---|---|
| **All ages** | **N/A** | **Field-based** | **Experiencing a behavioral health crisis** |

### Program Description and Target Population

Community Crisis Services (CCS) is comprised of the Crisis Contact Center (CCC), the Community Crisis Response Team (CCRT), and the contracted Crisis Mobile Response Team (CMRT). The CCC is a centralized location where anyone can call or text for immediate access to specially trained crisis staff. When necessary, CCC staff dispatch CCRT staff who provide urgent mobile field-based behavioral health services to individuals in cities throughout the County. CCRT and CMRT teams provide mobile crisis response in the East/Central Valley, West Valley, and High Desert regions of the County. Mobile crisis response is available 24 hours per day, 365 days a year at community locations through collaborations that include, but are not limited to: law enforcement, hospitals, schools, Department of Behavioral Health (DBH) clinics, contract providers, specialty programs, group homes, Board and Care (B&C) facilities, family members, and self-referrals.

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 226-229.

### Demographics

**Age**

**26%** Children
**22%** TAY
**39%** Adult
**7%** Older Adult
**7%** Unknown



**Gender Identity**





**47%** Male | **45%** Female | **<1%** Transgender | **7%** Other/Unknown

**Race/Ethnicity**

**14%** African American/Black
**18%** Caucasian/White
**<1%** American Indian/Alaska Native
**3%** Asian/Pacific Islander
**32%** Latinx/Hispanic
**33%** Other/Unknown

**N**=5,474

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

### Program Description and Target Population, cont.

CCS is committed to assisting San Bernardino County residents in the least restrictive manner by providing behavioral health services where the individual is experiencing their crisis.

### Services Offered

- Crisis assessment and intervention in the field, via text messaging, and/or virtual conferencing
- Follow-up services
- Linkage to community resources and providers
- Consultation for interruption of involuntary psychiatric hold (WIC 5150/5585)

### Positive Results

In FY 2023/24, 1,265 consumers were diverted from hospitalization, representing an approximate 6.6% increase in consumers diverted over the previous fiscal year. Of those diverted: 61 consumers were diverted to crisis residential treatment facilities, 720 consumers were diverted to crisis stabilization unit facilities, 158 consumers were diverted to crisis walk-in clinics, and 326 consumers were diverted to other qualified crisis intervention alternatives.

Additionally, CCRT provided therapeutic support services at 29 different community events in FY 2023/24. These events included, but were not limited to, the December 2nd Memorial event, Directing Change, Oak Glen/Forest Falls evacuation center, Recovery Happens event, Sound of Recovery Music event, and Into the Light gallery opening.

## Demographics

### Primary Language



**89%** English
**4%** Spanish
**7%** Other

**N**=5,474



### Primary Diagnosis

**9.7%** Anxiety disorders
**4.2%** Bipolar disorders
**39.1%** Depressive disorders
**4.1%** Disruptive disorders
**1.7%** None/Deferred
**3.2%** Neurodevelopmental/cognitive disorders
**18.4%** Psychosis disorders
**1.7%** Substance Use
**18.1%** Other

**N**=1,334

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

**Positive Results, cont.**

Additionally, to streamline access to Crisis Services, a toll-free number was established in January 2023. Community members experiencing a behavioral health crisis can call the CCC at the toll-free number, where specially trained crisis staff will triage the call and determine if a field response is needed.

**Challenges/Solutions**

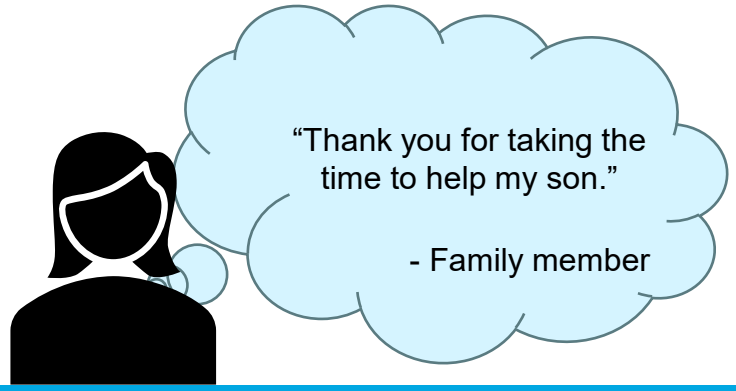
Due to promotional opportunities for current staff and increased competition from other healthcare providers in the county, recruitment and retention of qualified staff remains an ongoing challenge for CCS.

To address these staffing challenges, CCS participated in two hiring fairs to fill multiple vacancies: one hiring fair was solely for hiring staff for CCS and the second hiring fair was open departmentwide.

The Department of Health Care Services (DHCS) released Behavioral Health Information Notice (BHIN) 23-025 in June 2023 that mandated 24/7 mobile crisis response. The challenge was expanding services from 15 hours per day to 24 hours per day. Additionally, our Electronic Health Record (EHR) was not programmed to bill for Federal Benefits for mobile crisis response.

To meet this requirement, CCS established its first contract with a community partner to provide overnight mobile crisis response 365 days per year. Between CCS and the contractor, mobile crisis response is provided 24/7/365.The contract with the provider expires on March 31, 2025, therefore, CCS will seek procurement for mobile crisis response effective April 1, 2025. CCS is working with the EHR administrators to develop a system to bill for services provided according to the BHIN 23-025.

Another challenge was the requirement to use mandated tools issued by DHCS. This required training staff on the new tools as well as working with our Behavioral Health Information Management System (BHIMS) partner to integrate the tools into the Department's EHR. To address this, trainings were developed for staff and program management met with the BHIMS vendor to integrate the tools into the Department's EHR.



## Outreach and Engagement

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

| Activity Type | Number of Activities | Total Number of Participants |
|---|---|---|
| Law Enforcement Collaboration | 18 | 306 |
| School Collaboration | 20 | 243 |
| Disaster Relief Collaboration | 7 | 18 |
| Community Groups Collaboration | 4 | 89 |
| Other San Bernardino County Department Collaboration | 6 | 189 |
| Mental Health Provider/Clinics | 4 | 6 |
| **Total** | **59** | **851** |

## Program Updates

There are no planned updates for this program.

### Success Story

The Crisis Contact Center (CCC) received a text requesting a team be sent to an address in Rancho Cucamonga. When CCC staff called the number, it went to voicemail. Within a few minutes, an additional text was received from the same number that stated “I’m suicidal and depressed because I’m getting put out of my daughter’s house today. I’m afraid, please send someone to help me.”

The CCC staff called again, but the call went to voicemail. Due to not being able to confirm that the scene was safe for a crisis mobile team to respond, the Clinic Supervisor requested a welfare check by the Rancho Cucamonga Sheriff. A deputy responded and located a male who sent the texts. Per the deputy, the male did not meet the criteria for an involuntary hold, but stated the male did want to voluntarily admit himself; the deputy asked CCC for guidance on where the male could go. The male’s family agreed to transport, and the male was taken to a crisis stabilization unit.

## Crisis Intervention Training (CIT)

| Program Name | Actual Number Served FY 2023/24 | Estimated Number to be Served FY 2025/26 | Annual Budgeted Funds FY 2025/26 | Estimated Annual Cost per Person FY 2025/26 |
|---|---|---|---|---|
| Crisis Intervention Training | 2,505 | 1,820 | $6,996,318* | $759* |

| Program Serves | Symptom Severity | Location of Services | Typical Population Characteristics |
|---|---|---|---|
| **Ages 18+** | **N/A** | **Field-based** | **First responders and community partners** |

*Annual budget and cost per consumer represent CIT, CEP, and TEST.

### Program Description and Target Population

**The Crisis Intervention Training (CIT) program** provides behavioral health educational training to first responders and community partners**.** The goal of each training is to enhance participants' knowledge of behavioral health, ability to recognize signs of a behavioral health crisis, utilization of communication and de-escalation skills, stigma reduction, and familiarity with behavioral health programs and other support services and how to access them.

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 230-233.

### Demographics

**Age**

**<1%** Children
**10%** TAY
**59%** Adult
**3%** Older Adult
**28%** Declined to State



**Gender Identity**

**44%** Male
**28%** Female
**28%** Other/Decline to State

**Race/Ethnicity**

**9%** African American/ Black
**19%** Caucasian/White
**<1%** American Indian/ Alaska Native
**3%** Asian/Pacific Islander
**34%** Latinx/Hispanic
**35%** Multiple Races/Other

**N**=2,505

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

# CSS: Crisis Intervention Collaborative Programs



## Services Offered

- In collaboration with San Bernardino County Sheriff's Department:
  - 40-hour CIT course
  - 8-hour Senate Bill 29 (SB 29) Field Training Officer (FTO) CIT course
- In collaboration with Probation:
  - 8-hour Probation CIT course
- Multiple monthly training sessions for collaborative partners and first responders

"Great class. Thank you for all the great information. I will definitely apply it to my work environment. Enjoyed the games and class interaction. It made the time fly by, and we were having fun and learning too. Thanks!"

- CIT Student

## Demographics

### Primary Language



**69%** English

**<1%** Spanish

**30%** Unknown/Other

**N**=2,505 Note: not all numbers add to 100 due to rounding.

## Positive Results

In FY 2023/2024, law enforcement personnel and community partners received training through the CIT program:

- 383 law enforcement personnel completed the 40 Hour CIT Course
- 171 Field Training Officers (FTO) completed the 8 Hour FTO CIT Course
- 652 Probation Officers and Probation Correctional Officers completed the 4 Hour CIT Course
- 212 Fire personnel received training from the CIT program
- 1,087 community partners, public employees, and emergency departments received specialized training from the CIT program
- In total, 2,505 law enforcement, other first responders, and community partners received training from the CIT program in FY 2023/2024.

### Challenges/Solutions

The demand for CIT training program training requests has increased every year. However, staffing shortages were a significant challenge during the first half of FY 2023/24. A portion of the training requests were denied or outsourced when possible due to the staffing shortage. CIT continues to recruit and fill positions while leadership continues to work closely with Human Resources to brainstorm and resolve recruiting and hiring challenges.

Additionally, training new staff in certified curriculum has been difficult, as certification trainings are only offered out of the state and country or not offered at all. To address this challenge, CIT leadership is working on bringing LEAP and other trainings to the department for staff development.

### Outreach and Engagement

Through community education and outreach, DBH fosters an environment in which the public is more knowledgeable of crisis mitigation and de-escalation skills, self-care, and suicide prevention. San Bernardino County residents who may be experiencing mental health and/or substance use disorder concerns are made aware of diverse resources.

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

| Activity Type | Number of Activities | Total Number of Participants |
|---|---|---|
| Outreach/Networking Event | 2 | 250 |
| Community Collaborative Meeting | 11 | 302 |
| Gang and Drug Taskforce | 2 | 70 |
| 40 Hour CIT Course | 10 | 383 |
| 8 Hour Field Training Officer (FTO) Course | 7 | 171 |
| 4 Hour Probation Dept. CIT Course | 22 | 652 |
| Fire Trainings | 6 | 212 |
| Community Partner Trainings | 38 | 1,087 |
| **Total** | **98** | **3,127** |

**Program Updates**

There are no planned updates for this program.



Artwork by Roxanne Olsen

"The scenarios were done really well with very good acting and were extremely helpful."

- CIT Student



Artwork by Benjamin Vasquez

"After 15 years in law enforcement, I did not want to come to this training. However, this is possibly the best mental heath class I have attended. Great job by all and look forward to working with you all in the future."

- CIT Student

## Community Education Program (CEP)

| Program Name | Actual Number Served FY 2023/24 | Estimated Number to be Served FY 2025/26 | Annual Budgeted Funds FY 2025/26 | Estimated Annual Cost per Person FY 2025/26 |
|---|---|---|---|---|
| Community Education Program (CEP) | 755 | 1,425 | $6,996,318* | $759* |

*Annual budget and cost per consumer represent CIT, CEP, and TEST.

| Program Serves | Symptom Severity | Location of Services | Typical Population Characteristics |
|---|---|---|---|
| **Ages 16+** | **N/A** | **Field-based** | **General public, including but not limited to community-based organizations, faith institutions, education institutions, and government agencies** |

### Program Description and Target Population

**Community Education Program (CEP)** provides education and training opportunities to community members and community partners to promote a greater understanding of behavioral health.

This includes the coordination and facilitation of certified curriculum, such as Mental Health First Aid (MHFA), Applied Suicide Intervention Skills Training (ASIST), SafeTALK (Suicide Alertness Training), and Listen, Empathize, Agree, and Partner (LEAP) trainings.

### Demographics

**Age**

**0%** Children
**8%** TAY
**68%** Adult
**4%** Older Adult
**19%** Unknown

**N**=755

**Gender Identity**

**16%** Male
**65%** Female
**19%** Other/Decline to State

**Race/Ethnicity**

**15%** African American/Black
**18%** Caucasian/White
**<1%** American Indian/ Alaska Native
**4%** Asian/Pacific Islander
**33%** Latinx/Hispanic
**29%** Multiple Races/Other

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

## Program Description and Target Population, cont.

The Community Education Program (CEP) is a distinct program that is part of the Crisis Intervention Training (CIT) Program budget. Existing Workforce Education and Training staff and Public Relations staff and services that were forecasted and allocated in the Three-Year Plan transferred to the CIT budget to meet the needs of this new program.

## Services Offered

- Community Trainings:
  - Mental Health First Aid
  - Applied Suicide Intervention Skills Training (ASIST)
  - SafeTALK
  - Listen, Empathize, Agree, and Partner (LEAP)
- Community Behavioral Health Presentations

## Demographics

### Primary Language



**78%** English

**<1%** Spanish

**22%** Other/Decline to State

**N**=755 **Note**: not all numbers add to 100 due to rounding.

## Positive Results

A total of 41 trainings were facilitated, and 755 community members received training through the Community Education Program (CEP) in FY 2023/24.

- 139 Adult Mental Health First Aid
- 29 Applied Suicide Intervention Skills Training (ASIST)
- 81 SafeTALK
- 161 Listen, Empathize, Agree, and Partner (LEAP)
- 345 community members completed a non-certified CEP training or presentation

## Challenges/Solutions

The initial process of establishing the Community Education Program (CEP) was challenging, particularly in recruiting, hiring, and training new staff. This process spanned the first half of the fiscal year, official CEP training were made available to the public beginning in January 2024. CEP leadership worked with Human Resources to hire a new Staff Training Instructor in October of 2023 and is requesting a Mental Health Education Consultant for Fiscal Year 2024/25 as a solution to the staffing challenges.

Training new staff in certified curriculum has also been challenging, as many required trainings are only offered out of state or internationally or are not readily available. To address this challenge, CEP leadership is working on having the vendors for LEAP and potentially SafeTALK provide an in-house train-the-trainer course.

### Outreach and Engagement

For FY 2023/24, the Community Education Program (CEP)program conducted the following outreach and engagement activities:

| Activity Type | Number of Activity Type | Total Number of Participants |
|---|---|---|
| Gang and Drug Task Force | 2 | 70 |
| Community Collaborative Meetings | 9 | 277 |
| Listen, Empathize, Agree and Partner trainings | 10 | 161 |
| Mental Health First Aid – Adult trainings | 8 | 139 |
| SafeTALK trainings | 5 | 81 |
| ASIST trainings | 2 | 29 |
| Non-Certified CEP trainings | 16 | 345 |
| **Total** | **52** | **1,102** |

### Program Updates

There are no planned updates for this program.

"Excellent training! Instructors were knowledgeable, thorough, and clearly subject matter experts! Excellent training."

- CEP Student

"Both trainers were great. Both were engaged and helpful, full of info. They made me feel safe and confident that I can apply this in life. This training gave me a boost of confidence to continue my education in mental health."

- CEP Student

"The role-play Rachel conducted was impactful. It was a great way to showcase the material and present LEAP in a way that was tangible."

- CEP Student

## Triage, Engagement, and Support Teams (TEST)

| Program Name | Actual Number Served FY 2023/24 | Estimated Number to be Served FY 2025/26 | Annual Budgeted Funds FY 2025/26 | Estimated Annual Cost per Person FY 2025/26 |
|---|---|---|---|---|
| Triage, Engagement, and Support Teams | 4,613 | 5,975 | $6,996,318* | $759* |

*Annual budget and cost per consumer represent CIT, CEP, and TEST.

| Program Serves | Symptom Severity | Location of Services | Typical Population Characteristics |
|---|---|---|---|
| All ages | SED or SMI* | Field-based | Experiencing a behavioral health crisis |

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

### Program Description and Target Population

The main objective for the TEST program is the mitigation of unnecessary expenditures for law enforcement by reducing the amount of time law enforcement spends with individuals needing a behavioral health crisis intervention, thus reducing the number of encounters between law enforcement and individuals in behavioral health crisis.

TEST staff are co-located within 32 internal and external County partner agencies, including, but not limited to, law enforcement agencies, hospital emergency departments, and college campuses.

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 234-238.

### Demographics

**Age**



**14%** Children
**19%** TAY
**50%** Adult
**16%** Older Adult
**1%** Unknown

**N**=4,613

**Gender Identity**

**51%** Male
**47%** Female
**2%** Other

**Race/Ethnicity**

**13%** African American/ Black
**37%** Latinx/Hispanic
**3%** Asian/Pacific Islander
**<1%** Native American
**35%** Caucasian/White
**12%** Other/Unknown

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

**Program Description and Target Population, cont.**

The TEST program provides exclusive support to its partnering departments and agencies. TEST staff respond in the field alongside law enforcement personnel and/or assist other partnering agency staff in managing consumer behavioral health crises. Additionally, TEST provides follow-up case management services for up to 59 days, after initial contact, to link consumers with resources for ongoing behavioral health stability.

Four of the co-located sites are part of a new collaborative initiative known as Community Outreach and Support Team (COAST). COAST units are co-response teams comprised of a TEST social worker; a firefighter Emergency Medical Technician (EMT) with a therapy canine; and a plain-clothed, specially trained police officer. TEST's role as part of a COAST team is consistent with other co-located partnerships. The purpose of this model is to provide consumers with rapid access to crisis triage in a non-threatening manner.

**Services Offered**

- Crisis assessment and intervention in the field
- Case management
- Support for collateral contacts
- Referrals and linkages to community resources and providers
- Family and caretaker education
- Consumer advocacy
- Education and support for law enforcement and community partners regarding behavioral health concerns and resources

**Demographics**

**Primary Language**



**96%** English

**2%** Spanish

**3%** Other/Not Reported



**Primary Diagnosis**

**5.2%** Anxiety disorders

**3.5%** Bipolar disorders

**36.7%** Depressive disorders

**2.2%** Disruptive disorders

**<1%** Neurodevelopmental/cognitive disorders

**3.0%** None/deferred

**23.8%** Psychosis disorders

**3.9%** Substance use disorders

**21.0%** Other

**N**=772

**N**=4,613 **Note**: not all numbers add to 100 due to rounding.

## Positive Results

TEST program data is captured based on an "encounter," which refers to an instance in which TEST staff engage an individual for services. In FY 2023/24, TEST

- Recorded 12,358 encounters.
- Provided 15,150 referrals to behavioral health and community resources. Often, when TEST staff engage with an individual during an encounter, they identify that these individuals and/or families need more than one referral to multiple types of resources to help meet their needs.
- Increased access to and use of existing community resources.
- Continued use of alternative crisis interventions (e.g., CWIC, CCRT, CSU) resulted in 98% of TEST Crisis Interventions being diverted from hospitalization for FY 2023/24 compared to 92% in FY 2022/23.

## Challenges/Solutions

In FY 2023/24, the TEST program experienced challenges with finding qualified candidates for two positions for the San Bernardino County Sheriff's Department (SBCSD) in Needles. This location is in a remote area at the far end of San Bernardino County, making it difficult to fill these positions. Solutions for filling these positions for our Needles Sheriff Station include working with our county Human Resource (HR) Department to open a special recruitment specifically targeting qualified individuals residing in or near the Needles area and collaborating with the SBCSD, the TEST program Deputy Director (DD), San Bernardino County Board of Supervisors (BoS) and the City of Needles to promote the two vacancies.

As the program continues to expand, balancing staffing needs and budgetary constraints remains a challenge. Each co-location site requires infrastructure to accommodate the assigned staff, added costs for space, equipment such as laptops and cell phones, etc. The TEST program continues to look for ways to mitigate these costs into sustainable funding sources.

TEST experiences challenges with the crucial need to maintain a robust collaborative relationship with the various agencies. Continuous, active efforts in building and maintaining relationships with law enforcement and community partners include meetings with all co-location partners to ensure the partners are aware of the purpose of TEST staff. In addition, 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

## Outreach and Engagement

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

| Activity Type | Number of Activities | Total Number of Participants |
|---|---|---|
| Community Groups Collaboration | 148 | 2,138 |
| Law Enforcement Briefing | 1,738 | 26,525 |
| Homeless Outreach | 27 | 3,717 |
| CIT Presentations | 4 | 212 |
| Law Enforcement Outreach | 2,294 | 27,820 |
| School Outreach (K-12) | 5 | 618 |
| School Outreach Higher Education) | 4 | 332 |
| Food drive | 11 | 116 |
| Health and Wellness Outreach | 11 | 673 |
| **Totals** | **4,242** | **62,151** |

### Success Story

"I wanted to email you to thank you for your concern, and all of the kindness and resources that I have received from the Victor Valley Sheriff Department. I did not expect to encounter so many helpful and genuine individuals. My time in Victorville, although challenging, has opened my eyes to a brand-new perspective on life, but my time here is coming to an end as I move back to Los Angeles, fulltime, in two weeks. I was wondering if it would be possible to meet with Deputy D. Waters in person before I go, to say a proper thank you and goodbye."



Artwork by Garth Pezant Sr.

**Program Updates**

There are no planned updates for this program.

**Success Story**

"David" reported feeling extremely overwhelmed and depressed over the past few weeks due to the loss of a sibling and being kicked out of his home. He was experiencing homelessness and temporarily staying in a hotel room. He reported wanting to get out of his situation but did not have anyone to lean on during those times. David shared it had been challenging to work on creating friendships since he usually isolated himself. David had been diagnosed with anxiety and depression and was not taking any medication. Due to this depression and isolation, he began to use methamphetamine to cope with these feelings. David reported previous suicide attempts due to voices telling him that he was worthless.

A TEST social worker assisted David in completing an intake for substance use treatment services and provided regular follow-ups and resources for urgent mental health services. David was informed of bed availability and contacted his social worker to link him to services. David was scheduled to be picked up by the social worker and transported to a substance use treatment center. David was cooperative with maintaining contact with his social worker but stopped communication after the social worker's second attempt at calling him. After 45 minutes of waiting for David, he finally answered the social worker's attempts to contact him. David shared feeling overwhelmed and afraid of what his new future would look like. The social worker provided support and de-escalated him from experiencing a mental health crisis. After some encouragement, David agreed to follow through with receiving treatment. David was cooperative and spoke in a hopeful tone during transport to the center. David was successfully linked to SUD treatment services and thankful for being connected to the services he needed.

# CSS: Crisis Stabilization System of Care

## Introduction

The Crisis Stabilization System of Care operates as part of the 24-Hour and Emergency Services Division of DBH. The services offered through these programs are centered on providing immediate intervention along with stabilization services to consumers who are experiencing a mental health crisis. These care options are accessible in various settings operated by contracted treatment providers with DBH including Fee-For-Service Lanterman-Petris-Short (LPS) hospitals, Crisis Stabilization Units (CSUs), Crisis Walk-In Centers (CWICs), and Crisis Residential Treatment Centers (CRTs).

## Target Population

The table below displays the target population of consumers to be served by programs within the Crisis Stabilization System of Care for Fiscal Year 2025/26. The target population is categorized based on MHSA age categories. MHSA age categories are Children, TAY, Adult, and Older Adult.

**Crisis Stabilization System of Care Programs**

| Program Name | Target Population | | | |
|---|---|---|---|---|
| | Children | TAY | Adults | Older Adult |
| Crisis Walk-In Center (CWIC) | X | X | X | X |
| Crisis Stabilization Unit (CSU) | X | X | X | X |
| Crisis Residential Treatment (CRT) | | X | X | |

# CSS: Crisis Stabilization System of Care

**Number of Consumers to be Served**

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

| Program Name | | Ages Served | Service Area* |
|---|---|---|---|
| Crisis Walk-In Center | | 212 Children<br>496 TAY<br>1,246 Adult<br>145 Older Adult | 2,099 GSD |
| | | TOTAL = 2,099 | TOTAL = 2,099 |
| Crisis Stabilization Unit | | 366 Children<br>1,052 TAY<br>3,631 Adult<br>368 Older Adult | 5,417 GSD |
| | | TOTAL = 5,417 | TOTAL = 5,417 |
| Crisis Resident Treatment | Adult CRT | 50 TAY<br>416 Adult | 466 GSD |
| | | TOTAL = 466 | TOTAL = 466 |
| | TAY CRT | 101 TAY | 101 GSD |
| | | TOTAL = 101 | TOTAL = 101 |

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

## Crisis Stabilization Unit (CSU)

| Program Name | Actual Number Served FY 2023/24 | Estimated Number to be Served FY 2025/26 | Annual Budgeted Funds FY 2025/26 | Estimated Annual Cost per Person FY 2025/26 |
|---|---|---|---|---|
| Crisis Stabilization Unit (CSU) | 5,258* | 5,417 | $13,383,661** | $1,781** |

| Program Serves | Symptom Severity | Location of Services | Typical Population Characteristics |
|---|---|---|---|
| All Ages | All Levels | Clinic-based  | Experiencing a behavioral health crisis |

*This number does not include Outreach and Engagement (O&E).
**Annual budget and cost per consumer represent both CWIC and CSU.

### Program Description and Target Population

Crisis Stabilization Units (CSUs) provide voluntary mental health urgent care services in a community-based setting for consumers in need of immediate crisis stabilization as a result of a mental health crisis. These programs operate 24/7, and services last for less than 24 hours. Each CSU facility has 20 spaces for crisis stabilization services, which includes 16 for adults (aged 18 and older) and 4 for children and adolescents (aged 17 and under). CSU facilities are intended to serve as a home-like, community-based alternative to unnecessary psychiatric hospitalization or incarceration. Services are available to individuals of all ages experiencing a mental health crisis.

### Demographics

**Age**



**8%** Children
**20%** TAY
**65%** Adult
**6%** Older Adult

**Gender Identity**





**56%** Male **44%** Female **<1%** Other

**Race/Ethnicity**

**21%** African American/ Black
**3%** Asian/Pacific Islander
**24%** Caucasian/White
**50%** Latinx/Hispanic
**<1%** American Indian/ Alaska Native
**3%** Other/Unknown

**Primary Language**



**96%** English
**4%** Spanish
**<1%** Other

**N**=4,856

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

# CSS: Crisis Stabilization Unit



## Services Offered

- Crisis intervention and stabilization
- Psychiatric evaluation and medication, if needed
- Voluntary peer-to-peer enriched engagement and support
- Substance use disorder screening, assessment, and referral/linkage
- Therapeutic interventions

## Positive Results

The two Crisis Stabilization Unit (CSU) programs served a combined total of 5,258 unique consumers during FY 2023/24. These programs provided 8,206 episodes of crisis stabilization to these consumers.

Of the 8,206 admissions, 97.3% were successfully diverted from unnecessary psychiatric hospitalization at the time of receiving CSU services.

In FY 2023/24, the two Crisis Stabilization Units (CSUs) received referrals from a total of 87 unique collaborative partners, including psychiatric hospitals, hospital emergency departments, outpatient clinics, substance use treatment providers, law enforcement agencies/officers, schools, faith-based organizations, shelters, and other community agencies.

- 879 referrals originated from law enforcement, who utilize the CSUs as an alternate destination to psychiatric hospitals or detention facilities when encountering a mental health crisis in the community.
- 342 referrals originated from local hospitals, representing a population whose crisis was appropriately manageable at the CSU rather than at the inpatient level of care.

Voluntary consumer satisfaction surveys were provided to consumers who received crisis stabilization services. Of the 5,200 surveys issued by the two CSUs, the programs received a combined 94.2% consumer satisfaction rate with the services received.

## Demographics



**Primary Diagnosis**

| | |
|---|---|
| **10.3%** Anxiety disorders | **1%** Neurodevelopmental/Cognitive |
| **9.3%** Bipolar disorders | **30.9%** Psychosis disorders |
| **20.9%** Depressive disorders | **4.5%** Substance Related |
| **4.1%** None/deferred | **<1%** Disruptive disorders |
| **18.3%** Other | |

**N**=4,856

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 241-245.

## Challenges/Solutions

Maintaining qualified personnel to provide crisis stabilization services continues to be a challenge as remote work opportunities become more commonplace in the healthcare environment. Since CSU regulations require on-site staff 24/7, remote work is not an option for direct care staff, which impacts recruitment and retention.

To ensure ongoing availability of services and to address workforce challenges, CSUs have a robust intern program, that allows them to maintain a solid recruitment pipeline from internship to graduation for clinical roles. The programs are also focusing on retention efforts to maintain staffing rotation at a high capacity.

As CSU programs are housed in county-owned buildings, standard facilities management procedures created delays in addressing building-related issues communicated by CSU staff. These delays can affect the number of consumers the facility can accomodate while awaiting repairs.

Improved communication between the CSUs and DBH/County Facilities Management has facilitated smoother completions of work orders. DBH has also added Program Administration staff as dedicated support for all CSU concerns, which has resulted in a stronger follow-up and support system. The continued relationship growth and new workflow have been valuable in expediting critical fixes as the needs arise.

### Success Story

"Jack" came to the CSU feeling sad, hopeless, helpless, and unmotivated. CSU staff worked to stabilize him and provided him an array of services to assist him, including assistance with meals, nursing care, mental health services, and psychiatric evaluation. Staff were also able to connect him to a private faith-based rehabilitation program and advocate for him to be seen for a personal interview on the same day. The administrator of the program agreed to meet Jack for an interview, and he was admitted to the program a few hours later. Jack subsequently contacted the CSU to express his gratitude.

### Outreach and Engagement

CSU staff and DBH regularly conduct outreach presentations to the community and to partnering agencies to increase awareness of the availability of this service, educate on program criteria and how to appropriately refer, and how CSU programs coordinate with the DBH continuum of care.

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

| Activity Type | Number of Activities | Total Number of Participants |
|---|---|---|
| Collaborative Meetings | 41 | 947 |
| Event participation | 5 | 1,457 |
| Other Outreach Activities | 2 | 21 |
| Presentations | 39 | 1,278 |
| Telephonic/Electronic Outreach | 21 | 29 |
| **Totals** | **108** | **3,732** |

### Program Updates

There are no planned updates for this program.

### Success Story

"Bianca" visited the CSU frequently while she was staying in a room and board facility. She came back multiple times within a week, stating that remaining at the CSU assisted her with refraining from using substances. She reported that she was able to remain clean, felt clear-headed, and was thankful for the staff that let her stay almost every night to keep her safe and off drugs. Bianca is now living independently, remains connected to a program for ongoing treatment, and receives all her benefits.

## Crisis Walk-In Center (CWIC)

| Program Name | Actual Number Served FY 2023/24 | Estimated Number to be Served FY 2025/26 | Annual Budgeted Funds FY 2025/26 | Estimated Annual Cost per Person FY 2025/26 |
|---|---|---|---|---|
| Crisis Walk-In Center (CWIC) | 2,063* | 2,099 | $13,383,661** | $1,781** |

| Program Serves | Symptom Severity | Location of Services | Typical Population Characteristics |
|---|---|---|---|
| All ages | All Levels | Clinic-based | Experiencing a mental health crisis |

*This number does not include Outreach and Engagement (O&E).
**Annual budget and cost per consumer represent both CWIC and CSU.

### Program Description and Target Population

Crisis Walk-In Centers (CWIC) provide voluntary mental health urgent care services in a community-based setting for consumers in need of immediate crisis stabilization as a result of a mental health crisis. These programs operate 24/7, and services last for less than 24 hours. Each facility has 12 spaces for crisis stabilization services. CWIC facilities are intended to serve as a community-based alternative to unnecessary psychiatric hospitalization or incarceration. Services are available to individuals of all ages experiencing a mental health crisis.

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 246-250.

### Demographics

**Age**

**11%** Children
**23%** TAY
**59%** Adult
**8%** Older Adult

**Gender Identity**

**49%** Male
**51%** Female
**<1%** Other

**Race/Ethnicity**

**18%** African-American/Black
**41%** Caucasian/White
**<1%** American Indian/Alaska Native
**2%** Asian/Pacific Islander
**21%** Latinx/Hispanic
**17%** Other/Unknown

**Primary Language**

**97%** English
**2%** Spanish
**1%** Other/Unknown

**N**=2,051

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

## Services Offered

- Crisis intervention and stabilization
- Psychiatric evaluation and medication, if needed
- Voluntary peer-to-peer enriched engagement and support
- Substance use disorder screening, assessment, and referral/linkage
- Therapeutic interventions

## Positive Results

The two Crisis Walk-In Center (CWIC) programs served a total of 2,063 unique consumers during FY 2023/24. These programs provided a combined 3,064 episodes of crisis stabilization to these consumers.

Of the 3,064 admissions, 96.4% were successfully diverted from unnecessary psychiatric hospitalization at the time of receiving CWIC services.

Voluntary consumer satisfaction surveys were provided to consumers who received crisis stabilization services at the CWICs. Out of 1,952 surveys issued by the two CWICs, the programs received a combined 90.9% consumer satisfaction rate with the services received.

### Success Story

"Luke" presented at the CWC after recently being displaced from his home, which caused his mental health symptoms to increase. CWIC personnel were able to reconnect Luke with family out of state after he identified them as a support system. His family was open to assisting and housing Luke. CWIC was able to provide a bus ticket for him to travel to his family. CWIC staff researched and provided resources for Luke's continued recovery in the other state in which he would be residing.

## Demographics

### Primary Diagnosis



**14.0%** Anxiety disorders
**13.1%** Bipolar disorders
**31.8%** Depressive disorders
**<1%** Disruptive disorders
**1.2%** Neurodevelopmental/cognitive disorders
**27.2%** Psychosis disorders
**4.2%** Substance use disorders
**7.1%** Other
**<1%** None/Deferred

**N**=2,051

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

### Challenges/Solutions

The Crisis Walk-In Centers (CWICs) experienced challenges with recruitment and hiring, especially amid increasing demand for remote work availability, which is not possible for CWICs due to the nature of the services provided by the program.

To address workforce challenges, CWICs continue to implement salary market rate adjustments to remain competitive with other providers and maintains sign-on bonuses to boost recruiting and increase candidate pools.

Valley Star Behavioral Health, the contract provider CWICs, communicates any budget adjustment needs with DBH and cooperates in the analysis process to evaluate the need for additional funding.

### Success Story

"Matthew" came to the CWIC unmedicated, unhoused, and struggling with co-occurring mental health and substance use diagnoses. He was able to stabilize with the support of a therapist and Peer Support Counselor, who ultimately linked Matthew with housing and outpatient substance use services.

### Outreach and Engagement

CWIC staff and DBH provide frequent outreach presentations to the community and to partnering agencies to increase awareness of the availability of this service, educate on program criteria and how to appropriately refer, and how CWIC programs coordinate with the DBH continuum of care.

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

| Activity Type | Number of Activities | Total Number of Participants |
|---|---|---|
| Collaborative Meetings | 84 | 361 |
| Other Outreach Activities | 3 | 3 |
| Presentations | 17 | 449 |
| Telephonic/Electronic Outreach | 34 | 82 |
| **Totals** | **138** | **895** |

### Program Updates

There are no planned updates for this program.

## Adult Crisis Residential Treatment (CRT)

| Program Name | Actual Number Served FY 2023/24 | Estimated Number to be Served FY 2025/26 | Annual Budgeted Funds FY 2025/26 | Estimated Annual Cost per Person FY 2025/26 |
|---|---|---|---|---|
| Adult Crisis Residential Treatment | 485* | 466 | $16,610,099** | $29,295** |

*This number does not include Outreach and Engagement (O&E).
**Annual budget and cost per consumer represent both adult and TAY CRTs.

| Program Serves | Symptom Severity | Location of Services | Typical Population Characteristics |
|---|---|---|---|
| Ages 18-59 | SMI* | Facility-based  | Experiencing a behavioral health crisis |

*SMI = serious mental illness

### Program Description and Target Population

The Adult Crisis Residential Treatment (CRT) program offers short-term, voluntary crisis residential treatment options for San Bernardino County residents ages 18 to 59. Individuals may stay for up to 90 days to receive services in a home-like environment that supports and promotes the individual's recovery, wellness, and resiliency within the community. Services are designed for individuals who are experiencing an acute psychiatric episode or mental health crisis and are in need of short-term crisis residential treatment services to deter acute psychiatric hospitalization. CRT programs operate 24 hours a day, 7 days a week, 365 days a year.

### Demographics

**Age**



**0%** Children
**16%** TAY
**84%** Adult
**0%** Older Adult

**Gender Identity**

**60%** Male
**40%** Female

**Race/Ethnicity**

**23%** African American/Black
**32%** Caucasian/White
**<1%** American Indian/ Alaska Native
**3%** Asian/Pacific Islander
**39%** Latinx/Hispanic
**3%** Other/Unknown

**Primary Language**



**99%** English
**1%** Spanish
**<1%** Other

**N**=439

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

## Services Offered

- Comprehensive clinical assessments and therapy
- Crisis intervention
- Psychiatric and medication support
- Life skills coaching
- Peer and family support networks
- Coping techniques
- Recovery education
- Substance use education
- Community resource linkages

## Positive Results

During FY 2023/24, a total of 485 unique consumers were served by the four adult CRT programs. Of consumers who were discharged from the program during the fiscal year, 95% were successfully diverted from psychiatric hospitalization at the time of receiving CRT services.

DBH contracts with two agencies to provide Crisis Residential Treatment (CRT) services. Each agency delivers a unique consumer satisfaction survey after discharge from the facility. All surveys are voluntary.

The first contracted agency operates three CRT programs and evaluates consumer agreement with twenty statements including, but not limited to:

- I felt safe and supported during my crisis.
- I am more resilient and am more likely to overcome challenges after participating in the program.
- Staff understood, respected, and sympathized with my unique abilities.

Out of 158 surveys collected, the three programs received a combined average consumer satisfaction rating of 94% across all satisfaction questions, indicating that 94% of respondents agreed or strongly agreed with the given statements.

## Demographics

**Primary Diagnosis**



**5.9%** Anxiety disorders

**10.7%** Bipolar disorders

**21.6%** Depressive disorders

**<1%** None/Deferred

**48.3%** Psychosis disorders

**7.9%** Substance use disorders

**5.0%** Other

**N**=439

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

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 251-255.

**Positive Results, cont.**

The second contracted agency operates one CRT program and evaluates consumer agreement with twelve statements including, but not limited to:

- As a direct result of the services I received, I am better able to deal with crisis.
- Staff here believed that I could grow, change, and recover.
- I was able to get all the services I thought I needed.

Out of 59 surveys collected, this program received an average 89% consumer satisfaction rating across all satisfaction questions, indicating that 89% of respondents agreed or strongly agreed with the given statements.

**Challenges/Solutions**

Due to the national workforce shortage, and the sudden increase in the cost of living making current wages non-competitive, CRTs experienced challenges with recruitment and hiring. These challenges were further compounded by the growing demand for remote work opportunities, which is not feasible for CRTs due to the in-person nature of the services provided.

Additionally, CRTs are required to have a specific number of specialized staff on site per consumer being treated. Staff shortages have limited the number of consumers a CRT facility can admit on days when staffing numbers are lower than normal.

To address the workforce challenges, CRTs have completed salary market rate adjustments to remain competitive with other providers, implemented sign-on bonuses to boost recruiting and increase candidate pools, and hired a talent acquisition manager/team to engage in more targeted recruitment efforts such as hiring fairs and virtual recruitment projects.

To address the changing needs of the consumer population, CRTs have prioritized Adverse Childhood Experiences (ACE) screening tools, provided recovery-oriented and evidence-based interventions, emphasized the importance of trauma-informed care through hiring choices and workforce development, and worked to promote staff wellness.

### Outreach and Engagement

For FY 2023/24, the Crisis Residential Treatment (CRT) program conducted the following outreach and engagement activities:

| Activity Type | Number of Activities | Total Number of Participants |
|---|---|---|
| Collaborative Meetings | 38 | 158 |
| Planning Collaboration with other DBH programs | 57 | 173 |
| Presentations | 10 | 40 |
| Tours and presentations to increase collaborative partners | 5 | 10 |
| **Totals** | **110** | **381** |

### Program Updates

There are no planned updates for this program.

**Success Story**

After completing the CRT program, “Joseph” was able to fully eliminate his suicidal thoughts, as well as significantly reduce his depression and trauma response symptoms. James was successfully linked to a DBH shelter program with outpatient services to aid in maintaining stability.

**Success Story**

“Anabel” was referred to the CRT from one of the county’s CSUs. She took full advantage of the diverse groups offered in the program and was also able to meet weekly with a therapist and substance use counselor. When she left the program, Anabel felt much more stable and was able to connect with a room and board the clinician connected her to.

## TAY Crisis Residential Treatment (CRT)

| Program Name | Actual Number Served FY 2023/24 | Estimated Number to be Served FY 2025/26 | Annual Budgeted Funds FY 2025/26 | Estimated Annual Cost per Person FY 2025/26 |
|---|---|---|---|---|
| TAY Crisis Residential Treatment | 100 | 101 | $16,610,099* | $29,295* |

*Annual budget and cost per consumer represent both adult and TAY CRTs.

| Program Serves | Symptom Severity | Location of Services | Typical Population Characteristics |
|---|---|---|---|
| **Ages 18-25** | **SMI*** | **Facility-based**  | **Experiencing a behavioral health crisis** |

*SMI = serious mental illness

### Program Description and Target Population

TAY CRT, a specialty CRT for Transitional-Age Youth (TAY) colloquially known as "The STAY", is a short term, voluntary residential treatment center. The STAY accepts consumers ages 18-25 who are experiencing a mental health crisis. Individuals may stay for up to 90 days and receive services in a home-like environment that supports and promotes the consumer's recovery, wellness, and resiliency within the community. The STAY increases access to appropriate mental health services for TAY in crisis. Co-located with the DBH One-Stop TAY Center in San Bernardino, this unique program provides comprehensive and collaborative TAY-targeted services to support maximum recovery for young adults.

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 256-259.

### Demographics

**Age**



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

**N**=100

**Gender Identity**



**60%** Male
**40%** Female

**Race/Ethnicity**

**28%** African American/Black
**20%** Caucasian/White
**1%** American Indian/ Alaska Native
**1%** Asian/Pacific Islander
**48%** Latinx/Hispanic
**2%** Other/Unknown

**Primary Language**



**98%** English
**1%** Spanish
**1%** Unknown/ Not Reported

# CSS: Crisis Residential Treatment



## Services Offered

- Comprehensive clinical assessments and therapy
- Therapeutic and psycho-educational groups
- Activities and training that focus on daily living skills
- Behavioral intervention and modification training
- Individual and group counseling
- Crisis intervention
- Psychiatric and medication support
- Substance use disorder counseling and referrals
- Recreational therapy
- Educational assistance
- Pre-release and discharge preparation and planning

## Positive Results

In FY 2023/24, 100 unique consumers were served by TAY CRT. Of consumers who were discharged from the program during the fiscal year, 95% were successfully diverted from unnecessary psychiatric hospitalization at the time of receiving CRT services.

## Demographics

**Primary Diagnosis**



**N**=100

| | |
|---|---|
| **4%** Anxiety disorders | **27%** Depressive disorders |
| **13%** Bipolar disorders | **45%** Psychosis disorders |
| **1%** None/deferred | **5%** Other |
| **4%** Substance Use disorder | **1%** Neurodevelopmental/ Cognitive disorders |

The TAY CRT received referrals from a total of 17 unique collaborative partners, including psychiatric hospitals and hospital emergency departments, Crisis Stabilization Units (CSU) and Crisis Walk-in Centers (CWIC), outpatient clinics, law enforcement agencies/officers, and community agencies.

## Challenges/Solutions

Due to the national workforce shortage and sudden increase in the cost of living, making current wages non-competitive, TAY CRT experienced challenges with recruitment and hiring, especially amid increasing demand for remote work availability, which is not possible for CRTs due to the nature of the services provided by the program. To address these workforce challenges, TAY CRT continues to complete salary market rate adjustments to remain competitive with other providers and maintains sign-on bonuses to boost recruiting and increase candidate pools.

Additionally, an increasing number of TAY consumers are being routed to adult-oriented CRT programs instead of being referred to TAY CRT first. While all CRT programs deliver quality services that support each individual's stabilization and recovery amid their mental health crisis, TAY CRT programming includes age-appropriate interventions, collaborations, and linkage/referral opportunities that target the TAY age group. To improve the

### Challenges/Solutions, cont.

likelihood of referring entities connecting TAY consumers with the TAY initially, TAY CRT continues to provide outreach to community partners, ensuring they understand the benefits of connecting the consumer to the TAY, and working with other CRTs to refer to TAY CRT if consumers in the TAY age group were referred to their program.

### Outreach and Engagement

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

| Activity Type | Number of Activities | Total Number of Participants |
|---|---|---|
| Collaborations with other DBH programs | 52 | 171 |
| Participation in school event | 1 | 12 |
| **Totals** | **53** | **183** |

### Program Updates

There are no planned updates for this program.

**Success Story**

"Gina" was able to stabilize in 63 days, significantly decreasing psychosis and mood instability symptoms. She was successfully linked to outpatient services and reunited with her family for housing.

**Success Story**

"Athena" was able to stabilize in 84 days, fully eliminating suicidal ideation and self-harming behaviors, and significantly reducing repression and trauma response symptoms. She was linked to One Stop TAY in San Bernardino to aid in maintaining her stability.

## Introduction

Peer Support Programs coordinate service delivery efforts that offer stigma-free, peer support for consumers living with serious mental illness and/or seeking recovery from substance use and their family members. This person-centered, strengths-based approach embraces and incorporates each individual's lived experience into the recovery and support process. Peer Support Programs include Clubhouses, Community Connections, and Peer Provider Workforce Support.

**Clubhouses** are peer support centers that are recovery oriented for consumers 18 years or older. There are nine clubhouses located throughout the county that are dedicated to assisting consumers living with a serious mental illness or seeking recovery from substance use. Clubhouses are primarily consumer-driven and operate with minimal support from department staff. Clubhouse members drive all operations decisions such as support groups, community engagement, staffing, and activity choices.

The **Community Connections Program** focuses on connecting consumers ages 16 and older with opportunities such as improving pre-employment skills, volunteering, paid employment, and engaging in peer support. Participants partner with Employment Specialists to maximize their existing skills, while also considering their individual wellness goals in relation to potential community commitments.

**Peer Provider Workforce Support Program**, formerly titled Peer Workforce, the Peer Provider Workforce Support Initiative continues DBH's commitment to growing, supporting, and improving the inclusion of a fully integrated peer workforce. In FY 2023/24, these efforts were shifted under the Peer Programs division. Current efforts include ongoing support of Peer Certification, identification of department wide training needs, regularly scheduled engagement meetings with peer providers, and targeted training efforts for supervisors of peer providers.

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 260-266.

| Program Name | Actual Number Served FY 2023/24 | Estimated Number to be Served FY 2025/26 | Annual Budgeted Funds FY 2025/26 | Estimated Annual Cost per Person FY 2025/26 |
|---|---|---|---|---|
| Clubhouse and Community Connections | 35,560 | 35,288 | $5,897,718 | $167 |

| Program Serves | Symptom Severity | Location of Services | Typical Population Characteristics |
|---|---|---|---|
| 18+ | BHC* | Facility-based  | Seeking recovery-based support services |

*BHC = Behavioral Health Challenges

## Number of Consumers to be Served

The table below displays the estimated number of consumers to be served for FY 2025/26.

| Program | Service Area* | Total to be Served |
|---|---|---|
| Clubhouse and Community Connections | • 2,500 GSD<br>• 32,788 O&E | 35,288 |

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

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

## Target Populations

The table below identifies the target population of consumers to be served by the Peer Programs in the upcoming fiscal year.

| Program Name | Target Population | | | |
|---|---|---|---|---|
| | Children | TAY | Adult | Older Adult |
| Clubhouse | | X | X | X |
| Community Connections | | X | X | X |
| Peer Provider Workforce Support Program | | X | X | X |

## Program Description and Target Population

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

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

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

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

## Demographics

### Age



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

**N=**3,010

### Gender Identity



**58%** Male
**39%** Female
**3%** Other

### Race/Ethnicity

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

**N=**2,915

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

**Program Description and Target Population, cont.**

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

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

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

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

**Demographics**

**Primary Language**



**94%** English
**4%** Spanish
**2%** Other

**N=**3,010

**Region**

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

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

**Program Description and Target Population, cont.**

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

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

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

**Services Offered**

Services provided through the Clubhouse and Community Connections program include:

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

**Positive Results**

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

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

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

As a result of clubhouse participation:

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



**Positive Results, cont.**

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

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

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

**Challenges/Solutions**

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

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

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

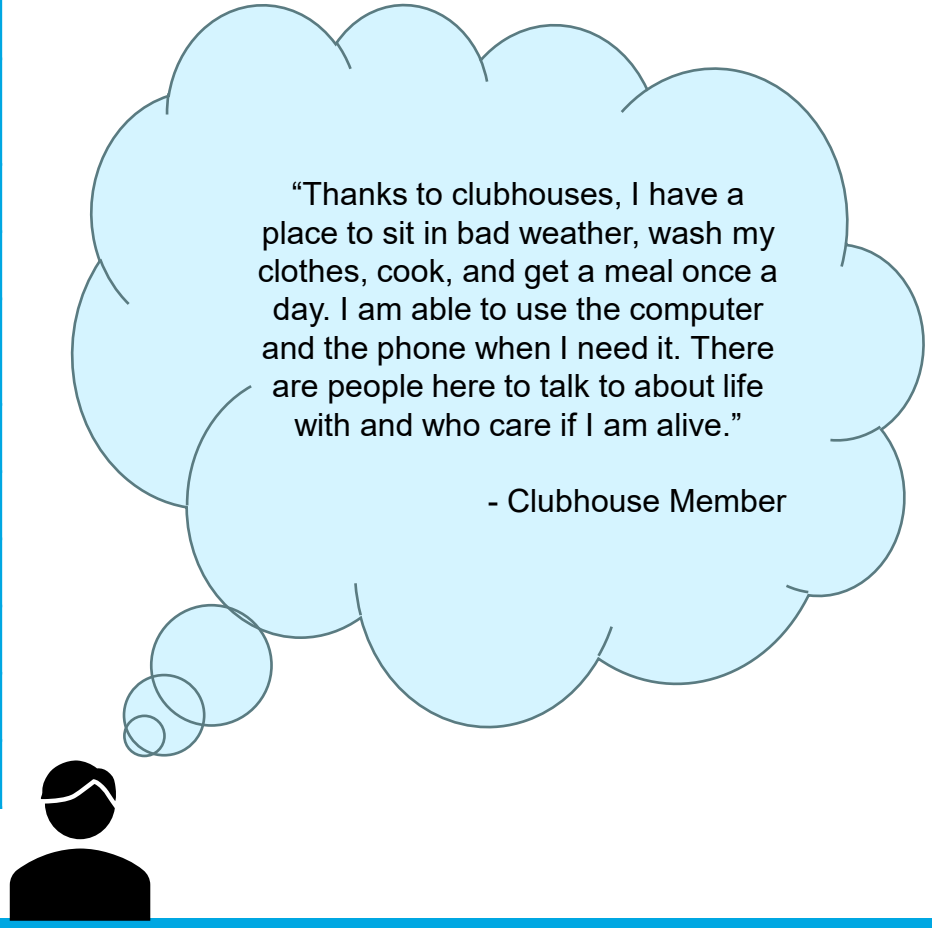
## Outreach and Engagement

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

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

## Program Updates

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



# CSS: Outreach, Access, and Engagement Programs

## Introduction

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

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

## Target Populations

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

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

# CSS: Outreach, Access, and Engagement Programs

## Number of Consumers to be Served

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

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

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

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

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




Artwork by Alcira Mendoza

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

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

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

*SMI = serious mental illness

## Program Description and Target Population

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

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

## Demographics

### Age



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

### Gender Identity



**46%** Male



**54%** Female



**<1%** Other

### Race/Ethnicity

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

### Primary Language



**96%** English
**3%** Spanish
**1%** Other

**N**=1,613

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

### Program Description and Target Population, cont.

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

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

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

### Services Offered

- Mental health assessments
- Psychiatric evaluations
- Substance Use Disorder (SUD) screenings
- Referrals and linkage to Full Service Partnership (FSP), Crisis Stabilization Unit (CSU), or Crisis Residential Treatment (CRT) programs

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

### Demographics



**N**=1,613

**Primary Diagnosis**

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

### Positive Results

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

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

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

### Challenges/Solutions

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

### Outreach and Engagement

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

### Program Updates

There are no planned updates for this program.

## Recovery Based Engagement Support Teams (RBEST)

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

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

### Program Description and Target Population

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

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

- Not active or successful in seeking and receiving necessary psychiatric care.
- The “invisible” consumer who is being cared for by family members and not linked or known to the public mental health system.
- Resistant to traditional engagement strategies due to a neurological condition (i.e., anosognosia) which disallows insight into their own behavioral health condition.
- Unable to navigate the behavioral health system of care to obtain appropriate treatment.

### Demographics

**Age**



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

**N**=303

**Gender Identity**

**63%** Male

**37%** Female

**Race/Ethnicity**

**20%** African American/ Black

**25%** Caucasian/ White

**<1%** American Indian/ Alaska Native

**3%** Asian/ Pacific Islander

**47%** Latinx/Hispanic

**4%** Other/Unknown

**Primary Language**



**94%** English
**6%** Spanish
**<1%** Other

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

### Program Description and Target Population, cont.

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

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

### Services Offered

Services offered by the RBEST program include:

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

### Demographics

**Primary Diagnosis**



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

**N**=303

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

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

**Positive Results**

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

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

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

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

**Success Story**

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

**Challenges/Solutions**

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

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

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

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

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

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

## Outreach and Engagement

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

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

## Program Updates

There are no planned updates for this program.

### Success Story

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

# CSS: Full Service Partnerships

## Introduction

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

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

## Services Offered

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

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

# CSS: Full Service Partnerships

## Number of Consumers to be Served

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

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

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

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

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

## Comprehensive Children and Family Support Services (CCFSS)

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

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

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

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

### Program Description and Target Population

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

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

### Demographics

**Age**

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

**Gender Identity**

**53%** Male
**47%** Female
**<1%** Other

**Race/Ethnicity**

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

**N**=2,494

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

## Program Description and Target Population, cont.

The three individualized and targeted FSP subprograms are:

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

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

## Positive Results

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

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

## Demographics

### Primary Language



**91%** English
**6%** Spanish
**4%** Other

**N**=2,494



### Primary Diagnosis

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

**Positive Results, cont.**

**Global Measurement of Life (Progression Report):**

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

**Specific Areas of Life Functioning (Impact Report):**

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

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

**Positive Results, cont.**

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

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

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

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

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

**Positive Results, cont.**

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

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

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

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

**Positive Result, cont.**

**Specific indicators likely to increase juvenile justice involvement:**

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

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

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

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

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

## Challenges/Solutions

### Wraproud Clinical Staffing Shortages

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

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

### Administrative Oversight Shortages

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

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

**Challenges/Solutions, cont.**

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

**Increased Acuity of Youth**

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

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

**AB 1051 Legislation**

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

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

## Outreach and Engagement

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

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

## Program Updates

There are no planned updates for this program.

### Success Story

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

## Integrated New Family Opportunities (INFO)

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

*This number includes FSP services only

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

*SED = serious emotional disturbance

### Program Description and Target Population

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

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

### Demographics

**Age**

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

**N**=96

**Gender Identity**

**88%** Male
**13%** Female

**Race/Ethnicity**

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

**Primary Language**

**76%** English
**21%** Spanish
**3%** Other/ Unknown

# CSS: Integrated New Family Opportunities C-2

## Services Offered

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

## Positive Results

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

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

## Challenges/Solutions

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

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

## Program Updates

There are no planned updates for this program.

## Demographics



**N**=197

**Primary Diagnosis**

**12.5%** Anxiety disorders

**0%** Bipolar disorders

**17.7%** Depressive disorders

**27.1%** Disruptive disorders

**3.1%** Neurodevelopmental/cognitive disorders

**0%** None/deferred

**0%** Psychosis disorders

**1.0%** Substance use disorders

**38.5%** Other

## One Stop Transitional Age Youth (TAY) Centers

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

*This number includes FSP services only

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

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

### Program Description and Target Population

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

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

### Demographics

**Age**

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

**N**=388

**Gender Identity**

**43%** Male
**57%** Female

**Race/Ethnicity**

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

**Primary Language**

**96%** English
**2%** Spanish
**2%** Other/ Unknown

# CSS: One Stop Transitional Age Youth Centers



## Program Description and Target Population, cont.

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

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

## Demographics

### Primary Diagnosis



**25.3%** Anxiety disorders

**14.7%** Bipolar disorders

**36.9%** Depressive disorders

**2.1%** Disruptive disorders

**0.8%** Neurodevelopmental/cognitive disorders

**0.5%** None/deferred

**11.6%** Psychosis disorders

**1.3%** Substance use disorders

**6.9%** Other

**N**=388

## Services Offered

Services include, but are not limited to:

- Assessment
- Evaluation
- Treatment plan development (Individual Services and Supports Plan)
- Therapy (individual and group)
- Crisis intervention
- Medication support services
- Targeted case management
- Collateral services
- Rehabilitative activities of daily living
- Counseling
- Substance use disorder and co-occurring services
- Groups/Activities
- Housing assistance
- Employment assistance
- Education assistance
- Legal assistance
- Transportation assistance
- Shower and laundry facilities
- Resource room with computer and internet access

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

**Positive Results**

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

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

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

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

**Positive Results, cont.**

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

## Challenges/Solutions

**Contractor Relinquished TAY Center Program Contract -**

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

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

**Staffing -**

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

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

**Bed Bug Infestation -**

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

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

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

- TAY Consumer

## Outreach and Engagement

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

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

## Program Updates

There are no planned updates for this program.

### Success Story

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

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

- TAY Consumer

## Adult Forensic Services (AFS)

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

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

*SMI = serious mental illness

### Program Description and Target Population

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

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

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

### Demographics

**Age**

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

**N**=851

**Gender Identity**

**78%** Male

**22%** Female

**Race/Ethnicity**

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

**Primary Language**

**97%** English
**<1%** Spanish
**2%** Other

**Program Description and Target Population, cont.**

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

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

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

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

## Demographics

**Primary Diagnosis**



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

**N**=851

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

**Program Description and Target Population, cont.**

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

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

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

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

**Positive Results**

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

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

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

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

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

**Positive Results, cont.**

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

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

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

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

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

**Success Points**

CSTAR

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

**Challenges/Solutions**

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

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

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

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

<u>STAR</u>

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

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

**Challenges/Solutions, cont.**

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

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

CSTAR

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

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

FACT, CFACT

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

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

**Challenges/Solutions, cont.**

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

JTMHC

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

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

**Success Points**

JTMHC

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

FACT/CFACT/CORE

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

## Outreach and Engagement

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

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

## Program Updates

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




Artwork by Desiree Caudillo

## Success Story

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

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

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

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

*SMI = serious mental illness

### Program Description and Target Population

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

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

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

### Demographics

**Age**

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



**N**=164

**Gender Identity**

**65%** Male

**35%** Female

**Race/Ethnicity**

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

# CSS: Assertive Community Treatment Model FSP Services A-3

### Program Description and Target Population, cont.

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

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

### Services Offered

Services and supports include comprehensive assessment, treatment, crisis intervention, case management, and immediate support 24/7. Through these programs, consumers have access to:

- Development of individualized service plans
- Psychiatric assessment and treatment
- Medication management and support
- Focused assessment and intervention
- Physical health screening
- Care coordination and referral
- Substance use disorder intervention
- Vocational counseling services
- Social skills building services
- Housing support
- Benefits and entitlements assistance
- Family support
- Education

## Demographics

### Primary Language



**98%** English

**2%** Spanish

**<1%** Other

**N**=164



### Primary Diagnosis

**2.4%** Anxiety

**8.5%** Depressive disorder

**77.4%** Psychosis

**4.3%** Bipolar disorder

**1.9%** Substance related

**4.9%** Other

**<1%** Neurodevelopmental/Cognitive disorders

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

**Positive Results**

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

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

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

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




Artwork by Keith Benitez

# CSS: Assertive Community Treatment Model FSP Services A-3

**Positive Results, cont.**

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

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

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

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

**Challenges/Solutions**

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

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

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

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

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

### Challenges/Solutions, cont.

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

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

### Outreach and Engagement

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

### Program Updates

There are no planned updates for this program.

### Success Story

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

# Regional Adult Full Service Partnerships (RAFSP)

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

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

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

## Program Description and Target Population

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

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

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

## Demographics

### Age



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

**N**=468

### Gender Identity

**45%** Male

**54%** Female

### Race/Ethnicity

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

## Program Description and Target Population, cont.

The ratio of staff to consumers is typically 1 to 10, allowing for intense support for consumers 24 hours a day, 7 days a week, but can include larger numbers as appropriate. RAFSP encourages individualized decision-making and reinforces self-responsibility. Consumers within the FSP programs are actively involved in ongoing planning, review of progress towards goals, and evaluation of their treatment. Additional services include activities that support consumers in their efforts to restore, maintain, and develop interpersonal and independent living skills through the Wellness, Recovery, and Resilience Model, and by providing culturally competent, evidence-based practices.

## Services Offered

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

## Demographics

### Primary Language



**95%** English

**4%** Spanish

**1%** Other

**N**=468

### Primary Diagnosis



**6.8%** Anxiety disorders

**13.7%** Bipolar disorders

**23.9%** Depressive disorders

**7.5%** Other

**1%** None/deferred

**39.1%** Psychosis disorders

**5.6%** Substance related

**1.9%** Neurodevelopmental/cognitive disorders

## Positive Results

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

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

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

## Challenges/Solutions

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

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

## Program Updates

There are no planned updates for this program.

## Introduction

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

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

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



Artwork by Frankie Greco

## Target Population

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

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

## Number of Consumers to be Served

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

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

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

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

# Community Reintegration Services (CRS)

## Program Description and Target Population

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

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

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

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

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

*SMI = serious mental illness

## Demographics

**Age**

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

**Gender Identity**

**67%** Male
**33%** Female

**Race/Ethnicity**

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

**Primary Language**

**100%** English

**N**=67

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

# Community Reintegration Services (CRS), cont.

### Services Offered

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

### Positive Results

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

Of the consumers served:

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

### Challenges/Solutions

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

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

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

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

### Demographics

**Primary Diagnosis**



**N**=67

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

# Community Reintegration Services (CRS), cont.

### Outreach and Engagement

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

### Program Updates

There are no planned updates for this program.

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

### Success Story

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

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

## Program Description and Target Population

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

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

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

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

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

*SMI = serious mental illness

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

## Program Description and Target Population, cont.

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

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

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

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

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

### Services Offered

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

FSP services may include:

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

### Challenges/Solutions

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

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

### Outreach and engagement

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

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

### Program Updates

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



Artwork by Stacey McDaniel

## Age Wise

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

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

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

*SMI = serious mental illness

### Program Description and Target Population

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

Through collaboration, Age Wise focuses on assisting unserved, underserved, and inappropriately served older adults to develop integrated care with respect to their physical and behavioral health needs. Additionally, this program provides outreach and engagement activities in the community to educate agencies, primary care providers, and the public about the behavioral health needs of the older adult population.

### Demographics

**Age**

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

**Gender Identity**

**28%** Male
**72%** Female

**Race/Ethnicity**

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

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

## Positive Results

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

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

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

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

## Demographics

### Primary Language



**80%** English
**17%** Spanish
**3%** Other

**N**=94

### Primary Diagnosis



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

**Positive Results, cont.**

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

**Challenges/Solutions**

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

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

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

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

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

**Challenges/Solutions, cont.**

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

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

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

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

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

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

## Outreach and Engagement

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

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

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

## Program Updates

There are no planned updates for this program.



Artwork by Jason Hanson

## Success Story

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

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

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

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

## Introduction

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

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

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



Artwork by Colleen Rowan

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

## Component Descriptions

### Homeless Outreach Support Team (HOST)

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

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

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

### Full Service Partnership (FSP) Supportive Services Program

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

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

### Innovative Remote Onsite Assistance Delivery (InnROADs)

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

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

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

### Number of Consumers to be Served

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

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

### Target Population

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

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

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

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

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

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

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

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

*SMI = serious mental illness

## Services Offered

**HOST:**

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

**Full Service Partnership (FSP) Supportive Services Programs:**

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

## Demographics

**Age**

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

**Gender Identity**

**40%** Male
**60%** Female
**<1%** Other

**Race/Ethnicity**

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

**Primary Language**

**95%** English
**4%** Spanish
**2%** Other

**N**=1,499

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

**Services Offered cont.**

**InnROADs:**

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

## Positive Results

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

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

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

## Challenges/Solutions

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

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

## Demographics

**Primary Diagnosis**

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



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

### Success Story

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

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

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

### Outreach and Engagement

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

### Program Updates

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

## Success Story

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

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

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

## Introduction

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

The Adult Transitional Care programs are comprised of:

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

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

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

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

## Target Population

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

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

**Number of Consumers to be Served**

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

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

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

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

# Adult Residential Facilities Certified in Social Rehabilitation Services

## Program Description and Target Population

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

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

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

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

*SMI = serious mental illness

## Demographics

### Age



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

### Gender Identity

**62%** Male

**38%** Female

### Race/Ethnicity

**24%** African- American/ Black

**37%** Caucasian/White

**4%** Other/Unknown

**4%** Asian/Pacific Islander

**32%** Latinx/Hispanic

### Primary Language



**98%** English

**<1%** Spanish

**<1%** Other/Not reported

**N**=106

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

## Adult Residential Facilities Certified in Social Rehabilitation Services, cont.

### Services Offered

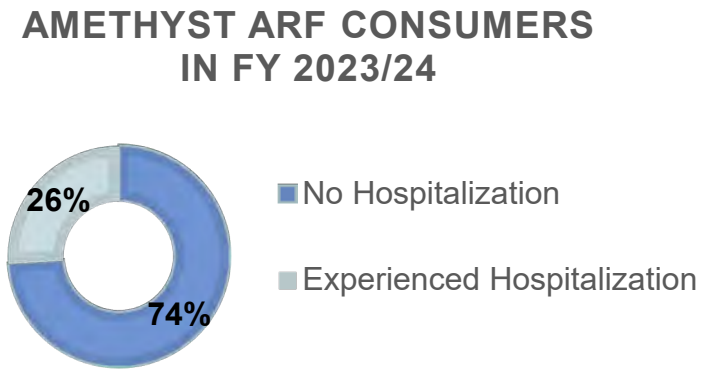
- Residential treatment
- Rehabilitative services
- Individual therapy/crisis management
- Group therapy
- Recovery groups
- Vocational groups
- Social activities

### Positive Results

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

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

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



# Adult Residential Facilities Certified in Social Rehabilitation Services, cont.

## Challenges/Solutions

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

## Outreach and Engagement

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

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

## Demographics



**Primary Diagnosis**

**2.8%** Bipolar disorders

**1.9%** Depressive disorders

**93.4%** Psychosis disorders

**1.9%** Other

**N**=106

## Success Stories

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

## Adult Residential Facilities Certified in Social Rehabilitation Services, cont.

### Program Updates

There are no planned updates for this program.

**Success Story**

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

**Success Story**

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

# Enhanced Assisted Living Program

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

*SMI = serious mental illness

## Program Description and Target Population

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

## Services Offered

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

## Demographics

### Age

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

**N**=17

### Gender Identity

**71%** Male

**29%** Female

### Race/Ethnicity

**18%** African American/Black

**6%** Asian/Pacific Islander

**59%** Caucasian/ White

**18%** Latinx/Hispanic

### Primary Language

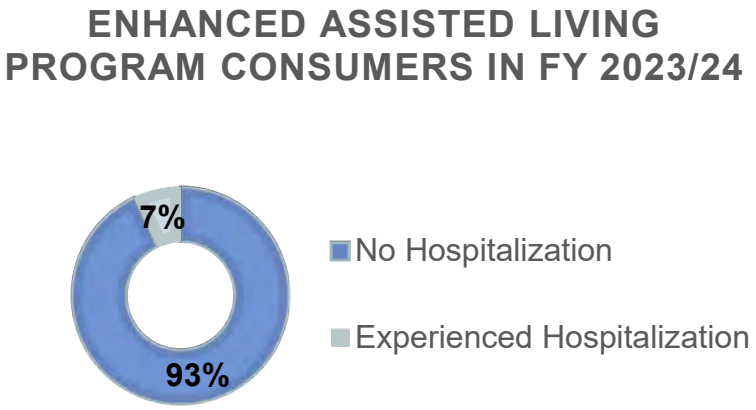
**100%** English

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

## Enhanced Assisted Living Program, cont.

### Positive Results

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




### Challenges/Solutions

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

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

### Demographics

**Primary Diagnosis**

**17.7%** Depressive disorders

**70.6%** Psychosis disorders

**5.9%** None/Deferred

**5.9%** Other

**N**=17

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

# Enhanced Assisted Living Program, cont.

## Outreach and Engagement

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

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

### Success Story

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

## Program Updates

There are no planned updates for this program.

# Enhanced Board and Care Program

## Program Description and Target Population

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

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

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

*SMI = serious mental illness

## Services Offered

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

## Demographics

### Age



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

### Gender Identity



**62%** Male



**38%** Female

### Race/Ethnicity

**24%** African American/ Black

**4%** Asian/Pacific Islander

**34%** Caucasian/White

**33%** Latinx/Hispanic

**5%** Other/Unknown

### Primary Language



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

**N**=165

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

## Enhanced Board and Care Program, cont.

### Positive Results

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

**ENHANCED BOARD AND CARE PROGRAM CONSUMERS IN FY 2023/24**




### Demographics

**Primary Diagnosis**

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

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

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

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

### Challenges/Solutions

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

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

# Enhanced Board and Care Program, cont.

### Challenges/Solutions, cont.

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

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

### Outreach and Engagement

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

### Program Updates

There are no planned updates for this program.

### Success Story

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

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

## Program Description and Target Population

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

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

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

*SMI = serious mental illness

## Demographics

### Age



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

**N**=140

### Gender Identity



**66%** Male



**34%** Female

### Race/Ethnicity

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

### Primary Language



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

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

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

## Services Offered

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

Services include:

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

## Demographics

**Primary Diagnosis**



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

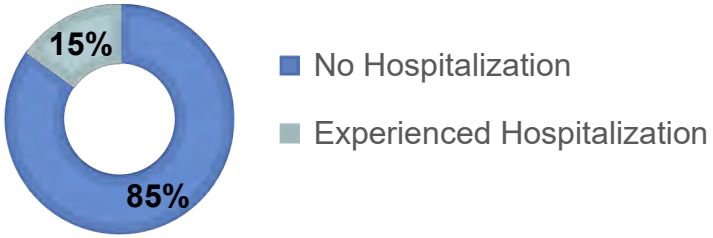
**N**=140

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

## Positive Results

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

**CHAS-PACES CONSUMERS IN FY 2023/24**



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

## Challenges/Solutions

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

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

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

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

## Outreach and Engagement

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

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

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

### Program Updates

There are no planned updates for this program.

### Success Story

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

SAN BERNARDINO COUNTY
Behavioral Health

# MHSA Annual Update for FY 25/26: Innovation

# Innovation

## Introduction

The goal of the Innovation component of the Mental Health Services Act (MHSA) is to test methods that adequately address the behavioral health needs of unserved and underserved populations through short-term projects. This is accomplished by expanding or developing services and supports that are considered to be innovative, novel, creative, and/or ingenious behavioral health practices that contribute to learning, rather than primarily focusing on providing services.

Innovation projects create an environment for the development of new and effective practices and/or approaches in the field of behavioral health. Innovation projects are time-limited to five years, must contribute to learning, and be developed through a process that is inclusive and representative, especially of unserved, underserved, and inappropriately served populations.

Innovation projects are designed to support and learn about new approaches to behavioral health care by doing one of the following:



- Introduce a behavioral health practice or approach that is new to the overall behavioral health system, including, but not limited to, prevention and early intervention.
- Make a change to an existing practice in the field of behavioral heath, including, but not limited to application to a different population.
- Apply to the behavioral health system a promising community-driven practice or an approach that has been successful in a non-behavioral health context or setting.

This component is unique because it focuses on research and learning that can be utilized to improve the overall public behavioral health system. All Innovation projects must be reviewed and approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC), which was renamed to Commission for Behavioral Health (CBH) in January 2025.

### MHSA Legislative Goals

The overall MHSA goal of the Innovation component is to implement and test novel, creative, time-limited, or ingenious mental health approaches that are expected to contribute to learning, transformation, and integration of the mental health system.

Every Innovation project must identify one of the following primary purposes as part of its design:

- Increase access to mental health services to underserved groups.
- Increase the quality of mental health services, including measurable outcomes.
- Increase access to mental health services.
- Promote interagency and community collaboration related to mental health services, supports, or outcomes.

All Innovation projects have been developed through extensive collaboration with DBH partners, stakeholders, consumers, and community members. Innovation projects are subject to approval by the San Bernardino County Board of Supervisors and the MHSOAC (now renamed the Commission for Behavioral Health [CBH] as of January 2025), with the local Behavioral Health Commission being responsible for confirming that the stakeholder process was complete.



# Innovation

INNOVATIVE PROJECTS

**2012**

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

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

**2014**

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

**2019**

**Innovative Remote Onsite Assistance Delivery (InnROADs):** **April 2019 – March 2024**
Provides intensive, field-based engagement model that supports multidisciplinary/multiagency teams that meet, engage, and provide treatment to consumers and their families where they live within homeless communities.

**2020**

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

**2021**

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

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

**2024**

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

# Innovative Remote Onsite Assistance Delivery (InnROADs)

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

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

**Target Population and Project Description**

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

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

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

## Consumer Demographics Highlights FY 2023/24

**Age**

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

**Sexual Orientation**

**3%** of consumers identified as LGBTQ+

**Gender Identity**

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

**Race/Ethnicity**

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

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

### InnROADs Collaborative Partners

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

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

### What have we learned during FY 2023/24?

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

**InnROADs Regional Outreach Team Reinstated:**

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



**An encampment visited by the InnROADs team.**

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

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

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

**Homeless Point in Time Count:**

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

**Additional Consumer Demographics Highlights FY 2023/24**

**Veterans**

**6%** of consumers identified as veterans

**Language**

**97%** English
**2%** Spanish
**1%** Other

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



**InnROADs staff contacting a participant under a freeway overpass.**

## InnROADs Services

InnROADs provides the following field-based services:

### *Mobile Treatment Options*

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

### *Mobile Linkages*

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

## Project Learning Goals

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

**Learning Goal #2:** What techniques build trust with those who are experiencing homelessness in order to support/encourage openness to engaging in (behavioral health) services (including overcoming barriers to engagement in services)? What are the different techniques that are particularly well-suited for different age groups, cultural groups, family structures, and diagnoses?

**Learning Goal #3:** What services, treatments, and ways of relating in the field are most effective for those who are experiencing homelessness, including medication, therapy, rehabilitation, and enhancing/strengthening support systems? What are the different services, treatments, and ways of relating that are particularly well-suited for different age groups, cultural group, family structures, and diagnoses?

**Learning Goal #4:** How can geographic information system (GIA) be used as a collaborative tool to better understand pattern, needs, and opportunities for continuous quality improvement by front-line staff, supervisors, administrators, and county-level agencies?

**7,579**
Records of Engagement for FY 2023/24

**41**
Medical Assessments documented

**72**
Crisis Activities

**2,266**
No. of total Referral/Linkage Activities

**722**
Counseling and/or Therapy Activities

**1,807**
unduplicated consumers received services during FY 2023/24

**Note:** A consumer may have more than one linkage.

## Program Updates

- InnROADs ended as an Innovation Project in March 2024 but will continue as a program with multidisciplinary staff serving the most vulnerable populations in San Bernardino County under the Community Services and Supports component.
- The Department of Behavioral Health (DBH) has officially taken over staffing for the Nurse Practitioner (NP) and Psychiatric Technician (Psychiatric Technician) positions. Previously, these roles were managed by the Department of Public Health (DPH), which struggled to find qualified candidates due to the specialized nature of the roles and ongoing staffing shortages. DBH's involvement aims to better address the staffing needs specific to the program and enhance service delivery.
- InnROADs has been incorporated into the DBH Continuum of Care under the Homeless and Supportive Services unit. InnROADs will continue to serve the homeless population by regions: East Valley, West Valley, High Desert and Morongo Basin.
- Program learning outcomes have been complied and will be shared.
- Community and stakeholder feedback has been incorporated into the InnROADs Final Report. The InnROADs Final Report will be sent to the Mental Health Services Oversight and Accountability Commission (MHSOAC), which was renamed to Commission for Behavioral Health (CBH) in January 2025, and be posted to the San Bernardino County DBH website.

## Eating Disorder Collaborative (EDC)

| Innovation Projects | Actual Number Served FY 2023/24 | Estimated Number Served FY 2025/26 | Annual Budgeted Funds FY 2025/26 | Estimated Annual Cost per Person FY 2025/26 |
|---|---|---|---|---|
| EDC INN Project | 50 | 134 | $2,815,958 | $21,015 |

| Program Serves | Symptom Severity | Location of Services |
|---|---|---|
| **All ages** | **N/A** |   |

### Target Population and Project Description

The Eating Disorder Collaborative focuses on increasing the regional understanding of eating disorders (EDOs) to facilitate early identification and access to effective treatments for those consumers needing higher levels of care. The goal of this project is to improve the system of care to better meet the physical and mental health needs of people with EDOs by achieving the following:

- Developing and distributing trainings and informational materials.
- Establishing a more robust initial eating disorder assessment tool.
- Creating and activating specialized, multidisciplinary eating disorder treatment teams.

### Consumer Demographics Highlights FY 2023/24

**Age**



**22%** Children
**58%** TAY
**20%** Adult
**0%** Older Adult

**Sexual Orientation**



**6%** of consumers identified as LGBTQ+

**Gender Identity**



**8%** Male



**88%** Female

**OTHER**
**4%**

**Language**

**90%** English
**6%** Spanish
**4%** Unknown

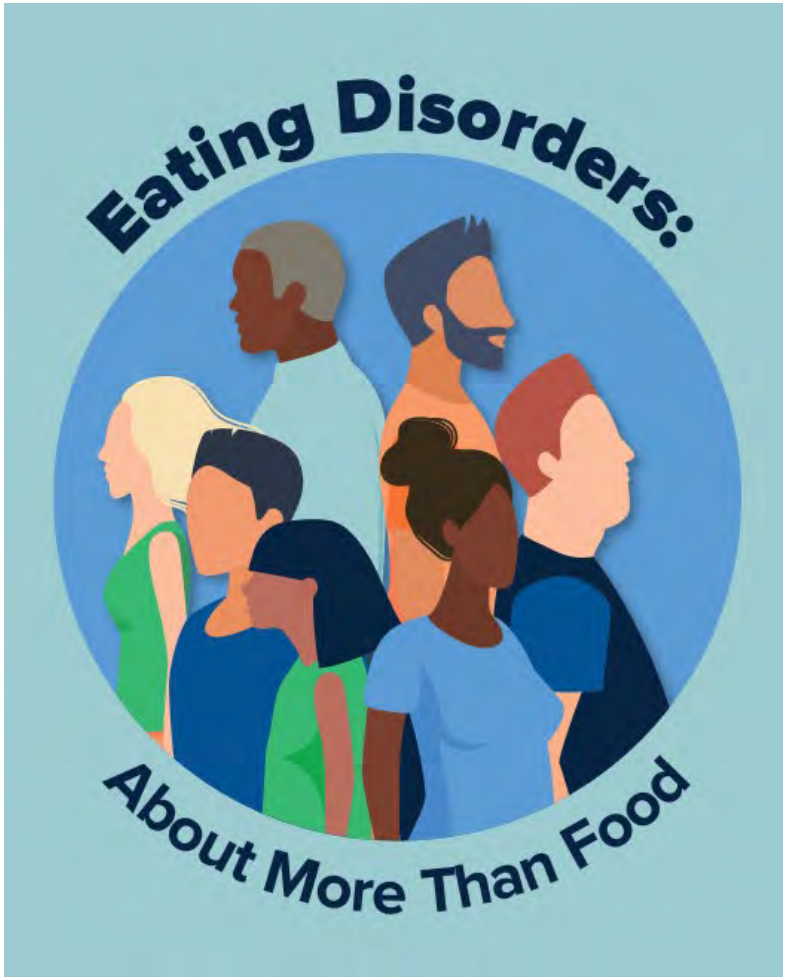
**Race/Ethnicity**

**6%** African-American/Black
**4%** Asian/Pacific Islander
**10%** Caucasian/White
**60%** Latinx/Hispanic
**0%** American Indian/Alaska Native
**20%** Multiple Races/Other

**Information represented is based on data collected and may not represent of the number of unique consumers served.**

**Challenges/Solutions**

- Although staff retention and turnover has affected the EDC program, staffing levels have improved, as hiring in Fiscal Years 2023/24 and 2024/25 have been successful and the EDC is almost fully staffed.
- In FY 23/24, a procurement for a dietician was not successful; however, the program is making headway in partnering with local dietitians in the area to work with EDC clients and provide individual assessments, nutrition therapy and group classes. Clients will benefit from working with a dietician by improving access to groups and other services.
- In the next fiscal year, EDC will begin a marketing campaign throughout the DBH outpatient clinics, informing staff of the program and offering resources for clients who may need eating disorder services.
- The EDC team continues to work with the local managed care plans to provide higher level of care services for clients in need of eating disorder treatment and services. These services include:
    - Residential Treatment Centers
    - Intensive Outpatient Program
    - Partial Hospitalization Program



## Program Updates

The current initiatives and updates include:

- **Staffing Improvements**: Although staffing has been challenging, improvements have been made toward the end of Fiscal Year 2023/24.
- **Clinic Manual Development**: A clinical manual is being developed that includes Policies & Procedures, Forms (such as referral and screening), and process flows.
- **Collaborative Relationships**: Efforts are ongoing to strengthen partnerships with Managed Care Plans (MCPs).
- **Training Plan**: A training plan has been developed to ensure DBH staff and contracted providers receive training in Family-based treatment (FBT) and Dialectical behavior therapy (DBT). This training will commence in the upcoming fiscal year.
- **Higher Level of Care:** For clients who require a higher level of care for eating disorder treatment, DBH is working collaboratively with the local MCPs. In FY 2023/24, EDC provided over $897,000 in funds to support 55 clients who were in need of higher level of care services.
- EDC is slated to end as an Innovation project on December 31, 2025.

## Project Learning Goals

**Learning Goal #1:** Examine the factors that make collaboration with local colleges effective for the development and utilization of public information campaigns/materials to educate populations most at risk for developing disordered eating.

**Learning Goal #2:** Examine the benefits and challenges of developing and disseminating a screening and referral tool which may be used in a variety of settings (e.g., college student centers, health centers, physician's offices); examine the effectiveness of the screening and referral tool at increasing the number of individuals assessed for disordered eating.

**Learning Goal #3:** Examine the effectiveness of engagement assessments in facilitating participation in treatment services.

**Learning Goal #4:** Examine the multiple dimensions of the best practices established for a multidisciplinary team, all comprised of MHP staff, effectively liaising with a variety of organizations (e.g. colleges, college health centers, individual physician's offices, Independent Physicians Associations, Managed Care Plans, and behavioral health providers) to (1) provide additional assessment services, (2) facilitate effective referrals, and (3) provide ongoing care as needed.

## Multi-County Full-Service Partnership (FSP) Initiative

| Innovation Projects | Actual Number Served FY 2023/24 | Estimated Number Served FY 2025/26 | Annual Budgeted Funds FY 2025/26 | Estimated Annual Cost per Person FY 2025/26 |
|---|---|---|---|---|
| Multi-County FSP Project | N/A | N/A | $0 | N/A |

### Target Population and Project Description

The Multi-County Full-Service Partnership (FSP) Initiative aims to implement a more uniform data-driven approach that provides counties with an increased ability to use data to improve FSP services and outcomes. Counties will leverage the collective power and shared learnings of a cohort to collaborate on how to provide the most impactful FSP programs and ultimately drive transformational change in the delivery of mental health services.



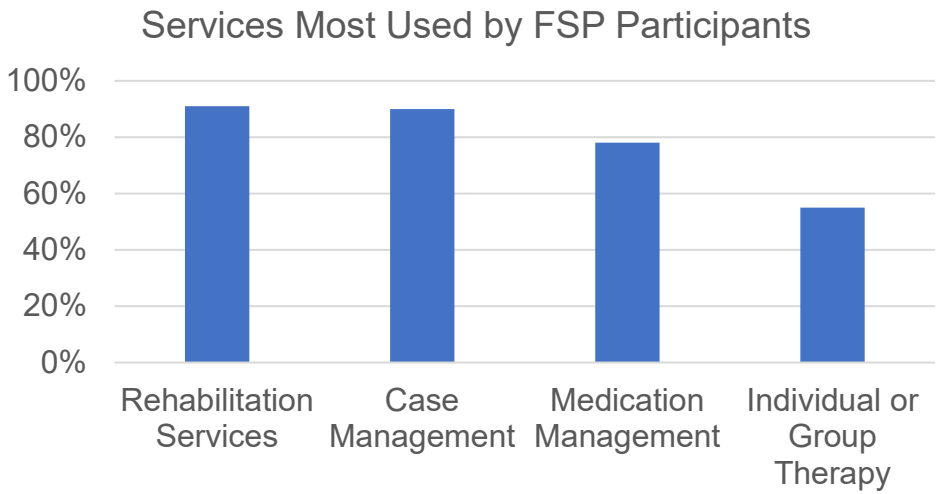
A cohort of six diverse counties — Fresno, Sacramento, San Bernardino, San Mateo, Siskiyou, and Ventura, in partnership with Third Sector, the California Mental Health Services Authority (CalMHSA), the Mental Health Services Oversight and Accountability Commission [(MHSOAC), which was renamed to Commission for Behavioral Health (CBH) in January 2025], and RAND Corporation, are participating in a 4.5-year Multi-County FSP Innovation Initiative that will leverage counties' collective resources and experiences to improve FSP service delivery across California.

In this next fiscal year, the Multi-County FSP initiative is focusing on continuous improvement and implementation and working with project partners.

**Milestones in FY 2023/24**

**RAND Evaluation Summary**

The California Mental Health Services Authority (CalMHSA) contracted with RAND, a non-profit research institute, to conduct an independent evaluation of the Multi-County FSP Innovation Project examining the period following implementation of 2021 through 2023. This is a summary from the report provided by RAND.




RAND analyzed electronic health records and program data to examine service utilization by FSP participants and the potential impact of FSP programs on participant outcomes. FSP participants receive services including case management, rehabilitation, medication management and psychotherapy, among others. The number of services received was counted during the first 12 months of FSP enrollment. Services most used include rehabilitation services, utilized by 91% of FSP participants at an average of 22 services in the first year of enrollment. Case management was the second most used service at 90% and an average of 11 services in the first year of enrollment. Medication management and individual or group therapy are the third and fourth most use services at 78% and 55% respectively.

The impact of FSP participation on stable housing, arrests and psychiatric admission outcomes was assessed by comparing the values one year prior to enrollment to the first year of enrollment. While on FSP, participants experienced an average increase of 100 days of stable housing compared to prior to FSP enrollment. Additionally, FSP participants experienced a 36% decrease in likelihood to be admitted for psychiatric inpatient care, compared to prior to FSP enrollment. Number of arrests were not affected as FSP enrollees did not have any arrests prior to enrollment nor after enrollment. This is a summary of the service utilization and changes in outcomes for FSP participants specific to San Bernardino County. The full report can be found on rand.org.

## Project Learning Goals

**Learning Goal #1:** Develop a shared understanding and more consistent interpretation of FSP's core components across counties, creating a common FSP framework.

**Learning Goal #2:** Increase the clarity and consistency of enrollment criteria, referral, and transition processes through developing and disseminating readily understandable tools and guidelines across stakeholders.

**Learning Goal #3:** Improve how counties define, collect, and apply priority outcomes across FSP programs.

**Learning Goal #4:** Develop a clear strategy for tracking outcomes and performance measures through various state-level and county-specific reporting tools.

**Learning Goal #5:** Develop new and/or strengthen existing processes that leverage data to foster learning, accountability, and meaningful performance feedback in order to drive continuous improvement in program operations and outcomes.



**Stakeholder Engagement Lessons Learned and Best Practices:**

- Ground decisions about policies and operational practices in consumer experience, including data reporting and outcomes measurement.
- Engage stakeholders early and often to ensure their voices are included.
- Compensate consumers for their participation.
- Leverage both county advocates and third-party facilitators as necessary to ensure consumers feel safe sharing their thoughts.
- Use trauma-informed and healing-centered techniques to reduce harm and avoid re-traumatization.
- Staff must be culturally competent.

**Cross-County Collaboration Lessons Learned:**

- It is essential to consider which activities are appropriate for statewide vs. local customization.
- Pursue a shared vision with flexibility tailored to individual county needs.
- Consider staff turnover and information gaps for long term projects.
- Counties with more developed data infrastructure may face more challenges in implementing changes.
- Embrace informal learning for counties to share information, challenges, and best practices with each other.

This project is now in its final evaluation stage where San Bernardino County will be working with RAND over the next fiscal year to collect, analyze, and share outcomes data for the determined populations in order to ensure continuous improvement.



# Cracked Eggs

| Innovation Project | Actual Number Served FY 2023/24 | Estimated Number Served FY 2025/26 | Annual Budgeted Funds FY 2025/26 | Estimated Annual Cost per Person FY 2025/26 |
|---|---|---|---|---|
| Cracked Eggs | 44 | 30 | $185,241 | $6,175 |

## Project Description

Cracked Eggs is a workshop series designed around teaching participants to utilize the symptoms from their mental illness as techniques to create art. This workshop empowers peers to not view their symptoms as negative but as aspects of themselves that can be used as a creative tool. Using a strength-based approach helps a participant find a form of expression, beyond words, that can be used to describe their lived experiences. The workshops are 100% peer-owned and operated by a production company, Bezerk Productions. Linda Sibio, the creator of Cracked Eggs, is an accomplished artist who lives with mental health challenges herself and has utilized art to help her cope.

## Target Population

The target population for this project are individuals living with mental illness over the age of 16.

## Consumer Demographics Highlights FY 2023/24

**Age**



**0%** Children
**100%** TAY
**0%** Adult
**0%** Older Adult
**0%** Unknown

**Sexual Orientation**



**36%** of consumers identified as LGBTQ+

**Gender Identity**



**29%** Male



**55%** Female

*11% identify as other

**Language**



**100%** English
**0%** Spanish

**Race/Ethnicity**

**20%** African American/Black
**2%** Asian/Pacific Islander
**32%** Caucasian/ White
**28%** Latinx/Hispanic
**2%** American Indian/Alaska Native
**16%** Multiple Races/ Other

**Information represented is based on data collected and may not represent of the number of unique consumers served.**

# Cracked Eggs

| Program Serves | Symptom Severity | Location of Services |
|---|---|---|
| 16+ | N/A | Various Clubhouses and TAY centers |

### Positive Results

In FY 2023/24, two successful cohorts were held, both held in person. These cohorts had consistent attendance with positive feedback.

- Cohort 5 was held from 08/14/2023 to 12/13/2023 and was hosted by San Bernardino One Stop Transitional Age Youth (TAY) Center. This cohort was successfully extended from a 12-week program to a 16-week program due to the overwhelming positive feedback from participants and TAY staff. This extension reflects the program's flexibility and the clients' willingness to continue engagement and progress. The additional weeks provided more opportunities for skill development in the variety of mediums including painting, charcoal and drawing.
- Cohort 6 was held from 01/22/2024 to 04/17/2024 and was hosted by the Victorville Campus TAY Center. In an effort to include the Barstow Campus TAY satellite location, an innovative hybrid format was implemented to increase participation and make the classes accessible to Barstow TAY. The hybrid classes was held once a week via zoom.

### Challenges/Solutions

Cohort 6 faced challenges in delivering an immersive experience to students due to audio and participation issues during the hybrid sessions. In-person classes were held in Victorville and through a virtual platform, students joined the class remotely from Barstow. Due to school and staffing conflicts, Barstow students participated only one day a week instead of two. This caused participants to miss out on key lessons and valuable interactions. Based on the analysis of attendance and feedback from staff and participants, the decision for the program to be an in-person class only moving forward was made to ensure a more cohesive and effective learning environment.



Artwork from Cohort 5 Final Show

"I've never used paint before, but I got to use it during this cohort, ink is so fun and then there's this technique that you do where you put the water first and you take the ink, and you throw it on the paper. Something about that really does visualize some part of your mental health." Cohort 6 Victorville TAY Participant

"I think Cracked Eggs helped me understand my mental health symptoms better because It helped me be creative in my own way and express it on paper." Cohort 5 San Bernardino TAY Participant



Artwork from Cohort 6 Final Show

**Program Updates**

- In FY 2023/24, two cohorts were held at the San Bernardino One Stop and Victorville Campus TAY centers. This was due to the success with the Valley Star Community Services One Stop TAY Center in Yucca Valley last fiscal year. Working with the TAY (16-25) group has had a positive impact on the overall quality and effectiveness of the cohorts, as well as the experience of the participants.
- Cohort 6 implemented the use of somatic exercises that can be used as self-regulation tools outside of class For example, using movement and breathing techniques during panic attacks, times of high anxiety or to provide deeper relaxation.
- The train-the-trainer portion of this project is in the beginning planning stages with the plan to implement in the next fiscal year.
- Cracked Eggs partnered with local businesses to host engaging art shows for participants and the community. Cohort 5 showcased their work at the Garcia Center for the Arts in San Bernardino for a week, while Cohort 6's art was displayed for a month at R&B Tea shop in Victorville. These collaborations have enhanced visibility for Cracked Eggs and contributed to efforts aimed at reducing stigma within the community.
- Cracked Eggs will be ending as an Innovation project on June 30, 2026, when the contract with Bezerk Productions expires.






**Cracked Eggs Community Partners:**
The Garcia Center for the Arts *(top)*
R & B Tea in Victorville *(bottom)*

## Evaluations

In addition to art workshops, three evaluation sessions are incorporated within the class. These evaluations are an important part of the Cracked Eggs Project, as student's feedback is used to determine how to proceed with the programs. For each cohort, the following mixed methodology was implemented to evaluate the Cracked Eggs program.

- Initial Evaluation
  - Introduction
  - Full scale Survey
  - Initial Goal Cards
- Mid-Point Evaluation
  - Goal Card Follow-up
  - Learning Goal Survey
  - Focus Group Discussion
- Final Evaluation
  - Full Scale Survey
  - Goal Card Follow-up
  - Learning Goal Survey
  - Focus Group Discussion

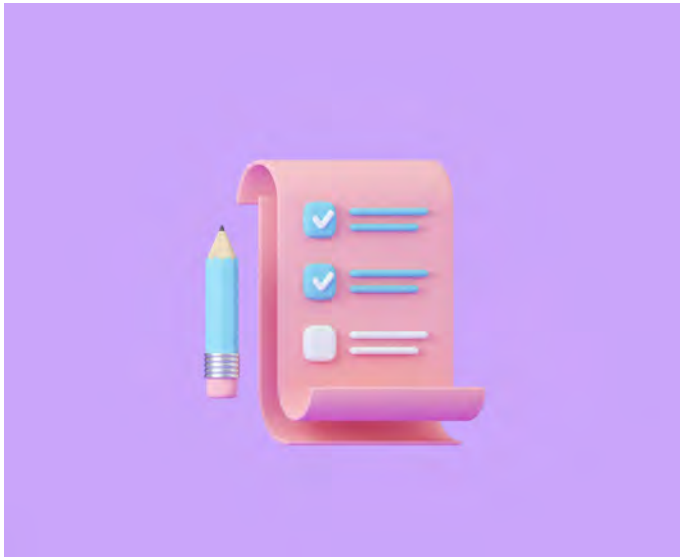
For the qualitative analysis component of the evaluation, focus group discussions were recorded and transcribed for both the midpoint and final assessments.



**What have we learned though the evaluations thus far?**

Participants in the study expressed agreement with the benefits of class activities for managing symptoms, enhancing creativity, and acquiring coping skills. The structured nature of class activities allowed them to have a sense of control over their symptoms. The evaluation showed notable findings that there was the substantial increase in self-perception among participants.

- There was a significant increase of 22% in individuals viewing their own mental illness through a more informed and empowered lens by the end of the cohort, compared to their initial learning goals.
- The majority of students (93%) agree that the program helped them with personal feelings and expression through art and taught them wellness techniques.
- Most students (92%) felt the instructor provided a comforting, stress free environment, and they were able to draw what they felt.
- Seventy-two percent of the students evaluated agree that they were able to portray feelings through art, use art as a coping mechanism, and have acquired valuable skills such as utilizing different tools, techniques and outlets after participating in the program.
- Three-fourths of students stated agree that participating in Cracked Eggs improved their confidence and allowed them to express themselves better.



**Quotes from students during the Focus Group Discussion portion of the evaluation:**

*"I feel like it has helped me through focusing on something, doing something more productive and creative. I know I am creating. Creating plays a big role in recentering, keeping you from thinking too hard about things."*

*"You can draw out your thoughts."*

*"[Cracked Eggs] made me view people differently with mental illness because it made me realize that everyone has their own point of view."*

*"[Cracked Eggs] opened my eyes to the fact that I can like do anything and I reap what I sow, I get what I give, and I can put out in the world what I can put out into the world my very best and I'll get the reward from it."*

*"I feel like I've gotten very comfortable with this group of people that I have had to dance in front of them, so it definitely gives you self-esteem."*

*"Well, it made me feel comfortable knowing that the teacher has schizophrenia just like me and she accomplished a lot."*

*"I feel like I got to open up more and use art as another form of coping."*



**Project Learning Goals**

These project goals are currently in progress as the program continues into its 7th cohort.

**Learning Goal #1:** Examine if participation in Cracked Eggs leads to consumers reaching treatment, social, educational/vocational, and other goals. Examine how participation in Cracked Eggs influences consumers' goals.

**Learning Goal #2:** Examine if participation in Cracked Eggs leads to improved consumer outcomes.

**Learning Goal #3:** Examine if Cracked Eggs, and not least of all Cracked Eggs exhibits and performances, lead to stigma reduction and increased understanding about mental health issues for both consumers and community participants.

**Learning Goal #4:** Examine the challenges and opportunities in scaling-up Cracked Eggs, including developing a train-the-trainer model/curriculum/toolkit.

**Learning Goal #5:** Examine how program evaluation can adapt to best capture emerging themes that consumers find important from their Cracked Eggs experience. Is there a way to include and centralize art as a leading indicator in an evaluation?

# Progressive Integrated Care Collaborative (PICC)

| Innovation Projects | Actual Number Served FY 2023/24 | Estimated Number Served FY 2025/26 | Annual Budgeted Funds FY 2025/26 | Estimated Annual Cost per Person FY 2025/26 |
|---|---|---|---|---|
| PICC INN Project | n/a | 160 | $2,816,114 | $17,601 |

## Project Overview

Escalating healthcare costs have prompted managed healthcare plans, county health care agencies, and consumers to seek ways to improve overall health while reducing the overall cost of care. One such initiative is the integration of medical and behavioral healthcare. The San Bernardino County Department of Behavioral Health (DBH) has developed the Progressive Integrated Care Collaborative (PICC) project to deliver integrated behavioral and physical health services to Medi-Cal enrollees at pilot clinic sites. The project will benefit these individuals through the delivery, coordination and payment for care related to the full continuum of their physical and behavioral health needs.

The lack of best practices disproportionally effects those with advanced behavioral health needs since those suffering from serious mental illness (SMI) or addiction face many obstacles when seeking and receiving needed medical care. This lack of timely and consistent medical treatment often results in preventable deaths decades earlier than the general population. The causes of death are often treatable medical conditions. Additionally, the lack of consistent, ongoing care forces these individuals to utilize hospital and emergency department services at rates far higher than if a primary care physician provided the care.

San Bernardino County Department of Behavioral Health (SBC-DBH) seeks to address these challenges through the implementation of the PICC Innovation Project.

## Project Approval

The PICC project was approved by the Mental Health Services Oversight and Accountability Commission [(MHSOAC), which was renamed to Commission for Behavioral Health (CBH) in January 2025] on May 25, 2023, and the San Bernardino County Board of Supervisors on June 13, 2023. PICC is currently in the first phase of development. More information regarding PICC can be found in the Innovation Plan 2023 online.

# Progressive Integrated Care Collaborative (PICC)

| Program Serves | Symptom Severity | Location of Services | Typical Population Characteristics |
|---|---|---|---|
| 18+ | N/A | Apple Valley Clinic | SMI |

## Target Population

Individuals 18 years and older experiencing serious mental illness, who are Medi-Cal beneficiaries enrolled with Inland Empire Health Plan as the managed care provider.

## Innovative Components

The PICC clinic is the newest innovation project that will provide the following physical health services to consumers of mental health and/or substance use services:

- On-site laboratory specimen collection (blood draws)
- On-site electrocardiograms
- On-site chronic disease management for example management of diabetes or hypertension
- Direct referral to physical health specialists through Managed Care Plan referral network
- Peer navigation and support
- Comprehensive medication reconciliation by clinical pharmacist
- On-site group nutritional education
- Individual nutrition coaching
- Direct referral for preventive health services




PICC will be located at DBH's Apple Valley Community Clinic.

**Project Overview**

The PICC Project will introduce the innovative concept of *Progressive Integration,* based on a strategy of selecting best practices from a given discipline and applying that uniformly across practice specialties.

- ***Laboratory Studies*:** Physical health, mental health and substance use treatment rely on the collection of laboratory specimens to evaluate and monitor patients' organ function, sobriety, medication effect, medication levels and other critical parameters. Onsite collection of urine, blood and other body fluids with pickup by a contracted laboratory partner will allow all disciplines to have reliable and timely access to this information. The first goal of the PICC project is to facilitate this either through nursing or through the addition of a trained phlebotomist.
- ***Electrocardiograms:*** Electrocardiograms provide critical insight into cardiac function, which is frequently altered by psychotropic medications, potentially leading to medical complications. Electrocardiogram results can offer a preliminary interpretation in the clinic but should be verified by a contracted cardiology service for final results.
- ***Data Sharing:*** Health information related to physician and staff notes, outside laboratory studies, medical imaging studies, specialist procedures and inpatient psychiatric visits greatly inform high-quality primary care, substance use treatment and mental health services. Uniform releases of information permitting bidirectional exchange of health information may be developed in the service of this goal. Initially, expansion of mutual read-only electronic health record access for healthcare providers and nursing staff would facilitate this goal. Constructing or implementing a data exchange infrastructure for regulated flow of health information across various electronic health record systems would permit integration into the greater system of care while upholding compliance with applicable regulations of disclosure of protected health information.
- ***Physical Health Specialist Consultation and Referrals:*** Provision of primary care requires a network of medical sub specialists for routine screenings as well as in addressing a variety of medical conditions beyond the scope of primary care. These may include cardiology, gastroenterology, infectious disease, oncology, dermatology, endocrinology, rheumatology, OB/GYN, urology, general surgery, otolaryngology, pain management, neurology, interventional radiology and orthopedic surgery. Optimally, PICC would establish a mechanism in which integrated care clinic staff can consult specialists for guidance on diagnosis and treatment recommendations.

**Project Overview, cont.**

- ***Billing:*** Cost data related to laboratory services, electrocardiogram and medical imaging, data-sharing infrastructure, specialist consultation and referral fees, as well as direct costs related to staffing, facilities, and consumables will be collected on an ongoing basis. This cost data will be aggregated and will inform a cost model for integrated care inclusive of mental health, substance use treatment, primary care and specialty physical health needs. Progressive gains in efficiency are anticipated as additional layers of integration accumulate.

**Program Updates**

- Space at the Apple Valley Clinic has been allocated for the PICC clinic and PICC staff.
  - This includes offices and cubicles for medical providers and clinic staff as well as two exam rooms, one medication room and one lab draw/vital signs room.

- Hiring of staff has commenced, with four staff already on board. PICC's physicians will be coming on through a contract with Vituity. Vituity is a physician partnership and healthcare staffing group the Department of Behavioral Health has contracted with to provide psychiatrists and primary care physicians to the department.

- Innovation staff have begun working collaboratively with DBH's biomedical technician to outfit the PICC clinic with all necessary medical and office equipment and supplies.

- Project development continues in collaboration with DBH's Facilities and Project Management unit, as well as the Information Technology (IT) unit, to ensure that all workspaces are setup and ready for staff's arrival.

SAN BERNARDINO COUNTY
Behavioral Health

# MHSA Annual Update for FY 25/26: Workforce Education and Training

# Workforce Education and Training

## Introduction

The passage of the Mental Health Services Act (MHSA) in November 2004 provided a unique opportunity to increase staffing and other resources to support public behavioral health programs. MHSA funds increased access to much-needed services and progress toward statewide goals for serving children, Transitional Age Youth (TAY), adults, older adults, and their families.

California's public behavioral health system has suffered from a shortage of behavioral health workers, changes in mental health occupational classifications, and the underrepresentation of diversity of professionals with consumer and family member experience. To address challenges faced by the public behavioral health workforce, the MHSA included a component for Mental Health Workforce Education and Training (WET) programs.

WET is a program that provides training opportunities to the Department of Behavioral Health's (DBH) staff and contract agency staff, promotes the recruitment and hiring of a culturally diverse workforce, offers financial incentives to recruit and retain staff, recruits volunteers for the department, facilitates clinical intern programs, supports the inclusion and incorporation of consumers and their family members into the behavioral health workforce, and is committed to addressing the workforce shortage within San Bernardino County through the utilization of various strategies to recruit and retain qualified behavioral health employees.



Artwork by Catherine Sutton

# Workforce Education and Training

## Introduction, cont.

WET carries forth the vision of the MHSA to create a transformed, culturally-competent system that promotes wellness, recovery, and resilience across the lifespan of all age groups and all cultural backgrounds.

### Success Story

The Training Unit partnered with Riverside University Health System to offer Solution-Focused Brief Therapy for staff from both San Bernardino and Riverside Counties. The training offered staff the chance to learn an effective, evidence-based modality to enhance consumer services. It was very successful and elicited positive feedback in the anonymous evaluation, such as the comment below:

"The trainer and her team were amazing. This is the first training that I felt I could walk away using these concepts the next day. I would 100% recommend to have other trainings by them or for my colleagues to do this training. It was such an interactive learning environment with competent and patient trainers."

## Positive Results

To meet the goal of addressing workforce shortages, needs assessments were completed in July of 2008 and 2013. Both assessments identified child psychiatrists and psychiatrists as hard-to-fill and retain positions. Since 2008, the WET program has been successful in increasing the number of applications received for qualified licensed staff. The WET program received an increase in applications for licensed positions in FY 2023/24, including Child Psychiatrist, Clinic Assistant, Nurse Manager, Nurse Supervisor, and Program Manager II.

"The rotation was extremely formative for me. I found that my patients had more to teach me than the text. Sharing their pain and joy helped me realized that we cannot control when or how we're hurt, but we can control how it shapes us. This realization helped me see life and suffering through a more positive perspective."

- Western University Medical Student

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 355-370.

# Workforce Education and Training

**Positive Results, cont.**

The table below shows the number of qualified applications received for specific job positions in FY 2023/24:

| Job Title | Number of Qualified Applications Received in FY 2023/24 | Job Title | Number of Qualified Applications Received in FY 2023/24 |
|---|---|---|---|
| Alcohol and Drug Counselor | 78 | Nurse Supervisor | 22 |
| Child Psychiatrist | 7 | Peer and Family Advocate I | N/A |
| Clinic Assistant | 101 | Peer and Family Advocate II | N/A |
| Clinic Supervisor | 46 | Peer and Family Advocate III | 305 |
| Clinical Therapist, LCSW | 60* | Pre-Licensed Clinical Therapist, Licensed Clinical Social Worker (LCSW) | 81 |
| Clinical Therapist, Marriage and Family Therapist (MFT) | 60* | Pre-Licensed Clinical Therapist, MFT | 340** |
| Clinical Therapist, Psychology | 60* | Pre-Licensed Clinical Therapist, Psychology | 340** |
| Clinical Therapist II | 4 | Pre-Licensed Clinical Therapist, Licensed Professional Clinical Counselor (LPCC) | 340** |
| Licensed Vocational Nurse | 69 | Program Manager I | 32 |
| Mental Health Education Consultant | 87 | Program Manager II | 51 |
| Mental Health Nurse II | 65 | Psychiatric Technician I | 27 |
| Mental Health Specialist | 110 | Psychiatrist | 25 |
| Nurse Manager | 98 | Research and Planning Psychologist | 23 |

*Clinical Therapists recruited together (LMFT, LCSW, and LPCC)

**Pre-Licensed Clinical Therapists recruited together (LMFT, LCSW, and LPCC)

# Workforce Education and Training

**Positive Results, cont.**

Another program that WET oversees is the License Exam Preparation Program (LEPP). LEPP was created to help pre-licensed clinicians become licensed.

The table below illustrates the progress that LEPP has had in helping staff obtain licensure for their discipline. For LEPP 1-14, there has been, on average, an approximately **77%** licensure rate among the participants.

| Program | Fiscal Year | # of Applicants | # Who Became Licensed | % Licensed |
|---|---|---|---|---|
| LEPP 1 | 2009/10 | 60 | 41 | 68% |
| LEPP 2 | 2011/12 | 38 | 24 | 63% |
| LEPP 3 | 2012/13 | 32 | 19 | 59% |
| LEPP 4 | 2013/14 | 18 | 18 | 100% |
| LEPP 5 | 2014/15 | 41 | 39 | 95% |
| LEPP 6 | 2015/16 | 59 | 55 | 93% |
| LEPP 7 | 2016/17 | 65 | 59 | 91% |
| LEPP 8 | 2017/18 | 49 | 39 | 80% |
| LEPP 9 | 2018/19 | 41 | 33 | 80% |
| LEPP 10 | 2019/20 | 35 | 32 | 91% |
| LEPP 11 | 2020/21 | 26 | 23 | 88% |
| LEPP 12 | 2021/22 | 31 | 23 | 74% |
| LEPP 13 | 2022/23 | 15 | 11 | 73% |
| LEPP 14 | 2023/24 | 40 | 9 | 23% |
| **Grand Total** | | **550** | **425** | **77%** |

# Workforce Education and Training

**Positive Results, cont.**

DBH expects the percentage of pre-licensed to licensed clinicians to continue to increase with the benefit of LEPP as seen below.

**Through 14 Cohorts of LEPP, Prior to Implementation of Revised LEPP***

| | Clinical Therapist I | Clinical Therapist I Psychologist | Total |
|---|---|---|---|
| Licensed | 45 | 2 | **47** |
| Pre-Licensed | 111 | 6 | **117** |
| Total | 156 | 8 | **164** |
| Percentage Licensed | 28.8% | 25.0% | **28.7%** |

*DBH has seen a decrease of 5.1% in the percentage of licensed staff in FY 2023/24.

## Success Points

- Two of the three 20/20 MFT interns in FY 2023/24 successfully completed the 20/20 MFT program and were hired on as Clinical Therapist Trainees. The third will end the program this December.
- One non-Employee Education Internship Program (EEIP) intern was also hired on as a Clinical Therapist Trainee after ending the internship.

With the passage of the MHSA and the creation of WET, DBH was able to consolidate and expand the Internship program. WET coordinates all aspects of the internships and practicums placed within DBH. Currently, the Internship program trains students enrolled in the following bachelor and graduate programs:

- Social Work
- Marriage and Family Therapy (MFT)
- Psychology

Depending on their discipline, interns participate in the Internship Program for 12 to 18 months. During that time, they learn to provide clinical services in a public community behavioral health setting. In FY 2023/24, there was a total of 27 interns in the Internship program across the Social Work and MFT disciplines. The Psychology program did not accept applications in FY 2023/24 while the program was in a transitional phase; however, the program has resumed the application process.

The Internship program continues to grow and receive positive feedback from participants, who report they received comprehensive training and a valuable experience during their time at DBH. It is hoped that integrating psychiatric residents into the clinical staff and supporting their understanding of the therapeutic process, as well as increasing their clinical skills, will lead to an increase in the retention and hiring of psychiatrists who complete their residency at DBH.

# Workforce Education and Training

**Positive Results, cont.**

DBH is committed to hiring applicants who were previous DBH interns. As seen in the following table, 16% of clinical hires in FY 2023/24 were DBH interns; twelve DBH interns were hired as pre-licensed Clinicians with the department in FY 2023/24.

| Pre-Licensed Clinicians Hired | FY 2023/24 |
|---|---|
| Total Number of Interns Hired | 12 |
| Total Number of Non-Interns Hired | 61 |
| % of Interns Hired | 16% |

The DBH Employee Educational Internship program was created to support current DBH staff in pursuing their Master of Social Work (MSW) or Marriage and Family Therapy (MFT) degree by allowing them to intern for up to 20 hours per week at DBH as part of their degree requirements. The program was created to support the WET initiative of building a more skilled workforce by "growing our own" qualified staff to fulfill the identified clinical shortages within the department. Since its implementation, the program has increased in popularity, and in April 2015, was expanded by adding the Alcohol and Drug Counselor (AOD) and Bachelor of Social Work (BSW) intern career path options.

Additionally, in FY 2016/17, the Medical Education program, which currently offers rotations to medical students and psychiatry residents, had its first Nurse Practitioner (NP) student complete a psychiatry rotation within the DBH clinics. Since then, WET has seen 87 NP students with seven of those in FY 2023/24.

To meet the goal of educating the workforce according to the general standards, DBH continues to incorporate the Wellness, Recovery, and Resilience Model in trainings.

The general standards set by the Mental Health Services Act (MHSA) include a Wellness, Recovery, and Resilience model that is culturally competent, supports the philosophy of a consumer/family driven behavioral health system, integrates services, and includes community collaboration.

Among the trainings provided in FY 2023/24, the following are examples of trainings that incorporate MHSA standards:

- Human Trafficking
- Law and Ethics for County Healthcare Providers
- Motivational Interviewing
- Objective Arts
- Transformational Collaborative Outcomes Management
- Trauma Informed Housing During Disasters and Homelessness
- Trauma and Eating Disorders
- Trauma and Post-traumatic Stress Disorder (PTSD)/Complex PTSD

**Positive Results, cont.**

The training information table below shows that the average evaluation score for the trainings in FY 2023/24 was 4.62 out of 5. This rating reflects a similar average trainee satisfaction as the previous two years. There was an 18% decrease in attendance of Live/Virtual trainings in FY 2023/24 largely due to the growth of DBH developed Interactive Online Modules which has seen an increase in learner completions from 328 in FY 2022/23 to 1,378 in FY 2023/24.

In FY 2023/24, WET began offering Reality Based Leadership, LLC, for leadership training and employee development. Reality Based Leadership, LLC, provides the Executive Leadership team support through quarterly one-on-one coaching sessions, interactive learning sessions, and group coaching sessions. The Leadership Development and Employee Development components included interactive learning sessions, books and support materials, and group coaching sessions (Leadership component). WET also offered courses centered around Trauma and Eating Disorders, and a new course titled Indirect Trauma & Empathy-Based Stress for Helping Professionals in an effort to improve the wellness of the care providers.

The table below provides further details regarding trainings provided by WET in FY 2023/24.

| Fiscal Year | Attendance | Classes Offered | Continuing Education Credits | Evaluation Average |
|---|---|---|---|---|
| FY 2013/14 | 3,095 | 136 | 939.45 | 4.5 |
| FY 2014/15 | 3,524 | 108 | 703 | 4.6 |
| FY 2015/16 | 3,867 | 120 | 391 | 4.6 |
| FY 2016/17 | 4,296 | 234 | 494.5 | 4.6 |
| FY 2017/18 | 4,477 | 231 | 281.5 | 4.64 |
| FY 2018/19 | 4,371 | 283 | 567.5 | 4.74 |
| FY 2019/20 | 4,173 | 221 | 886.5 | 4.7 |
| FY 2020/21 | 4,467 | 245 | 92 | 4.2 |
| FY 2021/22 | 3,812 | 293 | 177 | 4.6 |
| FY 2022/23 | 4,313 | 223 | 327 | 4.67 |
| FY 2023/24 | 3,658 | 235 | 540 | 4.62 |

**Positive Results, cont.**

Peer and Family Advocates (PFAs) are behavioral health consumers, or family members of behavioral health consumers, who provide crisis response services, peer counseling, linkages to services, and support for consumers of DBH services. They also assist with the implementation, facilitation, and ongoing coordination of activities with the Community Services and Supports (CSS) plan in compliance with MHSA requirements. The Peer and Family Advocate position also fulfills the MHSA Workforce Education and Training goal of increasing the number of consumers and family members of consumers employed in the public mental health system.

As shown in the table to the right, there has been a significant increase in PFAs hired in DBH over the last several years. This is largely due to increasing knowledge and evidence of the benefits when including Peer and Family Advocates in DBH programs and the positive outcomes it has yielded on the consumers served by these programs. DBH strives to continue to increase the number of PFAs being hired and maintained on staff and hosts an open recruitment for PFA, levels I, II, and III, annually. The recruitment, which includes advertising on social media, flyers, and emails circulated throughout the community, and posting on Jobinsocal.com, is widely popular amongst members of the community and garners between 150 to 200 applications annually. By utilizing different outlets to advertise for the PFA positions, especially social media and word of mouth through current DBH employees, the department increases public awareness of the PFA role and attracts a greater pool of qualified applicants each year.

**Total Peer and Family Advocates with DBH**

| **Fiscal Year** | Positions | **Fiscal Year** | Positions |
|---|---|---|---|
| FY 2005/2006 | 4 | FY 2015/2016 | 28 |
| FY 2006/2007 | 19 | FY 2016/2017 | 26 |
| FY 2007/2008 | 24 | FY 2017/2018 | 36 |
| FY 2008/2009 | 24 | FY 2018/2019 | 28 (Plus 7 Vacancies) |
| FY 2009/2010 | 21 | FY 2019/2020 | 35 (Plus 7 Vacancies) |
| FY 2010/2011 | 20 | FY 2020/2021 | 35 (Plus 7 vacancies) |
| FY 2011/2012 | 24 | FY 2021/2022 | 29 (Plus 20 vacancies) |
| FY 2012/2013 | 25 | FY 2022/2023 | 34 (Plus 21 vacancies) |
| FY 2013/2014 | 23 | FY 2023/2024 | 40 (Plus 16 vacancies) |
| FY 2014/2015 | 29 | | |

# Workforce Education and Training

**Positive Results, cont.**

Once a PFA starts working for DBH, they are encouraged to develop professionally and promote to a higher classification. The following table shows the number of PFAs promoted since 2008.

| PFAs Promoted | | | |
|---|---|---|---|
| **Fiscal Year** | Promotions | **Fiscal Year** | Promotions |
| FY 2007/2008 | 3 | FY 2017/2018 | 5 |
| FY 2011/2012 | 1 | FY 2018/2019 | 6 |
| FY 2012/2013 | 1 | FY 2019/2020 | 11 |
| FY 2013/2014 | 4 | FY 2020/2021 | 2 |
| FY 2014/2015 | 3 | FY 2021/2022 | 5 |
| FY 2015/2016 | 4 | FY 2022/2023 | 5 |
| FY 2016/2017 | 3 | FY 2023/2024 | 7 |

"I also appreciated the support from [the] WET supervisor and CYCS supervisor as they were significantly helpful in clarifying doubts, concerns, and questions related to the practice of my work and assisted in enhancing my knowledge."

- 20/20 Program Intern

The contract agencies that work with DBH are required to employ PFAs as well, although they may be given different working titles. The number of PFAs employed with DBH contract agencies continues to increase as more programs are choosing to utilize the benefits presented by incorporating peer support and advocacy into their practices.

Not all contract agencies use the PFA title. A few other titles they use are:

- Family Partner
- Youth Partner
- Peer Partner
- Parent Partner
- Family Support Partner
- Parent Family Advocate

In FY 2023/24, DBH implemented the Southern Counties Regional Partnership (SCRP) PFA pipeline development program intended to support PFAs who have achieved certification by offering stipends to retain them within the Public Mental Health System. These funds have been set aside specifically to address DBH's need to recruit and retain PFAs. Additionally, the stipends will address a gap in DBH's pipeline development and succession planning by creating a path for this classification to other positions within DBH.

**Positive Results, cont.**

To meet the goal of conducting focused outreach and recruitment to provide equal employment opportunities in the public mental health system for individuals who share racial/ethnic, cultural, and/or linguistic characteristics of consumers and family members, the Volunteer Services Coordinator participates in career fairs throughout the County, including remote areas such as Barstow and the Morongo Basin. As illustrated in the table below, the coordinator increased the number of participants in outreach efforts every year through FY 2017/18, subsequent years were impacted due to the COVID-19 pandemic, which caused the Volunteer Services Coordinator to attend fewer outreach events than in previous years. It had increased again every year since 2020 until FY 2023/24 when no new events were scheduled during the search for a new Volunteer Services Coordinator due to promotion.

| Fiscal Year | Number of Schools Visited | Number of Participants |
|---|---|---|
| FY 2011/12 | 13 | 2,470 |
| FY 2012/13 | 16 | 2,479 |
| FY 2013/14 | 23 | 1,706 |
| FY 2014/15 | 35 | 2,770 |
| FY 2015/16 | 35 | 4,139 |
| FY 2016/17 | 70 | 6,958 |
| FY 2017/18 | 82 | 9,303 |
| FY 2018/19 | 63 | 6,377 |
| FY 2019/20 | 59 | 5,818 |
| FY 2020/21 | 25 | 2,070 |
| FY 2021/22 | 32 | 3,093 |
| FY 2022/23 | 39 | 4,222 |
| FY 2023/24 | 21 | 1,582 |
| **Total** | **513** | **52,987** |

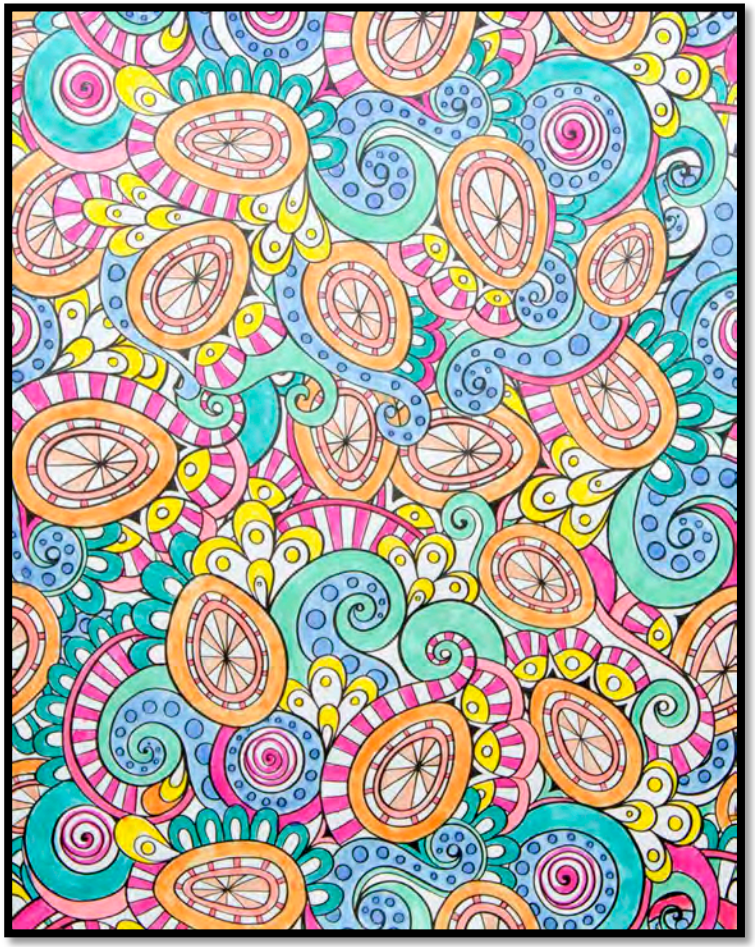
**Positive Results, cont.**

To reach the Spanish speaking community, the Volunteer Service Coordinator partnered with a bilingual co-presenter and translated presentations and handouts into Spanish. The co-presenter also helped to explain behavioral health career opportunities to monolingual parents that may not have a full understanding of what kind of career options are available for their children.

To meet the goal of recruiting, employing, and supporting individuals in the public mental health system who are culturally and linguistically competent—or, at a minimum, educated and trained in cultural competence—DBH strives to ensure that its staff provides culturally and linguistically competent services to consumers. To ensure that this measure is met, all staff are required to take either online or in-person cultural competency trainings (2 hours for non-clinicians and 4 hours for clinicians) annually.

"I had minimal desire to work with the adolescent population. After doing a rotation with Dr. Wigfall, I felt like the adolescent population was not so difficult to manage and that there was a great need to manage the mental health of the children."

- Charles R. Drew University Nurse Practitioner Student

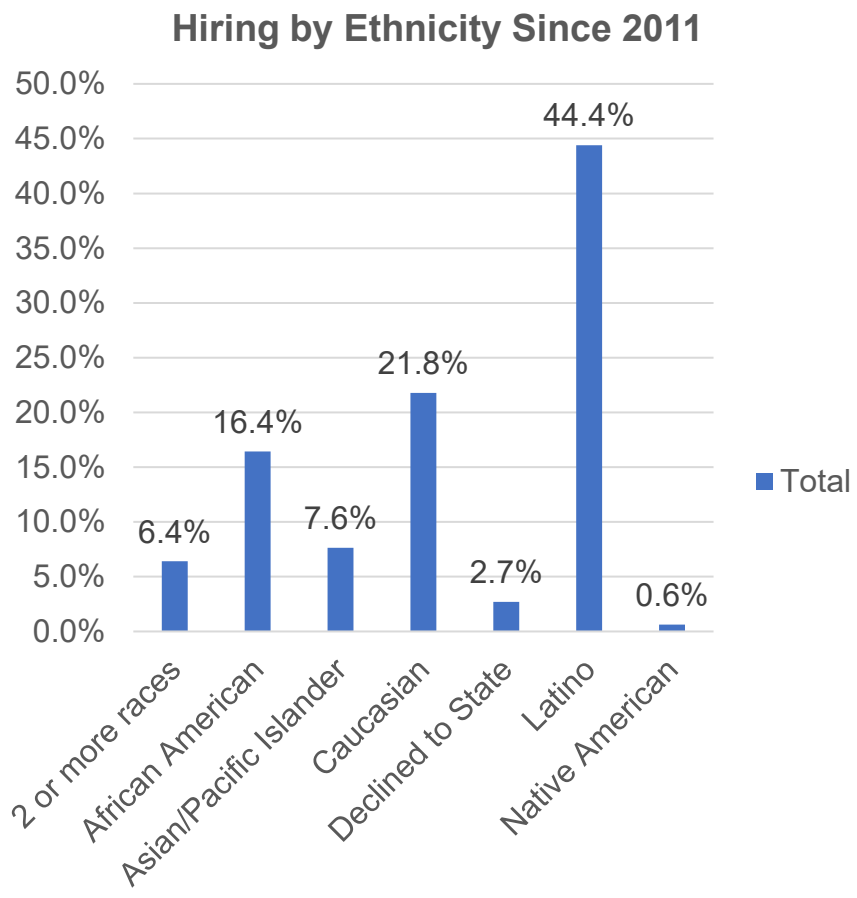


Artwork by Betsy Pruitt

# Workforce Education and Training

**Positive Results, cont.**

To help ensure DBH provides culturally and linguistically competent services, DBH continually recruits new employees that represent the diverse population of San Bernardino County, as can be seen in the chart below.




To provide culturally and linguistically competent services to consumers, DBH actively recruits applicants who are bilingual and bicultural. As can be seen below, DBH has increased the number of bilingual staff employed in FY 2023/24. It remains a top priority of the department to continue to recruit and retain bilingual staff.

| Fiscal Year | Number of Bilingual Staff |
|---|---|
| FY 2012/13 | 150 |
| FY 2013/14 | 165 |
| FY 2014/15 | 162 |
| FY 2015/16 | 171 |
| FY 2016/17 | 171 |
| FY 2017/18 | 170 |
| FY 2018/19 | 172 |
| FY 2019/20 | 211 |
| FY 2020/21 | 208 |
| FY 2021/22 | 214 |
| FY 2022/23 | 203 |
| FY 2023/24 | 247 |

Most bilingual staff speak Spanish, but other languages spoken by staff include Tagalog, Vietnamese, French, and German.

# Workforce Education and Training

**Positive Results, cont.**

WET has actively recruited bilingual interns to help provide services in other languages. Since FY 2008/09, on average, **35%** of interns are bilingual. In FY 2023/24, **31%** of interns were bilingual. Of the bilingual interns, **85%** were Spanish speakers.

The table below indicates the bilingual intern information:

| Fiscal Year | Total Bilingual | Total Interns | % of Bilingual Interns |
|---|---|---|---|
| 2008/09 | 16 | 39 | 41% |
| 2009/10 | 10 | 46 | 22% |
| 2010/11 | 18 | 41 | 44% |
| 2011/12 | 8 | 44 | 18% |
| 2012/13 | 13 | 47 | 28% |
| 2013/14 | 14 | 51 | 27% |
| 2014/15 | 16 | 43 | 37% |
| 2015/16 | 24 | 47 | 51% |
| 2016/17 | 16 | 39 | 41% |
| 2017/18 | 10 | 31 | 32% |
| 2018/19 | 15 | 39 | 38% |
| 2019/20 | 19 | 35 | 54% |
| 2020/21 | 14 | 33 | 42% |
| 2021/22 | 11 | 34 | 32% |
| 2022/23 | 11 | 41 | 27% |
| 2023/24 | 13 | 42 | 31% |
| **Total** | **228** | **652** | **35%** |

Historically, most bilingual staff speak Spanish, but other languages spoken by staff include Tagalog, Vietnamese, French, and German.

# Workforce Education and Training

**Positive Results, cont.**

The Employee Scholarship Program (ESP) was piloted in 2013 to meet the goal of providing financial incentives to recruit or retain employees within the public mental health system. Within the ESP program, $25,000 in funds are budgeted per year to be distributed among the awardees. The funding for ESP has been allocated to provide scholarships designed to pay student tuition (not to include books, travel, or other expenses) for employees who are working to earn a clinical or non-clinical certificate, associate or bachelor's degree, or a non-clinical master's or doctorate degree. This opportunity is expressly designed to promote the development of a strong, stable, and diverse workforce within DBH.

The table below provides a breakdown of which degrees the awardees were pursuing:

| Fiscal Year | Certificate | Associate | Bachelors | Masters | | Total Recipients |
|---|---|---|---|---|---|---|
| 12/13 | 0 | 2 | 5 | 5 | 0 | 12 |
| 13/14 | 0 | 0 | 5 | 6 | 0 | 11 |
| 14/15 | 1 | 0 | 4 | 3 | 0 | 8 |
| 15/16 | 1 | 0 | 5 | 4 | 0 | 10 |
| 16/17 | 1 | 1 | 5 | 2 | 0 | 9 |
| 17/18 | 0 | 0 | 6 | 4 | 0 | 10 |
| 18/19 | 0 | 0 | 2 | 1 | 0 | 3 |
| 19/20 | 0 | 0 | 0 | 0 | 0 | 0 |
| 20/21 | 0 | 0 | 1 | 2 | 1 | 4 |
| 21/22 | 0 | 0 | 2 | 5 | 1 | 8 |
| 22/23 | 0 | 0 | 2 | 1 | 0 | 3 |
| 23/24 | 0 | 0 | 2 | 3 | 0 | 5 |
| **Total** | **3** | **3** | **39** | **36** | **2** | **83** |

**Note:** In FY 2019/20, the program was paused due to budget concerns related to COVID-19 but resumed in FY 2020/21.

# Workforce Education and Training

**Positive Results, cont.**

The following table illustrates the number of ESP awardees who have promoted to new positions.

| Fiscal Year | Awardees Promoted | Fiscal Year | Awardees Promoted |
|---|---|---|---|
| 2012/13 | 1 | 2018/19 | 10 |
| 2013/14 | 2 | 2019/20 | 1 |
| 2014/15 | 2 | 2020/21 | 1 |
| 2015/16 | 0 | 2021/22 | 3 |
| 2016/17 | 1 | 2022/23 | 4 |
| 2017/18 | 3 | 2023/24 | 3 |

Awardees were given money up to their tuition amount. Sometimes their tuition was less than the award amount.

## Success Points

- Of the six third-year Psychiatric Residents, three were accepted into Child Psychiatry Fellowship.
- All fourth-year Psychiatric Residents graduated from their program.

WET was able to add the following DBH sites as approved National Health Service Corps (NHSC) designated sites in FY 2023/24, allowing DBH employees working at those sites to continue to be eligible for NHSC Financial Incentive programs including the Loan Repayment Programs:

- Apple Valley Community Clinic
- Juvenile Justice

"Seeing how the Attendings approached various patients, regardless of their background, to provide them with excellent care had a lasting impact on my career choice. Witnessing their dedication to patient-centered care and their ability to connect with individuals from diverse backgrounds taught me invaluable lessons in empathy, communication, and professionalism. This experience reinforced my commitment to delivering high quality care and will undoubtedly influence my approach to patient interactions, regardless of the specialty I ultimately choose."

- Western University Medical Student

# Workforce Education and Training

**Positive Results, cont.**

DBH uses multiple methods to meet the goal of incorporating the input of diverse racial/ethnic populations that reflect California's general population into WET programs and/or activities. DBH uses the Workforce Development Discussion (WDD) meeting and partners with the Office of Equity and Inclusion (OEI) to help maximize the ability of the existing and potential workforce, contract agencies, and fee-for-service providers to provide culturally and linguistically appropriate services to County residents by:

- Providing cultural competence training to all staff
- Developing policies that clarify the usage of bilingual staff for interpretation services, as well as guidelines on providing appropriate services for diverse cultural groups
- Providing interpreter training to all bilingual staff
- Recruiting and retaining multilingual and multicultural staff
- Working with the communities served to address the cultural needs of the community
- Participating in Cultural Competency Advisory Committee and fourteen culturally-specific awareness subcommittees

OEI also works closely with the WDD committee to ensure the needs of San Bernardino County's diverse racial/ethnic populations are being met.

To meet the goal of establishing regional partnerships, the Southern Counties Regional Partnership (SCRP) was created in 2009. SCRP is a collaborative effort between the ten Southern California counties. The Partnership's goals are to coordinate regional education programs, disseminate information and strategies throughout the region, develop common training opportunities, and share programs that increase diversity of the public behavioral health system workforce when those programs are more easily coordinated at a regional level. The ten member counties include:

- Kern
- Imperial
- Orange
- Riverside
- San Bernardino
- San Diego
- San Luis Obispo
- Santa Barbara
- Tri Cities
- Ventura

San Bernardino County was the fiscal agent of SCRP until June 30, 2014. Santa Barbara County assumed responsibility as the fiscal agent since FY 2014/15. San Bernardino County continues to participate in SCRP as a member county.

## Challenges/Solutions

In FY 2023/24, the WET program continued to face the challenge of maintaining a strong training curriculum across the department. However, with a fully staffed training division, WET successfully kept up with the latest training trends and implemented several new trainings that incorporated e-learning components using software like RISE and Articulate 360.

The employee scholarship program experienced only a slight increase in participation during FY 2023/24. To further address this ongoing challenge, WET will continue discussions to expand the program's eligibility criteria to boost employee involvement. WET broadened its advertising strategies by including direct advertisements to clinics and engaging clinic supervisors to serve as direct communication channels. WET also introduced information sessions to raise awareness and collaborated with the Public Relations Office for ongoing promotion during enrollment periods. To combat high turnover rates, WET plans to offer the scholarship opportunity twice per year and will review the application requirements to potentially include employees who were previously excluded due to being new to the department or on probation.

The shortage of placement sites for the Volunteer Services program and Internship program remains a significant challenge for WET. Additionally, the vacancy and subsequent hiring of a new Volunteer Service Coordinator led to a decrease in outreach efforts. Now that the position has been filled, WET will focus on enhancing outreach and pipeline development efforts. The Volunteer Service Coordinator role is now managed by the Public Relations Office to streamline outreach and volunteer activities on behalf of the department.

The addition of interactive online modules continues to highlight the high completion rates of online training in the department. While online training via the Learning Management System (LMS) has been utilized for many years, the data for this digital content was not being captured and utilized as only live trainings were reported. The development of online curriculum, especially that which includes interactive elements, is a time-intensive process. All digital content produced by DBH training staff must be maintained and updated regularly. This work produces measurable training hours that should be reported alongside live training for an accurate representation of WET. To account for the online training hours, WET continues to use newly-developed evaluation forms for all online courses to track staff completion within the fiscal year and collects feedback to help improve the online courses and their effectiveness.

# Workforce Education and Training

## Outreach and Engagement

In FY 2023/24, WET organized and/or participated in the following outreach and engagement activities:

| Activity Type | Number of Activity Type | Total Number of Participants |
|---|---|---|
| Community Event – Recovery Happens | 1 | 77 |
| College Career Fairs | 8 | 465 |
| Classroom Presentations | 9 | 862 |
| Mock Interviews | 3 | 178 |
| **Total** | **21** | **1,582** |

## Program Updates

During this reporting year, WET received two new positions: an Administrative Supervisor, and a Staff Training Instructor. With the addition of these two positions, WET is able to expand administrative support and increase the number of recurring trainings.

"All the faculty I've interacted with were very nice and welcoming. I'm excited to work with psychiatrists in the future. I feel that from their teachings, I have a better understanding for how to prescribe psych medications for patients as a primary care provider."

- California University of Science and Medicine Medical Student

"During my rotation, I had the opportunity to work closely with underrepresented patients. Connecting with the patients on a personal and cultural level was incredibly rewarding. I continue to recognize the significant need for culturally competent healthcare professionals in our community. This experience continues to influence my career choice and fuel my commitment to serving underrepresented patient populations."

- ARMC Resident

# Workforce Education and Training

**Collaborative Partners**

- Alder School of Professional Psychology
- American Career College
- American University of Antigua
- Argosy University
- Arrowhead Regional Medical Center (ARMC)
- Azusa Pacific University – High Desert Campus
- UMass Global University
- Cajon High School, San Bernardino – Get Psyched
- California Baptist University
- California State University, San Bernardino
- California State University, Fullerton
- Chaffey Joint Union High School District
- Colton-Redlands-Yucaipa Regional Occupational Program (CRY ROP)
- Fontana Unified School District
- Loma Linda University Medical
- Loma Linda University School of Medicine (LLUSM)
- Mountain Desert Career Pathways
- Pomona Valley Hospital Medical Center (PVHMC)
- Reach Out-Inland Health Professional Coalition (IEPC)
- Redlands Unified School District Collaborative
- San Bernardino City Unified School District
- San Bernardino Superintendent of Schools (SBSS)
- San Bernardino Valley College
- Touro University College of Osteopathic Medicine (TUCCOM)
- University of San Diego
- Western University of Health (WUH)



Artwork by Tabithia Wilkins

SAN BERNARDINO COUNTY
Behavioral Health

# MHSA Annual Update for FY 25/26: Capital Facilities and Technological Needs

# Capital Facilities and Technological Needs

## Introduction

The Capital Facilities and Technological Needs (CFTN) component must support the goals of the Mental Health Services Act (MHSA) and the provision of MHSA services. The planned use of CFTN funds willl produce long-term impacts with lasting benefits that support the behavioral health system's movement towards recovery, resiliency, culturally competent, and help first models, as well as opportunities for accessible community-based services for consumers and their families. These efforts include the development of various technological advancements, strategies, and/or community-based facilities that support culturally and linguistically appropriate integrated service experiences. Funds may also be used to support an increase in:

- Peer-support and consumer-run facilities,
- Development of community-based, least restrictive settings that reduce the need for incarceration or institutionalization, and
- The development of technological infrastructure for the public behavioral health system to facilitate high quality, cost-effective services and supports for consumers and their families.

For additional information, please refer back to the MHSA Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026, pages 371-374.

The San Bernardino County Department of Behavioral Health (DBH) has embraced these transformational concepts inherent to MHSA to develop a wellness focused Capital Facilities and Technological Needs component that supports the public behavioral health system and the infrastructure to improve delivery of services across the county.

## Program Description

### Capital Facilities

Capital facility expenditures must result in a capital asset that permanently increases the San Bernardino County Department of Behavioral Health's infrastructure. Simply stated, a building or space where MHSA services can be provided.

### Technological Needs

The overarching goal of the Technological Needs portion of the Capital Facilities and Technological Needs component is to support the modernization of information systems and to increase consumer/family empowerment by providing the tools for secure access to health and wellness information. These projects will result in improvements of the quality and coordination of care, operational efficiency, and cost-effectiveness across the Department.

# Capital Facilities and Technological Needs

**Program Description, cont.**

*Data Warehouse*

Research and Evaluation (R&E) manages the Data Warehouse which houses data from diverse sources that are then combined to provide consistency in advanced analytics and data mining. This framework supports the requirements of the California Advancing and Innovating Medi-Cal (CalAIM) program and the foundation for informed program planning across the continuum of care. By incorporating information about consumers and the services they receive with externally captured outcomes data, the Data Warehouse is uniquely poised to provide the next generation of analytics, dashboard reporting, and clinical decision support, needed to meet the County's vision for wellness.

*Behavioral Health Management Information Systems (BHMIS) Replacement – Electronic Health Record (EHR)*

Innovative Health Information Technology (iHIT) manages all technical solutions associated with the integrated BHMIS - with Billing, Claiming, & EHR functions. The BHMIS supports consumer care by providing secure access and exchange of health information by providers. The purpose of BHMIS is to provide an efficient system to support information collection and enhance coordination of care between internal and external providers. This allows providers to document care in a manner that fosters consumer and family interactions and enables highly functional reporting and data aggregation.

**Services Offered**

**Capital Facilities**

- Obtains permanent capital assets to deliver behavioral health services

**Technological Needs**

- Manage, maintain, and improve the Electronic Health Record (EHR)
- Maintain and utilize the Data Warehouse to
    - Generate Reports
    - Power Business Intelligence Dashboards
    - Conduct Statistical Analysis
    - Develop Outcomes data models
    - Monitor and report on Network Adequacy
- Respond to various aspects related to the 1115 Waiver Medi-Cal Program (Medi-Cal 2020)
- Support the delivery of services for clinicians onsite and remotely
- Provide 24/7 support to the DBH Call Center and Crisis Response Unit
- Support the connectivity, security, and access to resources for staff working remotely
- Support all deployments of staff in response to emergency incidents
- Support DBH's adherence to County directives in compliance with local State of Emergencies

## Positive Results

### Technological Needs

To address the goal of increasing access to services, DBH's Research and Evaluation (R&E) unit used the power of the Data Warehouse to streamline electronic Provider Directory development and reporting. Additionally, new timely access reports were created to assist with capacity planning and informed decision-making to ensure access to care. R&E also specifically monitors and reports on access to services for specialized populations such as foster youth, unsheltered individuals, and consumers shared by the Managed Care Plans. Data from the Data Warehouse supports grant requests and contract negotiations, which are instrumental in maintaining and expanding the DBH network of care.

The renewal of Statistical Analysis System (SAS) software licensing and maintenance agreement to support and expand the Data Warehouse, including text analytics, continues to improve data collection and reporting of new and existing requirements (MHSA, SB1291, Final Rule, CalAIM, Healthcare Effectiveness Data and Information Set (HEDIS), and Coronavirus Aid, Relief, and Economic Security (CARES) Act, etc.), and data modeling designed for use in clinical support tools. Due to the resilience of the programming for the Data Warehouse, the change to CalAIM service codes was smoothly transitioned, and the analytics staff using the Data Warehouse were able to continue to use it to provide information for decision makers.

The Data Warehouse also supports the monitoring and implementation of:

- Data quality improvement initiatives
- Data reporting and analysis for DBH housing programs
- Data reporting for MHSA annual reports, utilization, equity, audits, and reviews
- Expanded reporting to meet Network Adequacy requirements including monthly electronic submissions of the Provider Directory to the Department of Healthcare Services (DHCS).

To maintain and utilize the Data Warehouse, DBH incorporates the DHCS Plan Data Feed, containing Medi-Cal service and pharmacy data for DBH consumers from external providers along with the measurement of outcomes data over time. This data provides a more comprehensive view of DBH consumers for clinical and medical staff when utilized alongside the DBH EHR data.

The use of the DBH Data Warehouse has proven invaluable in establishing the positive outcomes of programs that originated through MHSA Innovations from Recovery Based Engagement Support Teams (RBEST) to Triage Engagement and Support Teams (TEST) and Innovative Remote Onsite Assistance Delivery (InnROADS), providing the information necessary to support program continuation of these key programs for high-needs populations.

## Challenges/Solutions

**Technological Needs**
The Data Warehouse challenges continue to be:

- The integration of the wide range of data, including new clinical data sources;
- The development and use of data mining in clinical support; and
- Integration of text analytics to extract data from text-based systems.

To address these continuing challenges, the Research and Evaluation (R&E) unit has formed a team to foster the development of data mining solutions.

The Plan Data Feed, which is based on services for consumers from other sources than DBH, has been integrated into R&E's processes for calculating a variety of HEDIS measures. Additionally, Emergency Department data coming from the Managed Care Plans is being processed and delivered to programs to assist in effective continuity of care efforts.

*Innovative Health Information Technology (iHIT)*
We face several challenges as we enhance and support technology systems to support programs like CalAIM, Payment Reform, and the Justice-Involved Reentry Initiative. These challenges include:

- **Updating data systems** to meet new Medi-Cal billing rules for Specialty Mental Health and Drug Medi-Cal services. This is critical to ensure we receive full payment for the services we provide.
- **Implementing the Justice-Involved Reentry Initiative,** a groundbreaking program that offers Medi-Cal services to youth and adults in state prisons, county jails, and youth correctional facilities.
- **Improving data sharing** with Medi-Cal Managed Care Plans to better coordinate care and streamline services.

These challenges require continuous system updates to ensure compliance and provide technology solutions that enhance health outcomes for our residents. The Department of Behavioral Health will continue to explore possible solutions to address the identified challenges in the upcoming year.

# Capital Facilities and Technological Needs

**Program Updates**

*Systems Operations and Support Team (SOaS) Expansion*

- SOaS added an Application Specialist position during FY 2023/24.

*Data Warehouse Maintenance and Support*

The Data Warehouse is instrumental in the development of new HEDIS measure reporting requirements from DHCS. Additionally, the Data Warehouse provides the processing power to develop systemwide key performance indicators (KPI) dashboards as part of the Departments ongoing commitment to use data to better serve San Bernardino County residents.



Artwork by Judy Whiting

SAN BERNARDINO COUNTY
Behavioral Health

# MHSA Annual Update for FY 25/26: Fiscal

## Introduction

As part of Department of Behavioral Health's (DBH) continued fiscal accountability, management, and transparency of MHSA funds, DBH has revised the reporting of program expenditures and revenues for this State Plan Update to align with actual anticipated utilization values based on historical trends and anticipated growths. This revision ensures more accurate reporting of usages and availabilities of MHSA funds allotted to DBH consistent with County of San Bernardino's ongoing goal of responsible resource use to ensure financial sustainability. This change does not affect the commitments approved by the Board of Supervisors.



Artwork by Tracy Hutchinson

**Funding Summary FY 2025/26**
**County of San Bernardino**
**Department of Behavioral Health**
**Mental Health Services Act (MHSA)**
**MHSA Annual Update Fiscal Year 2025/26**

| | MHSA Funding | | | | | |
|---|---|---|---|---|---|---|
| | A | B | C | D | E | F |
| | Community Services and Supports | Prevention and Early Intervention | Innovation | Workforce Education and Training | Capital Facilities and Technological Needs | Prudent Reserve |
| Estimated FY 2025/26 Funding | | | | | | |
| 1. Estimated Unspent Funds from Prior Fiscal Years | $ 136,874,251 | $ 47,956,191 | $ 22,914,693 | $ - | $ - | $ |
| 2. Estimated New FY 2025/26 Funding | $ 102,814,398 | $ 25,727,368 | $ 6,886,856 | | | $ |
| 3. Transfer in FY 2025/26 | $ (12,736,153) | $ | $ | $ 5,791,060 | $ 6,945,093 | $ |
| 4. Access Local Prudent Reserve in FY 2025/26 | $ | $ | $ | $ | $ | $ |
| 5. Estimated Available Funding for FY 2025/26 | $ 226,952,496 | $ 73,683,560 | $ 29,801,549 | $ 5,791,060 | $ 6,945,093 | $ |
| Estimated FY 2025/26 MHSA Expenditures | $ 148,517,355 | $ 29,562,079 | $ 3,665,585 | $ 5,791,060 | $ 6,945,093 | $ |
| FY 2025-26 Unspent Fund Balance | $ 78,435,141 | $ 44,121,481 | $ 26,135,964 | $ - | $ - | $ |

| Estimated Local Prudent Reserve Balance | |
|---|---|
| 1. Estimated Local Prudent Reserve Balance on June 30, 2025 | $ 21,655,429.00 |
| 2. Contributions to the Local Prudent Reserve in FY 2025/26 | $ |
| 3. Distributions from the Local Prudent Reserve in FY 2025/26 | $ |
| 4. Estimated Local Prudent Reserve Balance on June 30, 2026 | $ 21,655,429.00 |

**PREVENTION AND EARLY INTERVENTION FY 2025/26**
**County of San Bernardino**
**Department of Behavioral Health**
**Mental Health Services Act (MHSA)**
**MHSA Annual Update Fiscal Year 2025/26**

| PEI State and County Programs | Estimated PEI Funding | | | | | |
|---|---|---|---|---|---|---|
| | A | B | C | D | E | F |
| | Estimated Total Mental Health Expenditures | Estimated Prevention and Early Intervention Funding | Estimated Medi-Cal FFP | Estimated 1991 Realignment | Estimated Behavioral Health Subaccount | Estimated Other Funding |
| Access and Linkage to Treatment | | | | | | |
| 1. PEI SE-2 Child and Youth Connection | $ 27,634,088 | $ 14,575,691 | $ 11,980,962 | | | $ 1,077,434 |
| Outreach for Recognition of Early Signs of Mental Illness | | | | | | |
| 1. PEI CI-1 Promotores de Salud/Community Health Worker | $ 1,028,860 | $ 1,028,860 | | | | |
| 2. PEI CI-4 Behavioral Health Ministries Pilot Project | $ - | $ - | | | | |
| 3. PEI CI-5 Substance Use Prevention & Pathways to Outreach and Treatment (SUPPOrT) | $ 318,852 | $ 165,296 | $ 153,557 | | | |
| Suicide Prevention | | | | | | |
| 1. PEI SE-8 Office of Suicide Prevention | $ 391,919 | $ 391,919 | | | | |
| Stigma and Discrimination Reduction | | | | | | |
| 1. PEI CI-3 Native American Resource Center | $ 336,673 | $ 336,673 | | | | |

## PREVENTION AND EARLY INTERVENTION FY 2025/26, cont.

**County of San Bernardino**
**Department of Behavioral Health**
**Mental Health Services Act (MHSA)**
**MHSA Annual Update Fiscal Year 2025/26**

| PEI State and County Programs | Estimated PEI Funding | | | | | |
|---|---|---|---|---|---|---|
| | A | B | C | D | E | F |
| | Estimated Total Mental Health Expenditures | Estimated Prevention and Early Intervention Funding | Estimated Medi-Cal FFP | Estimated 1991 Realignment | Estimated Behavioral Health Subaccount | Estimated Other Funding |
| Prevention | | | | | | |
| 1. PEI SI-2 Preschool PEI Program | $ 481,463 | $ 481,463 | | | | |
| 2. PEI SI-3 Resilience Promotion in African-American Children | $ 587,373 | $ 587,373 | | | | |
| 3. PEI SE-1 Older Adult Community Services | $ 946,096 | $ 946,096 | | | | |
| 4. PEI SE-5 Lift Program | $ 471,616 | $ 471,616 | | | | |
| 5. PEI SE-6 Coalition Against Sexual Exploitation (CASE) | $ 258,403 | $ 258,403 | | | | |
| Prevention and Early Intervention | | | | | | |
| 1. PEI CI-2 Family Resource Center | $ 4,441,873 | $ 4,441,873 | | | | |
| 2. PEI SE-3 Community Wholeness and Enrichment | $ 827,807 | $ 827,807 | | | | |
| 3. PEI SE-4 Military Services and Family Support | $ 652,176 | $ 652,176 | | | | |
| 4. PEI SI-1 Student Assistance Program (SAP) | $ 5,334,646 | $ 1,358,706 | $ 3,130,791 | | | $ 845,149 |
| 5. PEI SE-7 Improving Detection and Early Access (IDEA) | $ 302,794 | $ 302,794 | | | | |
| PEI Programs | $ 44,014,640 | $ 26,826,746 | $ 15,265,310 | $ - | $ - | $ 1,922,583 |
| PEI Administration | $ 2,547,117 | $ 2,547,117 | | | | $ - |
| PEI Assigned Funds | $ 188,215 | $ 188,215 | | | | $ - |
| Total PEI Program Estimated Expenditures | $ 46,749,972 | $ 29,562,079 | $ 15,265,310 | $ - | $ - | $ 1,922,583 |

**COMMUNITY SERVICES AND SUPPORTS FY 2025/26**
**County of San Bernardino**
**Department of Behavioral Health**
**Mental Health Services Act (MHSA)**
**MHSA Annual Update Fiscal Year 2025/26**

| CSS Program Name | Estimated CSS Funding | | | | | |
|---|---|---|---|---|---|---|
| | A | B | C | D | E | F |
| | Estimated Total Mental Health Expenditures | Estimated CSS Funding | Estimated Medi-Cal FFP | Estimated 1991 Realignment | Estimated Behavioral Health Subaccount | Estimated Other Funding |
| FSP Programs | | | | | | |
| 1. C-1 Comprehensive Children and Family Support Program (CCFSS) | $ 51,690,012 | $ 33,702,858 | $ 17,987,153 | | | |
| 2. C-2 Integrated New Family Opportunities Program (INFO) | $ 1,732,183 | $ 1,047,441 | $ 684,743 | | | |
| 3. TAY-1 One Stop TAY Centers | $ 7,477,785 | $ 5,063,215 | $ 2,414,571 | | | |
| 4. A-2 Forensic Services Continuum of Care | $ 8,788,225 | $ 5,614,467 | $ 2,539,632 | | | $ 634,126 |
| 5. A-3 Assertive Community Treatment Model FSP | $ 2,616,921 | $ 1,611,968 | $ 1,004,952 | | | |
| 6. A-7 Homeless Services, Long-Term Supports, and Transitional Care Programs | $ 22,918,450 | $ 15,776,207 | $ 6,469,889 | | | $ 672,354 |
| 7. OA-1 Age Wise | $ 2,507,857 | $ 1,694,998 | $ 812,859 | | | |
| 8. A-11 Regional Adult Full Service Partnership (RAFSP) | $ 15,506,317 | $ 2,995,483 | $ 7,516,763 | | | $ 4,994,071 |
| 9. A-20 Collaborative Adult Full Service Partnership Services | $ 4,273,574 | $ 2,815,549 | $ 1,458,025 | | | |
| FSP Programs Total | $ 117,511,323 | $ 70,322,186 | $ 40,888,586 | $ - | $ - | $ 6,300,551 |

## COMMUNITY SERVICES AND SUPPORTS FY 2025/26, cont.
## County of San Bernardino
## Department of Behavioral Health
## Mental Health Services Act (MHSA)
## MHSA Annual Update Fiscal Year 2025/26

| CSS Program Name | Estimated CSS Funding | | | | | |
|---|---|---|---|---|---|---|
| | A | B | C | D | E | F |
| | Estimated Total Mental Health Expenditures | Estimated CSS Funding | Estimated Medi-Cal FFP | Estimated 1991 Realignment | Estimated Behavioral Health Subaccount | Estimated Other Funding |
| Non-FSP Programs | | | | | | |
| 1. A-1 Peer Programs | $ 5,897,718 | $ 5,897,718 | | | | |
| 2. A-4 Crisis Stabilization Units (CSU)/Crisis Walk-In Centers (CWIC) | $ 13,383,661 | $ 8,675,601 | $ 4,708,060 | | | |
| 3. A-5 Triage Transitional Services (TTS) | $ 2,033,100 | $ 847,487 | $ 1,185,613 | | | |
| 4. A-6 Community Crisis Services | $ 10,501,558 | $ 6,941,805 | $ 3,559,753 | | | |
| 5. A-9 Access, Coordination, and Enhancement (ACE) of Quality Behavioral Health Services | $ 1,724,506 | $ 653,784 | $ 1,070,722 | | | |
| 6. A-10 Crisis Residential Treatment Program (CRT) | $ 16,610,099 | $ 9,403,937 | $ 5,465,838 | | | $ 1,740,324 |
| 7. A-13 Adult Transitional Care Programs | $ 30,275,559 | $ 17,901,601 | $ 12,373,957 | | | |
| 8. A-15 Recovery Based Engagement Support Teams (RBEST) | $ 4,300,473 | $ 3,455,038 | $ 845,435 | | | |
| 9. A-16 Crisis Intervention Collaborative Programs | $ 6,996,318 | $ 4,491,022 | $ 2,167,626 | | | $ 337,671 |
| 10. A-17 Eating Disorder Collaborative | $ 2,815,958 | $ 2,815,958 | | | | |
| 11. A-18 Cracked Eggs | $ 185,241 | $ 185,241 | | | | |
| Non-FSP Programs Total | $ 94,724,192 | $ 61,269,192 | $ 31,377,005 | $ - | $ - | $ 2,077,995 |
| CSS Programs | $ 212,235,515 | $ 131,591,378 | $ 72,265,591 | $ - | $ - | $ 8,378,545 |
| CSS Administration | $ 21,483,785 | $ 16,925,976 | $ 4,557,809 | | | |
| Total CSS Program Estimated Expenditures | $ 233,719,300 | $ 148,517,355 | $ 76,823,400 | $ - | $ - | $ 8,378,545 |
| FSP Programs as Percent of Total | 50.3% | | | | | |

**INNOVATION FY 2025/26**
**County of San Bernardino**
**Department of Behavioral Health**
**Mental Health Services Act (MHSA)**
**MHSA Annual Update Fiscal Year 2025/26**

| Innovation Program Name | | | Estimated INN Funding | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | A | B | C | D | E | F |
| | | | Estimated Total Mental Health Expenditures | Estimated INN Funding | Estimated Medi-Cal FFP | Estimated 1991 Realignment | Estimated Behavioral Health Subaccount | Estimated Other Funding |
| INN Programs | | | $ | | | | | |
| 1. | INN-08 | Innovative Remote Onsite Assistance Delivery (InnROADS)* | $ - | | | | | |
| 2. | INN-09 | Eating Disorder Collaborative | $ - | $ - | | | | |
| 3. | INN-10 | Multi County Full Service Partnership (FSP) | $ - | | | | | |
| 4. | INN-11 | Cracked Eggs | $ - | $ - | | | | |
| 5 | INN-12 | Progressive Integrated Care Collaborative (PICC) | $ 2,816,114 | $ 2,816,114 | | | | |
| 6 | INN-13 | Vyvanse in Stimulate Addiction (VISA) | $ - | $ - | | | | |
| | | INN Programs | $ 2,816,114 | $ 2,816,114 | $ - | $ - | $ - | $ - |
| | | INN Administration | $ 849,471 | $ 849,471 | $ - | | | $ - |
| | | Total INN Program Estimated Expenditures | $ 3,665,585 | $ 3,665,585 | $ - | $ - | $ - | $ - |

*Transitioned to CSS A-7-effective April 2024

## WORKFORCE EDUCATION AND TRAINING FY 2025/26
### County of San Bernardino
### Department of Behavioral Health
### Mental Health Services Act (MHSA)
### MHSA Annual Update Fiscal Year 2025/26

| WET Program Name | Estimated WET Funding | | | | | |
|---|---|---|---|---|---|---|
| | A | B | C | D | E | F |
| | Estimated Total Mental Health Expenditures | Estimated CSS Funding | Estimated Medi-Cal FFP | Estimated 1991 Realignment | Estimated Behavioral Health Subaccount | Estimated Other Funding |
| WET FSP Programs | | | | | | |
| 1. Training and Technical Support | $ 608,563 | $ 608,563 | | | | |
| 2. Internship Program | $ 1,306,841 | $ 1,306,841 | | | | |
| 3. Psychiatric Residency Program | $ 1,309,684 | $ 1,309,684 | | | | |
| 4. Financial Incentive Program | $ - | | | | | |
| WET Programs | $ 3,225,088 | $ 3,225,088 | | | | |
| WET Administration | $ 2,369,519 | $ 2,369,519 | | | | |
| WET Contribution | $ 196,453 | $ 196,453 | | | | |
| Total WET Program Estimated Expenditures | $ 5,791,060 | $ 5,791,060 | $ - | $ - | $ - | $ - |

## CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS FY 2025/26

**County of San Bernardino**
**Department of Behavioral Health**
**Mental Health Services Act (MHSA)**
**MHSA Annual Update Fiscal Year 2025/26**

| Capital Facilities/Technological Needs | Estimated Capital Facilities/Technological Needs Funding | | | | | |
|---|---|---|---|---|---|---|
| | A | B | C | D | E | F |
| | Estimated Total Mental Health Expenditures | Estimated CSS Funding | Estimated Medi-Cal FFP | Estimated 1991 Realignment | Estimated Behavioral Health Subaccount | Estimated Other Funding |
| CFTN Programs - Capital Programs - Capital Facilities Projects | | | | | | |
| 1. Comprehensive Treatment Campus | $ - | | | | | |
| 2. Community Care Expansion - Facility Preservation | $ - | | | | | |
| | | | | | | |
| CFTN Programs - Technological Needs Projects | | | | | | |
| 1. Data Warehouse Continuation Project Empowered Communication/SharePoint Project | $ 365,270 | $ 365,270 | | | | |
| 2 Behavioral Health Management Information Systems (BHMIS), Electronic Health Record (EHR), Telemedicine Project | $ 4,834,785 | $ 4,834,785 | | | | |
| CFTN Projects | $ 5,200,055 | $ 5,200,055 | $ - | $ - | $ - | $ - |
| CFTN Administration | $ 1,745,038 | $ 1,745,038 | | | | |
| Total CFTN Program Estimated Expenditures | $ 6,945,093 | $ 6,945,093 | $ - | $ - | $ - | $ - |

SAN BERNARDINO COUNTY
Behavioral Health

# MHSA Annual Update for FY 25/26: Attachments

## Attachments Table of Contents

Attachment A – CPP Meeting Flyer English

Attachment B – CPP Meeting Flyer Spanish

Attachment C – CPP Meeting Web Blast

Attachment D – CPP Meeting Presentation English

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Attachment F – CPP Meeting Stakeholder Comment Form English

Attachment G – CPP Meeting Stakeholder Comment Form Spanish

Attachment H – 30 Day Posting Press Release

Attachment I – IOM Notification of 30 Day Posting to BOS, CAO

Attachment J – 30 Day Posting Web Blast

Attachment K – 30 Day Posting Stakeholder Comment Form English

Attachment L – 30 Day Posting Stakeholder Comment Form Spanish

Attachment M – Public Hearing Agenda

Attachment N – Public Hearing Press Release

Attachment O – List of Media Outlets that Received Press Release

Attachment P – Behavioral Health Assessment

Attachment Q – Community Planning Process Assessment

Attachment A

SAN BERNARDINO COUNTY | Behavioral Health

## MHSA Annual Update FY 2025/2026

# Planning Meetings

Please join us at a **Mental Health Services Act (MHSA) Annual Update FY 2025/26** stakeholder engagement meeting! Learn about service data from the last fiscal year and get information on program changes and enhancements.

**Event will be held in-person**

### January 2025

**08** — **10 a.m.**

**Mental Health and Substance Use Awareness Subcommittee**
**Call-In:** 1-415-655-0002
**WebEx Meeting Number:** 961 777 142

Join Meeting

**08** — **Noon**

**QMAC CEC & Family Member Advisory Subcommittee**
**Call-In:** 1-669-444-9171
**Zoom Meeting ID:** 959 6126 4010 **Passcode:** 421362

Join Meeting

**09** — **1 p.m.**

**PEI Quarterly Provider Meeting**
**Call-In:** 1-415-655-0002
**WebEx Meeting Number:** 2485 096 9219

Join Meeting

**09** — **10 a.m.**

**Disabilities Awareness Subcommittee**
**Call-In:** 1-415-655-0002
**WebEx Meeting Number:** 146 434 2208

Join Meeting

**09** — **3:30 p.m.**

**Second District Advisory Committee**
**Call-In:** 1-415-655-0002
**WebEx Meeting Number:** 2483 823 7369
**Password:** pxYctfry353

Join Meeting

**10** — **10 a.m.**

**Asian Pacific Islander Awareness Subcommittee**
**Call-In:** 1-415-655-0002
**WebEx Meeting Number:** 968 187 539

Join Meeting

**13** — **10 a.m.**

**Suicide Prevention Awareness Subcommittee**
**Call-In:** 1-415-655-0002
**WebEx Meeting Number:** 146 264 6760

Join Meeting

**13** — **10 a.m.**

**Victor Community Support Services**
**Call-In:** 1-669-444-9171
**Zoom Meeting ID:** 237 481 4005 **Passcode:** 865178

Join Meeting

**13** — **2 p.m.**

**African American Awareness Subcommittee**
**Call-In:** 1-415-655-0002
**WebEx Meeting Number:** 146 893 8322

Join Meeting

**14** — **1 p.m.**

**Spirituality Awareness Subcommittee**
**Call-In:** 1-415-655-0002
**WebEx Meeting Number:** 961 357 009

Join Meeting

**14** — **10:30 a.m.**

**Desert Stars Clubhouse**
1841 E. Main St., Barstow

**15** — **11 a.m.**

**Pathways to Recovery Clubhouse**
17053 E. Foothill Blvd. Suite B, Fontana

**15** — **2 p.m.**

**Transitional Age Youth (TAY) Awareness Subcommittee**
**Call-In:** 1-415-655-0002
**WebEx Meeting Number:** 960 523 715

Join Meeting

**15** — **Noon**

**Ontario Montclair School District - Health & Wellness Services Family Resource Center**
1556 S. Sultana Ave. Ontario

**15** — **6 p.m.**

**Fourth District Advisory Committee**
**Call-In:** 1-415-655-0002
**WebEx Meeting Number:** 2495 776 5577
**Password:** fBw5HAvQH23

Join Meeting

**15** — **11 a.m.**

**First District Advisory Committee**
**Call-In:** 1-415-655-0002
**WebEx Meeting Number:** 187 662 3366

Join Meeting

**16** — **1 p.m.**

**Cultural Competency Advisory Committee (CCAC)**
**Call-In:** 1-415-655-0002
**WebEx Meeting Number:** 969 101 891

Join Meeting

**21** 11 a.m.

### Amazing Place Clubhouse
2940 Inland Empire Blvd., Ontario

**21** 2 p.m.

### Native American Awareness Subcommittee
**Call-In:** 1-415-655-0002
**WebEx Meeting Number:** 146 996 4635
Join Meeting

**21** 10 a.m.

### MHSA Administration
**Call-In:** 1-415-655-0002
**WebEx Meeting Number:** 2498 681 4350
Join Meeting

**21** 5 p.m.

### MHSA Administration
**Call-In:** 1-415-655-0002
**WebEx Meeting Number:** 2495 495 7647
Join Meeting

**22** 11 a.m.

### Serenity Clubhouse
12625 Hesperia Rd. Suite B, Victorville

**22** 1 p.m.

### Women's Awareness Subcommittee
**Call-In:** +1-415-655-0002
**WebEx Meeting Number:** 967 920 279
Join Meeting

**23** 10 a.m.

### Older Adults Awareness Subcommittee
**Call-In:** 1-415-655-0002
**WebEx Meeting Number:** 961 983 483
Join Meeting

**23** 10 a.m.

### Latino Awareness Subcommittee
**Call-In:** +1-415-655-0002 - Spanish Only
**WebEx Meeting Number:** 966 009 041
Join Meeting

**24** 12:30 p.m.

### Pacific Clinics Family Resource Center
58457 Twenty Nine Palms Hwy, Suite 102, Yucca Valley

**27** 11 a.m.

### Consumer and Family Members Awareness Subcommittee
**Call-In:** +1-415-655-0002
**WebEx Meeting Number:** 2495 614 6844
Join Meeting

**28** 11 a.m.

### TEAM House Clubhouse
201 W. Mill Street, San Bernardino

**28** 11:30 a.m.

### Central Valley Fun Clubhouse
1501 S. Riverside Ave., Rialto

**28** 12:30 p.m.

### LGBTQ Awareness Subcommittee
**Call-In:** +1-415-655-0002
**WebEx Meeting Number:** 960 570 704
Join Meeting

**28** 5 p.m.

### Fifth District Advisory Committee
**Call-In:** 1-415-655-0002
**WebEx Meeting Number:** 187 027 1608
Join Meeting

**29** 11:30 a.m.

### Santa Fe Wellness Club Clubhouse
56020 Santa Fe Trail, Suite M, Yucca Valley

**30** 11:30 a.m.

### A Place to Go Clubhouse
32770 Old Woman Springs Rd. Suite B, Lucerne Valley

## February 2025

**3** 3 p.m.

### Veterans Awareness Subcommittee
**Call-In:** 1-415-655-0002
**WebEx Meeting Number:** 2482 788 1413
Join Meeting

**6** 9 a.m.

### Rim Family Services
**Zoom Meeting ID:** 825 7790 5597 **Passcode:** 1800
Join Meeting

**12** 10 a.m.

### Victor Community Support Services (San Bernardino)
600 N. Arrowhead Ave. Suite 300, San Bernardino

**12** 11 a.m.

### Third District Advisory Committee
**Call-In:** 1-415-655-0002
**WebEx Meeting Number:** 146 962 9460
Join Meeting

**19** 1 p.m.

### Senior Affairs Commission
784 E. Hospitality Lane, San Bernardino

**20** 10 a.m.

### Community Policy Advisory Committee
720 E. Carnegie Dr. Suite 150, San Bernardino

**Event will be held in-person**

If you speak another language, language assistance services are available free of charge by dialing (888) 743-1478. TTY users dial 711. DBH complies with applicable federal, civil rights laws and does not discriminate based on race, color, national origin, sex, gender identity, age, disability, or the inability to speak English (LEP).

**For more information, please visit** sbcounty.gov/dbh/

SAN BERNARDINO COUNTY | Behavioral Health

## Actualización annual de la MHSA para el año fiscal 2025/2026

# Reunión de Planificación

¡Le invitamos a unirse a una reunión de participación de las partes interesadas de la Actualización Anual de la Ley de Servicios de Salud Mental (Mental Health Services Act - MHSA) AF 2025/26! Conozca los datos de servicio del último año fiscal y obtenga información sobre los cambios y mejoras en los programas.

☐ **El evento se llevará a cabo en persona**

## Enero 2025

**08** — **10 a.m.**

### Subcomité de Concientización sobre la Salud Mental y el Uso de Sustancias
**Llamada telefónica:** 1-415-655-0002
**Número de reunión de WebEx:** 961 777 142

Ingresar a la reunión

**08** — **mediodía**

### Subcomité Asesor de la CCA y Miembros de la Familia de QMAC
**Llamada telefónica:** 1-669-444-9171
**ID de reunión de Zoom:** 959 6126 4010
**Código de acceso:** 421362

Ingresar a la reunión

**09** — **1 p.m.**

### Reunión Trimestral de Proveedores de PEI
**Llamada telefónica:** 1-415-655-0002
**Número de reunión de WebEx:** 2485 096 9219

Ingresar a la reunión

**09** — **10 a.m.**

### Subcomité de Concientización de Discapacidades
**Llamada telefónica:** 1-415-655-0002
**Número de reunión de WebEx:** 146 434 2208

Ingresar a la reunión

**09** — **3:30 p.m.**

### Comité Asesor del Segundo Distrito
**Llamada telefónica:** 1-415-655-0002
**Número de reunión de WebEx:** 2483 823 7369
**Código de acceso:** pxYctfry353

Ingresar a la reunión

**10** — **10 a.m.**

### Subcomité de Concientización de Asiáticos/Isleños del Pacifico
**Llamada telefónica:** 1-415-655-0002
**Número de reunión de WebEx:** 968 187 539

Ingresar a la reunión

**13** — **10 a.m.**

### Subcomité de Concientización de Prevención del Suicidio
**Llamada telefónica:** 1-415-655-0002
**Número de reunión de WebEx:** 146 264 6760

Ingresar a la reunión

**13** — **10 a.m.**

### Servicios de Apoyo Comunitario de Victor
**Llamada telefónica:** 1-669-444-9171
**Zoom Meeting ID:** 237 481 4005
**Código de acceso:** 865178

Ingresar a la reunión

**13** — **2 p.m.**

### Subcomité de Concientización de Afroamericanos
**Llamada telefónica:** 1-415-655-0002
**Número de reunión de WebEx:** 146 893 8322

Ingresar a la reunión

**14** — **1 p.m.**

### Subcomité de Concientización de Espiritualidad
**Llamada telefónica:** 1-415-655-0002
**Número de reunión de WebEx:** 961 357 009

Ingresar a la reunión

**14** — **10:30 a.m.**

### Casa Club Desert Stars
1841 E. Main St., Barstow

**15** — **11 a.m.**

### Casa Club Pathways to Recovery
17053 E. Foothill Blvd. Suite B, Fontana

**15** — **2 p.m.**

### Subcomité de Concientización de Jóvenes en Edad de Transición (TAY)
**Llamada telefónica:** 1-415-655-0002
**Número de reunión de WebEx:** 960 523 715

Ingresar a la reunión

**15** — **mediodía**

### Distrito Escolar Ontario Montclair – Centro de Servicios de Salud y Bienestar de Recursos Familiares
1556 S. Sultana Ave. Ontario

**15** — **6 p.m.**

### Comité Asesor del Cuarto Distrito
**Llamada telefónica:** 1-415-655-0002
**Número de reunión de WebEx:** 2495 776 5577
**Código de acceso:** fBw5HAvQH23

Ingresar a la reunión

**15** — **11 a.m.**

### Comité Asesor del Primer Distrito
**Llamada telefónica:** 1-415-655-0002
**Número de reunión de WebEx:** 187 662 3366

Ingresar a la reunión

**16** — **1 p.m.**

### Comité Consultivo de Competencia Cultural (CCAC)
**Llamada telefónica:** 1-415-655-0002
**Número de reunión de WebEx:** 969 101 891

Ingresar a la reunión

**21** 11 a.m.

### Casa Club Amazing Place
2940 Inland Empire Blvd., Ontario

**21** 2 p.m.

### Subcomité de Concientización de Nativos Americanos
**Llamada telefónica:** 1-415-655-0002
**Número de reunión de WebEx:** 146 996 4635

Ingresar a la reunión

**21** 10 a.m.

### Administración de MHSA
**Llamada telefónica:** 1-415-655-0002
**Número de reunión de WebEx:** 2498 681 4350

Ingresar a la reunión

**21** 5 p.m.

### Administración de MHSA
**Llamada telefónica:** 1-415-655-0002
**Número de reunión de WebEx:** 2495 495 7647

Ingresar a la reunión

**22** 11 a.m.

### Casa Club Serenity
12625 Hesperia Rd. Suite B, Victorville

**22** 1 p.m.

### Subcomité de Concientización de Mujeres
**Llamada telefónica:** +1-415-655-0002
**Número de reunión de WebEx:** 967 920 279

Ingresar a la reunión

**23** 10 a.m.

### Comisión de Asuntos para Adultos Mayores
**Llamada telefónica:** 1-415-655-0002
**Número de reunión de WebEx:** 961 983 483

Ingresar a la reunión

**23** 10 a.m.

### Subcomité de Concientización de Latinos
**Llamada telefónica:** +1-415-655-0002 - En español
**Número de reunión de WebEx:** 966 009 041

Ingresar a la reunión

**24** 12:30 p.m.

### Centro de Recursos Familiares de las Clínicas del Pacífico
58457 Twenty Nine Palms Hwy, Suite 102, Yucca Valley

**27** 11 a.m.

### Subcomité de Concientización de Consumidores y Miembros de Familias
**Llamada telefónica:** +1-415-655-0002
**Número de reunión de WebEx:** 2495 614 6844

Ingresar a la reunión

**28** 11 a.m.

### Casa Club TEAM house
201 W. Mill Street, San Bernardino

**28** 11:30 a.m.

### Casa Club del Valle Central
1501 S. Riverside Ave., Rialto

**28** 12:30 p.m.

### Subcomité de Concientización de LGBTQ
**Llamada telefónica:** +1-415-655-0002
**Número de reunión de WebEx:** 960 570 704

Ingresar a la reunión

**28** 5 p.m.

### Comité Asesor del Quinto Distrito
**Llamada telefónica:** 1-415-655-0002
**Número de reunión de WebEx:** 187 027 1608

Ingresar a la reunión

**29** 11:30 a.m.

### Casa Club del Bienestar de Santa Fe
56020 Santa Fe Trail, Suite M, Yucca Valley

**30** 11:30 a.m.

### Casa Club A Place To Go
32770 Old Woman Springs Rd. Suite B, Lucerne Valley

## Febrero 2025

**3** 3 p.m.

### Subcomité de Concientización de Veteranos
**Llamada telefónica:** 1-415-655-0002
**Número de reunión de WebEx:** 2482 788 1413

Ingresar a la reunión

**6** 9 a.m.

### Servicios Familiares de RIM
**Zoom Meeting ID:** 825 7790 5597
**Código de acceso:** 1800

Ingresar a la reunión

**12** 10 a.m.

### Servicios de Apoyo Comunitario de Victor (San Bernardino)
600 N. Arrowhead Ave. Suite 300, San Bernardino

**12** 11 a.m.

### Comité Asesor del Tercer Distrito
**Llamada telefónica:** 1-415-655-0002
**Número de reunión de WebEx:** 146 962 9460

Ingresar a la reunión

**19** 1 p.m.

### Comisión de Asuntos para Adultos Mayores
784 E. Hospitality Lane, San Bernardino

**20** 10 a.m.

### Comité Comunitario Consultivo de Políticas
720 E. Carnegie Dr. Suite 150, San Bernardino

**El evento se llevará a cabo en persona**

Si habla otro idioma, hay servicios de asistencia lingüística disponibles de forma gratuita llamando al (888) 743-1478. Los usuarios de TTY marcan 711. DBH cumple con las leyes federales y de derechos civiles aplicables y no discrimina por motivos de raza, color, origen nacional, sexo, identidad de género, edad, discapacidad o incapacidad para hablar inglés (LEP).

**Para obtener más información, visite** sbcounty.gov/dbh/

CPP Meeting Web Blast

DEPARTMENT OF
# BEHAVIORAL HEALTH UPDATES

January 8, 2025

## Mental Health Services Act



## Community Program Planning Meetings

Join one of our upcoming meetings and give your feedback!

### MHSA Annual Update FY 2025/26 Meeting Schedule

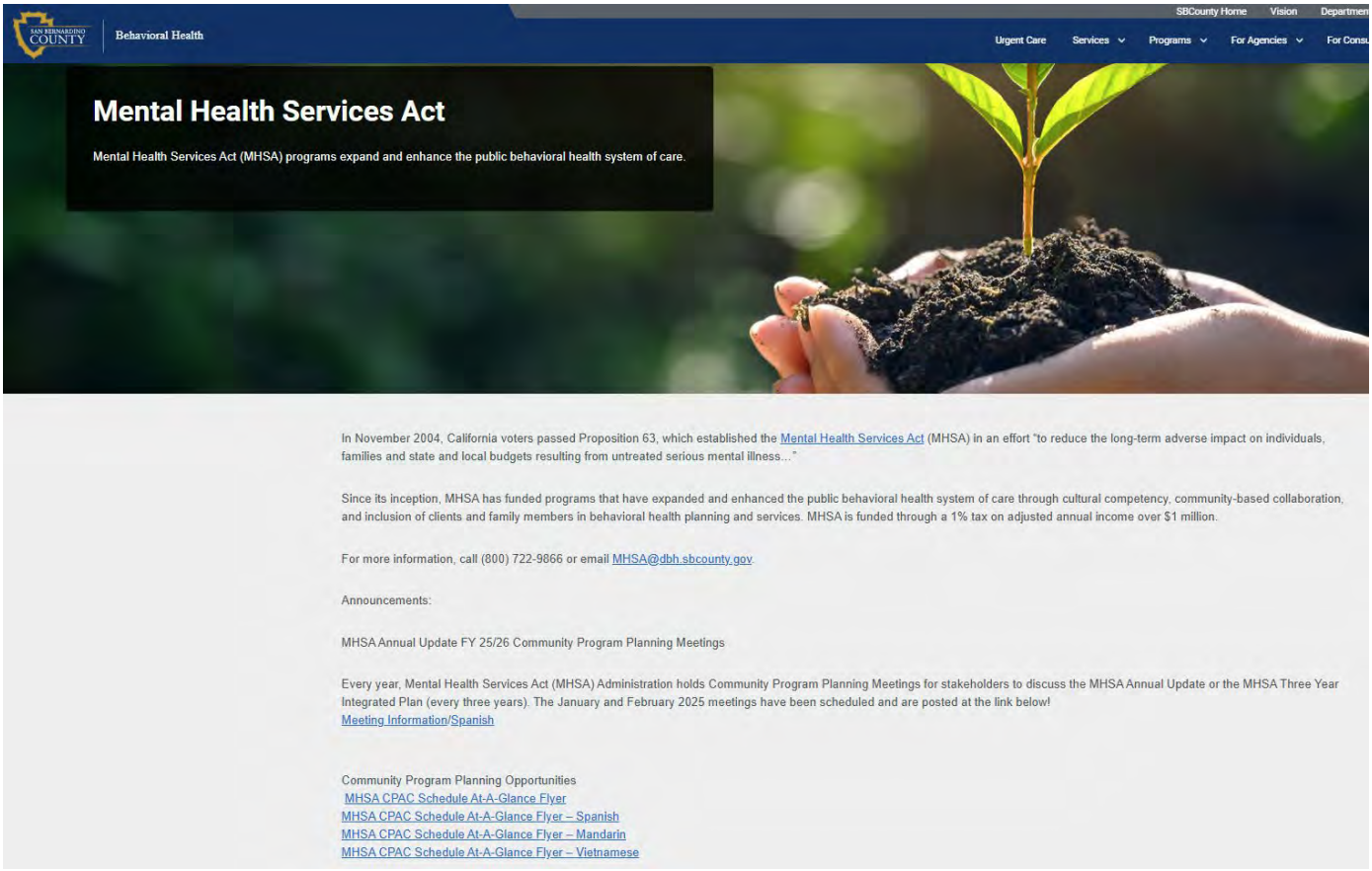
Every year, Mental Health Services Act (MHSA) Administration holds Community Program Planning Meetings for stakeholders to discuss the MHSA Annual Update or the MHSA Three Year Integrated Plan (every three years). The January and February MHSA Annual Update FY 2025/26 meetings have been scheduled and are posted to the Announcements section and the MHSA page of the DBH Website. If you have any questions regarding these meetings, please contact MHSA Administration at (909) 252-4021. We hope to see you at one of the 39 meetings.

Spanish MHSA CPP Flyer
Vietnamese MHSA CPP Flyer
Mandarin MHSA CPP Flyer

**The link below has been corrected to include the MHSA CPP flyer in English.*

English MHSA CPP Flyer

MHSA Website Announcement:




DHB Website Announcement:



Behavioral Health

# Mental Health Services Act Annual Update

**Fiscal Year 2025/26**

Community Program Planning Stakeholder Meeting



1



## Meeting **Objectives**



- Provide an overview of the Mental Health Services Act
- Provide an overview of the Mental Health Services Act Annual Plan Update
- Learn about program changes and updates
- Share the community program planning schedule
- Share the community program planning survey
- Provide an overview on Proposition 1
- DBH Capacity Assessment

2



## We Want to Know **More!**

- Later in today's presentation, we are asking that you complete a survey. This survey lets us know 'who' is in the audience.
- This information will also be used to identify community needs, determine Mental Health Services Act funding priorities, and guide the creation, implementation, and evaluation of programs.

3



## What is the Mental Health Services **Act?**

- The Mental Health Services Act, Prop 63, was passed by California voters in November 2004 and went into effect in January 2005.
  - The Act provides increased funding for mental health programs across the state.
  - The Act is funded by a 1% tax surcharge on personal income over $1 million per year.
- Fluctuations in tax payments impact fiscal projections and available funding.

4



## Mental Health Services Act Three Year **Plan**

- It is required by Mental Health Services Act regulations (Welfare Institution Code § 5847).
- Highlights trends, program goals, and outcomes of the Department of Behavioral Health programs and provides a roadmap to a unified system of care.
- Current plan covers the time period of Fiscal Years (FYs) 2023/24 through 2025/26.
- Approved on June 13, 2023, by the County Board of Supervisors.




5



## Annual Plan Update **Overview**



6

## What is an Annual Plan **Update?**

An Annual Plan Update provides:

- Service data for the prior fiscal year.
  - The data reported is for fiscal year 2023/24.
- Information on program planning for the upcoming fiscal year to our stakeholders.
- Updates to the Mental Health Services Act Three-Year Integrated Plan for FY 2023/2024 through 2025/2026.

The purpose of the Annual Plan Update is to:

- Evaluate short-term and long-term impacts of Mental Health Services Act funded programs.
- Use the document as evidence to demonstrate that we are meeting the regulatory requirements.

This year we will develop an Annual Plan Update for fiscal year 2025/26.

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**The Mental Health Services Act Plan and Annual Updates are constructed out of five components as well as a budget summary and component detail:**

**Community Services and Supports**

Programs and services intended for serious mental illness (SMI) populations with focus on individuals at risk of psychiatric hospitalization and/or homelessness due to the severity of the illness they are living with.

76% • • • Mental Health Services Act funds

**Prevention and Early Intervention**

Services are intended to stop a mental illness from becoming severe or to even deter the onset if possible. Target populations are those experiencing signs of symptoms or risk factors.

19% • • • Mental Health Services Act funds

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**Innovation**

Time-limited projects intended for us to do some short-term research that will help us improve the public mental health system. These programs test different strategies and allow us to incorporate successful strategies into public mental health services.

5% • • • Mental Health Services Act funds

**Workforce Education and Training**

Allows us to train and recruit staff at all levels to provide services across the continuum.

One time allocation-sustained through transferred CSS funding

**Capital Facilities and Technological Needs**

Space to provide services and technology to assist in collecting and storing consumer information and to assist in treatment planning.

One time allocation-sustained through transferred CSS funding

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## Community Program **Planning**



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## Community Program **Planning**

As part of the continuous feedback and improvement process, we meet with our stakeholders every month in many ways.

- Meetings take place via online platforms, such as Webex and Zoom, as well as in-person.
- This allows continuous communication between the department and our stakeholders regarding our services, outcomes, and other information related to the public behavioral health system.

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## Who are DBH's **Stakeholders?**

**WIC §5848 identifies who our stakeholders are, and beginning in January 2025, the required stakeholder groups are expanding. This includes individuals representing diverse viewpoints, including, but not limited to:**

| | | | | | |
|---|---|---|---|---|---|
| Eligible adults and older adults | Families of eligible children and **youth**, eligible adults, and eligible older adults | Youths or youth mental health or **substance use disorder organizations** | Providers of mental health services and **substance use disorder treatment services** | Public safety partners, including juvenile justice agencies | Local education agencies |
| Higher education partners | **Early childhood organizations** | **Local public health jurisdictions** | County social services and child welfare agencies | **Local representative organizations** | Veterans |
| Representative from Veterans organizations. | Health care organizations, including hospitals | Health care service plans, including Medi-Cal managed plans | **Disability insurers** | **Tribal and Indian Health Program designees** | **The five most populous cities in counties with a population greater than 200,000** |
| **Area agencies on aging** | **Independent living centers** | **Continuums of care, including representatives from the homeless service provider community** | **Regional centers** | **Emergency medical services** | **Community-based organizations serving culturally and linguistically diverse constituents** |

*Newly added

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## Examples of Stakeholder **Meetings**

- Cultural Competency Advisory Committee
- Cultural Competency Awareness Subcommittees
- Community Policy Advisory Committee (CPAC)
- Behavioral Health Commission Meeting
- District Advisory Committee Meetings (DACs)
- Consumer Clubhouse Governing Boards
- Association of Community Based Organizations (ACBO)

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## Program Changes and Updates **FY 2025/26**




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## Mental Health Services Act Program **Updates**

- The Department of Behavioral Health continuously reviews current expenditures, utilization, and availability of funding for stakeholder supported program updates and development.
- The review of feedback and stakeholder engagement is a continuous process that allows us to learn what programs and services best meet the needs of our community.
- The Department of Behavioral Health will continue using existing Mental Health Services Act funds to support existing programs.

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## Prevention and Early Intervention (PEI) **Updates**

**Child and Youth Connection – Budget Increase**

- The Children's Assessment Center (CAC), administered by Loma Linda University Children's Hospital (LLUCH) under the Child and Youth Connection (CYC) program, will increase funding from $62,000 to $165,000 per year. This funding change will increase early access and linkage to medically necessary care and treatment. It connects children and youth with severe mental health conditions to care as early in the onset of these conditions as practicable, to medically necessary care and treatment. It includes, but is not limited to, care provided by county mental health programs.
  - **Goals of the project:**
    - Pre-forensic examination counseling services to help minimize the children's/youths' trauma from the examination and decrease the psychological distress associated with child abuse allegations.
    - Provide pre-forensic examination counseling services to an estimated 900 unduplicated children and adolescents.
  - This program serves consumers ages 0-18 years old throughout San Bernardino County.

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## Prevention and Early Intervention (PEI) **Updates, cont.**

**Family Resource Center (FRC) – Expansion Update**

- Department of Behavioral Health, Prevention and Early Intervention (PEI) Family Resource Center is expanding their services to include a Family Wellness Center (FWC). The FWC expansion will include prevention and early intervention services as well as Specialty Mental Health Services for children, youth, and adults with mental health concerns. This expansion will increase the annual FRC budget by $1,500,000 from $2,774,774 to $4,274,774, previously budgeted increase in the MHSA Annual plan for FY 2022/23. This expansion will enable DBH to broaden its scope of services by providing a comprehensive approach to family wellness while continuing to offer essential services to promote wellness, recovery, and resiliency for its clients.
  - FRC programs offer:
    - Services tailored to individualized communities' specific needs and cultural requirements.
    - Services and activities at non-traditional locations, such as community centers, where other collateral services are also provided.
    - A reduction in stigma associated with seeking mental health services, increasing the likelihood that community members will use the services.
  - Population served will be children and their families throughout San Bernardino County.

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## Community Services and Supports (CSS) **Updates**

**Housing and Homeless Services Continuum of Care Program – Position Transfer**

- The Homeless Outreach Support Team (HOST) under the Housing and Homeless Services Continuum of Care Program is transferring a Clinical Therapist I Psychologist position to the Choosing Healthy Options to Instill Change and Empowerment (CHOICE) program under the Forensic Services Continuum of Care program.
  - This change will allow the CHOICE program to provide psychiatric services directly to consumers enrolled in the CHOICE Mental Health Outpatient program at the Probation Department Day Reporting Centers rather than referring them to another clinic.
  - This position will be funded under the AB109 Realignment funding.

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## Innovation (INN) Updates

**Eating Disorder Collaborative – Project Sunset**

- Eating Disorder Collaborative (EDC) is scheduled to sunset in December 2025. DBH is in the process of reviewing project data and outcomes to determine continuation of the project. DBH is considering options to continue the project or project services under Community Services and Supports (CSS) Full Service Partnership (FSP) program and/or other opportunities with Managed Care Plans (MCPs) to continue to provide project services where appropriate.

**Cracked Eggs – Project Sunset**

- The contract for Cracked Eggs ends June 2026 and will not continue as a standalone program. Low enrollment rates combined with the substantial operational costs have rendered it unsustainable. However, the project highlighted that art can be a therapeutic tool. DBH will explore ways to incorporate some of the artistic strategies learned during this Innovation project to include in our system of care where appropriate. The final report will be released in FY 2026/27.

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## 2025-Mental Health Services Act Annual Update Community Program Planning Schedule



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## Community Program Planning Schedule 2025

**JANUARY - FEBRUARY**
The CPP process is scheduled for January through February 2025.

**FEBRUARY – MARCH**
The Mental Health Services Act Annual Update is tentatively scheduled to be posted for public review and comment from February 14 - March 17, 2025.

**APRIL**
Public Hearing is tentatively set to be conducted at the regular Behavioral Health Commission Meeting on April 3, 2025.

**MAY**
The Annual Update is tentatively scheduled to be presented to the Board of Supervisors for approval in May 2025.

- 39 meetings will be held in all geographic regions of the County.
- Schedule will include all DBH's regular CPP Stakeholder meetings (CPAC, DACs, CCAC subcommittees, etc.).
- Schedule includes the Clubhouses - all regions.

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## Upcoming Community Planning Meetings

**Please use the link below for upcoming MHSA Community Program Planning Meetings:**

English: 2025-26 MHSA CPPFINAL.pdf

Spanish: 25-26 MHSA FINAL Span 1.7.25.pdf

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## We Want to Know More!

This information will be used to identify community needs, determine Mental Health Services Act funding priorities, and guide the creation, implementation, and evaluation of Mental Health Services Act -funded programs.

**Survey Link:**
https://survey123.arcgis.com/share/dc731d5c7c754ab7a18a69af3601764b?portalUrl=https://maps.sbcounty.gov/sbcgis

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## Paper Surveys

Paper surveys can be scanned and emailed to MHSA@dbh.sbcounty.gov.

Attendees may also mail a hard copy of the completed survey back to us at:

- Mental Health Services Act Administration
  1950 S. Sunwest Lane, Suite 200
  San Bernardino, CA 92415

**Or via Interoffice mail:**

- Mental Health Services Act Administration
  WET/Training Institute
  Attn: Mental Health Services Act Admin
  #0019

- If you did not receive a paper survey, please email us at MHSA@dbh.sbcounty.gov or you can add your email address to the chat.
- The deadline for receipt of the completed forms is close of business **February 25, 2025**.
- Items mailed in must be postmarked no later than **February 25, 2025**.

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# Proposition 1 **Update**



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**Proposition 1, which passed in March 2024, is a two-part measure that:**

- Amends California's Mental Health Services Act (SB 326), and
- Creates a $6.38 billion general obligation bond (AB 531).

| SB 326 | AB 531 |
|---|---|
| Changes MHSA to BHSA (Behavioral Health Services Act)<br>• Includes treatment for people with substance use disorders | Also known as the Behavioral Health Infrastructure Bond Act of 2024 |
| Directs the funding "buckets" into 3 major components:<br>• Behavioral Health Services and Support<br>• Full-Service Partnerships<br>• Housing Interventions | Creates a $6.38 billion bond to build 11,150 new behavioral health beds and housing units to meet the current and future needs of Californians. $1 billion is set aside specifically for veterans' housing. |
| Directs more money to the State (10% vs. 5%) and less to Counties (90% vs. 95%).<br>• Prevention 4%; Workforce 3%; Oversight & Monitoring 3%<br>• Increased costs to counties to continue current programs.<br>• Increases required stakeholder groups for Community Program Planning.<br>• Three-year plans no longer focus on MHSA funds only, it will be an Integrated Plan & will include all behavioral health programs & funding sources.<br>• The MHSA Annual Revenue and Expenditure Report (ARER) is replaced by the new County Behavioral Health Outcomes, Accountability, and Transparency Report (CBHOATR). | Will provide placement for complex patients with severe mental illness in need of subacute care and long-term support outside of the hospital setting. |
| Prioritizes investments in housing interventions for individuals experiencing homelessness or at risk of homelessness. | Aimed at resolving the dire shortage of subacute mental health beds. |

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# Priority Populations for **BHSA**

Behavioral Health Services Act funding targets individuals living with a range of behavioral health needs and prioritizes those disproportionately affected by mental health and/or SUD challenges with unmet needs. These priority populations mirror those for other statewide behavioral health initiatives and programs.

- Individuals experiencing homelessness or at risk of experiencing homelessness
- Justice-involved individuals or individuals at risk of criminal justice system involvement
- Children and youth, including those involved in the child welfare system
- Individuals in or leaving institutional settings, or those at risk of institutionalization

Per California Welfare and Institutions Code § 5892.(d)(1) & § 5892.(d)(2)

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# BHSA Components and Funding **Allocation**

| | |
|---|---|
| **Housing Interventions (30%)** | Includes rental subsidies, operating subsidies, shared housing, family housing for eligible children and youth, the nonfederal share for transitional rent, capital development projects, and project-based housing assistance. Housing interventions will not be limited to those in FSP or those enrolled in Medi-Cal. |
| **Full-Service Partnerships (35%)** | Includes mental health services, supportive services, and substance use disorder treatment services, to be provided pursuant to a whole-person approach that is trauma informed, age appropriate, and in partnership with families or an individual's natural supports. Services are provided in a streamlined and coordinated manner to help reduce any barriers to services. |
| **Behavioral Health Services and Supports (35%)** | Includes services for the children's system of care and for the adult and older adult system of care (excluding housing intervention services and FSPs), early intervention programs, outreach and engagement, WET, CFTN, and INN projects. |

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# BHSA **Changes**

| | |
|---|---|
| **Outreach and Engagement (O&E)** | Outreach and Engagement activities will be funded by the Behavioral Health Services and Supports category.<br>• 35% of funding for entire BHSS category. |
| **General System Development (GSD)** | The BHSA does not include language about General System Development.<br>• CSS GSD as we know it today will not continue under the BHSA. |
| **Full-Service Partnerships (FSP)** | Full-Service Partnerships will be a dedicated category under the BHSA.<br>• 35% of funding that counties receive. |

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# Where We are **Now**

- Current MHSA Programs and services will continue as approved through June 30, 2026.
- Expanding stakeholder engagement by identifying and connecting with new partners to ensure inclusive participation in the CPP process and program planning.
- Educating stakeholders on Proposition 1, discussing its program impacts, and soliciting actionable feedback to address community needs and guide future planning during monthly CPAC meetings.
- Continuing to meet with county partners and discuss program impacts.
- Developing mitigation plans to ensure a smooth transition.
- Maintaining a proactive role in the BHSA transition, engaging in Behavioral Health Transformation (BHT) listening sessions led by the state, and staying up-to-date on evolving policies and regulations to ensure informed decision-making and community alignment.

Additional information on stakeholder engagement can be found on the Department of Health Care Services (DHCS) website here: Stakeholder-Engagement

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## DBH Capacity **Assessment**




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## Capacity **Assessment**

- In November 2023, DBH partnered with Health Management Associates (HMA), an independent national research and consulting firm in the healthcare industry, to complete a behavioral health needs and capacity assessment and an assessment of DBH's Community Program Planning (CPP) process for developing the MHSA Three-Year Integrated Plan and Annual Updates.
- The final report identifies strengths, challenges, and recommendations for areas of opportunity within the Mental Health Services Act (MHSA) programming in San Bernardino County.
- The project ran from November 2023 to August 2024.
- The full report will be included as an attachment in the MHSA Annual Update for FY 2025/26.

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## Assessment **Methods**

HMA used a combination of data analysis, document review, and community engagement throughout the project to conduct the assessments. Some strategies used for qualitative and quantitative data collection included:

- Collected and analyzed available data on consumer services, demographics, capacity data, and workforce needs.
- Conducted interviews with outpatient and residential behavioral health providers, culturally specific organizations, social service agencies, and school district representatives, amongst others, to solicit their input on system strengths and areas for improvement.
- Facilitated focus groups with 200+ participants, where the groups included individuals with lived experiences.
- Administered a community survey that received 232 responses regarding system strengths, barriers, and unmet needs, as well as awareness and participation in the CPP.
- Convened townhalls as a forum to hear additional input from community members.

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## Behavioral Health Needs & Capacity **Assessment**

The qualitative feedback key findings of the behavioral health needs and capacity assessment are organized in the categories below:

**Strengths**

- Provider Collaboration
- Service Availability and Accessibility
- County Engagement Efforts
- Effectiveness of Services

**Opportunities for Improvement and Unmet Needs**

- Access and Service Availability
- Cultural Responsiveness and Disparity Reduction
- Workforce recruitment and retention
- Implementation of New Initiatives
- Internal and External Collaboration
- Operations
- Community Engagement

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## Behavioral Health Needs & Capacity **Assessment**

HMA provided recommendations that could have a significant impact on behavioral healthcare delivery in San Bernardino County. These are categorized into the five areas below:

1) Expand Access to High-Quality Services
2) Improve Service Integration and Coordination
3) Enhance External Communication and Engagement
4) Strengthen Administrative and Operational Processes
5) Address Workforce Challenges

DBH is reviewing the recommendations and developing strategies to help improve behavioral healthcare delivery in our County. This is a continuous process, and updates will be shared in future meetings.

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## Community Program Planning Process **Assessment**

Some key findings related to the observations of the Community Program Planning (CPP) process are listed below by strengths and opportunities for improvement:

**Strengths**

- Meetings were well attended, there were plenty of opportunities for constituent questions and feedback, and participants were engaged.
- A wide array of special population meetings were held.
- Information shared met Culturally and Linguistically Appropriate Services Standards.

**Opportunities for Improvement**

- There was a disconnect among constituents regarding the context and goal of the meetings and the connection between the Mental Health Services Act (MHSA) and the CPP.
- The process of submitting comments could be streamlined.
- The County could leverage online tools to improve interactions and engagement during meetings.

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## Community Program Planning Process Assessment

Some key findings related to the feedback on the Community Program Planning (CPP) process are listed below by strengths and opportunities for improvement:

**Strengths**

- The County has tested multiple strategies for outreach, including partnering with organizations to host meetings, virtual forums, surveys, etc.
- The intent behind the process and sub-committees is good, even if they are not always as effective and well-attended as participants would like.
- The County promotes the sessions to providers and the community and is generally good about receiving feedback.

**Opportunities for Improvement**

- Stakeholders have many competing requirements for their time and resources and want clearly defined goals, objectives, and action items for meetings with a stronger focus on operational application rather than statistics.
- There is a need for clearer communication on the objective of the CPP process.
- There is a desire to increase participation from individuals who have not traditionally been a part of the process, such as those who may have behavioral health needs but do not access services for one reason or another.

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## Community Program Planning Process Assessment

**Some of the HMA recommendations for improvement on the Community Program Planning (CPP) process are listed below:**

- Enhance External Communication and Engagement
  - Build awareness of the Community Program Planning process
  - Improve CPP progress and outcomes tracking
  - Leverage trusted partners to support information sharing
  - Improve connections with marginalized communities
  - Offer engagement opportunities in community settings
  - Leverage technology to support engagement

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## Current Steps

DBH is taking the following steps to address the assessment recommendations:

- Providing more context about MHSA and the CPP process during meetings to help educate stakeholders on the planning process and how their engagement and feedback helps to guide DBH programs.
- Expanding stakeholder groups to include more unserved/underserved populations, community members, service partners, faith-based organizations, children and youth groups, etc., to increase community engagement and feedback and to involve more service partners to increase information sharing with the community.
- Coordinating with other departments and organizations to participate in their community/patient needs assessments to identify the needs of the County and expand access and services to meet those needs.
- Holding the monthly Community Policy Advisory Committee (CPAC) meetings in more locations throughout the county to engage with stakeholders in community settings.

DBH leadership is working on identifying additional opportunities for improvement and continues to encourage stakeholder engagement and feedback to guide its programs and services.

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## Questions?



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## Concerns

To report any concerns related to MHSA Community Program Planning, please refer to the MHSA Issue Resolution Process located at:

https://wp.sbcounty.gov/dbh/wp-content/uploads/sites/121/2021/08/COM0947.pdf?x62087

To report concerns related to receipt of behavioral health services, please contact the DBH Access Unit at:

**(909) 386-8256**
**Toll Free 1 (888) 743-1478**
**or 7-1-1 for TTY users.**

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## Thank You!

For questions or comments, please contact:

Dr. Rebecca Scott Young, MBA, PHR
Mental Health Services Act
Administrative Manager
MHSA@dbh.sbcounty.gov
909-252-4021

www.SBCounty.gov/DBH

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Salud conductual

# Actualización anual de la Ley de Servicios de Salud Mental

Reunión de partes interesadas en la planificación del programa comunitario



1



## Objetivos de la reunión



- Proporcionar una descripción general de la Ley de Servicios de Salud Mental
- Proporcionar una descripción general de la actualización del plan anual de la Ley de Servicios de Salud Mental
- Informar sobre los cambios y actualizaciones del programa
- Compartir el cronograma de planificación del programa comunitario
- Compartir la encuesta de planificación del programa comunitario
- Proporcionar una descripción general de la Proposición 1
- Evaluación de la capacidad del DBH

2



## ¡Queremos saber más !

- Más adelante en la presentación de hoy, le pediremos que complete una encuesta. Esta encuesta nos permite saber "quién" está entre la audiencia.
- Esta información también se utilizará para identificar las necesidades de la comunidad, determinar las prioridades de financiación de la Ley de Servicios de Salud Mental y guiar la creación, implementación y evaluación de programas.

3



## ¿Qué es la Ley de Servicios de Salud Mental ?

- La Ley de Servicios de Salud Mental, Prop 63, fue aprobada por los votantes de California en noviembre de 2004 y entró en vigor en enero de 2005.
  - La Ley prevé una mayor financiación para los programas de salud mental en todo el estado.
  - La Ley se financia mediante un recargo fiscal del 1% sobre los ingresos personales superiores a un millón de dólares al año.
- Las fluctuaciones en los pagos de impuestos impactan las proyecciones fiscales y el financiamiento disponible.

4



## Plan trienal de la Ley de Servicios de Salud Mental

- Lo exigen las reglamentaciones de la Ley de Servicios de Salud Mental (Código de Instituciones de Bienestar § 5847).
- Destaca las tendencias, los objetivos del programa y los resultados de los programas del Departamento de Salud Conductual y proporciona una hoja de ruta hacia un sistema de atención unificado.
- El plan actual cubre el período de los años fiscales (AF) 2023/24 a 2025/26.
- Aprobado el 13 de junio de 2023 por la Junta de Supervisores del Condado.




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## Resumen de la actualización del plan anual



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## ¿Qué es una **actualización del plan anual?**

Una actualización del plan anual proporciona:

- Datos de servicio del año fiscal anterior.
  - Los datos informados corresponden al año fiscal 2023/24.
- Información sobre la planificación del programa para el próximo año fiscal a nuestros grupos de interés.
- Actualizaciones del Plan Integrado Trienal de la Ley de Servicios de Salud Mental para los años fiscales 2023/2024 a 2025/2026.

El propósito de la Actualización del Plan Anual es:

- Evaluar los impactos a corto y largo plazo de los programas financiados por la Ley de Servicios de Salud Mental.
- Utilice el documento como evidencia para demostrar que estamos cumpliendo con los requisitos reglamentarios.

Este año desarrollaremos una Actualización del Plan Anual para el año fiscal 2025/26.

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**El Plan de la Ley de Servicios de Salud Mental y las Actualizaciones Anuales se construyen a partir de cinco componentes, así como un resumen del presupuesto y detalles de los componentes:**

**Servicios y apoyos comunitarios**

Programas y servicios destinados a poblaciones con enfermedades mentales graves (SMI) con foco en individuos en riesgo de hospitalización psiquiátrica y/o falta de vivienda debido a la gravedad de la enfermedad con la que viven.

76% • • • Fondos de la Ley de Servicios de Salud Mental

**Prevención e intervención temprana**

Los servicios tienen como objetivo evitar que una enfermedad mental se agrave o incluso impedir su aparición si es posible. Las poblaciones objetivo son aquellas que experimentan signos de síntomas o factores de riesgo.

19% • • • Fondos de la Ley de Servicios de Salud Mental

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**Innovación**

Proyectos de duración limitada cuyo objetivo es que realicemos investigaciones a corto plazo que nos ayuden a mejorar el sistema de salud mental pública. Estos programas prueban diferentes estrategias y nos permiten incorporar estrategias exitosas en los servicios públicos de salud mental.

5% • • • Fondos de la Ley de Servicios de Salud Mental

**Educación y capacitación de la fuerza laboral**

Nos permite capacitar y reclutar personal en todos los niveles para brindar servicios en todo el espectro.

Asignación única, sostenida mediante fondos CSS transferidos

**Instalaciones de capital y necesidades tecnológicas**

Espacio para proporcionar servicios y tecnología para ayudar en la recopilación y almacenamiento de información del consumidor y para ayudar en la planificación del tratamiento.

Asignación única, sostenida mediante fondos CSS transferidos

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## **Planificación** de programas comunitarios



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## **Planificación** de programas comunitarios

Como parte del proceso continuo de retroalimentación y mejora, nos reunimos con nuestras partes interesadas cada mes de muchas maneras.

- Las reuniones se llevan a cabo a través de plataformas en línea, como Webex y Zoom, así como en persona.
- Esto permite una comunicación continua entre el departamento y nuestras partes interesadas con respecto a nuestros servicios, resultados y otra información relacionada con el sistema de salud conductual pública.

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## ¿Quiénes son los **interesados** de DBH ?

**El §5848 del WIC identifica quiénes son nuestras partes interesadas y, a partir de enero de 2025, los grupos de partes interesadas requeridos se expandirán. Esto incluye a personas que representan diversos puntos de vista, incluidos,**

| | | | | | |
|---|---|---|---|---|---|
| Adultos elegibles y adultos mayores | Familias de niños y jóvenes elegibles , adultos elegibles y adultos mayores elegibles | Organizaciones para jóvenes o para personas que padecen trastornos de salud mental o consumo de sustancias. | Proveedores de servicios de salud mental y servicios de tratamiento de trastornos por consumo de sustancias | Socios de seguridad pública, incluidas las agencias de justicia juvenil | Agencias locales de educación |
| Socios de educación superior | Organizaciones de la primera infancia | Jurisdicciones locales de salud pública | Servicios sociales del condado y agencias de bienestar infantil | Organizaciones representativas locales | Veteranos |
| Representante de organizaciones de veteranos. | Organizaciones de atención médica, incluidos hospitales | Planes de servicios de atención médica, incluidos los planes administrados por Medi-Cal | Aseguradoras de invalidez | Designados para el Programa de Salud Tribal e Indígena | Las cinco ciudades más pobladas en condados con una población mayor a 200.000 habitantes |
| Agencias locales sobre el envejecimiento | Centros de vida independiente | Continuos de atención, incluidos representantes de la comunidad de proveedores de servicios para personas sin hogar | Centros regionales | Servicios médicos de emergencia | Organizaciones comunitarias que prestan servicios a grupos de personas cultural y lingüísticamente diversos |

*Recién añadido

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## Ejemplos de **reuniones** de partes interesadas

- Comité Asesor de Competencia Cultural
- Subcomités de Concienciación sobre Competencia Cultural
- Comité Asesor de Políticas Comunitarias (CPAC)
- Reunión de la Comisión de Salud Conductual
- Reuniones del Comité Asesor Distrital (DAC)
- Juntas directivas de Consumer Clubhouse
- Asociación de Organizaciones Comunitarias (ACBO)

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## Cambios y actualizaciones del programa **Año fiscal 2025/26**




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## **Actualizaciones** del programa de la Ley de Servicios de Salud Mental

- El Departamento de Salud Conductual revisa continuamente los gastos actuales, la utilización y la disponibilidad de fondos para las actualizaciones y el desarrollo de programas apoyados por las partes interesadas.
- La revisión de la retroalimentación y la participación de las partes interesadas es un proceso continuo que nos permite conocer qué programas y servicios satisfacen mejor las necesidades de nuestra comunidad.
- El Departamento de Salud Conductual continuará utilizando los fondos existentes de la Ley de Servicios de Salud Mental para apoyar los programas existentes.

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## **Actualizaciones** sobre prevención e intervención temprana (PEI)

**Conexión de Niños y Jóvenes – Aumento de Presupuesto**

El Centro de Evaluación Infantil (CAC), administrado por el Hospital Infantil de la Universidad de Loma Linda (LLUCH), bajo el programa Conexión entre Niños y Jóvenes (CYC), aumentará los fondos del programa de $62,000 a $165,000 por año. Este cambio de financiación aumentará el acceso temprano y la vinculación con la atención y el tratamiento médicamente necesarios. Conecta a los niños y jóvenes con afecciones graves de salud mental con la atención lo más pronto posible desde la aparición de estas afecciones, con la atención y el tratamiento médicamente necesarios. Incluye, entre otros, la atención proporcionada por los programas de salud mental del condado.

- **Objetivos del proyecto:**
  - Servicios de asesoramiento previo al examen forense para ayudar a minimizar el trauma que sufren los niños/jóvenes durante el examen y disminuir la angustia psicológica asociada con las acusaciones de abuso infantil.
  - Brindar servicios de asesoramiento previo al examen forense a aproximadamente 900 niños y adolescentes no duplicados.
- Este programa atiende a consumidores de 0 a 18 años en todo el condado de San Bernardino.

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## **Actualizaciones** sobre prevención e intervención temprana (PEI)

**Centro de Recursos Familiares (FRC) - Actualización de Expansión**

El Centro de Recursos Familiares del Departamento de Salud Conductual, Prevención e Intervención Temprana (PEI) está ampliando sus servicios para incluir un Centro de Bienestar Familiar (FWC). La expansión del FWC incluirá servicios de prevención e intervención temprana, así como servicios de salud mental especializados para niños, jóvenes y adultos con problemas de salud mental. Esta expansión aumentará el presupuesto anual del FRC en $1,500,000 de $2,774,774 a $4,274,774, un aumento presupuestado previamente en el plan anual de la MHSA para el año fiscal 2022/23. Esta expansión permitirá al DBH ampliar su alcance de servicios al brindar un enfoque integral al bienestar familiar mientras continúa ofreciendo servicios esenciales para promover el bienestar, la recuperación y la resiliencia de sus clientes.

- Los programas de FRC ofrecen:
  - Servicios adaptados a las necesidades específicas y los requisitos culturales de cada comunidad.
  - Servicios y actividades en lugares no tradicionales, como centros comunitarios, donde también se ofrecen otros servicios complementarios.
  - Una reducción del estigma asociado con la búsqueda de servicios de salud mental, lo que aumenta la probabilidad de que los miembros de la comunidad utilicen los servicios.
- La población atendida serán niños y sus familias en todo el condado de San Bernardino.

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## Servicios y apoyos comunitarios (CSS) **Actualizaciones**

**Programa de Atención Continua para Viviendas y Servicios a Personas Sin Hogar – Transferencia de Posición**

El Equipo de Apoyo de Extensión para Personas sin Hogar (HOST, por sus siglas en inglés) bajo el Programa de Continuidad de Atención de Servicios de Vivienda y Personas sin Hogar está transfiriendo un puesto de Terapeuta Clínico/Psicólogo al programa de Elección de Opciones Saludables para Inculcar el Cambio y el Empoderamiento (CHOICE, por sus siglas en inglés) bajo el programa de Continuidad de Atención de Servicios Forenses.

- Este cambio permitirá que el programa CHOICE brinde servicios psiquiátricos directamente a los consumidores inscritos en el programa ambulatorio de salud mental CHOICE en los Centros de informes diurnos del Departamento de Libertad Condicional en lugar de derivarlos a otra clínica.
- Este puesto se financiará con el financiamiento de la Realineación AB109.

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## Actualizaciones de Innovación (INN)

**Colaboración para los trastornos alimentarios – Proyecto Sunset**

Está previsto que el proyecto colaboración para los trastornos alimentarios (EDC) finalice en diciembre de 2025. DBH está en proceso de revisar los datos y los resultados del proyecto para determinar la continuación del mismo. DBH está considerando opciones para continuar con el proyecto o los servicios del proyecto en el marco del programa de Asociación de servicios completos (FSP) de Servicios y apoyos comunitarios (CSS) y/u otras oportunidades con planes de atención administrada (MCP) para continuar brindando servicios del proyecto cuando corresponda.

**Cracked Eggs – Proyecto Sunset**

El contrato de Cracked Eggs finaliza en junio de 2026 y no continuará como un programa independiente. Las bajas tasas de inscripción combinadas con los importantes costos operativos lo han vuelto insostenible. Sin embargo, el proyecto destacó que el arte puede ser una herramienta terapéutica. DBH explorará formas de incorporar algunas de las estrategias artísticas aprendidas durante este proyecto de innovación para incluirlas en nuestro sistema de atención cuando sea apropiado. El informe final se publicará en el año fiscal 2026/27.

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## Actualización anual de la Ley de Servicios de Salud Mental de 2025: calendario de planificación de programas comunitarios



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## Cronograma de planificación del programa comunitario 2025

**ENERO - FEBRERO**
El proceso del CPP está programado para enero-febrero de 2025.

**FEBRERO – MARZO**
Está previsto tentativamente publicar la Actualización Anual de la Ley de Servicios de Salud Mental para revisión y comentarios públicos del 14 de febrero al 17 de marzo de 2025.

**ABRIL**
Se ha programado tentativamente una audiencia pública para realizarse en la reunión regular de la Comisión de Salud Conductual el 3 de abril de 2025.

**MAYO**
Está previsto tentativamente presentar la Actualización Anual a la Junta de Supervisores para su aprobación en mayo de 2025.

- Se llevarán a cabo 39 reuniones en todas las regiones geográficas del Condado.
- El calendario incluirá todas las reuniones regulares de las partes interesadas del CPP del DBH (CPAC, DAC, subcomités del CCAC, etc.).
- El calendario incluye las Casas Club - todas las regiones.

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## Próximas reuniones de planificación comunitaria

**Utilice el siguiente enlace para las próximas reuniones de planificación del programa comunitario de MHSA:**

Inglés: 2025-26 MHSA CPPFINAL.pdf

Español: 25-26 MHSA FINAL Span 1.7.25.pdf

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## ¡Queremos saber más!

Esta información se utilizará para identificar las necesidades de la comunidad, determinar las prioridades de financiación de la Ley de Servicios de Salud Mental y guiar la creación, implementación y evaluación de los programas financiados por la Ley de Servicios de Salud Mental.

**Enlace de la encuesta:**
https://qualtricsxmc3prhdp6w.qualtrics.com/jfe/form/SV_0ujJIQiY3VSZrF4

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## Encuestas en papel

Las encuestas en papel se pueden escanear y enviar por correo electrónico a MHSA@dbh.sbcounty.gov.

Los asistentes también pueden enviarnos por correo una copia impresa de la encuesta completa a:

- Administración de la Ley de Servicios de Salud Mental
  1950 S. Sunwest Lane, Suite 200
  San Bernardino, CA 92415

**O por correo interno:**

- Administración de la Ley de Servicios de Salud Mental
  Instituto de Formación WET
  A la atención de: Ley de Servicios de Salud Mental Admin
  #0019
- Si no recibió una encuesta en papel, envíenos un correo electrónico a MHSA@dbh.sbcounty.gov o puede agregar su dirección de correo electrónico al chat.
- La fecha límite para recibir los formularios completos es el cierre de operaciones **el 25 de febrero de 2025**.
- Los artículos enviados por correo deben tener matasellos a más tardar **el 25 de febrero de 2025**.

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# Actualización de la Proposición 1



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**La Proposición 1, que se aprobó en marzo de 2024, es una medida de dos partes que:**

- Modifica la Ley de Servicios de Salud Mental de California (SB 326) y
- Crea un bono de obligación general por $6.38 mil millones (AB 531).

| Ley SB 326 | AB 531 |
|---|---|
| Cambia la MHSA a BHSA (Ley de Servicios de Salud Conductual)<br>• Incluye tratamiento para personas con trastornos por consumo de sustancias. | También conocida como Ley de Bonos de Infraestructura de Salud Conductual de 2024 |
| Dirige los "cubos" de financiación en tres componentes principales:<br>• Servicios y apoyo de salud conductual<br>• Asociaciones de servicios completos<br>• Intervenciones en materia de vivienda | Crea un bono de $6.38 mil millones para construir 11,150 nuevas camas y unidades de vivienda para la salud conductual para satisfacer las necesidades actuales y futuras de los californianos. $1 mil millones están reservados específicamente para viviendas para veteranos. |
| Destina más dinero al Estado (10% frente a 5%) y menos a los condados (90% frente a 95%).<br>• Prevención 4%; Fuerza laboral 3%; Supervisión y monitoreo 3%<br>• Aumento de los costos para los condados para continuar con los programas actuales.<br>• Aumenta los grupos de partes interesadas necesarios para la planificación de programas comunitarios.<br>• Los planes trienales ya no se centrarán únicamente en los fondos MHSA, serán un Plan Integrado e incluirán todos los programas de salud conductual y fuentes de financiación.<br>• El Informe Anual de Ingresos y Gastos (ARER) de la MHSA se reemplaza por el nuevo Informe de Resultados, Responsabilidad y Transparencia de Salud Conductual del Condado (CBHOATR). | Proporcionará ubicación para pacientes complejos con enfermedades mentales graves que necesitan atención subaguda y apoyo a largo plazo fuera del entorno hospitalario. |
| Prioriza las inversiones en intervenciones de vivienda para personas sin hogar o en riesgo de quedarse sin hogar. | Destinado a resolver la grave escasez de camas para atención de salud mental subaguda. |

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# Poblaciones prioritarias para BHSA

El financiamiento de la Ley de Servicios de Salud Conductual se dirige a personas que viven con una variedad de necesidades de salud conductual y prioriza a aquellos afectados desproporcionadamente por problemas de salud mental y/o SUD con necesidades no satisfechas. Estas poblaciones prioritarias reflejan aquellas de otros programas e iniciativas de salud conductual a nivel estatal.

- Personas sin hogar o en riesgo de quedarse sin hogar
- Personas involucradas con la justicia o en riesgo de involucrarse en el sistema de justicia penal
- Niños y jóvenes, incluidos aquellos involucrados en el sistema de bienestar infantil
- Personas que se encuentran o salen de entornos institucionales, o que corren riesgo de institucionalización.

Según el Código de Bienestar e Instituciones de California § 5892.(d)(1) y § 5892.(d)(2)

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# Componentes y asignación de fondos de la BHSA

| | |
|---|---|
| **Intervenciones en materia de vivienda (30%)** | Incluye subsidios de alquiler, subsidios operativos, vivienda compartida, vivienda familiar para niños y jóvenes elegibles, la parte no federal para alquiler de transición, proyectos de desarrollo de capital y asistencia de vivienda basada en proyectos. Las intervenciones de vivienda no se limitarán a aquellos en FSP o aquellos inscritos en Medi-Cal. |
| **Asociaciones de servicios completos (35%)** | Incluye servicios de salud mental, servicios de apoyo y servicios de tratamiento de trastornos por uso de sustancias, que se brindarán de conformidad con un enfoque integral que tenga en cuenta el trauma, sea apropiado para la edad y en asociación con las familias o los apoyos naturales de un individuo. Los servicios se brindan de manera optimizada y coordinada para ayudar a reducir cualquier barrera a los servicios. |
| **Servicios y apoyos de salud conductual (35%)** | Incluye servicios para el sistema de cuidado de niños y para el sistema de cuidado de adultos y adultos mayores (excluidos los servicios de intervención de vivienda y los FSP), programas de intervención temprana, extensión y participación, proyectos WET, CFTN e INN. |

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# CAMBIOS en la BHSA

| | |
|---|---|
| **Difusión y participación (O&E)** | Las actividades de divulgación y participación se financiarán mediante la categoría de Servicios y apoyo de salud conductual.<br>• 35% de financiación para toda la categoría BHSS. |
| **Desarrollo de sistemas generales (GSD)** | La BHSA no incluye lenguaje sobre el desarrollo del sistema general.<br>• El CSS GSD tal como lo conocemos hoy no continuará bajo la BHSA. |
| **Asociaciones de servicios completos (FSP)** | Las asociaciones de servicio completo serán una categoría dedicada bajo la BHSA.<br>• 35% de la financiación que reciben los condados. |

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# Donde estamos ahora

- Los programas y servicios actuales de MHSA continuarán según lo aprobado hasta el 30 de junio de 2026.
- Ampliar la participación de las partes interesadas mediante la identificación y conexión con nuevos socios para garantizar una participación inclusiva en el proceso del CPP y la planificación del programa.
- Educar a las partes interesadas sobre la Proposición 1, discutir los impactos de su programa y solicitar comentarios prácticos para abordar las necesidades de la comunidad y guiar la planificación futura durante las reuniones mensuales del CPAC.
- Continuamos reuniéndonos con los socios del condado y discutiendo los impactos del programa.
- Desarrollar planes de mitigación para garantizar una transición sin problemas.
- Mantener un rol proactivo en la transición de la BHSA, participar en sesiones de escucha de Transformación de Salud Conductual (BHT) lideradas por el estado y mantenerse actualizado sobre las políticas y regulaciones en evolución para garantizar una toma de decisiones informada y la alineación con la comunidad.

Puede encontrar información adicional sobre la participación de las partes interesadas en el sitio web del Departamento de Servicios de Atención Médica (DHCS) aquí: Participación de las partes interesadas

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## Evaluación de la capacidad del DBH




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## Evaluación de capacidad

- En noviembre de 2023, DBH se asoció con Health Management Associates (HMA), una empresa de investigación y consultoría nacional independiente en la industria de la atención médica, para completar una evaluación de las necesidades y la capacidad de salud conductual y una evaluación del proceso de Planificación del Programa Comunitario (CPP) del DBH para desarrollar el Plan Integrado Trienal y las Actualizaciones Anuales de la MHSA.
- El informe final identifica fortalezas, desafíos y recomendaciones para áreas de oportunidad dentro de la programación de la Ley de Servicios de Salud Mental (MHSA) en el condado de San Bernardino.
- El proyecto se desarrolló desde noviembre de 2023 hasta agosto de 2024.
- El informe completo se incluirá como archivo adjunto en la Actualización Anual de la MHSA para el año fiscal 2025/26.

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## Métodos de evaluación

HMA utilizó una combinación de análisis de datos, revisión de documentos y participación de la comunidad durante todo el proyecto para realizar las evaluaciones. Algunas estrategias utilizadas para la recopilación de datos cualitativos y cuantitativos incluyeron:

- Recopilación y analisis de datos disponibles sobre servicios al consumidor, datos demográficos, datos de capacidad y necesidades de fuerza laboral.
- Realización de entrevistas con proveedores de salud conductual ambulatorios y residenciales, organizaciones culturalmente específicas, agencias de servicios sociales y representantes del distrito escolar, entre otros, para solicitar sus comentarios sobre las fortalezas del sistema y las áreas de mejora.
- Proporcionar grupos focales con más de 200 participantes, donde los grupos incluían personas con experiencias vividas.
- Se administró una encuesta comunitaria que recibió 232 respuestas sobre las fortalezas, barreras y necesidades insatisfechas del sistema, así como sobre la concientización y la participación en el CPP.
- Se organizaron asambleas comunitarias como un foro para escuchar aportes adicionales de los miembros de la comunidad.

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## Necesidades de salud conductual & Evaluación de capacidad

Los hallazgos clave de la retroalimentación cualitativa de la evaluación de las necesidades y la capacidad de salud conductual se organizan en las siguientes categorías:

**Fortalezas**

- Colaboración de proveedores
- Disponibilidad y accesibilidad del servicio
- Esfuerzos de participación del condado
- Eficacia de los servicios

**Oportunidades de mejora y necesidades insatisfechas**

- Acceso y disponibilidad del servicio
- Sensibilidad cultural y reducción de la disparidad
- Reclutamiento y retención de personal
- Implementación de nuevas iniciativas
- Colaboración interna y externa
- Operaciones
- Compromiso comunitario

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## Necesidades de salud conductual & Evaluación de capacidad

HMA proporcionó recomendaciones que podrían tener un impacto significativo en la prestación de servicios de atención médica conductual en el condado de San Bernardino. Estos se clasifican en las cinco áreas siguientes:

1) Ampliar el acceso a servicios de alta calidad
2) Mejorar la integración y coordinación de servicios
3) Mejorar la comunicación y el compromiso externos
4) Fortalecer los procesos administrativos y operativos
5) Abordar los desafíos de la fuerza laboral

DBH está revisando las recomendaciones y desarrollando estrategias para ayudar a mejorar la prestación de atención médica conductual en nuestro condado. Este es un proceso continuo y se compartirán actualizaciones en reuniones futuras.

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## Evaluación del proceso de planificación de programas comunitarios

A continuación se enumeran algunos hallazgos clave relacionados con las observaciones del proceso de Planificación del Programa Comunitario (CPP), ordenados por fortalezas y oportunidades de mejora:

**Fortalezas**

- Las reuniones tuvieron buena concurrencia, hubo muchas oportunidades para que los constituyentes formularan preguntas y ofrecieran sus comentarios, y los participantes se mostraron comprometidos.
- Se celebraron una amplia gama de reuniones especiales de población.
- La información compartida cumplió con los estándares de servicios cultural y lingüísticamente apropiados.

**Oportunidades de mejora**

- Hubo una desconexión entre los electores con respecto al contexto y el objetivo de las reuniones y la conexión entre la Ley de Servicios de Salud Mental (MHSA) y el CPP.
- Se podría agilizar el proceso de envío de comentarios.
- El condado podría aprovechar las herramientas en línea para mejorar las interacciones y la participación durante las reuniones.

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## Evaluación del proceso de planificación de programas comunitarios

A continuación se enumeran algunos hallazgos clave relacionados con la retroalimentación sobre el proceso de Planificación del Programa Comunitario (CPP), ordenados por fortalezas y oportunidades de mejora:

**Fortalezas**

- El condado ha probado múltiples estrategias de divulgación, incluida la asociación con organizaciones para organizar reuniones, foros virtuales, encuestas, etc.
- La intención detrás del proceso y los subcomités es buena, incluso si no siempre son tan efectivos y concurridos como los participantes desearían.
- El condado promueve las sesiones entre los proveedores y la comunidad y, en general, recibe comentarios positivos.

**Oportunidades de mejora**

- Las partes interesadas tienen muchos requisitos que compiten por su tiempo y recursos y desean metas, objetivos y elementos de acción claramente definidos para las reuniones con un enfoque más fuerte en la aplicación operativa que en las estadísticas.
- Es necesario que haya una comunicación más clara sobre el objetivo del proceso del CPP.
- Existe un deseo de aumentar la participación de personas que tradicionalmente no han sido parte del proceso, como aquellas que pueden tener necesidades de salud conductual pero no acceden a los servicios por una razón u otra.



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## Evaluación del proceso de planificación de programas comunitarios

A continuación se enumeran **algunas de las recomendaciones de HMA para mejorar el proceso de planificación de programas comunitarios (CPP):**

- Mejorar la comunicación y el compromiso externos
  - Crear conciencia sobre el proceso de planificación de programas comunitarios
  - Mejorar el seguimiento del progreso y los resultados del CPP
  - Aprovechar socios confiables para respaldar el intercambio de información
  - Mejorar las conexiones con las comunidades marginadas
  - Ofrecer oportunidades de participación en entornos comunitarios.
  - Aprovechar la tecnología para respaldar la participación



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## Pasos actuales

DBH está tomando las siguientes medidas para abordar las recomendaciones de la evaluación:

- Proporcionar más contexto sobre MHSA y el proceso CPP durante las reuniones para ayudar a educar a las partes interesadas sobre el proceso de planificación y cómo su participación y comentarios ayudan a guiar los programas de DBH.
- Ampliar los grupos de partes interesadas para incluir más poblaciones desatendidas o marginadas, miembros de la comunidad, socios de servicios, organizaciones religiosas, grupos de niños y jóvenes, etc., para aumentar la participación y la retroalimentación de la comunidad e involucrar a más socios de servicios para aumentar el intercambio de información con la comunidad.
- Coordinar con otros departamentos y organizaciones para participar en las evaluaciones de las necesidades de sus comunidades y pacientes para identificar las necesidades del condado y ampliar el acceso y los servicios para satisfacer esas necesidades.
- Celebrar reuniones mensuales del Comité Asesor de Políticas Comunitarias (CPAC) en más lugares del condado para interactuar con las partes interesadas en entornos comunitarios.

El liderazgo de DBH está trabajando para identificar oportunidades adicionales de mejora y continúa fomentando la participación y la retroalimentación de las partes interesadas para guiar sus programas y servicios.



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## ¿Preguntas?





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## Preocupaciones

Para informar cualquier inquietud relacionada con la planificación del programa comunitario de la MHSA, consulte el proceso de resolución de problemas de la MHSA que se encuentra en:

https://wp.sbcounty.gov/dbh/wp-content/uploads/sites/121/2021/08/COM0947.pdf?x62087

Para informar inquietudes relacionadas con la recepción de servicios de salud conductual, comuníquese con la Unidad de Acceso del DBH llame al:

**(909) 386-8256**
**Línea gratuita 1 (888) 743-1478**
**o 7-1-1 para usuarios de TTY.**



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## ¡Gracias!

Para preguntas o comentarios, por favor contactar a:

**Dra. Rebecca Scott Young, MBA, PHR**
**Gerente Administrativo de la Ley de Servicios de Salud Mental**
**MHSA@dbh.sbcounty.gov**
**909-252-4021**

**www.SBCounty.gov/DBH**

MENTAL HEALTH SERVICES ACT (MHSA)

# Stakeholder Survey Form

*MHSA Annual Update*
*Fiscal Year 2025/2026*
*Community Program Planning Meeting*

SAN BERNARDINO COUNTY | Behavioral Health

**1. What is your age?**
- ☐ 0-15 years
- ☐ 16-25 years
- ☐ 26-59 years
- ☐ 60+ years
- ☐ Prefer not to answer

**2. What sex were you assigned at birth?**
- ☐ Female
- ☐ Male
- ☐ Prefer not to answer

**3. How do you describe yourself?**
- ☐ Female
- ☐ Male
- ☐ Trans Female/Woman
- ☐ Trans Male/Man
- ☐ Genderqueer
- ☐ Nonbinary
- ☐ Questioning or Unsure of Gender Identity
- ☐ Other/Not Listed: _____
- ☐ Prefer not to answer

**4. Do you consider yourself:**
- ☐ Straight/Heterosexual
- ☐ Gay/Lesbian
- ☐ Bisexual
- ☐ Queer
- ☐ Questioning or Unsure about Orientation
- ☐ Other/Not Listed: _____
- ☐ Prefer not to answer

**5. What is the primary language spoken in your home?**
- ☐ English
- ☐ Mandarin
- ☐ Spanish
- ☐ Vietnamese
- ☐ Other/Not Listed: _____
- ☐ Prefer not to answer

**6. Are you a consumer of mental health services?**
- ☐ Yes (currently)
- ☐ No
- ☐ Yes (previously)
- ☐ Prefer not to answer

**7. Are you a consumer of alcohol and/or drug services?**
- ☐ Yes (currently)
- ☐ No
- ☐ Yes (previously)
- ☐ Prefer not to answer

**8. Are you a friend, family member, or loved one of a consumer of mental health services and/or alcohol and drug services?**
- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

**9. Have you ever served in the military?**
- ☐ Yes (currently)
- ☐ No
- ☐ Yes (previously)
- ☐ Prefer not to answer

**10. Which category best describes your race (i.e., physical/ancestral characteristics)?**
(Check all that apply)
- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ African American/Black
- ☐ Caucasian/White
- ☐ Latinx/Hispanic
- ☐ Native Hawaiian
- ☐ Pacific Islander
- ☐ Multiple races
- ☐ Other (please specify):_____
- ☐ Decline to state

**11. Which best describes your employer:**
- ☐ Community Based Service Provider
- ☐ Federal, State, County, or City Government
- ☐ Nonprofit
- ☐ Private Business
- ☐ Self
- ☐ Student/Intern
- ☐ Not Employed
- ☐ Other/Not Listed: _____
- ☐ Prefer not to answer

Please continue to next page.



**Updated 12/2024**

SAN BERNARDINO COUNTY | Behavioral Health

# Stakeholder Survey Form

*MHSA Annual Update*
*Fiscal Year 2025/2026*
*Community Program Planning Meeting*

**12. Are you connected to any of the following stakeholder groups (Employed, Affiliated, Represent)?** (Check all that apply)

- ☐ Alcohol and Drug Service Program Providers
- ☐ Area Agencies on Aging
- ☐ Continuum of Care
- ☐ Disability Insurers
- ☐ Education – Early Childhood Organizations
- ☐ Education – K-12 (direct child service)
- ☐ Education – School Districts, and other Agencies (no direct child services)
- ☐ Education – Higher Education Partners, Colleges, Trade Schools
- ☐ Emergency Medical Services
- ☐ Faith Based Organization
- ☐ Healthcare – Behavioral/Mental Health
- ☐ Healthcare – Physical Health
- ☐ Healthcare service plans, including Medi-Cal managed care plans (MCPs)
- ☐ Independent Living Centers
- ☐ Labor Representative Organizations
- ☐ Law Enforcement
- ☐ Regional Centers
- ☐ Social or Human Service Program/Agency
- ☐ Tribal and Indian Health Program designees established for Medi-Cal Tribal consultation purposes
- ☐ Veterans Organization
- ☐ Youth or Youth Mental Health or Substance Use Disorder Organizations/Providers
- ☐ Not Employed
- ☐ Other/Not Listed: _____
- ☐ Prefer not to answer

**13. Do you have a disability or other impairment that is expected to last longer than 6 months and substantially limits a major life activity, which is not the result of a severe mental illness?**

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

**14. Do you live or work in San Bernardino County? If both, list the region you live in:**

- ☐ Central Valley Region
  *e.g., Bloomington, Fontana, Grand Terrace, Rialto*
- ☐ Desert/Mountain Region
  *e.g., Adelanto, Amboy, Apple Valley, Baker, Big Bear City, Cima, Earp, Fort Irwin, Hesperia, Hinkley, Joshua Tree, Landers, Lucerne Valley, Ludlow, Morongo Valley, Mountain Pass, Needles, Nipton, Parker Dam, Phelan, Pioneertown, Sky Forest, Sugarloaf, 29 Palms, Wrightwood, Yermo, Yucca Valley*
- ☐ East Valley
  *e.g., Green Valley Lake, Highland, Lake Arrowhead, Loma Linda, Lytle Creek, Mentone, Patton, Redlands, Rimforest, Running Springs, San Bernardino, Yucaipa*
- ☐ West Valley
  *e.g., Chino Hills, Chino, Guasti, Mt. Baldy, Montclair, Ontario, Rancho Cucamonga*
- ☐ I live and work in a neighboring California County
  Zip Code: _____
- ☐ Prefer not to answer

**15. In the future how would you like to receive MHSA updates?** (Check all the apply)

- ☐ Community Policy Advisory Committee Meetings
- ☐ Webinar
- ☐ Email (Provide email address below)
  Name: _____
  Email: _____
- ☐ Social Media
- ☐ Special meeting in your community
- ☐ Other/Not Listed: _____
- ☐ Prefer not to answer

Thank you for taking the time to complete this survey. Your feedback will help us improve the community planning process to better meet the needs of our community. **All information provided will be kept confidential.**

Please continue to next page.

SAN BERNARDINO COUNTY | Behavioral Health

# Stakeholder Survey Form

*MHSA Annual Update*
*Fiscal Year 2025/2026*
*Community Program Planning Meeting*

**Meeting Name:** _____

1. **Were you satisfied that the MHSA Annual Update presentation met its goals and/or objectives?**
   - ☐ Very Satisfied
   - ☐ Satisfied
   - ☐ Neutral
   - ☐ Unsatisfied
   - ☐ Very Unsatisfied

2. **What did you learn about the MHSA Annual Plan Update?**

3. **What else would you like to learn about the MHSA process?**

4. **Do you have other concerns not addressed in this discussion?**

Please continue to next page.

Behavioral Health

# Stakeholder Survey Form

*MHSA Annual Update*
*Fiscal Year 2025/2026*
*Community Program Planning Meeting*

**5. Any additional comments or feedback?**

| |
|---|
| |

**Thank you again for taking the time to review and provide feedback.**

LEY DE SERVICIOS DE SALUD MENTAL (MHSA)

# Formulario de Comentarios para las Partes Interesadas

*Actualización Anual de la MHSA*
*Año Fiscal 2025/2026*
*Reunión de Planificación del Programa Comunitario*

SAN BERNARDINO COUNTY | **Departamento de Salud Mental**

**1. ¿Cuántos años tiene?**
- ☐ 0-15 años
- ☐ 16-25 años
- ☐ 26-59 años
- ☐ +60 años
- ☐ Prefiero no responder

**2. ¿Qué sexo le asignaron al nacer?**
- ☐ Femenino
- ☐ Masculino
- ☐ Prefiero no responder

**3. ¿Cómo se describiría a usted mismo?**
- ☐ Mujer
- ☐ Hombre
- ☐ Mujer transgénero
- ☐ Hombre transgénero
- ☐ Queer
- ☐ No binario
- ☐ Me cuestiono mi identidad de género o no estoy seguro de ella
- ☐ Otro/No está en la lista: _____
- ☐ Prefiero no responder

**4. ¿Cómo se considera a usted mismo?**
- ☐ Heterosexual
- ☐ Gay/Lesbiana
- ☐ Bisexual
- ☐ Queer
- ☐ Me cuestiono mi orientación o no estoy seguro de ella
- ☐ Otro/No está en la lista: _____
- ☐ Prefiero no responder

**5. ¿Qué idioma principal se habla en su casa?**
- ☐ Inglés
- ☐ Mandarín
- ☐ Español
- ☐ Vietnamita
- ☐ Otro/No está en la lista: _____
- ☐ Prefiero no responder

**6. ¿Es usted consumidor de servicios de salud mental?**
- ☐ Sí (actualmente)
- ☐ No
- ☐ Sí (en el pasado)
- ☐ Prefiero no responder

**7. ¿Es usted consumidor de servicios de tratamiento de alcohol y/o drogas?**
- ☐ Sí (actualmente)
- ☐ No
- ☐ Sí (en el pasado)
- ☐ Prefiero no responder

**8. ¿Es usted amigo, familiar o ser queridos de un consumidor de ser servicios de salud mental y/o servicios de tratamiento de alcohol y/o drogas?**
- ☐ Sí
- ☐ No
- ☐ Prefiero no responder

**9. ¿Ha servido alguna vez en el ejército?**
- ☐ Sí (actualmente)
- ☐ No
- ☐ Sí (en el pasado)
- ☐ Prefiero no responder

**10. ¿Qué categoría describe mejor su raza (es decir, características físicas/ancestrales)?**
(Marque todas las opciones que correspondan):
- ☐ Nativo de los Estados Unidos/ Nativo de Alaska
- ☐ Asiático
- ☐ Afroamericano/negro
- ☐ Caucásico/blanco
- ☐ Hispano/Latino
- ☐ Hawaiano nativo
- ☐ Isleño del Pacífico
- ☐ Más de una raza
- ☐ Otra/No está en la lista: _____
- ☐ Prefiero no responder

**11. ¿Qué opción describe mejor a su empleador?**
- ☐ Proveedor de servicios comunitarios
- ☐ Gobierno federal, estatal, del condado o de la ciudad
- ☐ Organización sin fines de lucro
- ☐ Empresa privada
- ☐ Trabajador por cuenta propia
- ☐ Estudiante/practicante
- ☐ No tengo empleo
- ☐ Otra/No está en la lista: _____
- ☐ Prefiero no responder

Favor de continuar a la próxima página.

SAN BERNARDINO COUNTY | Departamento de Salud Mental

# Formulario de Comentarios para las Partes Interesadas

*Actualización Anual de la MHSA*
*Año Fiscal 2025/2026*
*Reunión de Planificación del Programa Comunitario*

**12. ¿Está conectado a alguno de los siguientes grupos de partes interesadas (empleados, afiliados, representantes)?** (Marque todas las opciones que correspondan):

☐ Proveedores de programa de servicios de alcohol y drogas
☐ Agencias para la tercera edad
☐ Continuidad de atención
☐ Aseguradores de invalidez
☐ Educación- Organizaciones de primeria infancia
☐ Educación- K-12 (servicio directo de niños)
☐ Educación- Distritos escolares y otras agencias (sin servicios directos a niños)
☐ Educación- Socios de educación superior, universidades, colegios, y escuelas de oficios
☐ Servicios médicos de emergencia
☐ Organización religiosa
☐ Cuidado de salud – Salud mental/del comportamiento
☐ Cuidado de salud – Salud física
☐ Planes de salud, incluyendo los planes de salud administrados de Medi-Cal
☐ Centros de vida independiente
☐ Organizaciones de representación laboral
☐ Fuerzas policiales
☐ Centros regionales
☐ Programa/agencia de servicios sociales o humanos
☐ Programas de salud tribales e indios establecidos para el propósito de consultas tribales de Medi-Cal
☐ Organización de veteranos
☐ Organizaciones/proveedores de servicios de salud mental y/o servicios de alcohol y drogas para jóvenes
☐ No tengo empleo
☐ Otra/No está en la lista: _____
☐ Prefiero no responder

**13. ¿Tiene alguna discapacidad o deficiencia que dure más de 6 meses y que limita considerablemente la realización de actividades de vida diaria, que no sea consecuencia de una enfermedad mental grave?**

☐ Sí ☐ No
☐ Prefiero no responder

**14. ¿Vive o trabaja en el condado de San Bernardino? Si es así, indique la región:**

☐ Región del valle central
*p. ej., Bloomington, Fontana, Grand Terrace, Rialto*

☐ Región desértica/montañosa
*p. ej., Adelanto, Amboy, Apple Valley, Baker, Big Bear City, Cima, Earp, Fort Irwin, Hesperia, Hinkley, Joshua Tree, Landers, Ludlow, Morongo Valley, Mountain Pass, Needles, Nipton, Parker Dam, Phelan, Pioneertown, Sky Forest, Sugarloaf, 29 Palms, Wrightwood, Yermo, Yucca Valley*

☐ Región del valle del este
*p. ej., Green Valley Lake, Highland, Lake Arrowhead, Loma Linda, Lytle Creek, Mentone, Patton, Redlands, Rimforest, Running Springs, San Bernardino, Yucaipa*

☐ Región del valle del oeste
*p. ej., Chino Hills, Chino, Guasti, Mt. Baldy, Montclair, Ontario, Rancho Cucamonga*

☐ Vivo o trabajo en otro condado en California
Código postal: _____

☐ Prefiero no responder

Favor de continuar a la próxima página.

# Formulario de Comentarios para las Partes Interesadas

*Actualización Anual de la MHSA*
*Año Fiscal 2025/2026*
*Reunión de Planificación del Programa Comunitario*

SAN BERNARDINO COUNTY | **Departamento de Salud Mental**

**15. En el futuro, ¿cómo le gustaría recibir las actualizaciones de la MHSA?**
(Marque todas las opciones que correspondan)

☐ En las reuniones del Comité Asesor de Políticas Comunitarias
☐ En un seminario por internet (reunión virtual)
☐ Por correo electrónico (proporcione su dirección de correo electrónico a continuación)
Nombre: _____
Correo electrónico: _____
☐ Por redes sociales
☐ En una reunión especial en la comunidad
☐ Otra/No está en la lista: _____
☐ Prefiero no responder

Gracias por tomarse el tiempo para completar esta encuesta. Sus comentarios nos ayudarán a mejorar el proceso de planificación comunitaria para satisfacer mejor las necesidades de nuestra comunidad. **Toda la información proporcionada será confidencial.**

Favor de continuar a la próxima página.

SAN BERNARDINO COUNTY | Departamento de Salud Mental

# Formulario de Comentarios para las Partes Interesadas

*Actualización Anual de la MHSA*
*Año Fiscal 2025/2026*
*Reunión de Planificación del Programa Comunitario*

## Preguntas sobre la Actualización Anual de la MHSA Año Fiscal 2025/2026

1. **¿Quedo satisfecho/a que la presentación de la Actualización Anual de la MHSA cumplió con sus metas y/o objetivos?**
   - ☐ Muy satisfecho/a
   - ☐ Satisfecho/a
   - ☐ Neutral
   - ☐ Instaisfecho/a
   - ☐ Muy instaisfecho/a

2. **¿Qué aprendió sobre la actualización del plan anual de la MHSA?**

3. **¿Qué más le gustaría aprender sobre el proceso de la MHSA?**

4. **¿Tiene otras inquietudes que no se abordan en esta discusión?**

Favor de continuar a la próxima página.

Departamento de Salud Mental

# Formulario de Comentarios para las Partes Interesadas

*Actualización Anual de la MHSA*
*Año Fiscal 2025/2026*
*Reunión de Planificación del Programa Comunitario*

**5. ¿Algún comentario o sugerencia adicional?**

| |
|---|
| |

**Gracias de nuevo por tomarse el tiempo para revisar la encuesta y hacer comentarios.**

**From:** DBH - MHSA
**Subject:** FW: Courtesy Copy: Behavioral Health Seeks Input on Annual Update Plan
**Attachments:** SBCounty News Outlet Listserv CONFIDENTIAL.xlsx

**From:** [redacted]
**Sent:** Tuesday, February 18, 2025 11:12 AM
**To:** [redacted]
**Cc:** [redacted]
**Subject:** FW: Courtesy Copy: Behavioral Health Seeks Input on Annual Update Plan

Good Morning,

The MHSA press release was published. The listserv of news outlets to which this was sent is also attached.

Thank you,

Having trouble viewing this email? View it as a Web page.

SAN BERNARDINO COUNTY

# News Release

**For Immediate Release**
February 18, 2025

**Contact**
Miranda Canseco-Ochoa
Administrative Manager
Department of Behavioral Health
miranda.canseco@dbh.sbcounty.gov

**Behavioral Health Seeks Input on Annual Update Plan**



*Behavioral Health Commission Meeting - May 2024*

The San Bernardino County Department of Behavioral Health (DBH) invites community members to review and comment on the draft Mental Health Services Act (MHSA) Annual Update for Fiscal Year 2025/26.

The draft plan is a comprehensive report that illustrates the impact made by DBH and its contracted partners in addressing the behavioral health needs of San Bernardino County. This report also includes the proposed changes to MHSA programming for the upcoming fiscal year. View and comment on the draft plan by visiting

https://wp.sbcounty.gov/dbh/programs/mhsa/ starting February 14, 2025, **through March 17, 2025**.

Comment forms will be available in English and Spanish. For additional information on the update or to request interpretation services or disability-related accommodations, please call (800) 722-9866 (dial 7-1-1 for TTY users) or email mhsa@dbh.sbcounty.gov.

“Engaging stakeholders in the development of the Annual Update is crucial because their insights and experiences directly inform our approach, ensuring that we address the real needs of our communities. This feedback not only enhances the relevance and effectiveness of our programs but also fosters a sense of community ownership and trust in the solutions we provide” said DBH Director Dr. Georgina Yoshioka.

The MHSA was passed by California voters in November 2004 and is funded by a one percent tax surcharge on personal incomes over $1 million per year. Utilizing MHSA funding, DBH supports the Countywide Vision by providing behavioral health services and ensuring residents have the resources they need to promote wellness, recovery, and

resilience in the community. Information on the Countywide Vision and on DBH can be found at main.sbcounty.gov.

**About San Bernardino County:** San Bernardino County is a diverse public service organization serving America's largest county that for two consecutive years has led the nation in awards for innovation, efficiency, and outstanding public service. We are governed by an elected Board of Supervisors and dedicated to creating a community where nearly 2.2 million residents can prosper and achieve well-being in fulfillment of the Countywide Vision. It is comprised of 42 departments and agencies, which are staffed by more than 23,000 public service professionals who provide a wide range of vital services in the areas of public safety, health care, social services, economic and community development and revitalization, fiscal services, infrastructure, recreation and culture, and internal support. For more information, visit sbcounty.gov.

**View the DRAFT MHSA Annual Update**

Update your subscriptions, modify your password or e-mail address, or stop subscriptions at any time on your Subscriber Preferences Page. You will need to use your e-mail address to log in. If you have questions or problems with the subscription service e-mail subscriberhelp.govdelivery.com for assistance. All other inquiries can be directed to communications@cao.sbcounty.gov

This service is provided to you at no charge by San Bernardino County. Visit us on the web at http://www.sbcounty.gov/.

# 30 Day Posting Press Release on San Bernardino County Website




- Assessor-Recorder-County Clerk
- Auditor-Controller/Treasurer/Tax Collector
- Behavioral Health
- Big Bear Alpine Zoo
- Board of Supervisors
- Census
- Child Support Services
- Children and Family Services
- Children's Fund
- Children's Network
- Clerk of the Board
- Coalition Against Sexual Exploitation
- Code Enforcement
- Community Development and Housing
- Community Vital Signs
- County Administrative Office
- County Fire
- County History
- County Library
- County Museum
- County Surveyor
- Countywide Plan
- CountyWire
- Disasters
- District Attorney
- Economic Development Agency
- Environment
- Environmental Health Services
- Equal Opportunity Commission
- Facilities Management
- First 5 San Bernardino
- Fleet Management
- Government Works
- Grand Jury
- Homeownership Protection Program JPA
- Housing Authority
- Human Resources
- Human Services
- Innovation and Technology Department
- Land Use Services
- Office of Emergency Services
- Office of Homeless Services
- Photos
- Preparedness
- Preschool Services
- Probation Department
- Public Defender
- Public Health
- Public Works
- Purchasing Department
- Real Estate Services
- Redistricting Commission
- Regional Parks




*Behavioral Health Commission meeting – May 2024.*

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Comment forms will be available in English and Spanish. For additional information on the update or to request interpretation services or disability-related accommodations, please call 1-800-722-9866 (dial 7-1-1 for TTY users) or email mhsa@dbh.sbcounty.gov.

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SAN BERNARDINO COUNTY

# Interoffice Memo

**DATE:** January 14, 2025 **PHONE:** 909-252-5142

**FROM:** **DR. GEORGINA YOSHIOKA,** Director
Behavioral Health

**TO:** **MEMBERS**
Board of Supervisors

**LUTHER SNOKE,** Chief Executive Officer
County Administrative Office

**DIANE RUNDLES,** Assistant Executive Officer
County Administrative Office

**SUBJECT: POSTING OF THE DRAFT MENTAL HEALTH SERVICES ACT ANNUAL UPDATE FISCAL YEAR 2025-2026**

The purpose of this memo is to provide information regarding the posting of the Draft Mental Health Services Act (MHSA) Annual Update for Fiscal Year 2025/26. The development and public posting of this report to the San Bernardino County Department of Behavioral Health (DBH) Internet site is a statutory requirement to allow the public an opportunity to review and provide input concerning the programs funded through MHSA. Any substantive changes related to MHSA programs or budget require a 30-Day public review and comment period. The posting meets the required 30-day public review and comment period in accordance with Welfare and Institutions Code 5848 and can be accessed at https://wp.sbcounty.gov/dbh/programs/mhsa/.

**BACKGROUND**

Welfare and Institutions Code 5847 requires the development of a Three Year Integrated MHSA Plan, and subsequent Annual Updates to the Plan, for the purpose of highlighting the progress, accomplishments, and anticipated budget of MHSA programs. Each plan is required to be developed via a stakeholder engagement process, which includes a public posting and comment period; a Public Hearing hosted by the Behavioral Health Commission to affirm adherence to the stakeholder process; and approval by the Board of Supervisors. In our efforts to support the Countywide Vision initiative, DBH is connecting the general standards and principles of MHSA to the Wellness Component of our Countywide Vision. These programs serve to reduce health disparities through behavioral health education, promotion of healthy lifestyles, development of outcome-based services, and increased collaboration between and among providers, community-based organizations, and county departments.

DBH continues to utilize an effective, year-round community planning process to seek input from stakeholders. The department continues the use of best practices in our community planning process by:

- Publishing stakeholder meeting schedules as part of the draft plan, via public postings, hosting recurring meetings, email distribution lists, websites, and through the use of social media tools, such as Instagram, Facebook, and Twitter.
- Conducting thirty-nine special stakeholder engagement meetings in all regions (i.e., supervisory districts) to review proposed programmatic changes and new programs (please see attachment for list of meetings).
- Utilizing webinar technology to allow stakeholders to participate from home.
- Facilitating meetings in Spanish for monolingual community members in addition to providing translation services, as needed, at the other scheduled meetings.

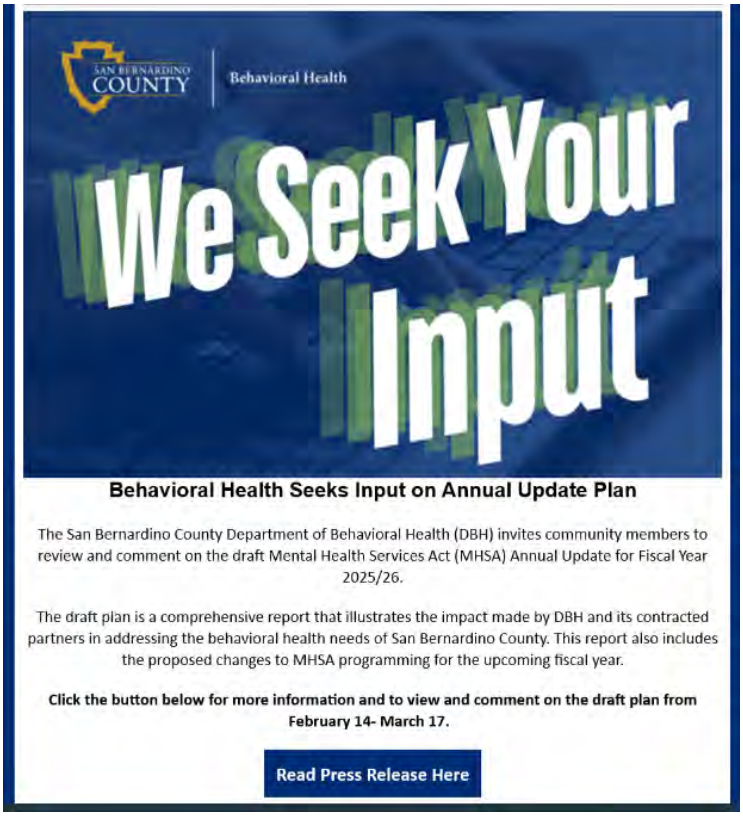
**STATUS / IMPLEMENTATION**

Per Welfare and Institutions Code 5848, the MHSA Annual Update for Fiscal Year 2025/26 will be available for a minimum 30-day public review and comment period on the DBH website from February 14, 2025, through March 17, 2025. Upon completion of the review period, all public input will be considered and incorporated into the report to reflect any substantive changes resulting from feedback received. A public hearing is scheduled to take place on April 3, 2025, at the regularly scheduled Behavioral Health Commission Meeting for a formal review of the community program planning process. The MHSA Annual Update is tentatively scheduled for Board approval in May 2025. Should you have any questions or need further information regarding the submission of the MHSA Annual Update for San Bernardino County, please contact my office. Thank you for your continued support!

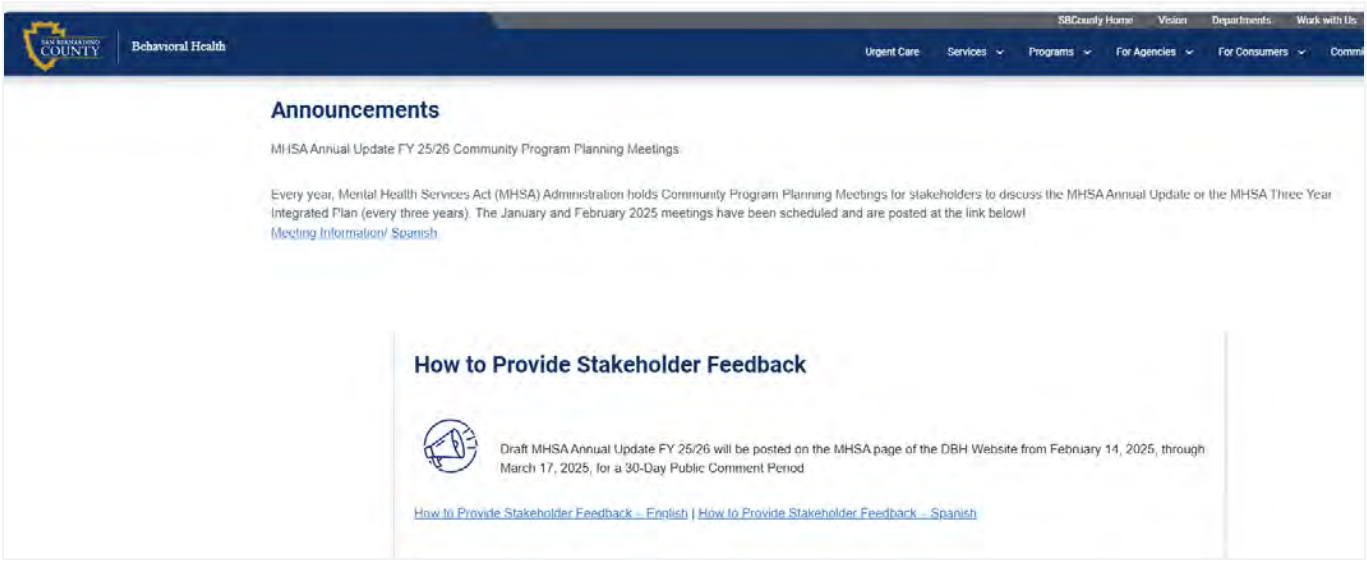
GY:RSY:mv

C: Victor Tordesillas, Deputy Executive Officer
Paul Garcia, Administrative Analyst III, Human Services
Members, Behavioral Health Commission
MHSA Community Policy Advisory Committee
Executive Management Team, Department of Behavioral Health
Roger Uminski, President, Association of Community Based Organizations
Maribel Gutierrez, Deputy Director, Community Engagement and Equity Services
Sonia Navarro, Senior Program Manager, MHSA Administration
Dr. Rebecca Scott Young, Department of Behavioral Health, MHSA Administrative Manager

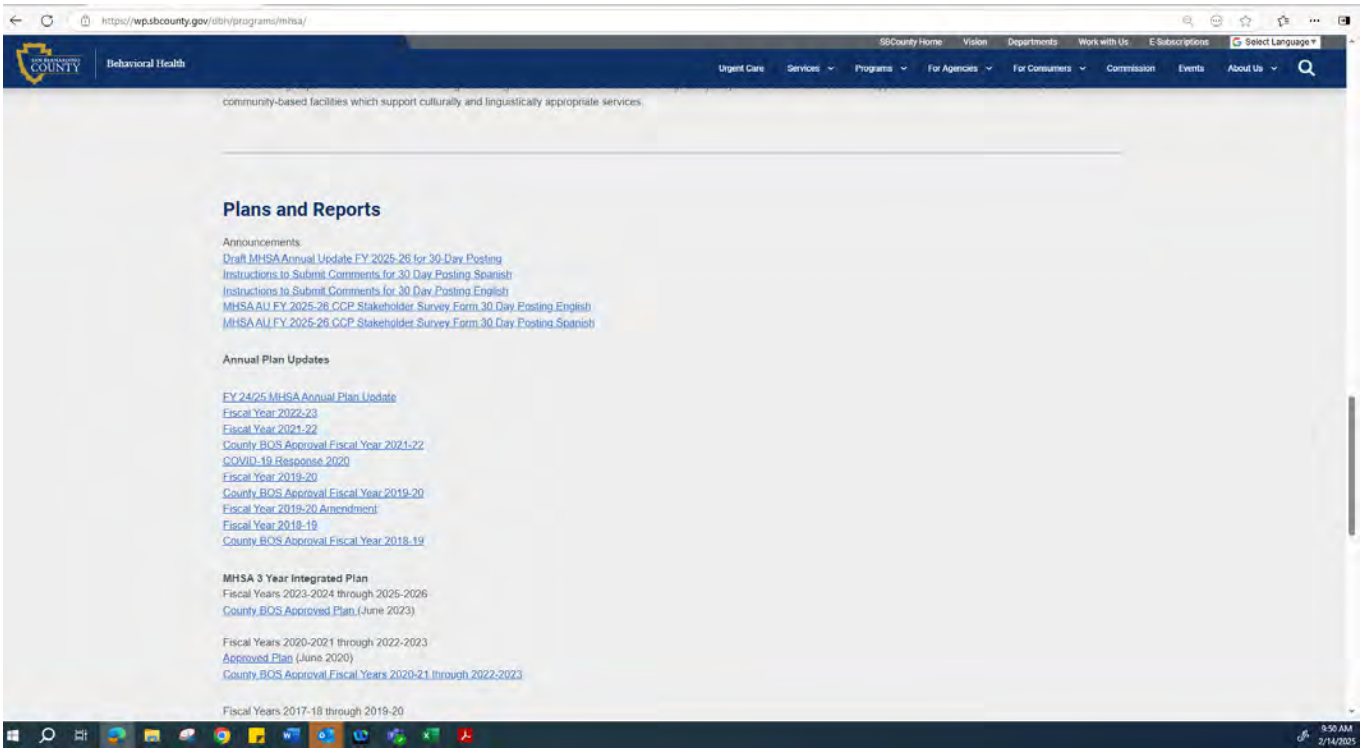
## 30 Day Posting Web Blast




## 30 Day Posting DBH Website Announcement



# 30 Day Posting MHSA Website Announcement



MENTAL HEALTH SERVICES ACT (MHSA)

# Stakeholder Survey Form

*MHSA Annual Update*
*Fiscal Year 2025/2026*
*30-Day Public Comment*

SAN BERNARDINO COUNTY | Behavioral Health

**1. What is your age?**
- ☐ 0-15 years
- ☐ 16-25 years
- ☐ 26-59 years
- ☐ 60+ years
- ☐ Prefer not to answer

**2. What sex were you assigned at birth?**
- ☐ Female
- ☐ Male
- ☐ Prefer not to answer

**3. How do you describe yourself?**
- ☐ Female
- ☐ Male
- ☐ Trans Female/Woman
- ☐ Trans Male/Man
- ☐ Genderqueer
- ☐ Nonbinary
- ☐ Questioning or Unsure of Gender Identity
- ☐ Other/Not Listed: _____
- ☐ Prefer not to answer

**4. Do you consider yourself:**
- ☐ Straight/Heterosexual
- ☐ Gay/Lesbian
- ☐ Bisexual
- ☐ Queer
- ☐ Questioning or Unsure about Orientation
- ☐ Other/Not Listed: _____
- ☐ Prefer not to answer

**5. What is the primary language spoken in your home?**
- ☐ English
- ☐ Mandarin
- ☐ Spanish
- ☐ Vietnamese
- ☐ Other/Not Listed: _____
- ☐ Prefer not to answer

**6. Are you a consumer of mental health services?**
- ☐ Yes (currently)
- ☐ No
- ☐ Yes (previously)
- ☐ Prefer not to answer

**7. Are you a consumer of alcohol and/or drug services?**
- ☐ Yes (currently)
- ☐ No
- ☐ Yes (previously)
- ☐ Prefer not to answer

**8. Are you a friend, family member, or loved one of a consumer of mental health services and/or alcohol and drug services?**
- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

**9. Have you ever served in the military?**
- ☐ Yes (currently)
- ☐ No
- ☐ Yes (previously)
- ☐ Prefer not to answer

**10. Which category best describes your race (i.e., physical/ancestral characteristics)?**
(Check all that apply)
- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ African American/Black
- ☐ Caucasian/White
- ☐ Latinx/Hispanic
- ☐ Native Hawaiian
- ☐ Pacific Islander
- ☐ Multiple races
- ☐ Other (please specify):_____
- ☐ Decline to state

**11. Which best describes your employer:**
- ☐ Community Based Service Provider
- ☐ Federal, State, County, or City Government
- ☐ Nonprofit
- ☐ Private Business
- ☐ Self
- ☐ Student/Intern
- ☐ Not Employed
- ☐ Other/Not Listed: _____
- ☐ Prefer not to answer

Please continue to next page.



**Updated 12/2024**

SAN BERNARDINO COUNTY | Behavioral Health

# Stakeholder Survey Form

*MHSA Annual Update*
*Fiscal Year 2025/2026*
*30-Day Public Comment*

**12. Are you connected to any of the following stakeholder groups (Employed, Affiliated, Represent)?** (Check all that apply)

- ☐ Alcohol and Drug Service Program Providers
- ☐ Area Agencies on Aging
- ☐ Continuum of Care
- ☐ Disability Insurers
- ☐ Education – Early Childhood Organizations
- ☐ Education – K-12 (direct child service)
- ☐ Education – School Districts, and other Agencies (no direct child services)
- ☐ Education – Higher Education Partners, Colleges, Trade Schools
- ☐ Emergency Medical Services
- ☐ Faith Based Organization
- ☐ Healthcare – Behavioral/Mental Health
- ☐ Healthcare – Physical Health
- ☐ Healthcare service plans, including Medi-Cal managed care plans (MCPs)
- ☐ Independent Living Centers
- ☐ Labor Representative Organizations
- ☐ Law Enforcement
- ☐ Regional Centers
- ☐ Social or Human Service Program/Agency
- ☐ Tribal and Indian Health Program designees established for Medi-Cal Tribal consultation purposes
- ☐ Veterans Organization
- ☐ Youth or Youth Mental Health or Substance Use Disorder Organizations/Providers
- ☐ Not Employed
- ☐ Other/Not Listed: _____
- ☐ Prefer not to answer

**13. Do you have a disability or other impairment that is expected to last longer than 6 months and substantially limits a major life activity, which is not the result of a severe mental illness?**

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

**14. Do you live or work in San Bernardino County? If both, list the region you live in:**

- ☐ Central Valley Region
  *e.g., Bloomington, Fontana, Grand Terrace, Rialto*
- ☐ Desert/Mountain Region
  *e.g., Adelanto, Amboy, Apple Valley, Baker, Big Bear City, Cima, Earp, Fort Irwin, Hesperia, Hinkley, Joshua Tree, Landers, Lucerne Valley, Ludlow, Morongo Valley, Mountain Pass, Needles, Nipton, Parker Dam, Phelan, Pioneertown, Sky Forest, Sugarloaf, 29 Palms, Wrightwood, Yermo, Yucca Valley*
- ☐ East Valley
  *e.g., Green Valley Lake, Highland, Lake Arrowhead, Loma Linda, Lytle Creek, Mentone, Patton, Redlands, Rimforest, Running Springs, San Bernardino, Yucaipa*
- ☐ West Valley
  *e.g., Chino Hills, Chino, Guasti, Mt. Baldy, Montclair, Ontario, Rancho Cucamonga*
- ☐ I live and work in a neighboring California County
  Zip Code: _____
- ☐ Prefer not to answer

**15. In the future how would you like to receive MHSA updates?** (Check all the apply)

- ☐ Community Policy Advisory Committee Meetings
- ☐ Webinar
- ☐ Email (Provide email address below)
  Name: _____
  Email: _____
- ☐ Social Media
- ☐ Special meeting in your community
- ☐ Other/Not Listed: _____
- ☐ Prefer not to answer

Thank you for taking the time to complete this survey. Your feedback will help us improve the community planning process to better meet the needs of our community. **All information provided will be kept confidential.**

Please continue to next page.

SAN BERNARDINO COUNTY | Behavioral Health

# Stakeholder Survey Form

*MHSA Annual Update*
*Fiscal Year 2025/2026*
*30-Day Public Comment*

1. **What did you learn about the MHSA Annual Plan Update?**

2. **What else would you like to learn about the MHSA process?**

3. **Do you have any concerns that were not addressed?**

4. **Any additional comments or feedback?**

**Thank you again for taking the time to review and provide feedback.**

LEY DE SERVICIOS DE SALUD MENTAL (MHSA)

# Encuesta para las partes interesadas

*Actualización anual de la MHSA*

*Año fiscal 2025/2026*

*Comentario público de 30 días*

SAN BERNARDINO COUNTY | Departamento de Salud Mental

**1. ¿Cuántos años tiene?**

☐ 0-15 años ☐ 26-59 años
☐ 16-25 años ☐ +60 años
☐ Prefiero no responder

**2. ¿Qué sexo le asignaron al nacer?**

☐ Femenino ☐ Masculino
☐ Prefiero no responder

**3. ¿Cómo se describiría a usted mismo?**

☐ Mujer ☐ Hombre
☐ Mujer transgénero ☐ Hombre transgénero
☐ Queer ☐ No binario
☐ Me cuestiono mi identidad de género o no estoy seguro de ella
☐ Otro/No está en la lista: _____
☐ Prefiero no responder

**4. ¿Cómo se considera ~~a~~ usted mismo?**

☐ Heterosexual ☐ Gay/Lesbiana
☐ Bisexual ☐ Queer
☐ Me cuestiono mi orientación o no estoy seguro de ella
☐ Otro/No está en la lista: _____
☐ Prefiero no responder

**5. ¿Qué idioma principal se habla en su casa?**

☐ Inglés ☐ Mandarín
☐ Español ☐ Vietnamita
☐ Otro/No está en la lista: _____
☐ Prefiero no responder

**6. ¿Usa los servicios de salud mental?**

☐ SÍ (actualmente) ☐ NO
☐ SÍ (en el pasado) ☐ Prefiero no responder

**7. ¿Usa los servicios para consumidores de alcohol o drogas?**

☐ SÍ (actualmente) ☐ NO
☐ SÍ (en el pasado) ☐ Prefiero no responder

**8. ¿Alguno de sus amigos, familiares o seres queridos usa los servicios de salud mental o los servicios para consumidores de alcohol o drogas?**

☐ SÍ ☐ NO
☐ Prefiero no responder

**9. ¿Alguna vez estuvo en el ejército?**

☐ SÍ (actualmente) ☐ NO
☐ SÍ (en el pasado) ☐ Prefiero no responder

**10. ¿Qué categoría describe mejor su raza (es decir, características físicas/ancestrales)?**

(Marque todas las opciones que correspondan):

☐ Nativo de los Estados Unidos o nativo de Alaska
☐ Asiático
☐ Afroamericano/negro
☐ Caucásico/blanco
☐ Hispano/latino
☐ Nativo de Hawái o de otra isla del Pacífico
☐ Más de una raza
☐ Otra/No está en la lista: _____
☐ Prefiero no responder

**11. ¿Qué opción describe mejor a su empleador?**

☐ Proveedor de servicios comunitarios
☐ Gobierno federal, estatal, del condado o de la ciudad
☐ Organización sin fines de lucro
☐ Empresa privada
☐ Trabajador por cuenta propia
☐ Estudiante/practicante
☐ No tengo empleo
☐ Otra/No está en la lista: _____
☐ Prefiero no responder

Continúe en la próxima página.

SAN BERNARDINO COUNTY | Departamento de Salud Mental

# Encuesta para las partes interesadas

*Actualización anual de la MHSA*
*Año fiscal 2025/2026*
*Comentario público de 30 días*

**12. ¿Está usted conectado a alguno de los siguientes grupos de partes interesadas (empleados, afiliados, representantes)?** (Marque todas las opciones que correspondan):

☐ Programa de servicios para consumidores de alcohol y drogas
☐ Agencias de la Tercera Edad
☐ Continuidad de la atención
☐ Aseguradoras de discapacidad
☐ Educación - Organizaciones de la primera temprana infancia
☐ Educación – K-12 (servicios directos de niños)
☐ Educación – Distritos escolares y otras agencias (sin servicios directos de niños)
☐ Educación – Socios de educación superior, colegios, escuelas vocacionales
☐ Servicios de urgencias medicas
☐ Organización religiosa
☐ Atención médica – Salud mental/de comportamiento
☐ Atención médica – Salud física
☐ Planes de servicios de Atención medica, incluidos los planes de atención administrada de Medi-Cal
☐ Centros de vida independiente
☐ Organización sindical representativa
☐ Fuerzas policiales
☐ Centros regionales
☐ Programa/agencia de servicios sociales o humanos
☐ Programa de Salud Tribales y Indígenas de personas designadas establecidas con propósito de consultas para Medi-Cal tribal
☐ Organización de veteranos
☐ Organización/Proveedores de salud mental o trastornos por consumo de sustancias para jóvenes
☐ No tengo empleo
☐ Otra/No está en la lista: _____
☐ Prefiero no responder

**13. ¿Tiene alguna discapacidad o deficiencia que se espera que dure más de 6 meses y que limita considerablemente la realización de una actividad de la vida diaria como resultado de una enfermedad mental grave?**

☐ SÍ ☐ No
☐ Prefiero no responder

**14. ¿Vive o trabaja en el condado de San Bernardino? Si vive y trabaja allí, indique la región en la que vive:**

☐ Región de Central Valley
*p. ej., Bloomington, Fontana, Grand Terrace, Rialto*

☐ Región desértica/montañosa
*p. ej., Adelanto, Amboy, Apple Valley, Baker, Big Bear City, Cima, Earp, Fort Irwin, Hesperia, Hinkley, Joshua Tree, Landers, Ludlow, Morongo Valley, Mountain Pass, Needles, Nipton, Parker Dam, Phelan, Pioneertown, Sky Forest, Sugarloaf, 29 Palms, Wrightwood, Yermo, Yucca Valley*

☐ East Valley
*p. ej., Green Valley Lake, Highland, Lake Arrowhead, Loma Linda, Lytle Creek, Mentone, Patton, Redlands, Rimforest, Running Springs, San Bernardino, Yucaipa*

☐ West Valley
*p. ej., Chino Hills, Chino, Guasti, Mt. Baldy, Montclair, Rancho Cucamonga*

☐ Vivo y trabajo en un condado vecino de California
Código postal: _____

☐ Prefiero no responder

**15. En el futuro, ¿cómo le gustaría recibir las actualizaciones de la MHSA?** (Marque todas las opciones que correspondan)

☐ En las reuniones del Comité Asesor de Políticas Comunitarias
☐ En un seminario por internet (reunión virtual)
☐ Por correo electrónico (escriba su correo electrónico abajo)
Nombre: _____
Correo electrónico: _____
☐ Por redes sociales
☐ En una reunión especial de la comunidad (escriba su información de contacto abajo)
Nombre: _____
Correo electrónico: _____
Número de teléfono: _____
☐Otra/No está en la lista: _____
☐ Prefiero no responder

Continúe en la próxima página.

SAN BERNARDINO COUNTY | Departamento de Salud Mental

# Encuesta para las partes interesadas

*Actualización anual de la MHSA*

*Año fiscal 2025/2026*

*Comentario público de 30 días*

Gracias por tomarse el tiempo para completar esta encuesta. Sus comentarios nos ayudarán a mejorar el proceso de planificación comunitaria para satisfacer mejor las necesidades de nuestra comunidad. **Toda la información brindada será confidencial.**

Continúe en la próxima página.

Departamento de Salud Mental

# Encuesta para las partes interesadas

*Actualización anual de la MHSA*

*Año fiscal 2025/2026*

*Comentario público de 30 días*

1. **¿Qué aprendió sobre la actualización del plan anual de la MHSA?**

2. **¿Qué más le gustaría saber del proceso de la MHSA?**

3. **¿Tiene alguna otra inquietud que no se haya tratado en este debate?**

4. **¿Tiene algún otro comentario?**

**Gracias de nuevo por tomarse el tiempo para revisar la encuesta y hacer comentarios.**

303 E. Vanderbilt Way, San Bernardino, CA 92415-0026 | Phone: 909.252.5142 Fax: 909.890.0435
www.SBCounty.gov

SAN BERNARDINO COUNTY

# Behavioral Health Commission

GENERAL SESSION AGENDA
Thursday April 3, 2025, 12:00pm – 2:00pm
County of San Bernardino Behavioral Health Services Auditorium
850 East Foothill Boulevard Rialto, CA 92376
Satellite Locations:
Apple Valley Clinic 18818 Highway 18 Apple Valley, CA 92307
Yucca Valley/Morongo 58945 Business Center Drive Yucca Valley, CA 92284
*If you require ADA accommodations (ASL Interpreter, other communication devices, or other interpreter services), please contact the Office of Equity and Inclusion at (909) 252-5150 prior to the meeting.

ALL MEETINGS OPEN TO THE PUBLIC

District 1
Lorrie Denson
Amanda Uptergrove
Jonathan C. Cahow

District 2
Dr. Valerie Samuel
Jennifer Oglesby, *Secretary*
Michael A. Hall

District 3
Allie Mink, *Chair*
Troy Mondragon
VACANT

District 4
Jennifer Spence
Delinia Lewis
VACANT

District 5
Veatrice Jews
Lynn Summers, *Treasurer*
Eloisa Contreras

Board of Supervisors
Jesse Armendarez, 2nd District

Clerk of the Commission
John Granado

| | POST IN PUBLIC VIEW |
|---|---|
| CALL TO ORDER<br>Pledge of Allegiance<br>Roll Call / Introductions<br>Satellite Location Introductions | Allie Mink, Chair |
| MINUTES<br>*Tab 5:* Review and approve General Session minutes from February 6, 2025 & March 6, 2025 | Members of the Commission |
| PUBLIC COMMENTS<br>Rialto Public Comments<br>Satellite Location Public Comments | |
| **CHAIR'S REPORT** | Allie Mink, Chair |
| COMMISSIONER REPORTS | Members of the Commission |
| SUBJECT MATTER PRESENTATION<br>*Tab 6:* MHSA Annual Update | Dr. Rebecca Scott Young |
| **DIRECTOR'S REPORT**<br>*Tab 1a:* Report and BOS Items | Dr. Georgina Yoshioka, Director |
| ADJOURNMENT | Allie Mink, Chair |

To request information/data regarding services, demographics, or to submit a Public Records Act Request, visit: https://sanbernardinocounty.nextrequest.com/.

Written materials for this meeting are available by request or at:

https://wp.sbcounty.gov/dbh/bhc.

**From:** San Bernardino County <sbcounty@public.govdelivery.com>
**Sent:** Friday, March 28, 2025 2:58 PM

**Subject:** Public Hearing for Mental Health Services Act (MHSA) Annual Update

Having trouble viewing this email? View it as a Web page.

SAN BERNARDINO COUNTY

# News Release

**For Immediate Release**
March 28, 2025

Miranda Canseco
Administrative Manager
Department of Behavioral Health

miranda.canseco@dbh.sbcounty.gov

## Public Hearing for Mental Health Services Act (MHSA) Annual Update



*Behavioral Health Commission Meeting*

The San Bernardino County Department of Behavioral Health (DBH) invites community members to a public hearing on Thursday, April 3, 2025, from noon to 2 p.m. The hearing will cover topics related to behavioral health services, program goals, and other relevant outcomes described in the draft Mental Health Services Act (MHSA) annual update for fiscal year 2025/26.

The public hearing will be conducted at the Behavioral Health Commission general session meeting on Thursday, April 3, 2025, from noon to 2 p.m. at the County of San Bernardino Health Services Building Auditorium, 850 E. Foothill Blvd., Rialto, CA 92376. A satellite location will also be available at the Department of Behavioral Health Apple Valley Community Clinic, 18818 Highway 18, Apple Valley, CA and the Family Resource Center at 58945 Business Center Drive Yucca Valley, CA 92284.

The draft plan is a comprehensive report that illustrates the impact made by DBH and its contracted partners in addressing San Bernardino County's behavioral health needs. This report also includes the proposed changes to MHSA programming for the upcoming fiscal year.

For more information on the public hearing, language interpretation services, and/or requests for disability-related accommodations, please call (800) 722-9866 or dial 7-1-1 for TTY users.

The Department of Behavioral Health supports the Countywide Vision by providing behavioral health and substance use disorder services that promote community wellness, recovery and resiliency. Information on the Countywide Vision and DBH can be found at www.sbcounty.gov.

**About San Bernardino County:** San Bernardino County is a diverse public service organization serving America’s largest county that for two consecutive years has led the nation in awards for innovation, efficiency, and outstanding public service. We are governed by an elected Board of Supervisors and dedicated to creating a community where nearly 2.2 million residents can prosper and achieve well-being in fulfillment of the Countywide Vision. It is comprised of 42 departments and agencies, which are staffed by more than 23,000 public service professionals who provide a wide range of vital services in the areas of public safety, health care, social services, economic and community development and revitalization, fiscal services, infrastructure, recreation and culture, and internal support. For more information, visit sbcounty.gov.

Public Hearing DBH email notice

MEETINGS




# County Inviting Community to Mental Health Public Hearing

San Bernardino County's Department of Behavioral Health (DBH) invites community members to a public hearing from noon to 2 p.m. Thursday, April 3, at the DBH Apple Valley Community Clinic (18818 Highway 18, Apple Valley).

The meeting is to discuss behavioral health services, program goals, and outcomes outlined in the draft Mental Health Services Act (MHSA) annual update for fiscal year 2025/26.

This comprehensive report details the impact of DBH and its partners on the county’s behavioral health needs and proposed programming changes.

For more details on the hearing, call (800) 722-9866.

303 E. Vanderbilt Way, San Bernardino, CA 92415-0026 | Phone: 909.252.5142 Fax: 909.890.0435
www.SBCounty.gov

SAN BERNARDINO COUNTY

**Behavioral Health**
**Administration**

**Dr. Georgina Yoshioka, DSW, MBA, LCSW**
Director

**Jennifer Alsina, MBA**
Assistant Director

**Marina Espinosa, MPA**
Assistant Director

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The Press-Enterprise
The Weather Group
Tri-Community NewsPlus
Univision
Valleywide Newspapers
Victorville Daily Press
Westside Story Newspaper
Yucaipa/Calimesa News Mirror
Yucca Valley TV

# *Assessment of Behavioral Health Needs and Capacity*

PREPARED FOR
SAN BERNARDINO COUNTY

BY
HEALTH MANAGEMENT ASSOCIATES

CHARLES ROBBINS, MBA
ROB MUSCHLER, MPA
RACHEL JOHNSON-YATES, MA, LMHC, LAC
PAUL FLEISSNER
GABRIEL VELAZQUEZ, MPH
CAMI COLLINS

DATE
AUGUST 30, 2024

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METHODOLOGY ..... 5

FINDINGS ..... 8

RECOMMENDATIONS ..... 23

CONCLUSION ..... 33

APPENDIX ..... 34

## EXECUTIVE SUMMARY

Health Management Associates (HMA) was contracted by the San Bernardino Department of Behavioral Health (DBH) to assess behavioral health needs and capacity, including workforce needs, and utilize a methodology for determining near-real-time system capacity for SUD residential services.

HMA utilized a mixed-method approach to conduct the assessments. Strategies for qualitative and quantitative data collection are highlighted below:

- Collected and analyzed available data on client services, demographics, capacity data, and workforce needs.
- Conducted interviews with outpatient and residential behavioral health providers, culturally specific organizations, social service agencies, and school district representatives, amongst others to solicit their input on system strengths and areas for improvement.
- Facilitated focus groups where 220+ individuals with lived experience shared their stories and experiences.
- Administered a community survey that received 232 responses regarding system strengths, barriers, and unmet needs.
- Convened townhalls as a forum to hear additional input from community members.

The qualitative and quantitative data gathered was presented to a team of DBH staff – called the Core Team – that represented a cross-section of departments to review, discuss, and inform recommendation development. These same data were also presented to a Community Advisory Group (CAG) that was convened to support this process. The CAG included representatives from community-based organizations working in and around the behavioral health system. Findings from the data collection efforts are summarized in this document, with additional details provided in the addendum.

HMA used the collected data and insights from discussions with the Core Team and CAG to develop recommendations for addressing identified areas in need of improvement. The recommendations are organized under the following areas:

1) Expand Access to High-Quality Services
2) Improve Service Integration and Coordination
3) Enhance External Communication and Engagement
4) Strengthen Administrative and Operational Processes
5) Address Workforce Challenges

The recommendations outlined in this report will build on the strong foundation of behavioral health services in San Bernardino County and help to support further enhancements to the behavioral health system and the CPP.

## INTRODUCTION

The San Bernardino Department of Behavioral Health (DBH) provides mental health and substance use disorder services to county residents who are experiencing serious mental illnesses (SMI) and/or substance use issues and are uninsured or insured through Medi-Cal, as well as individuals experiencing a behavioral health crisis. DBH serves all age groups and provides an array of prevention, early intervention, and treatment services for both mental health and substance use.

Nearly fifty DBH programs, services, and actions are supported through the Mental Health Services Act (MHSA), a state funded program designed to "reduce the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness". All MHSA programs are stakeholder informed and developed via a required Community Program Planning (CPP) process.

The Behavioral Health Continuum Infrastructure program (BHCIP), funded through the Department of Health Care Services (DHCS) provides investments in infrastructure funding alongside significant new state and federal resources to address homelessness, support healthcare delivery reform, and strengthen the social safety net. Together these commitments will address historic gaps in the behavioral health continuum to meet growing demand for services and supports. This funding opportunity allows DBH the ability to meet the needs of vulnerable populations with the greatest barriers to access, including people experiencing homelessness and justice involvement, utilizing direct stakeholder engagement and feedback.

Substance Use Disorder and Recovery Services (SUDRS) supports the recovery efforts of individuals by providing a drug and alcohol free sober social environment and other recovery resources by providing a full range of substance use disorder (SUD) treatment services and education. SUDRS services are offered through contracts with community-based organizations (CBOs) and county-operated clinics to promote prevention, intervention, recovery and resiliency for individuals (adolescents ages 12-17 and adults 18+) and families. SUD treatment services utilize the American Society of Addiction Medicine (ASAM) Criteria to determine appropriate level of care for covered SUD treatment services. SUDRS services are funded by multiple funding sources, which are informed by stakeholder engagement.

Health Management Associates (HMA) was contracted by DBH to assess behavioral health needs and capacity, including workforce needs, and utilize a methodology for determining near-real-time system capacity for SUD residential services. The following analysis highlights program strengths, challenges, and provides recommendations for areas of opportunity.

## METHODOLOGY

HMA utilized a mixed-method approach to conducting the assessment of the behavioral health system in San Bernardino County. Below is a summary of the primary domains of the assessments:

- Behavioral health system and workforce needs
- Behavioral health needs of unserved and under-served residents
- Cultural and linguistic needs of residents
- Linguistic capacity, provider diversity, and education and training needs for the behavioral health workforce

HMA met early in the process with key members of the San Bernardino Department Behavioral Health (DBH) to build a thorough understanding of the behavioral health ecosystem and current CPP. San Bernadino County, with a diverse array of public, private, and non-profit partners, provides a dynamic portfolio of behavioral health services that is ever evolving to meet the needs of San Bernadino residents. The unique geographic nature, including the sheer size of the county, creates unique demands on the behavioral health system.

The County plays a critical role in identifying behavioral health needs, disparities, and inequities across the behavioral health service system. The County also distributes funds, develops partnerships, networks of services, identifies, and supports the creation of evidence-based practices, and provides services. Because of the heightened need for behavioral health services since the COVID-19 pandemic and the availability of increased state and federal funding San Bernadino has added new partners and new services with a strong focus on equity leveraging these funds, but they continue to experience service gaps and barriers.

HMA leveraged these early discussions and collaboratively designed the project approach outlined below.

### Project Oversight

HMA and DBH created a project oversight structure to ensure the effective gathering of information and a collaborative approach to conducting the assessments. Three distinct groups were formed:

- A **Core Team** with representatives from a cross-section of DBH programs was convened to support data collection, review findings, and inform recommendation development. The Core Team met six times.
- A **Community Advisory Group (CAG)** with representatives from community-based organizations was convened to similarly review findings and inform recommendation development, but from an external perspective. The CAG met twice.
- Lastly, a **Project Management Team** with representatives from DBH leadership and various programs was established to support project management, coordination, and oversight. This group was tasked with supporting data collection and access to individuals and organizations to

engage in the assessment effort. The Project Management Team met approximately bi-weekly from December 2023 to June 2024.

### Data Collection Methods

Below is a brief overview of the primary quantitative and qualitative data collection efforts utilized in the assessment process. This is not meant to capture everything that was reviewed or incorporated into this effort, but instead offer an overview of primary sources and engagement efforts.

Quantitative Data Collection and Document Review: HMA relied on DBH staff to provide available data on client services, demographics, capacity data, and workforce needs to better understand the behavioral health system and needs. The analysis below is based on the data received. Additional information and materials were also collected and reviewed, such as the Mental Health Services Act Plan and Annual Updates, Cultural Competency Plan, applicable regulations, presentations to the Behavioral Health Commission and other bodies, and other previously developed reports and presentations outlining behavioral health and workforce needs.

Community Planning Process Observation: HMA consultants attended several meetings (both virtually and in-person) that were a part of the Community Planning Process. During these meetings, HMA consultants gathered and tracked several observational findings outlined in the section below.

Stakeholder Interviews: HMA interviewed individuals from nine separate organizations to build an understanding of the landscape and inform future data collection efforts.[1] Organizations engaged included outpatient and residential behavioral health providers, culturally specific organizations, social service agencies, and school district representatives, amongst others. In several instances, multiple individuals from an organization were interviewed. The interviews were broadly structured around an assessment of Strengths, Weaknesses, Opportunities, and Threats, as well as questions about the Community Planning Process. Interviewees were assured confidentiality to allow for candid responses. Their feedback was summarized and presented to the Core Team and CAG to review and reflect on.

Community Survey: HMA developed a web-based survey specifically designed to collect qualitative information in a person-centered, transparent, and culturally sensitive way. This survey was advertised through the distribution of a flyer in both English and Spanish. DBH distributed the flyers which included links/QR codes to the survey. The survey asked questions about the respondent's relationship to behavioral health services and their perspectives on the strengths, unmet needs, and barriers of the local behavioral health system, as well as disparities in care and opportunities for improvement. The survey was anonymous with the results analyzed by HMA. Data was disaggregated by respondent type – i.e., consumers of behavioral health services vs. providers of services – to better analyze findings. Findings were presented to the Core Team and CAG to review and reflect on. The community survey received 232 responses, with the demographic profile of respondents aligning with the overall demographics of the community.

[1] Asian American Resource Center, Boys Republic, Inland Empire Health Plan, Ontario-Montclair School District Counseling Center, Pacific Clinics, Reach Out, Riverside-San Bernardino County Indian Health, San Bernardino County Behavioral Health, South Coast Counseling Services

Focus Groups: HMA conducted a series of focus groups with individuals with lived experience with behavioral health conditions to gather their perspectives. These focus groups included individuals engaged in a variety of mental health and substance use services – including services funded by DBH. Focus groups were convened with the support of local behavioral health service providers, word-of-mouth information sharing, and the distribution of flyers in both English and Spanish.

Three focus groups were convened in person with another four convened virtually, and participants were compensated for their time and wisdom (30 gift cards of $50 value were provided to participants of the in-person focus groups and 90 gift cards of $25 value were provided electronically to participants of the virtual focus groups for a total of $3,750). In-person focus groups were attended by an HMA consultant who could interpret in Spanish, as needed. When registering for the virtual focus group(s) participants were asked to indicate if language interpretation was needed and if so, whether they preferred Zoom auto-translation or interpretation from an HMA team member. Auto-translation and/or interpretation services were then offered to those who requested them.

During the focus group(s), participants were asked about their experiences with the behavioral health system, barriers to access, unmet needs, and strengths. They were also asked to score – on a scale from 1 to 5 – the county's ability to engage clients in developing programs/services and in communicating about programs/services. HMA conducted seven focus groups (3 in-person and 4 virtually) with a total of 222 participants. Below is a list of the groups engaged:

- Yucca Valley Clubhouse – Monday, July 8th, *in person*
- Yucca Valley Family Resource Center – Monday, July 8th, *in person*
- Rialto Clubhouse – Tuesday, July 9th, *in person*
- Individuals who have experience with substance use and mental health services
    - Monday, August 12th, *virtual*
    - Monday, August 12th, *virtual*
    - Wednesday, August 14th, *virtual*
    - Monday, August 19th, *virtual*

Subcommittee Meeting: HMA also attended and facilitated a discussion at the African American Awareness Subcommittee meeting on August 19th, convened by DBH. Participants were encouraged to share their personal experiences with mental health and behavioral health services in San Bernardino County.

Townhalls (2): HMA promoted and convened two virtual townhall meetings on August 19th and August 21st. The townhalls were intended to be opportunities to share findings from the assessment process as well as solicit additional feedback from the community. Flyers in English and Spanish were created by HMA and distributed by San Bernardino County to promote the event. A total of 6 individuals were in

attendance between the two townhalls. As a result, limited additional data was collected from these efforts.

## FINDINGS

HMA utilized a combination of data analysis, document review, and community engagement throughout the project to assess trends and identify areas of need within the Mental Health Services Act (MHSA) programming in San Bernardino County. These engagements allowed HMA to gather diverse perspectives from data, individuals with lived experience, community members, service providers, and other key stakeholders. Through these efforts, valuable insights were gained regarding the effectiveness of current programs and critical gaps in services across the county.

Key findings are outlined in the sections below. They are broken down by the strengths and opportunities for improvement/unmet needs that emerged from the qualitative data collection methods, with findings related to the assessment of behavioral health system capacity, followed by sections that focus on the cultural, linguistic, and workforce needs identified through data analysis, as well as the residential substance use services capacity assessment.

### Qualitative Feedback- Strengths

Feedback from the community survey, interviews, focus groups, and discussions with the Core Team and CAG revealed numerous strengths of the behavioral health system and the County's behavioral health services. The feedback has been organized by four primary themes:

1) Provider Collaboration
2) Service Availability and Accessibility
3) County Engagement Efforts
4) Effectiveness of Services

***Provider Collaboration***

Provider collaboration was indicated as one of the primary strengths during the evaluation process. It was reported that, despite some gaps in the system, providers work closely together to support collaboration and effective care. There is also a sense of comradery and collaborative problem-solving that are seen as assets to the local community. Some specific examples include the following:

- Providers in the county reported that they have a strong network of provider organizations that support one another in terms of meeting agency goals and providing care for clients.
- Forums for collaboration are in place and operating smoothly to ensure collaboration and partnership across agencies.
- Providers are motivated to expand their knowledge regarding the array of services that may be available to clients. Often this connection and networking is done via word of mouth.

- Service recipients report feeling supported by their recovery and treatment networks and that they are actively being connected with the resources they need.

***Service Availability and Accessibility***

Many of the interviewees described an acknowledgment of the County's efforts over the past several years to improve access and availability of services to the community. They reported that these areas of inquiry have improved recently in many high-need areas.

- Providers report that there is a diverse set of services across the continuum available to the community.
- The community appreciates the recent expansion of services including:
    - School-based treatment
    - Telehealth
    - Clubhouses
- Service recipients stated that they were generally knowledgeable about and aware of the various types of services in the county that may benefit them.

***County Engagement Efforts***

Providers reported valuing their relationship with the County and appreciated their ongoing efforts to be collaborative partners through communication efforts, pursuit of funding, and dedication to county-wide behavioral health progress.

- Providers perceived the County to be invested in the well-being and outcomes of providers and persons served.
- Providers noted that the County proactively seeks ongoing funding to support the maintenance and enhancement of services in the county.
- The County is recognized for becoming more data-driven, though this is an ongoing effort.
- The County is perceived to generally be open to receiving feedback.
- The County actively works to build partnerships between provider organizations.

***Effectiveness of Services***

The qualitative analysis revealed that the community values the behavioral health services offered and believes them to be effective. They responded that the myriad of services offers a strong foundation for recovery and that providers are generally regarded with high esteem.

- One-on-one therapy services are highly valued, with participants noting significant positive impacts on their mental health and well-being.

- Participants reported a high appreciation of available services such as mental health providers, clubhouses, and social security benefits.
- Interviewees found significant value in clubhouse support groups (e.g., grief, mindfulness support, co-dependency, and substance use groups).
- Participants highlighted effective programs including sober living facilities (e.g., Cedar House, River Community, Caso Paseo), supportive social workers, and coordinated primary care services.

## Qualitative Feedback- Opportunities for Improvement and Unmet Needs

In addition to the strengths identified through the survey, interviews, focus groups, and engagement with the Core Team and CAG, these efforts also revealed opportunities for improvement and unmet needs. Each of the areas listed is perceived to have a significant impact on provider efficacy and client outcomes. Respondents indicated that enhancements in these areas would significantly improve the continuum of care and the overall well-being of behavioral healthcare consumers in San Bernadino County. The feedback has been organized by seven primary themes:

1) Access and Service Availability
2) Cultural Responsiveness and Disparity Reduction
3) Workforce
4) Implementation of New Initiatives
5) Internal and External Collaboration
6) Operations
7) Community Engagement

***Access and Service Availability***

While access and service availability have significantly improved over the past several years, gaps in the county's continuum of care persist. Respondents identified several areas with opportunities for improvement.

- There is a need for centralized communication and advertisement of resources in the community to minimize duplication of effort and ensure that providers and service recipients are aware of the services available to better access and coordinate care.
- Waitlists for care can be significant, particularly when they require an appointment with a psychiatrist. One interviewee estimated that it could take up to 6 months to receive intensive services given staffing shortages and bureaucratic delays.
- While the continuum of care is improving, there are several gaps that continue to exist. Areas identified by community partners and subject matter experts include:

    - Substance use disorder treatment
        - School-based
        - Residential
        - Medication management
        - Incentive-based programs
    - Inpatient psychiatric treatment
    - Crisis walk-in centers (sites in additional geographies)
    - Suicide prevention
    - Mental health management
    - Children/youth services
    - Clubhouses
- Providers often have limited hours of operation which restricts access to those who have daytime employment.
- Participants also described differences in access based on geographic location. San Bernardino is the largest in the United States, which creates a unique set of challenges. Providers noted a need for greater creativity and flexibility in how services are offered to improve access.
- Members of the African American Awareness Subcommittee expressed that services are not being brought or offered to them directly (through schools, health centers, etc.), but rather required them to seek out and navigate the complexities of access, eligibility, and outreach on their own.

***Cultural Responsiveness and Disparity Reduction***

Respondents noted several behavioral health outcome disparities that are present in the county. During the qualitative inquiry, HMA learned of many specific opportunities for improvement in this area that could promote more equitable outcomes for the community.

- There is a need for more specialized, culturally responsive services that are tailored to the specific needs of underserved populations, specifically the Black, Indigenous, and People of Color (BIPOC) population and the LGBTQIA+ population.
    - Members of the African American Awareness Subcommittee noted feeling an 'outside in' perspective of the resources and services available to their community.
- The County and Providers have limited outreach and trust with marginalized communities, especially the BIPOC community, potentially contributing to existing disparities.
- There is a significant need to increase language access to services for people who have limited English proficiency.

- There is a need for increased sign language interpreters.
- Social Determinants of Health can hinder access. Lack of transportation and need for stable housing were mentioned the most frequently with food insecurity and lack of clothing also identified in discussions.
    - Respondents also indicated that the public bus system has limited service hours, especially on weekends, and that the wait for a bus can be lengthy.

***Workforce***

Similar to national trends, San Bernadino County providers are struggling to recruit and retain qualified and skilled behavioral health professionals. This leads to significant gaps in client services, long waitlists, and decreased access across the system.

- Behavioral Health workforce continues to be a primary barrier to meeting the needs of persons served. Respondents noted two primary areas of concern:
    - General behavioral health staffing shortages, with the lack of psychiatrists and experienced therapists being the most significant concern.
    - Inability to pay competitive wages leading to trouble with recruiting and retention of staff.

***Implementation of New Initiatives***

Respondents were knowledgeable and understanding of the many intersecting requirements involved in the county-wide implementation of new initiatives but expressed that past initiatives could have benefitted from more intentional project oversight and communication. The lack of these efforts resulted in frustrating complications and administrative burden for providers.

- Providers reported that implementation of new initiatives could be more effective, and completed in a shorter timeframe if there were stronger planning, project management, and coordination.
- Lack of coordination and clarity of expectations has resulted in anxiety-inducing uncertainties and often extra administrative burden on providers. This burden impacts the accessibility of care for persons served.
- CalAIM and related initiatives were perceived to have slower and less clearly communicated rollouts in San Bernardino than in other counties which led to confusion, challenges, and implementation delays that were seen as bad for organizations and consumers.

***Internal and External Collaboration***

Participants acknowledged that the County has been continually improving collaboration efforts with the State and providers over the past several years, however, there continue to be opportunities for increased efficacy in this area.

- Providers report that there is often a delay in responses to questions, contract amendments, and decision-making within the County. Providers described not being able to get answers to – what they viewed as simple questions – which has had negative impacts on their financial stability and ability to provide services. One participant noted waiting over a year to get approval to use a subcontracted psychiatrist, which delayed patient care. While many providers noted that this was likely due to County staffing vacancies, they also named the lack of department-to-department coordination as another primary cause.

***County Operations***

Participants described experiences of systemic fragmentation unnecessarily complicating access to services. It appeared that various systems had been designed and implemented over the years but did not work together in a smooth manner. Thus, referrals are negatively impacted, and potential service recipients discontinue efforts to engage before they are connected with care.

- Interviewees reported that accessing County services can be complicated for clients and ultimately results in clients not accessing the care that they need.
- Respondents indicated that they felt that service connection required too many calls, steps, and requirements to access care.
- It was also indicated that there are linguistic, cultural, and educational barriers to the care connection process. They felt that the process should be simplified and designed with the target audience in mind, namely, historically underserved communities.
- Providers reported that the financial review and audit processes are punitive and do not reflect the realities of service provision. Interviewees gave examples of audit-based repayments occurring years after service delivery that felt unreasonable and jeopardized the financial stability of their organization. Substantial delays in review limit the provider's ability to satisfy County requests for additional information/documentation.

***Community Engagement***

Participants described an expectation similar to the national trend of "nothing about us without us." In practice, this concept means that services are designed and progressively adjusted based on ongoing, meaningful engagement and feedback from the community.

- Interviewees stated that they would like the County to have more engagement with its community to gain input and feedback regarding new and existing programming.

**Summary of Qualitative Findings**

Below is a summary of key findings from the qualitative assessment process, outlined in a Strengths, Weaknesses, Opportunities, and Threats (SWOT) table.

*Table 1. Qualitative SWOT Analysis*

| Strengths | Weaknesses |
|---|---|
| • Consumers value the services they receive<br>• Strong network of local providers<br>• Existing forums for collaboration<br>• Historically strong relationship between providers and the County<br>• Diverse continuum of services<br>• Increasing openness to behavioral health services among youth<br>• A willingness to learn and improve shown by the County | • Limited awareness of available services<br>• Need for more culturally-specific services, particularly for BIPOC and LGBTQIA+ communities<br>• Need for expanded SUD, residential, and crisis services<br>• Long waitlists and delays in care<br>• Slow implementation of new initiatives (e.g., CalAIM-related services)<br>• Significant administrative burden and duplication of effort<br>• Need for improved collaboration/ coordination between the state, county, and providers<br>• Overly punitive financial audits<br>• Complicated processes to access care<br>• More intentionality and clarity regarding the Community Planning Process |
| **Opportunities** | **Threats** |
| • Explore creative and flexible strategies to increase access to services<br>• Expand/expand access to culturally-specific services<br>• Improve the project management and communication around the implementation of new initiatives<br>• Improve coordination between County departments | • Behavioral health workforce challenges<br>• County size is a challenge to access<br>• Continuing changes tied to statewide behavioral health transformation (e.g., CalAIM, Prop 1, etc.) |

## Data Analysis – Population Assessment, Cultural and Linguistic Needs

HMA reviewed available data provided by the Department of Behavioral Health (DBH) – as well as data from other publicly available sources – to support an assessment of the cultural and linguistic needs of served and unserved county residents.

The initial domain for review was a comparison between the demographic of the county, compared to DBH clients (see table 2 below). Reviewing these data shows that Black residents are overrepresented in

the client population compared to county residents as a whole, as well as Other/Unknown. Hispanic/Latino residents are underrepresented by nearly 11%, while Asians are underrepresented by 6.3%. White residents are also underrepresented in the client population served by DBH, but to a lesser degree (1.3%).

**Table 2. Race/Ethnicity of Clients, Staff, and Community (2023/24)**

| Race/Ethnicity | SB County Residents* | DBH Clients | County Resident/Client Differential |
|---|---|---|---|
| Hispanic/Latino | 56.2% | 45.3% | -10.90% |
| White | 24.1% | 22.8% | -1.30% |
| Black/African American | 7.3% | 14.7% | 7.40% |
| Asian | 8.5% | 2.2% | -6.30% |
| Native American | 0.2% | 0.4% | 0.20% |
| Other/Unknown | 3.7% | 14.5% | 10.80% |

**U.S. Census Bureau, American Community Survey 2022, 1-Year Estimates, Demographic and Housing Estimates (DP05)*
*Source: San Bernardino County, Department of Behavioral Health*

While county-wide race/ethnicity data is important to review and understand, the racial/ethnic breakdown of Medi-Cal enrollees may be a better indicator to review as this is the primary funding mechanism/eligibility criteria for DBH services. Table 3 below captures statewide Medi-Cal enrollee data as well as San Bernardino-specific data, compared to the race/ethnicity of DBH clients. The data show that 57.7% of Medi-Cal enrollees in San Bernardino are Hispanic/Latino, compared to only 45.3% of clients. We also see fewer Asian/Pacific Islander clients compared to the proportion of county-wide enrollees. Conversely, we see an overrepresentation in the White and Black client population as compared to Medi-Cal enrollees.

**Table 3. Statewide and County Medi-Cal Enrollees, by Race/Ethnicity, and DBH Clients (2023/24)**

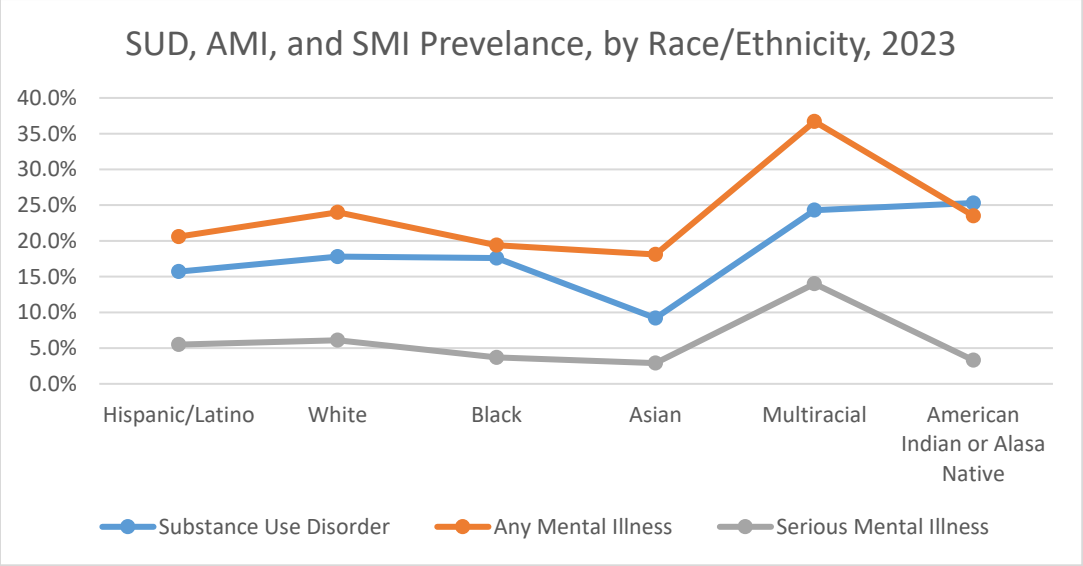
| Race/Ethnicity | Statewide Medi-Cal Enrollees* | San Bernardino Medi-Cal Enrollees* | DBH Clients | SB Medi-Cal Enrollees/Client Differential |
|---|---|---|---|---|
| Hispanic/Latino | 51.5% | 57.7% | 45.3% | -12.4% |
| White | 16.0% | 15.1% | 22.8% | 7.7% |
| Black/African American | 6.8% | 9.8% | 14.7% | 4.9% |
| Asian/Pacific Islander | 9.3% | 5.1% | 2.2% | -2.9% |
| American Indian/Alaska Native | 0.0% | 0.2% | 0.4% | 0.2% |
| Not Reported | 16.1% | 12.1% | 14.5% | 2.4% |

*Sources: California Health and Human Services, California Department of Healthcare Services, San Bernardino County, Department of Behavioral Health*
**Medi-Cal enrollment data for April 2024.*

According to prevalence data produced by the Substance Abuse and Mental Health Services Administration (SAMHSA), rates of substance use and mental health conditions by race/ethnicity are fairly similar, with some notable exceptions (see figure 1 and table 4 below). For substance use disorder, we see the highest rates for the American Indian or Alaska Native populations (25.3%) and Multiracial (24.3%), with much lower than average rates for Asians (9.2%). For Serious Mental Illness (SMI), we see much higher than average rates for Multiracial (14.0%), with similar rates for other races/ethnicities. This same national survey also found that Asian, Black, and Hispanic adults were less likely than White adults to have received mental health treatment for either an SMI or any mental health disorder. There were only minimal differences in SUD treatment by race/ethnicity. While these data are imperfect, they provide a general sense of anticipated prevalence of mental health and substance use disorders and treatment.

Given these data, we would expect to see a larger proportion of Native American individuals engaged in substance use services. We would also expect to see engagement rates in mental health services that are proportional to the overall population. This would signify an underrepresentation of the Hispanic/Latino populations in current behavioral health services.

**Figure 1. Substance Use Disorder, Any Mental Illness, and Serious Mental Illness, by Race/Ethnicity (2023)**




*Source: National Survey on Drug Use and Health, SAMHSA, 2023*

**Table 4. Substance Use Disorder, Any Mental Illness, and Serious Mental Illness, by Race/Ethnicity (2023)**

| Race/Ethnicity | Substance Use Disorder* | Any Mental Illness** | Serious Mental Illness*** |
|---|---|---|---|
| Hispanic/Latino | 15.7% | 20.6% | 5.5% |
| White | 17.8% | 24.0% | 6.1% |
| Black | 17.6% | 19.4% | 3.7% |
| Asian/Pacific Islander | 9.2% | 18.1% | 2.9% |
| Multiracial | 24.3% | 36.7% | 14.0% |
| American Indian or Alasa Native | 25.3% | 23.5% | 3.3% |
| **Overall** | **17.1%** | **22.8%** | **5.7%** |

*Source: National Survey on Drug Use and Health, SAMHSA, 2023*
**People aged 12 or older with substance use disorder in the past year*
***Adults aged 18 or older with any mental illness in the past year*
****Adults aged 18 or older with a serious mental illness in the past year*

In reviewing more localized data produced through the California Health Interview Survey, we see that of individuals with a self-reported mental health or substance use issue, Hispanic/Latino individuals were least likely to receive help (51.1%), followed by Asian (50.9%), and Black (48.3%). Compared to the statewide rates, we see that Black residents of San Bernardino County are less likely to receive help compared to Black residents statewide. The same is true for White residents and Hispanic/Latino residents to a lesser extent. Asian residents and residents that identify as Two or More Races were more likely to receive care then their statewide peers. Although local data is not available for the American Indian/Alaska Native population due to data instability, this population is least likely to receive treatment statewide.

**Table 5. Individuals with Self-Reported Mental/Emotional and/or Alcohol/Drug Issues Who Did Not Receive Help, by Race/Ethnicity (2018 - 2022)**

| Race/Ethnicity | San Bernardino County | California | County/State Differential |
|---|---|---|---|
| Hispanic/Latino | 51.1% | 47.9% | 3.20% |
| White | 45.6% | 38.8% | 6.80% |
| Black/African American | 48.3% | 40.5% | 7.80% |
| Asian/Pacific Islander | 50.9% | 52.4% | -1.50% |
| Two or More Races | 40.9% | 46.4% | -5.50% |
| American Indian/Alaska Native | N/A* | 48.0% | N/A |

**Data for AI/AN statistically unstable*
*Source: California Health Interview Survey, 2018 – 2022*

Data on services provided in different threshold languages was not provided to analyze. Data on the linguistic capabilities of county and contract providers compared to the county as a whole is analyzed below, however.

## Data Analysis – Workforce Needs Assessment

HMA conducted a workforce assessment, focused on linguistic capability, provider diversity, and education and training needs.

HMA first reviewed the racial/ethnic breakdown of county residents, DBH clients and DBH staff (see table 6 below). In the section above, the difference between county residents and the DBH client population were noted. From a workforce perspective, however, we see that there is very close alignment between the race/ethnicity of DBH clients and staff. As a top line statistic, this is quite impressive. We also analyze race/ethnicity by job categories, however, which shows areas for improvement.

**Table 6. Race/Ethnicity of Clients, Staff, and Community (2023/24)**

| Race/Ethnicity | SB County Residents* | DBH Clients | DBH Staff | Client/Staff Differential |
|---|---|---|---|---|
| Hispanic/Latino | 56.2% | 45.3% | 45.1% | -0.3% |
| White | 24.1% | 22.8% | 21.5% | -1.2% |
| Black/African American | 7.3% | 14.7% | 16.9% | 2.2% |
| Asian | 8.5% | 2.2% | 6.5% | 4.3% |
| Native American | 0.2% | 0.4% | 0.7% | 0.3% |
| Other/Unknown | 3.7% | 14.5% | 9.3% | -5.3% |

**U.S. Census Bureau, American Community Survey 2022, 1-Year Estimates, Demographic and Housing Estimates (DP05)*
*Source: San Bernardino County, Department of Behavioral Health*

Table 7 below captures the breakdown of each job category by race/ethnicity. We found disparities where the Hispanic/Latino population were underrepresented across a number of job categories. The largest disparities were in the Management Unit (26% Hispanic/Latino staff vs 45% of all clients), Nursing (19% vs 45%), and the Supervisory Nursing (20% vs 45%) job categories. Interestingly, there is a large Asian representation in the nursing profession (31% of nursing staff vs 2% of the total population). There may be some best practices that can be learned from the Asian nursing pipeline to develop a stronger nursing pipeline for the Hispanic/Latino population.

The Black population is overrepresented in behavioral health services, making up a larger proportion of clients compared to the community as a whole. At the same time, they are well represented across job categories. There is a large representation of Black people as Supervisory Nurses (40%) although the total number of staff small. That pipeline should also be examined to determine if there are recruiting, training, and retaining best practices.

**Table 7. Race/Ethnicity by Job Category (2023/24)**

| Job Category | Hispanic/ Latino | White | Black | Asian | Native Hawaiian or Other Pac. Islander | Native American | Two or More Races | Other/ Unknown |
|---|---|---|---|---|---|---|---|---|
| Administrative Svcs Unit (449) | 45% | 20% | 20% | 5% | 1% | 1% | 6% | 2% |
| Clerical Unit (232) | 60% | 13% | 14% | 5% | 1% | 1% | 5% | 1% |
| Craft, Labor & Trade (26) | 46% | 27% | 19% | 0% | 0% | 4% | 0% | 4% |
| Exempt Group (20) | 45% | 25% | 10% | 10% | 5% | 0% | 5% | 0% |
| Management Unit (63) | 26% | 46% | 14% | 2% | 0% | 2% | 5% | 5% |
| Nurses Unit (36) | 19% | 27% | 14% | 31% | 3% | 0% | 6% | 0% |
| Professional Svcs Unit (247) | 40% | 21% | 17% | 10% | 0% | 1% | 7% | 4% |
| Supervisory Unit (95) | 45% | 28% | 12% | 3% | 0% | 0% | 8% | 4% |
| Supervisory Nurses Unit (5) | 20% | 40% | 40% | 0% | 0% | 0% | 0% | 0% |
| Technical & Inspection (58) | 52% | 15% | 17% | 7% | 0% | 0% | 9% | 0% |
| **DBH Client Demographics** | 45% | 23% | 15% | 2% | N/A | 0.4% | N/A | 14% |

*Source: San Bernardino County, Department of Behavioral Health*

San Bernadino County also has linguistic gaps in its behavioral health service system. The largest and most significant gap is related to a lack of Spanish-speaking providers. 37.4% of the population in the county speaks Spanish as their primary language, but only 14.7% of county providers and 18.6% of contracted providers speak Spanish (see table 8 below). There are smaller gaps related to Mandarin/Cantonese/Other Chinese languages and Tagalog.

**Table 8. Linguistic Capacity by Provider Type (2023/24)**

| Language* | San Bernardino Residents** | County Provider # | County Provider % | Contract Provider # | Contract Provider % |
|---|---|---|---|---|---|
| English | 54.3% | 665 | 81.9% | 1,274 | 80.4% |
| Spanish | 37.4% | 119 | 14.7% | 294 | 18.6% |
| Mandarin/Cantonese/Other Chinese | 2.1% | 5 | 0.6% | 4 | 0.3% |
| Tagalog | 1.2% | 6 | 0.7% | 4 | 0.3% |
| Arabic | 0.9% | 7 | 0.9% | 3 | 0.2% |
| Vietnamese | 0.7% | 2 | 0.2% | 1 | 0.1% |
| Russian | 0.1% | 1 | 0.1% | N/A | N/A |
| Farsi | N/A | 3 | 0.4% | 4 | 0.3% |
| American Sign Language | N/A | 2 | 0.2% | N/A | N/A |
| Armenian | N/A | 2 | 0.2% | N/A | N/A |
| **Total** | | **812** | **100.0%** | **1,584** | **100.0%** |

**Linguistic counts do not reflect unduplicated figures as a provider could be both a "county" and "contract" provider and thus be double counted in the data. While the general theme of underrepresentation of Spanish-speaking providers is valid, further analysis of these figures should be done with caution.*

***U.S. Census Bureau, American Community Survey 2022, 1-Year Estimates, Language Spoken at Home for Population Over the Age of 5 (C16001)*

*Source: San Bernardino County, Department of Behavioral Health*

Looking by job category, we see that in the largest provider job categories – direct service job categories with 50+ county and/or contracted staff – none have a proportional number of Spanish-speaking providers. The closest is Licensed Clinical Social Workers at 23.6%, which is still 13%+ less than the community as a whole. The lowest proportion was found in Registered Nurses, of whom only 1.4% speak Spanish.

**Table 9. Proportion of Languages Spoken in Largest Provider Job Categories** (2023/24)**

| Language *** | LMFT* | ACSW* | Assoc. MFT* | LCSW* | Physician | Registered Nurse | Social Worker | CHW* |
|---|---|---|---|---|---|---|---|---|
| **English** | 83.9% | 75.6% | 73.5% | 72.8% | 82.1% | 97.9% | 77.5% | 79.8% |
| **Spanish** | 12.3% | 23.3% | 23.5% | 23.6% | 7.7% | 1.4% | 21.6% | 20.2% |
| **Mandarin/ Cantonese/ Other Chinese** | 1.3% | 0.0% | 0.0% | 0.5% | 5.1% | 0.0% | 0.0% | 0.0% |
| **Tagalog** | 0.3% | 0.4% | 0.9% | 0.5% | 2.6% | 0.7% | 0.0% | 0.0% |
| **Arabic** | 1.0% | 0.7% | 0.9% | 2.1% | 0.0% | 0.0% | 0.0% | 0.0% |
| **Vietnamese** | 0.0% | 0.0% | 0.0% | 0.0% | 2.6% | 0.0% | 0.0% | 0.0% |
| **Russian** | 0.0% | 0.0% | 0.4% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| **Farsi** | 1.0% | 0.0% | 0.4% | 0.5% | 0.0% | 0.0% | 0.0% | 0.0% |
| **American Sign Language** | 0.3% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| **Armenian** | 0.0% | 0.0% | 0.4% | 0.0% | 0.0% | 0.0% | 1.0% | 0.0% |

**Acronym Definitions: Licensed Marriage and Family Therapist (LMFT), Academy of Certified Social Workers (ACSW), Associate Marriage and Family Therapist (Assoc MFT), Licensed Clinical Social Worker (LCSW), Community Health Worker (CHW).*
***Direct service job categories with 50+ staff*
****Linguistic counts do not reflect unduplicated figures as a provider could be both a "county" and "contract" provider and thus be double counted in the data. While the general theme of underrepresentation of Spanish-speaking providers is valid, further analysis of these figures should be done with caution.*

To further inform recommendations to improve provider diversity and linguistic capacity, it is important to consider applicant and hiring data. DBH provided summary data for the 58,000+ applicants received in 2023-24. Table 10 below reflects the racial/ethnic breakdown of applicants, as compared to the county demographics as a whole. Looking strictly at the applicant pool, we see a smaller proportion of White, Hispanic/Latino, and Asian applicants compared to the county demographics, and an overrepresentation of Black applicants.

**Table 10. DBH Applicants by Race/Ethnicity (2023/24)**

| Race/Ethnicity | SB County Residents | Applicant Pool | County/Applicant Differential |
|---|---|---|---|
| **Hispanic/ Latino** | 56.2% | 52.5% | -3.70% |
| **White** | 24.1% | 15.7% | -8.40% |
| **Black/African American** | 7.3% | 14.8% | 7.50% |
| **Asian** | 8.5% | 5.4% | -3.10% |

| | | | |
|---|---|---|---|
| **Native Hawaiian or Other Pac. Isldr.** | N/A | 0.5% | N/A |
| **Native American** | 0.0% | 0.6% | 0.60% |
| **Two or More Races** | N/A | 8.9% | N/A |
| **Other/ Unknown** | 3.7% | 1.7% | -2.00% |

*Source: San Bernardino County, Department of Behavioral Health*

Looking now at hiring data by race/ethnicity, we see the highest hiring percentage about Native American applicants (3.8%), followed by White (2.7%), and Black (2.5%). The lowest hiring percentage beside Other/Uknown was Native Hawaiian/Pacific Islanders (.7%) and Hispanic/Latino applicants (1.9%).

**Table 11. DBH Hires by Race/Ethnicity (2023/24)**

| Race/Ethnicity | Number of Applicants | Number Hired | Percentage Hired |
|---|---|---|---|
| **Hispanic/ Latino** | 30,723 | 575 | 1.9% |
| **White** | 9,186 | 246 | 2.7% |
| **Black/African American** | 8,667 | 215 | 2.5% |
| **Asian** | 3,187 | 66 | 2.1% |
| **Native Hawaiian or Other Pac. Isldr.** | 276 | 2 | 0.7% |
| **Native American** | 346 | 13 | 3.8% |
| **Two or More Races** | 5193 | 119 | 2.3% |
| **Other/ Unknown** | 977 | 3 | 0.3% |

*Source: San Bernardino County, Department of Behavioral Health*

HMA also reviewed the racial/ethnic breakdown of internal vs external hire. We see from these data that internal hires are more likely to be White and Hispanic/Latino, and less likely to be Black/African American or Asian, compared to external hires. Although, rates are somewhat similar proportionally.

**Table 12. DBH Internal vs External Hires by Race/Ethnicity (2023/24)**

| Race/Ethnicity | External Hires | Internal Hires | Internal/External Differential |
|---|---|---|---|
| **Hispanic/ Latino** | 46% | 48% | 2% |
| **White** | 19% | 22% | 3% |
| **Black/African American** | 20% | 17% | -3% |
| **Asian** | 6% | 4% | -2% |
| **Native Hawaiian or Other Pac. Isldr.** | 1% | 1% | 0% |
| **Native American** | 1% | 1% | 0% |
| **Two or More Races** | 7% | 5% | -2% |
| **Other/ Unknown** | 0% | 2% | 2% |

*Source: San Bernardino County, Department of Behavioral Health*

## Data Analysis – Assessment of SUDRS Program Capacity, Including Residential Programs

HMA reviewed the **Drug Medi-Cal Organized Delivery System (DMC – ODS) FY23** Report produced by Behavioral Health Concepts, Inc. that provides data related to penetration rates for systems.

**Penetration Rate (PR)** – The penetration rate is the calculation of members served based on the total Medi-Cal eligible population. San Bernadino has a lower DMC-ODS PR rate than comparable counties and the state as a whole (see table 13 below). The lower penetration rates exist across age categories. The County has the highest PR amongst 18 – 64 year olds, but this age category also reflects the greatest discrepancy when compared to similar counties.

**Table 13. San Bernardino DMC-ODS Medi-Cal Eligible Population, Members Served, and Penetration Rates by Age, CY 2022**

| Age Groups | # Members Eligible | # Members Served | SB County PR | County Size Group PR | SB/ Comparable County Differential | Statewide PR |
|---|---|---|---|---|---|---|
| Ages 12 - 17 | 126,047 | 147 | 0.12% | 0.29% | -0.17% | 0.25% |
| Ages 18 - 64 | 524,441 | 4,167 | 0.79% | 1.29% | -0.50% | 1.19% |
| Ages 65+ | 75,287 | 257 | 0.34% | 0.56% | -0.22% | 0.49% |
| **Total** | **725,775** | **4,571** | **0.63%** | **1.04%** | **-0.41%** | **0.95%** |

*Source: FY 2023/24 Medi-Cal Specialty Behavioral Health External Quality Review, Behavioral Health Concepts, Inc.*

San Bernardino also has a lower PR for all racial/ethnic groups compared to similar counties and the state as a whole. The County has the highest PRs amongst White and Native American residents and the lowest amongst Asian/Pacific Islanders. Despite having the second highest PR within the county, Native American PR reflects the greatest discrepancy when compared to similar counties.

**Table 14. San Bernardino DMC-ODS Medi-Cal Eligible Population, Members Served, and Penetration Rates by Racial/Ethnic Group, CY 2022**

| Racial/Ethnic Group | # Members Eligible | # Members Served | SB County PR | County Size Group PR | SB/ Comparable County Differential | Statewide PR |
|---|---|---|---|---|---|---|
| African American | 79,379 | 421 | 0.53% | 1.29% | -0.76% | 1.19% |
| Asian/Pacific Islander | 39,911 | 47 | 0.12% | 0.15% | -0.03% | 0.15% |
| Hispanic/Latino | 412,148 | 2,148 | 0.52% | 0.74% | -0.22% | 0.69% |
| Native American | 1,855 | 21 | 1.13% | 2.34% | -1.21% | 2.01% |
| Other | 57,064 | 262 | 0.46% | 1.34% | -0.88% | 1.26% |
| White | 135,419 | 1,672 | 1.23% | 1.89% | -0.66% | 1.67% |

*Source: FY 2023/24 Medi-Cal Specialty Behavioral Health External Quality Review, Behavioral Health Concepts, Inc.*

San Bernardino is doing very well on their readmission rates after discharge from withdrawal management programs. The readmission rate within 30 days of discharge was 4.21% in CY 2022, which is half the statewide readmission rate of 8.79%.

**Table 15. San Bernardino DMC-ODS Residential Withdrawal Management Readmissions, CY 2022**

| Total | County | | Statewide | |
|---|---|---|---|---|
| Total DMC-ODS admissions into WM | 404 | | 13,062 | |
| | # | % | # | % |
| WM readmissions within 30 days of discharge | 17 | 4.21% | 1,148 | 8.79% |

*Source: FY 2023/24 Medi-Cal Specialty Behavioral Health External Quality Review, Behavioral Health Concepts, Inc.*

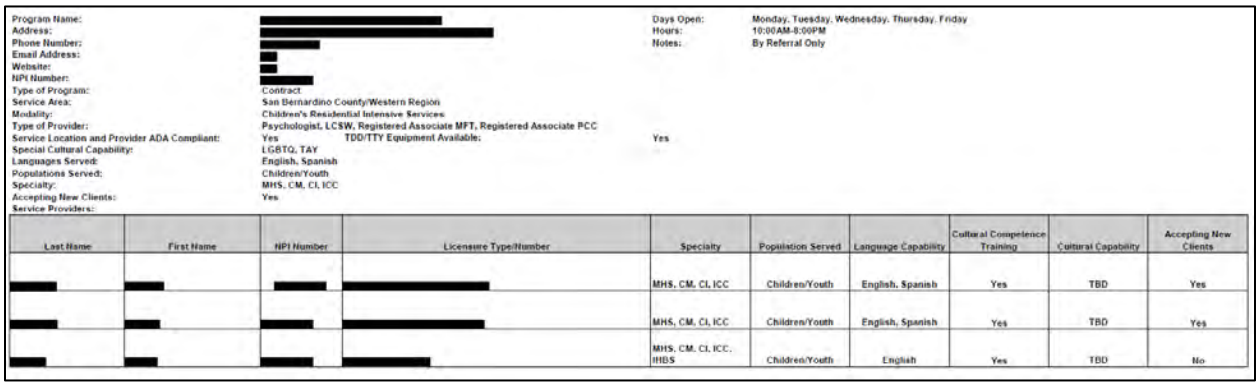
San Bernardino has gaps in rural areas, which could be addressed in part through a recommendation that emerged from the community engagement process to create enhanced clubhouse models. The County may also want to explore expanded telehealth and mobile clinics.

There is a gap with providers offering follow-up appointments for youth. This may be a system, training, or operational issue that should be analyzed. For example, in the DMC-ODS FY23-24 Final Report (page 30) it takes 13 business days for a child to be offered MAT (Medications for Addiction Treatment) services and 15 business days to get services delivered. Adults received their first offered service within 4 business days and received services within 8 business days.

The International Journal of Environmental Research and Public Health published a 2021 article **"Benchmarks for Needed Psychiatric Beds for the U.S. – A Test of Predictive Analytics."** The article highlights the need for beds at 34.9 per 100,000 people.

HMA analyzed the Provider Directory data. The information did not list total beds, bed days, or any other capacity information. It also does not include waiting list information. The Provider Directory does provide information about the organization, program/program modality, days of week/hours of day, clinicians, their specialty areas, population served, language capacity, cultural competency training, various cultural capabilities, and whether they are accepting new clients. See example below.

**Figure 2. Excerpt of Provider Directory**



Program Name: [redacted]
Address: [redacted]
Phone Number: [redacted]
Email Address: [redacted]
Website: [redacted]
NPI Number: [redacted]
Type of Program: Contract
Service Area: San Bernardino County/Western Region
Modality: Children's Residential Intensive Services
Type of Provider: Psychologist, LCSW, Registered Associate MFT, Registered Associate PCC
Service Location and Provider ADA Compliant: Yes TDD/TTY Equipment Available: Yes
Special Cultural Capability: LGBTQ, TAY
Languages Served: English, Spanish
Populations Served: Children/Youth
Specialty: MHS, CM, CI, ICC
Accepting New Clients: Yes
Service Providers:
Days Open: Monday, Tuesday, Wednesday, Thursday, Friday
Hours: 10:00AM-8:00PM
Notes: By Referral Only

| Last Name | First Name | NPI Number | Licensure Type/Number | Specialty | Population Served | Language Capability | Cultural Competence Training | Cultural Capability | Accepting New Clients |
|---|---|---|---|---|---|---|---|---|---|
| [redacted] | [redacted] | [redacted] | [redacted] | MHS, CM, CI, ICC | Children/Youth | English, Spanish | Yes | TBD | Yes |
| [redacted] | [redacted] | [redacted] | [redacted] | MHS, CM, CI, ICC | Children/Youth | English, Spanish | Yes | TBD | Yes |
| [redacted] | [redacted] | [redacted] | [redacted] | MHS, CM, CI, ICC, IHBS | Children/Youth | English | Yes | TBD | No |

*Source: San Bernardino County, Department of Behavioral Health*

In looking at clinicians providing Residential Intensive Services, most indicated an ability to accept new clients, but several did not. Several providers that seemed to specifically take more diverse clients had clinicians indicating they were not taking any new clients. This included Blissful Living Group Home and Father's Hearth Ranch.

Based on the penetration rates for the DMH-ODS system as a whole, however, HMA has found that there is insufficient capacity to meet the needs of eligible county residents. HMA was unable to assess the true SURDS residential system capacity, however, as capacity information was not available. In the recommendation section, HMA will outline steps that should be taken to better understand capacity, starting with gathering additional information on current waitlists and gaps for specific populations.

## RECOMMENDATIONS

Through this evaluation, it was clear that San Bernadino County has been making great strides in improving behavioral health care within its geography. As such, the County has a strong foundation from which focused enhancements could be implemented to improve the quality of care and access in the community and reduce disparities.

Based on the findings from this analysis, HMA has developed several recommendations that could have a significant impact on behavioral healthcare delivery in San Bernadino County. Recommendation areas are as follows, with additional details and strategies provided further below:

1) Expand Access to High-Quality Services
2) Improve Service Integration and Coordination
3) Enhance External Communication and Engagement
4) Strengthen Administrative and Operational Processes
5) Address Workforce Challenges

### Recommendation #1: Expand Access to High-Quality Services

San Bernadino County has spent the past several years investing in program expansion to ensure that community members have access to a variety of supportive services to address behavioral health concerns. However, gaps in the continuum of care persist. The County could significantly benefit from enhancing access to high-quality care that is more data-driven, culturally responsive, evidence-based, and innovative in-service delivery.

This may be accomplished through the following recommendations:

- *Asset Mapping and Strategic Planning:* First, it is recommended to complete a comprehensive asset mapping and strategic planning initiative to better understand the full array of service resources available in the community. This process would include both county-funded and independent programs that are being used by service recipients.

  The asset mapping process would include information regarding (1) type of service, (2) utilization of EBPs, (3) capacity and wait times, (4) gaps in the continuum of care for behavioral health services, (5) workforce trends, (6) disparity tracking, (7) other items as determined by the County.

Through this process, the County would develop a clear blueprint of existing resources, their quality, and areas for additional attention and/or investment. As a result, the County could develop a strategic plan to methodically improve the landscape and efficacy of behavioral health treatment in the county.

- *Expand the Use of Evidence-Based Practices (EBPs):* It is recommended that the County expand the use of EBPs in treatment programs. Interviewees reported that use of EBPs are limited and that many providers are not connecting their populations with EBPs that have been demonstrated to be effective with that particular group. The county could benefit from expanding access to training, and requiring reporting on use of EBPs with documented clinical supervision. The expansion of EBPs should include the use of culturally-specific or culturally-neutral tools and practices.

- *Enhance Data-Driven Reporting:* By enhancing the utilization of data-driven approaches, the County can better understand community needs, track outcomes, and allocate resources more effectively, leading to more targeted and efficient interventions.

  To enhance data-driven reporting, the County should consider implementing continuous quality improvement (CQI) efforts both internally, and for providers. Once this process is fully implemented, it will help ensure that County dollars are being dedicated to effective programs and will support providers in operating programs that are improving outcomes and decreasing disparities.

- *Improve Connections with Marginalized Communities:* It is recommended that the County build intentional pathways to improve outreach, communication, and trust with marginalized communities – specifically the BIPOC communities and the LGBTQIA+ community. These efforts will positively impact engagement in services and reduce disparities in the county.

- *Expand Access to Culturally-Specific Interventions:* Many respondents indicated a shortage of culturally-specific interventions for communities experiencing disparities in their communities. Specifically the Black, Indigenous, and People of Color (BIPOC) communities and the LGBTQIA+ communities. It is recommended that the County invest in increasing the presence and access to interventions for these communities to reduce disparities and improve outcomes for these and other populations.

- *Explore Utilization of Innovative Engagement Strategies to Improve Access:* It was reported that many social determinants of health barriers exist that limit people's access to services across the county. Transportation was listed among the top barriers.

To improve access to care for those with transportation barriers, it is recommended that the County explore innovative service delivery options that have been demonstrated to improve access in similar geographies. These may include initiatives such as mobile services, street outreach, behavioral health services co-located with other programs in rural communities, and/or expansion of telehealth.

- *Enhance Data Collection and Utilization for SURDS Residential Programs:* The County should improve data collection related to residential programs, to better understand utilization, waitlists, and gaps in care. We recommend developing a **Real-Time Capacity Roadmap** with the steps listed below. This is a long-term commitment to a process that will yield actionable information that will help the County maximize and prioritize resources. It would require incremental investments of phases to develop a comprehensive approach. Current reporting tools offer only limited information on residential beds/use, which restricts the County's ability to make data-informed decisions. The real-time tool would allow for tracking total beds, types of beds, bed utilization, and waitlists. This would help to improve access to care, support better coordination/collaboration across providers, and allow for stronger management and oversight by Department of Behavioral Health staff.

  ***1. Data Collection***

  - *Admission and Discharge Data:* Continuously collect data on admissions, discharges, and current occupancy levels. This includes the number of beds available, occupied, and reserved.
  - *Service Utilization Data:* Track the types of services provided, including length of stay, service intensity, and patient demographics.
  - *Staffing Levels:* Monitor staffing availability and shifts, as these can impact capacity and service delivery.

  ***2. Real-Time Data Integration***

  - *Electronic Health Records (EHRs):* Utilize EHR systems to get real-time updates on patient status, bed availability, and service utilization.
  - *Management Information Systems:* Employ software that integrates data from various sources for a comprehensive view of system capacity.

  ***3. Predictive Analytics***

  - *Historical Data Analysis:* Analyze historical data to identify trends and patterns in admissions, discharges, and capacity usage.
  - *Predictive Models:* Use statistical models and machine learning algorithms to predict future demand and identify potential bottlenecks. Consider factors like seasonal variations, treatment outcomes, and referral sources.

***4. Capacity Forecasting***

- *Demand Forecasting:* Estimate future demand based on current trends, seasonal factors, and external influences (e.g., changes in referral sources or policy changes).
- *Scenario Analysis:* Develop scenarios to understand how different factors (e.g., a sudden increase in admissions) might impact system capacity.

***5. Real-Time Monitoring***

- *Dashboard and Alerts:* Implement dashboards that provide real-time visibility into system capacity and performance metrics. Set up alerts for when capacity thresholds are approaching or when there are significant changes in demand.
- *Dynamic Resource Allocation:* Use real-time data to adjust resources and staffing levels dynamically to address fluctuations in capacity and demand.

***6. Feedback Loops***

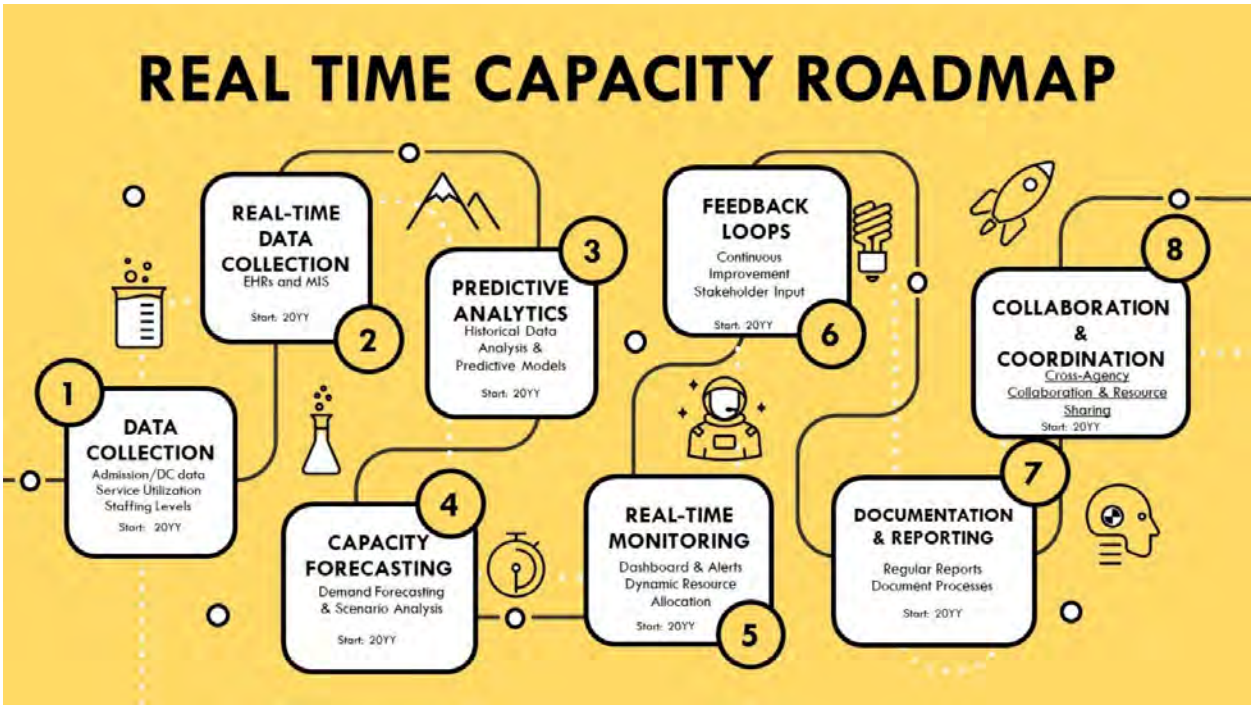
- *Continuous Improvement:* Establish mechanisms for regular review and adjustment of capacity management practices based on feedback from staff, patients, and data analysis.
- *Stakeholder Input:* Engage with stakeholders (e.g., clinicians, administrators) to understand practical challenges and opportunities for improving capacity management.

***7. Documentation and Reporting***

- *Regular Reports:* Generate regular reports on capacity utilization, trends, and predictive insights. Use these reports for strategic planning and to inform decision-making.
- *Documentation of Processes:* Document the processes and methodologies used for capacity determination to ensure consistency and facilitate future improvements.

***8. Collaboration and Coordination***

- *Cross-Agency Collaboration:* Collaborate with other service providers, community organizations, and government agencies to ensure a coordinated approach to capacity management.
- *Resource Sharing:* Explore opportunities for resource sharing or referrals to other services when capacity is reached.




### Recommendation #2: Improve Service Integration and Coordination

Efforts to improve service integration and coordination of care between behavioral health providers in San Bernadino County could lead to better outcomes, reduced disparities, and lessen duplication of effort. Care integration and coordination leads to ensuring that service recipients receive the right care at the right time with fewer gaps and increased effectiveness. Reducing duplication of effort- like multiple assessments and treatment plans- can optimize existing resources which leads to more efficient service delivery, improving outcomes across the county. The recommendations are as follows:

- *Create a Resource Guide for Existing Services and Resources:* Upon completion of the county-wide asset mapping process, it is recommended that the County develop, and annually update, a resource guide that members of the community can use to locate services, develop partnerships, and coordinate care.

- *Improve Care Coordination and Transitions of Care to Support Service Continuity:* Best practices in behavioral health service delivery indicate that discharge planning should begin at the time of intake. All areas of need including mental health, substance use disorder, and social determinants of health should be included in discharge planning. This means, providers should ensure that high-quality service continuity occurs quickly upon a service recipient's transition from care.

  It is recommended that the County develop standard guidelines for transitions of care and care coordination to which providers will be held accountable. This would be done with the intent of

enhancing partnerships between providers and increasing the quality of care and outcomes for persons served.

- *Leverage Certified Peers to Guide Care Coordination:* Research supports the positive impact on behavioral health service recipients of incorporating certified peers into treatment. One area where peers can make a significant impact is in the realm of care coordination. A person with lived experience will be able to speak to the myriad of supports necessary to maintain one's own definition of recovery. By increasing the breadth of the peer role, the County has an opportunity to enhance care coordination and improve outcomes.

### Recommendation #3: Enhance External Communication and Engagement

Enhancing external communication and engagement will help to build awareness of available services and support meaningful engagement with consumers and the community. These efforts should be targeted to historically marginalized communities and communities that are underrepresented in Department of Behavioral Health services.

- *Share Information About Available Services:* Once the Resource Guide developed above is finalized, it should be shared broadly and regularly. Both providers and community members felt that they did not have a clear understanding of what all was available to them, and the development and promotion of the guide could help this.

  The County should also review how it promotes County-operated and County-contracted services, with an eye to new strategies that could help to expand the universe of who is being reached. Sharing information through the established County-run forums can be effective, but also limits the reach of the message to individuals who are already actively engaged with behavioral health services.

- *Leverage Trusted Partners to Support Information Sharing:* In service of sharing information more broadly, the County should further leverage trusted partners within the community. While a message from the Department of Behavioral Health might be most effective for some, many community members – and in particular members of historically marginalized communities – are better reached and engaged by individuals/organizations they are connected to. This could include behavioral health providers but should also include schools and faith-based organizations that can reach individuals not already engaged with the behavioral health system. The County should also consider utilizing the peer workforce (e.g., certified peer support specialists, community health workers, etc.) to share information with clients and community members.

  To effectively leverage partners, the County should institute a process for how information and messages are distributed. It is not enough to email information to partner organizations with the hope that they share it. The County could develop and distribute posters, create videos that

could be shared, develop talking points, and do direct outreach to organizations to ensure that messages are being shared with key constituencies. County staff could also attend meetings convened by local organizations to share information.

- *Offer Engagement Opportunities in Community Settings:* As the County works to enhance its communication and community engagement, it is important to consider how to best connect with individuals in the community who may have more limited interaction with the behavioral health system. It is recommended that the County consider holding meetings and input-gathering sessions in more publicly accessible spaces, such as libraries, parks, or schools. This strategy dovetails with the recommendation about leveraging trusted partners. The County could work with said partners to convene meetings/groups, which could extend the County's reach to new individuals and communities. As the County pursues this strategy, it should also be mindful of geographic representation, and look to provide opportunities for engagement across the county.

### Recommendation #4: Strengthen Administrative and Operational Processes

The analysis indicated a need to strengthen administrative and operational processes to create a more streamlined and efficient system. Improvement in these areas enhances care by ensuring that regulatory guidelines are clear and consistent which will reduce administrative burden and inconsistencies in implementation across providers. This work would lead to faster access to services, reduced provider burnout, and improved outcomes.

- *Improve Cross-Departmental and External Collaboration:* Respondents stated that gaps in coordination and communication between the Department of Behavioral Health, other County entities, and the State led to fragmentation in guidelines, communication, implementation, and oversight of new initiatives. It is recommended that the County adopt a project management structure that would seek provider feedback early in the design and implementation process, transparent communication between agencies, and synthesized guidance for rollouts and maintenance of projects.

  The County should also conduct an internal assessment to identify opportunities to improve department-to-department coordination and, more importantly, decision-making to reduce administrative delays and confusion that can impact service delivery.

- *Assess Provider Contract Requirements to Reduce Administrative Burden:* Over time, provider contracts have evolved, often adding additional requirements that can lead to duplication of effort and administrative burden that reduces time spent in meaningful client interventions. Reviewing and streamlining contractual requirements placed on providers can eliminate unnecessary paperwork, redundant reporting, and complex compliance requirements that

consume valuable time and resources. Given the substantial – and ever-evolving – changes resulting from behavioral health transformation initiatives such as CalAIM and Prop 1, a regular review of requirements with an eye to reduce provider burden is crucial.

- *Expedite Requests and Decisions to Support Contract Providers:* Interviewees reported experiencing long wait times for responses from the County regarding important decisions that ultimately would impact provider operations and compliance. These wait times have led to delays in service delivery, negatively impacting client care. It is recommended that the County consider implementing a streamlined inquiry process with published timelines regarding responses and inquiry status so that providers can better understand where things are in the process.

### Recommendation #5: Address Workforce Challenges

The need for coordinated and intentional investment in behavioral health workforce improvements were identified repeatedly throughout the evaluation process as a critical need in San Bernadino County. The County and provider agencies have struggled with recruitment and retention of key team members who have the necessary skills to provide care. Investment in workforce improvements will lead to stronger outcomes and decreased disparities in the county.

- *Provide Workforce "Perks" to Improve Recruitment and Retention:* Interviewees – including both County and contracted providers – reported difficulties in offering salaries that are competitive with private practice and other fields of work. While underlying reimbursement rates that drive salaries may be difficult to change, the County should consider other, non-salary incentives to attract and retain critical workforce. Examples of meaningful incentives could include bonuses, childcare, loan forgiveness, amongst others. Incentives should be made available to contracted providers as well, to support the health of the behavioral health system as a whole.

- *Assess Workforce Requirements to Reduce Administrative Burden*: Interviewees reported feeling frustrated and demoralized by significant administrative burden taking away from time spent working with service recipients. Often, staff are working overtime in order to meet client needs due to the increasing volume of paperwork that is required. It is known that those in private practice often have far less administrative burden, and higher salaries which makes retention of behavioral health safety net staff progressively more difficult. It is recommended that the County collaborate with behavioral health providers to identify opportunities to streamline and reduce administrative burden overall.

- *Support Workforce Training and Professional Development:* One way the County could simultaneously enhance the behavioral health system while supporting recruitment and retention would be to expand access to specialized trainings and professional development opportunities. These trainings could be targeted to communities or populations that face disparities in care, thus expanding access to culturally-informed services. Many agencies and/or

individual providers cannot afford to pay for specialized training or lose the billable hours due to training time, however. It is recommended that the County explore priority trainings for the region and offer financial support for agencies that send attendees. As trainings and benefits are rolled out, these should be actively communicated to potential and current staff.

- *Increase Worker Flexibility, Where Possible:* Interviewees indicated that the limited flexibility of County positions has had negative impacts on hiring. During a time when staff across industries have seen increased flexibility, such as work-from-home options and more flexible hours, the County has mostly returned to traditional work settings and hours post-COVID. These policies should be reviewed and assessed for their impacts on recruitment, hiring, and retention of staff. Flexibility should also be offered to contracted agencies, as possible, to support the behavioral health system as a whole.

- *Improve Workforce Strategies Targeted to BIPOC Communities, and in Particular the Hispanic/Latino Community:* As outlined in the population and workforce assessment sections above, data shows that the County is underserving the Hispanic/Latino community and has too few Hispanic/Latino providers, especially Spanish-speaking providers. While the County must continue to monitor service engagement and workforce representation for other BIPOC communities, such as the Black/African American, Asian, and Native American, the data supports targeting the Hispanic/Latino community as an initial priority. Below are a sub-set of workforce recommendations for this community:
    - *Engage the Hispanic/Latino community in exploring career opportunities in behavioral health:* The County should conduct direct outreach to the community in an attempt to garner more interest in this field of study/work. The County could explore career fairs, job shadowing opportunities, paid internships, scholarships, and local forgiveness for Hispanic/Latino employees. The County could leverage trusted partners within the Hispanic/Latino community to support these outreach and engagement efforts. Similar strategies could be employed for other communities identified as priorities for hiring/retention.

    - *Established a Hispanic/Latino future leaders mentorship program:* The data reflects a substantial underrepresentation of Hispanic/Latino individuals in management roles within the County. Developing a mentorship program could help to expand the pool of future managers. We would recommend structuring it as a shared learning cohort, which would offer peer-to-peer support in addition to mentor-mentee relationship building. Similar strategies could be employees for other groups.

    - *Evaluate the success of hiring Asian nurses and Black nurse supervisors to leverage existing best practices:* The County should look to replicate successful strategies in hiring/retention. We would recommend evaluating the nurse and nurse supervisor job

categories to better understand what led to Asian and Black individuals being so well represented. The County should review other job categories that have seen similar successes.

- *Evaluate the hiring process:* HMA reviewed data on applicants and individuals hired, by race/ethnicity. While the County receives the most applicants by volume from Hispanic/Latino individuals, they are still underrepresented compared to the community as a whole. Further, the Hispanic/Latino hiring percentage is among the lowest by race/ethnicity. A deeper analysis of the hiring process should be conducted – keying in on service provision job categories – to better understand any barriers to hiring that may exist. This evaluation could also review the successes in attracting applicants from the Black/African American community, which receives approximately twice as many applicants as we might expect based on the community demographics.

## CONCLUSION

It is abundantly clear from the assessment process that San Bernardino County has a strong behavioral health system and provider community that are committed to meeting the needs of county residents. While this report outlines recommendations for how the system can be further enhanced, they build on a solid foundation and history of success. Health Management Associates appreciates the partnership with the Department of Behavioral Health in completing this work, as well as the multitude of providers, partners, individuals with lived experience, and other members of the community who gave their voice to this process. We appreciate your time, wisdom, and commitment to building a better behavioral health system of tomorrow.

HEALTH MANAGEMENT ASSOCIATES

SAN BERNARDINO COUNTY

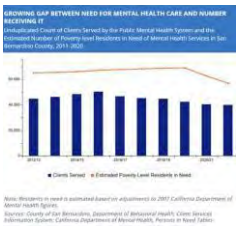
## Behavioral Health and Community Planning Process Assessment

Summary of Stakeholder Engagement Findings

1

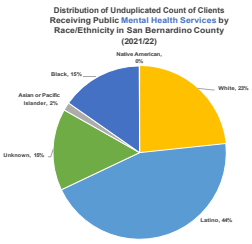
### BEHAVIORAL HEALTH SERVICE OVERVIEW

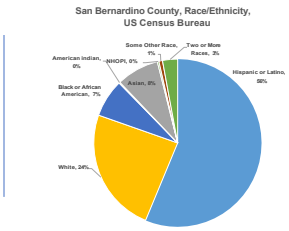
- The estimated prevalence for severe mental illness or emotional disturbance in the Medi-Cal eligible population is 9%, according to the National Institute of Mental Health.
- Under this construct, approximately 73,909 persons from all age groups, who are Medi-Cal eligible, could be considered in need of some level of behavioral health services in San Bernardino
- In FY 2021/22, approximately 42,872 individuals received a mental health service from the mental health plan




2

### BEHAVIORAL HEALTH SERVICE OVERVIEW

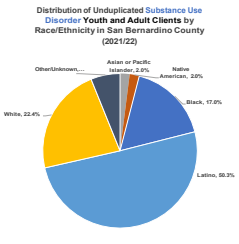


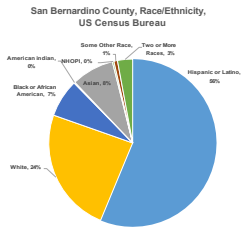




Source: San Bernardino County Department of BH, Client Services Information System; 2021/22

3

### BEHAVIORAL HEALTH SERVICE OVERVIEW




Source: San Bernardino County Department of BH, Client Services Information System; 2021/22

4

## COMMUNITY SURVEY RESULTS

5

## COMMUNITY SURVEY OVERVIEW

The San Bernardino Department of Behavioral Health distributed a survey that asked questions about the strengths, needs, and barriers of the local behavioral health system, as well as opportunities for improvement. The survey was anonymous with the results analyzed by HMA.

A total of **232** individuals completed the survey.

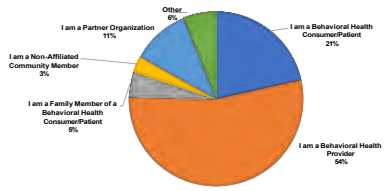
*Note: Based on our experience conducting similar surveys, we feel that 232 is a respectable number of responses. Recent surveys in the City of Minneapolis and Cabarrus County, North Carolina received 253 and 257 responses, respectively, but both surveys were open for 6+ weeks.*

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## RELATIONSHIP TO BEHAVIORAL HEALTH SYSTEMS

Of the 232 individuals, 200 provided their connection to the behavioral health system…

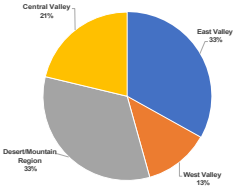



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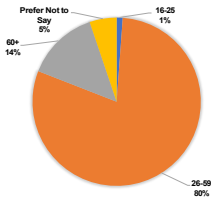
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## LOCATION & AGE

Of the 232 individuals, 127 provided their location....




Of the 232 individuals, 173 provided their age....

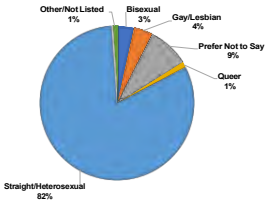



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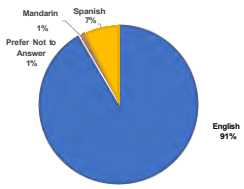
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## SEXUAL ORIENTATION

Of the 232 individuals, 173 provided their orientation....



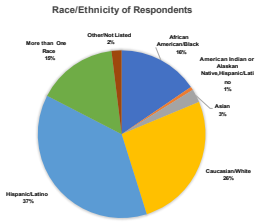

Of the 232 individuals, 166 provided their primary language....

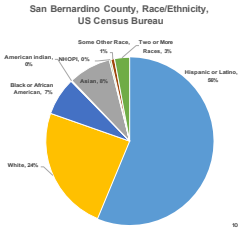



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## RACE/ETHNICITY

Of the 232 individuals, 171 provided their race/ethnicity....



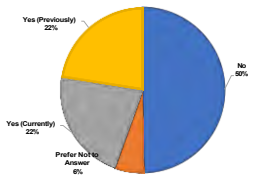




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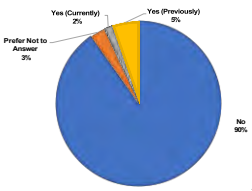
## RECIPIENT OF SERVICES

Of the 232 individuals, 173 provided information if they are receiving mental health or SUD services....

**Mental Health**




**Substance Use Services**




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## FINDINGS FROM THE COMMUNITY SURVEY

- The survey asked a set of questions about barriers to mental health and substance use services and the factors affecting client outcomes.
- The following slides show the top results and a comparison by respondent group.

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## COMPARISON OF TOP BARRIERS AND FACTORS IMPACTING CARE

| Consumers, Family Members, and Non-Affiliated Community Members | Providers and Partner Organizations |
|---|---|
| **Mental Health Services** | **Mental Health Services** |
| • Lack of access to housing and residential services (36%) | • Limited ability to hire and retain providers (69%)* |
| • Lack of access to food, transportation and other SDOH (36%) | • Lack of access to housing and residential services (45%) |
| • Stigma (28%) | • Lack of access to food, transportation and other SDOH (26%) |
| • Limited number of providers accepting patients (25%) | • Confusing/complex referral and intake process (17%) |
| • Confusing/complex referral and intake process (14%) | |

**Only providers were offered the ability to hire/retain staff option*

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## COMPARISON OF TOP BARRIERS AND FACTORS IMPACTING CARE

| Consumers, Family Members, and Non-Affiliated Community Members | Providers and Partner Organizations |
|---|---|
| **Substance Use Services** | **Substance Use Services** |
| • Stigma (26%) | • Limited ability to hire and retain providers (48%)* |
| • Lack of access to housing and residential services (25%) | • Lack of access to housing and residential services (46%) |
| • Lack of access to food, transportation and other SDOH (22%) | • Confusing/complex referral and intake process (28%) |
| • Limited number of providers accepting patients (21%) | • Stigma (27%) |
| • Confusing/complex referral and intake process (14%) | • Lack of access to food, transportation and other SDOH (26%) |

**Only providers were offered the ability to hire/retain staff option*

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## COMPARISON OF TOP BARRIERS AND FACTORS IMPACTING CARE

| Consumers, Family Members, and Non-Affiliated Community Members | Providers and Partner Organizations |
|---|---|
| **Factors Negatively Impacting Outcomes** | **Factors Negatively Impacting Outcomes** |
| • Poor access to stable housing (31%) | • Delays in care (51%) |
| • Lack of communication/coordination between providers (31%) | • Insufficient access to stable housing (48%) |
| • Confusing MH/SUD services system (30%) | • Insufficient access to MH/SUD residential services (43%) |
| • Poor access to MH/SUD inpatient services (26%) | • Insufficient access to MH/SUD inpatient services (41%) |
| • Poor access to MH/SUD residential services (26%) | • Difficulty with community/coordination between providers (41%) |
| • Delays in care due to difficulty accessing services (25%) | |

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## DISPARITIES IN ACCESS TO MENTAL HEALTH CARE

**Provider and Partner Organization Respondents were asked to rank the cultural, ethnic, or identify groups that experience the highest disparities in access to mental health care. Below is the rank order.**

1. African American/Black Americans
2. Undocumented Persons
3. Latino/a
4. Recent Immigrants
5. Native Americans / Tribal members
6. LGBTQIA+ Persons
7. Asian Americans
8. Justice-Involved Persons
9. Foster Youth
10. Pacific Islander Americans
11. Caucasian/White

1. Transitional Age Youth - 16 – 25
2. Older Adults/Seniors - 66+
3. Children and Adolescents - Birth – 15
4. Adults - 26 – 65

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## DISPARITIES IN ACCESS TO SUBSTANCE USE CARE

**Provider and Partner Organization Respondents were asked to rank the cultural, ethnic, or identify groups that experience the highest disparities in access to substance use care. Below is the rank order.**

1. African American/Black Americans
2. Latino/a
3. Undocumented Persons
4. Native Americans / Tribal members
5. Recent Immigrants
6. Asian Americans
7. LGBTQIA+ Persons
8. Foster Youth
9. Justice-Involved Persons
10. Pacific Islander Americans
11. Caucasian/White

1. Children 0 – 12
2. Adolescents 12 – 15
3. Transitional Age Youth 16 – 25
4. Adults 26 – 65
5. Older Adults/Seniors 66+

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## INTERVIEW FINDINGS

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## STAKEHOLDER ENGAGEMENT – COMPLETED AND PLANNED

- As a part of this project, HMA interviewed individuals from the organizations below. In several instances, multiple individuals from an organization were interviewed.
- The following slides contain themes and takeaways from the interviews. The themes are presented as strengths and opportunities for improvement/unmet needs in the following areas:
  - The behavioral health landscape
  - County services and operations
  - The Community Planning Process

| Organization |
|---|
| Asian American Resource Center |
| Boys Republic |
| Inland Empire Health Plan |
| Ontario-Montclair School District Counseling Center |
| Pacific Clinics |
| Reach Out |
| Riverside-San Bernardino County Indian Health |
| San Bernardino County Behavioral Health (Note: This included providers of BH services) |
| South Coast Counseling Services |

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## FINDINGS FROM INTERVIEWS – BEHAVIORAL HEALTH LANDSCAPE

**Strengths**

- Strong network of local provider organizations
- Organizations support one another and have forums for collaboration (e.g., Association of Community Based Organizations)
- Diverse set of services across the continuum available to the community
- Telehealth expansion has helped to address transportation issues
- Growing school-based behavioral health services and more openness to engage in services by youth
- Utilization of the CANS and Objective Arts System has been good and supports coordination

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## FINDINGS FROM INTERVIEWS – BEHAVIORAL HEALTH LANDSCAPE

### Opportunities For Improvement & Unmet Needs

***Access/Service Availability***

- Lack of awareness of available resources in the community which results in duplication of effort and/or gaps in care
- Long waitlists and delays in care – 6+ months in some cases
- Areas needing additional service capacity:
  - Substance use disorder treatment
    - In schools
    - Residential
    - Inpatient psych
  - Crisis
    - Walk-in center
  - Children/youth services
- Transportation is a barrier, especially for rural communities
- Limited hours restricts access to those who are working traditional hours
- Coordination around meeting SDOH is needed to improve access and outcomes
  - Transportation and housing mentioned frequently
  - Food insecurity and clothing mentioned as needs as well

***Workforce***

- Staffing shortages across the behavioral health system (psychiatrists in particular)
- Inability to pay competitive wages – providers are losing staff to Kaiser and private practice

***Cultural Responsiveness/Disparity Reduction***

- Need more specialized services for BIPOC and LGBTQIA+ communities
- Need to build more trust and efficacy with marginalized communities, especially the BIPOC community
- Need expanded language capacities

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## FINDINGS FROM INTERVIEWS – COUNTY BHD SERVICES & OPERATIONS

### Strengths

- Collaborative relationship between the County and providers
- There's a willingness to work with providers to address issues
- The County has helped to broker relationships between organizations
- The County seems to genuinely care and they try for their clients and providers
- The County is always looking for other funding streams to support work
- They're attempting to be more data-driven (although, it's a work in progress)

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## FINDINGS FROM INTERVIEWS – COUNTY BHD SERVICES & OPERATIONS

### Opportunities For Improvement & Unmet Needs

***Implementation***

- Implementation of new initiatives can be slow and are perceived as needing more intentional coordination
  - The lack of coordination and clarity of expectations puts an extra burden on providers that takes away from time dedicated to client care
- CalAIM and related initiatives were perceived to have slower and less clearly communicated rollouts in SB than in other counties which led to confusion and implementation challenges

***Collaboration***

- Better collaboration between county and state is needed – providers are negatively impacted by lack of alignment
- The County struggles to support contractors due to a lack of staffing – slow in getting responses, amending contracts, making decisions, etc. This can negatively impact providers' financial stability and service delivery.

***Operations***

- The fiscal review/audit process is punitive and occurs long after errors have occurred
  - "Clawing back" of funding occurs years after service delivery and is inflexible
- Accessing county services is complicated and results in clients not being able to connect with services
  - Interviewees reported: Too many calls, steps, and requirements
  - Need to consider linguistic, cultural, and educational barriers

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## FINDINGS FROM INTERVIEWS – COMMUNITY PLANNING PROCESS

### Strengths

- The County has tested multiple strategies for outreach, including partnering with organizations to host meetings, virtual forums, surveys, etc.
- The intent behind the process and sub-committees is good
- They promote the sessions to providers and the community
- The County is generally good about receiving programmatic feedback (not good at receiving feedback regarding fiscal procedures)

### Opportunities & Unmet Needs

- Intentional design of meetings could help minimize meeting fatigue/burnout:
  - Goals of CPP need to be more clearly defined to audience
  - Sessions can be too technical and could benefit from focusing on application rather than statistics.
  - Meetings should result in more tangible action
- Need representation from those who have had difficulty engaging as those individuals may have important perspectives
- Consider providing other, lower-barrier methods to engage and share information – such as social media updates, apps, etc.
- Several individuals interviewed had never heard of the CPP process

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## FOCUS GROUP FINDINGS

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## FOCUS GROUP FINDINGS

- The following slides contain themes and takeaways from focus groups with individuals with lived experience.
- HMA conducted focus groups with a total of 220+ participants. Below is a list of the groups engaged:
  - Mental Health and SUD Service Recipients (4 focus groups)
  - Yucca Valley Clubhouse
  - Yucca Valley Family Resource Center
  - Rialto Clubhouse
- Participants were asked about their experiences, barriers to access, unmet needs, and strengths. They were also asked to score – on a scale from 1 to 5 – the county's ability to engage clients in developing programs/services and in communicating about programs/services.

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## FOCUS GROUP FINDINGS

**Summary of Themes:** Yucca Valley Family Resource Center

### Strengths

- **Information Sources:** Participants reported having supportive networks available to them introducing and informing them about available resources.
- **Available Programs and Services:** Clubhouses and crisis centers provide critical support in times of need.
- **Appreciated Services:** Participants reported high appreciation of available services such as mental health providers, clubhouses, and social security benefits.

On average, participants rated the county's ability to engage clients in developing programs and services as a **1 out of 5.**

On average, participants rated the county's communication around programs and services as a **1 out of 5.**

### Opportunities & Unmet Needs

- **Communication:** Improve awareness and communication around available programs and services.
- **Engagement:** Enhance engagement with clients and patients in developing programs.
- **Service Availability:** Additional clubhouses, residential, and outpatient treatment centers with flexible hours.
- **Transportation:** Expand public transportation options, including more frequent buses and weekend services. Provide transportation assistance for individuals accessing mental health and SUD services.
- **Access Barriers**: Long waits, bureaucracy, high living costs, and housing access issues.
- **Mental Health**: Shortage of medication, providers, and experienced therapists.
- **Substance Use Services:** Insufficient treatment centers, inconsistent medication management, and lack of incentive programs.

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## FOCUS GROUP FINDINGS

**Summary of Themes:** Yucca Valley Clubhouse

### Strengths

- **Information Sources:** Word of mouth, referrals (outpatient, PCP, parole officer).
- **Appreciated Services:** Participants expressed having supportive counselors.
- **Clubhouse Programs:** Participants found significant value in clubhouse support groups (grief, mindfulness support, co-dependency, and substance use groups).
- **Personalized Care:** One-on-one therapy services are highly valued, with participants noting significant positive impacts on their mental health and well-being.

On average, participants rated the county's ability to engage clients in developing programs and services as a **1.5 out of 5.**

On average, participants rated the county's communication around programs and services as a **1 out of 5.**

### Opportunities & Unmet Needs

- **Communication:** Enhance awareness of services (e.g., 988 hotline), better advertisement of available resources (billboards, flyers, etc.).
- **Service Availability:** Increase evening/weekend services, diversify support groups, and provide more psychiatric services and suicide prevention resources.
- **Transportation & Financial Support:** Address transportation and financial barriers and improve support for those ineligible for services.
- **Access Barriers**: Transportation, financial limitations, long waitlists, limited staffing, and lack of service availability in rural areas.
- **Mental Health Services:** Specific services for veterans, increased awareness and availability of psychiatric care, and more diverse support groups.
- **Substance Use Services**: Need for veteran centers, residential and outpatient sober living facilities, and youth services.

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## FOCUS GROUP FINDINGS

**Summary of Themes:** Rialto Clubhouse

### Strengths

- **Information Sources:** Participants learn about services through word of mouth, counselors, organizations (Caso Paseo), PCP, and psychiatrists.
- **Knowledge of Services:** Participants demonstrated a high level of awareness and appreciation for various services. These include clubhouse support. (socialization, meals), IEHP Car Ride, and the STAY housing program.
- **Effective Programs:** Participants highlighted effective programs including sober living facilities (Cedar House, River Community, Caso Paseo), supportive social workers, and coordinated primary care services.

On average, participants rated the county's ability to engage clients in developing programs and services as a **4 out of 5.**

On average, participants rated the county's communication around programs and services as a **3 out of 5.**

### Opportunities & Unmet Needs

- **Improve Communication & Training:** Increase awareness and ads of services (988 hotline).
- **Service Availability:** Extend evening/weekend hours, broaden mental health management classes, and improve transportation options (e.g., bus passes like Riverside County).
- **Support for Unhoused Individuals:** Develop approaches to better serve individuals with mental health and substance use services.
- **Access Barriers:** Lack of medication management appointments, transportation, and accessible service hours.
- **Mental Health/SUD Services:** Need for more health education, culturally competent care, and diverse support groups.
- **Housing:** Long waits for housing programs and insufficient availability.
- **Cultural Responsiveness/Disparity Reduction:** Train healthcare professionals in cultural competence, and increase the availability of interpreters, including sign language.

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## FOCUS GROUP FINDINGS

**Summary of Themes:** Individuals who have experience with substance use services

### Strengths

- **Information Sources:** Participants learn about services through social media, other online research, their friends, and their PCP.
- **Effective Programs:** Participants highlighted the County's effective crisis intervention programs and successful utilization of community crisis response teams.
- **Access to Information:** Participants emphasized the volume of information and resources available to them and that accessing information is easy.

On average, participants rated the county's ability to engage clients in developing programs and services as a **3.5 out of 5.**

On average, participants rated the county's communication around programs and services as a **3.5 out of 5.**

### Opportunities & Unmet Needs

- **Substance Use Disorder Services:** Need for more early prevention programs focused on substance use.
- **Stigma Reduction:** Address stigma and racial bias within the healthcare space. Increase education efforts to reduce stigma and promote help-seeking behaviors.
- **Financial Support:** Address economic and financial instability and improve financial aid supports for those ineligible for services.
- **Workforce Diversity:** Enhance cultural competency and linguistic diversity in services to better serve the county's diverse population.
- **Continuous Program Evaluation**: Improve data collection and evaluation to inform service development and understand the evolving needs of the community.
- **Partnership:** Foster collaboration between healthcare, criminal justice, and social services to provide comprehensive support.

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## FOCUS GROUP FINDINGS

**Summary of Themes:** Individuals who have experience with substance use services

### Strengths

- **Information Sources:** Participants learn about services through social media, other online research, their friends, and their PCP.
- **Appreciated Services:** Many of the participants expressed appreciation for the county's mental health, counseling, and therapeutic services.
- **Effective Outreach Programs:** Participants expressed positive experiences with various community outreach programs.
- **Peer Supports:** Participants acknowledged the access to and availability of a range of peer support groups.

On average, participants rated the county's ability to engage clients in developing programs and services as a **4 out of 5.**

On average, participants rated the county's communication around programs and services as a **4 out of 5.**

### Opportunities & Unmet Needs

- **Access Barriers:** Continue to leverage technology, such as telehealth and online resources, to increase access to services.
- **Financial Support:** Increase accessibility by addressing financial barriers to affordable treatment options.
- **Substance Use Disorder Services:** Explore opportunities to increase recovery support services (e.g., Detoxification Services, Naloxone Distribution, and affordable Medication Assisted Treatment).
- **Long Wait Times:** Advocate and seek out opportunities for increased funding to expand substance use and treatment program services and reduce wait times.
- **Awareness:** Ensure all community members are aware of available resources through targeted outreach, educational sessions/workshops, and collaboration across departments.
- **Evaluate Services:** Continually assess and address both strengths and weaknesses of offered services to ensure they effectively meet the needs San Bernadino residents.

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## FOCUS GROUP FINDINGS

**Summary of Themes:** Individuals who have experience with substance use services

### Strengths

- **Information Sources:** Participants learn about services through their friends/family and online.
- **Appreciated Services:** Many of the participants expressed appreciation for the county's counseling and various support services.
- **Effective Programs:** Participants expressed community-based programs are working well.

On average, participants rated the county's ability to engage clients in developing programs and services as a **4 out of 5.**

On average, participants rated the county's communication around programs and services as a **4 out of 5.**

### Opportunities & Unmet Needs

- **Transportation Barriers:** Continue to improve transportation options (e.g., bus passes like Riverside County).
- **Cultural Competency:** Increase mental health services that are culturally sensitive and tailored to diverse populations.
- **Access Barriers:** Continue to leverage technology, such as telehealth and online resources, to increase access to services
- **Aftercare and Support:** Expand ongoing support and aftercare services, such as sober living environments and support groups.
- **Continual Education:** Seek additional opportunities for culturally appropriate trainings and workshops for the personnels across departments.

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## OBSERVATIONAL FINDINGS FROM CPP MEETINGS

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## OBSERVATIONAL FINDINGS OF CPP

**HMA consultants attended (virtually and in-person) several meetings that were a part of the Community Planning Process.**

**Below are several observational findings:**

- Meetings were well attended
- A wide array of special population meetings have been held
- Information shared by the County with participants meets CLAS standards
- Participants were engaged and given opportunities to provide feedback
- The process of submitting written comments could be streamlined (requires submitting a form)
- The County is doing a better job at connecting the dots between the Mental Health Services Act and the Community Planning Process

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# *Assessment of MHSA Community Planning Process*

PREPARED FOR
SAN BERNARDINO COUNTY

BY
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DATE
AUGUST 30, 2024

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## EXECUTIVE SUMMARY

Health Management Associates (HMA) was contracted by the San Bernardino Department of Behavioral Health (DBH) to assess the DBH Community Planning Process (CPP), a stakeholder process for developing the MHSA Three-Year Integrated Plan and Plan Annual Updates.

HMA utilized a mixed-method approach to conduct the assessment. Strategies for qualitative and quantitative data collection are highlighted below:

- Conducted interviews with outpatient and residential behavioral health providers, culturally specific organizations, social service agencies, and school district representatives, amongst others to solicit their input on CPP.
- Facilitated focus groups where 220+ individuals with lived experience shared their stories and experiences, including awareness of and participation in the CPP.
- Administered a community survey that received 232 responses regarding system strengths, barriers, and unmet needs, as well as awareness of and participation in the CPP.
- Convened townhalls as a forum to hear additional input from community members.
- Observed several DBH-run meetings that are a part of the CPP.

The qualitative and quantitative data gathered was presented to a team of DBH staff – called the Core Team – that represented a cross-section of departments to review, discuss, and inform recommendation development. These same data were also presented to a Community Advisory Group (CAG) that was convened to support this process. The CAG included representatives from community-based organizations working in an around the behavioral health system. Findings from the data collection efforts are summarized in this document, with additional details provided in the addendum.

HMA used the collected data and insights from discussions with the Core Team and CAG to develop recommendations for addressing identified areas in need of improvement. The recommendations outlined in this report will build on the strong foundation in San Bernardino County and help to support further enhancements to the CPP.

## INTRODUCTION

The San Bernardino Department of Behavioral Health (DBH) provides mental health and substance use disorder services to county residents who are experiencing serious mental illnesses (SMI) and/or substance use issues and are uninsured or insured through Medi-Cal, as well as individuals experiencing a behavioral health crisis. DBH serves all age groups and provides an array of prevention, early intervention, and treatment services for both mental health and substance use.

Nearly fifty DBH programs, services, and actions are supported through the Mental Health Services Act (MHSA), a state funded program designed to "reduce the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness". All MHSA programs are stakeholder informed and developed via a required Community Program Planning (CPP) process.

The Behavioral Health Continuum Infrastructure program (BHCIP), funded through the Department of Health Care Services (DHCS) provides investments in infrastructure funding alongside significant new state and federal resources to address homelessness, support healthcare delivery reform, and strengthen the social safety net. Together these commitments will address historic gaps in the behavioral health continuum to meet growing demand for services and supports. This funding opportunity allows DBH the ability to meet the needs of vulnerable populations with the greatest barriers to access, including people experiencing homelessness and justice involvement, utilizing direct stakeholder engagement and feedback.

Substance Use Disorder and Recovery Services (SUDRS) supports the recovery efforts of individuals by providing a drug and alcohol free sober social environment and other recovery resources by providing a full range of substance use disorder (SUD) treatment services and education. SUDRS services are offered through contracts with community-based organizations (CBOs) and county-operated clinics to promote prevention, intervention, recovery and resiliency for individuals (adolescents ages 12-17 and adults 18+) and families. SUD treatment services utilize the American Society of Addiction Medicine (ASAM) Criteria to determine appropriate level of care for covered SUD treatment services. SUDRS services are funded by multiple funding sources, which are informed by stakeholder engagement.

Health Management Associates (HMA) was contracted by DBH to assess the DBH Community Planning Process (CPP), a stakeholder process for developing the MHSA Three-Year Integrated Plan and Plan Annual Updates. The following analysis highlights program strengths, challenges, and provides recommendations for areas of opportunity.

## METHODOLOGY

HMA utilized a mixed-method approach to conducting the assessment of the Community Planning Process (CPP) in San Bernardino County. HMA met early in the process with key members of the San Bernardino Department Behavioral Health (DBH) to build a thorough understanding of the behavioral health ecosystem and current CPP. San Bernadino County, with a diverse array of public, private, and non-profit partners, provides a dynamic portfolio of behavioral health services that is ever evolving to meet the needs of San Bernadino residents. The unique geographic nature, including the sheer size of the county, creates unique demands on the behavioral health system.

The County plays a critical role in identifying behavioral health needs, disparities, and inequities across the behavioral health service system. The County also distributes funds, develops partnerships, networks of services, identifies, and supports the creation of evidence-based practices, and provides services. Because of the heightened need for behavioral health services since the COVID-19 pandemic and the availability of increased state and federal funding San Bernadino has added new partners and new services with a strong focus on equity leveraging these funds, but they continue to experience service gaps and barriers.

HMA leveraged these early discussions and collaboratively designed the project approach outlined below.

### Project Oversight

HMA and DBH created a project oversight structure to ensure the effective gathering of information and a collaborative approach to conducting the assessments. Three distinct groups were formed:

- A **Core Team** with representatives from a cross-section of DBH programs was convened to support data collection, review findings, and inform recommendation development. The Core Team met six times.
- A **Community Advisory Group (CAG)** with representatives from community-based organizations was convened to similarly review findings and inform recommendation development, but from an external perspective. The CAG met twice.
- Lastly, a **Project Management Team** with representatives from DBH leadership and various programs was established to support project management, coordination, and oversight. This group was tasked with supporting data collection and access to individuals and organizations to engage in the assessment effort. The Project Management Team met approximately bi-weekly from December 2023 to June 2024.

### Data Collection Methods

Below is a brief overview of the primary quantitative and qualitative data collection efforts utilized in the assessment process. This is not meant to capture everything that was reviewed or incorporated into this effort, but instead offer an overview of primary sources and engagement efforts.

Document Review: Information and materials were collected and reviewed, such as the Mental Health Services Act Plan and Annual Updates, Cultural Competency Plan, applicable regulations, presentations to the Behavioral Health Commission and other bodies, and other previously developed reports and presentations.

Community Planning Process Observation: HMA consultants attended several meetings (both virtually and in-person) that were a part of the CPP. During these meetings, HMA consultants gathered and tracked several observational findings outlined in the section below.

Stakeholder Interviews: HMA interviewed individuals from nine separate organizations to build an understanding of the landscape and inform future data collection efforts.[1] Organizations engaged included outpatient and residential behavioral health providers, culturally specific organizations, social service agencies, and school district representatives, amongst others. In several instances, multiple individuals from an organization were interviewed. The interviews were broadly structured around an assessment of Strengths, Weaknesses, Opportunities, and Threats, as well as questions about the CPP. Interviewees were assured confidentiality to allow for candid responses. Their feedback was summarized and presented to the Core Team and CAG to review and reflect on.

Community Survey: HMA developed a web-based survey specifically designed to collect qualitative information in a person-centered, transparent, and culturally sensitive way. This survey was advertised through the distribution of flyers in both English and Spanish. DBH distributed the flyers which included links/QR codes to the survey. The survey asked questions about the respondent's relationship to behavioral health services and their perspectives on the strengths, unmet needs, and barriers of the local behavioral health system, as well as disparities in care and opportunities for improvement. The survey also asked about awareness of and participation in the CPP. The survey was anonymous with the results analyzed by HMA. Data was disaggregated by respondent type – i.e., consumers of behavioral health services vs. providers of services – to better analyze findings. Findings were presented to the Core Team and CAG to review and reflect on. The community survey received 232 responses, with the demographic profile of respondents aligning with the overall demographics of the community.

Focus Groups: HMA conducted a series of focus groups with individuals with lived experience with behavioral health conditions to gather their perspectives. These focus groups included individuals engaged in a variety of mental health and substance use services – including services funded by DBH. Focus groups were convened with the support of local behavioral health service providers, word-of-mouth information sharing, and the distribution of flyers in both English and Spanish.

Three focus groups were convened in person with another four convened virtually, and participants were compensated for their time and wisdom (30 gift cards of $50 value were provided to participants of the in-person focus groups and 90 gift cards of $25 value were provided electronically to participants of the virtual focus groups for a total of $3,750). In-person focus groups were attended by an HMA consultant who could interpret in Spanish, as needed. When registering for the virtual focus group(s)

[1] Asian American Resource Center, Boys Republic, Inland Empire Health Plan, Ontario-Montclair School District Counseling Center, Pacific Clinics, Reach Out, Riverside-San Bernardino County Indian Health, San Bernardino County Behavioral Health, South Coast Counseling Services

participants were asked to indicate if language interpretation was needed and if so, whether they preferred Zoom auto-translation or interpretation from an HMA team member. Auto-translation and/or interpretation services were then offered to those who requested them.

During the focus group(s), participants were asked about their experiences with the behavioral health system, barriers to access, unmet needs, and strengths. They were also asked to score – on a scale from 1 to 5 – the county's ability to engage clients in developing programs/services and in communicating about programs/services, to support the CPP assessment. In total, HMA conducted seven focus groups (3 in-person and 4 virtually) with 222 participants. Below is a list of the groups engaged:

- Yucca Valley Clubhouse – Monday, July 8th, *in person*
- Yucca Valley Family Resource Center – Monday, July 8th, *in person*
- Rialto Clubhouse – Tuesday, July 9th, *in person*
- Individuals who have experience with substance use and mental health services
    - Monday, August 12th, *virtual*
    - Monday, August 12th, *virtual*
    - Wednesday, August 14th, *virtual*
    - Monday, August 19th, *virtual*

Townhalls (2): HMA promoted and convened two virtual townhall meetings on August 19th and August 21st. The townhalls were intended to be opportunities to share findings from the assessment process as well as solicit additional feedback on the CPP. Flyers in English and Spanish were created by HMA and distributed by San Bernardino County to promote the event. A total of 6 individuals were in attendance between the two townhalls. As a result, limited additional data was collected from these efforts.

## FINDINGS

HMA utilized a combination of data analysis, document review, and community engagement throughout the project to assess the Community Planning Process (CPP) in San Bernardino County. These engagements allowed HMA to gather diverse perspectives from individuals with lived experience, community members, service providers, and other key stakeholders. Key findings related to the CPP are outlined in the sections below. They are broken down by the strengths and opportunities for improvement that emerged from the data collection methods.

### Qualitative Feedback- Strengths

**Observations of the Community Planning Process**

As noted above, HMA attended several in-person and virtual meetings that were a part of the CPP. Below are several strengths observed during those sessions.

- Meetings were well attended.

- Constituents were asked to introduce themselves and there were plenty of opportunities for constituent questions and feedback.
- Participants were engaged, with many offering thoughts and comments.
- Information shared by the County with participants meets CLAS (Culturally and Linguistically Appropriate Services) Standards.
- A wide array of special population meetings have been held.

**Feedback on the Community Planning Process**

HMA asked for feedback on the CPP through the survey, interviews, focus groups, and other engagement efforts. Below is a summary of key themes that emerged:

- The County has tested multiple strategies for outreach, including partnering with organizations to host meetings, virtual forums, surveys, etc.
- The intent behind the process and sub-committees is good, even if they are not always as effective and well-attended as participants would like.
- The County promotes the sessions to providers and the community.
- The County is generally good about receiving feedback.

## Qualitative Feedback- Opportunities for Improvement

**Observations of the Community Planning Process**

As noted above, HMA attended several in-person and virtual meetings that are a part of the Community Planning Process. Below are several opportunities for improvement observed during those sessions.

- Initially there was a disconnect among constituents regarding the context and goal of the meetings and the connection between the Mental Health Services Act (MHSA) and the CPP. The County has started to provide more context about MHSA and CPP during meetings. This was an early verbal recommendation made to the Core Team and we recommend this effort continue.
- The process of submitting comments could be streamlined. It currently requires submitting a form which could be burdensome, particularly for virtual meetings.
- The County could leverage online tools to improve interactions and engagement during meetings.

**Feedback on the Community Planning Process**

HMA asked for feedback on the CPP through the survey, interviews, focus groups, and other engagement efforts. Below is a summary of key themes that emerged:

- Providers and members of the community report having many competing requirements for their time and resources. This is exacerbated by frequent meeting requirements from regulatory or

funding entities. Participants emphasized an intentional structuring of meetings, including the following, could improve this issue:

  - Clearly defined goals and objectives for each meeting
  - A stronger focus on technical assistance and operational application rather than statistics so that providers can leave with tools for programming
  - Clearly defined action items with follow-up so that progress is easily measured, tracked, and defined

- There is a desire to increase participation from individuals who have not traditionally been a part of the process, such as those who may have behavioral health needs but do not access services for one reason or another. Their participation would help to identify and address barriers to care that are not currently apart of the conversation(s). While interviewees noted that this is a challenge, they recommended holding more meetings "in the community" as one way to improve access.
- Participants described an expectation similar to the national trend of "nothing about us without us." In practice, this concept means that services are designed and progressively adjusted based on ongoing, meaningful engagement and feedback from the community.
- It was suggested that the County consider offering low-barrier engagement options, via social media posts, for example, to solicit additional feedback and perspectives.
- Several of the providers interviewed had not heard of the Community Planning Process. Most, however, had described engaging in meetings that are a part of the process, which speaks to the need for clearer communication on the objective of the CPP.

## RECOMMENDATIONS

Through this evaluation, it was clear that San Bernadino County has a very successful Community Planning Process. As such, the County has a strong foundation from which focused enhancements could be implemented to improve planning and engagement efforts. Based on the findings from this assessment, HMA has developed several recommendations that could have a significant impact on community planning in San Bernadino County.

### Recommendation: Enhance External Communication and Engagement

Enhancing external communication and engagement will help to build awareness of the CPP and support meaningful engagement with consumers and the community. These efforts should be targeted to historically marginalized communities and communities that are underrepresented in Department of Behavioral Health services.

- *Build Awareness of the Community Planning Process:* The County should be proud of its established Community Planning Process (CPP). Meetings are well attended, there are various forums and groups dedicated to special populations, and there is active engagement during sessions. That said, the County could serve to improve awareness of the process and its purpose. Many participants indicated limited to no awareness of the CPP – despite many attending sessions that are a part of the process. Even those who were aware of the CPP struggled to describe its purpose.

  The County should find ways to more clearly describe the CPP and consistently reinforce that messaging. However, this should be done in simple terms. Participants do not need to understand the nuances of Mental Health Service Act requirements but should understand how the meetings they attend are part of a larger process to hear from the community and improve services.

- *Improving CPP Progress and Outcomes Tracking:* A related recommendation is that the County should articulate more clearly how the information gathered is being used and report on progress made. This can help to build momentum and buy-in amongst CPP participants and community members.

- *Leverage Trusted Partners to Support Information Sharing:* In service of sharing information more broadly, including about the CPP, the County should further leverage trusted partners within the community. While a message from the Department of Behavioral Health might be most effective for some, many community members – and in particular members of historically marginalized communities – are better reached and engaged by individuals/organizations they are connected to. This could include behavioral health providers but should also include schools and faith-based organizations that can reach individuals not already engaged with the behavioral health system. The County should also consider utilizing the peer workforce (e.g., certified peer support specialists, community health workers, etc.) to share information with clients and community members.

  To effectively leverage partners, the County should institute a process for how information and messages are distributed. It is not enough to email information to partner organizations with the hope that they share it. The County could develop and distribute posters, create videos that could be shared, develop talking points, and do direct outreach to organizations to ensure that messages are being shared with key constituencies. County staff could also attend meetings convened by local organizations to share information.

- *Improve Connections with Marginalized Communities:* Aligned with to the previous recommendation, it is recommended that the County build intentional pathways to improve outreach, communication, and trust with marginalized communities – specifically the BIPOC

communities and the LGBTQIA+ community. So, as the County looks to identify partners in support of sharing information and engaging the community, special focus should be given to organizations/individuals serving these communities. These efforts will positively impact engagement and help to reduce disparities in the county.

- *Offer Engagement Opportunities in Community Settings:* As the County works to enhance its communication and community engagement, it is important to consider how to best connect with individuals in the community who may have more limited interaction with the behavioral health system. It is recommended that the County consider holding meetings and input-gathering sessions in more publicly accessible spaces, such as libraries, parks, or schools. This strategy also dovetails with the recommendation about leveraging trusted partners. The County could work with said partners to convene meetings/groups, which could extend the County's reach to new individuals and communities. As the County pursues this strategy, it should also be mindful of geographic representation, and look to provide opportunities for engagement across the county.

- *Leverage Technology to Support Engagement:* The County should explore how to better utilize technology to support engagement, especially during virtual meetings. The process to submit comment – via a form and/or survey – may serve as a barrier to engagement. It takes time to open, fill-out, and submit a comment/survey and, often, participants are asked to do so after a meeting has already ended which reduces response rates. HMA would recommend utilizing tools like Zoom polls, Mentimeter, and Miro as ways to garner real time feedback from participants. The tools are simple to use – especially Zoom polling, which is built directly into Zoom meeting functionality – and are great for capturing, displaying, and discussing feedback during the meeting itself.

## CONCLUSION

It is abundantly clear from the assessment process that San Bernardino County has established a successful Community Planning Process and provides numerous avenues for community engagement. While this report outlines recommendations for how the CPP can be further enhanced, they build on a solid foundation and history of success. Health Management Associates appreciates the partnership with the Department of Behavioral Health in completing this work, as well as the multitude of providers, partners, individuals with lived experience, and other members of the community who gave their voice to this process. We appreciate your time, wisdom, and commitment to building a better behavioral health system of tomorrow.

HEALTH MANAGEMENT ASSOCIATES

SAN BERNARDINO COUNTY

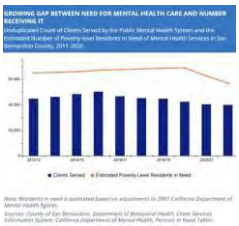
## Behavioral Health and Community Planning Process Assessment

Summary of Stakeholder Engagement Findings

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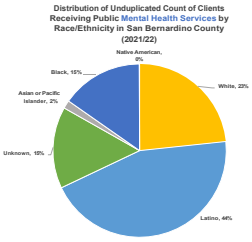
### BEHAVIORAL HEALTH SERVICE OVERVIEW

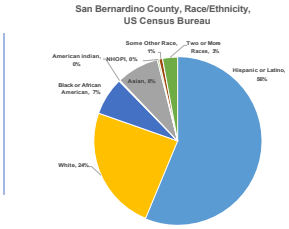
- The estimated prevalence for severe mental illness or emotional disturbance in the Medi-Cal eligible population is 9%, according to the National Institute of Mental Health.
- Under this construct, approximately 73,909 persons from all age groups, who are Medi-Cal eligible, could be considered in need of some level of behavioral health services in San Bernardino
- In FY 2021/22, approximately 42,872 individuals received a mental health service from the mental health plan




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### BEHAVIORAL HEALTH SERVICE OVERVIEW

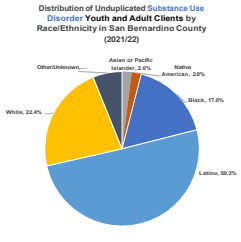


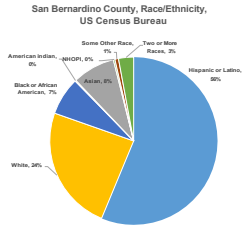




Source: San Bernardino County Department of BH, Client Services Information System; 2021/22

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### BEHAVIORAL HEALTH SERVICE OVERVIEW




Source: San Bernardino County Department of BH, Client Services Information System; 2021/22

4

## COMMUNITY SURVEY RESULTS

5

## COMMUNITY SURVEY OVERVIEW

The San Bernardino Department of Behavioral Health distributed a survey that asked questions about the strengths, needs, and barriers of the local behavioral health system, as well as opportunities for improvement. The survey was anonymous with the results analyzed by HMA.

A total of **232** individuals completed the survey.

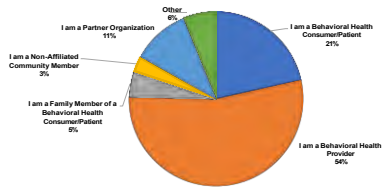
*Note: Based on our experience conducting similar surveys, we feel that 232 is a respectable number of responses. Recent surveys in the City of Minneapolis and Cabarrus County, North Carolina received 253 and 257 responses, respectively, but both surveys were open for 6+ weeks.*

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## RELATIONSHIP TO BEHAVIORAL HEALTH SYSTEMS

Of the 232 individuals, 200 provided their connection to the behavioral health system…

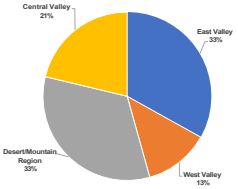



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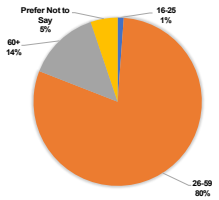
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## LOCATION & AGE

Of the 232 individuals, 127 provided their location....




Of the 232 individuals, 173 provided their age....

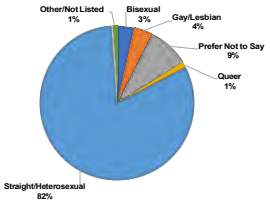



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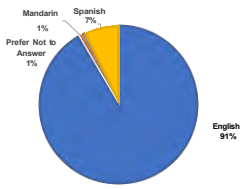
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## SEXUAL ORIENTATION

Of the 232 individuals, 173 provided their orientation....



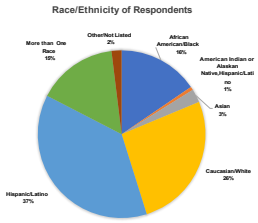

Of the 232 individuals, 166 provided their primary language....

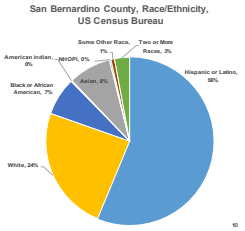



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## RACE/ETHNICITY

Of the 232 individuals, 171 provided their race/ethnicity....



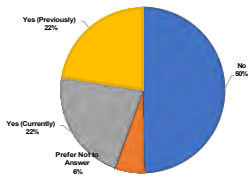




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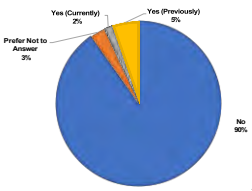
## RECIPIENT OF SERVICES

Of the 232 individuals, 173 provided information if they are receiving mental health or SUD services....

**Mental Health**




**Substance Use Services**




11

## FINDINGS FROM THE COMMUNITY SURVEY

- The survey asked a set of questions about barriers to mental health and substance use services and the factors affecting client outcomes.
- The following slides show the top results and a comparison by respondent group.

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## COMPARISON OF TOP BARRIERS AND FACTORS IMPACTING CARE

**Consumers, Family Members, and Non-Affiliated Community Members**

Mental Health Services

- Lack of access to housing and residential services (36%)
- Lack of access to food, transportation and other SDOH (36%)
- Stigma (28%)
- Limited number of providers accepting patients (25%)
- Confusing/complex referral and intake process (14%)

**Providers and Partner Organizations**

Mental Health Services

- Limited ability to hire and retain providers (69%)*
- Lack of access to housing and residential services (45%)
- Lack of access to food, transportation and other SDOH (26%)
- Confusing/complex referral and intake process (17%)

**Only providers were offered the ability to hire/retain staff option*

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## COMPARISON OF TOP BARRIERS AND FACTORS IMPACTING CARE

**Consumers, Family Members, and Non-Affiliated Community Members**

Substance Use Services

- Stigma (26%)
- Lack of access to housing and residential services (25%)
- Lack of access to food, transportation and other SDOH (22%)
- Limited number of providers accepting patients (21%)
- Confusing/complex referral and intake process (14%)

**Providers and Partner Organizations**

Substance Use Services

- Limited ability to hire and retain providers (48%)*
- Lack of access to housing and residential services (46%)
- Confusing/complex referral and intake process (28%)
- Stigma (27%)
- Lack of access to food, transportation and other SDOH (26%)

**Only providers were offered the ability to hire/retain staff option*

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## COMPARISON OF TOP BARRIERS AND FACTORS IMPACTING CARE

**Consumers, Family Members, and Non-Affiliated Community Members**

Factors Negatively Impacting Outcomes

- Poor access to stable housing (31%)
- Lack of communication/coordination between providers (31%)
- Confusing MH/SUD services system (30%)
- Poor access to MH/SUD inpatient services (26%)
- Poor access to MH/SUD residential services (26%)
- Delays in care due to difficulty accessing services (25%)

**Providers and Partner Organizations**

Factors Negatively Impacting Outcomes

- Delays in care (51%)
- Insufficient access to stable housing (48%)
- Insufficient access to MH/SUD residential services (43%)
- Insufficient access to MH/SUD inpatient services (41%)
- Difficulty with community/coordination between providers (41%)

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## DISPARITIES IN ACCESS TO MENTAL HEALTH CARE

**Provider and Partner Organization Respondents were asked to rank the cultural, ethnic, or identify groups that experience the highest disparities in access to mental health care. Below is the rank order.**

1. African American/Black Americans
2. Undocumented Persons
3. Latino/a
4. Recent Immigrants
5. Native Americans / Tribal members
6. LGBTQIA+ Persons
7. Asian Americans
8. Justice-Involved Persons
9. Foster Youth
10. Pacific Islander Americans
11. Caucasian/White

1. Transitional Age Youth - 16 – 25
2. Older Adults/Seniors - 66+
3. Children and Adolescents - Birth – 15
4. Adults - 26 – 65

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## DISPARITIES IN ACCESS TO SUBSTANCE USE CARE

**Provider and Partner Organization Respondents were asked to rank the cultural, ethnic, or identify groups that experience the highest disparities in access to substance use care. Below is the rank order.**

1. African American/Black Americans
2. Latino/a
3. Undocumented Persons
4. Native Americans / Tribal members
5. Recent Immigrants
6. Asian Americans
7. LGBTQIA+ Persons
8. Foster Youth
9. Justice-Involved Persons
10. Pacific Islander Americans
11. Caucasian/White

1. Children 0 – 12
2. Adolescents 12 – 15
3. Transitional Age Youth 16 – 25
4. Adults 26 – 65
5. Older Adults/Seniors 66+

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## INTERVIEW FINDINGS

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## STAKEHOLDER ENGAGEMENT – COMPLETED AND PLANNED

- As a part of this project, HMA interviewed individuals from the organizations below. In several instances, multiple individuals from an organization were interviewed.
- The following slides contain themes and takeaways from the interviews. The themes are presented as strengths and opportunities for improvement/unmet needs in the following areas:
  - The behavioral health landscape
  - County services and operations
  - The Community Planning Process

| Organization |
|---|
| Asian American Resource Center |
| Boys Republic |
| Inland Empire Health Plan |
| Ontario-Montclair School District Counseling Center |
| Pacific Clinics |
| Reach Out |
| Riverside-San Bernardino County Indian Health |
| San Bernardino County Behavioral Health (Note: This included providers of BH services) |
| South Coast Counseling Services |

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## FINDINGS FROM INTERVIEWS – BEHAVIORAL HEALTH LANDSCAPE

**Strengths**

- Strong network of local provider organizations
- Organizations support one another and have forums for collaboration (e.g., Association of Community Based Organizations)
- Diverse set of services across the continuum available to the community
- Telehealth expansion has helped to address transportation issues
- Growing school-based behavioral health services and more openness to engage in services by youth
- Utilization of the CANS and Objective Arts System has been good and supports coordination

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## FINDINGS FROM INTERVIEWS – BEHAVIORAL HEALTH LANDSCAPE

### Opportunities For Improvement & Unmet Needs

***Access/Service Availability***

- Lack of awareness of available resources in the community which results in duplication of effort and/or gaps in care
- Long waitlists and delays in care – 6+ months in some cases
- Areas needing additional service capacity:
  - Substance use disorder treatment
    - In schools
    - Residential
    - Inpatient psych
  - Crisis
    - Walk-in center
  - Children/youth services
- Transportation is a barrier, especially for rural communities
- Limited hours restricts access to those who are working traditional hours
- Coordination around meeting SDOH is needed to improve access and outcomes
  - Transportation and housing mentioned frequently
  - Food insecurity and clothing mentioned as needs as well

***Workforce***

- Staffing shortages across the behavioral health system (psychiatrists in particular)
- Inability to pay competitive wages – providers are losing staff to Kaiser and private practice

***Cultural Responsiveness/Disparity Reduction***

- Need more specialized services for BIPOC and LGBTQIA+ communities
- Need to build more trust and efficacy with marginalized communities, especially the BIPOC community
- Need expanded language capacities

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## FINDINGS FROM INTERVIEWS – COUNTY BHD SERVICES & OPERATIONS

### Strengths

- Collaborative relationship between the County and providers
- There's a willingness to work with providers to address issues
- The County has helped to broker relationships between organizations
- The County seems to genuinely care and they try for their clients and providers
- The County is always looking for other funding streams to support work
- They're attempting to be more data-driven (although, it's a work in progress)

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## FINDINGS FROM INTERVIEWS – COUNTY BHD SERVICES & OPERATIONS

### Opportunities For Improvement & Unmet Needs

***Implementation***

- Implementation of new initiatives can be slow and are perceived as needing more intentional coordination
  - The lack of coordination and clarity of expectations puts an extra burden on providers that takes away from time dedicated to client care
- CalAIM and related initiatives were perceived to have slower and less clearly communicated rollouts in SB than in other counties which led to confusion and implementation challenges

***Collaboration***

- Better collaboration between county and state is needed – providers are negatively impacted by lack of alignment
- The County struggles to support contractors due to a lack of staffing – slow in getting responses, amending contracts, making decisions, etc. This can negatively impact providers' financial stability and service delivery.

***Operations***

- The fiscal review/audit process is punitive and occurs long after errors have occurred
  - "Clawing back" of funding occurs years after service delivery and is inflexible
- Accessing county services is complicated and results in clients not being able to connect with services
  - Interviewees reported: Too many calls, steps, and requirements
  - Need to consider linguistic, cultural, and educational barriers

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## FINDINGS FROM INTERVIEWS – COMMUNITY PLANNING PROCESS

### Strengths

- The County has tested multiple strategies for outreach, including partnering with organizations to host meetings, virtual forums, surveys, etc.
- The intent behind the process and sub-committees is good
- They promote the sessions to providers and the community
- The County is generally good about receiving programmatic feedback (not good at receiving feedback regarding fiscal procedures)

### Opportunities & Unmet Needs

- Intentional design of meetings could help minimize meeting fatigue/burnout:
  - Goals of CPP need to be more clearly defined to audience
  - Sessions can be too technical and could benefit from focusing on application rather than statistics.
  - Meetings should result in more tangible action
- Need representation from those who have had difficulty engaging as those individuals may have important perspectives
- Consider providing other, lower-barrier methods to engage and share information – such as social media updates, apps, etc.
- Several individuals interviewed had never heard of the CPP process

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## FOCUS GROUP FINDINGS

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## FOCUS GROUP FINDINGS

- The following slides contain themes and takeaways from focus groups with individuals with lived experience.
- HMA conducted focus groups with a total of 220+ participants. Below is a list of the groups engaged:
  - Mental Health and SUD Service Recipients (4 focus groups)
  - Yucca Valley Clubhouse
  - Yucca Valley Family Resource Center
  - Rialto Clubhouse
- Participants were asked about their experiences, barriers to access, unmet needs, and strengths. They were also asked to score – on a scale from 1 to 5 – the county's ability to engage clients in developing programs/services and in communicating about programs/services.

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## FOCUS GROUP FINDINGS

**Summary of Themes:** Yucca Valley Family Resource Center

### Strengths

- **Information Sources:** Participants reported having supportive networks available to them introducing and informing them about available resources.
- **Available Programs and Services:** Clubhouses and crisis centers provide critical support in times of need.
- **Appreciated Services:** Participants reported high appreciation of available services such as mental health providers, clubhouses, and social security benefits.

On average, participants rated the county's ability to engage clients in developing programs and services as a **1 out of 5.**

On average, participants rated the county's communication around programs and services as a **1 out of 5.**

### Opportunities & Unmet Needs

- **Communication:** Improve awareness and communication around available programs and services.
- **Engagement:** Enhance engagement with clients and patients in developing programs.
- **Service Availability:** Additional clubhouses, residential, and outpatient treatment centers with flexible hours.
- **Transportation:** Expand public transportation options, including more frequent buses and weekend services. Provide transportation assistance for individuals accessing mental health and SUD services.
- **Access Barriers**: Long waits, bureaucracy, high living costs, and housing access issues.
- **Mental Health**: Shortage of medication, providers, and experienced therapists.
- **Substance Use Services:** Insufficient treatment centers, inconsistent medication management, and lack of incentive programs.

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## FOCUS GROUP FINDINGS

**Summary of Themes:** Yucca Valley Clubhouse

### Strengths

- **Information Sources:** Word of mouth, referrals (outpatient, PCP, parole officer).
- **Appreciated Services:** Participants expressed having supportive counselors.
- **Clubhouse Programs:** Participants found significant value in clubhouse support groups (grief, mindfulness support, co-dependency, and substance use groups).
- **Personalized Care:** One-on-one therapy services are highly valued, with participants noting significant positive impacts on their mental health and well-being.

On average, participants rated the county's ability to engage clients in developing programs and services as a **1.5 out of 5.**

On average, participants rated the county's communication around programs and services as a **1 out of 5.**

### Opportunities & Unmet Needs

- **Communication:** Enhance awareness of services (e.g., 988 hotline), better advertisement of available resources (billboards, flyers, etc.).
- **Service Availability:** Increase evening/weekend services, diversify support groups, and provide more psychiatric services and suicide prevention resources.
- **Transportation & Financial Support:** Address transportation and financial barriers and improve support for those ineligible for services.
- **Access Barriers**: Transportation, financial limitations, long waitlists, limited staffing, and lack of service availability in rural areas.
- **Mental Health Services:** Specific services for veterans, increased awareness and availability of psychiatric care, and more diverse support groups.
- **Substance Use Services**: Need for veteran centers, residential and outpatient sober living facilities, and youth services.

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## FOCUS GROUP FINDINGS

**Summary of Themes:** Rialto Clubhouse

### Strengths

- **Information Sources:** Participants learn about services through word of mouth, counselors, organizations (Caso Paseo), PCP, and psychiatrists.
- **Knowledge of Services:** Participants demonstrated a high level of awareness and appreciation for various services. These include clubhouse support. (socialization, meals), IEHP Car Ride, and the STAY housing program.
- **Effective Programs:** Participants highlighted effective programs including sober living facilities (Cedar House, River Community, Caso Paseo), supportive social workers, and coordinated primary care services.

On average, participants rated the county's ability to engage clients in developing programs and services as a **4 out of 5.**

On average, participants rated the county's communication around programs and services as a **3 out of 5.**

### Opportunities & Unmet Needs

- **Improve Communication & Training:** Increase awareness and ads of services (988 hotline).
- **Service Availability:** Extend evening/weekend hours, broaden mental health management classes, and improve transportation options (e.g., bus passes like Riverside County).
- **Support for Unhoused Individuals:** Develop approaches to better serve individuals with mental health and substance use services.
- **Access Barriers:** Lack of medication management appointments, transportation, and accessible service hours.
- **Mental Health/SUD Services:** Need for more health education, culturally competent care, and diverse support groups.
- **Housing:** Long waits for housing programs and insufficient availability.
- **Cultural Responsiveness/Disparity Reduction:** Train healthcare professionals in cultural competence, and increase the availability of interpreters, including sign language.

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## FOCUS GROUP FINDINGS

**Summary of Themes:** Individuals who have experience with substance use services

### Strengths

- **Information Sources:** Participants learn about services through social media, other online research, their friends, and their PCP.
- **Effective Programs:** Participants highlighted the County's effective crisis intervention programs and successful utilization of community crisis response teams.
- **Access to Information:** Participants emphasized the volume of information and resources available to them and that accessing information is easy.

On average, participants rated the county's ability to engage clients in developing programs and services as a **3.5 out of 5.**

On average, participants rated the county's communication around programs and services as a **3.5 out of 5.**

### Opportunities & Unmet Needs

- **Substance Use Disorder Services:** Need for more early prevention programs focused on substance use.
- **Stigma Reduction:** Address stigma and racial bias within the healthcare space. Increase education efforts to reduce stigma and promote help-seeking behaviors.
- **Financial Support:** Address economic and financial instability and improve financial aid supports for those ineligible for services.
- **Workforce Diversity:** Enhance cultural competency and linguistic diversity in services to better serve the county's diverse population.
- **Continuous Program Evaluation**: Improve data collection and evaluation to inform service development and understand the evolving needs of the community.
- **Partnership:** Foster collaboration between healthcare, criminal justice, and social services to provide comprehensive support.

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## FOCUS GROUP FINDINGS

**Summary of Themes:** Individuals who have experience with substance use services

### Strengths

- **Information Sources:** Participants learn about services through social media, other online research, their friends/family, and their PCP.
- **Appreciated Services:** Many of the participants expressed appreciation for the county's mental health, counseling, and therapeutic services.
- **Effective Outreach Programs:** Participants expressed positive experiences with various community outreach programs.
- **Peer Supports:** Participants acknowledged the access to and availability of a range of peer support groups.

On average, participants rated the county's ability to engage clients in developing programs and services as a **4 out of 5.**

On average, participants rated the county's communication around programs and services as a **4 out of 5.**

### Opportunities & Unmet Needs

- **Access Barriers:** Continue to leverage technology, such as telehealth and online resources, to increase access to services.
- **Financial Support:** Increase accessibility by addressing financial barriers to affordable treatment options.
- **Substance Use Disorder Services:** Explore opportunities to increase recovery support services (e.g., Detoxification Services, Naloxone Distribution, and affordable Medication Assisted Treatment).
- **Long Wait Times:** Advocate and seek out opportunities for increased funding to expand substance use and treatment program services and reduce wait times.
- **Awareness:** Ensure all community members are aware of available resources through targeted outreach, educational sessions/workshops, and collaboration across departments.
- **Evaluate Services:** Continually assess and address both strengths and weaknesses of offered services to ensure they effectively meet the needs San Bernadino residents.

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## FOCUS GROUP FINDINGS

**Summary of Themes:** Individuals who have experience with substance use services

### Strengths

- **Information Sources:** Participants learn about services through their friends/family and online.
- **Appreciated Services:** Many of the participants expressed appreciation for the county's counseling and various support services.
- **Effective Programs:** Participants expressed community-based programs are working well.

On average, participants rated the county's ability to engage clients in developing programs and services as a **4 out of 5.**

On average, participants rated the county's communication around programs and services as a **4 out of 5.**

### Opportunities & Unmet Needs

- **Transportation Barriers:** Continue to improve transportation options (e.g., bus passes like Riverside County).
- **Cultural Competency:** Increase mental health services that are culturally sensitive and tailored to diverse populations.
- **Access Barriers:** Continue to leverage technology, such as telehealth and online resources, to increase access to services
- **Aftercare and Support:** Expand ongoing support and aftercare services, such as sober living environments and support groups.
- **Continual Education:** Seek additional opportunities for culturally appropriate trainings and workshops for the personnels across departments.

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## OBSERVATIONAL FINDINGS FROM CPP MEETINGS

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## OBSERVATIONAL FINDINGS OF CPP

**HMA consultants attended (virtually and in-person) several meetings that were a part of the Community Planning Process.**

**Below are several observational findings:**

- Meetings were well attended
- A wide array of special population meetings have been held
- Information shared by the County with participants meets CLAS standards
- Participants were engaged and given opportunities to provide feedback
- The process of submitting written comments could be streamlined (requires submitting a form)
- The County is doing a better job at connecting the dots between the Mental Health Services Act and the Community Planning Process

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