SAN BERNARDINO COUNTY
Behavioral Health



Artwork by Belen Islas

Mental Health Services Act

Three-Year Integrated Plan for Fiscal Year 2023/2024 through Fiscal Year 2025/2026

Message from the Director

Welcome

Thank you for your interest in San Bernardino County, Department of Behavioral Health's (DBH) Mental Health Services Act (MHSA) Three-Year Integrated Plan for Fiscal Years 2023-24 through 2025-26. The MHSA Three-Year Integrated Plan is the opportunity for the Department to inform stakeholders, partners, consumers, and community members of MHSA-funded programs, funding priorities, programmatic changes, and key accomplishments from Fiscal Year 2021-22.

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

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

Highlights of the plan include program expansion of culturally specific programs to allow for service area expansion and serving additional children; addition of staff to manage, maintain and evolve the strategic plan for suicide prevention; program improvement that will provide additional enhanced board and care beds, reduce recidivism and extended stays in locked psychiatric settings; and implementing successful innovative practices across our continuum of care.

I hope you will find the MHSA Three-Year Integrated Plan informative and a depiction of our efforts to remain focused on MHSA programming that supports a healthy county and is meeting the specific needs of our community with a focus on culturally appropriate and inclusive care.

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

Sincerely,



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

Mensaje de la Directora

Bienvenido

Gracias por su interés en el Plan Integrado de Tres Años de la Ley de Servicios de Salud Mental (MHSA por sus siglas en inglés) del Departamento de Salud Mental (DBH por sus siglas en inglés) del Condado de San Bernardino para los años fiscales 2023-24 a 2025-26. El Plan Integrado de Tres Años de la MHSA es la oportunidad para que el Departamento informe a las partes interesadas, socios, consumidores y miembros de la comunidad sobre los programas financiados por la MHSA, las prioridades de financiación, los cambios programáticos y los logros clave del año fiscal 2021-22.

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

DBH se involucra en la evaluación continua de programas y proyecciones fiscales para garantizar que los servicios satisfagan las necesidades de los consumidores y la comunidad. Los cambios en el programa se realizan con el objetivo de construir un sistema de salud mental integrado, continuo y orientado a los resultados que promueva la equidad en la salud y garantice que los servicios críticos estén disponibles para quienes los necesitan al eliminar las disparidades de salud por raza, género, orientación sexual, ingresos y ubicación geográfica. En apoyo de este objetivo, los siguientes cambios y mejoras del programa destacan el compromiso de DBH de alinear su programación de salud mental con las necesidades identificadas por las partes interesadas, los socios, los consumidores y los miembros de la comunidad.

Los puntos destacados del plan incluyen la expansión de programas culturalmente específicos para permitir la expansión del área de servicio y atender a más niños; incorporación de personal adicional para gestionar, mantener y evolucionar el plan estratégico para la prevención del suicidio; mejora del programa que proporcionará alojamiento mejorado y camas de atención, reducirá la reincidencia y las estadías prolongadas en entornos psiquiátricos cerrados; e implementar prácticas innovadoras exitosas en nuestra atención continua.

Espero que encuentre el Plan Integrado de Tres Años de la MHSA informativo y una descripción de nuestros esfuerzos para mantenernos enfocados en la programación de la MHSA que apoya un condado saludable y satisface las necesidades específicas de nuestra comunidad con un enfoque en la atención inclusiva y culturalmente apropiada.



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

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 303 East Vanderbilt Way San Bernardino, CA 92415

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

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

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

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

Georgina Yoshioka _____ _____

Local Mental Health Director (PRINT) Signature Date

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: _San Bernardino_____

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

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

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

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

_Dr. Georgina Yoshioka
_____
Local Mental Health Director (PRINT)

_____
Signature Date

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

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

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

_____
Signature Date

SAN BERNARDINO COUNTY
Behavioral Health

MHSA Three-Year Program and Expenditure Plan for FYs 23/24-25/26: Community Program Planning

Overview of San Bernardino County

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

Over 80% 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 15% of the land, which 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 2,187,665 (*Source*: US Census Bureau). Approximately half of the County's population resides in the West Valley (29.12%) and East Valley (25.35%) region of the County, which accounts for only 2.5% of the land. The remaining population resides in the Central Valley (20.77%) and Desert or Mountain regions (24.59%). The remaining .17% of the population is unknown.

The residents of San Bernardino County fall into the following age groups: 44.98% are adults between the ages of 26 and 59 years old, 23.46% are children under the age of 15, 16.4% are older adults (age 60 and over), and the remaining 15.16% are between the ages of 16 and 25 years old.

San Bernardino County is the fifth largest county in the State of California in terms of population and ethnic diversity. The largest ethnic population in the County is Latino (53.4%), followed by Caucasian (28.4%), then African American (7.8%), Asian/Pacific Islander (7.4%), then Native American (0.4%). The remaining 2.6% is unknown.

The gender breakdown is almost even, with 50.2% male and 49.8% female.

Geographic Region	
21% Central Valley	**25%** East Valley
25% Desert/Mountain	**29%** West Valley

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

Race/Ethnicity	
8% African American/Black	**53%** Latinx/Hispanic
7% Asian/Pacific Islander	**<1%** Native American
28% Caucasian/White	**3%** Other/Unknown

Gender Identity	
50% Female	**50%** Male

N=2,187,665

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

Introduction

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

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

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

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

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, and web-conference style meetings are available for remote communities or for individuals who are unable to attend an in-person session or prefer the web format.

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

- Behavioral Health Commission (BHC): 12 annual meetings held monthly
- District Advisory Committee meetings: Five monthly meetings, one held in each of the five supervisorial districts within the county and led by the Behavioral Health Commissioners in each district
- Community Policy Advisory Committee (CPAC): 12 monthly meetings
- Cultural Competency Advisory Committee (CCAC), along with 14 separate cultural specific subcommittee/coalitions: 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 collective agreement of the attendees.

Additional regular stakeholder engagement and education meetings include:

- Quarterly PEI Provider Network meetings
- Clubhouse Consumer Peer Support Groups
- Consumer Evaluation Council
- All Clubhouse Consumer Board meetings
- Parent Partner Network

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

Cultural Competency

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

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

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

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

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

Stakeholder Feedback

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

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

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

When a MHSA Three-Year Integrated Plan is written and posted, feedback is regularly solicited during the 30-day public review posting on the content of the plan/programs. Feedback/comments can be submitted via email or via the phone at MHSA@dbh.sbcounty.gov or 1-800-722-9866. If feedback is received, it may be incorporated into the new MHSA Three-Year Integrated Plan, or if not incorporated, addressed in the final MHSA Three-Year Integrated Plan, as to why it was not incorporated.

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.

New program proposals and/or program enhancement services can be provided by DBH clinics or organizational contract providers. In many cases, programs are implemented using both DBH clinics and organizational contract providers working together to provide services in a system of care framework. For services provided by organizational providers, an RFP/procurement process is required. The RFP process can be accessed via the link here: https://wp.sbcounty.gov/purchasing/wp-content/uploads/sites/3/2021/07/How-to-do-Business-wi-San-Bernardino-County-7_9_21.pdf.

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

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 Three-Year Integrated Plan reflects program changes under Prevention and Early Intervention (PEI), Community Services and Supports (CSS), Innovation (INN), and Capital Facilities and Technological Needs (CFTN) components.

The following are proposed changes in programs and components:

Prevention and Early Intervention

Behavioral Health Ministries Pilot Project (BHMPP) – Project Ending
The Behavioral Health Ministries Pilot Project (BHMPP) is a collaboration between the Department of Behavioral Health (DBH) and the Inland Empire Concerned African American Churches (IECAAC) that creates a network of faith-based organizations to assist in identifying the unmet behavioral health needs of the faith-based African-American community. The pilot project began April 27, 2021 and will end April 30, 2023, at which time the data will be reviewed and evaluated to determine sustainability.

Resilience Promotion in African American Children – Program Expansion
This program will receive a funding increase of $727,523 per fiscal year This increase will serve an additional 3,135 children per year and expand the program to additional areas of the county that include San Bernardino, Victorville, Adelanto, Barstow, Fontana, Rancho Cucamonga and Rialto.

Office of Suicide Prevention – New Program
The Office of Suicide Prevention is a new program administered under Prevention and Early Intervention. The program will strengthen the infrastructure surrounding suicide prevention in San Bernardino County and provide ongoing community education and supports for suicide prevention.

Screening, Assessment, Referral, and Treatment (SART) & Early Identification and Intervention Services (EIIS) – Funding Increase
Both the SART and EIIS contracts, which are programs that provide mental health services to children, will be increased by 20% to adjust for inflation since 2018.

The Early Psychosis Program – Program Name Change
The Early Psychosis Program will be renamed Improving Detection and Early Access (IDEA) program. This name change does not affect the services provided or the contact information.

Community Services and Supports

Adult Transitional Care Programs – Program Expansion
The Adult Transitional Care programs will start expanding in Fiscal Year 2022/23 and will continue expanding during the upcoming fiscal years. The funds from this expansion will be used to address upcoming legislation, such as the Community Assistance, Recovery, and Empowerment (CARE) Court Program, increase the amount in social rehabilitation beds available to consumers, address the increase in the per day bed rate, and offer additional services at board and care facilities.

Crisis Intervention Training and Triage, Engagement, and Support Teams – Name Change
The Crisis Intervention Training (CIT) program and the Triage, Engagement, and Support Teams (TEST) are now being consolidated under the program name Crisis Intervention Collaborative Programs. This name change does not affect the services provided or the contact information.

Summary of Program Changes (cont.)

Community Services and Supports (cont.)

Diversion Programs – Name Change
The Diversion Programs will be renamed Triage Transitional Services (TTS). This name change does not affect the services provided or the contact information.

Adult Full Service Partnerships (FSP) – Name Change and Program Expansion
The Full-Service/FSP Permanent Support Housing will be renamed Adult Full Service Partnerships: Community FSP and Permanent Supportive Housing FSP. This program will also be expanding to accommodate an additional 125 consumers in Fiscal Year 2023/24, as required by upcoming permanent supportive housing projects.

Shelter Beds for all FSPs – Program Expansion
FSPs will receive an increase in funding to allow the expansion of contract shelter beds for those consumers who need placement in emergency shelters. The increase in bed days per year will provide consumers with additional time and case management while placed in emergency shelters, and allow for an appropriate and successful transition to stable housing.

Recovery Based Engagement Support Team (RBEST) Assisted Outpatient Treatment (AOT) – Program Expansion
AOT is court-ordered outpatient treatment for individuals who have a history of untreated mental illness and meet criteria as stipulated in WIC 5345-5349.5. The program is intended to interrupt the cycle of hospitalization, incarceration, and homelessness for adults ages 18 and older who are living with serious mental illness and have been unable and/or unwilling to participate in mental health services on a voluntary basis.

Innovation

Progressive Integrated Care Collaborative – New Project
This project will be based upon the strategy of the selection of best practices from a given discipline and applying those practices uniformly across the following specialties: laboratory studies, Electrocardiograms and Radiographic studies, Data Sharing, Physical Health Specialist consultation and referrals, and billing.

Vyvanse in Stimulant Addition (VISA) – New Project
The goal of this project is to evaluate the use of Vyvanse, a stimulant medication, as a Medication Assisted Treatment (MAT) for individuals addicted to methamphetamine. Addiction to methamphetamine plagues a significant proportion of consumers in San Bernardino County. There are no adequately supported MAT options for individuals with this condition.

Workforce Education and Training

Peer Workforce – New Program
The Peer Workforce program was developed to support DBH as it works to grow its peer support staff. WET will include two new positions dedicated to Peer Workforce. Additionally, San Bernardino County will renew the agreement with California Mental Health Services Authority (CalMHSA) as the county's Peer Support Specialist certifying entity.

Training and Technical Assistance – Funding Increase
Workforce Education and Training will receive a funding increase that will allow for trainings, technical assistance, and leadership development for staff.

Summary of Program Changes (cont.)

Capital Facilities and Technological Needs

Behavioral Health Continuum Infrastructure Program (BHCIP) – Funding Provided

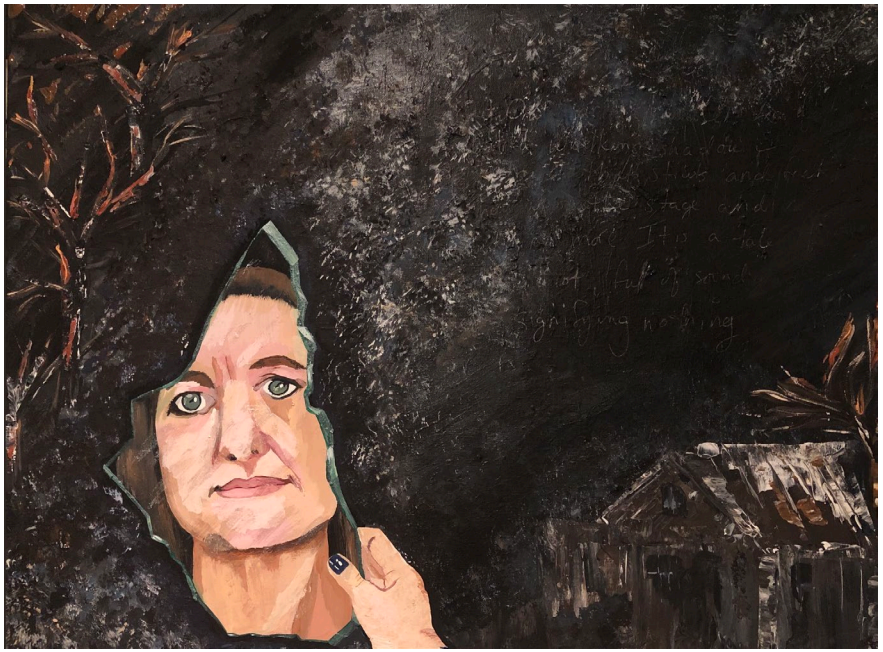
DBH will be accepting the BHCIP grant and will use MHSA funds from Capital Facilities and Technological Needs component to fund capital facilities projects that are in alignment with the public behavioral health system.

Community Care Expansion (CCE) Preservation Funds Grant – Funding Provided

DBH will be accepting the CCE grant and will use MHSA funds from Capital Facilities and Technological Needs component to fund capital facilities projects that are in alignment with the public behavioral health system. Funds from this grant will be used for the immediate preservation of existing licensed residential adult and senior care facilities.

Fiscal

As part of part of Department of Behavioral Health's (DBH) continued fiscal accountability, management, and transparency of MHSA funds, DBH has revised the reporting of program expenditures and revenues for this State Plan Update to be in-line with actual anticipated utilization values based on historical trends and anticipated growths. This revision helps ensure more accurate reporting of usages and availabilities of MHSA funds allotted to DBH consistent with County of San Bernardino's continued goal of responsible use of our resources to ensure financial sustainability and does not impact Board of Supervisors approved commitments. As part of year end reporting, it was found additional Community Support Services (CSS) transfer is required for the Workforce, Education and Training component. This additional transfer is reflected in the balance of unspent funds for CSS.



Rebuilding the Pieces of Me – artwork by Charmaine E. Phipps

MHSA Three-Year Integrated Plan: Community Program Planning Process

DBH is fully committed to a year-round stakeholder engagement process. Preparation and development of this MHSA Three-Year Integrated Plan included meetings hosted virtually, in multiple venues and available to each region of the County, monolingual Spanish sessions were hosted in collaboration with the Consulate of Mexico in San Bernardino, Family Resource Centers, Victor Community Support Services and Inland Association for Continuity of Care (IACC).

A total of **39** scheduled meetings were held throughout San Bernardino County. In addition to the 30-day public posting and comment period.

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



The MHSA Administrative Manager and Component Leads, in conjunction with the Office of Equity and Inclusion (OEI) and Public Relations and Outreach (PRO), have responsibility for coordination and management of 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. As a result of the COVID-19 pandemic, most meetings were held virtually to ensure safety for the stakeholders and presenters.

In order to increase opportunities for participation across the county, the department hosted additional online sessions on January 17, 2023, at 10:00 a.m. and February 2, 2023, at 5:00 p.m. These sessions provided additional opportunities outside of the regularly scheduled monthly stakeholder meetings for individuals to participate via computer, smart phones, and other technological devices.

At the end of each presentation, the facilitator opened the presentation to encourage discussion, allow stakeholders to have questions answered, and provide input. Once the question and answer session concluded, participants were advised about additional opportunities to review the posted draft of the MHSA Three-Year Integrated Plan and several ways to provide feedback. The QR code and link to the survey was provided in the presentation and on a separate handout. Participants were also provided information for alternative methods to provide input and feedback including the email address, phone number for the MHSA Coordinator, and a link to the posted Draft MHSA Plan that contained feedback instructions. Participants were also informed of the MHSA Issue Resolution that can be accessed at: https://wp.sbcounty.gov/dbh/wp-content/uploads/2021/08/COM0947.pdf.

MHSA Three-Year Integrated Plan: Community Program Planning Process (cont.)

To further support this Community Planning Process (CPP) effort, a special session of the Community Policy Advisory Committee (CPAC) was hosted by MHSA Administration on February 16, 2023. The session followed the format that had been established as a standard practice for all CPAC meetings.

A special session of the Cultural Competency Advisory Committee was hosted by the Prevention and Early Intervention (PEI) Program Manager to ensure additional opportunities for stakeholders to interact with decision making staff. Attendees at all stakeholder engagement meetings were afforded the opportunity to provide feedback and input into the MHSA Three-Year Integrated Plan via verbal comment and a post meeting survey in which stakeholders could provide written comments. Surveys were available in both English and Spanish accessible by a direct electronic survey link or QR code that directly linked electronic survey.

A total of **691** stakeholders attended this year's Community Program Planning (CPP) stakeholder sessions and DBH received **543** completed stakeholder comment forms as a result of those who attended the CPP stakeholder sessions.

Stakeholder Comments

During stakeholder meetings, community members asked how they might get additional information on what behavioral health services are available in the County.

Response: The County has an Access Unit that can be called for assistance in locating services and can be reached at 1-888-743-1478. Service directories are also available online at https://wp.sbcounty.gov/dbh/resources/.

During stakeholder meetings, it was noted that community members would like information about how to access funds related with MHSA programs.

Response: The Department releases several Requests for Proposals (RFPs) every year through a procurement process. MHSA funds can be accessed by successful applicants who participate in the procurement process and are determined to meet criteria for RFPs. RFPs may be accessed at the County website per the following link: https://epro.sbcounty.gov/bso/view/search/external/advancedSearchBid.xhtml?openBids=true. Opportunities for MHSA funded RFPs will be shared at the monthly Behavioral Health Commission (BHC) and Community Policy Advisory Committee (CPAC) meetings.

Some specific comments submitted during the CPP process include:

"I appreciate all the efforts that are made to help community members needs. Great goals to improve access and care."

"I learned how comprehensive the MHSA Three-Year Integrated Plan is and what is available and going to be available to us in the community."

"There are great resources available for the community. Thank you for the valuable information regarding expansion and title changes of each program."

"Many great changes and updates, new positions."

MHSA Three-Year Integrated Plan: Community Program Planning Process (cont.)

Stakeholder Comments (cont.)

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

Assistance for Disabled Individuals:

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

Reduction of Discrimination and Stigma:

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

Support for Parents and Caregivers:

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

Innovation Projects:

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

MHSA Three-Year Integrated Plan: Community Program Planning Process (cont.)

Stakeholder Comments (cont.)

Shelter Beds and Homeless Assistance:

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

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

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

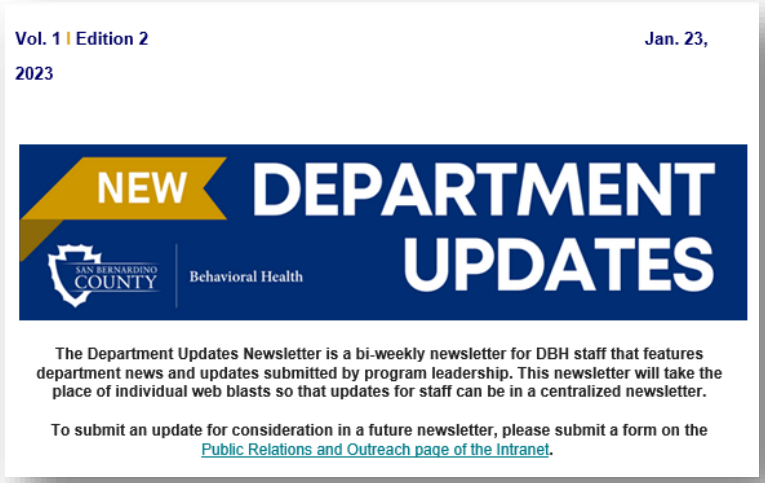
These programs are intended to:

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

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

MHSA Three-Year Integrated Plan: Community Program Planning Process (cont.)

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



Vol. 1 | Edition 2 Jan. 23, 2023

NEW DEPARTMENT UPDATES

San Bernardino County Behavioral Health

The Department Updates Newsletter is a bi-weekly newsletter for DBH staff that features department news and updates submitted by program leadership. This newsletter will take the place of individual web blasts so that updates for staff can be in a centralized newsletter.

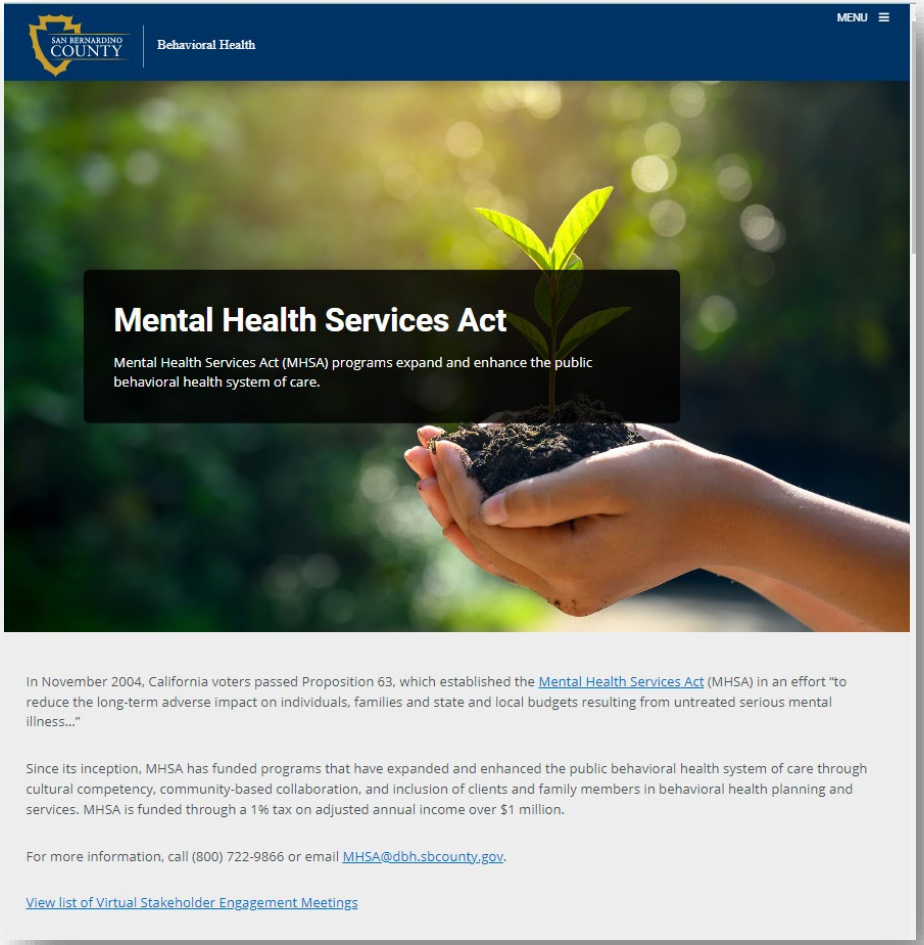
To submit an update for consideration in a future newsletter, please submit a form on the Public Relations and Outreach page of the Intranet.



Community Program Planning Meetings

Every year Mental Health Services Act (MHSA) Administration holds Community Program Planning Meetings for stakeholders to discuss the MHSA Annual Update, or the MHSA Three Year Integrated Plan (every three years). The January and February 2023 meeting have been scheduled and are posted to the homepage announcements on the DBH website.

View Meeting Information



San Bernardino County Behavioral Health MENU

Mental Health Services Act

Mental Health Services Act (MHSA) programs expand and enhance the public behavioral health system of care.

In November 2004, California voters passed Proposition 63, which established the Mental Health Services Act (MHSA) in an effort "to reduce the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness..."

Since its inception, MHSA has funded programs that have expanded and enhanced the public behavioral health system of care through cultural competency, community-based collaboration, and inclusion of clients and family members in behavioral health planning and services. MHSA is funded through a 1% tax on adjusted annual income over $1 million.

For more information, call (800) 722-9866 or email MHSA@dbh.sbcounty.gov.

View list of Virtual Stakeholder Engagement Meetings

Community Program Planning

SAN BERNARDINO COUNTY

Behavioral Health

Community Program Planning Meetings for the MHSA Three Year Plan Fiscal Years 2023-2026

Please join us at a MHSA Three Year Plan Fiscal Years 2023-2026 stakeholder engagement meeting!
Learn about service data from the last fiscal year and get new information on program planning for the upcoming three fiscal years.

January/February 2023

Third District DAC Wednesday, Jan. 4, 2023 3-4 p.m. Join Meeting Call-in: +1-415-655-0002 Meeting number (access code): 146 962 9460 Meeting Password: 2bcGjnSUk23	PEI Quarterly Provider Meeting Thursday Jan. 12, 2023 1-3 p.m. Join Meeting Call-in: +1-415-655-0002 Meeting number (access code): 2485 096 9219 Meeting Password: 68uGmpmdEF4	Asian/Pacific Islander Awareness Subcommittee Friday, Jan. 13, 2023 10-11:30 a.m. Join Meeting Call-in: +1-415-655-0002 Meeting number (access code): 968 187 539 Meeting Password: AP1123	Native American Awareness Subcommittee Tuesday, Jan. 17, 2023 2-3:30 p.m. Join Meeting Call-in: +1-415-655-0002 Meeting number (access code): 146 996 4635 Meeting Password: NAA123
AM WebEx Meeting Tuesday, Jan. 17, 2023 10-11 a.m. Join Meeting Call-in +1-415-655-0002 Meeting number (access code): 2498 257 7683 Meeting Password: BuyjcmbC333	Transitional Age Youth (TAY) Awareness Subcommittee Wednesday, Jan. 18, 2023 11 a.m.-noon Join Meeting Call-in: +1-415-655-0002 Meeting number (access code):960 523 715 Meeting Password: TAY123	Santa Fe Wellness Club Wednesday, Jan. 18, 2023 11 a.m.-noon In-person meeting 56020 Santa Fe Trail, Ste. M Yucca Valley 760-369-4057	Senior Affairs Commission Wednesday, Jan. 18, 2023 1-3 p.m. Join Meeting Call-in: 1-213-306-3065 Meeting number (access code): 146 770 9426#
4th District Advisory Committee Meeting Wednesday, Jan. 18, 2023 6-7 p.m. Join Meeting Call-In: +1-415-655-0002 Meeting number (access code): 2495 776 5577 Meeting Password: fBw5HAvQH23	Cultural Competency Advisory Committee (CCAC) Meeting Thursday, Jan. 19, 2023 1-2:30 p.m. Join Meeting Call-In: +1-415-655-0002 Meeting number (access code): 969 101 891 Meeting Password: CCAC123	A Place to Go Clubhouse (Pacific Clinics) Thursday, January 19, 2023 2-3:30 p.m. In-person meeting 32770 Old Woman Springs Rd., Ste.B Lucerne Valley 760-248-2327	Sky Forest-Rim Family Services with Big Bear Community Healthcare Dist. Thursday, Jan. 19, 2023 10-11 a.m. Join Meeting Call-in: +1-669-900-6833 Meeting ID: 892 0927 4207 Passcode: 371634

Consumer and Family Member Awareness Subcommittee Monday, Jan. 23, 2023 11 a.m.-noon Join Meeting Call-in: +1-669-900-9128 Meeting ID: 951 5082 7516 Passcode: 682466	African American Awareness Subcommittee Meeting Monday, Jan. 23, 2023 2-3:30 p.m. Join Meeting Call-in: +1-415-655-0002 Meeting number (access code): 2484 263 1294 Meeting Password: AAAS123	Victor Community Support Services and IACC in San Bernardino Tuesday, Jan. 24, 2023 9-10 a.m. Join Meeting Call-in: +1-669-444-9171 Meeting ID: 991 7036 3426 Passcode: 513371	LGBTQ Awareness Subcommittee Tuesday, Jan. 24, 2023 12:30-2 p.m. Join Meeting Call-in +1-415-655-0002 Meeting number (access code) 960 570 704 Meeting Password: LGBTQ123
5th District Advisory Committee Meeting Tuesday, Jan. 24, 2023 5-6 p.m. Join Meeting Call-in: +1-415-655-0002 Meeting number (access code): 187 027 1608 Meeting Password: dHmNMUI2v39	Our Place Clubhouse Wednesday, Jan. 25, 2023 In-person meeting 24950 Redlands Blvd., Ste I Loma Linda (909) 557-2145	Women's Awareness Subcommittee Wednesday, Jan. 25, 2023 1-3 p.m. Join Meeting Call-in: +1-415-655-0002 Meeting number (access code): 967 920 279 Meeting Password: WA123	Ontario Montclair School District-Family Solutions Collaborative Wednesday, Jan. 25, 2023 Noon – 1 p.m. Join Meeting Call-in: +1-877-853-5247 Meeting ID: 938 1487 6690 Passcode: 607520
Victor Community Support Services and IACC-Victorville Thursday, Jan. 26, 2023 10-11 a.m. Join Meeting Call-in: +1-669-444-9171 Meeting ID: 935 9099 1003 Passcode: 455463	Latino Awareness Subcommittee Thursday, Jan 26, 2023 10-11:30 a.m. Join Meeting Call-in: +1-415-655-0002 Meeting number (access code): 966 009-041 Meeting Password: LAS123	Yucca Valley Pacific Clinics Family Resource Center with Morongo Basin Healthcare Dist. Friday, Jan. 27, 2023 Join Meeting Call-in: +1-669-444-9171 Meeting ID: 825 6531 3224 Passcode: 402833	NAMI San Bernardino Monday, Jan. 30, 2023 4:30-5:30 p.m. Join Meeting Call-in: +1-669-900-6833 Meeting ID: 894 2025 7075 Passcode: 257801
Serenity Clubhouse Tuesday, Jan. 31, 2023 10:30-11:30 a.m. In-person meeting 12625 Hesperia Rd. Ste.B Victorville (760) 955-6224	PM Webex Meeting Thursday, Feb. 2, 2023 5-6 p.m. Join Meeting Call-in: +1-415-655-0002 Meeting number (access code) 2491 977 0291 Meeting Password: prQ6BYfME75	Veterans Awareness Subcommittee Monday, Feb. 6, 2023 3-4:30 p.m. Join Meeting Call-in: +1-415-655-0002 Meeting number (access code): 2482 788 1413#	Desert Stars Clubhouse Tuesday, Feb. 7, 2023 10:30-11:30 a.m. In-person meeting 1841 E. Main St. Barstow (760) 255-5705
TEAM House Clubhouse Tuesday, Feb. 7, 2023 11:30 a.m. -12:30 p.m. In-person meeting 201 W. Mill St. San Bernardino (909) 388-5640	Co-Occuring and Substance Abuse Subcommittee (COSAC) Wednesday, Feb. 8, 2023 10-11:30 a.m. Join Meeting Call-in: +1-415-655-0002 Meeting number (access code): 961 777 142 Meeting Password: COSAC123	Pathways to Recovery Clubhouse Wednesday, Feb. 8, 2023 11:30 a.m.-12:30 p.m. In-person meeting 17053 E. Foothill Blvd. Fontana (909) 347-1373	Disabilities Awareness Subcommittee Thursday, Feb. 9, 2023 10-11:30 a.m. Join Meeting Call-in: +1-415-655-0002 Meeting number (access code): 146 434 2208 Password: DAS123

2nd District Advisory Committee (DAC) Meeting Thursday, Feb. 9, 2023 3:30-4:30 p.m. Join Meeting Call-in: +1-415-655-0002 Meeting number (access code): 2483 823 7369 Meeting Password: pxYctfry353	Suicide Prevention Awareness Subcommittee Monday, Feb. 13, 2023 10-11:30 a.m. Join Meeting Call-in: +1-415-655-0002 Meeting number (access code): 146 264 6760 Meeting Password: SPA123	Spirituality Awareness Subcommittee Tuesday, Feb. 14, 2023 1-2:30 p.m. Join Meeting Call-in: +1-415-655-0002 Meeting number (access code): 961 357 009 Meeting Password: SA123	1st District Advisory Committee (DAC) Meeting Wednesday, Feb. 15, 2023 11 a.m.-Noon Join Meeting Call-in: +1-415-655-0002 Meeting number (access code): 187 662 3366 Password: u9APaZPXW39
Community Policy Advisory Committee (CPAC) Meeting Thursday, Feb. 16, 2023 10 a.m.-Noon Join Meeting Call-in: +1-415-655-0002 Meeting number (access code): 2486 716 4468 Meeting Password: MnMJKr8yQ22	Amazing Place Clubhouse Friday, Feb. 17, 2023 11 a.m.-Noon In-person meeting 2940 Inland Empire Blvd. Ontario (909) 458-1396	Central Valley Fun Clubhouse Thursday, Feb. 23, 2023 11 a.m.-Noon In-person meeting 1501 S. Riverside Ave. Rialto (909) 877-4889	

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).

SAN BERNARDINO COUNTY

Salud Mental

Reuniones de planificación del programa comunitario para el plan de tres años de la MHSA, años fiscales 2023-2026

¡Únase a nosotros en una reunión de participación de las partes interesadas del plan de tres años de la MHSA, años fiscales 2023-2026!
Obtenga información sobre los datos de servicio del último año fiscal y obtenga nueva información sobre la planificación de programas para los próximos tres años fiscales.

enero/febrero 2023

Comité Asesor del Distrito del 3ro Distrito Miércoles, 4 ene. 2023 3-4 p.m. Unirse a la reunión 0 llame: +1-415-655-0002 Numero de reunión: 146 962 9460 contraseña: 2bcGjnSUk23	Reunión trimestral de proveedores de PEI Jueves, 12 ene. 2023 1-3 p.m. Unirse a la reunión O llame: +1-415-655-0002 Numero de reunión: 2485 096 9219 contraseña: 68uGmpmdEF4	Subcomité de Concientización de Asiáticos/ Isleños del Pacifico Viernes, 13 ene. 2023 10-11:30 a.m. Unirse a la reunión O llame: +1-415-655-0002 Numero de reunión: 968 187 539 contraseña: AP1123	Subcomité de Concientización de Nativos Americanos Martes, 17 ene. 2023 2-3:30 p.m. Unirse a la reunión O llame: +1-415-655-0002 Numero de reunión: 146 996 4635 contraseña: NAA123
Reunión de WebEx por la mañana Martes, 17 ene. 2023 10-11 a.m. Unirse a la reunión O llame: +1-415-655-0002 numero de reunión: 2498 257 7683 contraseña: BuyjcmbC333	Subcomité de Concientización de Jóvenes en Edad de Transición Miércoles, 18 ene. 2023 11 a.m.-mediodía Unirse a la reunión O llame: +1-415-655-0002 numero de reunión: 960 523 715 contraseña: TAY123	Club de Bienestar Santa Fe Miércoles, 18 ene. 2023 11 a.m.-mediodía Reunión en persona 56020 Santa Fe Trail, Ste. M Yucca Valley 760-369-4057	Comisión de Asuntos de la Tercera Edad Miércoles, 18 ene. 2023 1-3 p.m. Unirse a la reunión O llame: 1-213-306-3065 numero de reunión: 146 770 9426#
Comité Asesor del Distrito del 4to Distrito Miércoles, 18 ene. 2023 6-7 p.m. Unirse a la reunión O llame: +1-415-655-0002 numero de reunión: 2495 776 5577 contraseña: fBw5HAvQH23	Comité Consultivo de Competencia Cultural Jueves, 19 ene. 2023 1-2:30 p.m. Unirse a la reunión O llame: +1-415-655-0002 numero de reunión: 969 101 891 contraseña: CCAC123	A Place to Go Casa club (Pacific Clinics) Jueves, 19 ene. 2023 2-3:30 p.m. Reunión en persona 32770 Old Woman Springs Rd., Ste B Lucerne Valley 760-248-2327	Sky Forest-Rim Family Services con Big Bear Community Healthcare Distrito Jueves, 19 ene. 2023 10-11 a.m. Unirse a la reunión O llame: +1-669-900-6833 numero de reunión: 892 0927 4207 contraseña: 371634

Community Program Planning

Subcomité de Concientización de Consumidores y Miembros de Familias Lunes, 23 ene. 2023 11 a.m.-mediodía Unirse a la reunión O llame: +1-669-900-9128 numero de reunión: 951 5082 7516 contraseña: 682466	Subcomité de Concientización de Afroamericanos Lunes, 23 ene. 2023 2-3:30 p.m. Unirse a la reunión O llame: +1-415-655-0002 numero de reunión: 2484 263 1294 contraseña: AAAS123	Servicios de Apoyo Comunitario Victor e IACC - San Bernardino Martes, 24 ene. 2023 9-10 a.m. Unirse a la reunión O llame: +1-669-444-9171 numero de reunión: 991 7036 3426 contraseña: 513371	Subcomité de Concientización de LGBTQ Martes, 24 ene. 2023 12:30-2 p.m. Unirse a la reunión O llame: +1-415-655-0002 numero de reunión: 960 570 704 contraseña: LGBTQ123
Comité Asesor del Distrito del 5to Distrito Martes, 24 ene. 2023 5-6 p.m. Unirse a la reunión O llame: +1-415-655-0002 numero de reunión: 187 027 1608 contraseña: dHmNMUI2v39	Casa club de Qur Place Miércoles, 25 ene. 2023 Reunión en persona 24950 Redlands Blvd., Ste I Loma Linda (909) 557-2145	Subcomité de Concientización de Mujeres Miércoles, 25 ene. 2023 1-3 p.m. Unirse a la reunión O llame: +1-415-655-0002 numero de reunión: 967 920 279 contraseña: WA123	Distrito Escolar de Ontario Montclair-Colaboración de Soluciones Familiares Miércoles, 25 ene. 2023 Mediodía – 1 p.m. Unirse a la reunión O llame: +1-877-853-5247 numero de reunión: 938 1487 6690 contraseña: 607520
Servicios de Apoyo Comunitario Victor e IACC - Victorville Jueves, 26 ene. 2023 10-11 a.m. Unirse a la reunión O llame: +1-669-444-9171 numero de reunión: 935 9099 1003 contraseña: 455463	Subcomité de Concientización de Latinos Jueves, 26 ene. 2023 10-11:30 a.m. Unirse a la reunión O llame: +1-415-655-0002 numero de reunión: 966 009-041 contraseña: LAS123	Centro de recursos familiares de Yucca Valley Pacific Clinics con Morongo Basin Healthcare Distrito Viernes, 27 ene. 2023 Unirse a la reunión O llame: +1-669-444-9171 numero de reunión: 825 6531 3224 contraseña: 402833	NAMI San Bernardino Lunes, 30 ene. 2023 4:30-5:30 p.m. Unirse a la reunión O llame: +1-669-900-6833 numero de reunión: 894 2025 7075 contraseña: 257801
Casa club Serenidad Martes, 31 ene. 2023 10:30-11:30 a.m. Reunión en persona 12625 Hesperia Rd. Ste.B Victorville (760) 955-6224	Reunión de Webex por la tarde Jueves, 2 feb. 2023 5-6 p.m. Unirse a la reunión O llame: +1-415-655-0002 numero de reunión: 2491 977 0291 contraseña: prQ6BYfME75	Subcomité de Concientización de Veteranos Lunes, 6 feb. 2023 3-4:30 p.m. Unirse a la reunión O llame: +1-415-655-0002 numero de reunión: 2482 788 1413#	Casa club Desert Stars Martes, 7 feb. 2023 10:30-11:30 a.m. Reunión en persona 1841 E. Main St. Barstow (760) 255-5705
Casa club TEAM House Martes, 7 feb. 2023 11:30 a.m. -12:30 p.m. Reunión en persona 201 W. Mill St. San Bernardino (909) 388-5640	Subcomité de Concientización de Diagnostico Dual y Drogadicción Miércoles, 8 feb. 2023 10-11:30 a.m. Unirse a la reunión O llame: +1-415-655-0002	Casa club Pathways to Recovery Miercoles, 8 feb. 2023 11:30 a.m.-12:30 p.m. Reunión en persona 17053 E. Foothill Blvd. Fontana (909) 347-1373	Subcomité de Concientización de Discapacidades Jueves, 9 feb. 2023 10-11:30 a.m. Unirse a la reunión O llame: +1-415-655-0002

	numero de reunión: 961 777 142 contraseña: COSAC123		numero de reunión: 146 434 2208 contraseña: DAS123
Comité Asesor del Distrito del 2do Distrito Jueves, 9 feb. 2023 3:30-4:30 p.m. Unirse a la reunión O llame: +1-415-655-0002 numero de reunión: 2483 823 7369 contraseña: pxYctfry353	Subcomité de Concientización de Prevención del Suicidio Lunes, 13 feb. 2023 10-11:30 a.m. Unirse a la reunión O llame: +1-415-655-0002 numero de reunión: 146 264 6760 contraseña: SPA123	Subcomité de Concientización de Espiritualidad Martes, 14 feb. 2023 1-2:30 p.m. Unirse a la reunión O llame: +1-415-655-0002 numero de reunión: 961 357 009 contraseña: SA123	Comité Asesor del Distrito del 1º Distrito Mieroles, 15 feb. 2023 11 a.m.-mediodía Unirse a la reunión O llame: +1-415-655-0002 numero de reunión: 187 662 3366 contraseña: u9APaZPXW39
Comité Asesor de Política Comunitaria (CPAC) Jueves, 16 feb. 2023 10 a.m.-mediodía Unirse a la reunión O llame: +1-415-655-0002 numero de reunión: 2486 716 4468 contraseña: MnMJKr8yQ22	Casa club Amazing Place Viernes, 17 feb. 2023 11 a.m.-mediodía Reunión en persona 2940 Inland Empire Blvd. Ontario (909) 458-1396	Casa club Central Valley Fun Jueves, 23 feb. 2023 11 a.m.-mediodía Reunión en persona 1501 S. Riverside Ave. Rialto (909) 877-4889	

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

Overview of Public Posting and Comment Period

The Department of Behavioral Health would like to thank those who participated in the public review and comment portion of the stakeholder process. The 30-day public posting of the MHSA Three-Year Integrated Plan occurred from February 13, 2023 through March 16, 2023. The MHSA Three-Year Integrated Plan was posted for 30-days, per Welfare and Institutions Code 5848, at http://wp.sbcounty.gov/dbh/programs/mhsa/. During this time, DBH promoted the 30-day public posting.

A press release, in English and Spanish, notifying the public of the posting was sent to over 7,000 subscribers of County Press Releases or the SB County Media contact list. A web blast in English and Spanish was released to community partners, community and contracted organizations, county agencies, cultural subcommittees and coalitions, and regularly scheduled stakeholder meetings. This information was also advertised on DBH sponsored social media sites, including Facebook, Instagram, and Twitter. Copies of the draft MHSA Three-Year Integrated Plan were available online for electronic viewing. Electronic submission of the comment forms were available in English and Spanish; hard copies were available upon request.

As a result, **39** completed surveys were received during the 30-day public posting and comment period, which provided general comments and support for the draft MHSA Three-Year Integrated Plan.

Overall, **84%** of stakeholders indicated that they were very satisfied or satisfied with the draft MHSA Three-Year Integrated Plan and stakeholder process.

Comments/recommendations were submitted via email to the DBH MHSA email box at MHSA@dbh.sbcounty.gov during the time the MHSA Three-Year Integrated Plan draft was posted for public comment. Stakeholders were also informed that comments may be received anytime through the year, but will not be included in the final MHSA Three-Year Integrated Plan unless provided during the 30-day public posting and comment period.

Comments/recommendations after the close of the 30-day public posting and comment period, may be submitted to the DBH MHSA email box at MHSA@dbh.sbcounty.gov or by calling 1-800-722-9866.

Overview of Public Posting and Comment Period (cont.)

Summary and Analysis of Substantive Comments

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

Question: What did you learn about the MHSA Three-Year Plan?

Comment: The plan is thorough and helps to convey the efforts and planned efforts of the County. I appreciate the community involvement and engagement process. I feel that I have had the opportunity to offer my feedback and actually see my input being valued and/or put into action.

Response: Thank you for comment. Information for review related to the stakeholder engagement process can be located in the Community Program Planning section of this Plan. DBH is committed to improving and growing existing programs along with investing in innovative ideas and welcomes comments and feedback. Your thoughts can be shared throughout the year at a stakeholder meeting, via email, phone call, or mail. For a calendar of stakeholder events, please visit https://wp.sbcounty.gov/dbh/media/. You may also contact MHSA Administration at (800) 722-9866, or by emailing MHSA@dbh.sbcounty.gov.

Question: What else would you like to learn about the MHSA process?

Comment: I would like to learn how the County prioritizes it's programs and the process to choose certain ones over the others.

Response: 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), requirements and program needs are considered. In addition to MHSA regulations.

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

Comment: We are missing a lot of services in the desert region.

Response: Thank you for your feedback. All MHSA programs were developed as part of a community program planning process with diverse stakeholders and include consumer and family members. DBH and MHSA services are available throughout each region of the County. Examples of a few MHSA programs available in the desert area include the Clubhouse and Community Connections program, the Regional Adult Full Service Partnership, Crisis Walk In Clinics, the Community Crisis Response Team, the Community Health Worker/ Promotores de Salud program, and Family Resource Centers. For more information about Behavioral Health services and locations, please visit our website at https://wp.sbcounty.gov/dbh/ or call (909) 388-0884.

Overview of Public Posting and Comment Period (cont.)

Stakeholder Demographics

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

- Individuals with serious behavioral health illness and/or serious emotional disturbance and/or their families.
- Providers of behavioral health and/or related services such as physical health care and/or social services.
- Representatives from the education system.
- Representatives of law enforcement and the justice system.
- Other organizations that represent the interests of individuals with serious a behavioral health illness and/or serious emotional disturbance and/or their families.

Groups Represented
4% Alcohol and Drug Service Program
16% Community-Based Organizations
41% Consumer of Mental Health Services
6% Consumer of Substance Use Disorder Services
18% Education/Students
<1% Faith-Based Organization
55% Family Member or Loved One
41% Federal, State, County, or City Government
41% Healthcare – Behavioral/Mental Health
1% Law Enforcement
19% Social or Human Service Program/Agency
2% Veterans Organization

Note: Some stakeholders selected more than 1 group

As listed in the schedule, special sessions of the Behavioral Health Commission's District Advisory Committee (DAC), along with other meetings, were conducted in each geographic region of the county. This schedule ensured representation and participation in each region of San Bernardino County.

To ensure participation of unserved, underserved, or inappropriately served cultural groups, the OEI provided stakeholder engagement meetings for the MHSA Three-Year Integrated Plan for each of their 14 Cultural Competency Advisory subcommittees. To further include community involvement, sessions were held in collaboration with Family Resource Centers, Clubhouses, and other community agencies such as the Department of Aging and Adult Services Senior Affairs Commission. Additionally, the PEI Provider meeting held a special session 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 Three-Year Integrated Plan and proposed program changes, as well as obtain feedback and recommendations for system improvement.

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

Stakeholder Demographics (cont.)

The tables to the right show the demographics in various categories for the individuals that participated in the CPP process and individuals that responded to the 30-Day Posting of this Three-Year Integrated Plan. Of the 691 participants, 582 returned a Stakeholder Feedback form. Not all participants responded to every question.

Age:
Of the individuals that completed a Stakeholder Feedback form, 75% were adults between the ages of 26 and 59 years old, while 15% were older adults age 60 and over. Individuals between the ages of 16 and 25 years old account for 4% of participants, while the remaining 6% is unknown.

Gender Identity:
The majority of CPP stakeholders identified as female (72%), while those who identified as male represent 19%. Individuals also identified as nonbinary (.3%), transgender (.3%), and genderqueer (.2%). The gender identity of the remaining 8% is unknown.

Race and Ethnicity:
Stakeholders identified their race/ethnicity as follows: 35% Latinx or Hispanic, 26% Caucasian, 13% African American, 3% Asian, 2% Native American, and 1% Native Hawaiian or Pacific Islander. About 9% of participants stated they identify as more then one race, while 11% did not disclose.

Primary Language:
The majority of stakeholders identified their primary language as English (83%), while 16% identified Spanish. Individuals also identified Mandarin (.5%), Arabic (.2%), Gujarati (.2%), and Vietnamese (.2%) as their primary language.

Geographic Region:
Participants stated that they lived or worked in the following regions: 21% East Valley, 19% Desert or Mountain, 17% West Valley, and 16% East Valley. Of the remaining participants, 7% said they lived or worked in a neighboring county, while 20% did not disclose.

Age	
0% Children	**75%** Adults
4% TAY	**15%** Older Adults

Gender Identity	
72% Female	**<1%** Nonbinary
<1% Genderqueer	**<1%** Trans Male/Man
19% Male	**7%** Other/Unknown

Race/Ethnicity	
13% African American/Black	**35%** Latinx/Hispanic
2% American Indian/Alaska Native	**1%** Native Hawaiian/Pacific Islander
3% Asian	**9%** More than one race
26% Caucasian/White	**11%** Other/Unknown

Primary Language	
<1% Arabic	**<1%** Mandarin
83% English	**16%** Spanish
<1% Gujarati	**<1%** Vietnamese

Geographic Region	
16% Central Valley	**21%** East Valley
19% Desert/Mountain	**17%** West Valley

N=582*

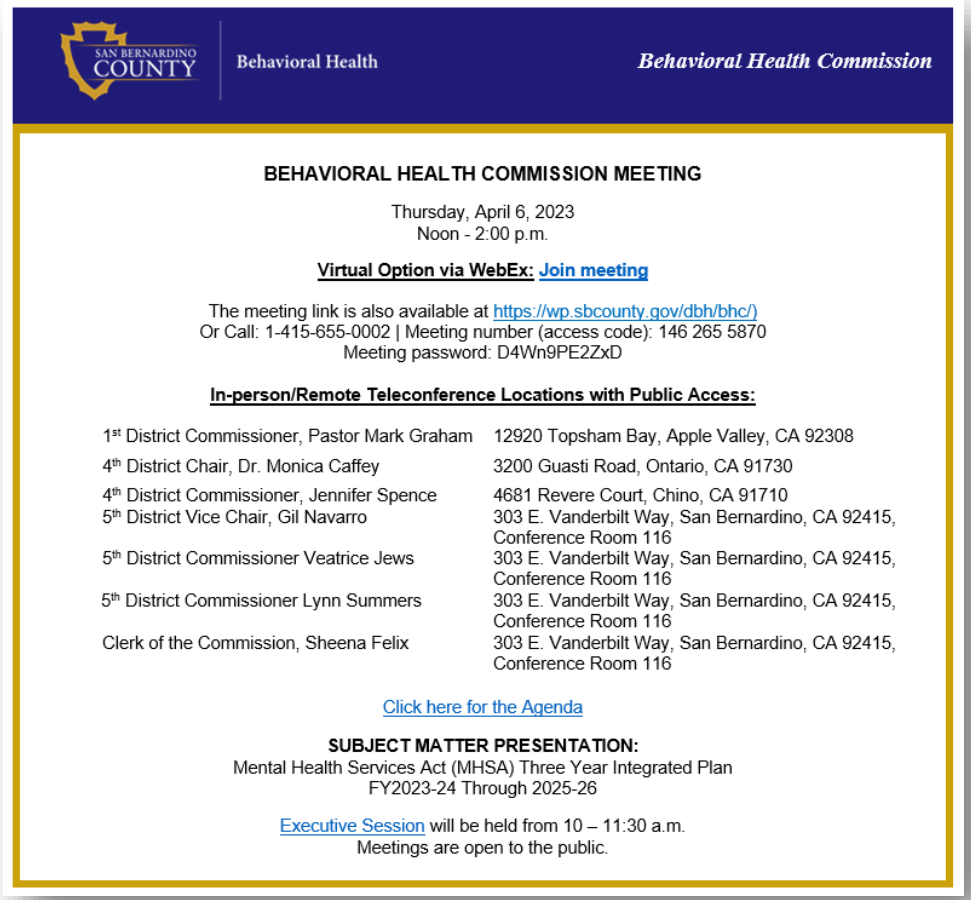
***Note:** Some respondents did not respond to every question. Not all responses equal 100 due to rounding.

Community Program Planning: Public Hearing

The Public Hearing hosted by the San Bernardino County Behavioral Health Commission was conducted on April 6, 2023 via a web-based forum. 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.

Comments received from the Behavioral Health Commissioners were addressed during the Public Hearing. One additional comment and question not responded to during the meeting focused on the definition of a Serious Mental Illness (SMI) or Serious Mental Disorder. Serious Mental Disorder means a mental disorder that is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time. Serious mental disorders include, but are not limited to, schizophrenia, bipolar disorder, post-traumatic stress disorder, as well as major affective disorders or other severely disabling mental disorders per Welfare and Institutions Code (WIC) 5600.3. 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 Three-Year Integrated Plan Fiscal Year 2023/24 through Fiscal Year 2025/26 to the San Bernardino County Board of Supervisors tentatively scheduled for approval in a May/June 2023 meeting and the subsequent submission to the Department of Health Care Services and Mental Health Services Oversight and Accountability Commission.



SAN BERNARDINO COUNTY | Behavioral Health | *Behavioral Health Commission*

BEHAVIORAL HEALTH COMMISSION MEETING

Thursday, April 6, 2023
Noon - 2:00 p.m.

Virtual Option via WebEx: Join meeting

The meeting link is also available at https://wp.sbcounty.gov/dbh/bhc/)
Or Call: 1-415-655-0002 | Meeting number (access code): 146 265 5870
Meeting password: D4Wn9PE2ZxD

In-person/Remote Teleconference Locations with Public Access:

1st District Commissioner, Pastor Mark Graham	12920 Topsham Bay, Apple Valley, CA 92308
4th District Chair, Dr. Monica Caffey	3200 Guasti Road, Ontario, CA 91730
4th District Commissioner, Jennifer Spence	4681 Revere Court, Chino, CA 91710
5th District Vice Chair, Gil Navarro	303 E. Vanderbilt Way, San Bernardino, CA 92415, Conference Room 116
5th District Commissioner Veatrice Jews	303 E. Vanderbilt Way, San Bernardino, CA 92415, Conference Room 116
5th District Commissioner Lynn Summers	303 E. Vanderbilt Way, San Bernardino, CA 92415, Conference Room 116
Clerk of the Commission, Sheena Felix	303 E. Vanderbilt Way, San Bernardino, CA 92415, Conference Room 116

Click here for the Agenda

SUBJECT MATTER PRESENTATION:
Mental Health Services Act (MHSA) Three Year Integrated Plan
FY2023-24 Through 2025-26

Executive Session will be held from 10 – 11:30 a.m.
Meetings are open to the public.

Improvements in Progress

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

- Multi-media and technological approaches to education and information sharing, including the use of social media platforms to introduce and engage stakeholders.
- Focus on specific populations for improvements.
- Additional locations and times for meetings to be held outside of current county meetings and locations.

The following are examples of Department responses to stakeholder feedback:

Approaches to Education and Information Sharing to Introduce and Engage Stakeholders

To better advertise, communicate, and educate our diverse stakeholders to the departments' activities, events, goals, resources, and programs examples of how the department is incorporating technology and varied media approaches to support education and stakeholder engagement are highlighted below:

- Hiring of additional staff dedicated to Public Relations and Outreach (PRO) to assist with communication and engagement of stakeholders via social media platforms.
- Collaboration of PRO and the Mental Health Services Act (MHSA) Administration Office to identify opportunities through out the CPP process where additional stakeholder engagement exist.
- Ensuring that additional networks and resources available are utilized to determine beneficial practices within other MHSA counties that have increased stakeholder engagement are implemented in San Bernardino County.
- Working with a consultant to assess the effectiveness of our CPP process and where there are areas growth is needed to engage stakeholders.

Focus on Specific Populations for Improvements

In an effort to improve outreach to the African American community, the Office of Prevention and Early Intervention (PEI) continues to assess current outreach programs to address concerns related to engagement with the African American community the below steps have been completed or are in progress:

- Extensive community program planning was conducted to gather information from stakeholders and community members for ongoing program needs and future expansions.
- An assessment of the current data collection methods was conducted to implement adjustments that will increase the likelihood for more ample results.
- PEI Providers have been meeting regularly with PEI program staff to develop ongoing solutions to challenges that have been identified when serving specific target populations.

Improvements in Progress (cont.)

Meeting Location and Times

To increase stakeholder participation and to continue to accommodate the needs of our stakeholders, Department of Behavioral Health (DBH) continues to be flexible in altering meeting times for stakeholder meetings and has also changed or alternated some the meeting locations to allow for easier accessibility.

During the Community Planning Process (CPP) meetings for the Mental Health Services Act (MHSA) Three-Year Integrated Plan virtual (Webex) and in person meetings were held. Virtual Sessions also had call-in options. In person meetings were held at locations accessible to consumers and their families. These included peer led Clubhouses and Family Resource Centers. To ensure representation from all regions meetings were coordinated and held with the Behavioral Health Commissions (BHC) District Advisory Committees.

To increase meetings outside of current county meetings and locations the following efforts will continue:

- Partner with community and faith based partners to host CPP meetings
- Collaborate and work with the Cultural Competency Advisory Committee, BHC and Consumer Evaluation Council to identify locations outside of county facilities to hold meetings.

SAN BERNARDINO COUNTY
Behavioral Health

MHSA Three-Year Program and Expenditure Plan for FYs 23/24-25/26: PEI Component including Annual Prevention and Early Intervention Report

Introduction

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

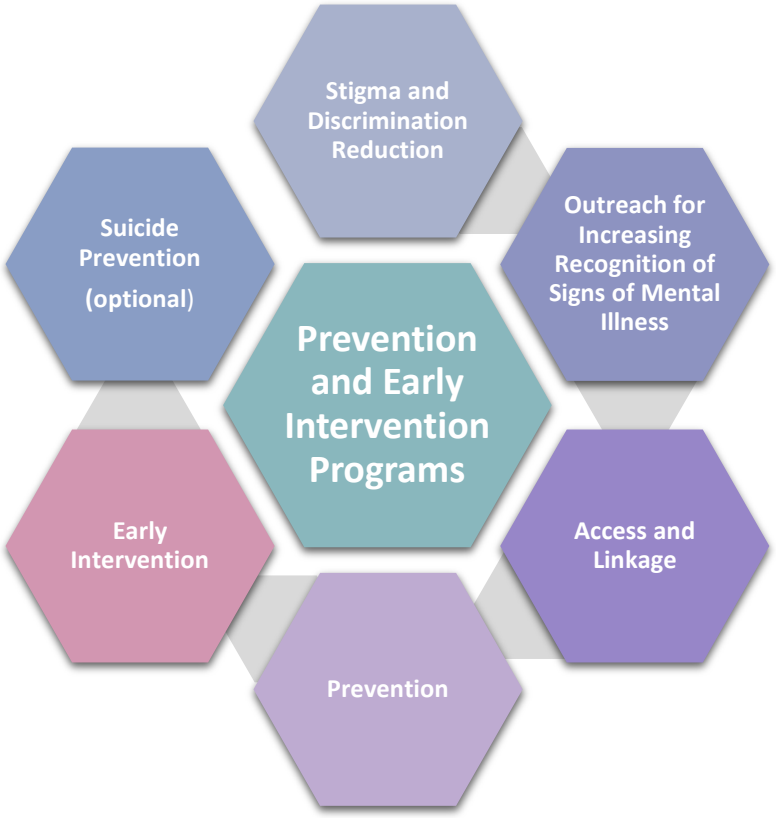
Strategies and activities are applied early on to avert the onset of mental health conditions or relapse among individuals. The component also seeks to change community conditions known to contribute to behavioral health concerns.

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

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

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

State-Defined Prevention and Early Intervention Programs



Introduction, cont.

Local PEI Construct

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

Stigma and Discrimination Reduction

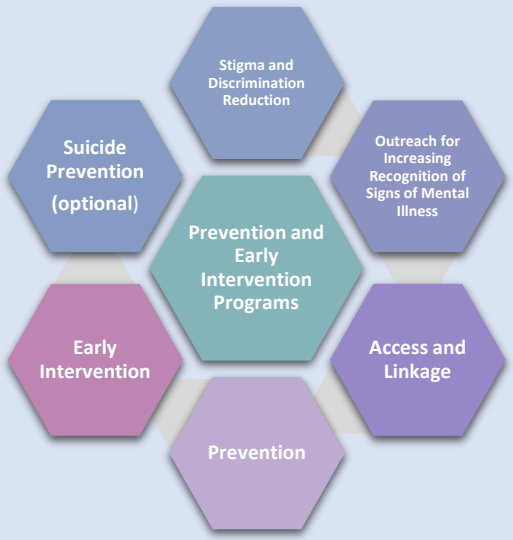
- Native American Resource Center (NARC)

Outreach for Increasing Recognition of Signs of Mental Illness

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

Access and Linkage to Treatment

- Child and Youth Connection (CYC)



Prevention

- Preschool PEI Program (PPP)
- Resilience Promotion in African American Children (RPiAAC)
- Lift
- 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

Introduction, cont.

MHSA Legislative Goals and Key Outcomes	Local Program
Increase early access and linkage to medically necessary care and treatment:	
• Connect children, adults, and seniors with severe mental illness, as early in the onset of these conditions as practicable to medically necessary care and treatment including, but not limited to, care provided by County mental health programs.	• CYC OACS • SAP Lift
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 • MSFS • SAP
Promote, design, and implement programs in ways that reduce and circumvent stigma:	
• Reduce and circumvent stigma, including self-stigma. • Reduce discrimination related to being diagnosed with a mental illness, having a mental illness, or seeking mental health services. • Increase service accessibility.	• NARC
Prevent suicide as consequence of mental illness:	
• Improve attitudes, knowledge, and/or behavior regarding suicide related to mental illness.	• MSFS • CWE • OACS
Increase recognition of early signs of mental illness:	
• Increase identification of early signs of potentially severe and disabling mental illness for potential responders. • Increase support to individuals with mental illness. • Increase referrals for individuals who need treatment or other mental health services.	• CHW/PdS • BHMPP • IEOCC • OACS
Reduce prolonged suffering associate with mental illness:	
• Reduce risk factors. • Reduce indicators. • Increase protective factors that may lead to improved mental emotional and relational functioning. • Reduce symptoms. • Improve recovery, including mental, emotional and relational functioning.	• OACS CYC • SAP FRC • PPP Lift • CASE MSFS • IDEA RPIAAC
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.	• CWE RPIAAC • CHW/PDS

Introduction, cont.

SB 1004 PEI Program Priority Areas

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

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

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

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

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

Prevention and Early Intervention

Introduction, cont.

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

A series of stakeholder engagement workshops were presented covering PEI programs grouped by topic. Each engagement workshop was presented twice with a lunch time workshop and an afternoon workshop to reach a greater audience.

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

Two additional meetings were held at the following standing meetings.

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

A total of 220 stakeholders attended the 10 engagement meetings, including the MHSA Executive Committee and PEI Provider Network Meetings

Invites were sent to general public, stakeholders, CPAC, Behavioral Health Commission, PEI providers, and Office of Equity and Inclusion

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

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

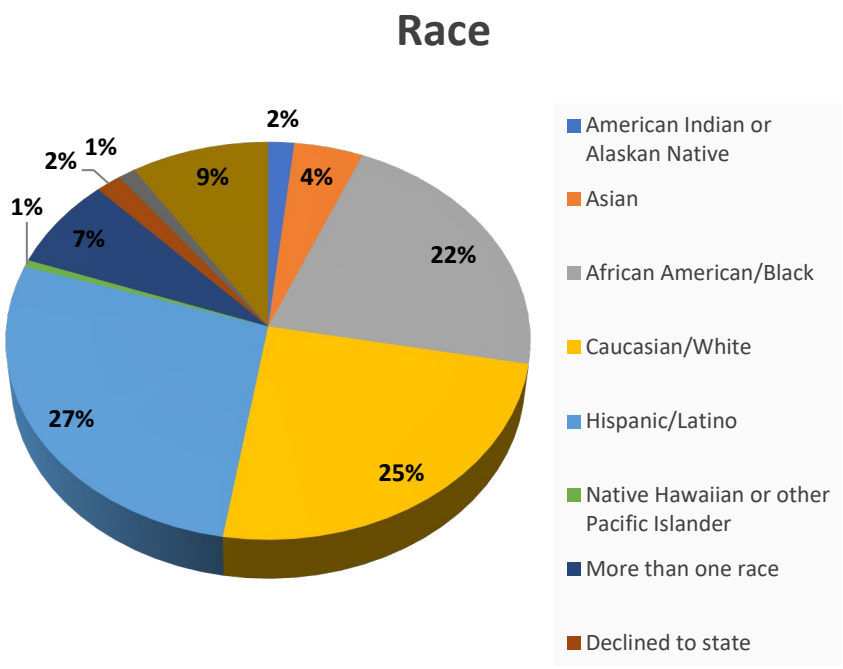
- Review staffing patterns in programs to include more paraprofessionals
- Strengthen partnerships with faith-based community to expand future access points to services
- Assess current data collection methods and identify areas of improvement
- Implement survey education prior to completion
- Improve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

Introduction, cont.

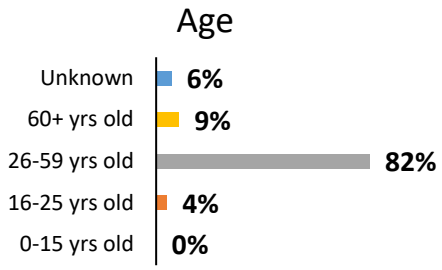
PEI Community Program Planning (cont.)

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

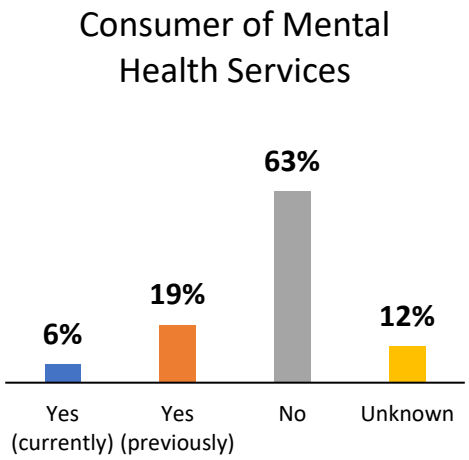
The rich racial diversity of San Bernardino County was reflected in the demographic data of the participants with 22% of the participants identifying as African American, 25% Caucasian, 27% Hispanic, and 4% Asian. In addition, 7% of participants indicated that they identify with more than one race.

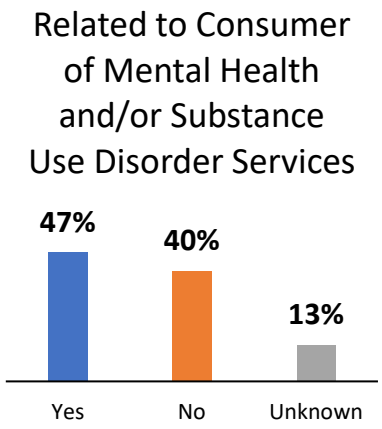


The majority of participants were adults, with 82% reporting that they were between 26-59 years old, 9% were older adults over 60, 4% TAY aged youth (16-25), and 6% who did not respond.



Participants comprised of a mix of individuals with 25% reporting that they are either a current or previous consumer of mental health services and 47% reporting that 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 data collection portal for activities related to prevention, outreach for increasing recognition of early signs of mental illness, access & linkage, improving timely access, and stigma & discrimination reduction. PEI program providers use the My Avatar 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 are described in greater detail in the sections that follow.



Painted Circles – artwork by Gabriel Horne

Introduction, cont.

PEI Statewide Project

PEI Statewide Projects intended to build PEI capacity across the state as well as 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, for the purpose of making 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 21/22 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 trainings 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 provided crisis support, capacity building, guidance, and resource navigation of stigma reduction, suicide prevention, and student mental health. The TA Team also hosted a Suicide Prevention Week 2021: Messaging Matters webinar covering the principles of safe and effective messaging about suicide prevention as well as a parent-focused webinar, Suicide Prevention 101 for Parents: Recognizing Signs and What to Do.



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 as well as stigma and discrimination reduction.

One hundred fifteen participants submitted a total of 41 films. Entries were submitted from filmmakers from seven San Bernardino County schools: Apple Valley High School, Upland High School, Hesperia High School, Entrepreneur High School, Options for Youth – Acton, Encore High School, and CHORDS at Del Vallejo Middle School. San Bernardino County filmmakers whose entries competed in the categories of Mental Health Matters, Suicide Prevention, Animated Short, and Through the Lens of Culture.

San Bernardino County hosted a Directing Change Recognition Ceremony at the Cinemark Theater in Rialto on May 18, 2022 to honor the San Bernardino County filmmakers.

Directing Change Mini-Grant: Granite Mountain Charter School received a Mini-Grant award. This is the first year that Granite Mountain Charter School has an ASB. These students will be creating the films. And piloting a few clubs, such as video production and editing, to encourage participation in future Directing Change submissions. This would be a fantastic opportunity and experience for their students to come together and collaborate for a great cause. For their event, they are considering a movie viewing and teaching a few lessons within ASB but to also host ASB events for students outside of the club.

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

Training	Description
Directing Change Judges Training	Online trainings that provided an overview of best practices in suicide prevention and mental health messaging, giving volunteer judges criteria to apply in evaluating student-submitted Directing Change videos.
Each Mind Matters Insiders Newsletter	A monthly electronic newsletter created specifically for service providers that provides information about relevant resources, upcoming events and opportunities for providers to get involved in California's Mental Health Movement.
Suicide Prevention 101 for Parents: recognizing Signs and What to Do	Webinar series providing information for parents including • Recognizing warning signs for suicide • How to have a conversation with your teen Actions to take if your teen is having suicidal thoughts • Tips and resources to support emotional and mental health during COVID-19 • Information about raising resilient teens
Suicide Prevention Week 2021: Messaging Matters	Participants learned about responsible media reporting, how to engage the news media as partners in suicide prevention, and how to create effective suicide prevention materials.

Number of Consumers to be Served

The tables below demonstrates the number of consumers to be served by program name for Fiscal Year (FY) 2023/24, FY 2024/25 and FY 2025/26:

Program Name	Fiscal Year 2023/24 Total	Fiscal Year 2024/25 Total	Fiscal Year 2025/26 Total
Native American Resource Center	1,751	1,751	1,751
Promotores de Salud/Community Health Worker	30,665	30,665	30,665
Inland Empire Opioid Crisis Coalition (IEOCC)	3,400	3,400	3,400
Child and Youth Connection	5,235	5,235	5,235
Preschool PEI	1,508	1,508	1,508
Resilience Promotion in African-American Children	4,190	4,190	4,190
Older Adult Community Services	3,166	3,166	3,166

Program Name	Fiscal Year 2023/24 Total	Fiscal Year 2024/25 Total	Fiscal Year 2025/26 Total
Lift	120	120	120
Coalition Against Sexual Exploitation (CASE)	1,500	1,500	1,500
Family Resource Center	26,945	26,945	26,945
Community Wholeness and Enrichment	2,956	2,956	2,956
Military Services and Family Support	3,878	3,878	3,878
Student Assistance Program	9,172	9,172	9,172
Early Psychosis Program / IDEA	26	26	26

Native American Resource Center (NARC)

Target Population and Program Description

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

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

The adjacent table provides an overview of the target population of the program, the location of services, the number of consumers to be served each year, the annual budget allocation, and the types of services offered. The Native American Resource Center program continually assesses the needs of its participants and updates the types of services offered, as necessary.

Program Summary	
Program Serves	Children TAY (16-25) Adults Older Adults (60+)
Location of Services	Counseling Centers
Number of Consumers to be Served	1,751
Annual Budget FY 2023-24	$500,000
Cost Per Client FY 2023-24	$285
Services Offered	Talking Circles Wellness Circles Drumming Circles Daughters of Tradition Cultural education and awareness Cultural arts therapy Cognitive therapy groups

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

Native American Resource Center (NARC), cont.

Program Highlights

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

Stigma & Discrimination Reduction

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

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

The utilization of behavioral health services decreased from 9,338 to 5,200 between FY 2020-21 to FY 2021-22 as shown in the table to the right. Although there was a decrease in actual services, the program exceeded their annual projected services.

Surveys used in this program include:

- Stigma Reduction Questionnaire (SRQ)
- Historical Trauma Conference Survey
- Wellbriety Movement: The Journey to Forgiveness Survey
- Dawnland Survey

As a result of the culturally-based mental wellness activities offered by the Native American Resource Center, the total number of individuals participating in Native American Resource Center activities continues to be greater than their projected targets. This is demonstrative of an increase in seeking and accepting assistance for behavioral health concerns.

The total participation decreased in FY 2021-22, more than half from the previous years. The decrease reflected in FY 2021-22 is partly due to the to the gradual reduction of COVID-19 testing and vaccination sites, where the NARC provided mental health resources and education during the pandemic.

Number of Participants / Number of Services Projected vs Actual

	Projected	Actual		
		FY 2019-20	FY 2020-21	FY 2021-22
Unduplicated Participants	1,751	3,555	8,469	4,138
Number of Services	2,544	4,169	9,338	5,200

Native American Resource Center (NARC), cont.

Program Highlights, cont.

Access & Linkage to Services

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

The number of participants who linked to referrals during the previous three fiscal years are shown in the table below. The number is relatively low in comparison to the total number served. This is an indicator that the program is successful in reducing a potential illness from becoming disabling.

Access and Linkage to Services Referrals			
	FY 2019-20	FY 2020-21	FY 2021-22
Number of Referrals Provided	7	6	5
Number of referrals to County-funded / administered programs	0	0	0
Number of referrals to other programs	7	6	5
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.

Improving Timely Access

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

Improving Timely Access Referrals			
	FY 2019-20	FY 2020-21	FY 2021-22
Number of Referrals Provided	127	139	294

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

Native American Resource Center (NARC), cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-50	60+	UNK
FY 2019-20	5%	8%	19%	3%	65%
FY 2020-21	1%	1%	3%	0%	95%
FY 2021-22	2%	2%	4%	1%	91%

Fiscal Year	Veteran Status
	% of consumers who identified as a veteran
FY 2019-20	1%
FY 2020-21	0%
FY 2021-22	0%

Fiscal Year	Sexual Orientation
	% of consumers who identified as LGBTQ+
FY 2019-20	<1%
FY 2020-21	<1%
FY 2021-22	0%

Fiscal Year	Disability
	% of consumers who identified a physical disability
FY 2019-20	3%
FY 2020-21	<1%
FY 2021-22	1%

Fiscal Year	Gender Identity			
	♂ Male	♀ Female	⚧ Other	UNK
FY 2019-20	17%	45%	<1%	38%
FY 2020-21	9%	18%	<1%	73%
FY 2021-22	11%	26%	0%	64%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 2019-20	100%	0%	0%	0%
FY 2020-21	100%	0%	0%	0%
FY 2021-22	97%	0%	0%	3%

Native American Resource Center (NARC), cont.

Demographics, cont.

	Race / Ethnicity			
		FY 2019-20	FY 2020-21	FY 2021-22
Race	African-American/Black	3%	0%	1%
	American Indian or Alaska Native	50%	4%	6%
	Asian	1%	0%	0%
	Native Hawaiian or Pacific Islander	0%	0%	0%
	More than One Race	13%	0%	1%
	Caucasian/White	4%	1%	1%
	Other Race	0%	0%	3%
	Declined to Answer	26%	93%	87%
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	8%	10%	1%
	Filipino	0%	0%	0%
	Japanese	0%	0%	0%
	Korean	0%	0%	0%
	Middle Eastern	0%	0%	0%
	Vietnamese	0%	0%	0%
	Other	0%	0%	1%
	More than one ethnicity	65%	1%	0%
	Declined to Answer	33%	99%	98%

Demographic Observations

- The NARC program provides services that are culturally appropriate to the Native American community.
- The number of participants served decreased in FY 2021-22. This was likely due to less presence at COVID-19 test and vaccination sites and as restrictions were relaxed.
- Traditionally, this program gathers demographic survey data from in-person services. Restrictions that limited contact with participants reduced the ability to distribute and collect surveys. A majority of participants were less comfortable completing an electronic demographic survey online.

Native American Resource Center (NARC), cont.

Program Goals

The goals of the Native American Resource Center are to:

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

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

By administering these types of surveys, they are able to measure changes in attitudes, knowledge, and behaviors related to behavioral health services.

During FY 2021-22, most of the activities have continued to be presented virtually. Although well received in attendance, the participant response to virtual surveys has significantly declined, resulting in a 5% response rate for the historical trauma surveys and 0% in the Stigma reduction Questionnaire surveys. Methods for collecting survey data are being evaluated to determine more culturally appropriate strategies.

Program Outcome Tools		
Survey Name	Historical Trauma Survey	Stigma Reduction Questionnaire (SRQ) Surveys
Description of Method	Mixed-use survey designed to measure changes in attitudes, knowledge, and behavior through a combination of survey questions, storytelling, and artistic expression	Survey to measure changes in attitudes, knowledge and behavior related to mental health services
Survey Type	Post-activity	Post-activity
Number Completed	FY 2019-20: 46 FY 2020-21: 74 FY 2021-22: 5	FY 2019-20: 195 FY 2020-21: 205 FY 2021-22: 0

Native American Resource Center (NARC), cont.

Outcome Discussion

Historical Trauma and Reduction of Stigma

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

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

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

The Native American Resource Centers held three presentations in various settings addressing historical trauma during FY 2021-22.

On October 1, 2021, Dawnland was presented to staff of Native Challenge programs, reaching 11 participants. A discussion of the effects that historical trauma and boarding schools has on survivors and their families followed the presentation. Staff explored historical, structural and systemic racism on families and the Truth and Reconciliation Commission of Maine.

As part of the Native American Heritage Month, NARC presented a seminar with the San Bernardino County Department of Children and Family Services, explaining what historical trauma is. The seminar addressed the barriers to care that Native Americans experience and how those barriers can increase certain negative behaviors. The seminar reached 11 participants and provided insight into the dynamics of working with a Native American family and tips on how to support and guide Native American families that they are working with.

NARC presented a cultural training to students in the Loma Linda University Psychology Department to a group of 68 participants. The presentation addressed the various challenges and barriers that Native American face when it comes to accessing mental health services. A history was provided as well as the importance of utilizing indigenous knowledge systems in prevention as well as client care.

Results from the completed surveys show that 100% of the respondents agree that these presentations provided a better understanding of how the impact of historical trauma affects at-risk populations, have increased participants' ability to address the effects of historical trauma when working with Native American and Alaskan Native clients, and the attending the programs will benefit the communities participants serve.

Native American Resource Center (NARC), cont.

Outcome Discussion, cont.

Stigma Reduction Surveys

The Native American Resource Center utilized the Stigma Reduction Questionnaire (SRQ) in FY 2021-22 as it's primary for capturing stigma related outcomes. The survey was certified by the Consumer Evaluation Council as being inclusive and appropriate prior to implementing the survey. This survey is used at events and activities that are intended to reduce stigma and discrimination. It assesses the changes in beliefs and perceptions of the participants as a result of the activity or presentation.

This is a reflective survey that is administered at the completion of the event or activity. Participants are asked how much more likely they would be willing to engage or support someone living with a mental health challenge. A sample of questions and responses are shown in the accompanying table.

As noted previous, during FY 2021-22, the activities have continued to be presented virtually. Electronic surveys have not been well received resulting in a significant decline in participant response. Methods for collecting survey data are being evaluated to determine more culturally appropriate strategies.

Percentage of participants who agreed that they would be more likely to engage or support someone living with a mental health challenge

	FY 2019-20 N=195	FY 2020-21 N=205
More likely to seek mental health support if needed	61%	76%
More likely to talk to a friend or family member about mental health needs	64%	77%
More likely to socialize with someone who has a mental illness	62%	80%
More likely to take action to prevent mental health discrimination	60%	78%
More likely to actively and compassionately listen to someone in distress	61%	83%

Native American Resource Center (NARC), cont.

Program Challenges/Solutions

The Native American Resource Center has consistently experienced challenges in collecting demographic data from program participants. The program does well in collecting qualitative and quantitative data. However, when participants are asked to provide demographic data (age, gender, sex at birth, etc.) the response rate declines. The NARC experienced additional challenges in data collection for fiscal year 2021-22 with the SRQ.

The NARC has developed services and presentations for San Bernardino County staff intended to increase awareness and knowledge of the impact of historical trauma, however the approval process of these materials has proved difficult and delayed delivery on their scheduled dates. During the fiscal year, the San Bernardino DBH developed and implemented an approval process and timeframe for such provider presentations. This process allowed for the NARC to create their presentations and plan activities in advance so the can be delivered by their planned dates.

Many community members prefer to meet in-person, however COVID-19 restrictions continued to limit in-person events and outreach. Virtual meeting platforms, such as Zoom, were utilized to reach and meet with the community. As restrictions were relaxed, the NARC began hosting in-person events in addition to virtual meeting spaces. Informational kits were also created for participants to complete at home for those that did not prefer them virtually.

Program Updates

There are no planned program updates for Fiscal Year 2023-24.



Golden Bird Feels Very Special – Art

Native American Resource Center (NARC), cont.

Collaborative Partners

A Greater Hope
Borrego Health
California State University of San Bernardino
Children's Network
Co-Occurring and Substance Abuse Awareness Subcommittee
Crafton Hills College
Crime Survivors Redlands
Fatherhood Juvenile Justice Program
First 5
Inland Empire Health Plan (IEHP)
Loma Linda University School of Social Work
Malki Museum
Morongo Tribal TANF
Native American Awareness Subcommittee
Office of Cultural Competency and Ethnic Services
Option House Domestic Violence Shelter
Partner Against Violence
Safe and Family Justice Center
Safe House
San Bernardino County Child Support Services
San Bernardino County Department of Behavioral Health
San Bernardino County District Attorney
San Bernardino County Public Social Services
San Bernardino County Victim Services
San Bernardino Sexual Assault
San Bernardino Unified School District Title 6 Program
San Bernardino Valley College
San Manuel Band of Mission Indians
Sherman Indian High School
TAY Center
Tribal Alliance - Partners in Both Riverside and San Bernardino County
U.S. Department of Forestry
University of California Riverside
University of Redlands
Victor Valley College
Women's Awareness Subcommittee

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

Target Population and Program Description

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 that were identified by community stakeholders as having the highest need : Latinx, African-American, Asian and Pacific Islander, LGBTQ+, and Native Americans.

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

The adjacent chart provides an overview of the program services.



Program Summary	
Program Serves	Children TAY (16-25) Adults Older Adults (60+)
Location of Services	Community based
Number of Consumers to be Served	30,665
Annual Budget FY 2023-24	$1,264,429
Cost Per Client FY 2023-24	$41
Services Offered	Mental Health and Substance Use Screenings and Assessments Mental Health Educational Presentations Case Management Resource Referrals Peer Counseling

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

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

Program Highlights

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, African American, 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 that share many of the same social, cultural, and economic characteristics as the target population. This increases the probability that communities will engage with Promotores de Salud or Community Health Workers.

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

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

The table below provides a demographic breakdown of the Promotores de Salud and Community Health Workers that make this program successful.

Promotores de Salud and Community Health Worker Demographics		
Promotores de Salud and Community Health Workers	Latinx/Hispanic	34
	Asian Pacific Islander	5
	African American	1
	LGBTQ+	1
	Native American	1
Peer Providers	African American	2
	LGBTQ+	2
	Native American	2
	Asian Pacific Islander	1



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

Program Highlights, cont.

Outreach

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

The PdS/CHW program community outreach efforts reached out to a total of 201,222 participants from FY 2019-20 through FY 2021-22. This figure includes potential responders in the community, who are people in the community that can identify early signs of mental illness and refer individuals to behavioral health services.

Unduplicated participant counts declined from FY 2020-21 to FY 2021-22. This is due partly to remaining restrictions set in place by the COVID-19 public health emergency at the start of the fiscal year. The restrictions were implemented in FY 2019-20 and continued into early FY 2021-22. PdS/CHW's used a combination of mostly virtual presentations in combination with field-based outreach strategies to reach potential responders. The program still collectively exceed the plan goals by exceeding the annual projected number to be served.

The table below shows the projected numbers to be served and the actual participant counts over the last three fiscal years.

Number of CHW Participants / Number of Services Projected vs Actual				
	Projected	Actual		
		FY 2019-20	FY 2020-21	FY 2021-22
Unduplicated Participants	11,500	13,523	15,904	12,820
Number of Services	15,520	14,241	16,825	13,851

Number of PdS Participants / Number of Services Projected vs Actual				
	Projected	Actual		
		FY 2019-20	FY 2020-21	FY 2021-22
Unduplicated Participants	23,885	58,562	50,539	49,875
Number of Services	25,385	61,426	50,777	58,519

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

Program Highlights, cont.

Outreach

The PdS/CHW program captures information on the number of potential responders trained each year. This enables in tracking the increase of mental health awareness in the community. Between FY 2019-20 through FY 2021-22 the program engaged an average of 66,500 potential responders per year.

Potential Responders			
	Number of Potential Responders		
	PdS	*CHW*	*Total*
FY 2019-20	58,565	13,441	72,006
FY 2020-21	50,539	15,607	66,146
FY 2021-22	48,753	12,610	61,363

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. Listed below are the specific potential responders who participated in the program.

- Consumer family members
- Families
- Community service providers
- Employers
- Leaders of faith-based organizations
- Primary health care providers
- Emergency medical providers
- Family law practitioners
- Children and Family Services personnel
- Law enforcement personnel
- Peer providers
- Military personnel and veterans

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

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

Types of Settings	
• Behavioral health clinics • Community-based organizations • Community events • County facilities • Cultural organizations • Family resource centers	• Faith-based organizations • Hospitals • Senior centers • Schools • Residences • Shelters • Virtual (Zoom, Webex, Facebook Live)

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

Program Highlights, cont.

Improving Timely Access to Underserved Populations

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

The program continues to find solutions to increase the data collection and outcomes after a referral is made. The PdS/CHW program has been successful in connecting underserved populations to timely services. There has been a decrease in the number of referrals each fiscal year since FY 2019-20 through FY 2021-22.

The program is actively examining program design to increase referrals.

Improving Timely Access Referrals			
	FY 2019-20	**FY 2020-21**	**FY 2021-22**
# of Referrals Provided	392	294	205
Referred To	• Prevention • Early Intervention • Treatment Beyond Early Onset		

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



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

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

Demographics

Fiscal Year	CHW Age (yrs. old)				
	0-15	16-25	26-50	60+	UNK
FY 2019-20	7%	7%	17%	7%	62%
FY 2020-21	<1%	<1%	2%	2%	95%
FY 2021-22	1%	2%	1%	2%	94%

Fiscal Year	PdS Age (yrs. old)				
	0-15	16-25	26-50	60+	UNK
FY 2019-20	8%	15%	62%	9%	7%
FY 2020-21	13%	18%	52%	7%	10%
FY 2021-22	12%	20%	56%	7%	6%

Fiscal Year	Sexual Orientation	Fiscal Year	Sexual Orientation
% of CHW consumers who identified as LGBTQ+		% of PdS consumers who identified as LGBTQ+	
FY 2019-20	0%	FY 2019-20	<1%
FY 2020-21	<1%	FY 2020-21	<1%
FY 2021-22	<1%	FY 2021-22	<1%

Fiscal Year	Disability	Fiscal Year	Disability
% of CHW consumers who identified a physical disability		% of PdS consumers who identified a physical disability	
FY 2019-20	<1%	FY 2019-20	<1%
FY 2020-21	<1%	FY 2020-21	<1%
FY 2021-22	<1%	FY 2021-22	<1%

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

Demographics cont.

Fiscal Year	CHW Gender Identity			
	Male	Female	Other	UNK
FY 2019-20	12%	21%	2%	65%
FY 2020-21	3%	6%	<1%	91%
FY 2021-22	4%	7%	<1%	90%

Fiscal Year	PdS Gender Identity			
	Male	Female	Other	UNK
FY 2019-20	41%	51%	0%	8%
FY 2020-21	38%	54%	0%	8%
FY 2021-22	31%	42%	0%	27%

Fiscal Year	CHW Primary Language			
	ENG	SPAN	OTH	UNK
FY 2019-20	81%	0%	1%	18%
FY 2020-21	86%	0%	2%	12%
FY 2021-22	46%	0%	2%	52%

Fiscal Year	PdS Primary Language			
	ENG	SPAN	OTH	UNK
FY 2019-20	9%	83%	0%	8%
FY 2020-21	6%	88%	5%	1%
FY 2021-22	5%	89%	0%	6%

Fiscal Year	CHW Veteran Status
	% of consumers who identified as a veteran
FY 2019-20	1%
FY 2020-21	<1%
FY 2021-22	<1%

Fiscal Year	PdS Veteran Status
	% of consumers who identified as a veteran
FY 2019-20	<1%
FY 2020-21	<1%
FY 2021-22	<1%

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

Demographics, cont.

	CHW Race / Ethnicity			
		FY 2019-20	FY 2020-21	FY 2021-22
Race	African-American/Black	6%	1%	<1%
	American Indian or Alaska Native	8%	<1%	2%
	Asian	3%	2%	2%
	Native Hawaiian or Pacific Islander	1%	<1%	<1%
	More than One Race	11%	<1%	0%
	Caucasian/White	6%	<1%	<1%
	Other Race	5%	<1%	<1%
	Declined to Answer	60%	96%	96%
Ethnicity	African	1%	<1%	<1%
	Asian Indian/South Asian	<1%	<1%	<1%
	Cambodian	0%	0%	0%
	Chinese	5%	2%	2%
	Eastern European	<1%	<1%	0%
	European	<1%	0%	0%
	Hispanic/Latino	4%	<1%	<1%
	Filipino	<1%	<1%	<1%
	Japanese	<1%	<1%	0%
	Korean	<1%	0%	<1%
	Middle Eastern	<1%	0%	0%
	Vietnamese	<1%	<1%	0%
	Other	<1%	<1%	<1%
	More than one ethnicity	0%	<1%	0%
	Declined to Answer	93%	96%	98%

Demographic Observations

- CHW demographic data includes all target population programs (African American, Asian Pacific Islander, LGBTQ+, Native American)
- Race is a social category. Individuals are classified based on socially significant characteristics.
- Ethnicity refers possession of a common heritage historically. This heritage includes behaviors, beliefs, customs, languages, and symbols.

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

Demographics, cont.

	PdS Race / Ethnicity			
		FY 2019-20	FY 2020-21	FY 2021-22
Race	African-American/Black	<1%	<1%	<1%
	American Indian or Alaska Native	<1%	0%	<1%
	Asian	<1%	<1%	<1%
	Native Hawaiian or Pacific Islander	0%	<1%	<1%
	More than One Race	<1%	1%	6%
	Caucasian/White	55%	61%	47%
	Other Race	14%	16%	6%
	Declined to Answer	30%	22%	40%
Ethnicity	African	1%	<1%	<1%
	Asian Indian/South Asian	<1%	<1%	<1%
	Cambodian	<1%	<1%	0%
	Chinese	<1%	<1%	0%
	Eastern European	<1%	0%	0%
	European	<1%	<1%	<1%
	Hispanic/Latino	79%	91%	92%
	Filipino	<1%	0%	0%
	Japanese	0%	0%	0%
	Korean	0%	0%	0%
	Middle Eastern	0%	0%	<1%
	Vietnamese	<1%	<1%	<1%
	Other	1%	22%	21%
	More than one ethnicity	3%	2%	<1%
	Declined to Answer	95%	76%	78%

Demographic Observations

- The PdS program served its primary target population all three fiscal years, with most participants identifying as Latinx/Hispanic.
- The primary language for participants for all three fiscal years was identified as primarily Spanish.
- The majority of PdS participants were adults aged 26-59 years old.
- Race is a social category. Individuals are classified based on socially significant characteristics.
- Ethnicity refers possession of a common heritage historically. This heritage includes behaviors, beliefs, customs, languages, and symbols.

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

Program Goals

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

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

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

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

The adjacent table provides a summary of the tool used and a brief description.

Program Outcome Tools		
Survey Name	Stigma Discrimination Reduction Surveys	PEI Outreach Survey
Description of Method	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)	PEI The Outreach Survey has a total of 16 questions. The first 9 are used to collect PEI demographic information and the last 7 are used to gather information on participants confidence with recognizing potential mental health challenges and seeking services if needed.
Survey Type	Post – after each Stigma Reduction presentation	Pre and Post each educational Outreach activity
Number completed	FY 2019-20: 3,752 FY 2020-21: 3,699 FY 2021-22: 4,277	FY 2019-20: 73 FY 2020-21: 72 FY 2021-22: 430

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

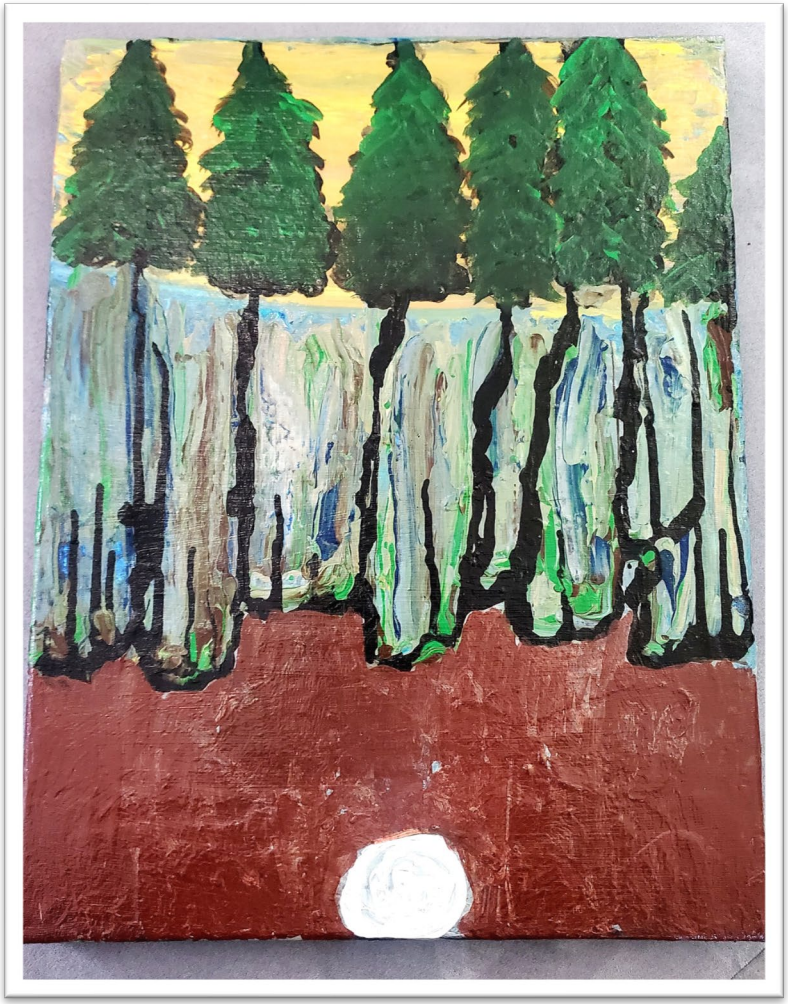
Outcome Discussion

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

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

An objective of this program is to train the potential responders and other members of the community to recognize behaviors or symptoms that may be indicative of someone who is suffering from a mental health challenge. Furthermore, the program helps people become more comfortable providing support to 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 a change in learning, perception and help seeking behaviors.



Here's to 22 – artwork by Bre Lopez

Promtores de Salud/Community Health Workers (PdS/CHW), cont.

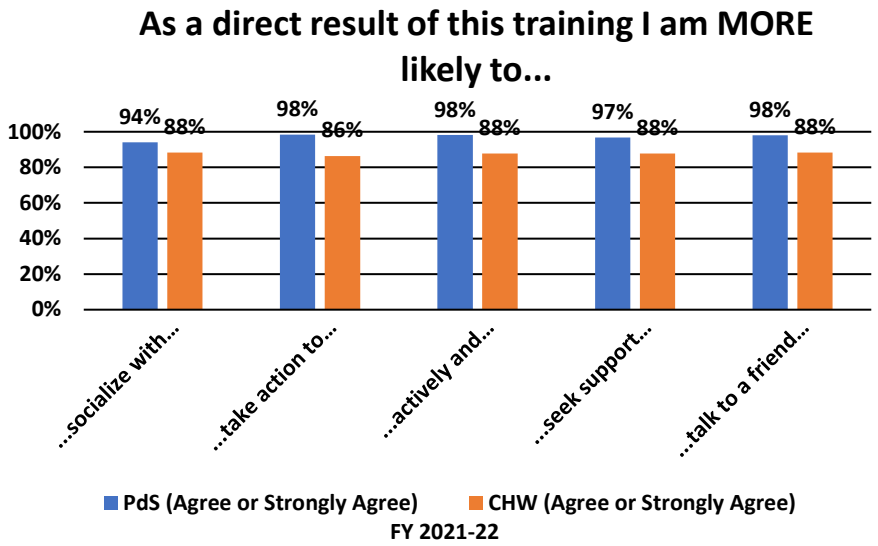
Outcome Discussion cont.

In FY 2021-22, the PdS/CHW program began using a newly constructed stigma survey to measure stigma-related outcomes. capture participant's changes in how they feel after participating in an event or activity. The new Stigma Reduction Questionnaire (SRQ), captures participant's changes in how they feel after participating in an event or activity. Sample questions include:

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

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

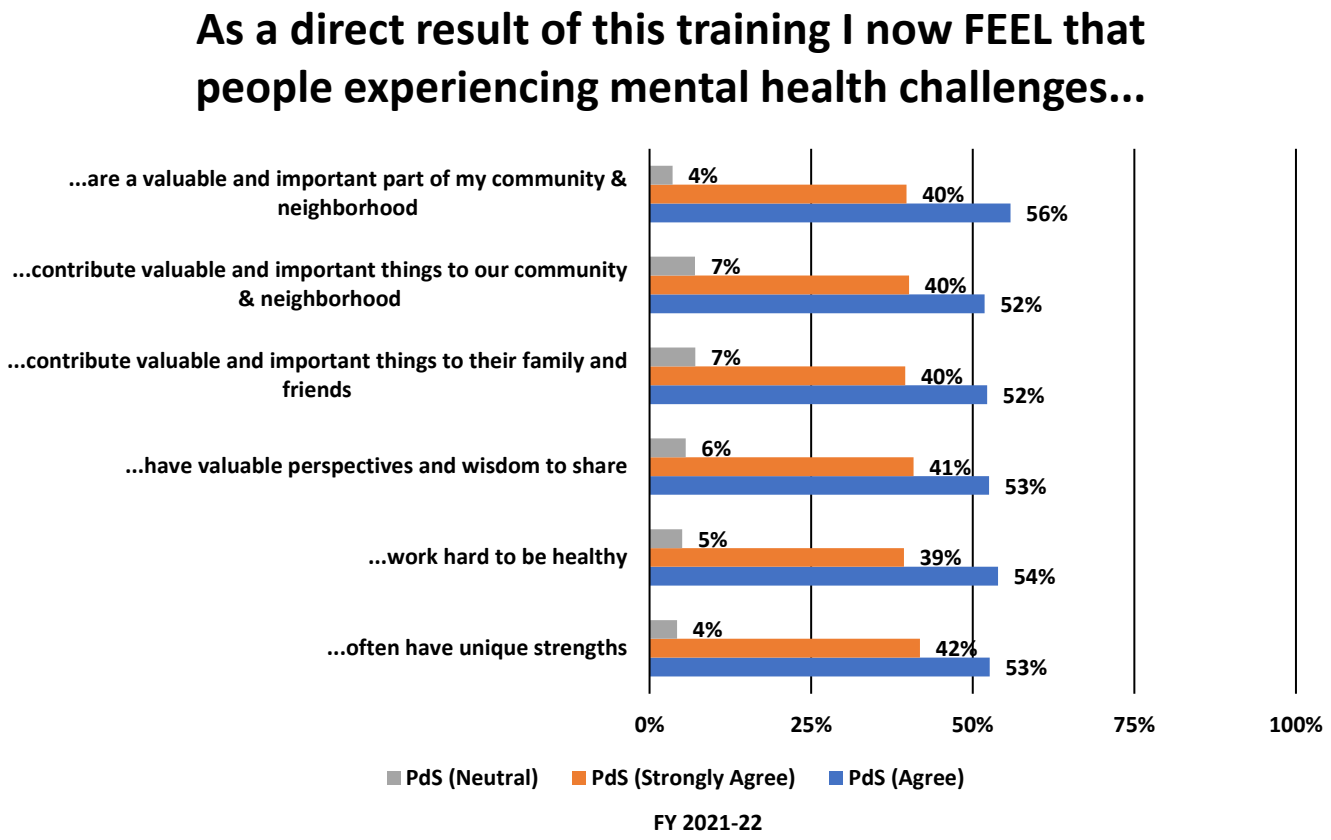
The results of the survey show most participants agree or strongly agree with the statements below as a direct result of what they learned after participating in an event or activity. Over 92% of participants agree or strongly agree with a sample of the stigma survey questions after attending an event or activity. The data collected is represented in the charts below. The results demonstrate that the stigma activities and education participants received resulted in an overall reduction of stigma surrounding mental health.



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

Outcome Discussion, cont.

The additional stigma survey results below demonstrate a change in attitudes of the participants who received a stigma-reduction activity. This is demonstrated by 96% of PdS participants agreeing or strongly agreeing that anyone experiencing mental health challenges are a valuable and important part of their community and neighborhood. Additionally, 93% of participants agreed or strongly agreed that people experiencing mental health challenges do work hard to be healthy.

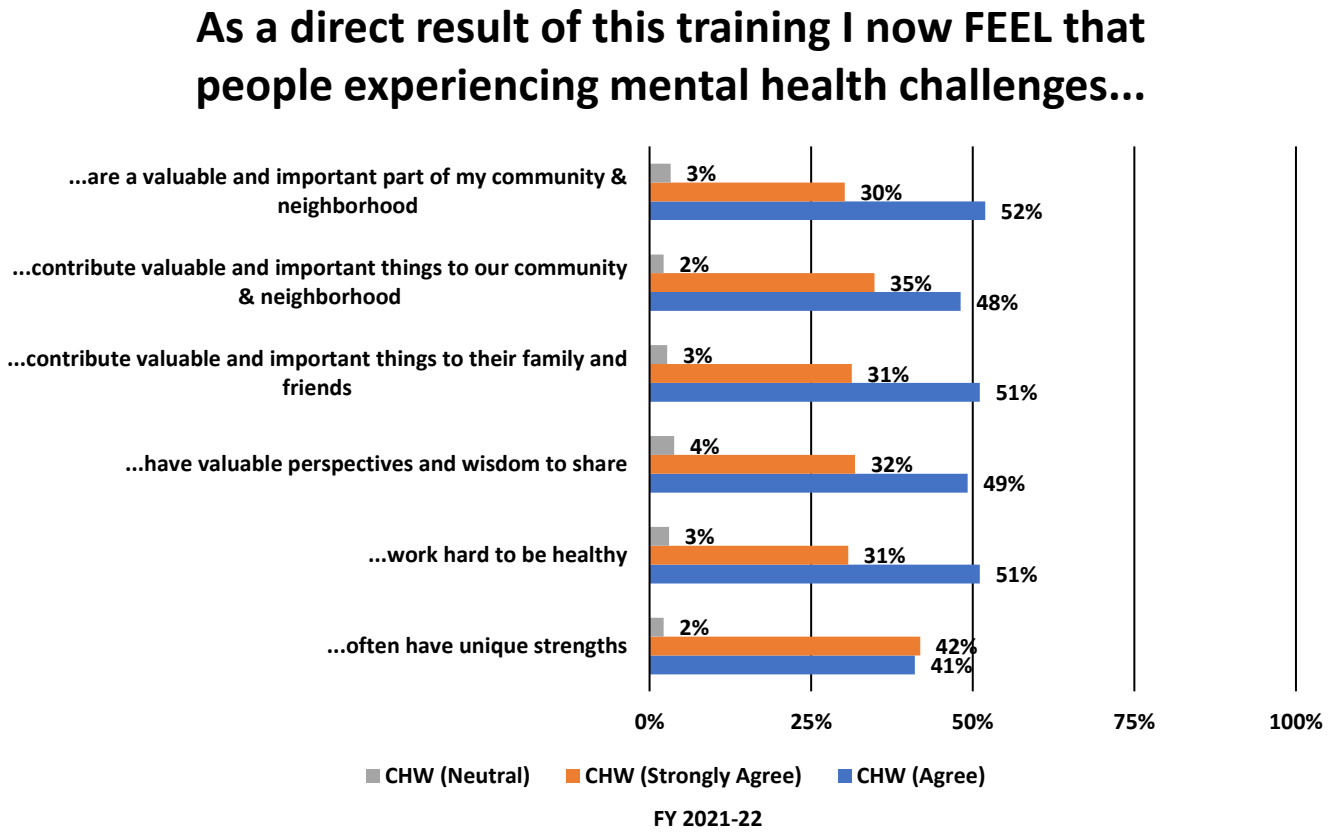


Promotores de Salud/Community Health Workers (PdS/CHW), cont.

Outcome Discussion, cont.

Similar outcomes show that the same could be concluded for CHW target populations. These outcomes show that 83% of participants either agree or strongly agree that people contribute valuable and important things to their family and friends while experiencing mental health challenges.

Lastly, 81% of participants either agree or strongly agree that people have valuable perspectives and wisdom to share while experiencing mental health challenges.



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

Program Challenges/Solutions

One of the primary challenges with PdS/CHW was adopting creative methods to provide in person presentations and services to the community amidst COVID-19 surges. Utilization of virtual meeting spaces continued as COVID-19 restrictions kept providers from providing in person services. While communicating via virtual chat applications became the best alternative to in person interaction, some communities experienced limited access to knowledge of technology.

The Asian and Pacific Islander (API) population has remained as a difficult population for CHWs to reach due to the stigma attached to mental health and illness. There is an ongoing effort to strengthen trust in the API community so that relationships can be built within the community and reduce the stigma associated with mental health.

PdS/CHWs experienced challenges in all target populations with collecting data through the demographic surveys. These surveys are an important means for collecting demographic data from participants and evaluating the effectiveness of the services provided. Providers cite that the length of the of the survey is a contributing factor to the decrease in accurate and complete data. Another contributing factor in collecting survey data is the stigma surrounding the nature of some survey questions. This can be exacerbated when services are targeted at traditionally underserved populations that have experienced historical trauma and discrimination. As a result, there is a large percentage of the participants that will not complete the survey or prefer not to answer all the questions.

With COVID-19 restrictions becoming more relaxed, PdS/CHWs will again be able to integrate in person outreach to the community, in combination with virtual outreach. Consumers have adapted to using virtual applications, which have allowed CHWs to host group chats, live art and live poetry. CHWs are also using social media platforms, such as Facebook and Instagram, to post resources to helpful information regarding mental health and wellness.

While PdS/CHWs have consistently had difficulty collecting data, they are implementing new engagement strategies to improve collection efforts. One strategy entails educating PdS/CHWs to understand the importance of gathering data so that they can then convey that message to the community when demographic surveys are completed.

Lessons Learned

As more in-person activities and events become available, PdS/CHWs can begin to resume some of their more traditional approaches to reaching their communities. Also, there will need to be continued effort by PdS/CHWs to provide survey education and implement strategies to encourage completion, which could include incentives or prizes.

Program Updates

There are no planned program updates for Fiscal Year 2023-24.

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

Collaborative Partners

211 Riverside & San Bernardino
Adelanto Unified School District Parent Engagement Centers
Advantage Health Care Services
African American Health Coalition
Alta Loma High School
Amazing Place Clubhouse
Amazonite Treatment Center (ATC)
Baldy View ROP
Barstow Unified School District (Barstow High School)
Barstow Community College
Borrego Health
Burning Bush Christian Church
C.A.S.A. of San Bernardino County
Catholic Charities
Catholic Diocese of San Bernardino Ministry of Life
Chaffey High School
Children and Family Services
Chino School District
Chino Valley YMCA
CIT - Crisis Intervention Training with Law Enforcement & DBH
City of Chino
City of Redlands Recreation & Senior Services
City of Rialto
City of Victorville
Colony High School
Community Health Systems Inc
Community In Unity
Community Policy Action Committee (CPAC)
Consulate of Mexico in San Bernardino
Consumer and Family Members Awareness Subcommittee
Crestline Christian Church
Cultural Competency Advisory Meeting
Disabilities Awareness Subcommittee
District Advisory Committee (DAC)
DOVES of Big Bear Valley
Eagle's Nest Community Center
El Sol Neighborhood Educational Services
ELAC English Learner Advisory Committee
Esperanza Project
Etiwanda High School
Etiwanda Intermediate High School
Family Assistance Program
Family Service Association
Fifth Senior Center
First Assembly of God
First Presbyterian Church
Fontana Community Assistance Program (CAP)
Fontana Community Senior Center
Fontana Police Department
Goodwin's Market
Guatemalan Consulate San Bernardino
Helendale School District Academy Charter Academy Carrier Exploration (ACE Academy)
Hesperia Parent Family Resource Center
Hesperia Unified School District
High Desert Church
Holy Catholic Church
Holy Innocents Catholic Church – Religious Education Program

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

Collaborative Partners

Holy Innocents Catholic Church – Religious Education Program
Homeless Coalition
Inland Coalition For Immigrant Justice (IC4IJ)
Inland Congregation United for Change (ICUC) organization
Inland Empire Career and Education Center
Inland Empire Disabilities Collaborative
Inland Empire Health Plan (IEHP)
Inland Empire Health Plan (IEHP) Community Resource Center High Desert
Inland Empire Health Plan (IEHP) San Bernardino Family Resource Center
Inland Valley Recovery Services
Lake Arrowhead Community Water District
Latino Awareness Subcommittee
Loma Linda University
Los Amigos Elementary School
Los Osos High School
Mary's Mercy Center Inc.
Mentone Elementary School
Montclair High School
Mountains Community Hospital
National Alliance on Mental Illness (NAMI)
Ontario High School
Ontario-Montclair School District Family Resource Centers
Option House, Inc. San Bernardino
Options for Youth
Our Lady of Hope Parish
Our Lady of the Lake Catholic Church
Perris Hill Senior Center
Planned Parenthood San Bernardino
Perris Hill Senior Center
Planned Parenthood San Bernardino
Preschool Services
Project Boon
Rancho Cucamonga High School
Reach Out
Restaurando Vidas Church
Rialto Unified School District Cesar Chavez/Dolores Huerta Center of Education District Parent Center
Rim of the World Unified School District
SAC Health System
Saint Francis Cabrini Catholic Church
Salvation Army
San Bernardine Dignity Health Center
San Bernardino City Unified School District (SBCUSD Parent/Family Engagement Centers-High Schools Centers)
San Bernardino City Unified School District (SBCUSD)
San Bernardino Community Action Partnership
San Bernardino County Department of Behavioral Health (DBH)
San Bernardino County Department of Child Support Services (DCSS)
San Bernardino County Department of Children and Family Services (DCFS)
San Bernardino County Preschool Services
San Bernardino County Sheriff Department
San Bernardino Police Department
Sick N' Tired Recovery Home
SOAR Charter School
South Coast Community Services
Spirituality Awareness Subcommittee

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

Collaborative Partners

Supremo Llamamiento Church
TELACU
The Children's Fund
The Stay
Times for Change
TruEvolution
Unidos Por La Musica (UPLM)
Valley Star
Valley View High School
Veronica's Home of Mercy
Victor Community Support Services
Victor Elementary School District
Victor Valley Community College
Victor Valley High School
Victor Valley Resource Center
Victor Valley Unified School District
Vision Radio Station 87.7 FM
Women, Infants, and Children (WIC) - Hesperia, Adelanto, and Victorville
Women's Awareness Subcommittee



In Autumn – artwork by Linda James

Behavioral Health Ministries Pilot Project (BHMPP)

Target Population and Program Description

The Behavioral Health Ministries Pilot Project is a collaboration between the Department of Behavioral Health (DBH) and the Inland Empire Concerned African American Churches (IECAAC). The project seeks to collaborate with a network of faith-based organizations and assist in identifying the unmet behavioral health needs of the faith-based, African American Community. The goal is to provide participants with education and resources to address the behavioral health needs of their congregations within church settings and provide appropriate and timely resources for members to access needed behavioral health resources. This pilot project is being implemented over a two (2) year time span from May 2021 through April 2023.

Program Summary	
Program Serves	Children TAY (16-25) Adults Older Adults (60+)
Location of Services	IECAAC member churches in the Central and West Valley regions
Number of Consumers to be Served	Total: 340
Annual Budget FY 2023-24	N/A
Cost Per Client FY 2023-24	N/A
Services Offered	Needs Assessment Asset Mapping Outreach Engagement Education Training Referrals to appropriate behavioral health services

Behavioral Health Ministries Pilot Project (BHMPP), cont.

Program Highlights

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

The BHMPP began developing trainings and presentations based on the feedback received from a series of town halls and focus group meetings. Some training topics that were identified and categorized included: mental health conditions, education and resources, trauma, and substance use. Following the analysis of town hall and focus group feedback, the BHMPP either held or attended over a dozen community outreach events or trainings. In May and June 2021, the first two months of the BHMPP, services were provided to 32 unduplicated participants. In fiscal year 2021-22, the program reached 288 unduplicated participants and provided over 551 services to their target population. The program reached 18 church leaders and 270 IEAAC members, congregants, and community leaders.

Number of Participants / Number of Services Projected vs Actual				
	Projected	Actual		
		FY 2019-20	FY 2020-21	FY 2021-22
Unduplicated Participants	340	N/A	32	288
Number of Services	600	N/A	32	551

Behavioral Health Ministries Pilot Project (BHMPP), cont.

Program Highlights, cont.

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

The project is comprised of 8 taskforce members that provide presentations to IECAAC congregations and community responders. The taskforce members have a combination of both lived experience and/or an educational background in mental health

The pilot project is divided into four phases. During the 2021-22 fiscal year, the BHMPP began implementing phases three and four, Community Engagement and Establishment of Behavioral Health Ministries and Reporting. The 2021-22 fiscal year is the first full year of survey and data collection. BHMPP seeks to serve forty (40) Church pastors and leaders and three-hundred (300) IECAAC members, congregants and community members per fiscal year of this project. The project looks to continue development in Phases III and IV.

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

Behavioral Health Ministries Pilot Project (BHMPP), cont.

Program Highlights, cont.

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

Types of Settings
• Community-based organizations • Community events • Faith-based organizations • Virtual (Zoom and Webex)

Potential Responders	
	Number of Potential Responders
FY 2019-20	N/A
FY 2020-21	N/A
FY 2021-22	149

Stigma & Discrimination Reduction

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

As part of the project's first phase, evaluations and surveys were developed to aid the project in measuring changes in behaviors, attitudes, and knowledge. The surveys measure these elements by gauging how the participant's perception of mental illness has transformed as a result of the attended activity. In the first full fiscal year of survey collection, results largely revealed that participants experienced positive changes in attitudes towards mental health and illness after attending BHMPP led activities. Of the participants that attended stigma reduction trainings, survey data showed that 42 participants strongly agreed that the training was relevant to them and other people of similar cultural backgrounds and experiences (race, ethnicity, gender, religion, etc.). In addition to this, 29 participants strongly agreed that they would seek support from a mental health professional if they thought it was needed. Lastly, 37 participants strongly agreed that they would encourage friends or family members to seek support from a mental health professional if they thought it was needed.

Behavioral Health Ministries Pilot Project (BHMPP), cont.

Program Highlights, cont.

Increase Recognition of Early Signs

As part of the project's second phase, the BHMPP developed their educational trainings and presentations with the purpose of reducing stigma and discrimination, and to educate and increase recognition of signs and symptoms of serious mental illness and emotional disturbance. These presentations were given to IECAAC members who could then be responders in their congregations and direct those in need to the necessary resources.



Pre and post survey data shows that there was a 16% increase in knowledge regarding mental health and a 19% increase in knowledge regarding mental illness. And with this knowledge, after responders completed their trainings, 12% would be able to better connect people with mental health challenges to appropriate county behavioral health programs, and 11% would be able to better connect people who are at-risk of mental illness to appropriate county behavioral health programs.

Behavioral Health Ministries Pilot Project (BHMPP), cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-59	60+	UNK
FY 2020-21	N/A	N/A	N/A	N/A	N/A
FY 2021-22	0%	2%	19%	26%	53%

Fiscal Year	Veteran Status
	% of consumers who identified as a veteran
FY 2020-21	N/A
FY 2021-22	2%

Fiscal Year	Sexual Orientation
	% of consumers who identified as LGBTQ+
FY 2020-21	N/A
FY 2021-22	0%

Fiscal Year	Disability
	% of consumers who identified a physical disability
FY 2020-21	N/A
FY 2021-22	4%

Fiscal Year	Gender Identity			
	♂ Male	♀ Female	⚧ Other	UNK
FY 2020-21	N/A	N/A	N/A	N/A
FY 2021-22	7%	12%	0%	81%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 2020-21	N/A	N/A	N/A	N/A
FY 2021-22	68%	1%	0%	31%

Behavioral Health Ministries Pilot Project (BHMPP), cont.

Demographics, cont.

	Race / Ethnicity		
		FY 2020-21	FY 2021-22
Race	African-American/Black	N/A	66%
	American Indian or Alaska Native	N/A	0%
	Asian	N/A	0%
	Native Hawaiian or Pacific Islander	N/A	0%
	More than One Race	N/A	1%
	Caucasian/White	N/A	1%
	Other Race	N/A	1%
	Declined to Answer	N/A	32%
Ethnicity	African	N/A	9%
	Asian Indian/South Asian	N/A	0%
	Cambodian	N/A	0%
	Chinese	N/A	0%
	Eastern European	N/A	0%
	European	N/A	0%
	Hispanic/Latino	N/A	4%
	Filipino	N/A	0%
	Japanese	N/A	0%
	Korean	N/A	0%
	Middle Eastern	N/A	0%
	Vietnamese	N/A	0%
	Other	N/A	45%
	More than one ethnicity	N/A	8%
	Declined to Answer	N/A	66%

Demographic Observations

- To date, demographic information collected from BHMPP indicates that the program continues to meet the targeted audience of African-American Adults.
- Most participants are from the 26-59 and 60+ age groups, indicating that there may be additional opportunities to reach the TAY 16-25 age group.
- Few participants identified as veterans or military members. The BHMPP is looking for opportunities to outreach to veteran groups within their congregations to increase awareness.
- Many participants declined to disclose their gender identity, and felt the question was inappropriate to ask or declined to answer. This reveals that there may still be stigma with different gender identities within the African American faith-based community.

Behavioral Health Ministries Pilot Project (BHMPP), cont.

Program Goals

The primary goal of BHMPP is to provide participants with education and resources to address the behavioral health needs of their congregations within church settings. BHMPP began to accomplish these goals in Phases II and III during fiscal year 2021/22 with Behavioral Health Education and Awareness and Community Engagement activities. The program set out to accomplish their goal of reaching an estimated three-hundred and forty (340) unduplicated participants with these efforts.



Program Outcome Tools	
Survey Name	Behavioral Health Ministries Pilot Project Pre and Post Surveys
Description of Method	A survey developed in collaboration with DBH to measure participant education, awareness, and stigma reduction at each for each BHMPP outreach and engagement activity held.
Survey Type	Before and after each engagement and outreach event
Completed Surveys	137

Behavioral Health Ministries Pilot Project (BHMPP), cont.

Below are the project goals for the BHMPP.

Behavioral Health Education and Awareness:

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

Community Engagement:

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

Outcome Discussion

Overall, there is an upward trend in religious communities encouraging the importance of mental health. Congregations are vital places that help shape the lives of members and are instrumental in shaping the positive narratives around behavioral health. Stigma is a predominant contributor to why members in the African-American faith-based community do not speak about or seek help or mental health resources.

An objective of this project is to train Inland Empire Concerned African American Churches (IECAAC) members and other community members to be potential responders to identify behaviors or symptoms that may be indicative of someone who is suffering from a mental health challenge. Furthermore, the program helps people become more comfortable providing support to those individuals. That support can include informing individuals of the risks surrounding untreated mental illness and reducing the stigma surrounding accessing services.

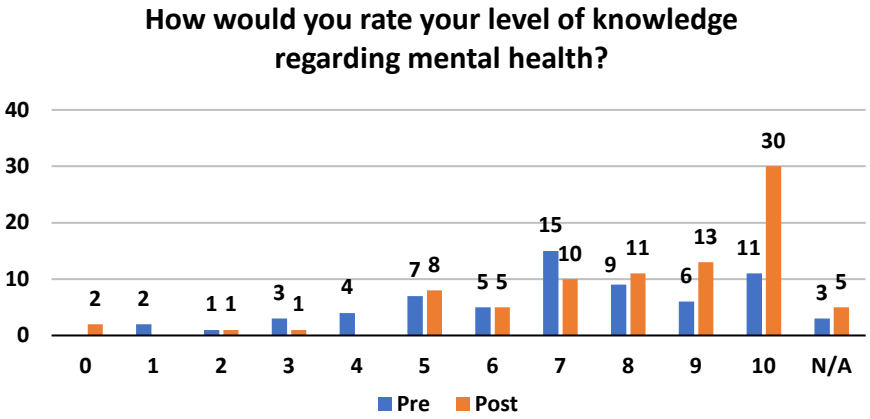
The San Bernardino County Department of Behavioral Health Office of Prevention and Early Intervention established aggressive goals at the commencement of the project. However, pre and post survey data shows that the target population already had a working knowledge of mental health, mental illness, and substance use disorders. Although the projected targets for each goal were not met, there was overall improvement in increasing knowledge and reducing stigma.

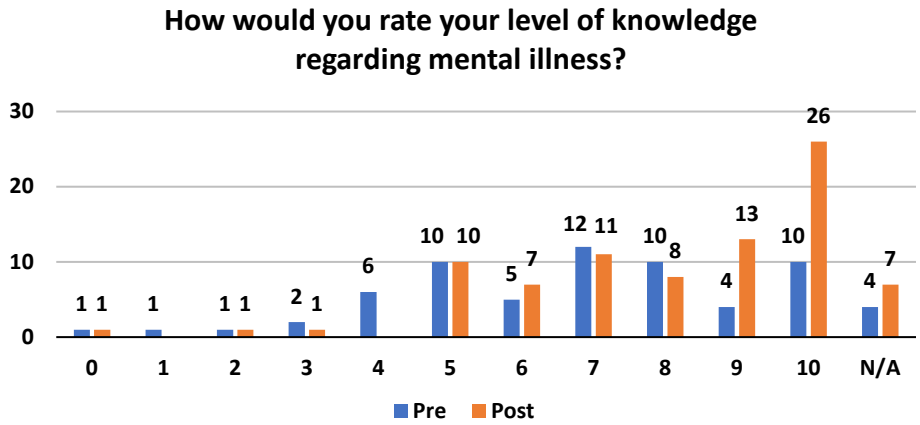
Behavioral Health Ministries Pilot Project (BHMPP), cont.

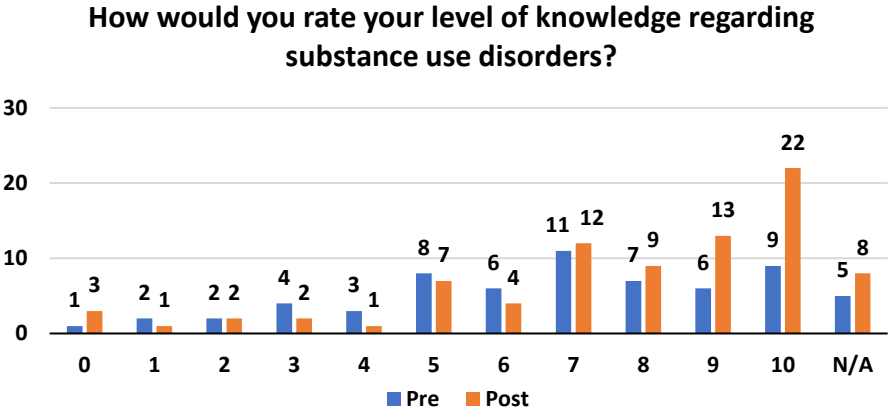
IECAAC, with assistance from the San Bernardino County Department of Behavioral Health's Research and Evaluations team, developed surveys that aligned with the MHSA Prevention and Early Intervention regulations to capture measurable outcomes for the project's goals. The project began collecting data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

The BHMPP surveys gauge the change in participant's attitudes, knowledge, and stigma prior to and after events or activities. Sample questions include:

On a scale from 0 to 10, with 0 having no knowledge and 10 having extensive knowledge, their knowledge of mental health, mental illness, and substance use disorders. These results reflect that the BHMPP presentations have been successful in increasing knowledge amongst its participants.

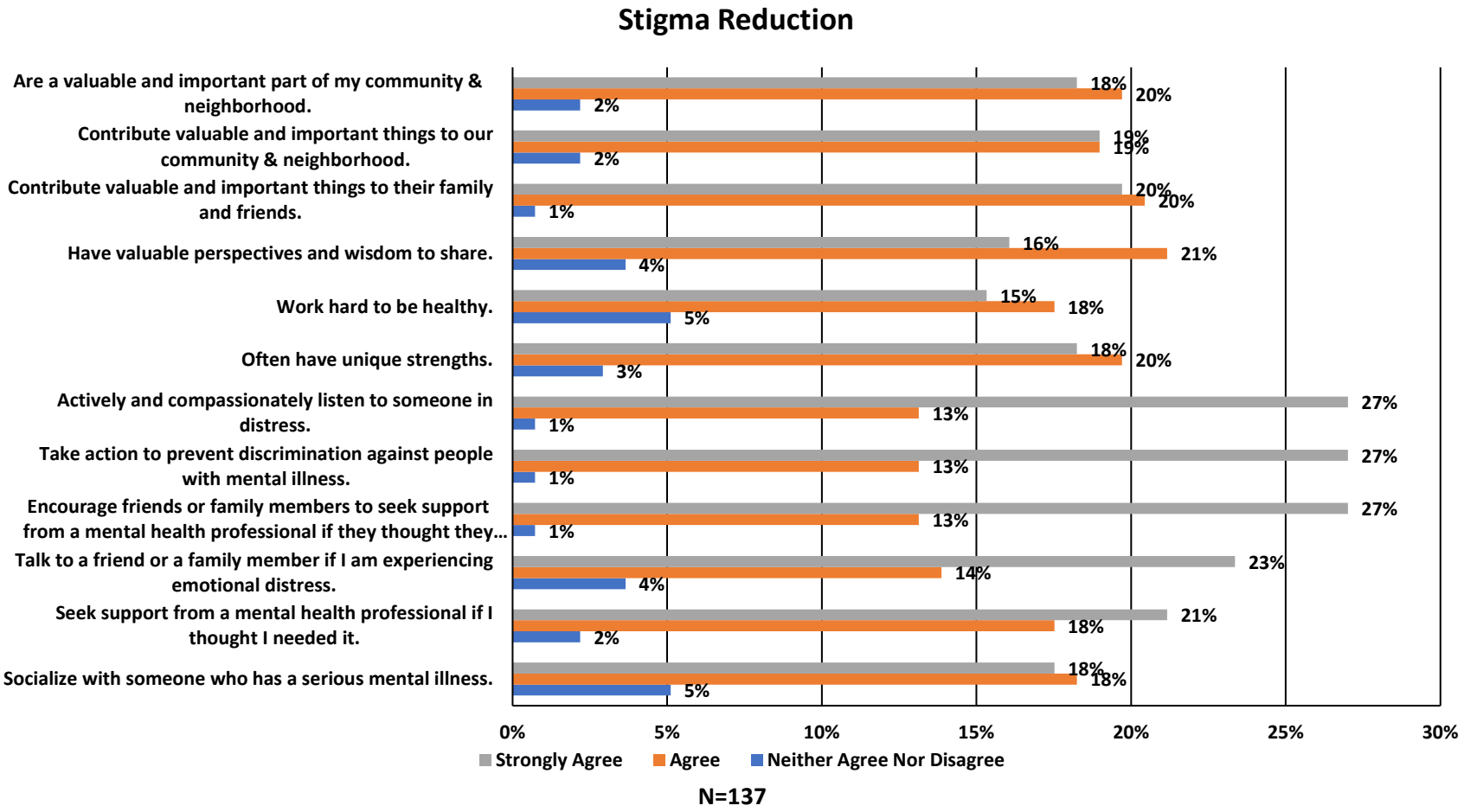






Behavioral Health Ministries Pilot Project (BHMPP), cont.

The survey developed for the BHMPP also captured changes in attitudes of the participants who received a stigma-reduction related presentation. Over 37% of participants agree or strongly agree that they are more likely to talk to a friend or family member if they were experiencing emotional distress. Furthermore, 40% of participants agree or strongly agree that they are more likely to take action to prevent discrimination against people with mental illness.



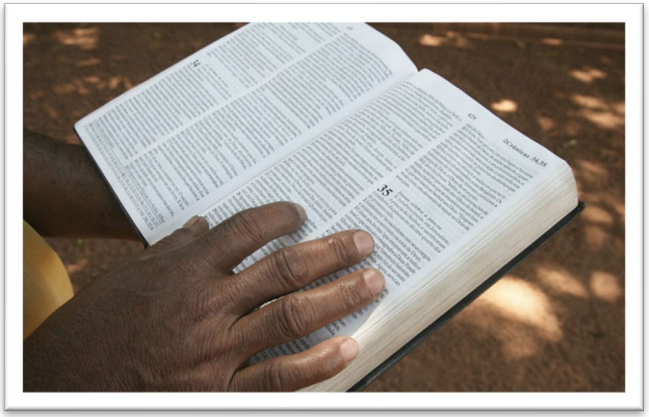
Behavioral Health Ministries Pilot Project (BHMPP), cont.

Program Challenges/Solutions

BHMPP encountered some of the same difficulties that were present in the project's early stages. With the IECAAC taskforce being largely comprised of volunteers that also have full-time schedules, finding availability for meetings and trainings became a hardship. There was also a change in BHMPP leadership at the mid-point of the fiscal year. Fiscal year 2021-22 was also the first full year of data collection and utilizing DBH provided tools to capture and input that data. Throughout the year there were occasional technical challenges to accessing the database and utilizing the clerical staff for data entry.

As evidenced by the age distribution, most participants were 60 years of age or older, who were less accustomed to or knowledgeable about using an electronic survey. Participants also did not feel comfortable answering the survey questions electronically, because of fear that their responses would used inappropriately. Also, the length of the survey discouraged some participants from completing the whole survey.

Throughout the year, the IECAAC taskforce members established recurring meeting times that accommodated its member's schedules. Following the BHMPP leadership change, the Office of Prevention and Early Intervention (PEI) provided technical assistance to assist the project in its data collection efforts. Based on feedback, the Office of PEI, in collaboration with Research and Evaluation team, was able to continuously aid in the evolution of the project's survey. Paper surveys were also created and administered for the participants that either encountered challenges with electronic surveys or preferred them.



Lessons Learned

Outcomes proved that the ambitious targets of BHMPP's program goals will require adjustments. It was revealed that more of the target population than originally thought already has knowledge of mental health and how to access resources. The progress of the BHMPP was delayed due to staffing changes during the early phases of the project.

Program Updates

The BHMPP will sunset April 2023 of fiscal year 2022-23.

Behavioral Health Ministries Pilot Project (BHMPP), cont.

Collaborative Partners

IECAAC taskforce members were from the following churches:

Diocese of San Bernardino - Office of Ministry to Catholics of African Descent
New Hope Missionary Baptist Church
St. Timothy Community Church
Temple Missionary Baptist Church
Ecclesia Christian Fellowship
Immanuel Praise Fellowship
New Jerusalem Church of God In Christ



Caricias - artwork by Beatrice Badioli

Inland Empire Opioid Crisis Coalition (IEOCC)

Program Description

The Inland Empire Opioid Crisis Coalition (IEOCC) is a new PEI program categorized as an Outreach for Increasing the Recognition of Early Signs of Mental Illness. IEOCC 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.

The IEOCC's success depends on its broad mix of partners working across sectors that include clinical care, advocacy, outreach, policy, and research. Wide-ranging collaboration has generated valuable community connections across the Inland Empire, and created tangible results, including nearly 3,000 patients referred to Medication-Assisted Treatment (MAT) in the past two years, naloxone distribution and training to 250 first responders, a stigma reduction campaign, and the achievement of sooner and better data for decision-making and hot-spotting of interventions; to name a few.

The Department of Behavioral Health (DBH) provides administrative support for this coalition.

Program Summary	
Program Serves	Children TAY (16-25) Adults Older Adults (60+)
Location of Services	School Campuses, Mental Health Clinics, In-home
Number of Consumers to be Served	3,400
Annual Budget FY 2022-23	$317,500
Cost Per Client FY 2022-23	$93
Services Offered	Medication Assisted Treatment (MAT) Substance Use Disorder Services Referrals Behavioral Health Services Referrals Community Education and Awareness

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

Inland Empire Opioid Crisis Coalition (IEOCC), cont.

MHSA Legislative Goals and Related Key Outcomes

- Reduced prolonged suffering associated with untreated mental illness:
  - Reduce risk factors.
  - Reduce indicators.
  - Increase protective factors that may lead to improved mental, emotional, and relational functioning.
- 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:
    a) Identify early signs of potentially severe and disabling mental illness.
    b) Provide support to individuals with mental illness.
    c) Refer individuals who need treatment or other mental health services.
  - Individuals:
    a) Recognize own symptoms.
    b) Respond to symptoms.



Inland Empire Opioid Crisis Coalition (IEOCC), cont.

The Challenge

Statistical data indicates that the opioid crisis has held the United States and the Inland Empire under its control for years. Estimates show that nearly 500,000 people died from an overdose involving opioids from 1999-2019. It has been documented that overdoses increased in 2020 – 2021 during the COVID-19 pandemic.

The crisis of opioid dependence and misuse impacts individuals, families and communities everywhere including San Bernardino County. Statistics show that 43% of DBH Substance Use Disorder and Recovery Services (SUDRS) consumers served have a primary diagnosis of Opioid Use Disorder (OUD) and 23% of DBH SUDRS consumers have co-occurring behavioral health conditions. For this reason, the IEOCC's work, and focus went from safe prescribing to harm reduction and program expansion to early intervention efforts.

The IEOCC continuously adapts as the make-up of the opioid crisis shifts. Growing evidence points to a recent increase in opioid related deaths caused by the presence of fentanyl. Assuring safe drug use by testing for the presence of fentanyl is an important prevention measure. This translates to a need for the IEOCC to employ a different, more harm-reduction informed approach to ensure effective prevention.

This program aims to solve challenges such as:

- Reduction of symptoms, improve recovery, reduce negative feelings/attitudes/beliefs/perceptions/stereotypes/discrimination related to having a behavioral health condition including OUD. Additional challenges at the pharmacy level have become more pervasive. While safe prescribing and access to buprenorphine and naloxone can be addressed with education and awareness-building, reducing stigma requires a different approach. Pharmacy Partnerships for Harm Reduction; although in its early stages of development, will focus on addressing this challenge with a multi-pronged stigma reduction campaign.
- Lessening of opioid use and opioid related deaths in San Bernardino County. Participation in this program will provide the needed time, attention, and expansion of resources for the IEOCC, to continue making an impact on access to life-saving interventions such as Medication Assisted Treatment (MAT), naloxone and continued Harm Reduction interventions.
- Decreasing of risk factors associated with behavioral health conditions including substance use. By being part of the IEOCC, DBH will have a specific built-in mechanism with an infrastructure to address the on-going opioid crisis from a different perspective. This shift will allow for new strategies, from an emphasis exclusively on what the healthcare industry can do to enhance current community-based and holistic efforts.

Inland Empire Opioid Crisis Coalition (IEOCC), cont.

The Challenge, cont.

The significance of harm reduction and stigma reduction at the pharmacy level is growing, while concerns about safe prescribing have abated. This program will allow Substance Use and Recovery Services (SUDRS) direct access and coordination to ongoing and require continued conversation across sectors within the Inland Empire. This will allow the IEOCC to remain nimble and responsive to this opioid crisis.

The value of IEOCC is about collaboration and information-sharing across counties and disciplines which necessitates a base threshold of multidisciplinary participation. Access challenges have shifted from getting providers X-waivered to an absence of services in remote areas, lack of equitable access (diversity of providers), and patient self-stigma of accessing resources.

DBH hopes to solve these challenges through the utilization of the four listed IEOCC's current Sub-Committees:

- Access to Treatment: including Medication-Assisted Treatment and other Harm Reduction and recovery community services.
- Pharmacy Partnerships for Harm Reduction: an updated focus for group formerly known the Safe Prescribing Workgroup.
- Methamphetamine Pilot: A new effort launched in March 2021 to address methamphetamine's role in overdoses.
- Prevention and Outreach: outreach and implementation strategies based on insights gained from growing opioid data resources.

The IEOCC program goals and strategies will focus on providing education, early intervention and awareness about substance use disorders, with an emphasis on opioid use disorder, early intervention treatment, and recovery to help reduce stigma to those residing in San Bernardino County. Substance Use and Mental Health services referrals will be provided on a 24-hour basis through the Substance Use Disorder Screening, Assessment, and Referral Center (SARC) and Access County operated programs.



The Self Destruction, The Intrusion, The Tears, The Garden – artwork by Ricardo Moctezuma

Inland Empire Opioid Crisis Coalition (IEOCC), cont.

Existing Efforts

Currently, the Department of Behavioral Health provides a range of prevention and early intervention services throughout San Bernardino County from four different contracting agencies under a Strategic Prevention Plan for Substance Use Disorder Prevention developed by the County of San Bernardino to address problems with substance use among its residents, particularly concerning opioid overdoses. In addition, several treatment programs within the county address opioid addiction through Medication Assisted Treatment.

The IEOCC will support and improve upon current efforts by having a specific built-in mechanism with an infrastructure to address the on-going opioid crisis from a distinctive perspective. This will allow us to look at new strategies, from an emphasis exclusively on what the healthcare industry can do to enhance current community-based and general efforts. These efforts will be based on real-time opioid fatal and non-fatal overdose data through an opioid dashboard which would be a new data tool.

Program Goals

The goal of the Inland Empire Opioid Crisis Coalition is to continue 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 San Bernardino County and minimize opioid use and opioid-related deaths in the Inland Empire.

Department of Behavioral Health's current MHSA legislative goals and central outcomes include the following:

- Symptom reduction, improve recovery, reduce negative, feelings/attitudes/beliefs/perceptions/stereotypes/discrimination related to having a behavioral health condition.
- Reduce opioid use and opioid related deaths in San Bernardino County.
- Decrease risk factors associated with behavioral health conditions including substance use.

The IEOCC program goals relate to the MHSA Legislative Goals and Key Outcomes, in that they align with the MHSA goals to expand and transform behavioral health and now substance use systems to better serve individuals with, and at risk of, serious mental health and substance use issues.

Program Updates

The IEOCC program is currently in the process of hiring the administrative staff.

Child and Youth Connection (CYC)

Target Population and Program Description

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 who are 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 aids children aged 0 to 6 who have social, physical, behavioral, developmental, and/or psychiatric difficulties but do not require the intense therapies provided by SART. Children that 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): Prior to forensic interviews and medical examinations for the review of child abuse charges, DBH collaborates with Loma Linda University Children's Hospital to promote a therapeutic partnership. As part of this cooperation, crisis intervention support, referrals, and trauma-focused counseling services are provided in a child-friendly atmosphere.
- Juvenile Public Defender's Office: In-home screenings for adolescents involved in the juvenile justice system are provided by the Department of Behavioral Health in collaboration with the Public Defender's Office Juvenile Division.
- Mentoring Network: DBH collaborates with Children's Network to conduct mentoring needs assessments of at-risk youth through a collaborative effort of several County departments including, 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 Summary	
Program Serves	Children
Location of Services	Desert/Mountain, East Valley, Central Valley, West Valley
Number of Consumers to be Served	5,235
Annual Budget FY 2022-23	$ 21,165,786
Cost Per Client FY 2022-23	Varies by Component
Services Offered	Assessments Comprehensive Treatment Services Case Management Services Mental Health Education

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

Child and Youth Connection (CYC), cont.

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.

As part of the prevention services, CYC offers education, outreach, case management, resource referrals and mentoring. 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 participant numbers were gradually increasing until FY 2020-21 when the COVID-19 public health emergency limited the service delivery for this target population. As the public health restrictions ease, we expect to see a gradual increase return for this program.

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 addresses 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.

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.

Number of Participants / Number of Services Projected vs Actual

	Projected	Actual		
		FY 2019-20	FY 2020-21	FY 2021-22
Unduplicated Participants	6,529	22,778	4,501	3,698
Number of Services	70,969	273,465	80,256	85,626

Prevention Participants / Services

	FY 2019-20	FY 2020-21	FY 2021-22
Prevention Participants	62	174	104
Number of Services	62	1,156	898

Child and Youth Connection (CYC), cont.

Early Intervention:

SART and EIIS are CYC programs that provide early intervention services, such as treatments and interventions, for children who have been exposed to trauma and/or have impaired functioning but do not require a wide range of ongoing services. Parent-Child Interaction Therapy (PCIT) and Infant Massage are examples of the treatments administered by this program. The table below illustrates the total number of episodes opened, the number of episodes closed, and the proportion of participants who met their treatment goals for each fiscal year.

Treatment Success by Fiscal Year

	Total Episodes	Closed Episodes	% Met Goals
FY 2019-20	3,459	1,583	46%
FY 2020-21	7,072	3,096	44%
FY 2021-22	2286	2,141	39%

Outreach:

The outreach component of the CYC program provides services to participants in order to engage, encourage, educate, and/or train potential responders on how to recognize and respond effectively to early indicators of potentially severe and disabling mental illness. These services reach a variety of potential responders in an equally variable number of settings as detailed below. As expected, due to the COVID-19 pandemic, there was a dip in services in Fiscal Year 2019-20. As providers learned to navigate the new virtual environment, and then reintroduce face to face outreach activities, the numbers increased again for Fiscal Year 2020-21.

Potential Responders Reached

	FY 2019-20	FY 2020-21	FY 2021-22
Potential Responders	673	1,144	917

Outreach
Types of Responders / Settings

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

Child and Youth Connection (CYC), cont.

Program Highlights, cont.

Access and Linkage to Treatment:

Children in need of 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. SART and EIIS providers 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, 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 in need of 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. Linkages to appropriate resources are part of the scope of each program. 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 2019-20	FY 2020-21	FY 2021-22
Number of Referrals	2,091	2,390	2,053
County-funded	2,091	2,390	2,053
Non-County Funded	0	0	0
Participants Engaged	1,621	1,686	1,519*

* The number shown is estimated due to a mid year change in data collecting. Actual numbers will be available in future fiscal year reporting.

"It was great to hear from someone that had a positive experience with a mentor, to know that my work is helpful, and I will apply this knowledge by sharing amongst other coworkers. Or if a youth or other mentor needs advice. I would be happy to share some of the information I learned today. I can inspire others."

Child and Youth Connection (CYC), cont.

Program Highlights, cont.

Improve Timely Access to Treatment:

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

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

The table below shows the number of referrals provided to a prevention, early intervention, or treatment beyond early onset service over the last three fiscal years. There was a significant decrease in Fiscal Year 2020/21. This is primarily due to an identified need for improvement in data collection with the implementation of the new PEI data collection system. DBH is actively working with providers to implement changes needed to accurately collect this data moving forward.

Improving Timely Access Referrals			
	FY 2019-20	FY 2020-21	FY 2021-22
Number of Referrals Provided	3,370	844	3,010



Child and Youth Connection (CYC), cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-59	60+	UNK
FY 2019-20	80%	4%	11%	1%	3%
FY 2020-21	82%	1%	7%	1%	9%
FY 2021-22	27%	<1%	4%	<1%	68%

Fiscal Year	Veteran Status
	% of consumers who identified as a veteran
FY 2019-20	0%
FY 2020-21	0%
FY 2021-22	0%

Fiscal Year	Sexual Orientation
	% of consumers who identified as LGBTQ+
FY 2019-20	0%
FY 2020-21	0%
FY 2021-22	0%

Fiscal Year	Disability
	% of consumers who identified a physical disability
FY 2019-20	1%
FY 2020-21	4%
FY 2021-22	0%

Fiscal Year	Gender Identity			
	♂ Male	♀ Female	⚧ Other	UNK
FY 2019-20	3%	9%	0%	88%
FY 2020-21	52%	45%	0%	3%
FY 2021-22	<1%	1%	0%	97%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 2019-20	92%	7%	0%	1%
FY 2020-21	90%	6%	4%	0%
FY 2021-22	38%	4%	<1%	57%

Child and Youth Connection (CYC), cont.

Demographics, cont.

	Race / Ethnicity			
		FY 2019-20	FY 2020-21	FY 2021-22
Race	African-American/Black	14%	10%	14%
	American Indian or Alaska Native	1%	<1%	1%
	Asian	<1%	<1%	1%
	Native Hawaiian or Pacific Islander	2%	<1%	<1%
	More than One Race	9%	2%	2%
	Caucasian/White	24%	16%	15%
	Other Race	45%	5%	1%
	Declined to Answer	5%	66%	66%
Ethnicity	African	0%	0%	<1%
	Asian Indian/South Asian	0%	0%	0%
	Cambodian	0%	0%	0%
	Chinese	0%	0%	0%
	Eastern European	0%	0%	0%
	European	0%	0%	0%
	Hispanic/Latino	8%	60%	40%
	Filipino	0%	0%	0%
	Japanese	0%	0%	0%
	Korean	0%	0%	0%
	Middle Eastern	0%	0%	0%
	Vietnamese	0%	0%	0%
	Other	0%	14%	1%
	More than one ethnicity	0%	1%	<1%
	Declined to Answer	91%	26%	59%

Demographic Observations

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



Child and Youth Connection (CYC), cont.

Program Goals

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

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

Improve timely access to services for underserved populations:

- Increased the extent to which individuals or families from underserved populations who need mental health services because of risk or presence of a mental illness 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, 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.

Program Outcome Tools	
Survey Name	Child and Adolescent Needs and Strengths Assessment (CANS)
Description of Method	CANS is a multi-purpose tool developed for children's services to support decision making, including level of care and service planning.
Survey Type	Every three months for duration of treatment
Number Completed	FY 2019-20: EIIS: N = 283 SART: N = 384 FY 2020-21: EIIS: N = 348 SART: N = 394 FY 2021-22: EIIS: N = 528 SART: N = 763

Child and Youth Connection (CYC), cont.

Outcome Discussion

The CYC program uses the Child and Adolescent Needs and Strengths (CANS) 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. A final assessment is completed at the conclusion of services.

The focuses 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 behavioral health needs of the child.
- 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.

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 behavior of the child in a school or similar setting.
- Family functioning rate 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 is functioning in their current living arrangement, which could be with a relative, in a foster home, etc.

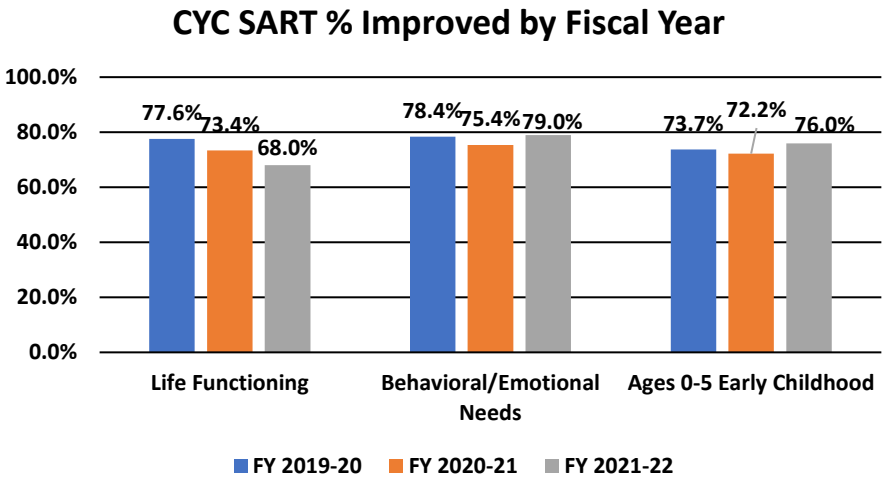
The Behavioral/Emotional Needs sub-domains include the following:

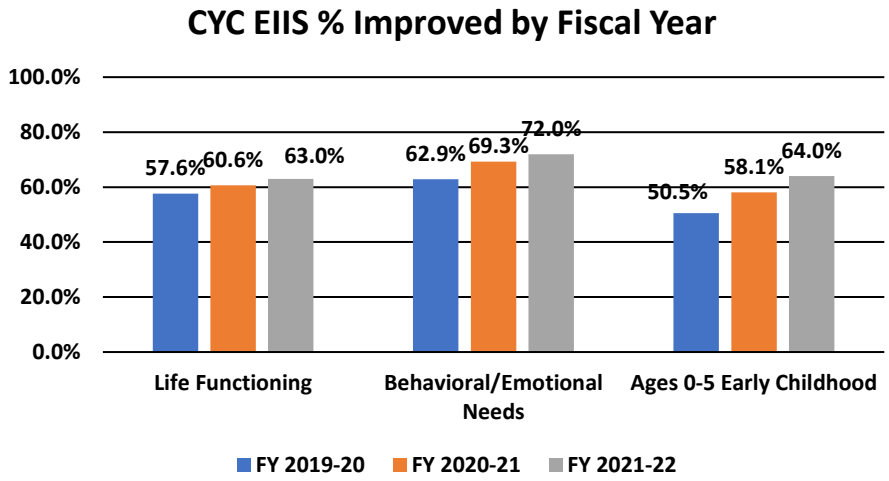
- Depression which rate the symptoms of the child such as irritable or depressed mood, social withdrawal, and loss of motivation.
- Anxiety which rate the symptoms of the child such as excessive fear and anxiety and related behavioral disturbances. Panic attacks can be a prominent type of fear response.
- Anger Control refers to the child's ability to identify and manage their 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 overall life functioning of a participant.

Child and Youth Connection (CYC), cont.

These graphs demonstrate global improvement in the elements of Life Functioning, Behavioral/Emotional Needs, and Ages 0-5 Early Childhood for both EIIS and SART participants of the CYC program. The percentages fluctuate slightly from year to year but remain above a 50% improvement in all domains.

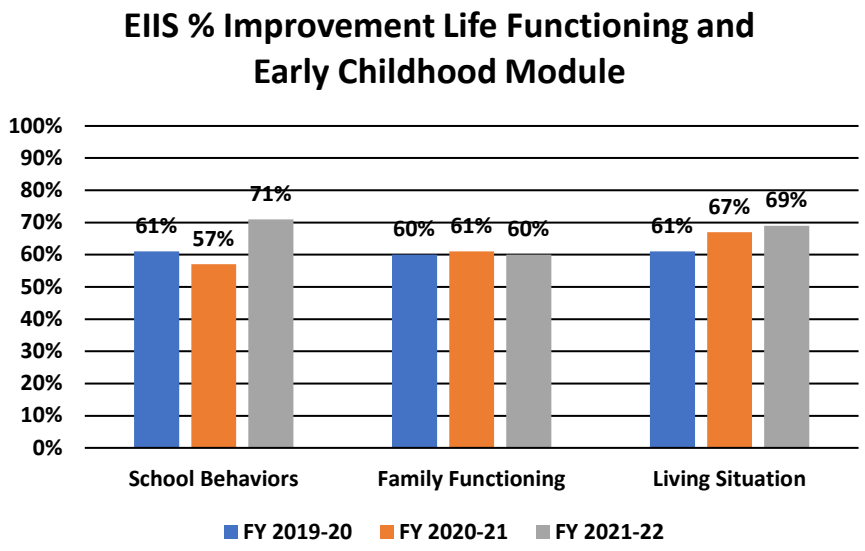


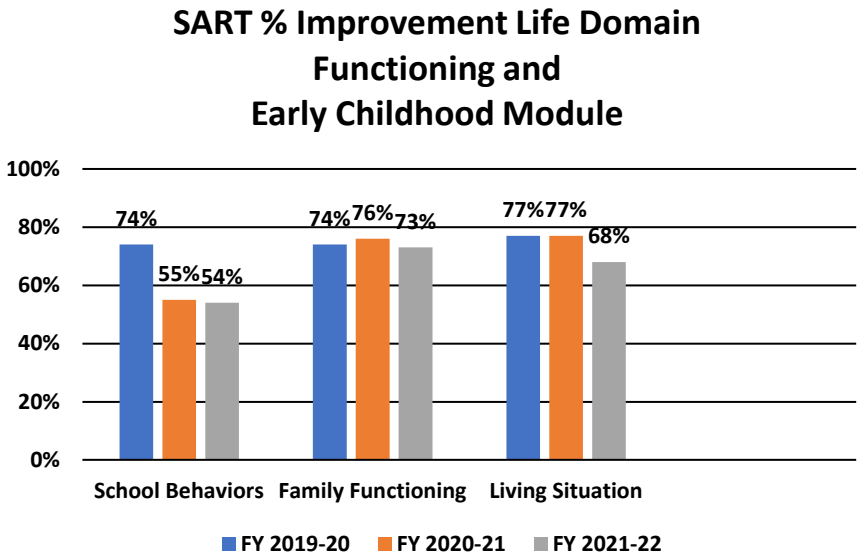


Child and Youth Connection (CYC), cont.

Outcome Discussion, cont.

The following graphs demonstrate the improvement of participants in each of these sub-domains over the last three fiscal years. The program saw steady improvements in the subdomains of family functioning and living situations. These increases indicate that the children are improving relationships with their family as a result of their engagement with the program. Improving the family bonds serves to strengthen protective factors. School functioning decreased as children were transitioned to distance learning for long periods of time. This was a trend that we expected to see as a result of the COVID-19 public health emergency.

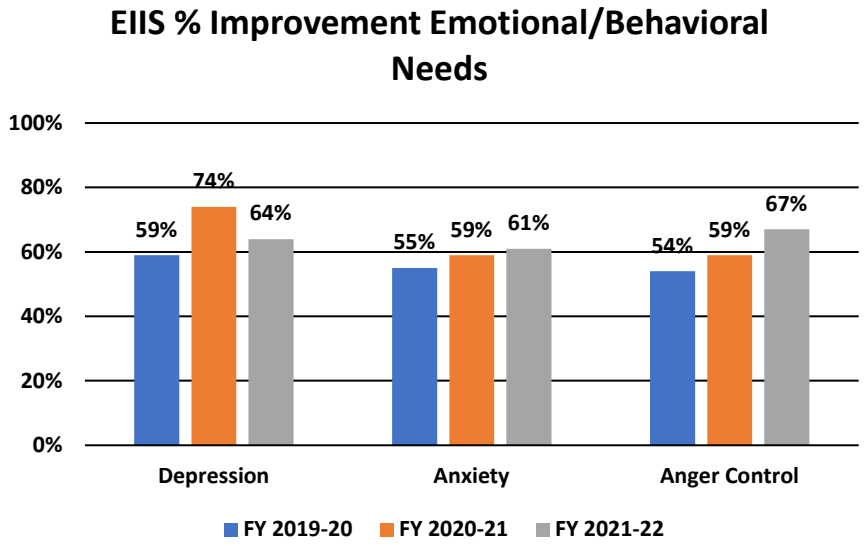


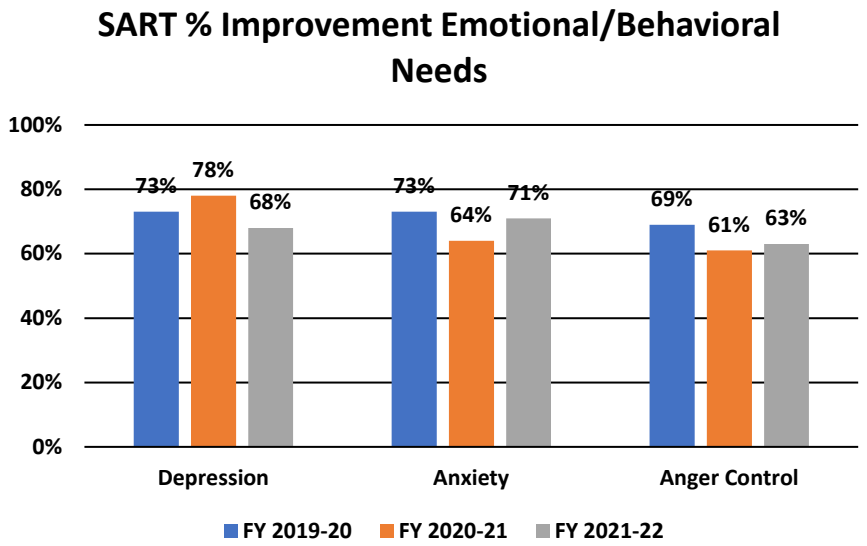


Child and Youth Connection (CYC), cont.

Outcome Discussion, cont.

Depression can be a significant barrier for child development. FY 2019-20 saw a slight decrease in improvement due to the onset of challenges COVID-19 presented. However, both programs have been successful in maintaining an average of 69% improvement in depression. Children who were referred and presented difficulties with regulating anger showed an average improvement of 62%. Reducing anxiety leads to improved behavioral and emotional functioning. The program maintains an average improvement of 66% over the three-year review period.





Child and Youth Connection (CYC), cont.

Program Challenges/Solutions

The ongoing challenge for CYC providers is caregiver acknowledgement of the benefits of mental health services, especially for the 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, as well as offered treatment via telehealth or other platforms to allow greater options for scheduling treatments for the children. Overall, this has helped to decrease missed appointments and increase the cooperation of caregivers.

Lessons Learned

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

Program Updates

The SART &EIIs contracts will be increased by 20% to adjust for inflation since 2018.

There was one youth that had experienced severe complex trauma. This youth was very depressed, experienced PTSD symptoms and was doing poorly in the domains of school and social functioning. The clinician quickly built rapport with the youth, explained the benefits of TF-CBT and began the gradual exposure process from the very beginning. The youth was engaged in services and rather quickly opened and began demonstrating progress in their goals. Now the youth has completed TF-CBT, she has established friendships and she is thriving in school.

Preschool PEI Program (PPP)

Target Population and Program Description

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

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

Program Summary	
Program Serves	Children TAY (16-25) Adults Older Adults (60+)
Location of Services	Preschool, In Home, and Counseling Centers
Number of Consumers to be Served	1,508
Annual Budget FY 2023-24	$425,000
Cost Per Client FY 2023-24	$281
Services Offered	Social-emotional development Screenings & assessments Trauma support Resources & referrals Behavioral health plan development Family support

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

Preschool PEI Program (PPP), cont.

Program Highlights

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

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

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

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

The PPP program seeks to reduce these risk factors by:

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

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

Building social-emotional skills in preschool-aged children helps the children to learn to recognize, understand, and manage powerful feelings, and also 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 are able to develop a sense of predictability and safety through the nurturing, stable, and consistent relationships with adults. This sense of predictability is further developed in the classroom with regular routines and consistent positive behavior management strategies.

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

Number of Participants / Number of Services Projected vs Actual

	Projected	Actual		
		FY 2019-20	FY 2020-21	FY 2021-22
Unduplicated Participants	1,508	1,172	750	697
Number of Services	3,757	2,659	2,659	3,183

Preschool PEI Program (PPP), cont.

Program Highlights, cont.

Teacher Training

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

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

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

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

Trauma, Loss, and Compassion Group (TLC)

In addition to the social-emotional development strategies that are used within the classroom, this group assists children who have experienced a trauma, loss, or separation from of a parent or significant care provider in their lives. This may include a parent, grandparent, or other person close to the child. The loss may be due to death, divorce, separation, foster care, military deployment, or parent incarceration. Groups meet for 10 weeks and help children cope with loss and trauma. The group offers children the opportunity to share feelings, thoughts, and stories during "circle time" with other children who are also experiencing trauma or loss.

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

Number of Children Participating in the TLC Group		
FY 2019-20	**FY 2020-21**	**FY 2021-22**
90	60	18

In an effort to improve child/family outcomes, families of children participating in the TLC group receive referrals to the Family Support Partners home visiting program to provide additional family support in the home. Growth in key areas are measured using the Life Skills Progression (LSP) survey.

Preschool PEI Program (PPP), cont.

Program Highlights, cont.

Access & Linkage to Services

During the previous three years, eighteen (18) participants were given referrals to the Screening, Assessment, Referral, and Treatment (SART) program and there were no referrals to independent service providers for higher level services beyond the preventative services offered by the PPP program.

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

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

Needs Assessment

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

Additionally, a need was recognized for further teacher training in preparation for returning to the classroom post-COVID-19. The COVID-19 public health emergency impacted everyone. Children and teachers were transitioned to distance learning which came with its own set of challenges. Additional trainings were implemented so that teachers would be able to recognize signs of trauma in children and families. The training included information on acclimating children in returning to school sites post-COVID-19.



Happy Place - artwork by Unknown

Preschool PEI Program (PPP), cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-50	60+	UNK
FY 2019-20	61%	2%	30%	1%	6%
FY 2020-21	61%	3%	26%	1%	9%
FY 2021-22	53%	45%	30%	1%	4%

Fiscal Year	Veteran Status
	% of consumers who identified as a veteran
FY 2019-20	1%
FY 2020-21	0%
FY 2021-22	0%

Fiscal Year	Sexual Orientation
	% of consumers who identified as LGBTQ+
FY 2019-20	1%
FY 2020-21	0%
FY 2021-22	0%

Fiscal Year	Disability
	% of consumers who identified a physical disability
FY 2019-20	3%
FY 2020-21	1%
FY 2021-22	3%

Fiscal Year	Gender Identity			
	♂ Male	♀ Female	⚧ Other	UNK
FY 2019-20	22%	32%	1%	45%
FY 2020-21	20%	39%	1%	40%
FY 2021-22	28%	44%	0%	26%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 2019-20	87%	5%	2%	6%
FY 2020-21	79%	7%	10%	4%
FY 2021-22	84%	7%	2%	0%

Preschool PEI Program (PPP), cont.

Demographics, cont.

	Race / Ethnicity			
		FY 2019-20	FY 2020-21	FY 2021-22
Race	African-American/Black	12%	11%	20%
	American Indian or Alaska Native	0%	1%	2%
	Asian	2%	2%	0%
	Native Hawaiian or Pacific Islander	0%	0%	0%
	More than One Race	3%	2%	5%
	Caucasian/White	22%	28%	33%
	Other Race	0%	1%	1%
	Declined to Answer	28%	22%	35%
Ethnicity	African	1%	0%	0%
	Asian Indian/South Asian	0%	0%	0%
	Cambodian	0%	0%	0%
	Chinese	0%	2%	0%
	Eastern European	0%	0%	0%
	European	0%	0%	0%
	Hispanic/Latino	32%	34%	42%
	Filipino	0%	0%	0%
	Japanese	0%	0%	0%
	Korean	0%	0%	0%
	Middle Eastern	1%	5%	1%
	Vietnamese	0%	0%	0%
	Other	3%	0%	0%
	More than one ethnicity	0%	0%	1%
	Declined to Answer	91%	89%	58%

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 social-emotional development of the children. As a result, The PPP program serves the adult population (adult, TAY, and older adult) in addition to the children who receive services.
- Questions related to gender and sexual orientation have a high rate of no responses.
  - Questions regarding sexual orientation are considered inappropriate to ask for the primary target population of preschool aged children and contribute to lack of responses in this area.
- The overall diversity of the participants within the PPP program reflects the diverse community of San Bernardino County.

Preschool PEI Program (PPP), cont.

Program Goals

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

Program Outcomes

The following tools are used to measure outcomes in the Preschool PEI Program. The Desired Results Developmental Profile (DRDP) is completed in the fall, winter, and spring of each year for all children enrolled in the Preschool PEI program.

Program Outcome Tools	
Survey Name	Desired Results Developmental Profile (DRDP)
Description of Method	Measures whether the child is at or above the California Learning Foundations age expectations in social-emotional development.
Survey Type	Fall, Winter, Spring
Number Completed	FY 2019-20: 1,172 FY 2020-21: 750 FY 2021-22: 2,451

Preschool PEI Program (PPP), cont.

Outcome Discussion

The Desired Results Developmental Profile (DRDP)

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 has been shown to be part of a child's social-emotional development. Children begin to manage their own emotions and acquire a sense of predictability, safety, and responsiveness in their social contexts when they have nurturing, stable, and consistent relationships with adults.

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

The results of the assessment shown in the table below illustrate the increase of 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.

Desired Results Developmental Profile									
Social-Emotional Development Domain	**FY 2019-20**			**FY 2020-21**			**FY 2021-22**		
	Pre	Post	Increase	Pre	Post	Increase	Pre	Post	Increase
Identity of Self in Relation to Others	43%	78%	35%	47%	71%	24%	49%	65%	16%
Social and Emotional Understanding	38%	71%	33%	48%	71%	23%	46%	62%	16%
Relationships and Social Interactions with Familiar Adults	45%	78%	33%	48%	75%	27%	48%	68%	20%
Relationships and Social Interactions with Peers	49%	80%	31%	not assessed*			53%	72%	19%
Symbolic and Sociodramatic Play	26%	55%	29%	25%	41%	16%	29%	44%	15%

* Relationships and Social Interactions with Peers was not assessed during FY 2020-21 due to lack of in-person peer-to-peer interaction resulting from COVID-19 limitations.

Preschool PEI Program (PPP), cont.

Outcome Discussion, cont.

Life Skills Progression (LSP)

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

Improvement was demonstrated by participating families in the following specific areas:

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

Life Skills Progression Results				
Fiscal Year	Pre	Post	Increase	% Increase
FY 2019-20	94.6	103.73	9.13	9.7%
FY 2020-21	103.54	109.99	6.45	6.2%

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

Preschool PEI Program (PPP), cont.

Program Challenges/Solutions

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

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

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

Lessons Learned

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

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

Program Updates

There are no planned program updates for Fiscal Year 2022-23.

Preschool PEI Program (PPP), cont.

Collaborative Partners

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

Success Stories

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

- MFT Intern #1

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

- MFT Intern #2

Resilience Promotion in African-American Children (RPIAAC)

Target Population and Program Description

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



Program Summary	
Program Serves	Children TAY (16-25)
Location of Services	School campuses, Family Resource Centers, Community organizations
Number of Consumers to be Served	4,190
Annual Budget FY 2023-24	$1,700,000
Cost Per Client FY 2023-24	$406
Services Offered	Cultural awareness and empowerment workshops Professional development presentations Mental health / SUD screenings Mental health / SUD education Counseling services Case management Homework assistance

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

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

Program Highlights

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

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



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

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

Number of Participants / Number of Services Projected vs Actual

	Projected	Actual		
		FY 2019-20	FY 2020-21	FY 2021-22
Unduplicated Participants	4,190	6,691	2,153	1,078
Number of Services	10,451	11,839	3,491	5,962

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

Early Intervention

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

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

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

The chart below shows the fluctuations in early intervention services as reported by the RPiAAC providers.

Early Intervention			
	FY 2019-20	FY 2020-21	FY 2021-22
Unduplicated Participants	207	23	41
Total Services	1,360	118	239

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

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

Treatment Success by Fiscal Year			
	FY 2019-20	FY 2020-21	FY 2021-22
Treatment Successful	20%	50%	50%
Treatment Partially Successful	80%	50%	50%
Treatment Not Successful	0%	0%	0%

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

Program Highlights, cont.

Outreach

RPiAAC's outreach and education services are designed to incorporate cultural and historical education for African American 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 which allow them to integrate themselves into the culture of schools. They engage with school leadership, teaching staff and students to reduce the stigma associated with mental health services which allows for services to begin rapidly. Examples of outreach activities include Principal's Meet and Greet, Meet a Pro, cultural awareness presentations and activities, and participation in school assemblies.

Collaborations with different agencies and stakeholders has allowed the program to identify and target the at-risk African-American 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 gradual decrease in number of potential responders reached in FY 2021-22.

Potential Responders Reached	
Fiscal Year	**Number of Potential Responders**
2019-20	5,880
2020-21	1,835
2021-22	977

Outreach Settings



- Schools
- Community events
- Community based organization facility

Types of Potential Responders



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

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

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-50	60+	UNK
FY 2019-20	38%	5%	17%	3%	37%
FY 2020-21	3%	3%	35%	1%	58%
FY 2021-22	13%	4%	0%	0%	83%

Fiscal Year	Veteran Status
	% of consumers who identified as a veteran
FY 2019-20	1%
FY 2020-21	0%
FY 2021-22	0%

Fiscal Year	Sexual Orientation
	% of consumers who identified as LGBTQ+
FY 2019-20	2%
FY 2020-21	0%
FY 2021-22	0%

Fiscal Year	Disability
	% of consumers who identified a physical disability
FY 2019-20	4%
FY 2020-21	2%
FY 2021-22	0%

Fiscal Year	Gender Identity			
	♂ Male	♀ Female	⚧ Other	UNK
FY 2019-20	17%	25%	0%	58%
FY 2020-21	1%	5%	0%	94%
FY 2021-22	34%	51%	0%	15%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 2019-20	58%	10%	1%	31%
FY 2020-21	58%	2%	0%	40%
FY 2021-22	88%	0%	12%	0%

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

Demographics, cont.

	Race / Ethnicity			
		FY 2019-20	FY 2020-21	FY 2021-22
Race	African-American/Black	16%	6%	77%
	American Indian or Alaska Native	0%	0%	0%
	Asian	0%	1%	0%
	Native Hawaiian or Pacific Islander	0%	0%	0%
	More than One Race	4%	0%	4%
	Caucasian/White	11%	3%	4%
	Other Race	11%	10%	1%
	Declined to Answer	56%	81%	3%
Ethnicity	African	12%	5%	82%
	Asian Indian/South Asian	0%	1%	0%
	Cambodian	0%	0%	0%
	Chinese	0%	0%	0%
	Eastern European	0%	0%	1%
	European	0%	0%	3%
	Hispanic/Latino	36%	12%	18%
	Filipino	0%	0%	0%
	Japanese	0%	0%	0%
	Korean	0%	0%	0%
	Middle Eastern	0%	0%	0%
	Vietnamese	0%	0%	0%
	Other	3%	1%	6%
	More than one ethnicity	3%	0%	4%
	Declined to Answer	82%	93%	2%

Demographic Observations

- The RPiAAC program has consistently served the target population over the last three fiscal years.
- There has been a significant increase in participants declining to answer demographic questions partly due to the age of the participants.
- Some of the questions being asked are considered inappropriate for the target population.
- There are ongoing barriers to capturing demographic data in virtual formats.
- There is less accountability to complete a survey online as opposed to in person.
- A notable observation is that although the program focuses on African-American students, RPiAAC has success with participants who identify as Latinx. The racial and ethnic Latinx population represents a majority in San Bernardino County, and it is encouraging to see that the outreach and participation in this program is inclusive of all students in the schools that they serve.

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

Program Goals

The RPiAAC program goal is to promote resilience in African-American children in order to reduce the risk factors that can lead to the development of mental illness or a substance use disorder.

RPiAAC utilizes curricula like NCTI Youth Crossroads to foster positive, pro-social behavior in Transitional Age Youth (16-25 years old). Pre and post tests are administered to measure the level of knowledge obtained by participants and the fidelity of the program implementation. Class topics include anger management, life skills, substance abuse prevention, and gang involvement



Outcome Discussion

RPiAAC intends to influence the following outcomes with early intervention treatment program:

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

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

The following chart shows the percent improvement by participants prior to and after participation in the NCTI curriculum.

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

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

On average, youth exhibited a percent improvement of 22% in their cognitive life skills, and skills managing substance & alcohol use and anger management.

NCTI Youth Crossroads			
Curriculum	**Average Pre-Test**	**Average Post-Test**	**Percent Improvement**
Cognitive Life Skills	4.59	5.63	23%
Alcohol and Substance Use	2.98	3.44	15%
Anger Management	2.50	3.20	28%

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

Program Challenges/Solutions

RPiAAC's provider faced challenges with providing an appropriate level of staffing to adequately provide services to the at-risk African-American population. Current funding created challenges in recruiting clinicians in today's competitive job market.

RPiAAC received an increase in referrals from the high desert region of San Bernardino County. There was a challenge to fulfil all the referrals received from this region of the county due to the amount of travel and not having a sufficient of clinical staff available.

Parent engagement continues to be a challenge in this program. The stigma associated with participating in mental health and wellness education remains a barrier. There have been new opportunities for the program to collaborate with new partners and strengthen parent engagement.

When it came to data entry, challenges with compatibility arose with the implementation and updates in new information management systems. Ongoing technical support is being provided to ensure that all critical data and outcomes can be recorded.

Lessons Learned

RPiAAC continued to face challenges with access and entering its data into the appropriate databases. RPiAAC discovered there was a growing need for services for at-risk African-American youth in the high desert region. Due to staff turnover and funding, it became difficult for RPiAAC's provider to consistently meet the demand. This demand will be explored and incorporated into the next RFP for RPiAAC.

Program Updates

This program is being expanded to serve additional areas of the County that include San Bernardino, Victorville, Adelanto, Barstow, Fontana, and Rancho Cucamonga. The program will receive an increase of $727,523 per fiscal year to support the expansion.



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

Collaborative Partners

Adelanto Elementary School District
- Adelanto High School

AT&T
Athletes for Life
Azusa Pacific University
Beauregard Therapy
Black Voice Newspaper
Blu Educational Foundation
BPC Mediaworks
Cal State University of San Bernardino
CHORDS
City of Rialto
Community Action Partnership
Emerge Beauty
Global Mass University
Hesperia Unified School District
- Mission Crest Elementary
- Mojave Elementary School
- Cedar Middle School
- Kingstone Elementary School

High Desert Premier Academy
Hope Through Housing
Inland Empire Health Plan
MHM Associates
Rialto Unified School District
- Rialto Middle School
- Carter High School
- Frisbee Middle School
- Eisenhower High School
- Rialto High School
- Hughbanks Elementary School
- Jehue Middle School
- Kolb Middle School

San Bernardino Community College District
San Bernardino County Superintendent of Schools
- High Desert Community Day School

San Bernardino Valley College
SoCal Gas
Time for Change Foundation
University of California Riverside
Walden University
Wal-Mart
Webb Family Enterprises
Wells Fargo Bank
Youth Action Project

Older Adult Community Services (OACS)

Target Population and Project Description

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

The program was 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 a variety of 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 level of personal and home safety. Older adults receive services and education in personal safety, home safety, preventing falls, and medication management.
- The Older Adult Suicide Prevention program provides suicide prevention education, screenings, and direct support services. These services are 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.

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..

Program Summary	
Program Serves	Older Adults (60+)
Location of Services	In-home, Senior Centers, Mobile Services, Mental Health Care Facilities, Churches
Number of Consumers to be Served	3,166
Annual Budget FY 2023-24	$963,818
Cost Per Client FY 2023-24	$304
Services Offered	Mental Health Education Mental Health/ SUD screenings Case Management Services Home Safety Screenings Transportation Assistance for High Desert residents Counseling Services Physical Fitness/Wellness Activities Suicide Prevention

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

Older Adult Community Services (OACS), cont.

Program Highlights

The OACS program is intended to promote healthy aging and assist in maintaining mental health wellness. OACS services must be delivered in a manner that is both convenient and engaging 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 will find a list of prevention activities and the associated risk and protective factors.

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

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

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

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

In FY 2019-20 the OACS program experienced a decrease in number of participants served but an increase in total services partly due to the pandemic and stay at home orders related to COVID-19.

Providers had to learn to transition services from in-person to virtual. Virtual services have reduced several barriers related to transportation. As seen in FY 2020-21 data, the OACS program exceeded the projected service targets which is consistent with overall mental health services trends.

Number of Participants / Number of Services Actual vs Projected				
	Projected	Actual		
		FY 2019-20	FY 2020-21	FY 2021-22
Unduplicated Participants	3,166	3,219	6,718	4,060
Number of Services	6,126	13,150	9,861	4,181

Older Adult Community Services (OACS), cont.

Program Highlights, cont.

Prevention Activity	Description	Risk Factors Addressed	Protective Factors Addressed
Wellness Activities • Socialization • Fitness • Nutrition • Craft/Art • Group Meals	• Senior social support groups, activities and education that are designed to engage seniors in wellness activities to increase social engagements, decrease isolation/loneliness and foster healthy personal and community interactions to prevent further escalation of mental health symptoms.	• Prolonged isolation • Ongoing stress • Chronic health conditions • Onset of mental illness	• Socialization • Education on mental wellness • Knowledge of physical health • Nutrition education • Improved flexibility and balance • Knowledge and access to services • Positive Coping Skills
Fall Prevention/Home Safety	• Older adults receive services and education in personal safety, home safety, disaster planning, preventing falls, and medication management.	• Prolonged isolation • Chronic health conditions • Ongoing stress • Lack of family support • Onset of mental illness	• Identification of potential household hazards • Increased safety in home • Knowledge and access to services
Step Down Groups	• Relapse prevention for clients who have received or are receiving mental health services	• Onset of mental illness • Depression • Severe trauma • Ongoing stress	• Positive coping skills • Socialization • Knowledge and access to services
Telephone Support Groups/Wellness Calls	• Provided social support for residents most impacted by the repercussions from COVID-19 isolation/quarantine. Support was provided in the form of calls to identified residents.	• Prolonged isolation • Access to physical and mental health care • Depression • Chronic physical health conditions	• Screenings for mental health and substance use • Knowledge and access to services • Socialization • Positive coping skills
Transportation Reimbursement Escort Program (TREP)	• Transportation reimbursement program provided to seniors in the High Desert communities for their medical appts, medication pick up, and errands.	• Prolonged isolation • Access to physical and mental health care	• Transportation assistance • Socialization • Knowledge and access to services
Budget Workshops	• These workshop empowered people with a knowledge on how to develop and implement a simple home budget	• Poverty - Insufficient food, shelter, healthcare • Ongoing stress	• Access to mental and physical health care • Knowledge and access to services

Older Adult Community Services (OACS), cont.

Program Highlights

Outreach

Outreach is a primary strategy in the OACS program for increasing recognition of early signs and symptoms of mental illness. As a result of successful outreach efforts, OACS has reached out to a total of 7,258 participants, also known as potential responders, from FY 2019-20 through 2021-22.

Potential responders for this program are engaged in many ways. They take part in educational presentations about the signs and symptoms of mental illness and age-related difficulties. They are also part of multidisciplinary teams that bring together diverse responders/providers from other disciplines to build the capacity of the teams. By collaborating they can better understand age-related difficulties, mental health issues, and other issues that affect older adults. Responders are well equipped to engage with older adults on a personal level 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. This includes senior centers and primary health care facilities. Potential responders come from all types of roles. A full list of outreach settings and types of potential responders are listed in the adjacent tables.

Outreach Settings



- Community Events
- Community Based Organizations
- Government Service Offices
- DBH Community Clubhouses
- Faith-Based Organizations
- Senior Centers
- Primary Health Care Facilities
- Hospitals

Types of Potential Responders



- Community Members
- Community Service Providers
- Healthcare Providers
- Faith-Based Organization Leaders
- Family Members
- Government Service Staff
- Primary Health Care Facilities
- Law Enforcement Personnel
- Emergency Medical Providers
- Primary Health Care Providers

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 2019-20	FY 2020-21	FY 2021-22
Unduplicated Participants/Open Episodes at any time during FY	33	24	21

The Early Intervention component has decreased over the last three fiscal years, as seen in the table above. Most of this program's early intervention services are offered to homebound elders. Due to COVID-19 and social distancing rules, the programs had to convert to virtual services. There are many reason that telehealth is not a favored method of connecting with older adults who are suffering with mental health issues. The most important reason is a lack of resources and understanding on how to use various virtual platforms and equipment. Many older adult participants in early intervention services do not have access to computers or smart phones.

Treatment Success by Fiscal Year			
	FY 2019-20	FY 2020-21	FY 2021-22
Treatment Successful	35%	36%	33%
Treatment Partially Successful	26%	27%	22%
Treatment Not Successful	39%	27%	38%
Missing or Other	N/A	10%	14%

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

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

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

Older Adult Community Services (OACS), cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-59	60+	UNK
FY 2019-20	1%	<1%	1%	80%	17%
FY 2020-21	<1%	<1%	2%	95%	2%
FY 2021-22	0%	0%	<1%	27%	72%

Fiscal Year	Veteran Status
	% of consumers who identified as a veteran
FY 2019-20	2%
FY 2020-21	<1%
FY 2021-22	<1%

Fiscal Year	Sexual Orientation
	% of consumers who identified as LGBTQ+
FY 2019-20	<1%
FY 2020-21	<1%
FY 2021-22	<1%

Fiscal Year	Disability
	% of consumers who identified a physical disability
FY 2019-20	4%
FY 2020-21	9%
FY 2021-22	10%

Fiscal Year	Gender Identity			
	♂ Male	♀ Female	⚧ Other	UNK
FY 2019-20	13%	35%	<1%	51%
FY 2020-21	14%	36%	0%	50%
FY 2021-22	18%	51%	<1%	31%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 2019-20	64%	10%	1%	25%
FY 2020-21	16%	1%	<1%	83%
FY 2021-22	10%	2%	<1%	88%

Older Adult Community Services (OACS), cont.

Demographics, cont.

	Race / Ethnicity			
		FY 2019-20	FY 2020-21	FY 2021-22
Race	African-American/Black	2%	2%	1%
	American Indian or Alaska Native	1%	0%	<1%
	Asian	1%	0%	<1%
	Native Hawaiian or Pacific Islander	0%	0%	<1%
	More than One Race	0%	0%	<1%
	Caucasian/White	27%	8%	8%
	Other Race	9%	2%	1%
	Declined to Answer	53%	78%	88%
Ethnicity	African	6%	0%	1%
	Asian Indian/South Asian	0%	0%	<1%
	Cambodian	0%	0%	<1%
	Chinese	1%	0%	<1%
	Eastern European	0%	0%	<1%
	European	17%	13%	19%
	Hispanic/Latino	16%	13%	24%
	Filipino	1%	0%	<1%
	Japanese	0%	0%	0%
	Korean	0%	0%	<1%
	Middle Eastern	0%	0%	<1%
	Vietnamese	0%	0%	0%
	Other	0%	1%	3%
	More than one ethnicity	1%	38%	1%
	Declined to Answer	0%	48%	48%

Demographic Observations

- The OACS program has consistently served the targeted demographics over the last three fiscal years.
- In Fiscal Years 2019-20 and 2020-21 it became increasingly difficult for providers to capture demographic data for an already skeptical population.
    - Older Adults historically are a difficult population to engage in services and provide demographic information because they grew up in eras where the government participated in harmful practices towards people who suffered with mental health challenges, LGBTQ+ and people from ethnic and minority groups.
- Fiscal Years 2019-20 and 2020-21 have also shown a reduction in participants identifying as male and an increase in people declining to answer the gender questions.
    - Studies show that older adult males, specifically White and Native American males, have higher rates of suicide attempts and death. This is a continued area of concern and focus for engagement that the OACS program will continue to monitor closely in the coming years.
- A notable increase was shown in serving persons with a physical disability in Fiscal Year 2020-21. This could be due to the increase in telehealth service options available during the pandemic.
    - All current OACS providers have committed to continuing to offer telehealth options.

Older Adult Community Services (OACS), cont.

Program Goals

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

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

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

Program Outcome Tools				
Survey Name	Adult Needs and Strengths Assessment (ANSA)	Satisfaction Survey	Outreach Questionnaires	PHQ-9
Description of Method	A comprehensive clinical decision support tool used during the behavioral health assessment that tracks consumer progress and changes to better determine appropriate level of care for consumer as well as provide information useful for performance outcomes.	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.	A seven-item questionnaire that assesses a participant's improved knowledge of signs and symptoms that can lead to a potentially severe mental illness.	Nine-question instrument given to patients in a healthcare setting to screen for the presence and severity of depression.
Survey Type	Intake, every 6 mo., and discharge	Post service and/or presentation	Pre/Post Mental Health educational presentation and/or activity.	Intake and every six months
Number Completed	FY 2019-20: 18 FY 2020-21: 29 FY 2021-22: 65	FY 2019-20: 112 FY 2020-21: 108 FY 2021-22: 255	FY 2019-20: n/a FY 2020-21: 49 FY 2021-22: 52	FY 2019-20: 61 FY 2020-21: 110 FY 2021-22: 25

Older Adult Community Services (OACS), cont.

Outcome Discussion

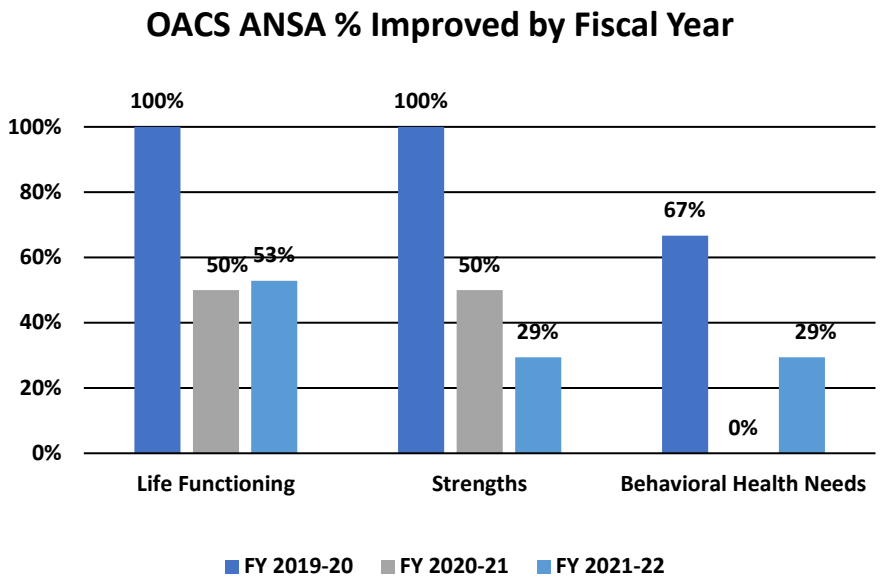
Early Intervention

The OACS program uses the Adult Needs and Strengths Assessment (ANSA-SB) to measure 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. When the ANSA is administered, each of the dimensions is rated on its own four-point scale. The ANSA-SB is administered at intake and at six-month intervals until discharge.

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

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

The chart below shows that all clients that started services with a need to improve Life Functioning, Strengths and Behavioral Health Needs improved by the end of their treatment. An area of concern is shown in FY 2019-20 where only 50% of participants increased in Life Functioning and Strengths and 0% improved in Behavioral Health Needs. The COVID-19 pandemic had a huge impact on older adult participants that did not transition well to telehealth services due to lack of access and knowledge on how to use the needed technology as well as isolation and lack of family and or community supports. All OACS providers are exploring creative options on how to maintain engagement in early intervention services through social distancing requirements.



Older Adult Community Services (OACS), cont.

Outcome Discussion

Outreach Survey Results

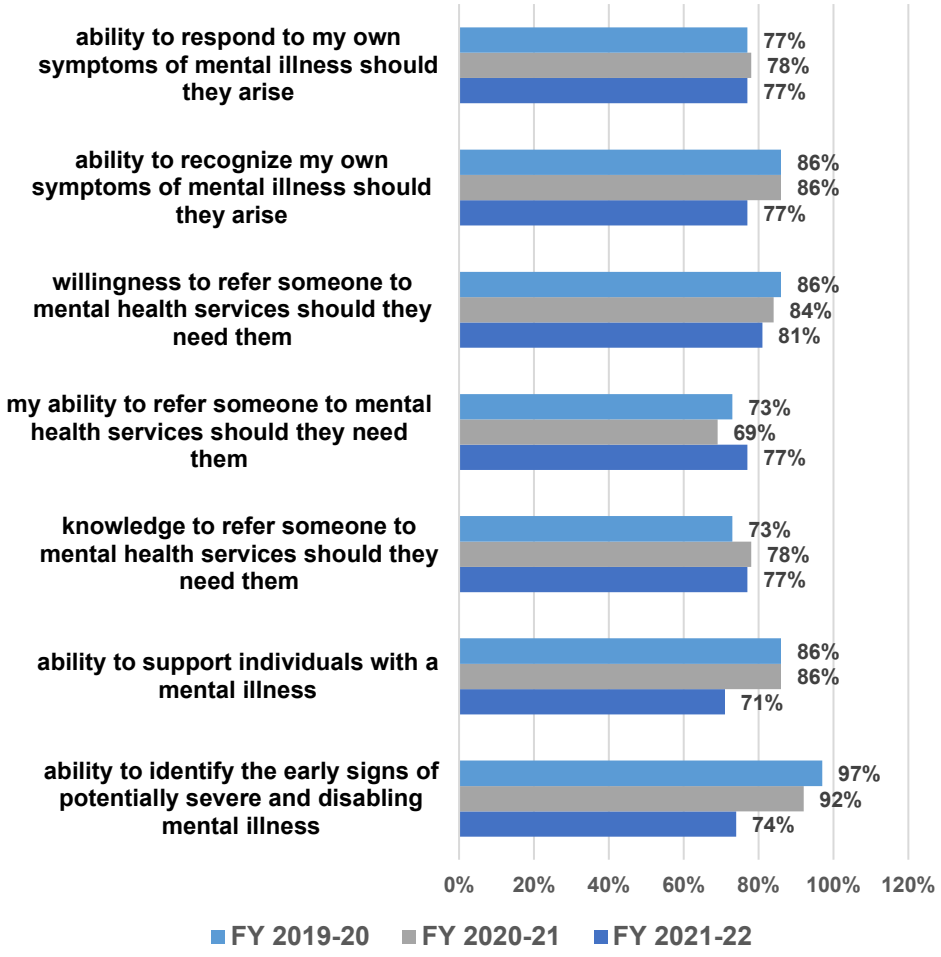
The OACS conducts a series of outreach activities. These activities include educational sessions for the community to learn more about mental health and wellness. It also includes events that disseminate information on signs and symptoms of mental illness and age-related difficulties. Participants are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

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

Almost all those surveyed agreed that they feel more confident in their ability to identify the early signs of mental illness. Over 85% of people feel that they are able support individuals with mental illness and can recognize their own symptoms of mental illness should they arise. The results also show an overall improvement in the referral process knowledge of referrals and intent to seek mental health services should they be needed.

Education and promoting behavioral health prevention and wellness has shown to be a successful strategy in increasing community awareness on mental health and available resources.

Outreach Survey Results



Older Adult Community Services (OACS), cont.

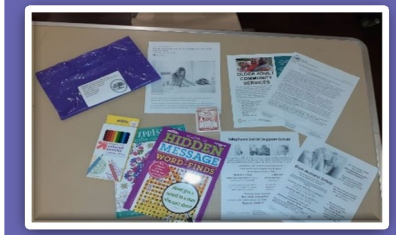
Program Outcomes, cont.

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



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

100% stated that program helped improve their mental health
100% stated that they would continue walking due to the positive effects on their physical health
66% 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.

74% of OACS participants agreed or totally agreed that participants improved knowledge on mental health and stigma reduction
86% of OACS Wellness presentation participants agreed that the presentations were useful, and the speaker delivered information.



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

93% of participants stated they learned something new at Mobile Outreach or Health screening event
100% of participants found value in having services delivered in mobile settings

Older Adult Community Services (OACS), cont.

Program Challenges/Solutions

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

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

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

The OACS program is always on the lookout for novel ways to address transportation issues. They've developed agreements with local health insurance providers that will transport clients to and from medical appointments. They assist older adults with information and training courses on how to access the public transit system.

The OACS program also have access to the San Bernardino County Department of Aging and Adult Services (DAAS) transportation voucher program. OACS participants who meet the program's requirements have access to a variety of ride-sharing and driver reimbursement options.

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 smart phones. Many others have no interest in learning to use platforms such as Zoom or Facebook to access mental health services. Increased technological use has been more beneficial for those with physical disabilities as they are more accustomed to embracing creative ways to stay connected.

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

Program Updates

There are no planned program updates for Fiscal Year 2022-23.

Lift Program

Target Population and Program Description

The Lift Program is a Prevention program that is a collaborative effort between the Department of Behavioral Health and Preschool Services Department. The program 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 both child and family are thriving in their environment.

Referrals to the Lift program come from a variety of 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.

Program Summary	
Program Serves	Children TAY (16-25) Adults Older Adults (60+)
Location of Services	In home
Number of Consumers to be Served	120
Annual Budget FY 2023-24	$396,000
Cost Per Client FY 2023-24	$3,300
Services Offered	Parent education and support Post-natal depression screenings Nurturing activities to increase maternal attachment Developmental milestones education Life and employment skills development Community referrals

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

Lift Program, cont.

Program Highlights

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

The tools and assessments used are:

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

Typically, these screenings take the form of a survey or a conversation. Lift nurses make referrals to partner agencies that specialize in these types of supportive services. These services contribute to the development of protective factors by providing tangible support during times of difficulty and by providing participants with information tailored to their specific needs. Additionally, this strengthens feelings of social connection, as Lift nurses provide support and reassurance. As a result of the early screening and identification process, participants gain a better understanding of parenting and child development. They discuss the effects of smoking, attachment, and depression on the mother-child bond and the developing child.

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

Number of Participants / Number of Services Projected vs Actual

	Projected	Actual		
		FY 2019-20	FY 2020-21	FY 2021-22
Unduplicated Participants	120	125	114	154
Number of Services	1,728	1,095	1,094	759

Lift Program, cont.

Program Highlights, 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. Nurses and Marriage and Family Therapists (MFTs) provide the appropriate interventions, services and resources based upon the results of the assessment.

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

Identification of Depression Related Mental Health Needs

	FY 2019-20 (N= 93)	FY 2020-21 (N= 60)	FY 2021-22 (N= 46)
Exhibited signs of depression	28 (30%)	9 (15%)	1 (0%)
Received mental health supportive services	28 (100%)	9 (100%)	5 (100%)
Required clinical intervention	0 (0%)	1 (11%)	1 (0%)

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.

The majority of 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 in order to provide the necessary resources and services.



Artwork by Catherine Maldonado

Lift Program, cont.

Program Highlights, cont.

Fagerstrom Test for Nicotine Dependence

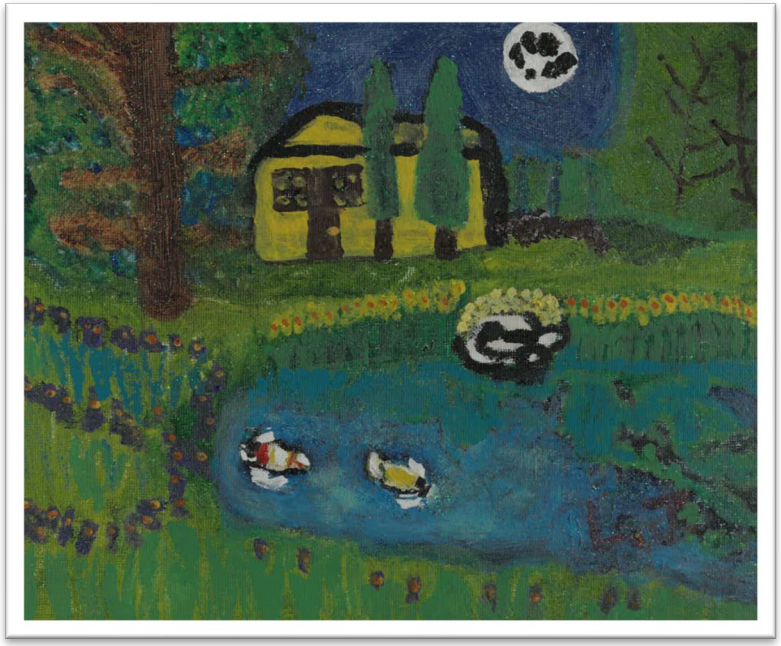
Smoking during pregnancy is a risk factor associated with adverse pregnancy outcomes. It negatively impacts the development of the unborn child, decreases impulsivity control, and causes delays in developmental milestones. Risk factors associated with neurochemical imbalance and substance use/reliance are reduced by reducing nicotine dependency.

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

The Fagerstrom Test is useful in the development of a smoking cessation plan for the pregnant mother.

Survey of smokers and non-smokers			
	FY 2019-20	FY 2020-21	FY 2021-22
% of mothers who smoke less than 10 cigarettes per day	8%	2%	0%
% of mothers who are non-smokers	92%	98%	98%

Mothers who smoke are provided education about the risks of smoking on unborn babies as well as referrals to smoking cessation programs. As a result, all of the mothers who reported smoking participated in the smoking cessation programs and quit smoking during their pregnancy.



A Farmhouse with a Pond - artwork by Unknown

Lift Program, cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-50	60+	UNK
FY 2019-20	24%	18%	41%	0%	17%
FY 2020-21	34%	19%	44%	0%	3%
FY 2021-22	39%	18%	27%	0%	4%

Fiscal Year	Veteran Status
	% of consumers who identified as a veteran
FY 2019-20	1%
FY 2020-21	2%
FY 2021-22	0%

Fiscal Year	Sexual Orientation
	% of consumers who identified as LGBTQ+
FY 2019-20	11%
FY 2020-21	12%
FY 2021-22	1%

Fiscal Year	Disability
	% of consumers who identified a physical disability
FY 2019-20	7%
FY 2020-21	4%
FY 2021-22	2%

Fiscal Year	Gender Identity			
	♂ Male	♀ Female	⚧ Other	UNK
FY 2019-20	10%	74%	0%	16%
FY 2020-21	18%	79%	0%	3%
FY 2021-22	21%	69%	0%	9%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 2019-20	53%	10%	11%	26%
FY 2020-21	77%	6%	5%	12%
FY 2021-22	74%	8%	7%	8%

Lift Program, cont.

Demographics, cont.

	Race / Ethnicity			
		FY 2019-20	FY 2020-21	FY 2021-22
Race	African-American/Black	16%	19%	22%
	American Indian or Alaska Native	1%	1%	2%
	Asian	0%	0%	0%
	Native Hawaiian or Pacific Islander	0%	0%	0%
	More than One Race	8%	9%	8%
	Caucasian/White	25%	32%	27%
	Other Race	5%	3%	10%
	Declined to Answer	15%	8%	27%
Ethnicity	African	29%	19%	5%
	Asian Indian/South Asian	0%	0%	0%
	Cambodian	0%	0%	0%
	Chinese	0%	0%	0%
	Eastern European	0%	0%	0%
	European	0%	0%	2%
	Hispanic/Latino	71%	68%	38%
	Filipino	1%	0%	0%
	Japanese	0%	0%	0%
	Korean	0%	0%	0%
	Middle Eastern	0%	1%	1%
	Vietnamese	0%	0%	0%
	Other	0%	0%	4%
	More than one ethnicity	10%	1%	1%
	Declined to Answer	59%	57%	45%

Demographic Observations

- The Lift program primarily targets first-time pregnant women and new mothers along with their families.
  - The Lift program has consistently served the targeted demographics over the last three fiscal years. The majority of participants are TAY and adult women.
  - We also see a small percentage of male participants, which is reflective of 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.
  - It is notable that members of the Asian/Pacific-Islander community are not currently participating in the Lift program. Efforts will be made in the upcoming program years to engage this community.

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 how to care for and nurture their children and provide safe and consistent practices of child discipline.
- Improve maternal development by helping mothers to develop a vision and plan for their own 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 Outcome Tools		
Survey Name	Maternal Fetal Attachment Scale	Life Skills Progression Tool
Description of Method	The Maternal Fetal Attachment Scale is a tool used to determine the attachment between a mother and her unborn child.	The Life Skills Progression is a tool used to monitor participants' strengths and needs.
Survey Type	1x at the beginning of services	1x at the beginning of services
Number Completed	FY 2019-20: 93 FY 2020-21: 60 FY 2021-22: 46	FY 2019-20: 108 FY 2020-21: 60 FY 2021-22: 40

Lift Program, cont.

Program Outcomes, cont.

Maternal Fetal Attachment Scale

The Maternal Fetal Attachment Scale is a questionnaire used to assess the bond between expectant mothers and their unborn child. Elevated scores indicate a greater degree of prenatal attachment. The Maternal Fetal Attachment Scale is administered to participants in the Lift program, and the results are analyzed to determine their unique needs.

Identifying and addressing early indicators of maternal fetal attachment promotes protective factors in both mother and baby by increasing bonding, strengthening family support, and fostering a stable and healthy home environment, all of which contribute to the child's positive outcomes.

Lift nurses support mothers in the program by providing individualized support in key areas identified by the Maternal Fetal Attachment Scale. Key measures indicate whether pregnant mothers are willing to give up harmful activities for their child, their body image, their future hopefulness, and reading to their unborn child. Support may take the form of education, positive nurturing activities, and family counseling, all of which contribute to the development of more positive nurturing relationships.

The following tables illustrate the percentage of new mothers reporting the indicated levels of attachment in the subdomains of nurturing and attachment, family supports, economic security, self-empowerment, and mastery and control over the future.

When evaluating nurturing and attachment, mothers had a positive responses modifying their lifestyle to support a healthy environment for their child. They also agreed reading to the child was an important in strengthening the family bond.

These results play an important part for Lift nurses providing education and support about pregnancy and child development. It provides feedback on education and a healthy strategy for supporting emotional development.

Nurturing & Attachment			
	FY 2019-20	FY 2020-21	FY 2021-22
I desire this baby / I'm not sorry I became pregnant	97%	100%	100%
I am willing to give up certain things to protect my baby	72%	100%	67%
I read to my baby / unborn child	80%	80%	50%

Lift Program, cont.

Program Highlights, cont.

Family Supports			
	FY 2019-20	FY 2020-21	FY 2021-22
My mate wants this pregnancy	41% No	0% No	0% No
My pregnancy interferes with my relationship with my mate	4% Yes	0% Yes	33% Yes
My family supports my pregnancy	69% Yes	95% Yes	72% Yes
My family will help in caring for my baby	85% Yes	96% Yes	65% 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 above show that over a three-year period only a small percentage said that their mate did not want the pregnancy. There was also a small percentage that felt that their pregnancy interfered with their relationship with their mate. Those participants are offered family counseling to reconcile those feelings. Feelings about family supporting the pregnancy increased in the three-year review period. Including all family members in Lift program intervention reinforces the supports for the expectant mother during pregnancy.

Economic Security, Self-Empowerment, Mastery & Control Over Future			
	FY 2019-20	FY 2020-21	FY 2021-22
I feel uncertain as to what the future holds for me and my baby	32%	23%	30%

These results you see above help guide the Lift nurses in providing education and support about pregnancy, child development, and area resources. This is necessary in establishing concrete supports in times of need. The Lift program also offers support and referrals to education and career development opportunities through diploma completion programs and internship opportunities. The Lift program offers assistance in enrolling children in Early Head Start and Head Start programs at appropriate ages to provide for safe and reliable childcare. These efforts all serve to provide stability for the future of the mother and her newborn child.

Through these one-on-one home visits with registered Lift nurses, participating mothers gained insight into the physical and mental development of their unborn and newborn children. By working individually with the participants and identifying existing strengths and needs the Lift nurses are able to help the mothers reduce risk factors and promote protective factors leading to improved health, well-being, and self-sufficiency for first-time pregnant and parenting mothers and their families.

Lift Program, cont.

Outcome Discussion, cont.

Life Skills Progression (LSP) Tool

The Life Skill Progression tool captures a portrait of the behaviors, attitudes, and skills of mothers enrolled in the Lift program. It helps to establish a baseline of participant profile and identifies their strengths and needs and plans for interventions and monitors outcomes to show that interventions are working.

In the Lift program, the LSP is used to assess needs related to education and employment. As seen in the table below, during FY 2019-20 and 2021-22 there is a strong correlation between the education level and stable employment. There was a significant decrease in unemployment and an increase in stable employment for FY 2021-22. The percentage of participants with less than a high school education significantly decreased within the last three years.

Participant Education Level and Employment Stability

	FY 2019-20	FY 2020-21	FY 2021-22
Less than high school education	25%	10%	1%
Unemployed / work occasionally	76%	95%	61%
Some college	23%	18%	26%
Stable employment	24%	5%	26%

Stable employment reduces risk factors related to poverty and unemployment and increases protective factors related to economic security. The Lift program includes support and referrals to high school diploma completion programs. Completing high school and earning a diploma also increases protective factors such as increasing future opportunities, improving feelings of mastery and control, as well as increasing self-esteem through accomplishment. The Lift program also provides referrals to Preschool Services Department Apprenticeship program and other training programs for career options. Families obtaining stable employment reduces risk factors by helping with self-esteem, self-efficacy, and economic security.



Artwork by Aubrey Sanchez

Lift Program, cont.

Program Challenges/Solutions

Due to the ongoing COVID-19 pandemic and the rising number of cases throughout the year the department has continued to phase challenges. The department had one Registered Nurse out for an extensive period of time for a serious medical condition. This had an impact on recruitment efforts and put a strain on the remaining staff.

To address these challenges, the program continues to follow the procedures put in place in response to the COVID-19 pandemic such as telephonic or virtual visits to ensure the safety of both program participants and the staff. The department assessed the staffing issue by reviewing the caseloads and equally distributing the participants to the remaining staff, including but not limited to utilizing the Supervising Nurse Case Manager to conduct field visits to cover periods of time when staff were out on vacation or sick. Recruiting efforts were scaled back to ensure that the number of participants did not exceed established guidelines and impact the quality of service provided to participants of the program.

Lessons Learned

Education about the interrelation between the mental and physical developmental milestones of unborn and newborn infants is an important consideration of behavioral health, more emphasis can be placed on conducting follow-up screenings to better measure the overall growth of participating mothers. The Edinburgh Postnatal Depression Scale is a useful tool to screen for early signs of postnatal depression and allows the nurse to develop a case plan, and it would also be an effective tool to measure the success of the interventions if it were administered at appropriate intervals.

Additionally, the Maternal Fetal Attachment Scale is used to assess the overall mother-infant attachment, additional outcome data could be evaluated if the tool was re-administered to determine what levels of change had been affected as a result of participation in the Lift program. There is an opportunity to expand the use of the Life Skills Progression Tool. It is currently being used to measure one area related to education and employment, however the LSP has the capability to measure development in eight key life areas.

The Lift program is currently seeking to implement an increase in the frequency and scope of these measurement tools to provide more comprehensive data in upcoming years.

During the COVID-19 pandemic, the Lift program adapted to providing services by telephone to ensure that participants would have the support they needed. Although this was a necessary action to continue services, it is noted that in-person services provide more comprehensive results and provide a greater opportunity to observe and interact with participants in a natural setting.

Program Updates

There are no planned program updates for Fiscal Year 2022-23.

Lift Program, cont.

Collaborative Partners

- San Bernardino County Black Infant Health Program (BIH)
- Victor Community Support Services
- San Bernardino County Library & First 5 – Online High School Diploma Program
- Transitional Assistance Department – Home Visiting Program
- Children's Fund
- 211 Inland SoCal United Way – PSD 211 Specialist
- Dr. Bergin – Marriage, Family Therapy
- Women, Infants and Children
- San Bernardino County Juvenile Probation Department
- Community Action Partnership
- Rose of Sharon Pregnancy Resource Center

Success Stories

"Being a part of LIFT from late pregnancy to early motherhood has been nothing but helpful, and great. From being assigned an at home nurse who was always available at any time to answer any questions and concerns I had as a new mother to offering any information and an opportunity to find my daughter affordable and reliable care for when I returned to work. The LIFT program helped me find many resources when I was struggling, and always listened to any problems I had with a want to help me find a solution. At every visit I was offered diapers and wipes for my daughter, so the times I found myself in need of diapers my daughter was taken care of. I had nothing but a pleasant experience with LIFT and appreciated the hard work, compassion, and understanding they put in to help me as a new mom."

- Client #1

"Hello, the LIFT program has helped me and my family to set goals, and milestones for my son with their help and motivation has helped me to better myself and help me to reach these goals and milestones. Also the fact they worked with my schedule was the best. Due to their program I was also able to get my child diapers, baby wipes and a car seat. I really appreciate all their kindness and help they have given me. Just be prepared to get attached to the staff the fact that they are so loving and caring I have nothing bad to say about this program. I regret not putting my second child in this program due to always being at work."

- Client #2

Coalition Against Sexual Exploitation (CASE)

Target Population and Program Description

The Coalition Against Sexual Exploitation (CASE) of San Bernardino County is a collaboration of public and private organizations with the common goal of pooling resources to combat the commercial sexual exploitation of children. CASE partner organizations combine resources to educate the community and protect, intervene, and treat children and youth who are victims of commercial sexual exploitation.

CASE provides direct services to children who have been identified as commercially sexually exploited, or CSEC. The multidisciplinary team includes social workers from Children and Family Services, Public Defenders Office, and Behavioral Health; attorneys from the District Attorney's office and Public Defenders office; a probation officer, a public health nurse, an Alcohol and Drug Counselor, and advocates from Court Appointed Special Advocate (CASA), Open Door; and an educational consultant from San Bernardino County Superintendent of Schools provides direct services.

Program Summary	
Program Serves	Children Youth and TAY (16-25)
Location of Services	Foster care placements, hospitals, schools, community settings
Number of Consumers to be Served	1,500
Annual Budget FY 2023-24	$245,974
Cost Per Client FY 2023-24	$164
Services Offered	Mental health assessments Crisis Intervention Case Management including linkage and referrals School enrollment assistance Therapeutic interventions Transportation assistance Placement consultation Outreach and community awareness training

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

Coalition Against Sexual Exploitation (CASE), cont.

Program Highlights

CASE seeks to reduce the number of those who are commercially sexually exploited or at risk of commercial sexual exploitation. The multi-agency collaboration model supports the state Prevention categorization through the services aimed at decreasing risk factors associated with children becoming commercially sexually exploited and increasing the protective factors.

CASE also 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 that may be at risk of sexual exploitation and provide information and resources on how to keep children safe.

Early Intervention services are available to CASE participants. However, the CASE team members do not directly provide these services. The multi-disciplinary team assesses, refers and links children identified as needing early intervention supports.

Number of Participants / Number of Services Projected vs Actual

	Projected	Actual		
		FY 2019-20	FY 2020-21	FY 2021-22
Unduplicated Participants	1,500	1,529	1,352	1,398
Number of Services	1,500	2,453	3,269	1,899



Artwork by One Stop TAY Center

Coalition Against Sexual Exploitation (CASE), cont.

Program Highlights, cont.

Prevention

Risk factors identified for CASE participants are running away, trauma exposure (e.g. history of sexual abuse and child welfare or probation system involvement), school failure/chronic absenteeism, poverty, substance use and violence. Protective factors for CASE participants include: positive adult interactions, school/community involvement, resourcefulness, resiliency, peer relationships, optimism, leadership, and life skills. CASE prevention activities seek to address the risk factors and protective factors with the following services:

- Placement assistance, advocacy, safety planning and CASE Youth Resource cards to help reduce the risk factors for homeless/runaway youth.
- Support, consultations, and advocacy from the San Bernardino Superintendent of Schools, Probation, and the District Attorney's office to help reduce risk factors for youth with a history of violations with truancy, curfew, and/or involvement with the juvenile justice system.
- Creation of safety plans, Child Family Services Social Worker assignment, Child Family Team (CFT) meetings, mentor assignment, Public Health, and therapeutic services are available to youth that face sexual abuse, physical abuse and neglect risk factors.
- Assignment of an Alcohol and Drug Counselor and/or Behavioral Health referral are services provided to youth identified as having a substance use disorder and assist them in creating a recovery plan.
- A prevention activity for CASE is Girls' Court. Girls' Court is a program for at-risk females from the ages of 12-17 years old that are involved in the legal system. If they complete the program successfully, their criminal records are sealed prior to turning 18 to alleviate further stigmatization of having prior juvenile justice involvement.

Number of participants / Number of services			
	FY 2019-20	FY 2020-21	FY 2021-22
Prevention Participants	100	64	63
Number of Services	737	1,981	582

Girls' Court Completion Rate			
	FY 2019-20	FY 2020-21	FY 2021-22
Completion Rate	60%	60%	20%

Coalition Against Sexual Exploitation (CASE), cont.

Program Highlights cont.

Outreach

Outreach is a primary strategy used with CASE to educate the community and partner agencies that provide services to children. CASE has reached a total of 4,025 potential responders from FY 2019-20 through 2021-22. CASE provides free CSEC awareness, identification, and assessment trainings throughout San Bernardino County. They provide training at conferences, community events, in-service staff meetings, and resource fairs. The information below provide details of CASE Outreach efforts.



Amazing Colors - artwork by Manuel Cordoba

Potential Responders Reached			
	FY 2019-20	FY 2020-21	FY 2021-22
Outreach Participants	1,429	1,288	1,317
Number of Services	1,716	1,288	1,317

Outreach Types of Responders / Settings	
Types of Responders	Settings
• Child serving agency service providers • Law enforcement personnel • School personnel • Medical professionals • Educators • Community service providers • Faith based leaders • Child protective services • Families	• Churches • Community based organizations • Community events • Law enforcement departments • Schools • County facilities • Hospitals

Coalition Against Sexual Exploitation (CASE), cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-50	60+	UNK
FY 2019-20	12%	38%	43%	4%	3%
FY 2020-21	3%	30%	32%	0%	35%
FY 2021-22	0%	11%	20%	1%	68%

Fiscal Year	Veteran Status
	% of consumers who identified as a veteran
FY 2019-20	0%
FY 2020-21	0%
FY 2021-22	0%

Fiscal Year	Sexual Orientation
	% of consumers who identified as LGBTQ+
FY 2019-20	4%
FY 2020-21	0%
FY 2021-22	1%

Fiscal Year	Disability
	% of consumers who identified a physical disability
FY 2019-20	2%
FY 2020-21	0%
FY 2021-22	0%

Fiscal Year	Gender Identity			
	♂ Male	♀ Female	⚧ Other	UNK
FY 2019-20	18%	78%	0%	4%
FY 2020-21	6%	31%	1%	62%
FY 2021-22	10%	23%	0%	60%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 2019-20	99%	1%	0%	0%
FY 2020-21	100%	0%	0%	0%
FY 2021-22	100%	0%	0%	0%

Coalition Against Sexual Exploitation (CASE), cont.

Demographics, cont.

	Race / Ethnicity			
		FY 2019-20	FY 2020-21	FY 2021-22
Race	African-American/Black	40%	4%	4%
	American Indian or Alaska Native	0%	0%	0%
	Asian	2%	0%	3%
	Native Hawaiian or Pacific Islander	0%	0%	0%
	More than One Race	1%	0%	0%
	Caucasian/White	40%	3%	9%
	Other Race	9%	0%	0%
	Declined to Answer	8%	93%	83%
Ethnicity	African	0%	0%	0%
	Asian Indian/South Asian	0%	0%	2%
	Cambodian	0%	0%	0%
	Chinese	0%	0%	0%
	Eastern European	0%	0%	0%
	European	0%	0%	0%
	Hispanic/Latino	2%	1%	43%
	Filipino	0%	0%	2%
	Japanese	0%	0%	0%
	Korean	0%	0%	0%
	Middle Eastern	1%	0%	0%
	Vietnamese	0%	0%	0%
	Other	0%	4%	0%
	More than one ethnicity	0%	0%	0%
	Declined to Answer	0%	96%	51%

Demographic Observations

- CASE has consistently served the targeted demographics over the last three fiscal years. Females between the ages of 16 – 50 are among the highest recipients of CASE services. The demographic totals represent both Prevention and Outreach service demographics.
- The number of people declining to answer demographic questions significantly increased in FY 2020-21 most likely due to the virtual nature of data collection. The percentage of individuals declining to answer decreases in FY 2021-22 as participants return to in-person services or become more comfortable with providing information using virtual formats.
- The ethnic and racial make up of CASE participants has fluctuated over the last three years. There was a spike of participants identifying as Caucasian in FY 2021-22.
- Because of the decreasing representation in engagement over the last three fiscal years, LGBTQ+ youth and males have been identified as areas of focus for CSEC identification and engagement.

Coalition Against Sexual Exploitation (CASE), cont.

Program Goals

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

The CASE program outcomes for this population include: improved life satisfaction, decreased hopelessness/increased hope, decreased impairment in general areas of life functioning (e.g., health/self-care-housing, occupation/education, legal, money management, interpersonal/social).

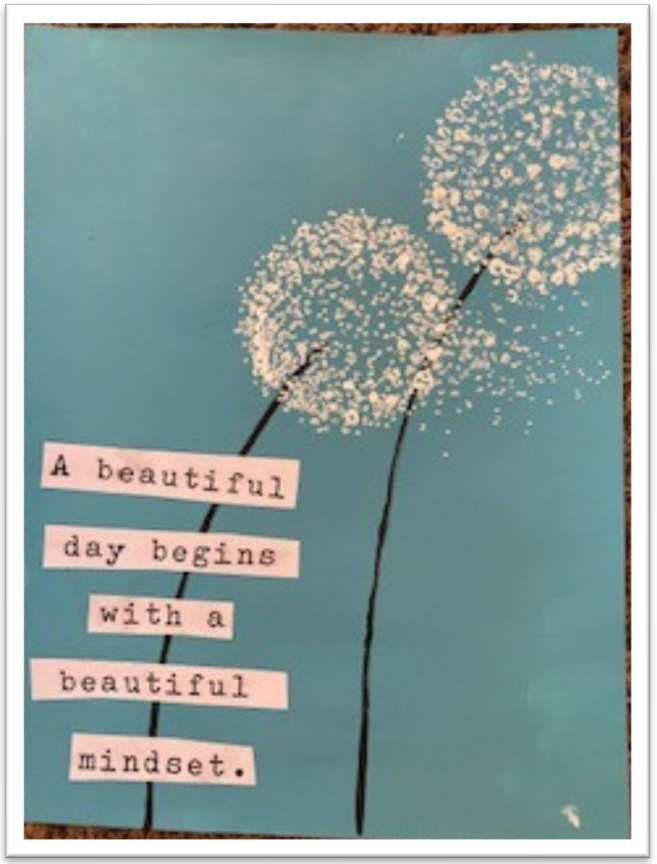
CASE uses the Child and Adolescent Needs and Strengths (CANS) to direct treatment services and evaluate early intervention outcomes.

Program Outcome Tools	
Survey Name	Child and Adolescent Needs and Strengths (CANS)
Description of Method	CANS is a multi-purpose tool developed for children's services to support decision making, including level of care and service planning. Only those youth connected to a mental health Medi-Cal Provider are required to have a CANS.
Survey Type	Intake, every 6 mo., and discharge
Number Completed	FY 2019-20: 18 FY 2020-21: 53 FY 2021-22: 35

Coalition Against Sexual Exploitation (CASE), cont.

Outcome Discussion, cont.

The CANS is used to monitor the outcomes and impact of services on the participants. The tool is used to support individual case planning and evaluation of services. The CANS is typically administered at intake and at six-month intervals until discharge. The chart below shows that CASE participants have made significant improvements in the areas of Life Functioning, Strengths, Behavioral Health Needs and Risk Behaviors when their treatment ended. The monitoring of CANS outcomes helps CASE team members adjust their prevention activities to support the identified needs addressed.



Coalition Against Sexual Exploitation (CASE), cont.

Program Challenges/Solutions

In effort to capture and collect data that reflect the array of services each client receives, CASE has contracted ITSD to help develop a CASE MDT database to assist capturing all of the work being done.

In regard to placement instabilities, there are no immediate resolutions at this time. The CASE team continues to discuss and plan ways to resolve this statewide topic.

Lessons Learned

The capacity to effectively track and collect data that reflects the array of services each client receives is a barrier with CASE. One aspect is that each agency is self-contained, and services may begin and terminate at different times with overlap. CASE participants receive intense case management services but there is currently no effective mechanism to track each service (e.g. hours, efforts, and services) that each team member provides to each participant. A database is needed that can track all of the participants and their encounters with each County and contract agency.

Multiple placement changes are common for CASE participants, as is chronic Absent Without Leave (AWOL) status. As a result, obtaining long-term or acceptable assignments remains difficult. Placement instability is a major factor that contributes to the difficulty of using CANS consistently to appropriately monitor progress or regress of CASE participants.

Collaborative Partners

- District Attorney
- Public Defender
- Children and Family Services
- Department of Probation
- Departments of Public Health
- Children's Network
- Department of Behavioral Health
- San Bernardino County Superintendent of Schools
- San Bernardino Superior Court – Juvenile Division
- Court Appointed Special Advocates of San Bernardino (C.A.S.A)
- Open Door – Advocate/Survivor Run Program

Program Updates

CASE is currently being assessed for program expansion in Fiscal Year 2023-24.

Coalition Against Sexual Exploitation (CASE), cont.

Success Stories

"I wanted to share a success story of a young adult mother that defied the odds in her life by her involvement in heavy trafficking and gang ties to become a great mother and advocate to others. The client came into care at the early age of 3 and was under guardianship with her great maternal aunt until the age of 12 when she returned to care due to defiance and refusing to move out of state.

Although, since the age of 12, she had multiple placements and through her placements became a victim of human trafficking as well as increased gang activities. Throughout the process the undersigned remained in her corner to advocate for her safety and well-being. Through her commitment to redirect and change her lifestyle and understanding the impact of a victim, of trafficking she has had no trafficked incidents since age 17. At the age of 17 she is the proud mother of a daughter age 1. The client is currently 18, and has taken advantage of her EFC benefits and is in her EFC apartment housing as well as working fulltime. She has become an advocate to girls that have suffered as victims of human trafficking and shares her testimony freely to help others.

The CASE SW has maintained a relationship/mentorship with the youth during the youth's involvement with CFS and Probation. The client has Graduated Girls Court. Completed two Probation Terms. Completed services with "Open Door" R2R "Run to Rescue" LA County. Cooperated with both San Bernardino County Public Defender's Office and District Attorney's Office. She has also maintained support from Department of Behavioral Health. The collaboration from the CASE MDT and teamwork has provided for success and perseverance in this success story."

- CFS Social Worker

On 4/19/22 PHN received referral from the CASE Public Defender. The youth was confirmed CSEC and pregnant. The client was in need of educational services as well as assistance and guidance in signing up for WIC. On 04/28/22 PHN made contact with client and spoke with the client regarding receiving her contact information from social worker from the Public Defenders Office. PHN inquired on the client's physical health condition and discussed health condition and answered any questions the client had. PHN provided WIC phone number, Family Nurse Partnership phone number, and offered other written resources and verified mailing address. PHN offered contact information and requested that the client reach out when she had any health-related concerns or questions.

Resources mailed:

- Bathing and diapering
- Burping a baby
- Welcome to pregnancy care
- Baby Blues and You
- Perinatal Mood Disorder
- For families and dads: Dealing with Postpartum Mood Disorder
- You Are Not Alone
- Cribs for Kids
- Shaken Baby Syndrome – Enjoy your Baby

As of 5/16/22 PHN has not had contact with client and the package mailed out was not returned by USPD.

- Public Health Nurse

Family Resource Center (FRC)

Target Population and Program Description

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 offered. 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 how to apply healthy coping skills and how to avoid reliance on unhealthy and sometimes dangerous coping mechanisms.

If left untreated, poor mental health can seriously affect many aspects of people's lives. Relationships deteriorate, friendships may be lost, family conflicts may arise, and school or work performance suffers. This can result in symptoms of depression and anxiety, making recovery even more difficult and time-consuming. In contrast, early awareness makes it easier for people to self-identify early signs of recurring mental health symptoms. 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.

Program Summary	
Program Serves	Children TAY (16-25) Adults Older Adults (60+)
Location of Services	Counseling Centers
Number of Consumers to be Served	26,945
Annual Budget FY 2023-24	$3,350,000
Cost Per Client FY 2023-24	$124
Services Offered	After school youth projects and activities Behavioral health education workshops Maternal mental health Personal development Skills-based education for adults Family counseling Individual therapy

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

Family Resource Center (FRC), cont.

Program Highlights

Family Resource Centers offer a mix of Prevention and Early Intervention activities.

Prevention

Prevention activities serve to promote mental wellness by reducing risk factors and building protective factors.

The FRCs offer a variety of prevention activities which include parenting classes, NCTI Crossroads© workshops, art programs, computer skills workshops, resume and job search workshops, and assistance in accessing basic needs through online applications. Prevention activities are often structured to focus on building strong relationships and reliable support systems with family and friends, participation in community activities, developing good coping skills, developing a healthy diet and exercise routine, building optimism and self-sufficiency, and providing access to support services. These activities help support mental wellness by developing protective factors in the participant such as strengthening community involvement, nurturing family engagement, and building resilience and self-reliance.

The following table shows the total number of projected participants and the number of services to be provided per year along with the actual number of participants served and services provided per year. The Family Resource Centers serve an average of 26,945 participants annually.

Number of Participants / Number of Services Projected vs Actual

	Projected	Actual		
		FY 2019-20	FY 2020-21	FY 2021-22
Unduplicated Participants	26,945	30,973	22,434	28,355
Number of Services	51,011	49,967	37,881	39,861

Early Intervention

Early Intervention activities are designed to address and promote recovery through therapeutic treatment services including individual counseling, family counseling, group therapy, and relapse prevention services. The table below illustrates the total number of participant episodes, the number of episodes closed in the fiscal year, and the percentage of those participants who met their treatment goals.

Treatment Plan Completion Rate

FY 2019-20	907 total episodes	691 closed episodes
	52% of participants met their treatment goals (356 of 691)	
FY 2020-21	873 total episodes	604 closed episodes
	51% of participants met their treatment goals (307 of 604)	
FY 2021-22	873 total episodes	700 closed episodes
	51% of participants met their treatment goals (307 of 700)	

Family Resource Center (FRC), cont.

Program Highlights, cont.

Access & Linkage to Services

Family Resource Centers provide access and linkage to services to higher levels of care for participants who need treatment beyond early intervention. Participants in need of higher level of care services are given referrals to service providers that can meet their needs. Many of the Family Service Centers provide "warm hand-offs" to higher level providers by calling in advance or making in-person introductions to ensure that the participants are able to connect to their referral partners. The number of participants who received access and linkage referrals during the previous three fiscal years are shown in the table below:

Access and Linkage to Services Referrals			
	FY 2019-20	FY 2020-21	FY 2021-22
Number of Referrals Provided	68	91	52
Number of referrals to County-funded / administered programs	61	72	7
Number of referrals to other programs	7	19	45
Number of participants who followed through and engaged in services at a County-funded / administered program at least once	15	5	42

Improving Timely Access

Family Resource Centers work to improve timely access to mental health services for members of historically underserved populations by providing referrals to appropriate prevention, early intervention, and/or higher-level care services as needed. Members of historically underserved populations include individuals who are so poorly served that they are at risk of homelessness, institutionalization, incarceration, out-of-home placement as well as members of ethnic/racial, cultural, and linguistic populations that 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. Family Resource Centers actively work to identify and engage individuals in need and provide referrals that meet their mental health care needs in a culturally relevant manner.

Improving Timely Access Referrals			
	FY 2019-20	FY 2020-21	FY 2021-22
Number of Referrals Provided	393	119	209

Family Resource Center (FRC), cont.

Program Highlights, cont.

Outreach

Outreach and education services provide information about recognizing early signs and symptoms of mental illness to individuals that provide support and encouragement to people exhibiting early signs of mental illness.

Outreach activities provided education to a variety of potential responders including community service providers, families, law enforcement personnel, peer providers, primary health care providers, and school personnel.

Potential Responders Reached			
	FY 2019-20	FY 2020-21	FY 2021-22
Number of Potential Responders Reached	21,874	8,992	17,714

The program has seen large scale activities designed to educate community members about recognizing early signs and symptoms of mental illness, such as a community-wide film screenings about mental health concerns topics, followed by a question-and-answer panel with mental health experts.

Some of the outreach activities supported by the FRCs have been participation in community walks to raise awareness of mental health and the establishment of Mental Health Awareness Groups at local high schools, implementing peer-to-peer support program on local campuses to increase mental health awareness, recognizing symptoms of mental health disorders, increasing suicide awareness, and recognizing signs of bullying.

There was a significant reduction in the number of potential responders reached by Outreach efforts in FY 2020-21 due to the COVID-19 pandemic continuing throughout the year. Many community events, health fairs, and other large-scale activities were cancelled due to ongoing social distancing efforts. Strides were made at reaching potential responders through virtual platforms, using Zoom meetings, and reaching out to people through social media platforms such as Facebook and Instagram. However, the volume of potential responders has since increased due to the easement of pandemic regulations and schools reopening.

Surveys modeled after the California MOQA surveys were developed in FY 2020-21. Questions were developed to measure the participants' change in knowledge about mental health issues allowing for additional data in future reports.

Family Resource Center (FRC), cont.

Program Highlights, cont.

Stigma and Discrimination Reduction

In designing prevention and early intervention activities, Family Resource Centers use non-stigmatizing and non-discriminatory strategies to reduce stigma associated with seeking and receiving services. Some examples of ways the Family Resource Centers achieve this are:

- Family Resource Centers are located in non-clinical settings, inviting participants to come in without the stigma of attending a mental health clinic.
- Activities are designed to be fun and inclusive to all.
- Activities are designed to be linguistically inclusive to reduce stigma so that individuals can seek services in their native languages.

In planning an event that included a question-and-answer session, the Family Resource Center included a text messaging option so that individuals could ask questions without the stigmatizing effect of having to stand at a public microphone to ask their questions. Using this strategy, 98% of the participants chose to text their questions as opposed to using the microphone.

Client (mom) was referred by DCFS for parenting, anger management, and therapy. Client was able to demonstrate assertion skills, setting healthy boundaries, increasing support system, and utilize healthy coping skills.

Needs Assessment

The Family Resource Centers look for opportunities to address the needs of participants within their local communities by hosting or participating in community meetings, seeking feedback from community members about the types of services that they would like to see offered. They accomplish this by:

- Listening to clients and their families about the types of supports that are needed.
- Seeking feedback through open meetings.
- Communicating with local collaborative partners such as school districts, Children and Family Services, Department of Aging and Adult Services, Probation and Parole Department community coalitions, and non-profit agencies

By actively participating in these community meetings, the Family Resource Centers can identify gaps in services and develop new programs and activities that will fill these gaps in a way that is meaningful and relevant to the local community, allowing the Family Resource Centers to be responsive to local needs.

Family Resource Center (FRC), cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-50	60+	UNK
FY 2019-20	24%	9%	34%	6%	27%
FY 2020-21	22%	9%	51%	3%	15%
FY 2021-22	9%	4%	19%	1%	67%

Fiscal Year	Veteran Status
	% of consumers who identified as a veteran
FY 2019-20	1%
FY 2020-21	1%
FY 2021-22	<1%

Fiscal Year	Sexual Orientation
	% of consumers who identified as LGBTQ+
FY 2019-20	1%
FY 2020-21	<1%
FY 2021-22	<1%

Fiscal Year	Disability
	% of consumers who identified a physical disability
FY 2019-20	4%
FY 2020-21	2%
FY 2021-22	2%

Fiscal Year	Gender Identity			
	♂ Male	♀ Female	⚧ Other	UNK
FY 2019-20	14%	25%	<1%	60%
FY 2020-21	11%	25%	<1%	63%
FY 2021-22	12%	30%	<1%	57%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 2019-20	60%	16%	0%	24%
FY 2020-21	74%	24%	2%	0%
FY 2021-22	71%	16%	11%	2%

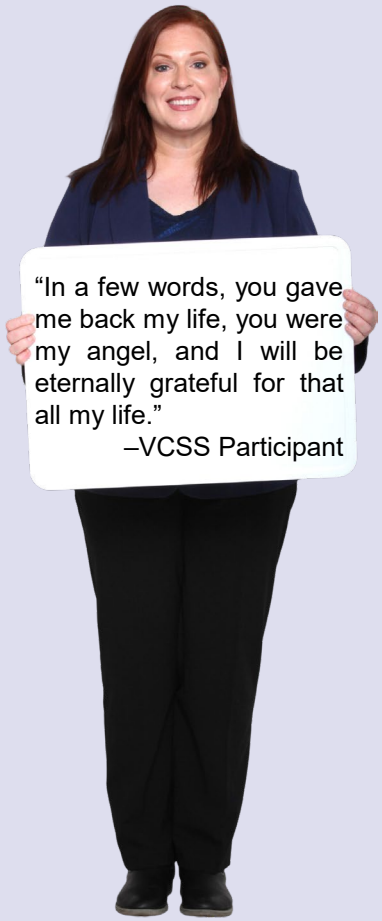
Family Resource Center (FRC), cont.

Demographics, cont.

	Race / Ethnicity	FY 2019-20	FY 2020-21	FY 2021-22
Race	African-American/Black	6%	3%	3%
	American Indian or Alaska Native	1%	0%	3%
	Asian	1%	0%	1%
	Native Hawaiian or Pacific Islander	0%	0%	0%
	More than One Race	2%	22%	4%
	Caucasian/White	16%	15%	16%
	Other Race	18%	8%	14%
	Declined to Answer	19%	51%	59%
Ethnicity	African	1%	0%	3%
	Asian Indian/South Asian	0%	0%	1%
	Cambodian	0%	0%	0%
	Chinese	0%	0%	0%
	Eastern European	0%	0%	0%
	European	9%	9%	5%
	Hispanic/Latino	38%	22%	39%
	Filipino	0%	0%	0%
	Japanese	0%	0%	0%
	Korean	0%	0%	0%
	Middle Eastern	0%	0%	0%
	Vietnamese	0%	0%	0%
	Other	18%	5%	16%
	More than one ethnicity	5%	1%	2%
	Declined to Answer	66%	84%	34%

Demographic Observations

- The FRC program has consistently served the targeted demographics over the last three fiscal years. In Fiscal Years 19-20 through 21-22 it became increasingly difficult for providers to capture demographic data utilizing virtual formats.
    - TAY-aged and older adult populations show the lowest participation rates. This may be due to the availability of age-specific programs that are designed to meet the needs and challenges of these populations.
- All current FRC providers have committed to continuing to offer a mix of in-person and telehealth options since the pandemic restrictions have lifted.

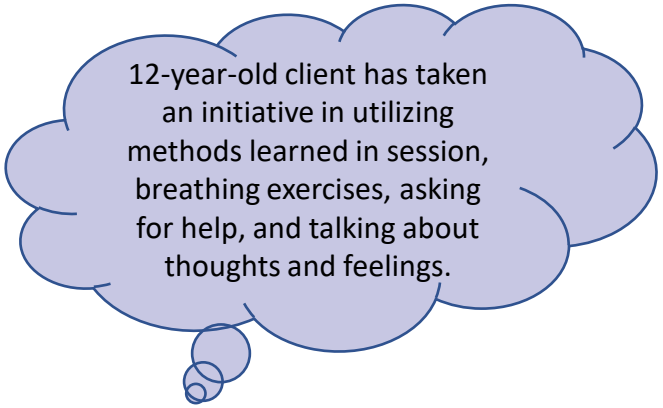


Family Resource Center (FRC), cont.

Program Goals

The goal of the Family Resource Center program is to reduce prolonged suffering associated with untreated mental illness. In conducting prevention activities, this is achieved by deducing risk factors, reducing indicators, and increasing protective factors that may lead to improved mental, emotional, and relational functioning.

For early intervention activities, this is achieved by providing counseling and treatment that leads to reduced symptoms and improved recovery, including mental, emotional, and relational functioning. Additional goals are to use strategies to reduce stigma associated with mental illness as well as improving early access to services by connecting participants with severe mental illness to medically necessary care and improving timely access for historically underserved populations.



Program Outcome Tools				
Survey Name	Children and Adolescent Needs and Strengths Assessment (CANS)	Adult Needs and Strengths Assessment (ANSA)	NCTI Crossroads ©	Life Skills Progression (LSP)
Description of Method	CANS is a multi-purpose tool developed for children's services to support decision making, including level of care and service planning.	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.	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.	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.
Survey Type	Every three months for duration of treatment	Every three months for duration of treatment	2 times Initial & completion	2 times Initial & completion
Number Completed	FY 2019-20: 49 FY 2020-21: 56 FY 2021-22: 211	FY 2019-20: 231 FY 2020-21: 209 FY 2021-22: 130	FY 2019-20: 115 FY 2020-21: 91 FY 2021-22: 98	FY 2019-20: 149 FY 2020-21: 141 FY 2021-22: 154

Family Resource Center (FRC), cont.

Outcome Discussion

Early Intervention

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 Assessments (CANS) and Adult Needs and Strengths Assessments (ANSA).

Child and Adolescent Needs and Strengths Assessment (CANS)

The Child and Adolescent Needs and Strengths assessment is a multi-purpose tool that helps develop the level of care and service planning and allows for the monitoring of outcomes of services. The table below shows that children and youth participating in Family Resource Centers' early intervention activities have made improvements in these domains.

Child and Adolescent Needs and Strengths Improvement in Primary Domains

	FY 2019-20	FY 2020-21	FY 2021-22
Life Functioning Domain	55.2%	69.6%	45.5%
Strengths Domain	56.9%	69.6%	84%
Behavioral Health Needs Domain	49.8%	70.7%	42.3%

Children and youth participating in the Family Resource Centers are presented with a variety of challenges. The table on the right shows some of the most prevalent subdomains with the corresponding rates of improvement.

Child and Adolescent Needs and Strengths Improvement in Subdomains

	FY 2019-20	FY 2020-21	FY 2021-22
Life Functioning Domain			
Family Functioning	87%	80%	76%
Social Functioning	80%	80%	75%
School Achievement	100%	50%	61%
Strengths Domain			
Family Strengths	90%	81%	70%
Interpersonal	100%	63%	70%
Resiliency	100%	94%	70%
Resourcefulness	57%	86%	69%
Behavioral Health Needs			
Depression	100%	87%	83%
Anxiety	88%	84%	71%
Anger Control	100%	80%	71%
Risk Behaviors			
Suicide Risk	100%	100%	85%
Non-Suicidal, Self-Injurious Behavior	N/A	50%	72%

Suicide is a rising concern, as shown in the increasing numbers of participants presenting with suicidal risk and non-suicidal, self-injurious behaviors. These concerns were exacerbated in FY 20-21 with the COVID-19 pandemic, however, have continued to improve with the ease of pandemic regulations. Suicide awareness and prevention efforts are incorporated into FRC assessments and treatment plans when suicidal risk behaviors are presenting concerns.

Family Resource Center (FRC), cont.

Outcome Discussion

Adult Needs and Strengths Assessment (ANSA)

The Adult Needs and Strengths Assessment is a multi-purpose tool developed for adult behavioral health services to support decision-making, including the level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. The ANSA helps care providers decide which of an individual's needs are the most important to address in a treatment plan. The ANSA also helps to identify strengths.

Overall, adults participating in the Family Resource Centers' early intervention activities whose treatment sessions opened and closed within the same fiscal year made improvements in the following primary domains as shown in the chart below:

Adult Needs and Strengths Improvement in Primary Domains

	FY 2019-20	FY 2020-21	FY 2021-22
Life Functioning Domain	78.4%	83.9%	62.9%
Strengths Domain	75.7%	79.6%	59.3%
Behavioral Health Needs Domain	66.2%	77.4%	61.1%

The ANSA contains several subdomains for each of the primary domains. The table on the right shows the percentage of improvement in adult FRC early intervention participants who presented with needs in the subdomains listed.

Adult Needs and Strengths Improvement in Subdomains

	FY 2019-20	FY 2020-21	FY 2021-22
Life Functioning Domain			
Family Functioning	92%	92%	59%
Social Functioning	90%	92%	64%
Decision-Making /Judgment	95%	93%	76%
Parenting Roles	84%	82%	63%
Strengths Domain			
Family Strengths/Family Support	89%	94%	55%
Community Connection	78%	78%	42%
Natural Supports	89%	89%	37%
Resiliency	92%	97%	70%
Resourcefulness	100%	97%	64%
Behavioral Health Needs Domain			
Depression	90%	95%	69%
Anxiety	91%	94%	60%
Adjustment to Trauma	91%	88%	58%
Eating Disturbances	100%	89%	68%

Eating disorders are an emerging concern. During FY 2021-22, there were 15 initial participants presenting with eating disturbances, which were able to improve through offered services. Growing awareness and additional research around eating disorders will help to address this growing rate of participants seeking help in this area.

Family Resource Center (FRC), cont.

Outcome Discussion

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 improve 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 2019-20	6.26	7.22	15%
FY 2020-21	8.61	9.48	10%
FY 2021-22	5.73	9.46	65%

Note: Beginning with the FY 2019/20, NCTI reporting outcomes changed from percentage-based scores to raw number scores. The calculation for percent improvement remained the same.

Life Skills Progression (LSP)

Life Skills Progression surveys are developed by considering in-depth information about the family through interviews, conversations, and observations about family functioning. The LSP is completed at intake to develop a profile of family strengths and needs as well as develop a service plan. The LSP is completed again at the completion of services to monitor progress in outcomes.

The LSP measures the participants' growth in five key areas of relationships, access to resources, medical health, mental health, and essentials. These are important because studies show links between these areas and their effects on mental health and well-being. For example, strong relationships lead to higher levels of self-esteem and result in lower rates of anxiety and depression.

The outcomes showing the average percent increase in these areas from the previous three years are shown in the following table:

Life Skills Progression Percent Improvement					
	Relationships	Resources	Medical	Mental Health	Basic Essentials
FY 2019-20	14.1%	20.8%	7.0%	38.6%	9.4%
FY 2020-21	16.4%	27.3%	9.6%	29.1%	13.7%
FY 2021-22	13.8%	29.0%	8.6%	37.9%	10.9%

Family Resource Center (FRC), cont.

Participant Satisfaction Surveys

Following services, participants were given satisfaction surveys to determine whether the services provided are meeting their needs and what areas could be improved upon. The three most common themes across the Family Resource Centers show that the services provided are helpful, improve mental health, and participants agree they would participate in the program again.

Although most of the comments said the services received were good or excellent, some expressed the need for more options, particularly in the area of housing assistance and resources, showing that meeting basic needs such as stable housing is important to mental health and well-being. In recognizing this need, FRCs offer referrals to appropriate resources along with assistance empowering participants to access these resources independently. FRCs provide directions to private and public service agencies that provide these resources or provide education and assistance in accessing these resources through virtual and web-based services.

Participant Satisfaction Survey Results

	FY 2019-20	FY 2020-21	FY 2021-22
Improved mental health	93%	87%	100%
Services were helpful	98%	83%	100%
Would participate in the program again	97%	80%	100%
Will use the information in the future to support good mental health	99%	74%	100%
Recommendations for improvement:	• Need more housing assistance / resources • Program does not offer income assistance • Need more options		
Limitations: Small sample size, some questions were activity specific.			









Family Resource Center (FRC), cont.

Program Challenges/Solutions

Challenges to the Family Resource Center include a continuing need to reduce barriers to seeking mental health services within many communities. Collaboration with partners such as the Mexican and Guatemalan Consulates identified the need to expand the reach of mental health services, mental health awareness workshops, and other mental health resources to nearby communities.

The solutions implemented by Family Resource Centers to address program challenges include educating the community about mental health services and resources available in order to help promote prevention and early intervention for better mental health. In addition, Family Resource Centers developed collaboration with new partners in the surrounding communities to provide local mental health awareness workshops and information about mental health resources within the community.

A new challenge has been getting the community to sign up for services. Now that pandemic restrictions have settled, many people are feeling overwhelmed in adjusting to the new normal. Even though schools are providing in-person instruction, many students have inconsistent attendance due to current state mandates and protocols. As the referrals for case management services have increased, the is a shortage of providers which is causing delays in services. The FRC program is in the process of hiring new mental health providers to meet the needs of the community. FRC is also following-up with those waiting for services and providing and referring to emergency services for those in crisis-mode while they are waiting to receive preventative and early intervention services.

These challenges show that flexibility in the manner that services are offered is important to provide the best availability to participants.

Lessons Learned

One of the lessons learned over the last three fiscal years is the providers' processes of filing and managing data can be a hindrance to their ability to extract and evaluate it. Moving forward, providers will develop an improved system for storing data so that it may be more easily accessible for them and for DBH.

Additionally, adoption of the new PEI database system in Fiscal Year 2020-21 was challenging for providers, which made collecting and aggregating data challenging. This has been resolved with the providers now solely entering data into the PEI database system.

Program Updates

There are no planned Program updates for Fiscal Year 2022-23.



Community Wholeness and Enrichment (CWE)

Target Population and Program Description

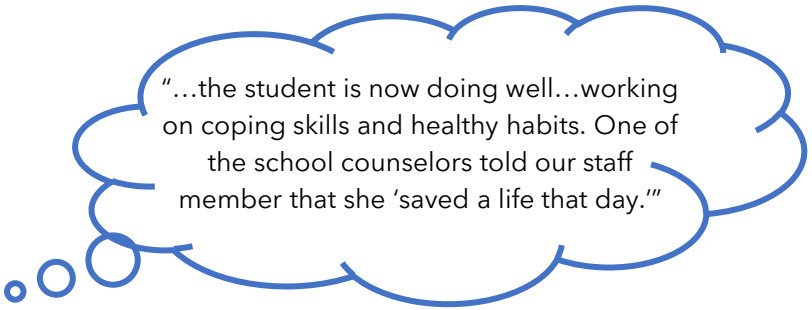
The Community Wholeness and Enrichment (CWE) program is categorized as a Prevention and Early Intervention program. CWE identifies and helps to manage the early onset of mental health symptoms in transitional age youth (TAY) ages 16-25 and adults ages 26-59 who are experiencing the initial onset of a mental or emotional illness and/or substance use disorder.

The primary goal of the CWE program is to address mental health disorders early in their onset, utilizing the prevention and early intervention services to prevent the onset or reduce the severity of a mental illness. Although prevention and early intervention can be implemented over the lifespan, the benefits are maximized when people are targeted at or around the time of onset of a mental disorder. Utilizing stakeholder feedback and community needs assessments, CWE providers work closely with their communities to understand their needs and to ensure those needs are met. CWE services include screenings and 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. Utilizing various screenings, including the immediate needs screening tool, CWE providers can evaluate a participant's risk factors. The screenings also address previous experience with mental health, including past services received to determine the participant's current mental health need.

Program Summary	
Program Serves	TAY (16-25) Adults (26-59)
Location of Services	Central Valley, Desert/Mountain, East Valley, West Valley
Number of Consumers to be Served	2,956
Annual Budget FY 2023-24	$850,000
Cost Per Client FY 2023-24	$287
Services Offered	Screenings/Assessment Case Management, Linkage & Referrals Support Groups (includes suicide bereavement) Mental Health Education Early Intervention Counseling Services

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



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. To ensure participants are connected to appropriate services, the program uses strategies to increase and improve linkage and timely access to services. The program had some COVID-related barriers that created challenges in meeting their target number of unduplicated participants per year.

Number of Participants / Number of Services Projected vs Actual				
	Projected	Actual		
		FY 2019-20	FY 2020-21	FY 2021-22
Unduplicated Participants	2,956	2,341	3,634	2,091
Number of Services	7,809	5,622	8,306	6,052

Prevention

The risk factors associated with those experiencing early onset of a mental illness can include experience of trauma, stressful life events, and isolation. Building protective factors such as social connections, coping skills, and resilience helps to combat these risk factors.

A large focus of the prevention component of the CWE program is supportive groups. The providers of the CWE program offer several support groups topics including relapse prevention, depression, anxiety, and suicide bereavement for those who have lost a loved one to suicide.

The table below illustrates the number of participants who received a prevention service over the last three fiscal years, and the number of services those participants received. CWE has struggled in the past three years to provide prevention services. Support group attendance has been low, this is due to participants being uncomfortable in group settings. Switching these services to telehealth during the COVID-19 pandemic also made it difficult for building participation. Furthermore, staffing issues created obstacles as well as ever-changing mandates due to COVID-19 created barriers with participation.

Prevention Participants / Services			
	FY 2019-20	FY 2020-21	FY 2021-22
Prevention Participants	1,373	2,588	1,624
Number of Services	1,685	3,160	1,186

Early Intervention

The CWE program offers early intervention services such as evidence-based treatments and therapies, as well as relapse prevention services. The program's objective is to address and promote early recovery and functional outcomes for a mental illness.

The table on the following page shows the total number of episodes opened, the number of episodes closed, and the proportion of participants who met their treatment goals for each fiscal year.

Community Wholeness and Enrichment (CWE), cont.

Treatment Success by Fiscal Year			
	Total Episodes	Closed Episodes	% Met Goals
FY 2019-20	260	200	46%
FY 2020-21	480	319	41%
FY 2021-22	399	264	53%

Program Highlights, cont.

The CWE program is looking for ongoing solutions to increase the percent of participants that meet treatment goals.

Outreach

The CWE engages new participants and educates potential responders about the signs and symptoms of mental illness, as well as to recognize their own symptoms and seek services if needed. These outreach services provide participants an opportunity to identify signs and symptoms in their friends and family, as well as themselves, leading to a greater likelihood of seeking services for a mental health need.

The following table illustrates the number of potential responders reached and the types of settings where outreach occurred over the last three fiscal years. There was a decrease in number served for FY 2021-22. This was due to the transition from virtual classes in school back to in-person/on campus. The schools struggled with different COVID-19 mandates and staffing issues, which created barriers in providing services to the community.

Potential Responders Reached			
	FY 2019-20	FY 2020-21	FY 2021-22
Potential Responders	1,001	2,789	1,040

Outreach Types of Responders / Settings	
Types of Responders	Settings
• Community service providers • Families • Employers • Primary health care providers • School personnel • Leaders of faith-based organizations • Peer providers • Consumer family members	• Community events • Community-based organizations • Social media outreach • County facilities • Family resource centers • Faith-based organizations • Schools • Virtual platforms

Access & Linkage

The CWE program targets those with early onset mental illness, however the program is also designed to serve participants with severe mental illness. So, while the program does utilize the Access and Linkage to Treatment strategy, CWE providers rarely have a need to link individuals to a higher level of care. The CWE program made four referrals to treatment beyond early onset over the last three fiscal years.

Community Wholeness and Enrichment (CWE), cont.

Program Highlights, cont.

Improve Timely Access to Treatment

The CWE program occasionally provides referrals as part of the Improve Timely Access to Services strategy. In the last three years, CWE providers have made five referrals to either early intervention or treatment beyond early onset services. As with Access and Linkage, CWE providers do not make many referrals for Improve Timely Access. This is due to the provider agencies having the capacity to provide these services within their own program.

Improve Timely Access to Services			
	FY 2019-20	FY 2020-21	FY 2021-22
Number of Referrals	4	1	1
Participants Engaged	2	0	0
Average # of Days Participant Engaged	6.5	0	0

Within the Improve Timely Access strategy, CWE providers served the following underserved populations:

Underserved Populations	
• Trauma-exposed	• LGBTQ+
• Co-occurring	• Homeless
• Justice-involved	• African-American
• TAY age foster children	• Latinx

Suicide Prevention

One focus of the CWE program is to provide support for suicide. This includes providing services that are centered around the prevention of suicides. The program distributes information to the community on the signs and symptoms of someone who may be at risk of suicide.

In addition, the program organizes specific educational opportunities to learn more about suicide prevention. They provide access to gatekeeper trainings such as Applied Suicide Intervention Skills Training (ASIST), safeTALK and Question, Persuade, Refer (QPR) to build the capacity of the communities to respond to a suicide related crisis. They also customize suicide prevention trainings for the specific needs of the community. Community member organizations can reach out to the program and request individualized trainings for specific communities, such as men, women, and youth within the underserved population of Latinos and African Americans.

The COVID-19 pandemic created challenges in providing suicide prevention trainings. Providers began to implement virtual trainings and utilized curriculums that could be delivered in a virtual platform, such as QPR, with the intention of increasing participation once again.

Providers of the CWE program have trained a total of 1,157 participants in suicide prevention over the last three fiscal years.

Suicide Prevention Trainings			
	FY 2019-20	FY 2020-21	FY 2021-22
Unduplicated Participants	665	342	150

Community Wholeness and Enrichment (CWE), cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-59	60+	UNK
FY 2019-20	1%	22%	57%	12%	8%
FY 2020-21	6%	30%	35%	0%	29%
FY 2021-22	<1%	11%	28%	<1%	60%

Fiscal Year	Veteran Status
	% of consumers who identified as a veteran
FY 2019-20	3%
FY 2020-21	1%
FY 2021-22	<1%

Fiscal Year	Sexual Orientation
	% of consumers who identified as LGBTQ+
FY 2019-20	5%
FY 2020-21	3%
FY 2021-22	0%

Fiscal Year	Disability
	% of consumers who identified a physical disability
FY 2019-20	15%
FY 2020-21	9%
FY 2021-22	3%

Fiscal Year	Gender Identity			
	♂ Male	♀ Female	⚧ Other	UNK
FY 2019-20	24%	53%	3%	20%
FY 2020-21	27%	53%	1%	19%
FY 2021-22	7%	18%	0%	75%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 2019-20	75%	11%	3%	11%
FY 2020-21	90%	7%	0%	3%
FY 2021-22	80%	17%	0%	3%

Community Wholeness and Enrichment (CWE), cont.

Demographics, cont.

	Race / Ethnicity			
		FY 2019-20	FY 2020-21	FY 2021-22
Race	African-American/Black	16%	5%	5%
	American Indian or Alaska Native	<1%	1%	<1%
	Asian	2%	2%	<1%
	Native Hawaiian or Pacific Islander	<1%	1%	<1%
	More than One Race	22%	9%	4%
	Caucasian/White	22%	24%	15%
	Other Race	32%	21%	23%
	Declined to Answer	4%	37%	52%
Ethnicity	African	<1%	2%	0%
	Asian Indian/South Asian	1%	0%	<1%
	Cambodian	0%	0%	0%
	Chinese	5%	1%	<1%
	Eastern European	<1%	0%	0%
	European	1%	14%	3%
	Hispanic/Latino	63%	29%	29%
	Filipino	<1%	0%	<1%
	Japanese	0%	0%	0%
	Korean	<1%	0%	0%
	Middle Eastern	<1%	0%	<1%
	Vietnamese	1%	0%	0%
	Other	1%	3%	5%
	More than one ethnicity	4%	7%	1%
	Declined to Answer	21%	23%	61%

Demographic Observations

- The CWE program served primarily TAY and adults which is consistent with its target population.
- Mental health concerns are prevalent in TAY and young adult populations. Young adulthood comes with numerous stressors such as new and multiple responsibilities/roles, demands, and financial obligations. Early identification of mental health concerns and thorough assessments are critical in order to provide adequate services and ensure better outcomes.
- Consistently over the last three fiscal years, the program has served almost twice as many females as males.
- This is consistent with research that demonstrates that mental illness in the past year has been more prevalent in females than males. As of 2020, roughly 25.8% of females had experienced mental illness in the previous year, compared to 15.8% of males. Depression, anxiety, and mood disorders are some of the most diagnosed mental illnesses.



Community Wholeness and Enrichment (CWE), cont.

"[Clinician] always made me feel comfortable, safe, and motivated to continue making progress in every session."

Program Goals

The primary objective of the CWE program is to address mental health disorders early on in their development by utilizing prevention and early intervention services to avert or lessen the severity of a mental illness.

While prevention and early intervention can be implemented throughout a person's lifetime, the benefits are greatest when young people are targeted at or near the onset of mental health disorders.

In order 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 crisis by providing supports early in the emergence of a mental health concern.

They also provide support and education to the families. These services include information on how to support their family member who is experiencing a mental health crisis.

Respite care is an important element of this program. Family members are provided with information on identifying their own signs and symptoms of a potential mental health concern. They have access to services that can help reduce the stressors associated with caring for a loved one suffering with a mental illness.

Program Outcome Tools	
Survey Name	Adult Needs and Strengths Assessment (ANSA)
Description of Method	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.
Survey Type	Every three months for duration of treatment
Number Completed	FY 2019-20: 142 FY 2020-21: 291 FY 2021-22: 234

Community Wholeness and Enrichment (CWE), cont.

Outcome Discussion

The CWE program uses the Adult Needs and Strengths Assessment (ANSA) to measure outcomes of the early intervention treatments.

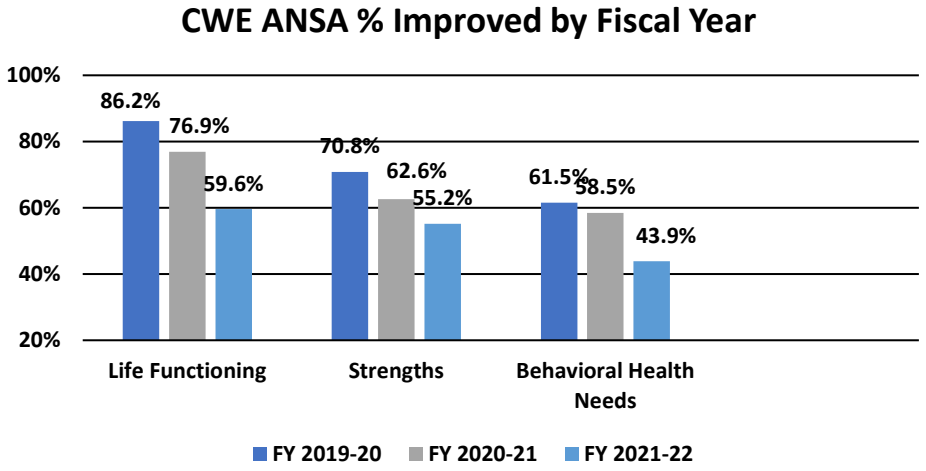
ANSA is an information integration tool for adults with behavioral health challenges. The tool is used to support individual case planning and the planning and evaluation of service systems. When the ANSA is administered, each of the dimensions is rated on its own four-point scale. The ANSA is administered at intake and at six-month intervals until discharge.

The ANSA is a multi-purpose tool developed for adult behavioral health services that focuses on a consumer's primary needs and strengths. CWE focuses on three primary domains:

- Life Functioning domain which evaluates factors like an individual's family relationships, social functioning, decision-making, self-care, and knowledge of illness.
- Strengths domain which evaluates factors like family support, optimism, interpersonal and social connectedness, relationship permanence, vocational and resilience.
- Behavioral Health Needs which evaluates factors like thought disorders, depression, anxiety, antisocial behavior, adjustment to trauma, and substance use.

Over the course of three fiscal years, CWE participants improved at varying rates. These variations may be the result of the COVID-19 pandemic delaying recovery. The pandemic also made it more difficult for people to develop their strengths and overcome challenges in areas such as life functioning and behavioral health needs. The program continues to see impacts due to the COVID-19 variants. The older adult community is not comfortable with Zoom as a therapy or group platform.

These challenges contributed to the gradual decrease over the three-year period. This data will be compared with future data models to evaluate the impact of the COVID-19 pandemic on participants accessing services. The learning will be used to improve future programming.



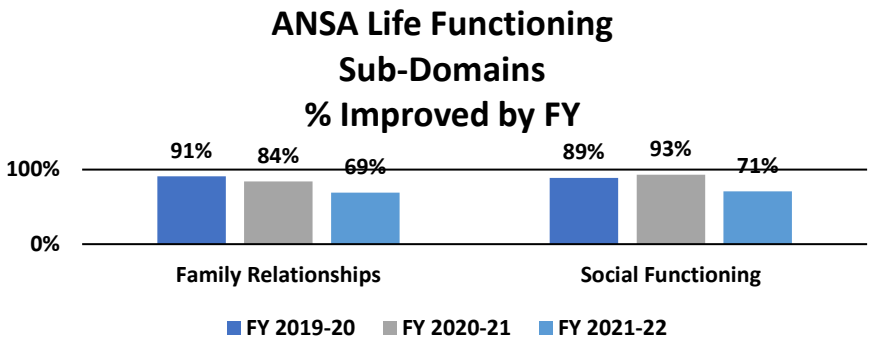
Community Wholeness and Enrichment (CWE), cont.

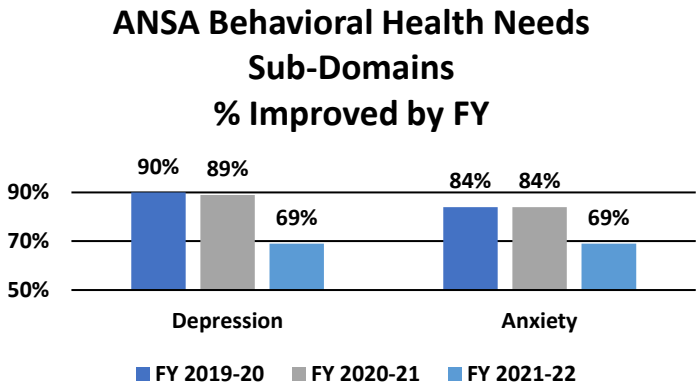
Outcome Discussion, cont.

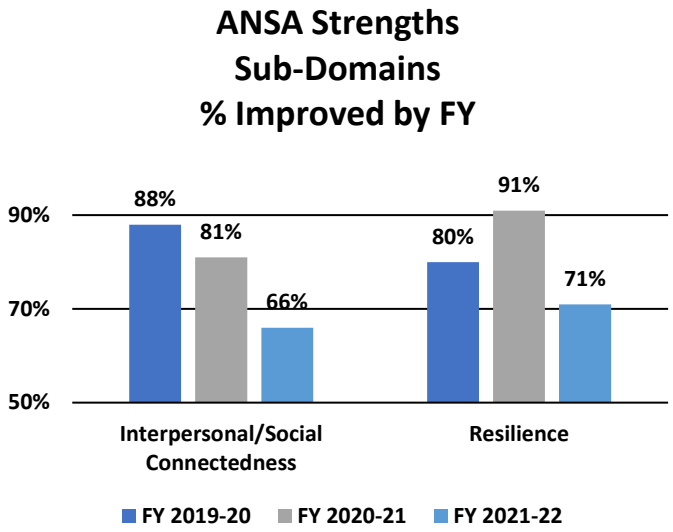
Each domain contains sub-domains that measure:

- Depression
- Anxiety
- Family Relationships
- Social Functioning
- Interpersonal/Social Connectedness
- Resilience

These subdomains were found to align most closely with the goals of the CWE program. The charts on this page illustrate the percentage of improvement in each domain. The improvements are indicators that the interventions provided by the program helped to avert or lessen the severity of a mental illness.







Community Wholeness and Enrichment (CWE), cont.

Program Challenges/Solutions

The most persistent challenge CWE providers report is the stigma associated with seeking mental health services and providing the prevention service of support groups targeting loved ones of those with a mental health disorder. It has been difficult engaging participants due to the community feeling overwhelmed trying to get back to "normal." Another challenge for FY 2021-22 was staffing; due to short staffing, especially in the schools, services were not as readily available as in previous years.

CWE providers continue to build community connections to ensure the communities they serve are aware of all the services CWE offers, including support groups. By continuing to partner with community organizations and providing education to the community, CWE providers continue to reduce the stigma associated with mental health, especially regarding suicide of a loved one. The CWE program will continue to advocate for the importance of attending a suicide bereavement group for survivors of those who have died by suicide. According to a study published in The Journal of Crisis Intervention and Suicide Prevention, findings "suggest that programs to increase social support after suicide loss may be an important aspect of suicide postvention."[1]

Lessons Learned

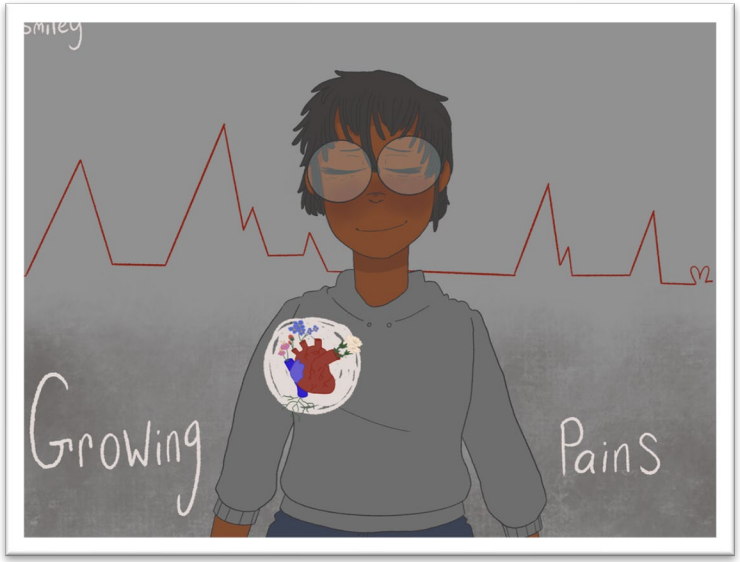
PEI has learned that over the last three fiscal years, the process of managing CWE data within the agencies has made it challenging to retrieve and analyze. Providers will improve their methods for handling their data in the future so that it is more easily accessible to them and DBH.

[1]Oexle, N. and Sheehan, L. (2019). Perceived Social Support and Mental Health After Suicide Loss. *The Journal of Crisis Intervention and Suicide Prevention, 41(1),* 65-69.

Additionally, staffing issues during FY 2021-22 created challenges in keeping up with data entry and documentation, however the providers are working to hire and train more staff and create a more streamlined process for entering data into the PEI database.

Program Updates

There are no planned program updates for Fiscal Year 2023-24.



Growing Pains - artwork by Moe Moffatt

Military Services and Family Support (MSFS)

Target Population and Program Description

The Military Services and Family Support program is a Prevention and Early Intervention program which targets active duty military service members of all branches, veterans, retired military, and their families.

This program is designed to address 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 which makes the participant comfortable, which can can include participant homes or nearby public places.

Utilizing stakeholder feedback and community needs assessments, MSFS providers work closely with their communities to understand the needs and to ensure those needs are met.

MSFS services include screenings and assessments, therapeutic treatment, resources and education.

Program Summary	
Program Serves	Children TAY (16-25) Adults Older Adults (60+)
Location of Services	Central Valley, Desert/Mountain, East Valley
Number of Consumers to be Served	3,878
Annual Budget FY 2023-24	$525,000
Cost Per Client FY 2023-24	$135
Services Offered	Mental Health Education Mental Health/Substance Use Disorder screenings Case Management and Referrals Psychoeducation Counseling Services Suicide Prevention

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

Military Services and Family Support (MSFS), cont.

Program Highlights

The MSFS program is categorized as a Prevention and Early Intervention program. In addition to prevention and early intervention services, the program also offers outreach education and suicide prevention. The MSFS program utilizes the Access and Linkage and Improve Timely Access strategies to ensure participants are linked to the necessary services to meet their individual needs. The program has consistently met or exceed the projected unduplicated participant goal each fiscal year.

Number of Participants / Number of Services Projected vs Actual

	Projected	Actual		
		FY 2019-20	FY 2020-21	FY 2021-22
Unduplicated Participants	3,605	5,377	6,050	6,091
Number of Services	6,990	9,345	10,718	10,168

Prevention

The risk factors associated with military service include: experience of trauma, isolation, moral injury, substance use, and stress. In order to combat these risk factors, prevention services seek to build protective factors in participants which can include: supportive care, inclusion, and services relevant to military experience. The following table illustrates the number of prevention participants and the number of services received by fiscal year.

Prevention Participants / Services

	FY 2019-20	FY 2020-21	FY 2021-22
Prevention Participants	2,976	3,329	292
Number of Services	5,125	5,138	1,100

Early Intervention

Early intervention services, treatments, and interventions are aimed at addressing and promoting recovery and related functional outcomes for a mental illness early in its emergence. Services are provided to individuals identified as experiencing the first onset of a serious mental illness. These treatment services include developing a treatment plan with goals that are meaningful to the individual participant.

The table below illustrates the total number of early intervention episodes opened in each fiscal year, the number of episodes closed in the fiscal year, and the percentage of participants who met their treatment goals. There was an additional increase in total episodes in Fiscal Year 2021-22, which continues the upward trend seen in FY 2020-21.

Treatment Success by Fiscal Year

	Total Episodes	Closed Episodes	% Met Goals
FY 2019-20	174	75	61%
FY 2020-21	301	95	38%
FY 2021-22	335	122	40%

Military Services and Family Support (MSFS), cont.

Program Highlights, 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. Offering outreach services to this high-risk population provides potential responders an opportunity to identify signs and symptoms in both themselves and their friends and family.

Potential Responders Reached			
	FY 2019-20	FY 2020-21	FY 2021-22
Potential Responders	1,695	2,453	5,786

Outreach Types of Responders / Settings	
Types of Responders	Settings
• Community service providers • Families • Military personnel/veterans • Peer providers • Consumer family members • Cultural brokers • Law enforcement personnel	• Community events • Hospitals • Social media outreach • Community-based organizations • Schools • Military facilities • Residences • Virtual platforms

Access & Linkage

Access and Linkage to Treatment services are integrated into the MSFS program to connect participants and/or their family members with severe mental health concerns to care and treatment that will meet their needs as early as possible in the onset of these conditions.

The table below illustrates the number of referrals made to a higher level of care each fiscal year. The table also includes those referred to a County or non-County funded entity. The table includes data on those that were referred and engaged in treatment. For the most part, MSFS providers can provide referrals to County-funded programs. Occasionally, there is a need to refer to a non-County funded provider, such as a private physician. Regardless of where they are referred, almost all participants engaged in the services to which they were referred for each fiscal year.

Access and Linkage to Services Referrals			
	FY 2019-20	FY 2020-21	FY 2021-22
Number of Referrals	18	9	15
County-Funded	17	8	15
Non-County Funded	1	1	0
Participants Engaged	18	9	15

Military Services and Family Support (MSFS), cont.

Improve Timely Access to Treatment

The Improve Timely Access to Treatment strategy focuses on providing appropriate services based on needs such as accessibility, cultural and language appropriateness, transportation, family focus, available hours, and cost of services in order to increase access to appropriate mental health services for underserved populations.

The MSFS program services are made available in whatever setting is most comfortable to a participant. If the participant would prefer to receive services in-home, for example, the MSFS program will accommodate that need. The goal of the Improve Timely Access to Services strategy is to refer participants of underserved populations to prevention, early intervention, or higher level of care services.

Active military troops, Reserve and National Guard members, recently retired military/veterans, and their families are among the underserved populations supported by the MSFS program.

The Improve Timely Access to Services table illustrates the number of participants who were given a referral to a prevention, early intervention, or higher level of care service, the number of those referred who engaged in services, and the average number of days from date of referral to date engaged in services. Over the last three fiscal years, participants were engaged, on average, no more than nine days after the date of referral. This illustrates the MSFS program is providing linkage and referrals timely in order to provide participants with needed services as soon as possible.

Improve Timely Access to Services

	FY 2019-20	FY 2020-21	FY 2021-22
Number of Referrals	126	171	86
Participants Engaged	117	83	10
Average # of Days Participant Engaged	4.08	3.12	9.5

Underserved Populations

- Trauma-exposed
- Co-occurring
- Children and youth in stressed families
- Family members ineligible for VA benefits
- Veterans who do not qualify for VA services

Military Services and Family Support (MSFS), cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-59	60+	UNK
FY 2019-20	18%	7%	54%	6%	15%
FY 2020-21	1%	2%	7%	1%	89%
FY 2021-22	3%	3%	16%	3%	75%

Fiscal Year	Veteran Status
	% of consumers who identified as a veteran
FY 2019-20	18%
FY 2020-21	5%
FY 2021-22	7%

Fiscal Year	Sexual Orientation
	% of consumers who identified as LGBTQ+
FY 2019-20	1%
FY 2020-21	1%
FY 2021-22	1%

Fiscal Year	Disability
	% of consumers who identified a physical disability
FY 2019-20	5%
FY 2020-21	1%
FY 2021-22	0%

Fiscal Year	Gender Identity			
	♂ Male	♀ Female	⚧ Other	UNK
FY 2019-20	13%	17%	0%	70%
FY 2020-21	3%	8%	0%	89%
FY 2021-22	13%	23%	0%	64%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 2019-20	100%	0%	0%	0%
FY 2020-21	74%	0%	0%	26%
FY 2021-22	91%	1%	0%	8%

Military Services and Family Support (MSFS), cont.

Demographics, cont.

	Race / Ethnicity			
		FY 2019-20	FY 2020-21	FY 2021-22
Race	African-American/Black	5%	4%	5%
	American Indian or Alaska Native	6%	0%	0%
	Asian	2%	0%	1%
	Native Hawaiian or Pacific Islander	1%	0%	1%
	More than One Race	6%	1%	4%
	Caucasian/White	31%	10%	18%
	Other Race	12%	3%	4%
	Declined to Answer	43%	86%	62%
Ethnicity	African	3%	0%	0%
	Asian Indian/South Asian	2%	0%	0%
	Cambodian	0%	0%	0%
	Chinese	0%	0%	0%
	Eastern European	0%	0%	0%
	European	1%	0%	3%
	Hispanic/Latino	16%	4%	10%
	Filipino	2%	0%	0%
	Japanese	0%	0%	0%
	Korean	0%	0%	0%
	Middle Eastern	0%	0%	0%
	Vietnamese	0%	0%	0%
	Other	1%	1%	7%
	More than one ethnicity	1%	0%	9%
	Declined to Answer	84%	68%	80%

Demographic Observations

- The MSFS program is designed to serve military service members, veterans, and their families.
- The MSFS program reached a notable portion of veterans, which aligns with its target population. However, the program serves military families as well, which is why there is still a significant portion of non-veterans.
- The largest age group served consistently was the adult population from ages 26-59. This would align with the program's goal of serving those with military service.
- There has been an overall reduction in decline to answer and/or unknown responses in from participants in the MSFS program FY 2021/22.

Military Services and Family Support (MSFS), cont.

Program Goals

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

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

Improve timely access to services for underserved populations:

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

Reduce prolonged suffering:

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

Reduce stigma and discrimination associated with mental illness:

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

Program Outcome Tools		
Survey Name	Adult Needs and Strengths Assessment (ANSA)	PTSD Checklist for Active and Veteran Military (PCL-M)
Description of Method	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.	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.
Survey Type	Every three months for duration of treatment	Every three months for duration of treatment
Number Completed	FY 2019-20: 108 FY 2020-21: 42 FY 2021-22: 42	FY 2019-20: 22 FY 2020-21: 5 FY 2021-22: 6

Military Services and Family Support (MSFS), cont.

Outcome Discussion

The Adult Needs and Strengths Examination - San Bernardino (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 a variety of essential life areas and aids in decision-making, level of care and service planning, and ensuring that planned goals are realized. Based on the individual's response, he/she receives a rating from 0 to 3, with 0 revealing there is no evidence of needs and 3 requiring immediate and/or intensive action.

The Life Functioning Domain focuses on the different areas of social interaction in a participant's life. This can include how they function individually, within family, peer, school, and community realms.

The Strengths Domain refers to the individual assets a participant can use to advance healthy development. Identifying areas where strengths can be built is a significant element of service planning.

The Behavioral Health Needs Domain identifies the behavioral health needs of a participant.

The following graph illustrates the percentage of participant improvement in global areas of Life Functioning, Strengths, and Behavioral Health Needs.

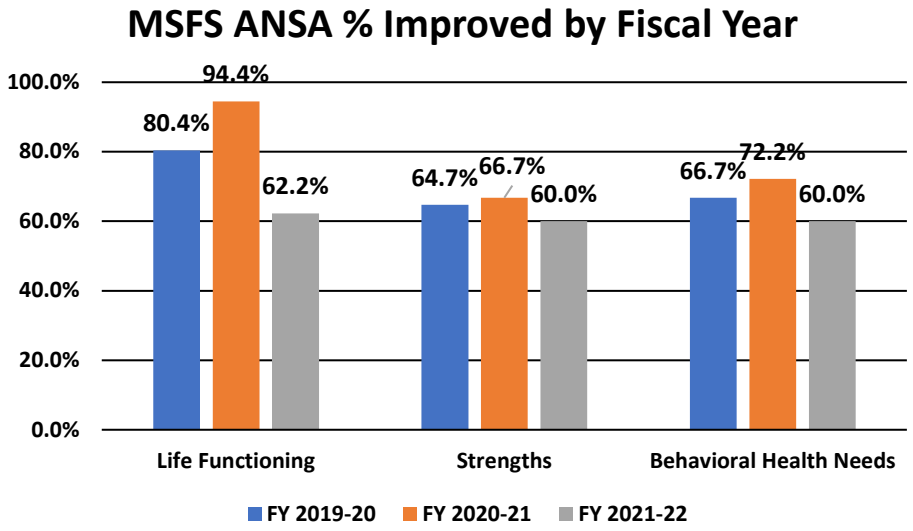
Domain improvement leads to improved recovery including emotional and relational functioning. These improvements reduce the prolonged suffering related to an untreated mental health concern.

These sub-domains are used to measure the specific service needs of each individual. During FY 2021/22, individuals improved an average of 61% in the Life Functioning, Strengths, and Behavioral Health Needs domains.

The Life Functioning Domain saw an average improvement of 79% over the three-year period.

The Strengths remained steady with an improvement at approximately 64% over the three-year period.

The percentage of improvement for Behavioral Health needs began to decrease as restrictions were relaxed and COVID-19 transmission began to decrease.



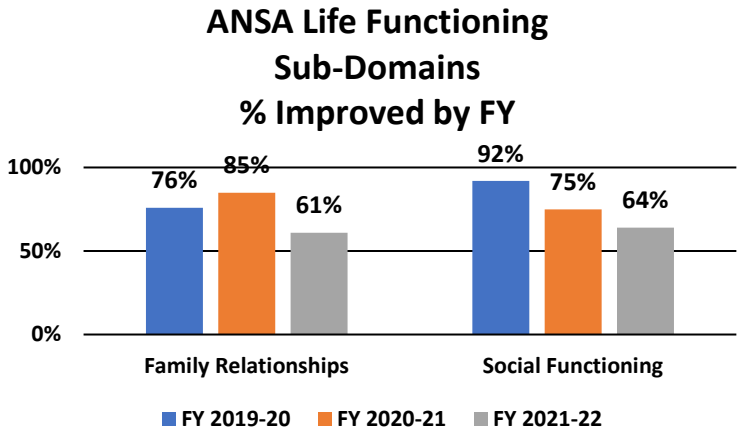
Military Services and Family Support (MSFS), cont.

Outcome Discussion, cont.

Each domain includes sub-domains that help to evaluate the participant's readiness to participate in early intervention services.

In the domain of Life Functioning, the sub-domain of family relationships evaluates and rates the participant's relationships with those who are in their family: spouse/partner, children, and other family members. Improvement in this sub-domain indicates that a significant need, such as problems with a spouse impacting the participant's ability to function has improved.

The sub-domain of social functioning rates social skills and relationships for a participant. An improvement in this area indicates the participant had a significant need, such as low quality of social relationships, which posed a threat to the individual's safety, health, or development.

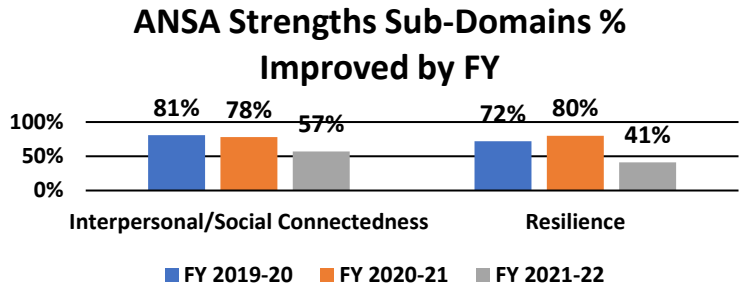


In the domain of Strengths, the sub-domain of interpersonal/social connectedness measures a participant's social and relationship skills. An improvement in this domain indicates the participant had a need to increase social functioning to avoid unhealthy isolation.

The domain of resilience measures a participant's ability to recognize their own internal strengths and use them to manage their daily life. Lower scores in this domain indicates the participant had the ability to identify their personal strengths, and/or utilize them effectively.

The Interpersonal/Social Connectedness drastically improved from year one to year two. The improvement rate decreased slightly in year three as COVID-19 restrictions relaxed and in-person interaction increased.

Individuals improved in the Resilience sub-domain at an 64% average over the last three years. These results demonstrate the effectiveness of early intervention services on MSFS participants' ability to recognize and capitalize on their personal strengths.

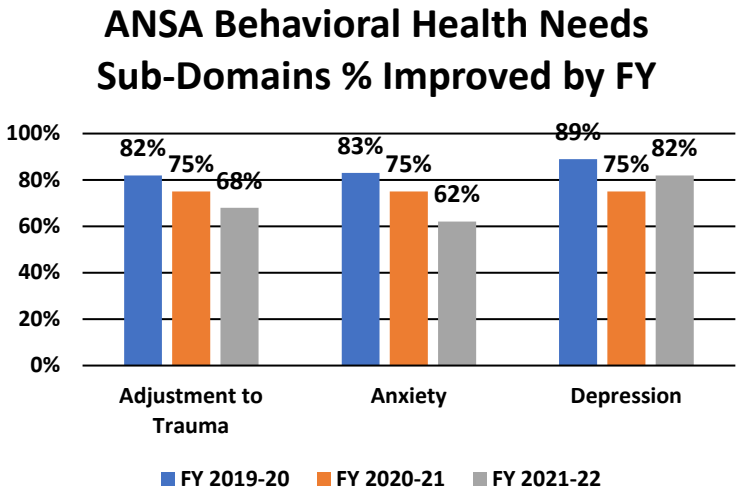


Military Services and Family Support (MSFS), cont.

The Behavioral Health Needs sub-domain of adjustment to trauma is used to help the participant define their difficulties related to a traumatic experience. An improvement in an identified need indicates that a participant has improved a debilitating level of trauma symptoms.

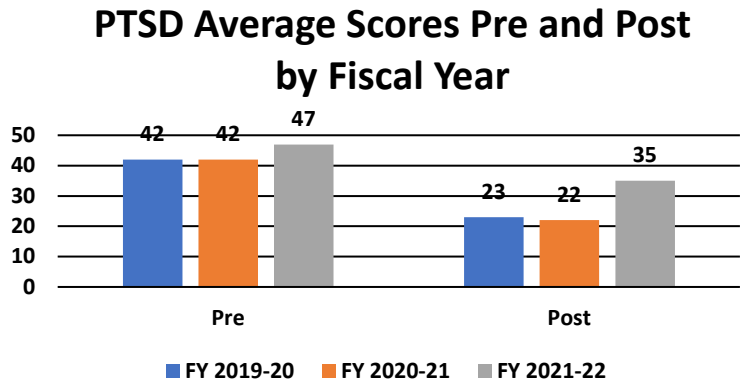
The anxiety sub-domain rates the symptoms of anxiety as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). Improvement in this domain indicates a participant improved anxiety symptoms such as excessive fear and anxiety related to behavioral disturbances.

The sub-domain of depression rates symptoms of depression as defined by the DSM-5. Improvement in this domain may indicate a decrease in symptoms such as irritable or depressed mood, social withdrawal, and sleep disturbances.



The following graph illustrates the comparison of participant pre and post scores on the Post-Traumatic Stress Disorder (PTSD) Checklist for Active and Veteran Military members (PCL-M). The PCL-M uses 17 questions to assess the degree to which participants experience symptoms of PTSD, such as: trouble falling or staying asleep, being "hyper alert" or watchful and on guard or feeling jumpy and/or easily startled. Higher scores indicate a greater intensity of PTSD symptoms.

Total Symptom Severity Scores can range anywhere from 17 to 85. A cutoff score of 50 or more suggests the presence of a significant level of symptom severity. Results indicate that before receiving treatment, early intervention participants, on average, scored 47 points out of a total of 85 on the PCL-M. At the end of treatment, on average participants scored 35 points, indicating a significant reduction in total symptom severity. MSFS participants reduced their total symptom severity score by an average of 12 points, which is above a 10-point reduction to indicate clinical meaningfulness of PTSD symptom reduction.



Military Services and Family Support (MSFS), cont.

Program Challenges/Solutions

Providing in-person services continued to be a challenge due to COVID-19 restrictions amidst COVID-19 surges. All schools did not permit outside visitors on their campuses to provide in-person service with students. Group participation also continues to be a challenge as participants prefer individual meetings via video conferencing as opposed to group meetings. Participants have also shared that they prefer virtual individual meetings as they help preserve anonymity within their communities. As a consequence, participation from participants within group settings via video conferencing has decreased as it is no longer the most desired method of service. In our more remote service regions, transportation and reliable internet service have also become a challenge for participants.

To combat this challenge, MSFS providers outreach to potential referral sources so as to build a larger referral base. MSFS providers will also continue to offer prevention groups and early intervention services until the participant is able to see a psychiatric provider.

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 are adapting to the increase on telehealth services and engaging in staff recruitment as participants also begin to request in-person services.

Program Updates

There are no planned program updates for Fiscal Year 2023-24.



Artwork by Bre Lopez

Military Services and Family Support (MSFS), cont.

Collaborative Partners

American Red Cross - Fort Irwin
American Red Cross Services to the Armed Forces
Barstow Community College
Basin Wide Foundation
Borrego Health
Cactus Corner Child Development Center
City of Redlands
Community Day School
Community Day School
Copper Mountain College
Counsel on Aging-Southern California
Crisis Center
Crisis Residential Treatment Facility
Crisis Walk In Clinic
Department of Veterans Affairs
Desert Mountain Children's Services
Desert Parkway Behavioral Health Hospital
Equus Medendi
Family Advocacy Program – Fort Irwin
Hi-Desert Behavioral Health
High Desert Pregnancy Clinic
Hope Through Housing
InnROADs
Loma Linda Veterans Affairs
Lutheran Social Services
Mental Health Systems Center for Change
Morongo Basin Community Health Care District
Morongo Basin Partners Against Crime
Morongo Unified School District
Naval Hospital Twentynine Palms
San Bernardino County Department of Aging and Adult Services
San Bernardino County Department of Children and Family Services
San Bernardino Valley College
Santa Fe Social Club
Twentynine Palms Marine Base Government & External Affairs (GEA)
Unity Home
Valley Star Transitional Age Youth and Full Service Partnership
Weed Army Community Hospital
Young Visionaries Youth Leadership Academy
Yucca Valley Family Medical Clinic

Student Assistance Program (SAP)

Target Population and Program Description

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 network of support for students.

The target population of SAP participants 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, and 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).

Program Summary	
Program Serves	Children Youth/TAY (16-25)
Location of Services	School Campuses, Mental Health Clinics, In-home
Number of Consumers to be Served	9,172
Annual Budget FY 2023-24	$7,791,269
Cost Per Client FY 2023-24	$849
Services Offered	Mental Health and Substance Use Screenings and Assessments Mental Health Educational Presentations Critical Incident Stress Debriefing Individual and Group Counseling Alcohol and Drug Education and Intervention

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

Student Assistance Program (SAP), cont.

Program Highlights

SAP uses a school-based approach to provide focused services to students needing interventions for substance abuse, mental health, academic, emotional, and/or social issues. It is a process that connects students to a network of support. SAP identifies students in need and links them to services that can perform a full assessment of 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 are intended to 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
- Suicide Prevention

The chart below compares the total number of unduplicated participants and the number of services for the last three fiscal years compared to the projected numbers for the program. The program saw a significant reduction in the last two years of reporting due to the implementation of distance learning.

Number of Participants / Number of Services Projected vs Actual

	Projected	Actual		
		FY 2019-20	FY 2020-21	FY 2021-22
Unduplicated Participants	9,172	30,349	12,766	12,594
Number of Services	20,682	32,425	30,705	20,280

Student Assistance Program (SAP), cont.

Program Highlights, cont.

Early Intervention

The program's 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 student well-being. They include ongoing supports 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 2019-20	FY 2020-21	FY 2021-22
Unduplicated Participants	927	805	1,001
Total Services	12,252	9,654	9,333

SAP early intervention services rely heavily on school site referrals originating from prevention services. When schools transitioned to distance learning, prevention services were temporarily suspended. The result was a slight decline in participants in the 2020-21 reporting year, however, the number of participants began to increase in the 2021-22 reporting year.

The chart below provides an overview of clients' success. Data shows their treatment plans drop slightly over the last three fiscal years. Clients were being displaced during the pandemic and moving out of their program service area causing interruptions in services. Some clients did not have the adequate technology or space needed for a successful transition to telehealth services. These are some causes that are under further review to develop a solution for future reporting years.

Treatment Success by Fiscal Year			
	FY 2019-20	FY 2020-21	FY 2021-22
Treatment Successful	58%	52%	38%
Treatment Partially Successful	11%	13%	22%
Treatment Not Successful	21%	26%	32%
Missing or Other	5%	9%	8%

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 a variety of settings. School staff meetings, community meetings, and schoolwide psychoeducation are the most commonly used by all providers. The tables below detail the settings in which Outreach is carried out, as well as the types of potential responders who took part in the educational activities.

San Bernardino County Superintendent of Schools, in collaboration with the Department of Behavioral Health, hosts a multi-day Student Wellness Conference that trains and supports all those who work closely with children and youth. Each year, approximately 450 people attend to learn about positive behavior interventions for the classroom including identifying behavioral issues and referring to services. Through this partnership, schools also have access to year-round training and support for the implementation of the Positive Behavioral Intervention and Supports (PBIS) model on their school site campuses.

Outreach Settings



- Schools
- Community Events
- Health Fairs
- Family Resource Center
- Community Based Organization Facility
- Faith Based Organizations
- Southern Region Student Wellness Conference
- Behavioral Health Clinics
- Student Attendance Review Board Meetings
- Shelters

Types of Potential Responders



- Families
- Parents
- Community Members
- School Officials/Staff
- Community Service Providers
- Law Enforcement
- Peer Providers
- Student Attendance Review Boards
- Mediators
- Prevention/Treatment Professionals
- Social Service Providers

Student Assistance Program (SAP), cont.

Demographics

Fiscal Year	Age (yrs. old)				
	0-15	16-25	26-50	60+	UNK
FY 2019-20	69%	7%	17%	1%	6%
FY 2020-21	34%	6%	28%	1%	31%
FY 2021-22	49%	3%	30%	1%	17%

Fiscal Year	Veteran Status
	% of consumers who identified as a veteran
FY 2019-20	<1%
FY 2020-21	<1%
FY 2021-22	<1%

Fiscal Year	Sexual Orientation
	% of consumers who identified as LGBTQ+
FY 2019-20	<1%
FY 2020-21	0%
FY 2021-22	1%

Fiscal Year	Disability
	% of consumers who identified a physical disability
FY 2019-20	<1%
FY 2020-21	<1%
FY 2021-22	1%

Fiscal Year	Gender Identity			
	♂ Male	♀ Female	⚧ Other	UNK
FY 2019-20	42%	51%	1%	6%
FY 2020-21	16%	32%	0%	51%
FY 2021-22	7%	14%	0%	79%

Fiscal Year	Primary Language			
	ENG	SPAN	OTH	UNK
FY 2019-20	85%	8%	0%	7%
FY 2020-21	74%	3%	0%	22%
FY 2021-22	60%	4%	1%	36%

Student Assistance Program (SAP), cont.

Demographics, cont.

	Race / Ethnicity			
		FY 2019-20	FY 2020-21	FY 2021-22
Race	African-American/Black	10%	13%	8%
	American Indian or Alaska Native	5%	1%	<1%
	Asian	1%	2%	2%
	Native Hawaiian or Pacific Islander	1%	1%	<1%
	More than One Race	5%	6%	3%
	Caucasian/White	21%	28%	20%
	Other Race	25%	9%	14%
	Declined to Answer	33%	41%	38%
Ethnicity	African	1%	3%	0%
	Asian Indian/South Asian	0%	1%	0%
	Cambodian	0%	0%	0%
	Chinese	0%	0%	0%
	Eastern European	0%	0%	0%
	European	1%	2%	1%
	Hispanic/Latino	44%	31%	15%
	Filipino	0%	0%	0%
	Japanese	0%	0%	0%
	Korean	0%	0%	0%
	Middle Eastern	0%	1%	<1%
	Vietnamese	0%	0%	0%
	Other	4%	4%	4%
	More than one ethnicity	2%	8%	3%
	Declined to Answer	0%	80%	90%

Demographic Observations

- The SAP program has consistently served the targeted demographics over the last three fiscal years. Children and Youth are the significant participants served.
- 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 the participants and some of the questions being inappropriate to ask as well as the difficulty with capturing this information in a virtual way.
- The ethnic and racial participation is consistent with the demographics of the general population of San Bernardino County.

Student Assistance Program (SAP), cont.

Program Goals

The State program 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, assist students in building academic and emotional achievement, and decrease the period of untreated mental illness. The tools used to measure the effectiveness of the SAP program are listed in the table below.

Program Outcome Tools			
Survey Name	**Description of Method**	**Survey Type**	**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 2019-20: 766 FY 2020-21: 489 FY 2021-22: 712
Behavior Assessment Form (BAF) /Student Behavioral Questionnaire (SBQ)	The BAF / SBQ surveys include a series of questions that indicate if the client struggles behaviorally using a Likert scale. The surveys are completed by a school official. These tools are used to evaluate the progress that the client makes as a result of participating in a skill building group. These tools can also be used to determine the effectiveness of the evidence-based curriculum/services provided.	1st and last day of group services	FY 2019-20: 157 FY 2020-21: 78 FY 2021-22: 266
Measurement Outcomes and Quality Assessment (MOQA_-SPP/SDR	The MOQA surveys are used to gather information regarding 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 2019-20: 108 FY 2020-21: 67 FY 2021-22: 17
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 2019-20: 367 FY 2020-21: 237 FY 2021-22: 124

Student Assistance Program (SAP), cont.

Outcome Discussion, cont.

The SAP program uses the Child 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.

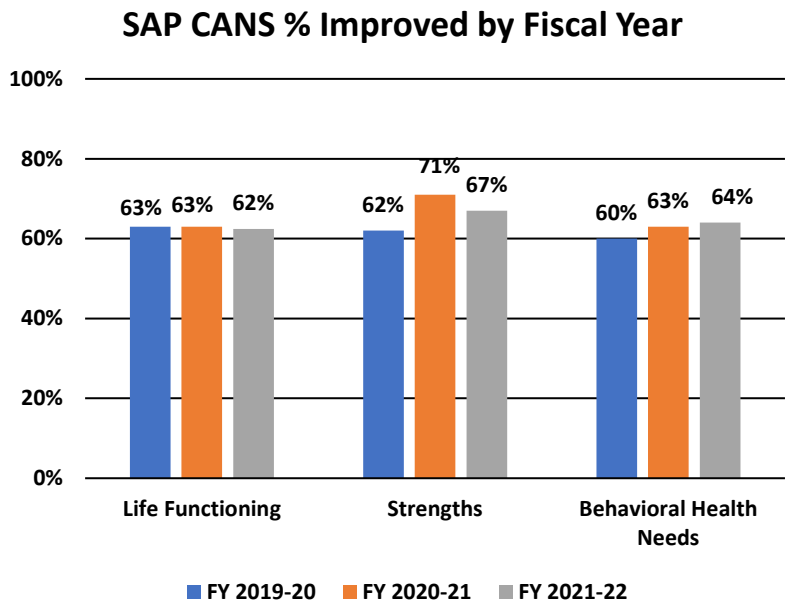
Within the first 30 days of receiving assistance, children and TAY receive the initial CANS-SB assessment. Every three to six months, follow-up assessments are conducted, and a final assessment is completed at the conclusion of services.

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.

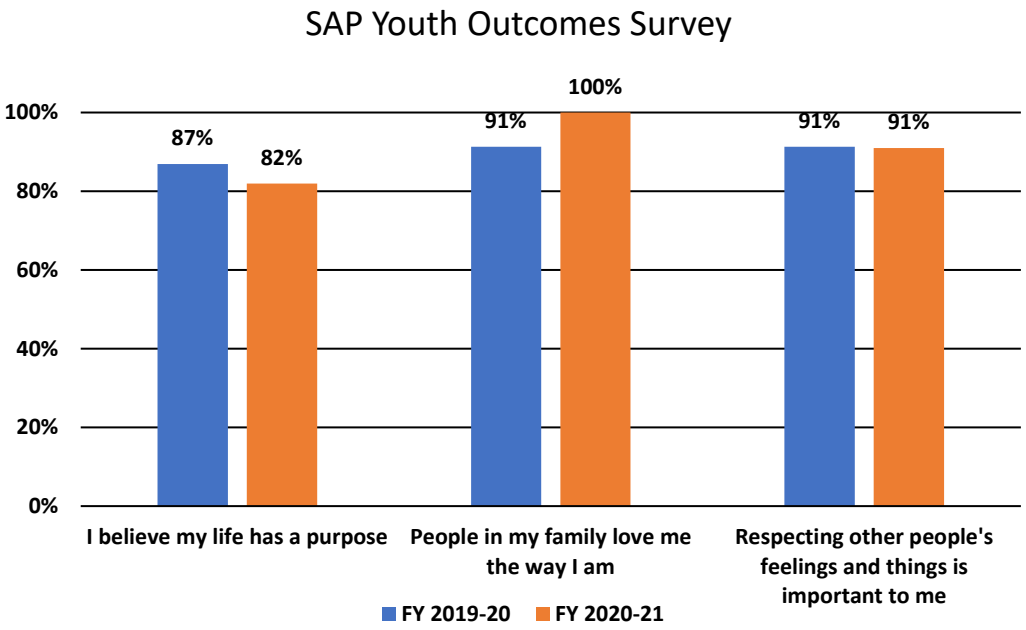
The results demonstrate consistent success in approximately 64% of all three domains. The increase leads to an overall improvement in reducing symptoms and recovery, including mental and relational functioning.

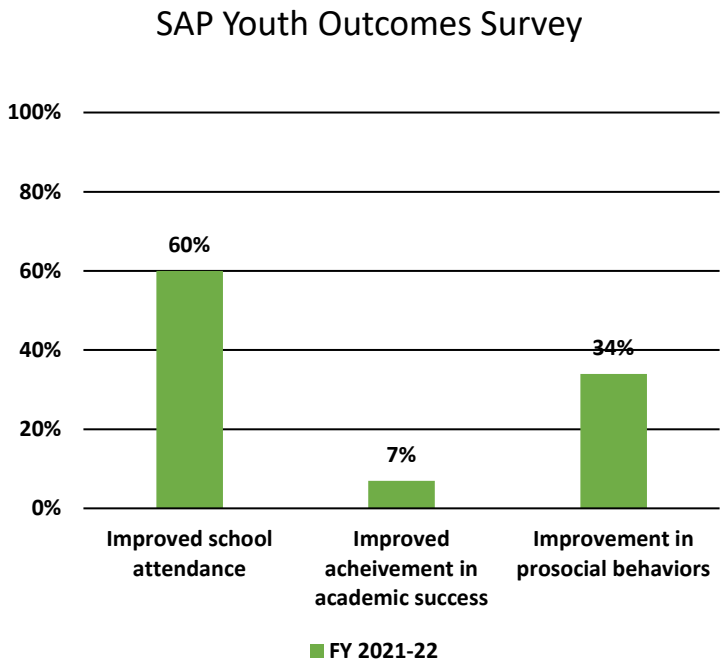


Student Assistance Program (SAP), cont.

Outcome Discussion, cont.

The SAP Youth Outcomes survey highlights the improvement of youth outcomes related to self-esteem and prosocial behaviors after their participation in activities within the SAP program. New in FY 2021-22, SAP providers are using measurements in improved school attendance and achievement in academic success as well as improvement in prosocial behaviors as indicators of successful outcomes.





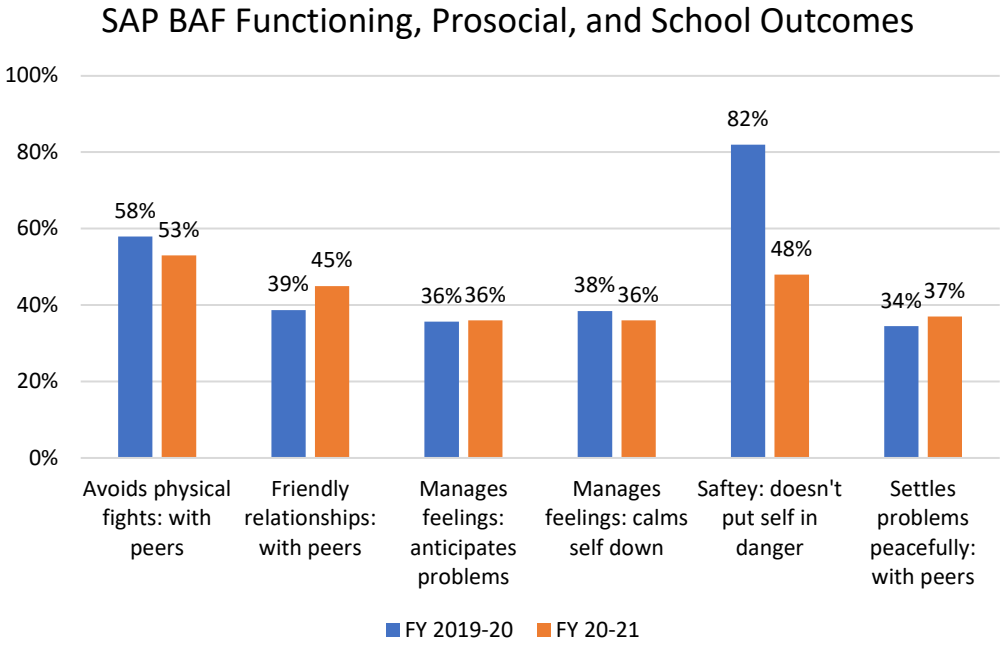
Student Assistance Program (SAP), cont.

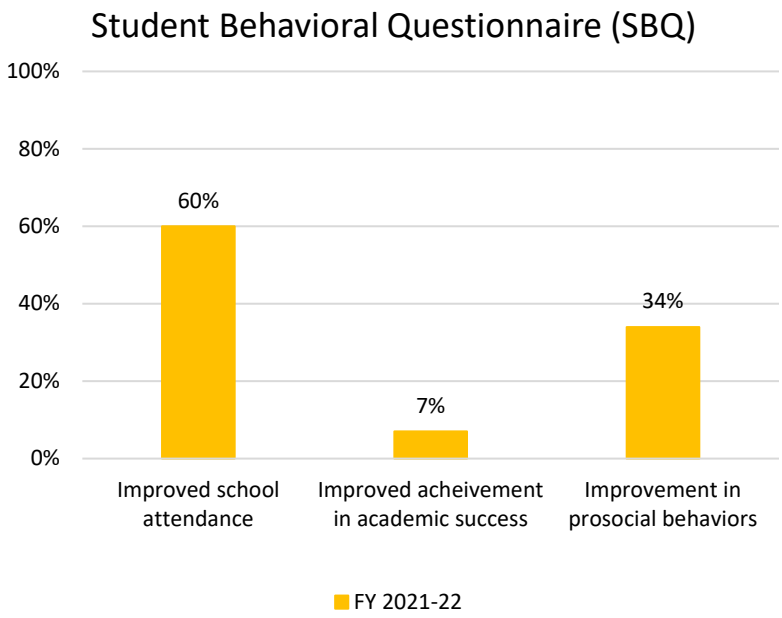
Outcome Discussion, cont.

Functional behavior analysis allows professionals to develop an intervention plan to help target negative behaviors and introduce more functional and appropriate replacement behaviors.

The Functional Behavior Assessment, also known as BAF, helps parents, teachers, and professionals to identify specific behavior patterns. The chart below shows the improvement across all measures of the assessment, based upon observation by the student's teacher or counselor.

Beginning in FY 21-22, SAP providers implemented the Student Behavioral Questionnaire (SBQ), a similar measurement tool as the BAF. In addition to showing improvement in the prosocial behaviors observed in the BAF, the SBQ also allows the students' teacher or counselor to gauge improvement in other key indicators of successful outcomes, such as improved school attendance and academic success as shown in the graph below.

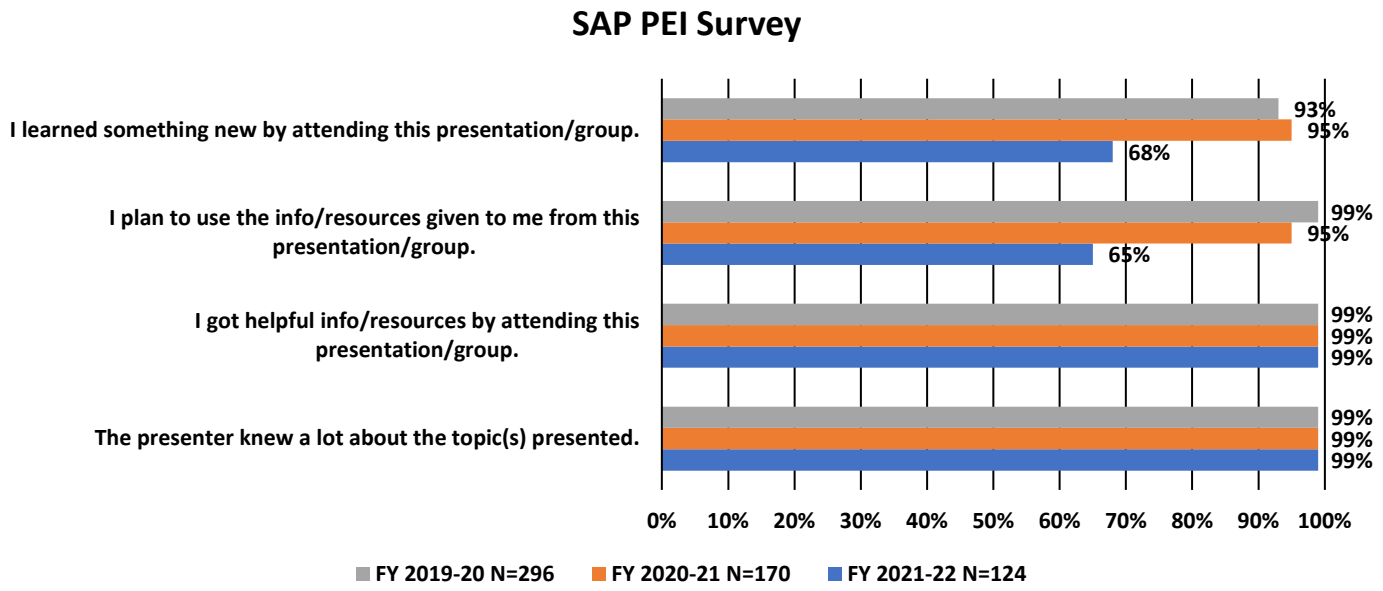




Student Assistance Program (SAP), cont.

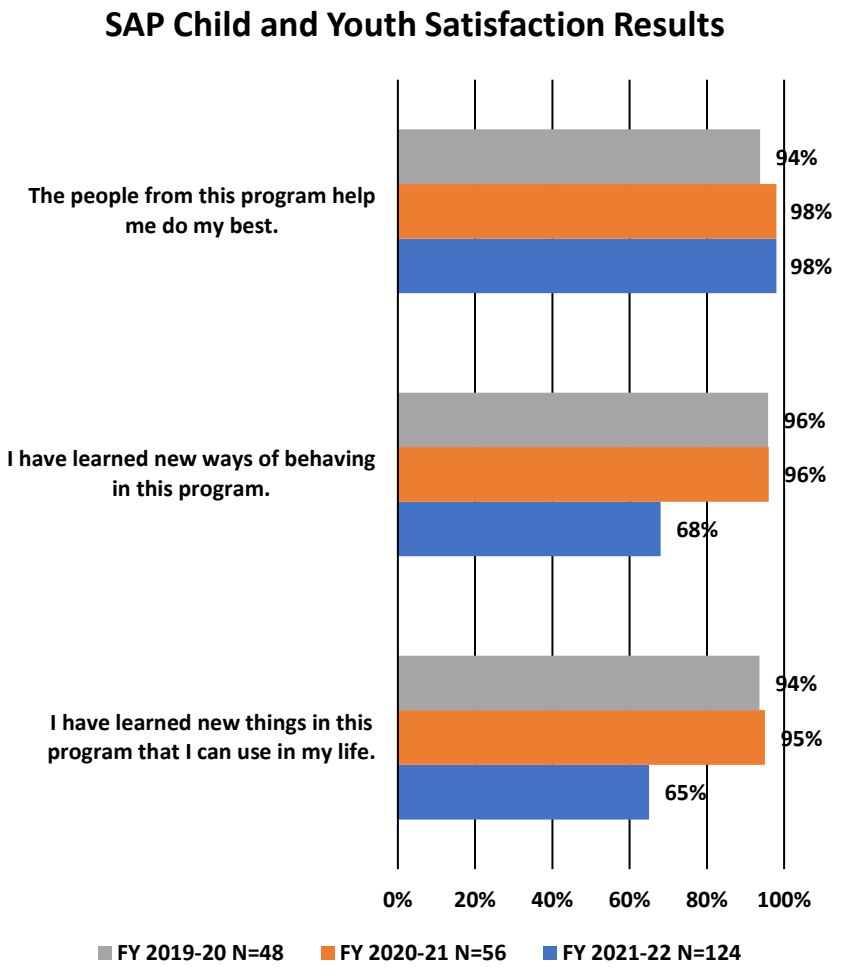
Client Satisfaction Surveys

Client satisfaction surveys are used to determine whether the participants are gaining useful and valuable information from the program as well to determine whether the participants are engaging in the program in a way that is satisfying and enjoyable. The following charts provide data on the success of SAP. The PEI survey results show that the majority of those who participated in a SAP presentation agreed that they learned something new, they received helpful information and resources, and they plan to use or implement the information they received.



Student Assistance Program (SAP), cont.

Client Satisfaction Surveys, cont.



The SAP Child and Youth Satisfaction survey shows that the majority of the children and youth who participated in the SAP program agreed that the program is changing the way they think or behave and that they are using the ideas and skills that they learned from the SAP program.



Artwork by Unknown

Student Assistance Program (SAP), cont.

Program Challenges/Solutions

An ongoing challenge for SAP is Substance Use among teens in the mountain communities. There are not many accessible treatment programs for children with substance use disorders.

The solution to this challenge is increased Substance Use education and prevention efforts for the providers serving the mountain communities. Additionally, providers will be collaborating with other agencies that can provide additional support to the families in identifying the potential signs of substance abuse.

Receiving appropriate referrals has been another program challenge. Incomplete referrals make it difficult for providers to coordinate services for students identified as having a need. Missing information causes students to miss out on beneficial group sessions or educational presentations. Furthermore, the lack of communication is leading to low parent engagement hindering the authorization and support for student participation.

It is critical for SAP providers to increase communication with key administrators to ensure that the referral process is implemented properly. SAP providers are working to streamline the referral and check-in process. They discovered that accuracy can be improved by aligning with school site Positive Behavioral Interventions and Supports (PBIS) teams in the coordination of referrals. Both programs share similar goals. By working collaboratively, they can avoid duplicating efforts or causing confusion among teachers and school staff.

Lessons Learned

In late FY 2019-20 and FY 2020-21, SAP program providers had a hard time finding appropriate space on school campuses to provide confidential and non-stigmatizing services. This problem was exacerbated by mandatory nationwide shutdowns and social distancing requirements. Schools and providers had to learn to adapt to a new virtual service delivery model and navigate technology challenges and resources.

Additional lessons learned will be available after the 30-day posting period.

Program Updates

SAP services will be expanded in the Central Valley, East Valley, and High Desert regions as a result of securing additional funding from the Mental Health Student Services Act.



Artwork by Unknown

Improving Detection and Early Access (IDEA) Program

Target Population and Program Description

Psychosis is a serious mental health illness in which thought and emotion are so disrupted that one loses contact with external reality. Early warning signs and symptoms, which can last from a few days to several weeks or years, typically predict the start of a serious and long-lasting mental condition accompanied by psychotic symptoms. This phase of forewarning is a powerful point at which intervention can help to reduce a worsening of mental symptoms, distress, and functional impairment. People at this early stage are at a Clinical High Risk (CHR) of developing a serious illness.

The majority of people who develop psychosis exhibit symptoms between the ages of 16 and 25. According to existing treatment model research, some people can escape a lifetime of impairment and find fulfillment in their everyday lives with proper and timely intervention.

The goal of the IDEA program, previously referred to as the Early Psychosis Care (EPC) program, is to identify patients at clinically high risk of psychosis as early as feasible in the warning phase and to begin treatment as soon as possible during the first episode of psychosis.

The IDEA program seeks to serve a total of 26 unduplicated participants annually through the TAY One-Stop Centers and the Premier Program.

Program Summary	
Program Serves	TAY (16-25)
Location of Services	TAY Centers, Mental Health Clinics, Hospitals
Number of Consumers to be Served	26
Annual Budget FY 2023-24	$1,000,000
Cost Per Client FY 2023-24	$38,462
Services Offered	Mental Health and Substance Use Screenings and Assessments Mental Health Educational Presentations Individual and Group Counseling Case Management Family Education and Support Supported Employment and Education

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

Improving Detection and Early Access (IDEA) Program, cont.

Existing Efforts

The Department of Behavioral Health continues to offer a continuum of services that includes prevention and early intervention, crisis assistance, and a variety of outpatient and short-term residential treatments that vary in intensity based on the needs of clients. The continuum allows patients to obtain care in a variety of ways and provides an existing infrastructure for identifying and treating early episodes of psychosis as well as the precursor signs and symptoms (e.g., Clinical High Risk or prodromal phase). The grant-funded Premier program is part of the continuum. Individuals who have been recognized as having their first episodes of psychosis are currently served through the Premier program. Individuals in the Premier program are often identified and referred from inpatient mental hospitals.

IDEA Updates:

As stated in the previous annual update the original structure and scope of the IDEA program (previously the Early Psychosis Program (EPC)) introduced in the FY 2020-21 Three-Year Integrated Plan has been modified as a result of funding reductions due to COVID-19. Program administrators continue to plan to use the existing infrastructure within the continuum of services offered by the Department of Behavioral Health. However, 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 budget has been reduced from $1,000,000 to $250,000.
- The program's annual projected participants to be served was reduced from 105 participants per year to 26 participants per year.
- The IDEA program will redirect program planning and implementation from the development of several Coordinated Specialty Care (CSC) teams to the establishment of a small unit consisting of a Clinical Therapist I and a clerical staff.
- This unit will be responsible for the coordination of referrals and development of trainings and workshops that aim to build the Department's and partnering agencies' capacity to identify participants with a Clinical High Risk (CHR).

The progress of implementing this program has been delayed due to the restrictions experienced due to the COVID-19 pandemic. Currently, the program is waiting on approvals to recruit and hire program staff.

Improving Detection and Early Access (IDEA) Program. cont.

The IDEA program will be developed through the following phases:

Phase I: Needs Assessment

- Identify programs within DBH infrastructure that have the capacity to be trained to identify Clinical High Risk (CHR).
- Complete needs assessment to identify training gaps.
- Map existing resources.
- Locate screening tool to be used to identify CHR.

Phase II: Recruitment of Program Support Staff

The program staff will coordinate program referrals and serve as a resource hub and centralized access point for mental health providers by connecting them to a network of resources and programs that will work to facilitate participants' access to timely and appropriate services.

Phase II will consist of the following:

- Recruit and hire a program Clinical Therapist I to operate as program referral coordinator and CHR Trainer. This position will be utilized to coordinate and provide the delivery of specialized workshops that build the capacity and expertise of the entire mental health care system.
- Recruit and hire a program Office Assistant II to support clinical staff and facilitate access and linkage services.

Phase III: Clinical High-Risk Training and Education

The program coordinator will provide training and workshops to program staff within the DBH infrastructure.

Training will be provided to:

- Prevention and Early Intervention program providers
- TAY program administrators
- Premier program staff.



The Door – artwork by J. Hossa

Office of Suicide Prevention

Program Description

The Office of Suicide Prevention is a new PEI program categorized as a stand-alone Suicide Prevention Program.

As legislation changes and suicide prevention efforts increase across the state, DBH will need to consider how to meet the changing needs of the communities. Recent community planning supports the need to strengthen the infrastructure surrounding suicide prevention by enhancing our current programming to include staff that can direct their attention to implementing, coordinating, and evaluating suicide prevention efforts in San Bernardino County. There is an opportunity to be amongst one of the few counties in California to invest in the reduction of suicide by creating a local office that can lead the suicide prevention efforts in our county.

The Office of Suicide Prevention will consist of full-time staff dedicated to guiding the continued implementation of a strategic plan for suicide prevention for San Bernardino County. The anticipated implementation date for this program is July 1, 2023.

Program Summary	
Program Serves	Children TAY (16-25) Adults Older Adults (60+)
Location of Services	County wide
Number of Consumers to be Served	1,500
Annual Budget FY 2023-24	$380,504
Cost Per Client FY 2023-24	$253
Services Offered	Community Education and Awareness Capacity Building Technical Assistance

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



SAN BERNARDINO COUNTY
Behavioral Health

MHSA Three-Year Program and Expenditure Plan for FYs 23/24-25/26: Community Services and Support

Community Services and Supports

Introduction

Under the Mental Health Services Act (MHSA), 76% of MHSA funding is mandated to be directed toward the Community Services and Supports (CSS) component. The CSS component provides access to an expanded continuum of care for persons living with a serious mental illness (SMI) or serious emotional disturbance (SED).

Community Services and Supports Goals
• Reduce the subjective suffering from serious mental illness for adults and serious emotional disorders for children and youth
• Reduce homelessness and increase safe and permanent housing
• Increase in self-help and consumer/family involvement
• Increase access to treatment and services for co-occurring problems, substance use, and health
• Reduction in disparities in racial and ethnic populations
• Reduce the number of multiple out-of-home placements for foster care youth
• Reduce criminal and juvenile justice involvement
• Reduce the frequency of emergency room visits and unnecessary hospitalizations
• Increase a network of community support services

The CSS section is organized according to programs that operate with similar service responsibilities but may serve different target populations. Programs intended to provide interventions or supports during a mental health crisis are described in the Crisis System of Care section of the CSS component. There are eight Full Service Partnership (FSP) Programs that are contained in the FSP section; and FSP programs that provide housing, long term supports, and transitional care are also contained within their own section.

The Peer Support Programs section highlights programs that are consumer driven and work from a lived experience perspective. The goal of all CSS programs is to provide the necessary services and supports that help consumers achieve mental health and wellness and recovery goals.

Community Services and Supports Programs
Crisis System of Care • A-5: Triage Transitional Services • A-6: Community Crisis Services • A-16: Crisis Intervention Collaborative
Crisis Stabilization Continuum of Care • A-4: Crisis Walk-In Centers (CWICs)/Crisis Stabilization Units (CSUs) • A-10: Crisis Residential Treatment (CRT)
Peer Support Programs • A-1: Clubhouse and Community Connections
Outreach, Access, and Engagement Programs • A-9: Access, Coordination, and Enhancement (ACE) • A-15: Recovery Based Engagement Support Team (RBEST)
Full Service Partnerships • C-1: Comprehensive Children and Family Support Services (CCFSS) • C-2: Integrated New Family Opportunities (INFO) • TAY-1: Transitional Age Youth (TAY) One Stop Centers • A-2: Forensic Services • A-3: Assertive Community Treatment Model FSP Services • A-11: Regional Adult Full Service Partnership (RAFSP) • OA-1: Age Wise
Homeless Services, Long-Term Supports, and Transitional Care • A-7: Housing and Homeless Services Continuum of Care Programs (FSP) • A-13: Adult Transitional Care Programs

CSS Capacity Assessment

The Community Services and Supports component comprises seventeen (17) programs designed to support a continuum of services that support the mental health needs of diverse children, TAY, Adults, and Older Adults according to need. In compliance with 9 CCR § 3650, each program was developed through the Community Program Planning process and includes a description of services, goals of the program, the targeted number of people to be served by age group, demographics of consumers, program outcomes, and includes a summary of challenges and solutions related to program implementation.

As part of program implementation, the Department of Behavioral Health is committed to an ongoing review of community behavioral health needs, the capacity of staff, the public behavioral health system, and the implementation of continuous improvement efforts based on qualitative and quantitative data and informatics.

DBH collects, prepares, and presents data and information to its stakeholders. Stakeholders review the information and provide feedback on identifying additional populations, program improvement and design, priorities, and unmet needs.

Priority Issues by Age Group

Based on a recent analysis of stakeholder data from the past three years, the following priorities have been identified by age group:

Children/Youth
• Identify innovative approaches to reach more justice-involved youth • Mental health services for children in ALL regions of the county • Better education for parents, caregivers, and loved ones on the effects of mental illness on youth • Increase use of "parent partners" as system navigators
Transitional Age Youth
• Increase the use of new technology to increase access to services • Increase outreach to underserved populations • Increase access to youth-centered substance use treatment • Decrease youth homelessness
Adults
• Increase shelter infrastructure; Homelessness • Integrate Substance Use Disorder Recovery Services with Mental Health Services • Greater appreciation given to regional specific barriers to access • Increase access to diversion programs in order to prevent unnecessary psychiatric hospitalizations
Older Adults
• Virtual Outreach Events • Improved access • Lack of transportation • Integrate Mental Health Services with other Social Services Programs, such as Aging and Adult Services

CSS Capacity Assessment (cont.)

Demographic Overview

The Department of Behavioral Health prepared an analysis of available San Bernardino County data to understand the scope of mental health needs among the four age-specific target populations. The data was reviewed and analyzed to determine estimates of the unserved, underserved, and inappropriately served individuals in the county.

According to California Department of Finance estimates for 2022, San Bernardino County has a total population of 2,182,824 with a projected growth of 28% between 2020 and 2045. The current breakdown of the population by gender, age, and racial and ethnic categories is indicated in the table below.

Total Population	2,182,824
Gender	**%**
Female	49.9%
Male	50.1%
Age*	**%**
Under 18 years	26.0%
18-64 years	61.7%
65+ years	12.1%
Unknown	<0.2%
Ethnicity	**%**
African American	7.94%
Asian/Pacific Islander	8.36%
Caucasian	25.95%
Latino	53.67%
Native American	0.39%
Other/Unknown	3.69%

*Age categories provided by US Census Bureau may not align with standard MHSA-reported demographic categories.

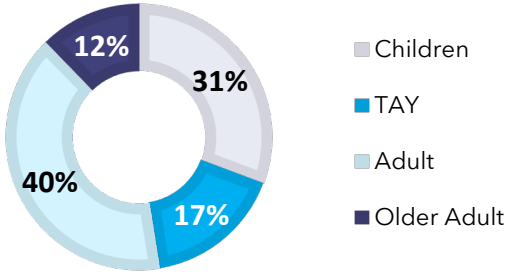
CSS Capacity Assessment (cont.)

Medi-Cal Beneficiaries

At the end of FY 2021/22, an estimated 882,259 San Bernardino County residents were Medi-Cal beneficiaries (Medi-Cal Enrollment Data, June 2022). The infographics below provide an overview of the demographics for San Bernardino County Medi-cal eligible beneficiaries.

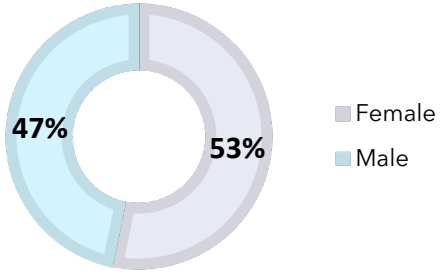
Age

Medi-Cal eligible beneficiaries by age group were as follows: 30.7% were children, 16.8% were TAY (16-25 years), 40.2% were adults, and 12.3% were older adults (60 years and up).



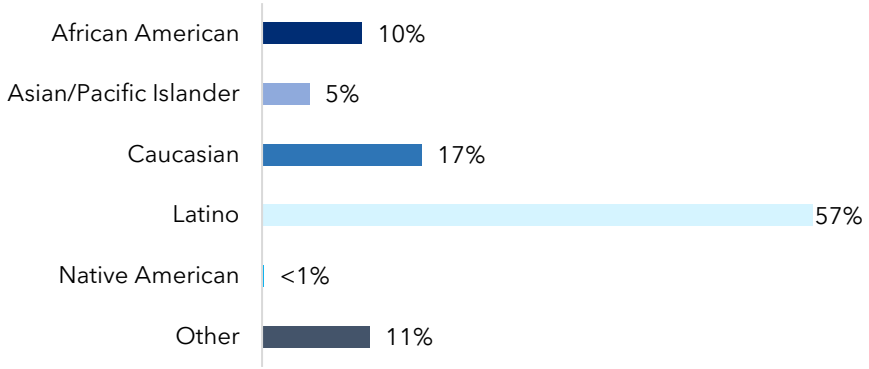
Gender Identity

Medi-Cal eligible beneficiaries by gender were as follows: 53.2% were female and 46.8% were male.



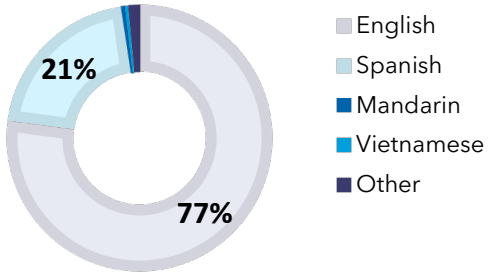
Race/Ethnicity

Medi-Cal eligible beneficiaries by race/ethnicity were as follows: 10.3% were African American, 4.9% were Asian/Pacific Islander, 16.5% were Caucasian, 57% were Latino, 0.2% were Native American, and 11.1% identified as Other.



Language

Medi-Cal eligible beneficiaries' language preference was as follows: English 77.1%, Spanish 20.7%, 0.5% Mandarin, 0.4% Vietnamese, and 1.3% identified as Other.

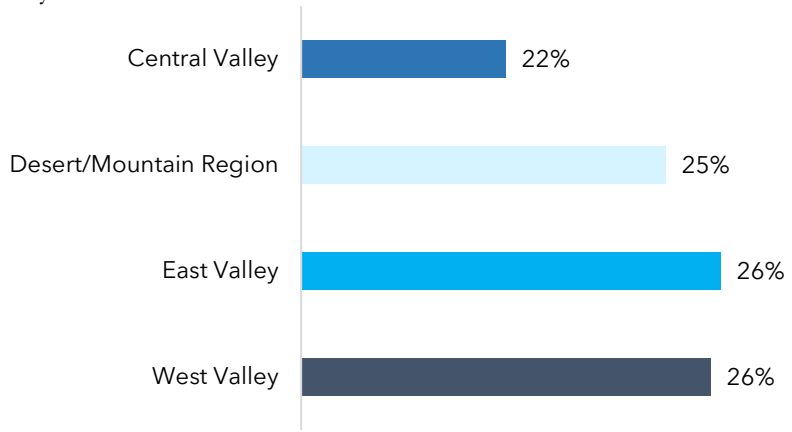


CSS Capacity Assessment (cont.)

Medi-Cal Beneficiaries (cont.)

Geographic Region

The Medi-Cal population is geographically distributed throughout the county: 25.3% reside in the Desert/Mountain region, 26.4% reside in the East Valley region, 22.1% in the Central Valley, and 26.2% in the West Valley.





Artwork by Aubrey Sanchez

CSS Capacity Assessment (cont.)

Estimation of Needs: Medi-Cal Eligible to Medi-Cal Mental Health Beneficiaries Served

Several disparities can be identified by comparing the Medi-Cal eligible beneficiaries' group to the Mental Health Medi-Cal clients served in FY 2021/2022.

Age

In terms of age, children represented 25.7% of beneficiaries served, compared to 30.7% of Medi-Cal eligible. Transitional Age Youth (TAY) 16-25 years represented 17.2% of beneficiaries served, compared to 16.8% of Medi-Cal eligible. Adults 26-59 years represented 48.4% of beneficiaries served, compared to 40.2% of Medi-Cal eligible. Older Adults 60+ years represented 8.7% of beneficiaries served compared to 12.3% of Medi-Cal eligible. By age group, the lowest penetration rate was for Older Adults (60+) at 2.4%, followed by Children at 2.9%. While the penetration rates for TAY and Adults were 3.5% and 4.1%, respectively.

Gender

In terms of gender, females represent 53.2% of Medi-Cal eligible beneficiaries and only 49.4% of Medi-Cal beneficiaries served. A disparity can also be seen in male Medi-Cal beneficiaries at 46.8%, which was greater than their percentage of the Medi-Cal eligible population of 45.8%. This data does not account for individuals who identify as transgender, gender fluid or other. Other/Not listed represented 0% of clients served.

Race/Ethnicity

In terms of Race/Ethnicity, although Latinos represented 57% of Medi-Cal eligible beneficiaries, they only represented 45.7% of beneficiaries served. A similar trend was found with the Asian/Pacific Islander (API) population. Although 6.3% of the total County population and 4.9% of Medi-Cal eligible, they represented only 2.1% of the beneficiaries served. Further investigation is needed to identify why these two populations are using services less than other populations or are not in need of services; one area to explore is preferred language. In contrast, the opposite trend was noted with the African American, Caucasian and Native American populations. The African American group represented 10.3% of Medi-Cal eligible beneficiaries and 14.2% of beneficiaries served; Caucasians represented 16.5% of Medi-Cal eligible and 25.4% of beneficiaries served; and Native Americans 0.2% of Medi-Cal eligible and 0.6% of beneficiaries served. Native Americans have the highest penetration rate (8.6%) of all racial/ethnic groups but this may be due to the fact that they are a very small percentage of the overall population.

Language

In terms of preferred languages of Medi-Cal eligible beneficiaries and Medi-Cal clients, 20.7% of Medi-Cal eligible beneficiaries preferred Spanish, while only 5.5% of Medi-Cal clients served preferred Spanish. The vast majority of Medi-Cal clients preferred English (91.2%). In comparison, 77.1% of Medi-Cal beneficiaries preferred English. The data may suggest that we are underserving the Spanish speaking Medi-Cal population. The penetration rate for the preferred Spanish language group was .9%, the lowest for all the language groups. The second lowest penetration rate was for the preferred Vietnamese language group (2.0%).

CSS Capacity Assessment (cont.)

Estimation of Needs: Medi-Cal Eligible to Medi-Cal Mental Health Beneficiaries Served

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, either through a Managed Care Organization or the mental health plan.

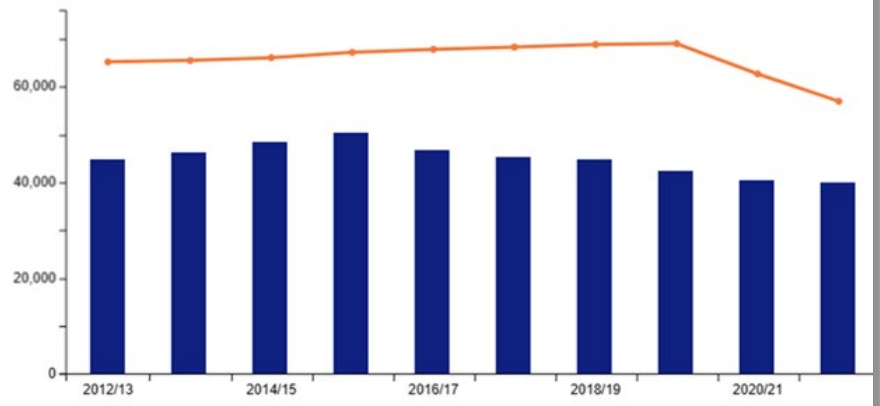
- In FY 2021/22, approximately 42,872 individuals received a mental health service from the mental health plan (this number excludes individuals participating in prevention programs or mental health services coordinated through a Managed Care Organization).
- Additional review of data from FY 2021/22 indicates that of individuals served by the mental health plan:
  - 4,670 individuals participate(d) in a Full Service Partnership to be considered fully served.
  - 5,731 individuals were provided early intervention services through Prevention and Early Intervention component programs.

Limitations of this analysis include the absence of data summarizing the number of individuals provided mental health services via the Managed Care Organizations serving San Bernardino County in FY 2021/22.

According to research conducted by the County of San Bernardino for the Community Vital Signs Report for 2020, it is estimated that approximately 26,506 qualifying persons in the county could remain in need of some level of mental health intervention and could possibly be unserved in FY 2019/20. The first CSS Component Plan from February 2006 identified an estimated 54,893 individuals that could be in need of behavioral health services. In comparison, this is a notable improvement. This improvement is highlighted in the following table. The table, taken from San Bernardino County's Community Vital Signs Report, shows that the gap between the number of possible Medi-Cal eligible residents (residents estimated to be at poverty level) that are in need of mental health care and the number of clients served by SBC-DBH has been in steady decline since FY2019/20.

GROWING GAP BETWEEN NEED FOR MENTAL HEALTH CARE AND NUMBER RECEIVING IT

Unduplicated Count of Clients Served by the Public Mental Health System and the Estimated Number of Poverty-level Residents in Need of Mental Health Services in San Bernardino County, 2011-2020



Note: Residents in need is estimated based on adjustments to 2007 California Department of Mental Health figures.

Sources: County of San Bernardino, Department of Behavioral Health, Client Services Information System; California Department of Mental Health, Persons in Need Tables

CSS Capacity Assessment (cont.)

Populations for Full Service Partnerships

The CSS section of this Three-Year Plan contains detailed overviews of all Full Service Partnership (FSP) programs, including demographics, numbers projected to be served, goals, and key outcomes. Programs are designed to meet the needs of the specific populations. Below is a list of the prioritized populations to be served in FSP programs by age.

Children and Youth

- Those children and youth identified as living with serious emotional disturbances
- Those children and youth having problems at school or at risk of dropping out
- Those children and youth at risk of, or are involved in the juvenile justice system
- Those children and youth in need of crisis intervention and /or at serious risk of psychiatric hospitalization
- Those children and youth at risk of residential treatment or are stepping down from residential treatment
- Those children and youth who are homeless or at risk of homelessness
- Those children and children who are high users of service; multiple hospitalizations/institutions
- Those children and youth who are at risk due to lack of services because of cultural, linguistic, or economic barriers
- Those children and youth at risk due to exposure to domestic violence, physical, emotional, verbal, sexual abuse.
- Those children and youth with co-occurring disorders
- Children and Youth at-risk of or experiencing sexual exploitation

Transitional Aged Youth

- Those transitional age youth who have serious mental illness or serious emotional disturbances
- Those transitional age youth who have repeated use of emergency mental health services
- Those transitional age youth who have co-occurring disorders
- Those transitional age youth who are homeless or at risk of homelessness
- Those transitional age youth who are at risk of involuntary hospitalization or institutionalization
- Those transitional age youth who are involved in the juvenile justice system
- Those transitional age youth who are in out-of-home placement
- Those transitional age youth aging out of or part of the child welfare system
- Those transitional age youth who are high utilizers of hospital services

Adults

- Those adults living with serious mental illness
- Those adults who are homeless or at risk of homelessness
- Those adults who have co-occurring substance use disorders
- Those adults who are involved in the criminal justice system or who are in transitioning/discharged from the criminal justice system
- Those adults who are recently discharged from psychiatric hospitals/higher levels of care
- Those adults who are frequently hospitalized or are frequent users of emergency room services for psychiatric problems

Older Adults

- Those older adults who have serious mental illness
- Those older adults who are homeless or at risk of homelessness
- Those older adults who are frequent users of emergency room services for psychiatric problems or are frequently hospitalized
- Those older adults who have reduced personal and/or community functioning due to physical and/or health problems
- Those older adults who have co-occurring substance use disorder
- Those older adults who are isolated and at risk for suicide due to stigma surrounding their mental health problems

Introduction

The primary goals of Crisis System of Care (CSOC) programs are to reduce hospital emergency room visits and unnecessary acute psychiatric hospitalization, improve consumer participation in outpatient services after a crisis, and reduce the percentage of consumers who return for additional crisis services within a short timeframe.

CSOC programs serve MHSA populations utilizing system development strategies that help enhance the capacity to provide value-driven, evidence-based services. Through system development, counties improve program services and supports for all consumers and families, enhance their service delivery systems, and build transformational programs and services. CSOC is comprised of a continuum of programming that provides education and support for community partners. Field-based responses from these programs are prompted by calls from the community, agency partners, or consumers experiencing a behavioral health crisis and facilitate access to walk-in clinics and centers, crisis stabilization units, and crisis residential treatment facilities in an effort to divert from unnecessary psychiatric hospitalization when a more appropriate level of care is available.

Programs under the CSOC are:

- A-5 Triage Transitional Services
  - Triage Transitional Services (TTS)
- A-6 Community Crisis Services
  - Community Crisis Response Team (CCRT)
- A-16 Crisis Intervention Collaborative Programs
  - Crisis Intervention Training (CIT)
  - 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 for the upcoming three fiscal years (Fiscal Years 2023/24 – 2025/26). The target population is broken up into MHSA age categories: MHSA age categories are: Children, TAY, Adult, and Older Adult.

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
Triage Engagement and Support Teams (TEST)	X	X	X	X

Projected Number of Consumers to be Served

The tables below represent the projected number of consumers to be served by programs within the Crisis System of Care for the upcoming three fiscal years (Fiscal Years 2023/24 – 2025/26). For each fiscal year, the projected total is broken up into two MHSA categories: age and service. MHSA age categories are: Children, TAY, Adult, and Older Adult. MHSA service categories are: Full Service Partnership (FSP), General System Development (GSD), and Outreach and Engagement (O&E).

Program	Fiscal Year	Ages Served	Service Area
Triage Transitional Services (TTS)	2023/24	400 TAY	1,800 GSD
		1,300 Adults	
		100 Older Adults	
		TOTAL = **1,800**	TOTAL = **1,800**
	2024/25	400 TAY	1,800 GSD
		1,300 Adults	
		100 Older Adults	
		TOTAL = **1,800**	TOTAL = **1,800**
	2025/26	400 TAY	1,800 GSD
		1,300 Adults	
		100 Older Adults	
		TOTAL = **1,800**	TOTAL = **1,800**

Program	Fiscal Year	Ages Served	Service Area
Community Crisis Response Team (CCRT)	2023/24	613 Children	2,452 GSD
		638 TAY	6,095 O&E
		1,005 Adults	
		196 Older Adults	
		TOTAL = **2,452**	TOTAL = **8,547**
	2024/25	674 Children	2,697 GSD
		701 TAY	6,705 O&E
		1,106 Adults	
		216 Older Adults	
		TOTAL = **2,697**	TOTAL = **9,402**
	2025/26	742 Children	2,967 GSD
		771 TAY	7,376 O&E
		1,216 Adults	
		238 Older Adults	
		TOTAL = **2,967**	TOTAL = **10,343**

*Full Service Partnership (FSP) consumers represent the number of consumers participating in FSP programs and services.
*General System Development (GSD) references consumers served in activities related to improving the County's mental health service delivery system for all consumers. Activities may or may not be provided to consumers enrolled in an FSP.
*Outreach and Engagement (O&E) references the number of consumers served while educating the community about mental health services offered and linking consumers to the appropriate services.

Projected Number of Consumers to be Served

The tables below represent the projected number of consumers to be served by programs within the Crisis System of Care for the upcoming three fiscal years (Fiscal Years 2023/24 – 2025/26). For each fiscal year, the projected total is broken up into two MHSA categories: age and service. MHSA age categories are: Children, TAY, Adult, and Older Adult. MHSA service categories are: Full Service Partnership (FSP), General System Development (GSD), and Outreach and Engagement (O&E).

Program	Fiscal Year	Ages Served	Service Area
Crisis Intervention Training (CIT)	2023/24	300 TAY	1,800 O&E
		1,200 Adults	
		300 Older Adults	
		TOTAL = **1,800**	TOTAL = **1,800**
	2024/25	300 TAY	1,800 O&E
		1,200 Adults	
		300 Older Adults	
		TOTAL = **1,800**	TOTAL = **1,800**
	2025/26	300 TAY	1,800 O&E
		1,200 Adults	
		300 Older Adults	
		TOTAL = **1,800**	TOTAL = **1,800**
Triage Engagement and Support Teams (TEST)	2023/24	450 Children	3,880 GSD
		1,030 TAY	1,000 O&E
		2,000 Adults	
		400 Older Adults	
		TOTAL = **3,880**	TOTAL = **4,880**
	2024/25	495 Children	4,238 GSD
		1,103 TAY	1,130 O&E
		2,200 Adults	
		440 Older Adults	
		TOTAL = **4,238**	TOTAL = **5,368**
	2025/26	545 Children	4,643 GSD
		1,189 TAY	1,261 O&E
		2,425 Adults	
		484 Older Adults	
		TOTAL = **4,643**	TOTAL = **5,904**

*Full Service Partnership (FSP) consumers represent the number of consumers participating in FSP programs and services.
*General System Development (GSD) references consumers served in activities related to improving the County's mental health service delivery system for all consumers. Activities may or may not be provided to consumers enrolled in an FSP.
*Outreach and Engagement (O&E) references the number of consumers served while educating the community about mental health services offered and linking consumers to the appropriate services.

Triage Transitional Services (TTS)

Program Name	Actual Number Served FY 2021-22	Estimated Number to be Served FY 2023-24	Annual Budgeted Funds FY 2023-24	Estimated Annual Cost per Person FY 2023-24
Triage Transitional Services	1,508	1,800	$2,462,019	$1,368

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) (formally known as Diversion Programs) were designed to assess consumers who voluntarily present themselves 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.

Services Provided

- Crisis assessment and intervention
- Case management
- Collateral contacts
- Transportation assistance
- Linkage with housing assistance
- Linkage with outpatient resources and providers
- Referrals to medical and social services agencies
- Family and caretaker education
- Consumer advocacy

Services Provided (cont.)

In Fiscal Year 2021/22, the Placement After Stabilization (PAS) program, an expansion of TTS, continued to discharge planning and act as a liaison to placement for each of the five (5) contracted Crisis Residential Treatment (CRT) facilities throughout San Bernardino County, in the following areas: San Bernardino (2 sites), Joshua Tree, Victorville, and Fontana. The staff work collaboratively with CRT staff to provide services that are intended to divert and reduce psychiatric inpatient hospitalization, assist consumers to maintain self-sufficiency, increase housing stability, and assist consumers to successfully reintegrate into the community.
Clinical Therapists are co-located at each CRT site to provide the following services:

- Screening for discharge services
- Assessments
- Discharge planning
- Placement assistance
- Transportation

Consumer Demographics Highlights FY 2021/22

The tables to the right show the demographics in various categories for the TTS program for Fiscal Year 2021/22. The demographic information is also explained below. TTS staff were able to successfully reach the target population of adults who have a serious mental illness and are experiencing a behavioral health crisis.

Age:
Of the 1,508 consumers served by TTS, 79% were adults between the ages of 26 and 59 years old. Of the remaining consumers, 16% were between the ages of 16 and 25, while 5% were age 60 and older.

Gender Identity:
Of the consumers served by TTS, 35% identified as male and 65% identified as female.

Race and Ethnicity:
The top three groups served by TTS identify as Latinx or Hispanic (44%), Caucasian (29%), and African American (21%). Consumers who identify as Asian or Pacific Islander represent 2% of the TTS population, while Native American represents less than 1%. The remaining 3% identify as more than one race.

Primary Language:
The majority of respondents identified English as their primary language (96%), while 3% identified Spanish as their primary language. Less than 1% identified a primary language other than English or Spanish, and the remaining preference is unknown.

Primary Diagnosis:
Of the consumers served by TTS, 45% have been diagnosed with psychosis and 22% with depression. TTS also served consumers diagnosed with bipolar disorder (10%), substance related disorders (5%), and anxiety (3%). The remaining 15% represents consumers with other or deferred diagnosis.

Age	
0% Children	**79%** Adult
16% TAY	**5%** Older Adult

Gender Identity	
65% Female	**35%** Male

Race/Ethnicity	
21% African American/Black	**44%** Latinx/Hispanic
2% Asian/Pacific Islander	**<1%** Native American
29% Caucasian/White	**3%** Multiple Races/Other

Primary Language	
96% English	**<1%** Other
3% Spanish	**<1%** Unknown

Primary Diagnosis	
3% Anxiety	**45%** Psychosis
10% Bipolar	**5%** Substance Related
22% Depression	**14%** Other
1% Deferred Diagnosis	

N=1,508

MHSA Legislative Goals and Related Key Outcomes

- ✓ Reduce the frequency of emergency room visits and unnecessary hospitalizations:
  - Reduced rate of emergency room visits for mental health concerns
  - Increase use of alternative crisis interventions (e.g., CWIC, CCRT, CSU)
  - Increase in number of individuals diverted from unnecessary psychiatric hospitalizations

Positive Results

In Fiscal Year 2021/22, TTS staff served a total of 2,090 consumers. A total of 1,065 (51%) of those consumers were diverted from unnecessary hospitalization.

Additionally, for discharge services provided at the CRTs as part of the PAS expansion of TTS services, in FY 2021/22, these expanded services assisted a total of 373 consumers:

- 257 remained in the CRT program long enough to receive discharge services
- 254 (99%) successfully discharged to safe and sustainable community placements

Challenges and Solutions

Over the past year, the TTS program has experienced continued staffing challenges. Access to timely outpatient psychiatric appointments and clinic intakes is a challenge due to limited staff.

Program staff experienced difficulty accessing placement resources due to limited availability of rapid housing solutions.

TTS staff encountered billing challenges shifting to the new Electronic Health Record and are adjusting to the new requirements.

In an ongoing effort to increase resources, TTS staff continue to establish collaborative relationships with community partners and other DBH programs, learn about changes to resources, and ensure TTS consumers received the most accurate information available. TTS staff have been working closely with the Crisis Stabilization Unit (CSU) staff to divert consumers to the CSU for follow up services.

Success Story

"Ellie's" child had been removed from her. She came to the Crisis Residential Treatment program experiencing a mental health crisis and homelessness. She received residential mental health treatment and worked with the Placement After Stabilization team on her discharge goals. The team obtained a housing voucher, follow-up mental health treatment and worked with Ellie to re-unite her with her child.

Outreach and Engagement

For Fiscal Year 2021/22, a combined total of 55 participants attended two presentations where staff members from the TTS program were available to discuss their program and offer resources.

Success Story

"Joe" presented himself to the BHU Triage Unit within ARMC hospital as homeless, without stable housing or transportation for medical and psychiatric follow up.

DBH staff assisted him with locating emergency shelter housing, scheduling an outpatient appointment with a DBH clinic, and scheduling a medical appointment. Staff linked "Joe" to a Full-Service Partnership program and obtained follow-up wraparound services after his hospital visit to ensure he was able to navigate to and attend the appointments made.

Joe is successfully attending appointments, continues to maintain housing and receives case management to obtain permanent housing.

Program Updates

The PAS program, which falls under the TTS umbrella within MHSA, expanded to provide for a Mental Health Specialist (MHS) position, deemed a "Placement Navigator", which navigates the ongoing placement needs for consumers in time limited emergency shelter housing which requires immediate case management services.

This Placement Navigator will also work with consumers on a permanent housing plan, which may eventually be transitioned to another Division within the Department as appropriate. The Placement Navigator will also work with the program/unit leadership and staff on any barriers that may present from a consumer in that Division, such as complex needs and transitioning placement when needed.

Collaborative Partners

- Arrowhead Regional Medical Center (ARMC)
- Contracted Fee-For-Service hospitals
- Helping Hearts of California
- Law enforcement agencies throughout San Bernardino County
- Los Angeles, Orange, and Riverside County Department of Mental Health
- San Bernardino County, Children and Family Services (CFS)
- San Bernardino County, Department of Aging and Adult Services (DAAS)
- San Bernardino County, Office of the Public Guardian
- San Bernardino County, Probation
- State Parole
- Telecare Corporation

Community Crisis Response Team (CCRT)

Program Name	Actual Number Served FY 2021-22	Estimated Number to be Served FY 2023-24	Annual Budgeted Funds FY 2023-24	Estimated Annual Cost per Person FY 2023-24
Community Crisis Response Team	6,241	8,547	$9,011,882	$1,054

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 Response Team (CCRT) provides urgent behavioral health services to residents of San Bernardino County. CCRT regional teams are located in the East/Central Valley, High Desert, and West Valley regions of San Bernardino County. CCRT responds to community locations through collaborations that include, but are not limited to, law enforcement, hospitals, schools, Department of Behavioral Health (DBH) clinics and contract providers, specialty programs, group homes, Board and Care (B&C) facilities, family members, and self-referrals.

Anyone in San Bernardino County may obtain services from CCRT in the event of a behavioral health crisis. CCRT is committed to assisting San Bernardino County residents in the least restrictive manner by providing behavioral health services on site where the individual is experiencing their crisis.

Services Provided

- Crisis assessment and intervention in the field, via text messaging, and/or via virtual conferencing
- Medication referrals
- Linkage to community resources and providers
- Consultation for interruption of involuntary psychiatric hold (5150/5585)

Community Crisis Response Team (CCRT)

Consumer Demographics Highlights FY 2021/22

The tables to the right show the demographics in various categories for the CCRT program for Fiscal Year 2021/22. The demographic information is also explained below. The CCRT program was able to successfully reach the target population of individuals experiencing a behavioral health crisis throughout San Bernardino County.

Age:
Of the 6,241 consumers served by CCRT, 34% were adults between the ages of 26 and 59 years old. CCRT also served consumers ages 15 and under (25%), consumers between the ages of 16 and 25 (22%) and those ages 60 and older (6%). The age of the remaining 13% is unknown.

Gender Identity:
Of the consumers served by CCRT, 48% identified as male and 48% identified as female. The remaining consumers identified as transgender (1%) or chose not to disclose this information (3%).

Race and Ethnicity:
CCRT served consumers that identify as Latinx or Hispanic (34%), Caucasian (15%), and African American (12%). Consumers who identify as Asian or Pacific Islander represent 2%, while those who identify as American Indian/Alaska Native represent less than 1% of consumers served. Consumers who identify as more than one race represent 2%, while 34% is unknown.

Primary Language:
Of the consumers served by CCRT, 92% identified English as their primary language. Spanish represented 3% and 5% identified a primary language other than English and Spanish.

Primary Diagnosis:
CCRT consumers have been diagnosed with depression (40%), psychosis (13%), anxiety (12%), bipolar disorder (5%), and disruptive disorder (6%). CCRT also served consumers with neurodevelopmental or cognitive disorders (2%) and with substance related disorders (1%). The remaining 21% is unknown.

Age	
25% Children	**34%** Adult
22% TAY	**6%** Older Adult

Gender Identity	
48% Female	**1%** Transgender
48% Male	

Race/Ethnicity	
<1% American Indian/Alaska Native	**15%** Caucasian/White
12% African American/Black	**34%** Latinx/Hispanic
2% Asian/Pacific Islander	**2%** Multiple Races/Other

Primary Language	
92% English	**5%** Other
3% Spanish	

Primary Diagnosis	
12% Anxiety disorders	**2%** Neurodevelopmental/ cognitive disorders
5% Bipolar disorders	
40% Depressive disorders	**13%** Psychosis
6% Disruptive disorders	**1%** Substance Related

N=6,241*

*NOTE: This number is an approximation. Some consumers may not have been counted. Primary Diagnosis information was collected for 1,173 consumers.

Community Crisis Response Team (CCRT)

MHSA Legislative Goals and Related Key Outcomes

✓ Reduce the frequency of emergency room visits and unnecessary hospitalizations:
- Reduce rate of emergency room visits for mental health concerns
- Increased use of alternative crisis interventions (e.g., CWIC, CSU)
- Increase in number of individuals diverted hospitalization
- Increase a network of community support services:
- Increase in number of collaborative partners

Positive Results

In Fiscal Year 2021/22, 1,486 consumers were diverted from unnecessary hospitalization to alternative crisis interventions such as the Crisis Walk-In Centers, Crisis Stabilization Units, and Crisis Residential Treatment. This is a 36% increase in diversions from the previous fiscal year, as Fiscal Year 2020/21 encountered restricted field responses during the global pandemic.

Success Story

CCRT received a number of requests for service by a local group home for the same minor, "Jasmine" over a number of weeks. Jasmine disclosed that she didn't feel comfortable speaking with the therapist at the group home because he is a male. CCRT staff did an excellent job working with Jasmine, successfully encouraging her to talk when she refused to talk with anyone else. CCRT connected her with appropriate DBH services by completing a referral for the specialized children's programs. As a result, Jasmine was connected with a female therapist to meet her comfort level. With CCRT's intervention, future crisis situations and hospitalizations may have been diverted for Jasmine, in addition to successfully connecting Jasmine with the help she needs.

Challenges and Solutions

Maintaining appropriate staffing levels to meet community needs and support community partners including law enforcement and schools, has been a challenge. Solutions the CCRT program used to combat this challenge include proposing flexible schedules to meet staff needs and decrease burn out, encouraging and promoting self-care amongst direct care staff and leadership, and participating in staff retention trainings.

Developing the Crisis Contact Center: securing building space, desk, office and IT equipment. Securing initial staffing positions, writing policies and procedures for a new program was another challenge. Requesting additional staff positions, allowing the Crisis Contact Center hours to mirror CCRT hours (7-days per week; 7am-10pm), promoting the new program in the community, highlighting the single crisis number for emergent crisis support.

Program Updates

Community Crisis Services (CCS) proposes expanding and enhancing the County mobile crisis services program by establishing a Crisis Contact Center (CCC) that receives all behavioral health crisis calls through a single crisis number. When a field response is warranted, CCC completes a warm hand-off with a deployed CCRT unit. Specially trained CCRT field responders in County vehicles will be readily available for immediate response to behavioral health crisis calls in the community and to provide support to law enforcement and schools/colleges. Text messaging and virtual conferencing services will remain available.

Community Crisis Response Team (CCRT)

Outreach and Engagement

For Fiscal Year 2021/22, the following outreach and engagement activities were conducted:

Activity Type	Number of Activities	Total Number of Participants
Law Enforcement Briefings/Meetings	69	740
Health Care/Clinic Collaboration	4	38
Church/Religious Collaborations	2	6
Apartment/Residential Outreach	1	40
School Collaboration	4	84
Group Home Collaboration	1	7
Foster Family Agency	3	10
Options4Youth	1	1
Hope Soars	1	3
DBH Clubhouse	1	5
Behavioral Health Contract Providers	1	10
District Attorney/Victim's Advocate	1	12
Community Groups Collaboration	3	47
Total	**92**	**1,003**

Collaborative Partners

- Arrowhead Regional Medical Center
- Barstow Community Hospital
- Barstow, Chino, Colton, Fontana, Montclair, Ontario, Redlands, Rialto, Upland Police Departments
- Bear Valley Community Hospital
- Canyon Ridge Hospital
- Chino Valley Hospital
- Desert Valley Medical Center
- Family Resource Centers
- Hi-Desert Medical Center
- Inland Regional Center (IRC)
- Juvenile Group Homes
- Kaiser Hospital Emergency Department and Outpatient Services
- Loma Linda Behavioral Medical Center
- Loma Linda University Medical Center
- Mountains Community Hospital
- National Alliance of Mental Illness (NAMI)
- Needles Desert Community Hospital
- Office of Veterans Affairs
- Red Carnation House
- Redlands Community Hospital
- San Antonio Regional Hospital
- San Bernardino Community Hospital
- San Bernardino County, Department of Aging and Adult Services (DAAS)/Office of the Public Guardian
- San Bernardino County, Children and Family Services (CFS)
- San Bernardino County, Probation Department (Adult and Juvenile)
- San Bernardino County, Sheriff's Departments (Countywide)
- St. Bernadine Medical Center
- St. Mary Medical Center
- Victor Valley Global Medical Center

Crisis Intervention Training (CIT)

Program Name	Actual Number Served FY 2021-22	Estimated Number to be Served FY 2023-24	Annual Budgeted Funds FY 2023-24	Estimated Annual Cost per Person FY 2023-24
Crisis Intervention Training	2,273	2,000	$6,101,847*	$3,051

*Annual budget and cost per client represent both TEST and CIT.

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Ages 16+	N/A	Field-based	First responders

Program Description and Target Population

The Crisis Intervention Training (CIT) program provides training to first responders and community partners who encounter behavioral health crises in the community. The goal of each training is to enhance participants' ability to recognize signs of a mental health crisis, utilize communication and de-escalation skills, and access behavioral health resources for persons in crisis.

Services Provided

- In collaboration with San Bernardino County Sheriff's Department:
  - Quarterly 40-hour CIT course
  - Quarterly 8-hour Senate Bill 29 (SB 29) Field Training Officer (FTO) CIT course
- In collaboration with Probation:
  - Bi-weekly 8-hour CIT course
- Multiple monthly collaborative partner trainings



Crisis Intervention Training (CIT)

Consumer Demographics Highlights FY 2021/22

The tables to the right show the demographics in various categories for the CIT program for Fiscal Year 2021/22. The demographic information is also explained below. The CIT program was able to successfully reach the target population of first responders and community partners who encounter behavioral health crises in the community.

Age:
Of the 2,273 individuals that received training, 68% were adults between the ages of 26 and 59 years old. Other individuals in training were between the ages of 16 and 25 (7%) and age 60 and older (3%). The ages of the remaining 22% is unknown.

Gender Identity:
Of the individuals that received training, 40% identified as female and 38% identified as male. The gender identity of the remaining 22% is unknown.

Race and Ethnicity:
CIT served individuals that identify as Latinx or Hispanic (34%), more than one race (31%), and Caucasian (20%). Individuals who identify as African American represent 10%, while those who identify as Asian or Pacific Islander represent 4%. Individuals who identify as American Indian or Alaska Native represent 1% of trainees.

Primary Language:
Of the individuals that received training, 75% identified English as their primary language. Spanish represented 1% and 24% identified a primary language other than English and Spanish or did not disclose this information.

Primary Diagnosis:
The primary diagnosis for this program is not collected, as the purpose is to train first responders and community partners.

Age	
0% Children	**68%** Adult
7% TAY	**3%** Older Adult

Gender Identity	
40% Female	**38%** Male

Race/Ethnicity	
1% American Indian/Alaska Native	**20%** Caucasian/White
10% African American/Black	**34%** Latinx/Hispanic
4% Asian/Pacific Islander	**31%** Multiple Races/Other

Primary Language	
75% English	**24%** Other/Unknown
1% Spanish	

Primary Diagnosis
Data Not Collected

N=2,273

Crisis Intervention Training (CIT)

MHSA Legislative Goals and Related Key Outcomes

✓ Reduction in criminal and juvenile justice involvement:
- Decreased rate of incarcerations
- Decreased arrests
- Decreased in jail bookings
- Decreased sustained allegations
- Reduced jail/prison recidivism

✓ Reduce the frequency of emergency room visits and unnecessary hospitalizations:
- Reduced rate of emergency room visits for mental health concerns
- Increased use of alternative crisis interventions (e.g., CWIC, CCRT, CSU)
- Increase in number of individuals diverted from hospitalization

✓ Increase a network of community support services:
- Increase in number of collaborative partners
- Increased coordination of care

Positive Results

In Fiscal Year 2020/21, 2,273 law enforcement and community partners received training from the CIT program.
- 169 law enforcement personnel completed the 40-hour CIT course
- 71 Field Training Officers (FTO) completed the 8-hour FTO CIT course
- 793 Probation Officers and Probation Correctional Officers completed the 8-hour CIT course

Positive Results (cont.)

- 1,352 community partners, including fire, public employees, and emergency departments received specialized training from the CIT program
- CIT program staff attended 57 outreach and engagement events
- CIT program staff completed 94 formal trainings to first responders and community partners

Challenges and Solutions

The CIT program was faced with staff attrition challenges during FY 2021/22. To ensure continued services to community partners, CIT courses were reassigned to the remaining staff training instructors. In order to address staffing challenges, leadership quickly initiated the hiring process to fill the vacancy of the Staff Training Instructor. Additionally, the Program Manager and Mental Health Education Instructor have begun facilitating and instructing courses along with the Staff Training Instructors to support staff as much as possible.

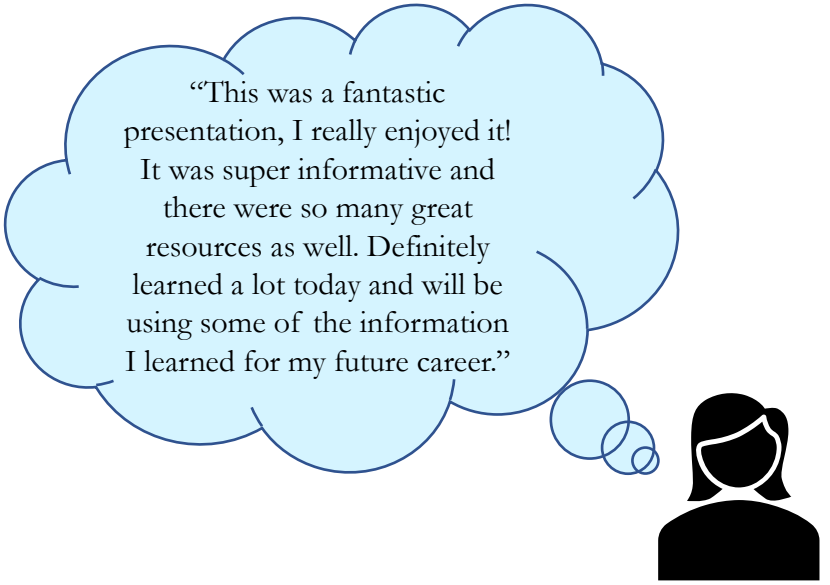
Additionally, many CIT classes continue to be delivered virtually, resulting in decreased engagement and motivation to participate. The CIT program continues to encourage class discussion and the utilization of virtual aids such as Aha Slides, where participants can take quizzes and submit answers virtually and instantly within the presentation. The CIT program is encouraging the community partners to request in-person training rather than virtual.

Crisis Intervention Training (CIT)

Outreach and Engagement

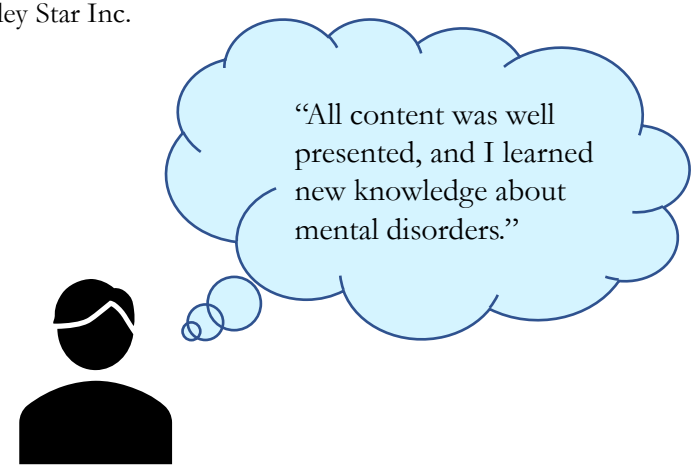
For Fiscal Year 2021/22, the CIT program conducted the following outreach and engagement activities:

Activity Type	Number of Activities	Total Number of Participants
Community Collaborative Meeting	50	3002
Gang and Drug Taskforce	4	140
Coffee with a Cop	1	40
Outreach/Networking Event	2	500
Total	**57**	**3,682**



Collaborative Partners

- CAL Fire
- California Highway Patrol
- City of Chino Police Department
- Inland Counties Emergency Medical Agency
- Inland Regional Center
- National Alliance on Mental Illness (NAMI)
- Office of Veteran Affairs (federal)
- San Bernardino County, Children's Network
- San Bernardino County, Department of Aging and Adult Services/Office of the Public Guardian (DAAS/OPG)
- San Bernardino County, Probation Department
- San Bernardino County, Sheriff's Department
- The Counseling Team
- Valley Star Inc.



Triage, Engagement, and Support Teams (TEST)

Program Name	Actual Number Served FY 2021-22	Estimated Number to be Served FY 2023-24	Annual Budgeted Funds FY 2032-24	Estimated Annual Cost per Person FY 2023-24
Triage, Engagement, and Support Teams	826	4,880	$6,101,847*	$1,250*

*Annual budget and cost per client represent both CIT 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 29 internal and external County partner agencies, including, but not limited to, law enforcement agencies, hospital emergency departments, and college campuses. The TEST program provides exclusive support to these partnering departments and agencies. Staff respond in the field with law enforcement personnel and/or assist other partnering agency staff in managing consumer behavioral health crises. TEST provides follow-up case management services for up to 59 days, after initial contact, to link consumers with resources for ongoing behavioral health stability.

Services Provided

- Crisis assessment and intervention in the field
- Case management
- Support to collateral contacts
- Referrals and linkages to community resources and providers
- Family and caretaker education
- Consumer advocacy
- Education and support to law enforcement and community partners regarding behavioral health concerns and resources

Triage, Engagement, and Support Teams (TEST)

Consumer Demographics Highlights FY 2021/22

The tables to the right show the demographics in various categories for the TEST program for Fiscal Year 2021/22. The demographic information is also explained below. The TEST program was able to successfully reach the target population of individuals of all ages with a serious emotional disturbance or serious mental illness experiencing a behavioral health crisis.

Age:
Of the 826 consumers served by TEST, 51% were adults between the ages of 26 and 59 years old. TEST also served consumers between the ages of 16 and 25 (20%), consumers age 15 and under (15%), and consumers ages 60 and older (14%).

Gender Identity:
Of the consumers served by TEST, 51% identified as male and 49% identified as female.

Race and Ethnicity:
TEST served consumers that identify as Caucasian (42%), Latinx or Hispanic (35%), and African American (17%). Consumers who identify as Asian or Pacific Islander represent 3%, while those who identify as more than one race represent 3%.

Primary Language:
Of the consumers served by TEST, 97% identified English as their primary language. Spanish represented 2% and 1% identified a primary language other than English and Spanish.

Primary Diagnosis:
Consumers served by TEST have been diagnosed with depression (33%), psychosis (26%), bipolar disorder (7%), anxiety (6%), and substance related disorders (6%). TEST consumers have also been diagnosed with disruptive disorder (2%) and neurodevelopmental or cognitive disorders (less than 1%). The remaining 19% is unknown.

Age	
15% Children	**51%** Adult
20% TAY	**14%** Older Adult

Gender Identity	
49% Female	**51%** Male

Race/Ethnicity	
17% African American/Black	**35%** Latinx/Hispanic
3% Asian/Pacific Islander	**3%** Multiple Races/Other
42% Caucasian/White	

Primary Language	
97% English	**1%** Other/Unknown
2% Spanish	

Primary Diagnosis	
6% Anxiety disorders	**<1%** Neurodevelopmental/ cognitive disorders
7% Bipolar disorders	
33% Depressive disorders	**26%** Psychosis
2% Disruptive disorders	**6%** Substance Related

N=826*

*NOTE: Not all percentages add to 100 due to rounding.

Triage, Engagement, and Support Teams (TEST)

MHSA Legislative Goals and Related Key Outcomes

- ✓ Reduce the frequency of emergency room visits and unnecessary hospitalizations:
  - Increase access to and use of existing community resources (e.g., housing mental health services, substance use services, medical treatment, education services, etc.
  - Increased use of alternative crisis interventions (e.g., CWIC, CCRT, CSU)
  - Increase in number of individuals diverted from unnecessary psychiatric hospitalizations

Positive Results

In Fiscal Year 2021/22, TEST experienced an increase of 87% in encounters and 63% increase in the number of referrals in comparison to the prior fiscal year. The program provided 12,095 encounters and 16,333 referrals to behavioral health and community resources which resulted in:

- 146% increase in linkage to alternative Residential Treatment (i.e., adult residential treatment or crisis residential treatment in the DBH continuum of care) from Fiscal Year 2020/21 to Fiscal Year 2021/22.
- 70% of TEST crisis interventions were diverted from hospitalizations, an increase of .89% compared with Fiscal Year 2020/21.

Challenges and Solutions

Due to statewide college closures, TEST staff co-located at college campuses were temporarily relocated to other DBH offices where they were available to serve students via telephone and provide supportive services to other co-location sites. As a result of potential high-risk factors within hospital emergency departments, TEST staff co-located in those emergency departments temporarily relocated to DBH offices throughout the county where they remain available to serve students via telephone and provide support to other co-location sites as needed.

The demand for TEST services at co-location sites throughout San Bernardino County continues to grow. Three co-location sites were added in FY 2021/2022 for the TEST program. Filling the vacancies resulting from these added sites has been a challenge.

Solutions in progress include continued active efforts in building and maintaining relationships with law enforcement and community partners. This includes 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. There also continues to be a priority placed on filling TEST staff vacancies to help meet the staffing needs.

Triage, Engagement, and Support Teams (TEST)

Outreach and Engagement

For Fiscal Year 2021/22, the TEST program conducted the following outreach and engagement activities:

Activity Type	Number of Activities	Total Number of Participants
Homeless Outreach	2	60
Multi Enforcement Team (MET)	11	165
Community Engagement Outreach	32	2,347
Vista Clinic Meeting	1	7
Ontario Police Citizens Academy	1	50
Mental Health Awareness - Amazon	1	150
Fontana High School Outreach	1	20
Intelligence Lead Policing	3	88
Public Safety meeting	1	36
Law Enforcement Briefings/Collaborative Meetings	1,308	8,811
Totals	**11,423**	**15,317**

Program Updates

TEST program anticipates collaborating and providing services at an additional two co-location sites throughout San Bernardino County during FY 2022/2023, which will be accompanied by the challenges inherent to a growing program. Continued expansion requires the program to balance staffing needs and budgetary constraints.

Success Story

"Keiko" recently had her case closed with the TEST program but needed resources. TEST staff met with Keiko and listened to her progress and her current stressors, which included separation from her daughter due to unstable housing.

After living in a hotel for the past several months, she had finally found a place to live and would be moving soon, which would enable her to have overnight visits with her daughter. However, the logistics surrounding the move were causing Keiko severe amounts of stress, leading to a mental health crisis. TEST provided Keiko with crisis intervention services to stabilize the crisis.

TEST staff connected her to community agencies that were able to provide a bed along with bedding and a pillow, for her to provide for her daughter. Keiko expressed her gratitude to TEST staff for resolving her crisis.

Triage, Engagement, and Support Teams (TEST)

Collaborative Partners

- Adelanto Sheriff's Office
- Apple Valley Sheriff's Office
- Barstow Police Department
- Barstow Sheriff's Office
- Big Bear Sheriff's Office
- California State University, San Bernardino
- Central Station Sheriff's Office
- Chino Hills Sheriff's Office
- Chino Police Department
- Fontana Police Department
- Fontana Sheriff's Office
- Hesperia Sheriff's Office
- Highland Sheriff's Office
- Joshua Tree Probation
- Kaiser Hospital
- Montclair Police Department
- Morongo Basin Sheriff's Office
- Ontario Police Department
- Phelan Sheriff's Office
- Rancho Cucamonga Sheriff's Office
- Redlands Police Department
- Rialto Police Department
- San Bernardino Police Department
- Twin Peaks Sheriff's Office
- Upland Police Department
- Victorville Sheriff's Office
- Victor Valley College
- Yucaipa Sheriff's Office

Success Story

TEST staff met with "Rodney," an 80-year-old male, outside of his daughter's apartment, where he and his wife were also living. Rodney refused to go back into the apartment due to his adult daughter's alleged verbal abuse. He reported feeling disrespected and wanted to go live with another daughter in another country, where his brother also lives.

TEST staff spoke to the adult daughter, who was also Rodney's caretaker, and informed her of Rodney's concerns. His daughter, "Kara," reported feeling overwhelmed with the situation and wanted the best for her parents. It was agreed that Kara would continue to be her parents' caretaker but would reside elsewhere.

Two months later, Kara called TEST staff to report that she was able to arrange moving her parents to be with their other daughter and near Rodney's brother. Kara reported that her parents are very happy there and thanked TEST staff for the intervention.

Introduction

The Crisis Stabilization Continuum of Care (CSCC) operates as part of the 24-Hour and Emergency Services Division of DBH. The services offered through CSCC are centered on providing immediate intervention along with stabilization services to consumers who are experiencing a mental health crisis. These care options are accessible through various settings operated by contracted treatment providers with DBH including Fee-For-Service Lanterman-Petris-Short (LPS) hospitals, Crisis Stabilization Units (CSUs), Crisis Walk-In Centers (CWICs), and Crisis Residential Treatment Centers (CRTs).

- **Crisis Stabilization Units (CSUs)** and **Crisis Walk-In Centers (CWICs)** provide urgent mental health care for individuals of all ages. Services are voluntary and include, but are not limited to crisis intervention, crisis risk assessments, medication support as needed, substance use screening and referral, and evaluations for hospitalization, when necessary. Each CSU has twenty (20) spaces – sixteen (16) for adults and four (4) for children and adolescents. Each CWIC has twelve (12) spaces for any age.

- **Crisis Residential Treatment (CRT)** programs provide a structured treatment environment for 30 days with two possible 30-day extensions, not to exceed 90 days. There are five (5) CRTs within CSCC and four (4) serving adults aged 18 to 59 and one (1) CRT serving the Transitional-Age Youth (TAY) population. Each CRT in CSCC has sixteen (16) beds, and the TAY CRT has fourteen (14) beds. Services include, but are not limited to, comprehensive assessment, therapy, psychiatric and/or medication support, life skills coaching, peer and family support, coping techniques, recovery education, and community resource linkages and referrals.

Target Population

The table below demonstrates the target population of consumers to be served by programs within the Crisis Stabilization System of Care for the upcoming three fiscal years (Fiscal Years 2022/23 – 2025/26.) The target population is broken up into MHSA age categories: MHSA age categories are: Children, TAY, Adult, and Older Adult.

Crisis Stabilization Continuum 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

Projected Number of Consumers to be Served

The tables below indicate the projected number of consumers to be served by programs within the Crisis Stabilization Continuum of Care for the upcoming three fiscal years (Fiscal Year 2022/23 – 2025/26). For each fiscal year, the projected total is broken up into two MHSA categories: age and service. MHSA age categories are: Children, TAY, Adult, and Older Adult. MHSA service categories are: Full Service Partnership (FSP), General System Development (GSD), and Outreach and Engagement (O&E).

Program	Fiscal Year	Ages Served	Service Area
Crisis Walk-In Center (CWIC)	2023/24	185 Children	1,930 GSD
		475 TAY	
		1,125 Adults	
		145 Older Adults	
		TOTAL = 1,930	**TOTAL = 1,930**
	2024/25	185 Children	1,930 GSD
		475 TAY	
		1,125 Adults	
		145 Older Adults	
		TOTAL = 1,930	**TOTAL = 1,930**
	2025/26	185 Children	1,930 GSD
		475 TAY	
		1,125 Adults	
		145 Older Adults	
		TOTAL = 1,930	**TOTAL = 1,930**
Crisis Stabilization Unit (CSU)	2023/24	450 Children	4,500 GSD
		1,200 TAY	
		2,600 Adults	
		250 Older Adults	
		TOTAL = 4,500	**TOTAL = 4,500**
	2024/25	450 Children	4,500 GSD
		1,200 TAY	
		2,600 Adults	
		250 Older Adults	
		TOTAL = 4,500	**TOTAL = 4,500**
	2025/26	450 Children	4,500 GSD
		1,200 TAY	
		2,600 Adults	
		250 Older Adults	
		TOTAL = 4,500	**TOTAL = 4,500**
Crisis Residential Treatment (CRT)	2023/24	130 TAY	530 GSD
		400 Adults	
		TOTAL = 530	TOTAL = 530
	2024/25	130 TAY	530 GSD
		400 Adults	
		TOTAL = 530	**TOTAL = 530**
	2025/26	130 TAY	530 GSD
		400 Adults	
		TOTAL = 530	**TOTAL = 530**

*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.

Crisis Stabilization Unit

Program Name	Actual Number Served FY 2021-22	Estimated Number to be Served FY 2023-24	Annual Budgeted Funds FY 2023-24	Estimated Annual Cost per Person FY 2023-24
Crisis Stabilization Unit (CSU)	5,227*	4,500	$13,085,899**	$2,908**

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 O&E.
**Annual budget and cost per client represent both CWIC and CSU.

Program Description and Target Population

The Crisis Stabilization Units (CSUs) offer urgent stabilization services to individuals experiencing a mental health crisis. Consumers are evaluated by a multidisciplinary team and connected to an appropriate level of care in an effort to avoid unnecessary psychiatric hospitalization. CSU facilities are intended to serve as a home-like, community-based alternative to unnecessary incarceration or psychiatric hospitalization.

Services Provided

- 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
- Referral and linkage to culturally and linguistically appropriate services

Success Story

"Jerome" had a long history of homelessness, severe mental illness and substance use. He had been to the CSU in the past and received support; however, recovery efforts had not yet been successful. Jerome arrived at the CSU again, living with the same mental illness and homelessness. Throughout his stay, he became violent towards himself and others, and was later given medication to stabilize overnight. CSU staff utilized a strengths-based perspective and reflective listening when working with Jerome the next day to support individual empowerment and build rapport with him. This time, he disclosed his hardships with mental health and how it had affected his life and relationships. This was the first time that Jerome was vulnerable with the staff, and it was incredibly helpful in understanding his unique situation. As rapport continued to strengthen, Jerome became receptive to receiving support and willingly requested a referral to a crisis residential treatment (CRT) program as he became determined to stabilize and turn his life around. The CSU was successful in placing him with a CRT and transporting him to the facility. In the final moments with Jerome before discharge, he thanked the staff for taking the time to listen and understand him. He ended services by stating that the CSU made him regain hope within himself again, something that he had not felt in a long time.

Consumer Demographics Highlights FY 2021-22

The tables to the right show the demographics in various categories for CSUs for Fiscal Year 2021/22. The demographic information is also explained below. CSU staff were able to successfully reach the target population of individuals experiencing a behavioral health crisis throughout San Bernardino County.

Age:
In Fiscal Year 2021/22, 64% of consumers served by CSUs were adults between the ages of 26 and 59 years old. Of the remaining consumers, 22% were between the ages of 16 and 25, 8% age 15 and under, and 6% age 60 and older.

Gender Identity:
Of the consumers served by CSUs, 55% identified as female and 45% identified as male.

Race and Ethnicity:
The largest group of consumers served by CSUs identify as Latinx or Hispanic (49%). The second largest group was consumers who identify as Caucasian (24%), followed by 20% African American. Consumers who identify as Asian or Pacific Islander represent 2% and those who identify as American Indian or Alaska Native represent 1% of consumers served. The remaining 4% of consumers identify as more than one race.

Primary Language:
Of the consumers served by CSUs, 95% identified English as their primary language. Spanish represented 4%, while 1% identified a primary language other than English or Spanish, or the primary language is unknown.

Primary Diagnosis:
CSU consumers have been diagnosed with psychosis (30%), depression (26%), bipolar disorders (13%), and anxiety disorders (11%). CSUs also serve consumers that are diagnosed with substance related disorders (4%), disruptive disorders (1%), and neurodevelopmental or cognitive disorders (1%). Consumers with deferred diagnosis represent 2%, while 12% have a different primary diagnosis.

Age	
8% Children	**64%** Adult
22% TAY	**6%** Older Adult

Gender Identity	
55% Female	**45%** Male

Race/Ethnicity	
20% African American/Black	**24%** Caucasian/White
1% American Indian/Alaska Native	**49%** Latinx/Hispanic
2% Asian/Pacific Islander	**4%** Multiple Races/Other

Primary Language	
95% English	**1%** Other/Unknown
4% Spanish	

Primary Diagnosis	
11% Anxiety disorders	**1%** Neurodevelopmental/ cognitive disorders
13% Bipolar disorders	**30%** Psychosis
26% Depressive disorders	**4%** Substance Related
2% Deferred diagnosis	**12%** Other
1% Disruptive disorders	

N=5,227*

*NOTE: This number is an approximation. Some consumers may not have been counted.

MHSA Legislative Goals and Related Key Outcomes

✓ Reduce the subjective suffering from serious mental illness for adults and serious emotional disorders for children and youth:
- Decrease hopelessness/increased hope
- Increased resiliency
- Decreased impairment in general areas of life functioning (e.g., health/ self-care/housing, occupation/education, legal, managing money, interpersonal/social)

✓ Reduce the frequency of emergency room visits and unnecessary hospitalizations:
- Reduced rate of emergency room visits for mental health concerns
- Reduced number of emergency room visits for routine medical concerns
- Reduced administrative hospital days
- Increase use of alternative crisis interventions (e.g., CWIC, CCRT, CSU)
- Increase in number of individuals diverted from hospitalization

✓ Increase a network of community support services:
- Increase in self-help/support/12-step/community/school group or healthcare provider attendance and frequency per consumer
- Increased coordination of care

Positive Results

The CSUs served a combined total of 5,227 consumers in Fiscal Year (FY) 2021/22. The combination of outreach efforts resulted in an increase in services provided by the end of FY 221/22. These programs provided 7,910 crisis stabilization services to those consumers. Of those 7,910 admissions, 97.8% were successfully diverted from psychiatric hospitalization.

Windsor CSU received a total of 587 surveys; of those, 90.1% reported a satisfaction rating, capturing consumer responses to questions regarding how they were treated, cultural sensitivity, services offered, linkage to resources, overall setting, and likeliness to recommend to others in need.

Merrill CSU received a total of 4,298 surveys; of those, 93.4% reported a satisfaction rating, capturing consumer responses to questions regarding how they were treated, cultural sensitivity, services offered, linkage to resources, overall setting, and likeliness to recommend to others in need.

Similarly, 9.0% of referrals to these programs originated from local hospitals, representing a population whose crisis was appropriately manageable at the CSU rather than at the inpatient level of care.

In FY 2021/22, the two CSUs received referrals from a total of 329 unique collaborative partners, including psychiatric hospitals and hospital emergency departments, outpatient clinics, substance use treatment providers, law enforcement agencies/officers, schools, faith-based organizations, shelters, and other community agencies.

Challenges and Solutions

Although improved, recruiting and staffing efforts for CSU programs remained challenging as other healthcare agencies began expanding their hiring processes to meet surges in service demand as the COVID-19 pandemic subsides.

To be more competitive in recruiting and retaining staff, CSUs increased wages to attract qualified staff and remain competitive with the workforce. In addition, to avoid turnover of staff during the uncertainty the pandemic placed on delivering care, CSUs implemented COVID pay incentives and implemented treatment protocols to ensure that services continued to be provided for suspected or confirmed COVID-19 positive mental health consumers. Recruiting efforts shifted to virtual hiring events and virtual clinician recruitment fairs with local universities.

The CSUs are also implementing a scheduling team that will utilize a centralized on-call pool of staff. In addition, the CSU programs maintained a collaborative partnership with local universities to continue an internship training program which has served to create a robust hiring pool of trained bachelor and masters level staff to fill vacancies across multiple program types.

Challenges were experienced in stabilizing consumers and providing linkage/placement within 24 hours. Intake procedures have since been expanded for potential placement programs to which the CSUs refer due to the COVID-19 pandemic.

Challenges and Solutions (cont.)

The need for additional screening, COVID-testing, and other infection control efforts led to some delays in consumer linkage and placement, standard screening and referral procedures for other potential placement programs led to delays in timely discharge and warm hand-off to the next appropriate level of care. To streamline both the admission process and the placement process following discharge, CSUs implemented Antigen COVID tests for consumers admitted to the programs.

Success Story

"Ramon" visited the CSU multiple times over the course of several years. Historically, he was unable to commit to services due to a prolonged substance use history with a co-occurring mental health disorder. Ramon would be transported to the CSU by a referring agency but would walk out of the program without completing stabilization to return to using substances. During a visit to the CSU this year, Ramon was able to engage in services and complete admission, including an evaluation by psychiatrist to begin medication. He also completed a referral and screening through the DBH Screening, Assessment, and Referral Center (SARC) and received a plan for placement in a program providing substance use treatment.

Outreach and Engagement

For Fiscal Year 2021/22, the CSU program conducted the following outreach and engagement activities.

Activity Type	Number of Activities	Total Number of Participants
Presentations to community agencies	235	314
Presentations to DBH or DBH-contracted agencies	32	523
Connections with former clients	27	27
Presentations to healthcare agencies or hospitals	18	48
Law enforcement briefings and presentations	10	373
Contacting potential clients or their collateral supports	84	84
Presentations to schools	10	249
Total	**416**	**1,618**

Program Updates

There are no planned updates for this program.

Collaborative Partners

- Arrowhead Regional Medical Center
- Canyon Ridge Hospital
- Community Hospital of San Bernardino
- Local law enforcement
- Local Room and Board facilities
- Local schools and universities
- Loma Linda University Behavioral Medicine Center
- Path of Life
- Salvation Army
- San Bernardino County, Children and Family Services (CFS)
- San Bernardino County, Department of Aging and Adult Services/Office of the Public Guardian (DAAS/OPG)
- San Bernardino County, Department of Behavioral Health CCRT, clinics, and contract agencies
- San Bernardino County, Probation Department
- San Bernardino County, Sheriff's Department
- Set Free
- St. Bernadine Medical Center

Success Story

"Nancy" came into the CSU with her children and family supports after learning that her husband had died by suicide that morning. She was in need of guidance and support in sharing this news with her children. The CSU team assisted Nancy with how to communicate this tragedy and then remained present to support the family as the conversation with her children unfolded. Nancy and her children were provided with counseling and coping skills along with grief resources.

Crisis Walk-In Center

Program Name	Actual Number Served FY 2021-22	Estimated Number to be Served FY 2023-24	Annual Budgeted Funds FY 2023-24	Estimated Annual Cost per Person FY 2023-24
Crisis Walk-In Center (CWIC)	2,018*	2,567	$13,085,899**	$5,098**

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 O&E.
**Annual budget and cost per client represent both CWIC and CSU.

Program Description and Target Population

The Crisis Walk-In Centers (CWICs) are unlocked, voluntary, 24-hour mental health urgent care centers located in Yucca Valley (Morongo Basin Region) and Victorville (High Desert Region). They offer voluntary mental health urgent care stabilization services for less than 24 hours to individuals experiencing a mental health crisis. Consumers are evaluated by a multidisciplinary team and connected to an appropriate level of care in an effort to avoid unnecessary psychiatric hospitalization.

Services Provided

- 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
- Referral and linkage to culturally and linguistically appropriate services



House of Moorten's – By Louis Buchhold

Consumer Demographics Highlights FY 2021/22

The tables to the right show the demographics in various categories for consumers served at CWICs during Fiscal Year 2021/22. The demographic information is also explained below. The program was able to successfully reach the target population of individuals experiencing a behavioral health crisis in the Morongo Basin and High Desert Regions.

Age:
In Fiscal Year 2021/22, 60% of CWIC consumers were adults between the ages of 26 and 59 years old. Consumers between the ages of 16 and 25 represent 24%, while consumers that are 15 and under and those who are 60 and older represent 8% each.

Gender Identity:
Of the consumers served by CWICs, 50% identified as female and 50% identified as male.

Race and Ethnicity:
CWICs served consumers that identify as Caucasian (43%), having more than one race (19%), Latinx or Hispanic (18%), and African American (17%). Consumers that identify as Asian/Pacific Islander represent 2% and consumers that identify as American Indian or Alaska Native represent 1% of those served.

Primary Language:
The majority of CWIC consumers identified their primary language as English (97%). Spanish was also identified as a primary language for 2% of the consumers served. The remaining 1% either identified a language other than English or Spanish, or this information is unknown.

Primary Diagnosis:
Consumers served at CWICs have been diagnosed with psychosis (28%), depressive disorders (23%), bipolar disorders (18%), anxiety (16%), and other or unknown (10%). CWICs also served consumers that have been diagnosed with substance related disorders (3%), disruptive disorders (1%), and neurodevelopmental or cognitive disorders (1%).

Age	
8% Children	**60%** Adult
24% TAY	**8%** Older Adult

Gender Identity	
50% Female	**50%** Male

Race/Ethnicity	
17% African American/Black	**43%** Caucasian/White
1% American Indian/Alaska Native	**18%** Latinx/Hispanic
2% Asian/Pacific Islander	**19%** Multiple Races/Other

Primary Language	
97% English	**1%** Other/Unknown
2% Spanish	

Primary Diagnosis	
16% Anxiety disorders	**1%** Neurodevelopmental/ cognitive disorders
18% Bipolar disorders	**28%** Psychosis
23% Depressive disorders	**3%** Substance Related
1% Disruptive disorders	**10%** Other

N=2,018

*NOTE: This number is an approximation. Some consumers may not have been counted.

MHSA Legislative Goals and Related Key Outcomes

✓ Reduce the subjective suffering from serious mental illness for adults and serious emotional disorders for children and youth:
- Improved life satisfaction
- Decrease hopelessness/increased hope
- Increased resiliency
- Decreased impairment in general areas of life functioning (e.g., health/
  self-care/housing, occupation/education, legal, managing money, interpersonal/social)

✓ Reduce the frequency of emergency room visits and unnecessary hospitalizations:
- Reduced rate of emergency room visits for mental health concerns
- Increase use of alternative crisis interventions (e.g., CWIC, CCRT, CSU)
- Increase in number of individuals diverted from hospitalization

Positive Results

The CWICs served a combined total of 2,018 consumers in Fiscal Year 2021/22. A total of 3,157 crisis stabilization services were provided to those consumers. Of those 3,157 consumer interactions, 93.3% were successfully diverted from psychiatric hospitalization at the time of receiving services.

The CWICs received a combined total of 1,293 surveys; of those, 94.8% reported a satisfaction rating, capturing consumer responses to questions regarding how they were treated, cultural sensitivity, services offered, linkage to resources, overall setting, and likeliness to recommend to others in need.

Additionally, 8.0% of all referrals to these programs originated from law enforcement, who utilize the CWICs as an alternate destination to psychiatric hospitals or detention facilities when encountering a mental health crisis in the community. Similarly, 3.6% of referrals to these programs originated from local hospitals, representing a population whose crisis was appropriately manageable at the CWIC rather than at the inpatient level of care.

Success Story

"Brian" came to the CWIC experiencing a plethora of mental health issues. He also communicated a long history of trauma that he was trying to manage on his own. He was separated from his children, and he had been homeless for a month. CWIC staff worked with Brian to complete a medication evaluation and to identify housing resources for him. Brian worked closely with CWIC staff to secure placement in a Crisis Residential Treatment (CRT) program, and he was transported to the CRT following discharge. As he left, Brian appeared relieved and excited about obtaining support and stabilization services, and he expressed aspirations to regain custody/visitation of his children.

Challenges and Solutions

Due to continued increased strain on staff due to staffing shortages, in addition to outside agencies paying significantly higher wages, the programs experienced difficulty retaining qualified staff to remain compliant with contract requirements and local/state/federal guidelines. In order to address these hiring challenges, CWICs increased wages for all positions and are working with their recruiting department to incentivize recruitment and fill open positions. Programs flexed staffing in order to staff based on census to mitigate expenses and maintained full staffing only when clients were present.

Program census was also lower than in years preceding the COVID-19 pandemic due to increased intake requirements that necessitated COVID testing for all admitted individuals. To increase census, programs worked with neighboring hospitals in educating those who had the ability to test residents for COVID prior to referral to the CWIC. CWICs also worked with their laboratory partners to accommodate the increased volume of COVID tests that needed rapid processing.

CWICs began testing clients onsite using rapid tests to avoid the need for hospital medical clearance, and lengths of stay were often increased to ensure clients remained safe while placement efforts were underway.

Intake procedures have also been expanded for potential placement programs to which the CWICs refer due to the COVID-19 pandemic. The need for additional screening, COVID-testing, and other infection control efforts led to some delays in consumer linkage and placement.

Outreach and Engagement

For Fiscal Year 2021/22, the CWIC program conducted the following outreach and engagement activities:

Activity Type	Number of Activities	Total Number of Participants
Presentations to community or faith-based organizations	35	133
Fairs or community events	4	425
Presentations to DBH or contracted programs	9	32
Presentations to schools or personnel	27	93
Presentations to other community agencies	23	366
Contact with healthcare agencies	17	26
Brochure distribution around the community	34	34
Totals	**149**	**1,109**

Collaborative Partners

- Arrowhead Regional Medical Center (ARMC)
- Barstow Community Hospital
- Barstow Police Department
- Bear Valley Community Hospital
- Canyon Ridge Hospital
- Chino Valley Medical Center
- Children's Intensive Case Management Services
- Coalition Against Sexual Exploitation (CASE)
- Community Hospital of San Bernardino
- Desert Valley Medical Center
- Family Resource Centers
- Hi-Desert Medical Center
- Loma Linda University Behavioral Medical Center
- Loma Linda University Medical Center (LLUMC)
- Mountains Community Hospital
- National Alliance of Mental Illness (NAMI)
- Needles Desert Community Hospital
- Office of Veterans Affairs
- Private providers (medical and psychiatric)
- Public and private schools
- Red Carnation House
- Redlands Community Hospital
- San Antonio Regional Hospital
- San Bernardino County Children's Network
- San Bernardino County Children and Family Services (CFS)
- San Bernardino County Department of Aging and Adult Services (DAAS)

Collaborative Partners (cont.)

- San Bernardino County Department of Behavioral Health CCRT, One Stop TAY Centers, TEST, clinics, and contract agencies
- San Bernardino County Probation Department
- Can Bernardino County Sheriff's Department
- St. Bernadine Medical Center
- St. Mary Medical Center
- The Counseling Team International
- Victor Valley Global Medical Center
- Yucca Valley Chamber of Commerce

Success Story

"Gwen" was seen at the CWIC multiple times in one month for a mental health issue. During her initial visits, the CWIC team advised her to seek treatment in the nearest Crisis Residential Treatment (CRT) program, but she repeatedly declined these resources, stating she was not ready to accept such intensive mental healthcare. Gwen returned to the CWIC once more, later in the month, stating that she was ready to accept help as her mental health had led her to become homeless. While at the CWIC, Gwen took advantage of all the services available to her, and she was able to be accepted into the CRT. Upon discharge, Gwen stated to staff that she was thankful and very excited to begin her treatment journey in a safe environment with others who shared commonalities with her.

Adult Crisis Residential Treatment

Program Name	Actual Number Served FY 2021-22	Estimated Number to be Served FY 2023-24	Annual Budgeted Funds FY 2023-24	Estimated Annual Cost per Person FY 2023-24
Adult Crisis Residential Treatment	413*	976	$14,111,651**	$14,459**

**This number does not include O&E.
**Annual budget and cost per client 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. The length of stay begins at 30 days initially, with the option of two 30-day extensions. The length of stay is based on medical necessity, and cannot exceed a total of 90 days. Services are for individuals who are experiencing an acute psychiatric episode or behavioral health crisis and are in need of short-term crisis residential treatment services to deter acute psychiatric hospitalization. CRTs consist of a home-like environment that supports and promotes the consumer's recovery, wellness, and resiliency within the community. Services are offered 24-hours a day, 7 days a week, 365 days a year (24/7).

Services Provided

- 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

Success Story

"Caleb" came to a CRT expressing challenges with his mental health and substance use. He had not been taking his psychiatric medications for some time and had been drinking and using substances to self-medicate. During his stay, he was able to use the groups and treatment team to plan his recovery and develop steps that he can take to improve and maintain his mental health. Caleb was able to start back on his medications and understood the importance of being consistent in taking them. He also received education regarding his substance use and the long-term negative effect it would have on his mental health. Caleb was discharged with a follow-up treatment for both mental health and substance use disorder treatment.

Adult Crisis Residential Treatment

Consumer Demographics Highlights FY 2021/22

The tables to the right show the demographics in various categories for consumers served at Adult CRTs during Fiscal Year 2021/22. The demographic information is also explained below. CRT staff were able to successfully reach the target population of adults with a serious mental illness experiencing a behavioral health crisis.

Age:
In Fiscal Year 2021/22, 92% of consumers served by CRTs were adults between the ages of 26 and 59 years old. The Adult CRTs also served consumers between the ages of 16 and 25 (7%) and consumers age 60 and older (1%).

Gender Identity:
Of the 413 consumers served by Adult CRTs, 67% identified as male and 33% identified as female.

Race and Ethnicity:
Consumers served by Adult CRTs identify as Latinx or Hispanic (34%), Caucasian (32%), and African American (28%). Consumers who identify as multiple races represent 3% of those served, while Asian or Pacific Islander represent 2% and American Indian or Alaska Native represent 1% of consumers served.

Primary Language:
Of the consumers served by Adult CRTs, 99% identified English as their primary language, while Spanish represented 1%.

Primary Diagnosis:
Adult CRT consumers have been diagnosed with psychosis (55%), depression (16%), and bipolar disorders (14%). Other consumers were diagnosed with substance related disorders (7%) and anxiety (4%). The remaining consumers either had a different diagnosis (3%) or deferred diagnosis (1%).

Age	
0% Children	**92%** Adult
7% TAY	**1%** Older Adult

Gender Identity	
33% Female	**67%** Male

Race/Ethnicity	
28% African American/Black	**32%** Caucasian/White
1% American Indian/Alaska Native	**34%** Latinx/Hispanic
2% Asian/Pacific Islander	**3%** Multiple Races/Other

Primary Language	
99% English	**1%** Spanish

Primary Diagnosis	
4% Anxiety disorders	**55%** Psychosis
14% Bipolar disorders	**7%** Substance Related
16% Depressive disorders	**3%** Other
1% Deferred diagnosis	

N=413*

*NOTE: This number is an approximation. Some consumers may not have been counted.

Adult Crisis Residential Treatment

MHSA Legislative Goals and Related Key Outcomes

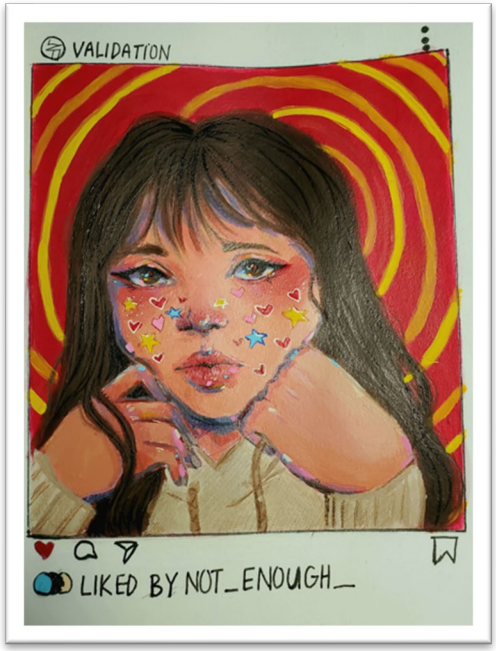
- ✓ Reduce the subjective suffering from serious mental illness for adults and serious emotional disorders for children and youth:
  - Decrease hopelessness/increased hope
  - Increased resiliency
  - Decreased impairment in general areas of life functioning (e.g., health/ self-care/housing, occupation/education, legal, managing money, interpersonal/social)

- ✓ Reduce the frequency of emergency room visits and unnecessary hospitalizations:
  - Reduced rate of emergency room visits for mental health concerns
  - Reduced number of emergency room visits for routine medical concerns
  - Reduced administrative hospital days
  - Increased use of alternative crisis interventions (e.g., CWIC, CCRT, CSU)
  - Increase in number of individuals diverted from hospitalization

Positive Results

413 unique consumers were admitted to the four adult CRT facilities during Fiscal Year 2021/22. Of those, 394 were discharged within the FY. Of consumers who were discharged from the program during FY 2021/22, 94.4% were successfully diverted from psychiatric hospitalization at the time of receiving CRT services.

In FY 2021/22, the four (4) CRTs received referrals from a total of 41 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.



Artwork by Natalie Flores

Adult Crisis Residential Treatment

Challenges and Solutions

In Fiscal Year 2021/22, the COVID-19 pandemic continued to created challenges with admissions and facility requirements. CRTs were required to implement prevention, mitigation, and containment measures which resulted in weekly supply orders to ensure adequate medical equipment to comply with mandates for weekly surveillance and/or COVID testing. This also resulted in additional expenses and strain on staff. Programs experienced difficulty retaining staff to remain compliant with contract requirements and local, state, and/or federal guidelines.

To address the staffing concerns, CRT programs implemented COVID Emergency Plans approved by Community Care Licensing and flexed staffing to have full staff present only when there was the greatest need, which also helped mitigate expenses. To mitigate the concerns with retaining staff, programs increased wages for all positions and focused on incentivizing recruitment to fill open positions and remain compliant with their staffing requirements and guidelines.

During the ongoing pandemic, positive COVID cases necessitated implementation of COVID infection control procedures and plans. This created anxiety and stress for both clients and staff. These cases also impacted census (due to decreased bed capacity because of infection control) to include physical distancing and quarantine procedures.

Programs quickly adapted and implemented all safety procedures. Quarantine areas were created with the use of plastic zip walls, and an area for new admissions in "COVID precaution/quarantine" was created so CRT could continue receiving new admissions.

Challenges and Solutions (cont.)

Increased safety protocols and implementation of the COVID screening and isolation zones set up in the CRTs assisted in mitigating some anxieties, as clients and staff began to see the increased measures being taken to ensure health and welfare as a main priority. Reduced risk of exposure due to these measures enabled both staff and clients to feel more protected while in the program.

Outreach and Engagement

For Fiscal Year 2021/22, the CRT program conducted the following outreach and engagement activities:

Activity Type	Number of Activities	Total Number of Participants
Presentations to community or faith-based organizations	9	25
Meetings with DBH programs/clinics	2	18
Meetings with hospitals and healthcare partners	5	7
Meetings with law enforcement	2	11
School outreach	4	30
Other outreach	13	198
Totals	**35**	**289**

Adult Crisis Residential Treatment

Program Updates

No program updates reported for the upcoming fiscal year.

Collaborative Partners

- Arrowhead Regional Medical Center
- Aurora Charter Oak Hospital
- Canyon Ridge Hospital
- Community Hospital of San Bernardino
- Pacific Grove Hospital
- Redlands Community Hospital
- San Bernardino County, Children and Family Services (CFS)
- San Bernardino County, Department of Aging and Adult Services/Office of the Public Guardian (DAAS/OPG)
- San Bernardino County, Department of Behavioral Health CHOICE, clinics, CSU, CWIC, Helping Hearts, Homeless Services, MAPS, One Stop TAY Centers, RBEST, TEST, TTS, and the STAY
- San Bernardino County, Probation Department
- San Bernardino County, Sheriff's Department
- Other local LPS facilities

Success Story

"Cynthia" was referred to a CRT following a psychiatric hospitalization. Prior to arriving at the CRT, Cynthia struggled with severe mental illness. She had been hospitalized several times prior and lacked social/family support. She told CRT staff she hadn't been able to make progress with outpatient mental health services.

Cynthia was initially guarded and untrusting of staff and peers, struggling to fully participate in daily groups and establish healthy relationships with peers. As she began to work with staff and engage in weekly therapy and daily groups, she became more trusting and forthcoming about her symptoms and began to show great improvements in her ability to utilize coping skills and overall motivation to make progress towards her mental health goals. Eventually, Cynthia became able to interact with staff and peers in a positive and appropriate manner and established several close supports prior to discharging. She was also nominated as Resident President, allowing her to gain increased self-esteem and find purpose in helping others.

Cynthia was discharged and transitioned to a room and board in San Bernardino County with established outpatient services through the county to continue to participate in weekly therapy, psychiatric evaluation, medication management, and case management to continue to manage her mental health needs.

TAY Crisis Residential Treatment

Program Name	Actual Number Served FY 2021-22	Estimated Number to be Served FY 2023-24	Annual Budgeted Funds FY 2023-24	Estimated Annual Cost per Person FY 2023-24
TAY Crisis Residential Treatment	91	100	$14,111,651*	$13,115*

*Annual budget and cost per client 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

The STAY, a specialty CRT for Transitional-Age Youth (TAY), is a short term, voluntary residential treatment center. The STAY accepts consumers ages 18-25 who are experiencing an acute psychiatric episode or crisis. CRTs consist of 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.

Services Provided

- 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

Services Provided (cont.)

- Substance use disorder counseling and referrals
- Recreational therapy
- Educational assistance
- Pre-release and discharge preparation and planning

Success Story

"Rain" (they/them) admitted into the CRT struggling with psychosis, suicidal ideation, and self-harm. Their symptoms were exacerbated by the gender dysphoria that resulted from their inability to access hormonal replacement therapy (HRT). Rain successfully completed the program within approximately 85 days. During that time, CRT staff assisted them with beginning HRT, which helped to affirm their identity and alleviate their symptoms. Upon discharge, they were connected to TAY housing and outpatient services and were able to be placed in housing that aligned with their gender identity.

TAY Crisis Residential Treatment

Consumer Demographics Highlights FY 2021/22

The tables to the right show the demographics in various categories for consumers served at TAY CRTs during Fiscal Year 2021/22. The demographic information is also explained below. CRT staff were able to successfully reach the target population of individuals between the ages of 16 and 25 with a serious mental illness experiencing a behavioral health crisis.

Age:
All consumers served at TAY CRTs were between the ages of 16 and 25 years old.

Gender Identity:
Of the 91 consumers served by TAY CRTs, 57% identified as male and 43% identified as female.

Race and Ethnicity:
The largest group of consumers served by TAY CRTs identify as Latinx or Hispanic (46%). Consumers who identify as Caucasian represent 26% of those served and those who identify as African American represent 22%. The remaining consumers identify as multiple races/other (5%) and American Indian or Alaska Native (1%).

Primary Language:
Of the consumers served by TAY CRTs, 99% identified English as their primary language, while Spanish represented 1%.

Primary Diagnosis:
TAY CRT consumers have been diagnosed with psychosis (48%), bipolar disorders (23%), and depression (17%). TAY CRTs also serve consumers that are diagnosed with anxiety (4%), substance related disorders (2%), and disruptive disorders (1%). The remaining 5% represent those that have a different diagnosis or no diagnosis.

Age
100% TAY

Gender Identity	
43% Female	**57%** Male

Race/Ethnicity	
22% African American/Black	**26%** Caucasian/White
1% American Indian/Alaska Native	**46%** Latinx/Hispanic
	5% Multiple Races/Other

Primary Language	
99% English	**1%** Spanish

Primary Diagnosis	
4% Anxiety disorders	**48%** Psychosis
23% Bipolar disorders	**2%** Substance Related
17% Depressive disorders	**5%** Other/None
1% Disruptive disorders	

N=91

TAY Crisis Residential Treatment

MHSA Legislative Goals and Related Key Outcomes

- ✓ Reduce the frequency of emergency room visits and unnecessary hospitalizations:
  - Reduced number of emergency room visits for routine medical concerns
  - Increased use of alternative crisis interventions (e.g., CWIC, CCRT, CSU)
  - Increase in number of individuals diverted from hospitalization
- ✓ Increase a network of community support services:
  - Increase in number of collaborative partners

Positive Results

During FY 2021/22, 103 unique consumers were admitted to the TAY CRT program. Of those 103 consumers, 96.2% were successfully diverted from psychiatric hospitalization at the time of receiving services.

In FY 2021/22, the TAY CRT received referrals from a total of 32 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 and Solutions

For FY 201/22, the TAY CRT faced staffing challenges, which required the program to find innovative approaches to retaining and hiring staff. Due to an increased strain on staff and competition from outside agencies, the TAY CRT program experienced difficulty retaining the needed staff to remain in compliance with contract requirements and guidelines set forth by local, state, and/or federal agencies. To address those challenges, the program implemented COVID Emergency Plans which were approved by Community Care Licensing and are updated as state/local/licensing mandates shift. In addition, the program flexed staff schedules to mitigate expenses and ensure that staff were present when consumers needed them. To address the concern regarding hiring, the program increased wages for all positions and incentivized recruitment to fill open positions.

Another challenge the TAY CRT program faced was having consumers who came into the program needing to quarantine while still in crisis because they were not tested for COVID prior to placement. Staff addressed this issue by educating neighboring hospitals on testing consumers prior to placement, to ensure that consumers could immediately integrate into the CRT service groups.

TAY Crisis Residential Treatment

Outreach and Engagement

For Fiscal Year 2021/22, the TAY CRT program conducted the following outreach and engagement activities:

Activity Type	Number of Activities	Total Number of Participants
Presentations with DBH programs/contracted programs/clinics	21	107
Presentations to community or faith-based organizations	2	5
Totals	**23**	**112**

Success Story

"Noah" (he/him) admitted into the CRT while experiencing mental illness. He struggled with accessing support systems due to his housing insecurity and previous justice involvement, making it challenging to begin his journey to recovery. Upon discharge from the CRT program, Noah was successfully linked to the DBH Community Supervised Treatment After Release (CSTAR) program, which facilitated access to housing and continued mental health services.

Program Updates

Beginning in Fiscal Year 2022/23, the TAY CRT contract will reflect an increase of $200,000, for a total of $2,800,00 per year, to enable the continuation of services and the competitive recruitment and retention of qualified direct-care staff, in addition to the need to combat the rising cost of program operations.

Collaborative Partners

- Arrowhead Regional Medical Center
- Aspiranet
- Canyon Ridge Hospital
- Cedar House
- Community Hospital of San Bernardino
- Davis Residential Living Room and Board
- SBC-DBH Crisis Stabilization Units and Crisis Walk-in Clinics
- Del Amo Hospital
- Helping Hearts
- Job Corp
- Loma Linda University Behavioral Medicine Center
- Members Assertive Positive Solutions (MAPS)
- Molding Hearts
- Orchid Court
- Premier Program
- San Bernardino County, Public Guardian's Office (PGO)
- San Bernardino County One-Stop TAY Center
- Red Carnation Homeless Program
- True Vines Women's Home

Introduction

Peer Support Programs offer stigma-free, emotional support for consumers living with serious mental illness in recovery. This person-centered, strengths-based approach embraces and incorporates each individual's lived experience into the recovery and support process. Peer Support Programs include Clubhouse and the Community Connections Program.

Clubhouses are peer support centers that are recovery oriented for consumers 18 years or older. There are ten clubhouses located throughout the county that are dedicated to assisting consumers living with a serious mental illness. Clubhouses are primarily consumer-driven and operate with minimal support from department staff. Clubhouse members have significant opportunity for input related to support groups, classes, and activity choices.

The **Community Connections Program**, formerly the Employment Services Program, focuses on connecting consumers ages 16 and over with opportunities such as improving pre-employment skills, volunteering, paid employment and engaging in peer support. Participants partner with Employment Specialists to maximize their existing skills, while also considering their individual wellness goals.

Target Populations

The table below identifies the target population of consumers to be served by the Clubhouse and Community Connections program for the upcoming three fiscal years (Fiscal Year 2023/2024 – 2025/2026).

Peer Support Programs				
Program Name	**Target Population**			
	Children	TAY	Adults	Older Adult
Clubhouse			X	X
Community Connections		X	X	X

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 Years 2023/24 – 2025/26:

Program	Fiscal Year	Service Area	Total Served
Clubhouse and Community Connections	2023/24	• 15,000 GSD • 9,000 O&E	**24,000**
	2024/25	• 20,000 GSD • 13,000 O&E	**33,000**
	2025/26	• 21,000 GSD • 15,000 O&E	**36,000**

*General System Development (GSD) references consumers served in activities related to improving the County's mental health service delivery system for all consumers. Activities may or may not be provided to consumers enrolled in an FSP.
*Outreach and Engagement (O&E) references the number of consumers served while educating the community about the mental health services offered and linking consumers to the appropriate services.

Clubhouse and Community Connections

Program Description

Clubhouses are peer-driven support centers for adults age 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, living with a serious mental illness. There are ten clubhouses located throughout the county that are dedicated to enhancing and supporting recovery. The Clubhouses are located in the cities of Barstow, Fontana, Loma Linda, Lucerne Valley, Morongo Basin, Ontario, Rialto, San Bernardino, Victorville, and Needles.

The main objectives of the Clubhouse Program are to assist members in making their own choices, providing peer support, and connecting 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-incorporating daily living skills for individuals recently housed.

Clubhouses are operated by the members through peer elected governing boards. In an effort to increase overall functioning and community reintegration, members meet regularly and are encouraged to provide input to program and activity choices.

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

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
18+	BHC*	Facility-based 	Seeking recovery-based support services

*BHC = Behavioral Health Challenges.

Program Description (cont.)

The Community Connections Program, formerly Employment Services, focuses on providing consumers with the opportunity to develop and improve pre-employment skills. The program also assists with coordinating opportunities 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 Employment Specialists 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.

Participants are consumers 16 and older from all entry points of the system who have a desire to explore community connections. Referrals can come from any DBH program, other social service programs, community, and self-referrals.

Services Provided

Services provided through the **Clubhouse 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

Services provided through **Community Connections** include:

- Intensive case management
- Education
- Career assessment
- Employment counseling
- Job development and coaching

Outreach and Engagement

In Fiscal Year 2021/2022, the Clubhouse and Community Connections program organized and/or participated in the following outreach and engagement activities:

Activity Type	Number of Activities	Total Number of Participants
Crisis Intervention Training	12	900
Cultural Celebrations	24	1,200
Behavioral Health Wellness Triathlon	3	350
Community Food Distribution	6	3,200
Unhoused Outreach	12	3,200
Clubhouse Media Outreach	3	436
Consumer Evaluation Council (CEC)	24	240
Peer Certification Stakeholder Process	24	427
Total	**108**	**9,953**

Consumer Demographics Highlights FY 2021/22

The tables to the right show the demographics in various categories for the Clubhouse and Community Connections program for Fiscal Year 2021/22. The demographic information is also explained below. The program was able to successfully reach the target population of adult consumers living with a serious mental illness and seeking recovery-based support services.

Age:
While the Clubhouse and Community Connections services are available to consumers ages 16 and over, the data collected shows 100% are adults between the ages of 26 and 59.

Gender Identity:
Of the 15,769 members served by the Clubhouse and Community Connections program, 53% identified as male and 42% identified as female. The remaining 5% was undisclosed.

Race and Ethnicity:
The largest group of members identify as Latinx/Hispanic at 36%. The second largest category was Caucasian at 33%. African American individuals accounts for 19% of members. Following that, 6% identify as Asian/Pacific Islander, 4% as American Indian or Alaska Native, and 2% reported multiple races or other.

Geographic Region:
The majority of Clubhouse and Community Connections members live in the Desert and Mountain regions of San Bernardino County. This group accounts for 44% of members served. The second largest group of members live in the West Valley region (24%), followed by the Central Valley region (18%) and the East Valley region (14%).

Primary Diagnosis:
Information regarding primary diagnosis is not collected for the Clubhouse and Community Connections program, as the program does not focus on treatment services.

Age
100% Adult

Gender Identity	
42% Female	**53%** Male

Race/Ethnicity	
19% African American/Black	**36%** Latinx/Hispanic
6% Asian/Pacific Islander	**4%** Native American
33% Caucasian/White	**2%** Other/Unknown

Region	
18% Central Valley	**14%** East Valley
44% Desert/Mountain	**24%** West Valley

Primary Diagnosis
Data Not Collected

N=15,769

*NOTE: This number is an approximation. Some consumers may not have been counted.

MHSA Legislative Goals and Related Key Outcomes

✓ Reduce the subjective suffering from serious mental illness for adults:
- Improve life satisfaction
- Decrease feelings of hopelessness
- Increase resiliency
- Decrease impairment in general areas of life functioning

✓ Increase in self-help and consumer/family involvement:
- Increase number of new participants in Clubhouses
- Increase in program attendance and frequency per consumer
- Increase in self-help/support/12 step group attendance and frequency per consumer

Positive Results

During FY 2022/23, 90% of clubhouses have returned to and surpassed pre-pandemic service delivery. Clubhouses added weekly supports from alcohol and drug counselors at all county-run locations. Clubhouses continued to organize social events, such as cultural celebrations throughout the year and the Behavioral Health Wellness Triathlon.

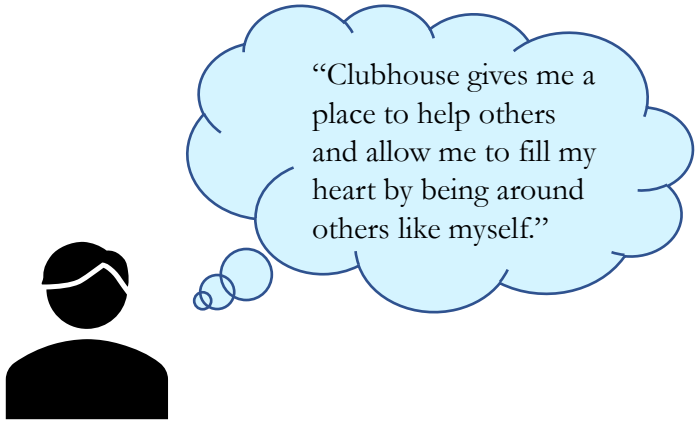
Clubhouses continued outreach and engagement efforts throughout the county. One area of focus was on the unhoused population. During FY 2021/22, there were approximately 3,200 participants in unhoused outreach. As a result, Clubhouses saw an increase in the amount of services provided to unhoused members, such as the use of laundry facilities, showers, and access to food. There was an average of over 180 unduplicated individuals served per month representing over 800 service deliveries per month.

Positive Results (cont.)

Clubhouse and Community Connections launched the first consumer created outcomes metrics tool in FY 2021/22. Titled "Consumer Empowerment Evaluation", this outcomes tool was created in partnership with the Consumer Evaluation Council (CEC) and Research and Evaluation (R&E). After researching validating tools, the CEC combined elements of a variety of evaluation measures and adapted wording to be focused on recovery model, peer-led, and strengths-based outcome metrics.

All metrics are self-reported in order to preserve the integrity of measuring subjective suffering. Early results of the first round of implementation included:

- **96%** felt they could talk openly while in group at clubhouse
- **99%** have someone they can trust to give good advice in a crisis at least some of the time
- **86%** reported being able to understand themselves better
- **85%** reported that they were satisfied with themselves
- **98%** believe it is possible to change
- **97%** reported being hopeful about their future
- **84%** were able to develop positive relationships with other people



Program Challenges

The Clubhouse Expansion program, now referred to as Clubhouse and Community Connections, was intended to address the increasing attendance and need for additional space. One challenge has been the economic and environmental climate. Continued supply chain delays and inflation costs resulted in two planned relocations (Barstow and San Bernardino) not being completed. The Needles Clubhouse was unable to open a physical location for services. Services for this location are now being offered via telehealth.

Another challenge is the substantial increase in consumers joining the Clubhouses who were self-medicating or disconnected from services as a result of the pandemic. This led to an increase in the need for linkage to services.

Program Solutions

To address these challenges, Facilities and Project Management are currently re-engaging in negotiations and planning for both relocations. A third identified expansion for the Victorville location has also entered into the beginning stages of planning. These projects will result in adding space as well as much needed regional resources, such as showers and laundry to the High Desert Clubhouses. Needles Clubhouse staff continue to offer virtual services as well as monthly food distribution. In the coming fiscal year, all parties involved will be working towards a resolution that will allow for a physical space to open for daily in-person services.

Clubhouses engaged with both RBEST and InnROADs outreach teams to provide on site support to consumers in need. Local partnerships were also made with teams such as the Fontana Community Outreach and Support Team (COAST) to support local efforts. Clubhouses also partnered with SUDRS to have weekly support from Alcohol and Drug Counselors. In future years, Clubhouses will continue to move towards fulfillment of the commitment of full-time alcohol and drug counselors as county staffing levels rebound.

Program Updates

Clubhouse and Community Connections continues to work to expand the physical locations of clubhouses in an effort to serve more community members. The program also expects an increase in staffing opportunities. Senate Bill (SB) 803 recognizes Peer Support Specialists as a provider type that can render Medi-Cal billable services.

In an effort to share information about this opportunity and obtain community feedback, a series of stakeholder engagement meetings were held throughout the county. Meetings were held at all Clubhouse locations and at a number of community meetings, including the Community Policy Advisory Committee (CPAC) and the Behavioral Health Commission District Advisory Committees (DAC). Stakeholder Surveys were used to collect feedback about where peer providers would be useful and how programs can be developed to include them.

DBH is assisting existing peer providers, both DBH staff and contract providers, with the certification process. Programs are also being evaluated to determine where additional peer support staff could be utilized, which would increase the availability of this valuable service. During the next three fiscal years, (FY2023/24-2025/26), there will be no change in program funding, however, more of the existing funding will be used to help build the Peer and Family Advocate workforce. For more information on the development of the peer workforce, please reference the **Workforce Education and Training** section of this plan.

Program Name	Actual Number Served FY 2021-22	Estimated Number Served FY 2023-24	Annual Budgeted Funds FY 2023-24	Estimated Annual Cost per Person FY 2023-24
Clubhouse and Community Connections	15,769*	15,000*	$4,962,549	$331

**This number does not include O&E.

Collaborative Partners

Community Partners:

- California State University San Bernardino
- Community Action Partnership of San Bernardino
- Fontana Senior Center
- Frazee Community Center
- High Desert Outreach Center
- Hillside Community Church
- Inland Valley HOPE Partners Food Pantry
- Inland Valley Regional Services
- Loma Linda University Behavioral Medicine Center
- Morongo Band of Mission Indians
- San Juan Capistrano Mission
- San Manuel Casino
- The ROCK Church and World Outreach Center
- Victor Valley College

San Bernardino County Departments:

- Aging and Adult Services
- Patients' Rights
- Probation
- Public Health
- Sheriff's Department
- Transitional Assistance Department
- Veterans Affairs

City Departments:

- City of Fontana
- Fontana Police Department
- City of Rialto
- Ontario Police Department

Collaborative Partners (cont.)

Providers and Other Supports:

- Alcoholics Anonymous
- American Red Cross
- California Association of Mental Health Peer Run Organizations (CAMHPRO)
- Goodwill Industries, Inc.
- Legal Aid Society
- Mental Health Systems, Inc.
- National Alliance on Mental Illness (NAMI) Narcotics Anonymous
- NorCal Mental Health America (MHA) Mental Health America
- OmniTrans
- Pacific Clinics
- Reach Out.com
- Recovery International
- Rimrock Villa Convalescent Hospital
- San Bernardino Room and Board Coalition
- South Coast Community Services
- SOVA Community Food and Resource Program
- Sprout's Farmer's Markets, Inc.
- Stater Brothers
- The Salvation Army
- Trader Joe's
- United Way
- Victor Community Support Services
- Volunteers of America

CSS: Outreach, Access, and Engagement Programs

Introduction

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

The Outreach, Access, and Engagement programs include the:

- **Access, Coordination, and Enhancement (ACE) of Quality Behavioral Health Services.** The ACE program provides psychiatric evaluations between 7 days of a hospital discharge and within fourteen days of a walk-in clinic requests.
- **Recovery Based Support Teams (RBEST).** The RBEST program is a voluntary, client-centered program, which provides community (field-based) services to individuals with untreated mental illness in an effort to activate them into appropriate treatment.

Target Populations

The table below identifies the target population of consumers to be served by Outreach, Access and Engagement programs for the upcoming three fiscal years (Fiscal Year 2023/2024 – 2025/2026).

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	

Number of Consumers to be Served

The table below indicates the number of individuals projected to be served by ACE and RBEST over the upcoming three fiscal years (Fiscal Year 2023/24 - 2025/26). Also represented are the projected numbers to be served in each service category. MHSA service categories are: Full Service Partnership (FSP), General System Development (GSD), and Outreach and Engagement (O&E).

Program Name	Fiscal Year	Service Area	Total Served
Access, Coordination, and Enhancement (ACE) of Quality Behavioral Health Services	2023/24	• 36 FSP • 2,486 GSD • 460 O&E	**2,982**
	2024/25	• 36 FSP • 2,566 GSD • 670 O&E	**3,272**
	2025/26	• 36 FSP • 2,646 GSD • 880 O&E	**3,562**
Recovery Based Engagement Support Teams (RBEST) • Connecting Families	2023/24	• 250 GSD • 700 O&E	**950**
	2024/25	• 275 GSD • 700 O&E	**975**
	2025/26	• 300 GSD • 700 O&E	**1,000**

*General System Development (GSD) references consumers served in activities related to improving the County's mental health service delivery system for all consumers. Activities may or may not be provided to consumers enrolled in an FSP.
*Outreach and Engagement (O&E) references the number of consumers served while educating the community about the mental health services offered and linking consumers to the appropriate services.

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

Program Description and Target Population

The Access, Coordination, and Enhancement (ACE) for Quality Behavioral Health Services programs seeks to improve the timeliness of access to the Department of Behavioral Health (DBH) outpatient services. The ACE program was implemented at the four large regional outpatient clinics (Phoenix in San Bernardino, Mariposa in Ontario, Mesa in Rialto, and Victor Valley in Victorville) and in the two rural outpatient clinics (Barstow and Needles).

The ACE program enhanced the outpatient care system to ensure that consumers receive the right services to meet their needs. ACE program staff perform initial screenings, intake assessments, and evaluate the best level of care for the consumer. ACE provides evaluations within 7 days of a hospital discharge and within 14 days of walk-in clinic requests. The goal is to provide rapid access to mental health services, and to provide consumers, who have been discharged from a psychiatric hospital or walk-in clinic, with a referral to a regional outpatient clinic where a follow up appointment can be scheduled as soon as possible.

Services provided through the ACE program include:

- Mental health assessments
- Psychiatric evaluations
- Substance Use Disorder (SUD) screenings
- Referrals and linkage to Full Service Partnership (FSP), Crisis Stabilization Unit (CSU) or Crisis Residential Treatment (CRT)
- Access to appropriate services

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

*SMI = severe mental illness

The ACE program operates at each clinic from 8:00 a.m. to 5:00 p.m. Monday through Friday. Individual consumers and families seeking mental health treatment can access services either by walking in without a scheduled appointment or by calling the clinic to request an initial assessment appointment. The DBH Access Unit, Managed Care organizations (Inland Empire Health Plan and Molina Healthcare), and psychiatric hospital discharge staff can also refer consumers for treatment at the clinics.

Consumers seeking services are provided with an initial crisis screening by a clinical therapist. Consumers in crisis are immediately evaluated to determine the most appropriate path for the consumer. All other individuals receive a mental health assessment or may be scheduled for a more convenient time for the consumer to return for their assessment. When appropriate, the clinical therapist will consult with the psychiatrist regarding the need for psychiatric evaluation and medication assessment. Treatment is based on the consumer's symptoms and their ability to function in the community.

Program Description and Target Population (cont.)

The ACE program includes case managers that can help make connections to:

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

ACE program staff serve as a resource for consumers, assisting consumers to access the necessary medical care that directly impacts mental health and daily functioning in a timely and efficient manner. Staff link consumers to medical care, improve consumer access and communication with pharmacy services, and provide necessary education and access to reduce crisis situations and inpatient hospitalization. ACE staff focus their efforts on providing ongoing care, thus improving the overall care at each clinic.

Below is an estimate of how the program expects to perform during the next fiscal year and the associated cost:

Program Name	Actual Number Served FY 2021-22	Estimated Number to be Served FY 2023-24	Annual Budgeted Funds FY 2023-24	Estimated Annual Cost per Person FY 2023-24
ACE	2,586*	2,982	$3,515,917	$1,179

*NOTE: This number is an approximation. Some consumers may not have been counted.

Outreach and Engagement

In Fiscal Year 2021/2022, the ACE program organized and/or participated in the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Barstow Community Health Fair	1	200
Barstow College Presentation	1	100
Barstow High School Presentation	1	250
Recovery Happens	1	400
Total	**4**	**950**

Over the past three fiscal years (2018/19 – 2020/21), outreach and engagement activities for ACE have more than doubled. A large contributing factor to this is the Recovery Happens Event, which was not previously being captured as outreach and engagement data. The ACE program, like many other DBH programs, expects outreach efforts to continue to increase in the post-pandemic environment.

Consumer Demographics Highlights FY 2021/22

The tables to the right show the demographics in various categories for the ACE program for Fiscal Year 2021/22. The demographic information is also explained below. The ACE program was able to successfully reach the target population of consumers experiencing a behavioral health crisis throughout San Bernardino County.

Age:
In Fiscal Year 2021/22, 64% of consumers served by the ACE program were adults between the ages of 26 and 59 years old. Of the remaining consumers, 16% were between the ages of 16 and 25, 10% age 60 and older, and 10% age 15 and under.

Gender Identity:
Of the consumers served by the ACE program, 62% identified as male and 38% identified as female.

Race and Ethnicity:
The largest group of consumers served by the ACE program identify as Caucasian (43%). The second largest group was consumers who identify as Latinx or Hispanic (37%), followed by 15% African American. Consumers who identify as Asian or Pacific Islander and as Native American represent 1% each, while 3% is unknown.

Primary Language:
Of the consumers served by ACE, 95% identified English as their primary language. Spanish represented 4%, while Chinese dialect, which includes Mandarin and Cantonese, was less than 1% of consumers.

Primary Diagnosis:
ACE consumers have been diagnosed with depression (30%), psychosis (22%), bipolar disorder (21%), and anxiety (11%). Other consumers have a primary diagnosis of substance related disorders (6%), neurodevelopmental or cognitive disorders (5%), or other diagnosis not listed above (4%). The remaining consumers have been diagnosed with disruptive disorders (less than 1%) or deferred diagnosis (less than 1%).

Age	
10% Children	**64%** Adult
16% TAY	**10%** Older Adult

Gender Identity	
38% Female	**62%** Male

Race/Ethnicity	
15% African American/Black	**37%** Latinx/Hispanic
1% Asian/Pacific Islander	**1%** Native American
43% Caucasian/White	**3%** Other/Unknown

Primary Language	
<1% Chinese Dialect	**4%** Spanish
95% English	**<1%** Other/Unknown

Primary Diagnosis	
11% Anxiety	**5%** Neurodevelopmental/ neurocognitive
21% Bipolar	
30% Depression	**22%** Psychosis
<1% Deferred Diagnosis	**6%** Substance related
<1% Disruptive	**4%** Other

N=1,208

*NOTE: This number is an approximation. Some consumers may not have been counted.

MHSA Legislative Goals and Related Key Outcomes

✓ Reduce the frequency of emergency room visits and unnecessary hospitalizations:
- Increase access to and use of existing community resources
- Reduce number of emergency room visits for mental health concerns
- Increase use of alternative crisis interventions (e.g., CWIC, CCRT, CSU)
- Increase in number of individuals diverted from hospitalizations

✓ Provide capacity in response to the demand for care:
- Decrease the wait time from hospital discharge to first therapy appointment
- Provide shorter waiting times and shorter times between appointments
- Decrease the time from the first service to necessary/needed medication services

✓ Provide scheduled or non-scheduled appointments from inpatient referrals:
- Decrease the wait time from hospital discharge to first outpatient service

Positive Results

The ACE program was successful in linking hospital discharges with appointments during Fiscal Year 2021/22, as shown below:

1,731 Referrals from Acute Psychiatric Hospitals	
1,323 (76%)	Scheduled appointments within **7 days** of discharge
408 (24%)	Scheduled appointments within **14 days** of discharge

The ACE program staff utilized direct communication between the hospital and clinic to ensure that individuals released from the hospital are given rapid access to assessment. When a client is released from the hospital, an intake appointment is reserved within a week. Clients are assessed by a therapist at intake and may continue therapy and have access to an appointment with a psychiatrist within 14 days.

During Fiscal Year 2021/22, the ACE program also experienced an increase in staff. Increasing skilled crisis staffing has allowed diversion from hospitalization and increased access to community resources. Additionally, the ACE program observed an increase in use of Crisis Stabilization Units and after-hours crisis lines, also contributing to diversion from hospitalization.

Success Story

"Suzy" was referred to ACE from a Crisis Stabilization Unit. She was relocated to a shelter in the area under a housing voucher since she had no income. She was enrolled in the Barstow Full Service Partnership program. The case manager was able to link her to a current source of income. She was placed on Section 8 for housing. She received therapy and medication services at our clinic. Recently she has moved to a Section 8 apartment. Her mental health symptoms are stable. She continued to attend individual therapy, group therapy, and her medication appointments regularly. She is considering getting a job and going back to school. She is being reunited with her child.

Program Challenges

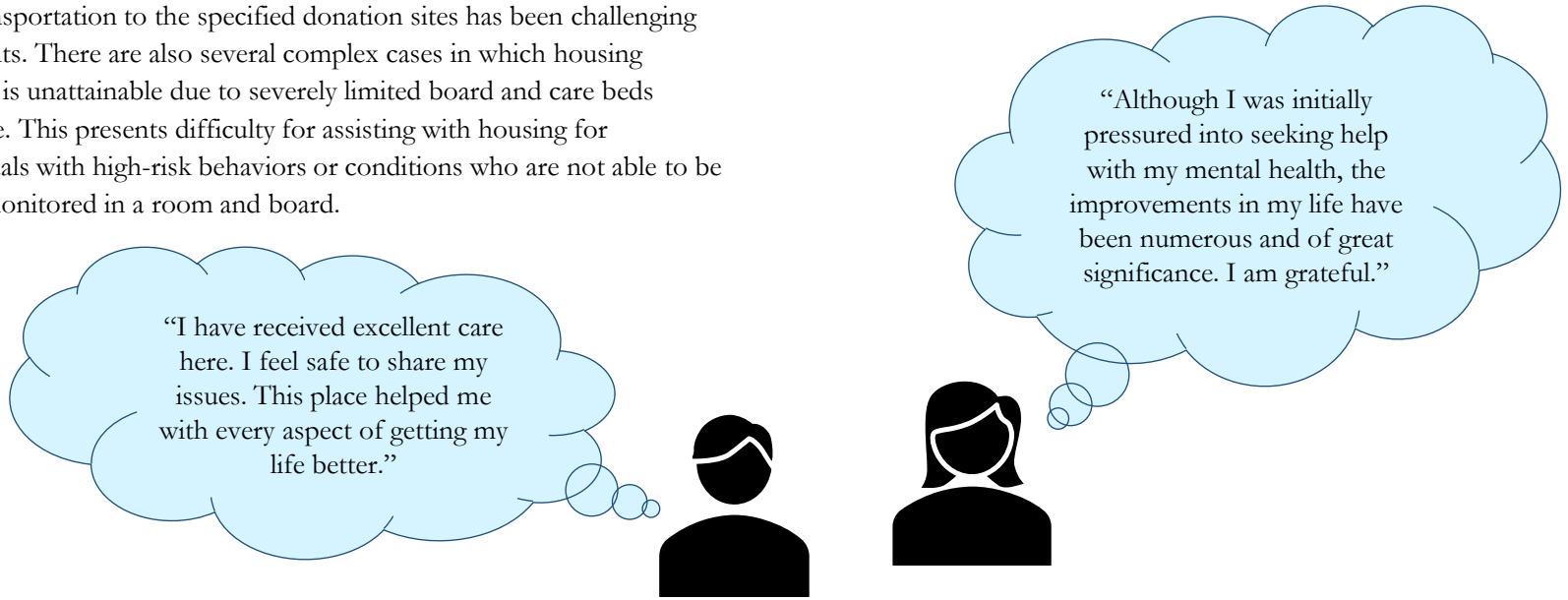
The pandemic necessitated changes in practice at the clinics and within the program. One of these changes was providing virtual services, rather than face-to-face services. As clinics work to return to face-to-face services, one challenge is that clients have become accustomed to, and in some cases prefer, telehealth services. While providing services via telehealth has its advantages, it can also be beneficial to interact in person. The ACE program continues to work to find balance and meet clients' preferences, while ensuring services are delivered effectively and efficiently.

Another challenge that the ACE program faces when assisting clients to attain stability in housing and reduce psychiatric hospitalizations is the current lack of resources available. For example, food bank availability and transportation to the specified donation sites has been challenging for clients. There are also several complex cases in which housing stability is unattainable due to severely limited board and care beds available. This presents difficulty for assisting with housing for individuals with high-risk behaviors or conditions who are not able to be safely monitored in a room and board.

Program Solutions

The use of personal protective devices, social distancing, and other safety precautions are utilized in all DBH clinics. To motivate clients to return to clinics for services, there has been an increase in outdoor activities so that clients can participate and engage with each other in a safe environment. Programs are also offering new groups and incentives, such as providing transportation, coffee, and snacks, for active participation.

To address the lack of available resources, one adjustment that the ACE program was able to make was scheduling services around food bank availability. This allowed program staff to provide clients with transportation to food bank sites so that they could get their needs met. The program continues to seek additional qualified staff to further support the community's needs.



Collaborative Partners

Healthcare Organizations and Treatment Centers:

- Arrowhead Regional Medical Center (ARMC) – Behavioral Health Unit
- Canyon Ridge Hospital
- Cedar House Life Changing Center
- Colorado River Medical Center
- Community Hospital of San Bernardino
- Desert Manna
- Gibson House
- Inland Empire Health Plan (IEHP)
- Inland Valley Recovery Services
- Kaiser Permanente
- Loma Linda University Behavioral Medical Center
- Molina Healthcare
- Redlands Community Hospital
- San Antonio Community Hospital

Government Partners:

- California Department of Motor Vehicles (DMV)
- Needles Unified School District
- Rialto Fire Department
- Rialto Police Department
- San Bernardino County, Probation
- San Bernardino County, Sheriff's Department
- San Bernardino County, Transitional Assistance Department (TAD)
- Social Security Administration
- U.S. Department of Veterans Affairs-Veterans Administration (VA)

Community Partners:

- Association of Community Based Organizations (ACBO)
- Chemehuevi Indian Tribe
- Fort Mohave Indian Tribe
- Helping Hearts
- Lutheran Social Services
- Needles Mental Health Services (MHS) Center for Change
- St. Vincent de Paul Church
- Westcare Arizona



Recovery Based Engagement Support Teams (RBEST)

Program Description and Target Population

Recovery Based Engagement Support Teams (RBEST) is a voluntary, consumer-centered program providing community (field-based) services to individuals living with untreated or inappropriately treated mental illness. The program is "non-clinical" in its orientation with a primary focus on meeting the needs and supporting the goals of the consumer and helping them eliminate obstacles to recovery.

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

Connecting Families is an expansion project under the RBEST program. The Connecting Families component is an educational/support group for families and caretakers of individuals living with a severe and persistent mental illness. The goal is to increase awareness and knowledge base among family members and caretakers about issues relating to mental illness while providing a safe space for sharing and peer support.

Program Name	Actual Number Served FY 2021-22	Estimated Number Served FY 2023-24	Annual Budgeted Funds FY 2023-24	Estimated Annual Cost per Person FY 2023-24
RBEST	164	250	$3,100,449	$12,401

*Annual Budget total includes increase in funding for the RBEST AOT expansion, but the number of consumers to be served by RBEST AOT is TBD with future community planning.

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

Services provided by the RBEST program include:

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

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

- Not active or successful in seeking and receiving necessary psychiatric care.
- The "invisible" client who is being cared for by family members and not linked or known to the public mental health system.
- Resistant to traditional engagement strategies due to a neurological condition (i.e. anosognosia) which disallows insight into their own behavioral health condition.
- Unable to navigate the behavioral health system of care to obtain appropriate treatment.

Consumer Demographics for FY 2021/22

The tables to the right show the demographics in various categories for the RBEST program for Fiscal Year 2021/22. The demographic information is also explained below. The RBEST program was able to successfully reach the target population of adults living with untreated or inappropriately treated mental illness.

Age:
Of the 164 consumers served by RBEST, 78% were adults between the ages of 26 and 59 years old. Older adults, age 60 and over, accounted for 13% of consumers served, while consumers between the ages of 16 and 25 accounted for 9% of the population served.

Gender Identity:
Of the consumers that were served by the RBEST program, 56% identified as male and 44% identified as female.

Race and Ethnicity:
The largest group of consumers served by the RBEST program identify as Latinx or Hispanic, which represents 46%. The second largest group was consumers who identify as Caucasian (29%), followed by 18% African American. Consumers who identify as Asian or Pacific Islander represent 5% of RBEST consumers, and 2% is unknown.

Primary Language:
Of the consumers that were served by the RBEST program, 96% identified English as their primary language and 4% identified Spanish.

Primary Diagnosis:
RBEST consumers have been diagnosed with psychosis (46%), depression (12%), bipolar disorder (8%), substance related disorders (4%), and anxiety (2%). The remaining 28% of consumers have a primary diagnosis other than those listed above.

Age	
0% Children	**78%** Adult
9% TAY	**13%** Older Adult

Gender Identity	
44% Female	**56%** Male

Race/Ethnicity	
18% African American/Black	**46%** Latinx/Hispanic
5% Asian/Pacific Islander	**2%** Other/Unknown
29% Caucasian/White	

Primary Language	
96% English	**4%** Spanish

Primary Diagnosis	
2% Anxiety	**46%** Psychosis
8% Bipolar	**4%** Substance related
12% Depression	**28%** Other

N=164

MHSA Legislative Goals and Related Key Outcomes

- ✓ Reduce the frequency of emergency room visits and unnecessary hospitalizations:
  - Reduce number of emergency room visits for mental health concerns.
  - Reduce administrative hospital days.
  - Increase use of alternative crisis interventions (e.g. CWIC, CCRT, CSU).

Success Story

"Edna" (she/her) is a 53-year-old Hispanic female who was referred to RBEST by an acute psychiatric hospital, following recent hospitalization. She was unable to leave her home due to anxiety and overwhelming thoughts, and she was suffering from medical conditions which she was not taking medication for. RBEST staff engaged Edna throughout one year. By the time she was successfully discharged from the program, Edna was attending Clubhouses, attending Primary Care Physical appointments to address her medical concerns, actively taking medications, and attending mental health services appointments. Edna was also connected with General Relief to assist in her daily living. RBEST also worked with Edna to improve her interaction with family members. She has stated, "Thanks to you, I am no longer scared. I'm ready to let go now, and I slept for the first time in over a year."

Positive Results

The RBEST program used a three-tier analysis conducted by Research and Evaluation to evaluate engagement efforts. The analysis examined the 30 days post-RBEST engagement in comparison to the 30 days before RBEST engagement. The analysis results for 65 RBEST consumers showed:

- 40% decrease in psychiatric hospital bed days
- 25% decrease in psychiatric hospital admissions
- 310% increase in routine outpatient services, including individual therapy, medication services, rehabilitation, activities of daily living, and residential services.

Challenges and Solutions

One challenge that the RBEST program experienced was meeting timely access requirements for psychiatric care due to staffing shortages and the limited amount of psychiatrist time at the various clinics. The RBEST program was also challenged with limited resource availability, particularly with appropriate housing options. The program experienced difficulty in obtaining access to Crisis Response Treatment facilities. RBEST is an engagement program and seeks to begin this process as soon as possible. However, RBEST had difficulty in accessing entry into psychiatric hospitals during client stabilization in an effort to engage while in the hospital.

RBEST staff continually work to foster relationships with community partners in which to provide effective and appropriate timely linkage. Staff have been working to provide presentations, education, and training in an effort to make appropriate connections and establish working relationships and procedures.

Outreach and Engagement

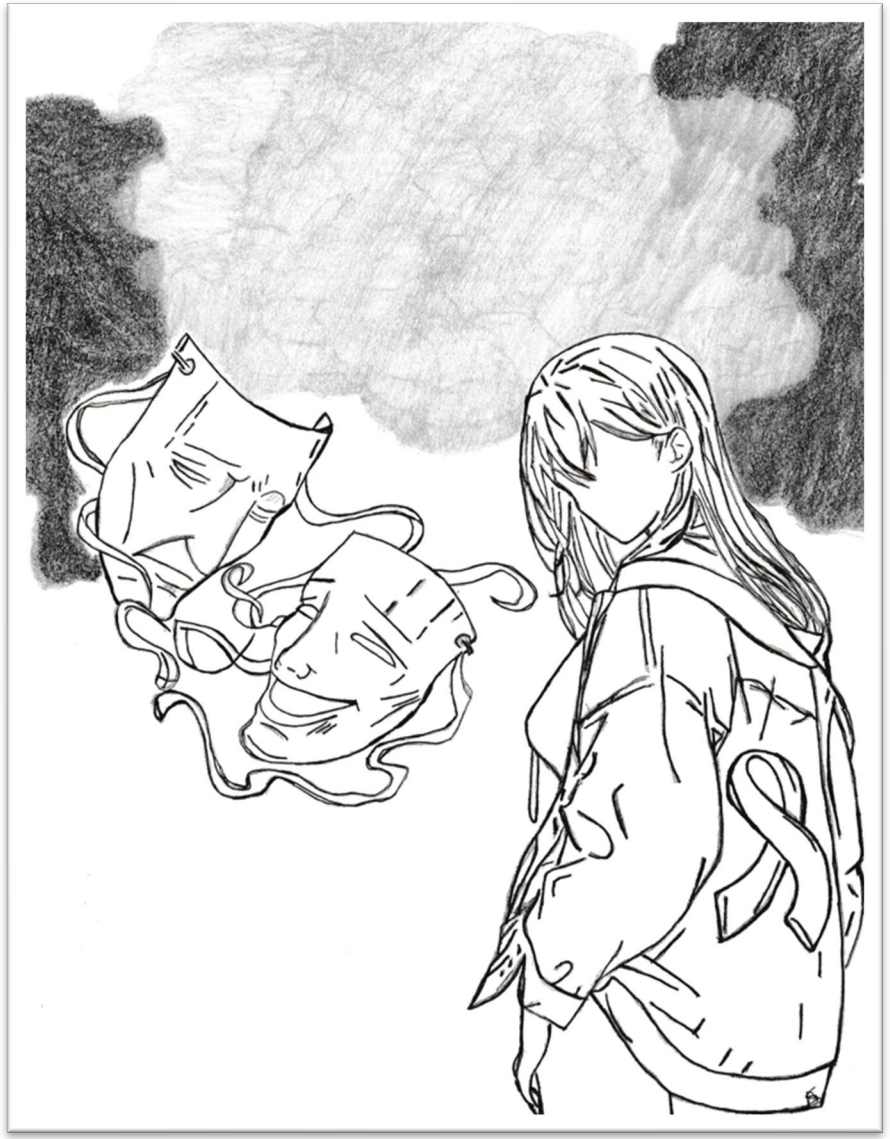
In Fiscal Year 2021/2022, the RBEST program organized and/or participated in the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Crisis Intervention Training (40 hours)	5	185
Connecting Families Groups	30	438
Outreach Presentations	7	105
LEAP Training	1	15
Total	**43**	**743**

The Connecting Families groups continue to be a significant way to reach and engage with the target population to provide valuable resources. The Crisis Intervention Trainings are also useful in educating partners and increasing the resources available to the community.

Success Story

"Chen" (they/them) is a 29-year-old with chronic depression, anxiety, and inability to concentrate who had struggled with suicidal thoughts. They were referred to RBEST by their family member who wanted to assist with improving their quality of life. RBEST worked with Chen to obtain a 30-day substance use treatment program and mental health services. Once completed, RBEST assisted them to obtain employment, which they are still able to maintain. Recently, Chen sent the RBEST staff a card with a copy of their first paycheck, which stated: "Thank you for all your help! Thank you for treating me like a normal person. Thank you for making a positive impact in my life."



Artwork by Dani Sablan

Program Updates

The RBEST program consistently meets performance outcomes for decreasing psychiatric hospital admissions and increasing routine outpatient and medication services. Since program inception, RBEST has seen 70% more referrals annually than originally anticipated and planned for. Additionally, RBEST anticipates increased referrals as a result of the County's implementation of CARE court and Assisted Outpatient Treatment legislation, in an attempt to engage consumers voluntarily into the behavioral health system prior to involuntary commitment to the court system.

To address the growing need for RBEST services, and to account for new legislative changes, RBEST is planning multiple program expansions which include:

- Developing regionalized teams in the Valley Region and High Desert Region, which will require increased staffing specialized to those areas.
- Increasing staff to help manage the growth in administrative data collection and reporting due to legislative requirements.
- Creating a team designed to assist consumers while they are in the hospital emergency departments. This allows for engagement early, while stabilized in the hospital. This will reduce the burden on hospital emergency departments as well as reduce recidivism to psychiatric hospitalization.
- Creating an Assisted Outpatient Treatment (AOT) program as allowed under Laura's Law (AB 1421). AOT is court-ordered outpatient treatment for individuals who have a history of untreated mental illness and meet criteria as stipulated in WIC 5345-5349.5.

Program Updates (cont.)

The program is intended to interrupt the cycle of hospitalization, incarceration and homelessness for adults ages 18 and older who are living with serious mental illness and have been unable and/or unwilling to participate in mental health services on a voluntary basis.

The RBEST AOT program will:

- Provide Assertive Community Treatment Model Full Service Partnership (FSP) services to consumers meeting criteria after they have been referred by the RBEST Engagement team.
- Offer services that include intensive treatment, case management and rehabilitation services, that are provided in the field by a multidisciplinary team. Staffing will include a 1:10 ratio.
- Utilize a "whatever it takes" approach to providing services focused on building therapeutic relationships that facilitate trust, linkage to services and, ultimately, treatment adherence.

These changes are expected to result in an increase in the likelihood of contact with the consumer, immediate connection and rapport building, and quicker connection to follow up outpatient services and linkage in an effort to reduce recidivism. Incorporating RBEST into the FSP program will also increase the resources available to better serve the community and allow RBEST staff to divert individuals from involuntary commitment, by engaging them early and linking them to outpatient services and supports.

Future Integrated Plans and Annual Updates will report the RBEST program in the Full Service Partnership section and reflect appropriate data for FSPs.

Introduction

Full Service Partnership (FSP) programs provide intensive case management for consumers living with serious mental illness (SMI) or severe emotional disturbance (SED). The full-service partnership framework is based on a "no fail" philosophy and does "whatever it takes" to meet the needs of consumers. This includes providing strong connections to community resources to our consumers, and when appropriate, their families and supports, as well as 24 hours per day, 7 days per week (24/7) field-based services.

The primary goals of FSP programs are to improve quality of life by implementing practices which consistently promote good outcomes for the consumer. These outcomes include reducing the subjective suffering associated with mental illness, increasing safe and permanent housing, reducing out of home placement for children and youth, avoiding criminal or juvenile justice involvement, and high frequency use of psychiatric hospitalizations or emergency and crisis services.

FSP programs strive to provide stabilizing services for the consumer at the lowest level of care allowing for maximum flexibility to support wellness, resilience, and recovery.



Artwork by Caitlin De Marteau

CSS: Full Service Partnerships

Number of Consumers to be Served

The table below demonstrates the number of consumers to be served by program name, ages served and service areas for Fiscal Year (FY) 2023/24, FY 2024/25 and FY 2025/26:

Program Name	Fiscal Year 2023/24 Ages Served	Fiscal Year 2023/24 Service Area*	Fiscal Year 2023/24 Total	Fiscal Year 2024/25 Ages Served	Fiscal Year 2024/25 Service Area*	Fiscal Year 2024/25 Total	Fiscal Year 2025/26 Ages Served	Fiscal Year 2025/26 Service Area*	Fiscal Year 2025/26 Total
Comprehensive Children and Family Support Services (CCFSS)	6,411 Children 1,839 TAY	2,700 FSP 5,550 O&E	8,250	5,342 Children 1,296 TAY	2,700 FSP 5,550 O&E	8,250	5,342 Children 1,296 TAY	2,700 FSP 5,550 O&E	8,250
Integrated New Family Opportunities (INFO)	60 Children 88 TAY	59 FSP 89 GSD	148	63 Children 93 TAY	62 FSP 94 GSD	156	63 Children 75 TAY	62 FSP 76 GSD	138
Transitional Age Youth (TAY) One Stop Centers	11,114 TAY	510 FSP 562 GSD 10,042 O&E	11,114	11,114 TAY	510 FSP 562 GSD 10,042 O&E	11,114	11,114 TAY	510 FSP 562 GSD 10,042 O&E	11,114
Forensic Services Continuum of Care	250 Adults	250 FSP	250	263 Adults	263 FSP	263	276 Adults	276 FSP	276
Assertive Community Treatment (ACT) Model Full Service Partnership (FSP) Services	135 Adults	135 FSP	135	135 Adults	135 FSP	135	135 Adults	135 FSP	135
Regional Adult Full Service Partnership (RAFSP)	673 Adults	673 FSP	673	673 Adults	673 FSP	673	673 Adults	673 FSP	673
Age Wise	2,131 Older Adults	131 FSP 2,000 O&E	2,131	2,664 Older Adults	164 FSP 2,500O&E	2,664	3,205 Older Adults	205 FSP 3,000 O&E	3,205

* Service Area - 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. 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.

CSS: Full Service Partnerships

Services Provided

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
- Housing assistance/placement
- Medication support services (intensive if needed)
- Recreation activities
- Linkage to community programs and agencies
- Interagency collaboration with other County departments
- Vocational/educational training
- Peer mentoring (Peer Support Specialist)
- Food assistance
- Clothing assistance
- Housing supports, including but not limited to, rent subsidies, housing vouchers, house payments, residence in a drug/alcohol rehabilitation program, and transitional and temporary housing
- Cost of health care treatment
- Respite care



Artwork by Mary Cantoran

Comprehensive Children and Family Support Services (CCFSS)

Program Name	Actual Number Served FY 2021-22	Estimated Number Served FY 2023-24	Annual Budgeted Funds FY 2023-24	Estimated Annual Cost per Person FY 2023-24
CCFSS	2,492*	8,250	$48,513,217	$5,880

*This number includes FSP services only

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 severe emotional disturbance (SED) or intensive mental health needs. CCFSS provides culturally competent "wraparound" services to children and their families in their natural environment in order to achieve a positive set of outcomes through unconditional care. The program continues to be comprised of three unique Full-Service Partnership (FSP) programs 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.

The three individualized and targeted Full-Service Partnership (FSP) subprograms are:

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

Program Description and Target Population

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 sub-program 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.

Outreach and Engagement

For Fiscal Year 2021/22, the Comprehensive Children and Family Support Services program conducted the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Consultations/screenings, presentations, outreach efforts, coordination, consultations (e.g., AB 1299, ASC, Health Homes re-screens, IPC)	10,391	20,221
Total	**10,391**	**20,221**

Consumer Demographics Highlights FY 2021/22

The tables to the right show the demographics in various categories for consumers served by the CCFSS program during Fiscal Year 2021/22. The demographic information is also explained below. CCFSS staff were able to successfully reach the target population of individuals aged 25 and under with a serious mental illness and/or a serious emotional disturbance, who are involved with the Departments of Probation or Children and Family Services.

Age:
The majority of consumers served by CCFSS were children under the age of 15 years old (68%). The program also served consumers between the ages of 16 and 25 years old (31%), as well as some adults between the ages of 18 and 59 years old (less than 1%).

Gender Identity:
Of the consumers served by CCFSS, 54% identified as male and 46% identified as female.

Race and Ethnicity:
The largest group of consumers served by CCFSS identify as Latinx or Hispanic (48%). Consumers who identify as Caucasian represent 21% of those served and those who identify as African American represent 20%. The remaining consumers identify as multiple races/other (9%), American Indian or Alaska Native (1%), and Asian or Pacific Islander (1%).

Primary Language:
Of the consumers served by CCFSS, 92% identified English as their primary language, while Spanish represented 5%. The remaining 3% of consumers said they had a primary language other than English or Spanish.

Primary Diagnosis:
CCFSS consumers have been diagnosed with anxiety disorders (24%), depression (24%), disruptive disorders (15%), and neurodevelopmental/cognitive disorders (14%). CCFSS also serve consumers that are diagnosed with bipolar (3%), psychosis (2%), substance related disorders (1%), and childhood/adolescent onset (less than 1%). The remaining population represents those that have a different diagnosis (14%) or no diagnosis (3%).

Age	
68% Children	**<1%** Adult
31% TAY	**0%** Older Adult

Gender Identity	
46% Female	**54%** Male

Race/Ethnicity	
20% African American/Black	**21%** Caucasian/White
1% American Indian/Alaska Native	**48%** Latinx/Hispanic
1% Asian/Pacific Islander	**9%** Other

Primary Language	
92% English	**3%** Other
5% Spanish	

Primary Diagnosis	
24% Anxiety disorders	**14%** Neurodevelopmental/ neurocognitive
3% Bipolar disorders	**2%** Psychosis
<1% Childhood/Adolescent Onset	**1%** Substance Related
24% Depressive disorders	**14%** Other
15% Disruptive disorders	**3%** None/Deferred Diagnosis

N=3,184

*NOTE: This number is an approximation. Some consumers may not have been counted. Not all percentages add to 100 due to rounding.

MHSA Legislative Goals and Related Key Outcomes

✓ Reduce the subjective suffering from serious emotional disorders for children and youth:
- Improve life satisfaction
- Decrease hopelessness/increased hope
- Increased resiliency
- Decreased impairment in general areas of life functioning (e.g., health/ self-care/housing, occupation/education, legal, managing money, interpersonal/social)

✓ Reduce homelessness and increase safe and permanent housing:
- Increase residence stability

✓ Reduce criminal and juvenile justice involvement:
- Reduce behaviors that increase the likelihood of juvenile justice involvement
- Reduce difficulties related to conduct disorders

Positive Results

Global Measurement of Life:

Item/Issue	Presented with a Need	Improvement of the Need
Having at least one area of impaired life functioning	97.6%	72.9%

Specific Areas of Life Functioning (Impact Report):

Item/Issue	Presented with a Need	Improvement of the Need
Family Difficulties	80%	65%
Social Functioning	73%	64%
Recreational	50%	60%
Sleep	49%	70%
School Behavior	50%	68%
School Achievement	58%	62%
School Attendance	33%	63%
Decision Making	79%	64%

*Data was collected using the Child and Adolescent Needs and Strengths (CANS) evaluation tool. CANS outcomes for CCFSS include all sub-programs (Children's Residential Intensive Services, Wraparound, and Success First/Early Wrap).

Positive Results (cont.)

Global Measurement of Behavioral and Emotional Needs:

Item/Issue	Presented with a Need	Improvement of the Need
Having at least one significant behavioral or emotional need	98.1%	71.2%

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

Item/Issue	Presented with a Need	Improvement of the Need
Impulsivity/Hyperactivity	56%	61%
Depression	65%	70%
Anxiety	56%	63%
Anger Control	65%	70%
Adjustment to Trauma	62%	56%
Emotional and/or Physical Dysregulation	72%	67%

*Data was collected using the Child and Adolescent Needs and Strengths (CANS) evaluation tool. CANS outcomes for CCFSS include all sub-programs (Children's Residential Intensive Services, Wraparound, and Success First/Early Wrap).

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

Item/Issue	Presented with a Need	Improvement of the Need
Caregivers indicated needing help to obtain a more stable residence	5%	79%
Children needing help improving their functioning within their living situation	57%	66%
Caregivers significantly uninvolved with the mental health needs of their children at time of admission	14%	63%
Caregivers showing a detrimentally low level of knowledge regarding the child's mental health needs at the start of services	44%	70%

Specific indicators likely to increase juvenile justice involvement:

Item/Issue	Presented with a Need	Improvement of the Need
Delinquency	40%	74%
Danger to Others	49%	77%
Runaway	44%	79%
Conduct Disorder Behaviors	38%	77%
Oppositional Behaviors	68%	59%

Challenges and Solutions

The two primary challenges for Children's MHSA programs during this past fiscal year have been the continued impact of the COVID-19 pandemic and related, and unrelated, staffing challenges.

COVID-19 Challenges

The pandemic presented unique challenges to the delivery of Behavioral Health Services throughout the world. In San Bernardino County, Wrap and Success First/Early Wrap responded quickly by transforming the specialty mental health services from primarily in person services to providing most services via Telehealth.

Several of the challenges that presented with providing services via a virtual platform included:

- Keeping children and youth engaged via a virtual platform which sometimes required providers to meet more frequently with the youth for shorter periods of time as well as increasing collateral contacts with the care provider.
- Conducting services that were 100% confidential. Some youth lived with multiple family members in a small, confined space.

Modifying the provision of services via Telehealth also had many benefits:

- There was a decrease in the number of no shows to appointments.
- It allowed for care providers with multiple children to be able to access and remain in treatment.
- It allowed children and youth to receive services that they may not have had otherwise due to remote living and transportation issues.
- It allowed children and youth to receive services from a provider outside of their catchment area.
- It allowed services to continue when someone was COVID positive but asymptomatic.

Most ChRIS staff who provide mental health services to youth in group homes continued with their in-person sessions, but some clinicians conducted Telehealth sessions to minimize COVID exposure. A challenge for ChRIS staff was to address the emotional and behavioral upheaval of the pandemic and the associated quarantine with their youth. Some ChRIS homes also had youth and staff test positive which magnified the stress level. Barriers that the ChRIS staff encountered were physical space and technology limitations that restricted Telehealth services, especially Child and Family Team meetings. Without adequate Wi-Fi, private space, and computer hardware, the youth could not adequately participate in Telehealth sessions and Child and Family Team Meetings (CFTMs). Homes that successfully solved this difficulty purchased tablets for youth and explored ways to ensure a confidential, secure space for therapy and Child and Family Team sessions.

Initially, the programs responded to the pandemic by conducting 90-95% of their services via Telehealth services. Starting in June/July of 2021, providers started increasing in-person sessions to the point that by December 2021 some providers were providing about 25% of their therapy services in-person rather than Telehealth. Providers developed extensive policies and procedures to ensure safe practices for their youth, families, and staff. These providers also purchased technology equipment for their families and youth to overcome this gap in resources.

Discussions with the clinical staff of these programs indicated that the clinical impact of Telehealth was mixed, and certainly varied by youth and therapist. Some clinicians reported that initially it was novel and successful despite the chaotic nature of the newly COVID world. However, as the months passed, an increasing number of clinicians found that the youth wanted the personal touch of a face-to-face session. To respond to this,

Challenges and Solutions (cont.)

clinicians created ways to conduct occasional in-person sessions with youth outdoors. They also made quick visits by dropping off various therapy tools, guidebooks, or physical reminders of the treatment relationship.

As COVID continues to have its devastating impact into late 2022, supervisors and clinicians will need to continue to adapt their practices to meet the evolving needs of their youth and families.

Staffing Challenges

Staffing has been challenging as Wrap, Success First/Early Wrap and ChRIS operate 7-days per week including weekends. Crisis calls often resulted in overtime, leading to staff burnout and compassion fatigue. Additionally, in 2021, many individuals continued to be reticent to work in high-COVID-exposure environments such as field-based teams, where in-person contact was required. In fact, several of the ChRIS homes had sites that were placed on hold due to COVID exposure or staffing shortages, or both.

During the height of the pandemic and even into 2022, programs experienced significant staffing challenges due to sickness and staff being out. Other staff had to cover additional caseloads counts for lengthy periods of time. Program leadership consistently needed to monitor staff burnout and morale. Staff were concerned for their own safety as well as their family's safety. Programs also had staff pass away from COVID, which continued to impact the teams, emotionally and vacancy-wise.

All of the programs continued to experience challenges filling positions in FY 2021 and 2022. A major reason is a shortage of clinical staff due to an increase in program demand. STRTPs, Foster Family Agencies (FFAs), School Mental Health Services, Health Plans, and expanding existing mental health programs are all vying for the same pool of staff, so competition is fierce. In addition, many classifications want telecommuting options. Attracted by the higher pay, schedule flexibility, and at-home work options, some staff have left the community mental health field to provide services through the growing online mental health services market. Frequently, the existing applicants require higher starting pay, which results in complicated hiring decisions, as current staff learn of the unequal pay rates.

Solutions for FY 2022/2023

Contract providers have more flexibility in adapting to some of these staffing challenges. Programs are currently developing policies and procedures to adapt to the demand for telecommuting, telehealth services and flexible schedules. Programs are also modifying their budgets, to the extent possible, to offer signing bonuses and increased pay to respond to the increasing competition. As possible, DBH is modifying some of the requirements for certain positions to allow for concurrent course enrollment rather than the previous degree-requirement. Increasing the use of peer and parent advocates with valuable lived experience will increase the pool of candidates at the non-clinical level. Continuing to explore these staffing modifications is a solution for the coming year.

Solutions for FY 2023/2024

Longer-range solutions for the staffing issues will be directed at continuing to increase the pool of qualified candidates in the mental health field. Increasing the number of intern and student staff is a relatively easy option. Working with the San Bernardino County Workforce, Employment and Training program to increase the relationship with local colleges and universities is another solution. A tight partnership with these educational programs will help to ensure that incoming staff have the specific skills and experience needed for the clinical programs. This collaboration would reduce the extent and intensity of job onboarding and increase the overall quality of the clinical services delivered.

Collaborative Partners

- All God's Children
- Alpha Connections Youth and Family Services
- Aspiranet
- Berhe Group Home
- Boys Republic
- Childhelp, Inc.
- Children's Hope Group Home
- Crittenton Services
- South Coast Children's Society
- David and Margaret Youth and Family Services
- DBH Transitional Age Youth Centers
- East Valley CHARLEE
- Eggleston Youth Centers, Inc.
- Ettie Lee Homes, Inc.
- Father's Heart – A Ranch for Children
- Field's Comprehensive Youth Services
- First Step Group Homes
- Girls Republic
- Guiding Light Home for Boys, Inc.
- Inland Empire Residential Center
- Inspire A Youth, Inc.
- Lutheran Social Services
- McKinley's Childrens Center
- Mental Health Systems, Inc.
- Mountain Valley Child & Family
- New Dawn
- Oak Grove Center
- Pacific Clinics
- PHILOS Adolescent Treatment
- Plan It Life, Inc.
- Riverstones Residential Treatment Centers
- Rosemary Children's Services
- San Bernardino County, Children and Family Services (CFS)
- San Bernardino County, First Five
- San Bernardino County, Probation
- San Gabriel Childrens Center, Inc.
- School Attendance Review Boards
- School Districts
- Silence Aloud, Inc.
- South Coast Community Service
- Starshine Treatment Center
- Tender Loving Care Home for Boys (Corinthians)
- Trinity Youth Services
- Victor Community Support Services
- Victor Treatment Centers

Success Story

"Timothy" first came to us after a 72-hour hold after a suicide attempt. He reported he had been bullied at school for being transgender and that his parents "didn't even try" to use his preferred pronouns. Timothy and his family received a full array of Success First/Early Wraparound services. Through individual therapy, he learned to use assertive communication and was able to process trauma he had experienced as a young child. Through family therapy, Timothy and his family grew to have a deeper understanding of what his transgender identity meant to him and to his family and this led to his caregivers making an effort to support his name change and pronoun preference. Timothy's treatment team was able to advocate for him at school and Timothy joined the Gay/Straight Alliance club at school. At discharge, Timothy had a solid friend group and his caregivers had gotten used to his new name and pronouns and most importantly, Timothy no longer experienced any suicidal ideation.

Integrated New Family Opportunities (INFO)

Program Name	Actual Number Served FY 2021-22	Estimated Number Served FY 2023-24	Annual Budgeted Funds FY 2023-24	Estimated Annual Cost per Person FY 2023-24
INFO	73*	148	$1,947,326	$13,158

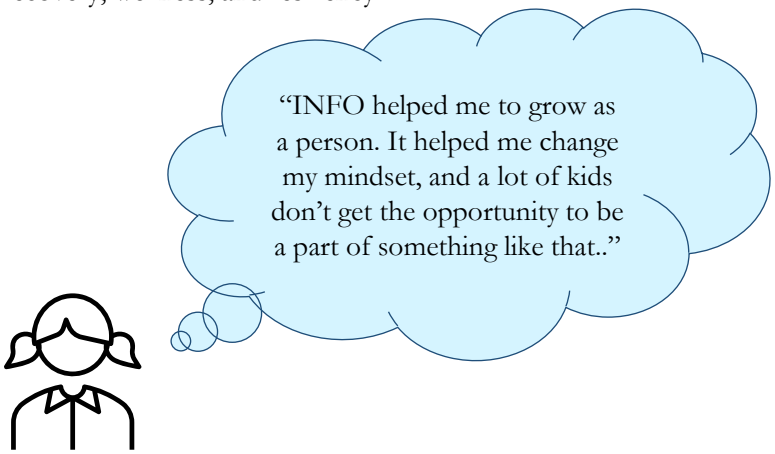
*This number includes FSP services only

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





Smile of a Lifetime – Art

Consumer Demographics Highlights FY 2021/22

The tables to the right show the demographics in various categories for consumers served by the INFO program during Fiscal Year 2021/22. The demographic information is also explained below. INFO staff were able to successfully reach the target population of individuals between the ages of 13 and 17 with a serious emotional disturbance, who are involved with the Departments of Probation or Children and Family Services.

Age:
Of the consumers served by the INFO program, 78% were between the ages of 16 and 25 years older, while 22% were ages 15 and under.

Gender Identity:
Of the consumers served by the INFO program, 83% identified as male and 17% identified as female.

Race and Ethnicity:
The largest group of consumers served by the INFO program identify as Latinx or Hispanic (67%). Consumers who identify as African American represent 18%, while those who identify as Caucasian represent 9% of those served. The remaining consumers identify as American Indian or Alaska Native (less than 1%), Asian (less than 1%), and as an other or unknown race (5%).

Primary Language:
Of the consumers served by the INFO program, 79% identified English as their primary language, while Spanish represented 10%. Less than 1% identified Mandarin as their primary language. The remaining 10% identified a primary language other than English or Spanish.

Primary Diagnosis:
INFO consumers have been diagnosed with anxiety (25%), disruptive disorders (15%), and depression (13%). Other consumers have been diagnosed with substance related disorders (3%), bipolar disorders (2%), and neurodevelopmental or cognitive disorders (1%). The remaining consumers have a different diagnosis (25%) or deferred diagnosis (16%).

Age	
22% Children	**0%** Adult
78% TAY	**0%** Older Adult

Gender Identity	
17% Female	**83%** Male

Race/Ethnicity	
18% African American/Black	**9%** Caucasian/White
<1% American Indian/Alaska Native	**67%** Latinx/Hispanic
<1% Asian	**5%** Other/Unknown

Primary Language	
79% English	**<1%** Mandarin
10% Spanish	**10%** Other

Primary Diagnosis	
25% Anxiety disorders	**1%** Neurodevelopmental/ Cognitive
2% Bipolar disorders	**3%** Substance Related
13% Depressive disorders	**25%** Other
15% Disruptive disorders	
16% Deferred Diagnosis/ None	

N=209*

*NOTE: This number is an approximation. Demographic information for the INFO program may include FSP and GSD service activities. Not all numbers add to 100 due to rounding.

MHSA Legislative Goals and Related Key Outcomes

✓ Increase self-help and consumer/family involvement:
- Increase in number of encounters with collateral contacts, such as family members and informal supports

✓ Reduce criminal and juvenile justice involvement:
- Decrease sustained allegations
- Reduce jail/prison recidivism
- Decrease jail days

Positive Results

Youth saw an increase of 3% in collateral contacts while in the program in FY 2021/22. Youth who completed the program served significantly less days in detention after the program *(relative to before the program)* compared to youth who were terminated from the program as well as youth who declined to participate in the program. 13.87 days for those who completed compared to 50.11 days for those who terminated. Fiscal Year 2021/22 also had a 75% decrease in sustained allegations.

Challenges and Solutions

The greatest challenges in FY 2021/22 were addressing ways to improve treatment team partner relationships to maximize integration and engagement with families and youth served and building a central network of new community partner resources to assist families and youth to have more options for community service and overall family support as resources have changed.

To address these challenges INFO will provide onboarding training to any new Probation and DBH staff. This will allow for opportunities to have consistent communication. INFO will also have leadership team meetings to discuss successes, opportunities, and collaborative plans to address opportunities.

Challenges and Solutions (cont.)

INFO will provide education about the program to community-based organizations and establish a partnership for cross referrals. Field visits to other organizations will be conducted resulting in the development of an Excel spreadsheet with the newly formed partnerships contact information to be disseminated and shared with the whole treatment team and families.

Collaborative Partners

- Boys & Girls Club of San Bernardino
- Catholic Charities
- Children's Fund
- Colton Joint Unified School District
- Community Action Partnership of San Bernardino County
- Fontana Unified School District
- Mary's Mercy Center
- National Alliance on Mental Illness (NAMI)
- Native American Resource Center
- North San Bernardino Jr. All-American Football & Cheer
- Options for Youth
- Rialto Unified School District
- Riverside and San Bernardino County Indian Health, Inc.
- Salvation Army San Bernardino
- San Bernardino County, Museum
- San Bernardino County, Superintendent of Schools
- San Bernardino County, Department of Behavioral Health
- San Bernardino County, District Attorney
- San Bernardino County, Probation
- San Bernardino County, Public Defender
- San Bernardino County, Juvenile Court

Transitional Age Youth (TAY) One Stop Centers

Program Name	Actual Number Served FY 2021-22	Estimated Number Served FY 2023-24	Annual Budgeted Funds FY 2023-24	Estimated Annual Cost per Person FY 2023-24
TAY	592*	510*	$6,981,719	$628

*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

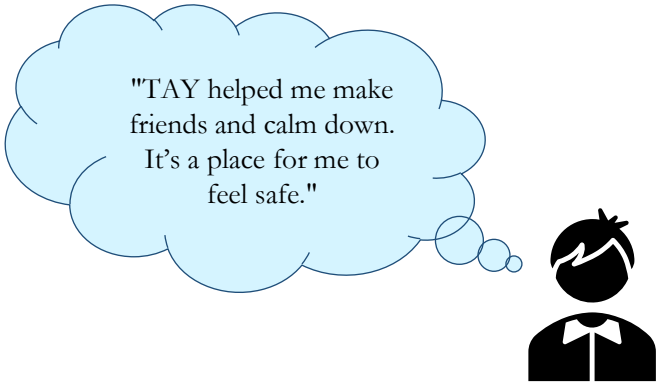
The Department of Behavioral Health supports four One Stop Transitional Age Youth (TAY) Centers in each region of San Bernardino County. TAY Centers provide integrated services to the unserved, underserved, and inappropriately served youth of San Bernardino County. The target populations for the program are youth who are below 200% of the federal poverty level, living with mental health concerns, and includes an emphasis on Latino and African American youth who are disproportionately over-represented in the justice system and in out-of-home placements (e.g., foster care, group homes, and institutions).

Centers provide drop-in services to TAY and, when appropriate, their families. These services address employment, educational opportunities, housing, behavioral health, physical well-being, drug and alcohol use, legal issues, trauma, domestic violence, and physical, emotional, and/or sexual abuse. Additionally, Full Service Partnership (FSP) services include behavioral health outpatient services for youth with serious emotional disturbances (SED) and/or serious mental illness (SMI). Centers also offer TAY participants shower and laundry facilities, a resource room with computer and internet access, recreational activities, access to co-located services, and referrals to appropriate community-based services.

Outreach and Engagement services and events are provided to unserved TAY, and when appropriate their families, to engage and educate them on the County's behavioral health system.

Services include, but are not limited to:

- Health fairs
- Job fairs
- Street outreach
- Weekly orientations



Consumer Demographics Highlights FY 2021/22

The tables to the right show the demographics in various categories for consumers served at TAY One Stop Centers during Fiscal Year 2021/22. The demographic information is also explained below. TAY Center staff were able to successfully reach the target population of individuals between the ages of 16 and 25 with a serious mental illness and/or serious emotional disturbance.

Age:
The majority of consumers served at TAY Centers were between the ages of 16 and 25 years old (94%). Adults between the ages of 26 and 59 years old represent 6% of consumers served.

Gender Identity:
Of the consumers served at TAY Centers, 58% identified as female and 42% identified as male.

Race and Ethnicity:
The largest group of consumers served at TAY Centers identify as Latinx or Hispanic (55%). Consumers who identify as Caucasian represent 22% of those served and those who identify as African American represent 15%. The remaining consumers identify as multiple races/other (5%), Asian or Pacific Islander (2%), and American Indian or Alaska Native (1%).

Primary Language:
Of the consumers served at TAY Centers, 95% identified English as their primary language, while Spanish represented 5%.

Primary Diagnosis:
TAY Center consumers have been diagnosed with depression (45%), anxiety (20%), bipolar disorders (12%), and psychosis (12%). TAY Centers also serve consumers that are diagnosed with disruptive disorders (3%), substance related disorders (2%), and neurodevelopmental or neurocognitive disorders (1%). The remaining 5% represent those that have a different diagnosis.

Age	
0% Children	**6%** Adult
94% TAY	**0%** Older Adult

Gender Identity	
58% Female	**42%** Male

Race/Ethnicity	
15% African American/Black	**22%** Caucasian/White
1% American Indian/Alaska Native	**55%** Latinx/Hispanic
2% Asian/Pacific Islander	**5%** Multiple races/Other

Primary Language	
95% English	**5%** Spanish

Primary Diagnosis	
20% Anxiety disorders	**1%** Neurodevelopmental/ neurocognitive
12% Bipolar disorders	**12%** Psychosis
45% Depressive disorders	**2%** Substance Related
3% Disruptive disorders	**5%** Other

N=507

*NOTE: This number is an approximation. Some consumers may not have been counted.

MHSA Legislative Goals and Related Key Outcomes

- ✓ Reduce the subjective suffering from serious mental illness for adults and severe emotional disturbance for children and youth:
  - Increase resiliency
  - Decrease impairment in general areas of life functioning (e.g., health, self-care, housing, occupation/education, legal, money management, interpersonal/social)

- ✓ Reduce homelessness and increase safe and permanent housing:
  - Decrease rate of homelessness for consumers
  - Increase independent living skills

- ✓ Increase a network of community support services:
  - Increase number of collaborative partners

Positive Results

Results from the ANSA for the period of July 1, 2020, through June 30, 2022* show the number of youth who presented with a significant issue on an item within the Life Functioning and Strengths domains and the percentage of youth who had that issue improve by the completion of the TAY program:

Item/Issue	Presented with a Need	Improvement of the Need
Intimate Relationships	84	44%
Educational Attainment	84	60%
Family/Family Strengths/Support	131	44%
Interpersonal/Social Connectedness	132	53%
Optimism/Hopefulness	97	59%
Educational Setting	56	61%
Community Connection	135	51%
Resilience	67	43%
Resourcefulness	66	42%
Living Skills	99	53%
Residential Stability	76	49%

*Due to the length of time most TAY consumers spend in the program, data was pulled for FY 2020/21-2021/22 in order to showcase the level of progression that TAY members experience over time.

Positive Results (cont.)

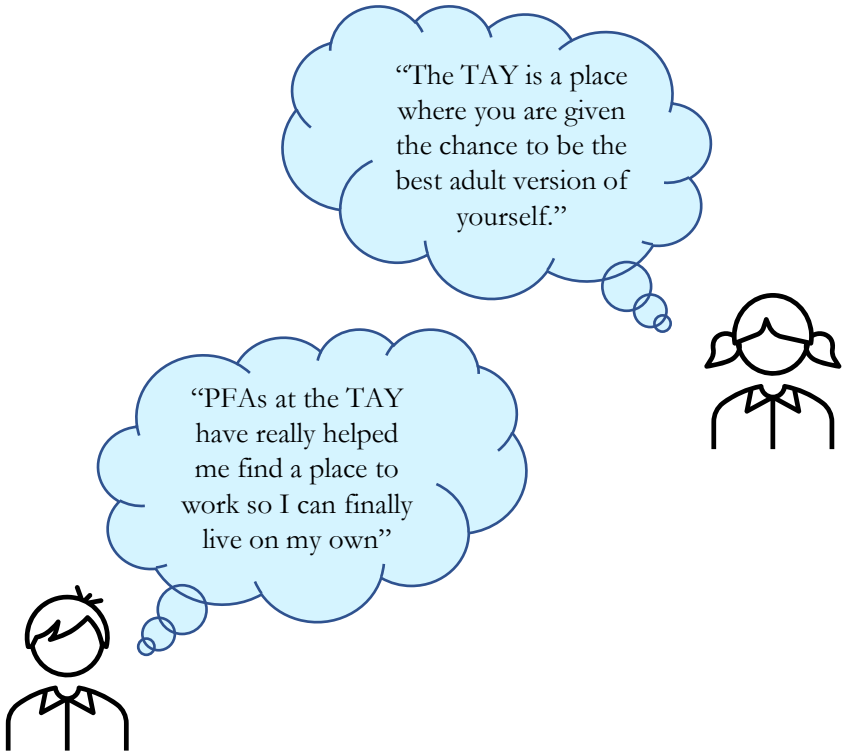
Results from the ANSA for the period of July 1, 2020, through June 30, 2022* show the number of youth who presented with a significant issue on an item within the Life Functioning and Strengths domains and the percentage of youth who had that issue improve by the completion of the TAY program:

Item/Issue	Presented with a Need	Improvement of the Need
Family Relationships	146	49%
Social Functioning	147	55%
Recreational	128	59%
Legal	14	21%
Physical/Medical	27	26%
Sleep	99	56%
Living Skills	99	53%
Residential Stability	76	49%
Self-Care	91	45%
Medication Compliance	25	20%
Decision-Making/Judgement	116	52%

*Due to the length of time most TAY consumers spend in the program, data was pulled for FY 2020/21-2021/22 in order to showcase the level of progression that TAY members experience over time.

Success Story

After several years in the TAY Center program – years in which the youth struggled, was homeless and utilized the TAY Emergency Shelter Services program – they made progress with their mental health, and sometimes regressed, but the hard work and perseverance has finally paid off. The youth is now living on their own and is working as a Peer and Family Advocate.



Challenges and Solutions

Challenges in FY 2021/22 centered around staffing and data entry and reporting. The Ontario TAY Center found it difficult to fill their Licensed Psychiatric Technician position. They went through most of the year without one. Ontario TAY also reported that it was difficult to maintain staff such as case manager and data entry clerks.

Yucca Valley TAY had a reduction in staffing due to transfers and one Peer and Family Advocate needing reduced hours to meet practicum hours toward licensure. The San Bernardino TAY Center experienced some staffing issues that included the loss of a Case Manager position and one General Service Worker who mainly provides client transportation duties.

Ontario TAY data entry and data reporting staff found that collecting and reporting data was difficult to do while working from home and short staffed. Staff at the Victorville/Barstow TAY Center program experienced issues with their billing system, which effected their data collection and reporting.

To address their inability to fill vacant positions, the Ontario TAY is discussing salaries and how they can offer competitive wages so that they can fill their vacant positions. Yucca TAY staff have come together to ensure all requirements for delivering care and services to clients are being met by having appropriate full-time staff cover take on tasks as needed.

To address the staffing shortages to provide full case management services for all TAY clients, San Bernardino TAY Center Psychology Interns took on Case Management tasks for some clients. To be able to provide transportation services to all clients in need, one of the Case Managers adjusted their tasks to begin providing transportation services to clients. Staff duties may be adjusted again, when additional staff are hired.

To address their problems with data entry and reporting, staff from other programs in other Mental Health Systems, Inc. programs are helping the Ontario TAY Center program with their data entry and reporting. To address their billing system issues, staff at the Victorville/Barstow TAY Center program are working with their billing system vendor to resolve known system issues.

Outreach and Engagement

For Fiscal Year 2021/22, the Transitional Age Youth One Stop Centers program conducted the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Agency/Org/Program Tour	1	6
Collaborative Meetings	159	4,582
Community Outreach	995	6,377
Conference Resource Booth	5	472
Health/Resource Fair	7	240
Mental Health Events Attended	2	73
Online Media	23	1,239
Orientation	413	419
Other (e.g., Community Client Contact)	101	86
Presentations	6	149
Total	**1,712**	**13,643**

Collaborative Partners

- Alta Loma High School
- Apple Valley Unified School District Workforce Investment Opportunities Act (WIOA) Work Experience Resource
- Basin Wide Foundation
- CalWORKS Advisory Committee
- Chaffey College Independent Scholars and EOPS
- Chaffey High School
- Chamber of Commerce - Yucca Valley
- Children's Fund
- Children's Network Collaborative
- Chino Neighborhood House
- Cobalt Institute for Math and Sciences
- Colony High School
- Community Crisis Response Team
- Copper Mountain College
- Cut Studio
- Department of Aging and Adult Services
- Desert Hills Presbyterian Church
- Desert Mountain Children's Center
- Etiwanda High School
- Five Star Catering
- Helendale Community Services District
- Hesperia Unified School District Family Resource Center
- Hesperia Unified School District Hispanic Community Liaison
- Hi-Desert Behavioral Health
- High Desert Senior & Disability Collaborative
- Homeless Youth Taskforce
- House of Ruth
- Interagency Council on Homelessness
- Kiwanis of Yucca Valley
- Los Osos High School
- Molding Hearts Housing
- Montclair School District
- Morongo Basin Community Coalition
- Morongo Basin Haven
- Morongo Basin Sexual Assault Services
- Morongo Basin Unified District
- Moses House
- Native American Resource Center
- Ontario High School
- Operation New Hope
- Options for Youth
- Probation Department
- Rancho Cucamonga Center
- Rancho Cucamonga HS
- Rotary of Yucca Valley
- Saint Phillip Neri Catholic Church
- San Bernardino County, Children and Family Services
- San Bernardino County, Department of Behavioral Health Children's
- Services
- Silverado High School
- Snowline Joint Unified School District
- Town of Yucca Valley
- Twenty-Nine Palms High School
- Valley Star Crisis Walk in Clinic
- Valley Star STAY
- Valley View High School
- Victor Community Support Services Victorville Campus
- Victor Valley Behavioral Health Clubhouse
- Victor Valley College
- Victor Valley High School
- Walden Family Services
- Yucca Valley High School

Forensic Services (FS) Continuum of Care

Program Name	Actual Number Served FY 2021-22	Estimated Number Served FY 2023-24	Annual Budgeted Funds FY 2023-24	Estimated Annual Cost per Person FY 2023-24
Forensic Services	233	250	$6,723,626	$26,895

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
Ages 25-59	SMI*	Clinic and Field	Justice Involvement

*SMI = serious mental illness

Program Description and Target Population

The Forensic Services (FS) [Formerly Adult Criminal Justice (ACJ)] Continuum of Care program is designed to serve adults living with severe mental illness (SMI) who are involved in the criminal justice system. The program consists of nine (9) 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)
- Choosing Healthy Options to Instill Change and Empowerment (CHOICE)
- Diversion Opportunities for Outpatient Recovery Services (DOORS) General Diversion
- Re-Integrative Supportive Engagement Services (RISES)

The **Supervised Treatment After Release (STAR)** and **Forensic Assertive Community Treatment (FACT)** Full Service Partnership (FSP) programs serve clients living with serious mental illness (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 (re-incarcerations) 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 differs from STAR as it assists clients who have difficulty participating in traditional outpatient mental health services. FACT services are community based; however, intensive program services, supportive case management, and psychiatric services are provided in the home for those individuals who need a higher level of care. **Joshua Tree Mental Health Court (JTMHC)** is operated by Valley Star and provides program and services similar to the STAR program for clients referred through the Joshua Tree Mental Health Court.

Program Description and Target Population (cont.)

The **Community STAR (CSTAR)** and **Community FACT (CFACT)** Full Service Partnership programs operate in the same capacity as STAR and FACT; however, clients 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 clients transitioning from the Choosing Healthy Options to Instill Change and Empowerment (CHOICE) program as well as Mental Health Diversion (MHD) Court. CFACT clients transition from either MHD Court, other Forensic Services programs, or general community but must be referred through Department of Behavioral Health (DBH) Forensic Services (FS).

The **Corrections Outpatient Recovery Enhancement (CORE)** 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 that are often not admitted to other community-based services as they have complex and unique treatment needs that are further compounded by criminogenic factors.

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

The **Diversion Opportunities for Outpatient Recovery Services (DOORS) General Diversion** program also known as DOORS M-IST will service Mental Health Diversion individuals determined to be appropriate by Diversion Courts under PC 1001.36 who live with Severe Mental Illnesses, but who do not meet the specific requirements of the current Department of State Hospitals (DSH) grant funded DOORS program under WIC 4361. The new program will provide intensive behavioral health treatment consisting of: Case management, mental health treatment, transportation, emergency shelter, and SUD referral services.

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

Consumer Demographics Highlights FY 2021/22

The tables to the right show the demographics in various categories for consumers served by the Forensic Services Continuum of Care during Fiscal Year 2021/22. The demographic information is also explained below. Forensic Services staff were able to successfully reach the target population of adults with a serious mental illness who are involved with the justice system.

Age:
The majority of consumers served by Forensic Services were adults between the ages of 26 and 59 years old (85%). The programs also served consumers between the ages of 16 and 25 years old (9%), and those who are age 60 and older (6%).

Gender Identity:
Of the consumers served by Forensic Services, 69% identified as male and 31% identified as female.

Race and Ethnicity:
Consumers that identify as Latinx or Hispanic represent 31% of those served, while consumers who identify as African American and those who identify as Caucasian each represent 30% of those served by Forensic Services. The Forensic Services program also serves consumers that identify as Asian or Pacific Islander (2%), American Indian or Alaska Native (1%), and those who identify a different unknown race (6%).

Primary Language:
Of the consumers served by Forensic Services, 98% identified English as their primary language, while Spanish represented 1%. The remaining 1% of consumers identified a primary language other than English or Spanish.

Primary Diagnosis:
Forensic Services consumers have been diagnosed with psychosis (49%), bipolar disorders (19%), depression (11%), substance related disorders (11%) and anxiety (4%). The remaining consumers have a different diagnosis (3%) or no diagnosis (3%).

Age	
0% Children	**85%** Adult
9% TAY	**6%** Older Adult

Gender Identity	
31% Female	**69%** Male

Race/Ethnicity	
30% African American/Black	**30%** Caucasian/White
1% American Indian/Alaska Native	**31%** Latinx/Hispanic
2% Asian/Pacific Islander	**6%** Other

Primary Language	
98% English	**1%** Other
1% Spanish	

Primary Diagnosis	
4% Anxiety disorders	**11%** Substance Related
19% Bipolar disorders	**3%** Other
11% Depressive disorders	**3%** None/Deferred Diagnosis
49% Psychosis	

N=286

*NOTE: This number is an approximation. Some consumers may not have been counted.

MHSA Legislative Goals and Related Key Outcomes

✓ Reduce the subjective suffering from serious mental illness for adults:
- Improve life satisfaction
- Decrease hopelessness/increase hope
- Increase resiliency
- Decrease impairment in general areas of life functioning (e.g., health, self-care, housing, occupation/education, legal, money management, interpersonal/social)

✓ Reduce homelessness and increase safe and permanent housing:
- Decrease rate of homelessness for consumers
- Increase residential stability

✓ Reduce criminal justice involvement:
- Decrease rate of incarcerations
- Decrease arrests
- Decrease jail bookings
- Decrease sustained allegations
- Decrease jail days
- Reduce jail/prison recidivism
- Reduce behaviors which increase likelihood of criminal justice involvement

✓ Reduce the frequency of emergency room visits and unnecessary hospitalizations:
- Reduce rate of emergency room visits for mental health concerns
- Reduce the number of emergency room visits for routine medical concerns
- Reduce administrative hospital days
- Increase use of alternative crisis interventions (e.g., CWIC, CCRT, CSU)
- Increase number of individuals diverted from hospitalization

Positive Results

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

The tables below show the number of clients who were housed through emergency shelter placement and/or received interim housing assistance during FY 2021/2022.

Program	Number of clients who received shelter/housing assistance
STAR	37
CSTAR	20
FACT/CFACT	30
CORE	55
JTMHC	7
Total Sheltered	**149**

In comparison to pre-enrollment levels, participants enrolled in the Forensic Services programs have shown high rates of diversion from incarceration. The following table represents the reduction in jail days for clients who completed their first full year of the program during FY 2021/22 compared to the year prior to program admittance.

Program	Percentage Reduction in Jail Days
STAR	95%
CSTAR	98%
JTMHC	87%

Positive Results (cont.)

In comparison to pre-enrollment levels, participants enrolled in the Forensic Services programs have shown rates of diversion from psychiatric hospitalization. The following data represents the reduction in psychiatric hospital days for clients in FY 2021-22 compared to the year prior to program enrollment.

Program	Percentage Reduction
CORE	-22%
STAR	7%
CSTAR	17%
FACT/CFACT	75%
JTMHC	17%

*Although there was an increase in hospitalizations from last year's outcomes, most hospitalization days came from a small group of clients. Seven clients (21%) accounted for 82% of hospitalization days for CORE. Three clients (13%) accounted for 81% of hospitalization days for STAR. Four clients (10%) accounted for 86% of hospitalization days for CSTAR. One client (5%) accounted for 100% of all hospitalization days for FACT/CFACT. One client (10%) accounted for 100% of all hospitalization days for JTMHC.

Challenges and Solutions

The Forensic Services programs endured various challenges throughout FY 2021/2022. Some program challenges seen across all programs under the Forensic Services Continuum of Care consisted of staffing vacancies and high turnover. Clients not having their own transportation and relying on public assistance and/or public modes of transport. There are limited housing options among justice involved clients and it is hard to obtain housing for PC 290, Registered Sex Offenders and the female population.

The Forensic Services programs are addressing these challenges by continuously looking at ways of increasing staff levels to accommodate the needs of clients. Forensic specific position recruitments are conducted.

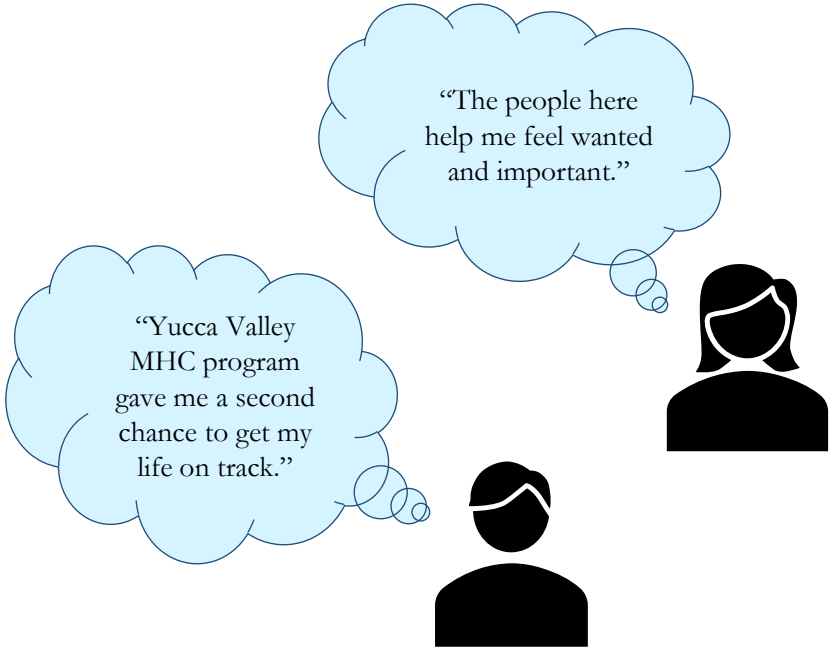
The Forensic Services programs are in the process of requesting proposals for vendors interested in contracting with DBH to provide emergency shelter services, as well as collaborating with the Homeless and Supportive Services programs to address housing needs.

Programs within the Forensic Services Continuum of Care continue to provide transportation and public assistance with limited resources. Staff will also continue inspecting shelters for cleanliness and work with providers in addressing cleanliness concerns.

Outreach and Engagement

In Fiscal Year 2021/22, the Forensic Services Continuum of Care program conducted the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Collaborative Meetings	80	555
Community Outreach	233	1,239
Health/Resource Fair	3	5
Mental Health Court Graduation	6	6
Total	**322**	**1,805**



Collaborative Partners

- Abria Del Cielo Assisted Living
- Adult Day Health Care Programs
- Adult Protective Services
- Alzheimer Association
- American Sports University Student Dormitory
- American Surgical Pharmacy
- Avila's Room and Board
- Behavioral Health Commissioners
- Cal State San Bernardino
- California State University of San Bernardino CARE Team
- Cedar House Life Change Center
- Cedar House Rehabilitation Center
- Center for Employment Training
- Chaffey College
- Coalition Against Sexual Exploitation (CASE)
- Comfort Place Room and Board
- County of San Bernardino Correctional Mental Health Services
- County of San Bernardino Probation Department
- County of San Bernardino Sheriff Department
- County of San Bernardino Transitional Assistance Department (TAD)
- CR Sober Living
- D'Langs Community Center Room and Board
- Del Rosa Villa Nursing Center
- Department of Aging and Adult Services
- Department of Vocational Rehabilitation
- District Attorney's Office
- Emergency Shelter Services Housing Providers
- Gibson House for Men
- Gibson House for Women

Collaborative Partners (cont.)

- Goodwill of Southern California
- Helping Hands 24/7 Sober Living Home
- Hernandez Room and Board
- Hi-Desert Behavioral Health Services
- Hope Homes
- House of Angels Sober Living
- Inland Counties Legal Services
- Inland Empire Concerned African American Churches
- Inland Regional Center
- Inland Valley Recovery Services
- Institute for Public Strategies
- J's Famous Residential Room and Board
- Judges/Commissioners of San Bernardino County Superior Courts Victorville, Joshua Tree, Rancho Cucamonga, and San Bernardino)
- Kai's Room and Board
- Loma Linda Veteran's Affairs Healthcare System
- Mental Health Clubhouses/Wellness Centers
- Mission Adult Day Health Care Center
- Mt. San Antonio College
- National Alliance on Mental Illness (NAMI)
- New Hope Missionary Baptist Church
- NP Guest Home Room and Board
- Office of Veteran Affairs
- OmniTrans
- Our Place Clubhouse (South Coast Community Services)
- Pacific Clinics
- Patton State Hospital
- Rialto Kiwanis Club
- SACHS Norton
- San Bernardino Adult Day Health Care Center (formerly Catleya Adult Day Health Care Center)
- San Bernardino Adult School
- San Bernardino City Police Department
- San Bernardino County, Sheriff's Department/West Valley Detention Center
- San Bernardino County, Superior Mental Health Courts
- San Bernardino County, District Attorney's Office
- San Bernardino County, Public Defender Offices
- San Bernardino Valley College
- Saving Grace Sober Living
- Serenity Sisters Sober Living
- Shanti House Board and Care
- Social Security Administration's Institutions Unit
- Solvang Room and Board
- St. John of God Health Care Services
- Steps 4 Life Sober Living
- Telecare Crisis Walk-In Center
- Tender Heart Adult Day Health Care
- The Center for Effective Change
- The Counseling Team International
- The Ranch Recovery Centers, Inc.
- Valley Healthcare Center Skilled Nursing Facility
- Veteran's Center of Colton
- Waterman Convalescent Hospital
- Westside Action Group
- Women of Courage Sober Living

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

Program Name	Actual Number Served FY 2021-22	Estimated Number Served FY 2023-24	Annual Budgeted Funds FY 2023-24	Estimated Annual Cost per Person FY 2023-24
ACT Model FSP Services	170	135	$2,779,852	$20,591

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

*SMI = serious mental illness

Program Description and Target Population

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

The difference between the two programs is that ACT specializes in assisting those who may be transitioning from institutional settings, such as State Hospitals, Institutions for Mental Disease (IMDs) or locked psychiatric facilities, whereas MAPS assists those who are historically high users of acute psychiatric inpatient and crisis services. These consumers may also have a history of a co-occurring substance use disorder (SUD) or a history of identifying as homeless.

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

Success Story

"Enrique" (he/him) states that recovery is a process and a journey. In Enrique's words, "I have been trying to take [this journey] for a long time but didn't have any support. Thanks to Telecare, I can finally say I finished a task and I have tools from you guys and the rehab, that I can use." Enrique was successful in remaining in his placement without relocating. His independence has been a challenge, yet with the support from the team and ongoing services provided, he was able to stay consistent in following through with his treatment.

Consumer Demographics Highlights FY 2021/22

The tables to the right show the demographics in various categories for consumers served by ACT Model FSP services during Fiscal Year 2021/22. The demographic information is also explained below. ACT staff were able to successfully reach the target population of adults with a serious mental illness who are high users of hospitalization services.

Age:
The majority of consumers served were adults between the ages of 26 and 59 years older (79%). The ACT FSP program also served adults aged 60 and older (17%) and consumers between the ages of 16 and 25 years old (4%).

Gender Identity:
Of the consumers served by the ACT FSP program, 63% identified as male and 37% identified as female.

Race and Ethnicity:
The ACT FSP program served consumers that identify as Latinx or Hispanic (38%), Caucasian (34%), and African American (15%). The program also served consumers that identify as Asian or Pacific Islander (5%), and those who identify a different race than those listed above (8%).

Primary Language:
Of the consumers served by the ACT FSP program, 97% identified English as their primary language. The remaining 3% identified a primary language other than English or Spanish.

Primary Diagnosis:
ACT FSP consumers have been diagnosed with psychosis (88%), bipolar disorders (4%), and depression (2%). The remaining 6% represent those that have a different diagnosis than those listed above.

Age	
0% Children	**79%** Adult
4% TAY	**17%** Older Adult

Gender Identity	
37% Female	**63%** Male

Race/Ethnicity	
15% African American/Black	**38%** Latinx/Hispanic
5% Asian/Pacific Islander	**8%** Other
34% Caucasian/White	

Primary Language	
97% English	**3%** Other

Primary Diagnosis	
4% Bipolar disorders	**88%** Psychosis
2% Depressive disorders	**6%** Other

N=86

*NOTE: This number is an approximation. Some consumers may not have been counted.

MHSA Legislative Goals and Related Key Outcomes

✓ Reduce the subjective suffering from serious mental illness for adults:
- Improve life satisfaction
- Decrease hopelessness/increase hope
- Increase resiliency
- Decrease impairment in general areas of life functioning (e.g., health, self-care, housing, occupation/education, legal, money management, interpersonal/social)

✓ Reduce homelessness and increase safe and permanent housing:
- Decrease rate of homelessness for consumers
- Increase residential stability

✓ Increase self-help and consumer/family involvement:
- Increase number of encounters with collateral contact, such as family members and informal supports

✓ Increase access to treatment and services from co-occurring problems; substance abuse and health:
- Increase encounters in specialty co-occurring and substance abuse interventions
- Increase transportation to non-mental health co-occurring appointments (such as substance use disorder, integrated health, primary care, etc.) provided

✓ Reduce disparities in racial and ethnic populations:
- Reduce mental health and health care disparities

✓ Reduce the frequency of emergency room visits and unnecessary hospitalizations:
- Reduce rate of emergency room visits for mental health concerns
- Increase use of alternative crisis interventions (e.g., CWIC, CCRT, CSU)
- Increase number of individuals diverted from hospitalizations

Positive Results

Out of the 91 consumers served by the ACT program in FY 2021/22, 100% were able to maintain safe, stable housing for the duration of the FY.

Out of the 79 consumers served by the MAPS program in FY2 021/22, 98.7% were able to maintain safe, stable housing for the duration of the FY.

More than 25% of the ACT services and more than 20% of MAPS services provided throughout FY 2021/22 were in collaboration with family, other provider agencies, and the consumers' support systems. The ACT team worked in coordination with Public Guardian staff, linked members to resources out in the community, housed members to reduce homelessness, worked to reduce hospitalizations, and incorporated consumer support systems to help support consumer stabilization and ongoing recovery.

In FY 2021/22, ACT served 91 consumers and MAPS served 79. The following represents MAPS and ACT outcomes and percentages of consumers that meet the criteria:

Outcome	ACT	MAPS
Experienced one acute psychiatric hospitalization	15	6
Experienced two hospitalizations	1	1
Experienced three hospitalizations	2	3
Percentage of consumers who ere able to avoid psychiatric hospitalization during the FY	80.2	87.3

Challenges and Solutions

The challenges in FY 2021/22 included consumers struggling with program structure changes such as the implementation of the TIER system. This resulted in an increase in resistance and crisis associated with consumer reticence to graduate from the program in favor of wanting to continue receiving services.

Consumers experienced challenges in locating and maintaining housing and/or placement options due to a variety of barriers including consumer behavior history, bed bug outbreaks in the facilities, restricted acceptance of individuals with certain medical conditions, and environmental safety.

The program has addressed these challenges by educating existing and new members on the newly implemented TIER system, and discharge planning conversations are happening at enrollment, during re-assessments, and during annual assessments. Educational opportunities to acclimate consumers to the programs include Welcoming Groups and Graduations Groups.

Program staff continue to research housing resources, locate new placements, coordinate with vendors out in the community, and strengthen collaborative relationships to help expedite securing placement for our members as needed.

Outreach and Engagement

For Fiscal Year 2021/22, the ACT Model FSP Services program conducted the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
MAPS team outreach	1	30
ACT team outreach	1	9
SUD groups with ACT and MAPS	48	480
Clinic Days	48	1,056
Total	**98**	**1,575**

Collaborative Partners

- Cash Assistant Program for Immigrants (CAPI)
- Catholic Charities
- Community Action Partnership (CAP) of San Bernardino County
- Habitat for Humanity
- Home Energy Assistance Program (HEAP)
- Humane Society
- Mary's Table
- MHSA Housing Program
- The Rock Church and World Outreach Center
- San Bernardino County, Department of Adult and Aging Services/Office of the Public Guardian (DAAS/OPG)

Regional Adult Full Service Partnerships (RAFSP)

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., to provide additional FSP services throughout the various regions of San Bernardino County. The RAFSP programs provide access and linkage, as well as full wraparound care to consumers. These services include intensive level of care provided at clinics and in the field, services that assist individuals in accessing various levels of care and housing, and/or step down to a lower level of care in the least restrictive setting possible.

Individuals requiring this level of care are often unable to maintain independence in the community without the assistance of intensive case management support. The ratio of staff to consumers is typically one to ten to allow for intense support for consumers 24 hours a day/7 days per week but can include larger numbers as appropriate. 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.

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

*SMI = serious mental illness

Program Name	Actual Number Served FY 2021-22	Estimated Number Served FY 2023-24	Annual Budgeted Funds FY 2023-24	Estimated Annual Cost per Person FY 2023-24
RAFSP	654	673	$14,506,366	$21,555

Outreach and Engagement

For Fiscal Year 2021/22, the Regional Adult Full Service Partnership program conducted the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Homeless Services Collaboration with City	2	5
Total	**2**	**5**

Consumer Demographics Highlights FY 2021/22

The tables to the right show the demographics in various categories for consumers served by the RAFSP program during Fiscal Year 2021/22. The demographic information is also explained below. RAFSP staff were able to successfully reach the target population of adults living with a serious mental illness.

Age:
Of the consumers served by RAFSPs, 72% were adults between the ages of 26 and 59 years old. The RAFSP program also served consumers age 60 and older (16%), consumers between the ages of 16 and 25 years old (11%), and those under the age of 15 (1%).

Gender Identity:
Of the consumers served by RAFSPs, 57% identified as female and 43% identified as male.

Race and Ethnicity:
The RAFSP program served consumers that identify as Latinx or Hispanic (37%), Caucasian (34%), and African American (21%). Consumers who identify as Asian or Pacific Islander represent 2% and those who identify as American Indian or Alaska Native represent 1% of those served. The remaining 5% identify as a race different from those listed above.

Primary Language:
Of the consumers served by RAFSPs, 93% identified English as their primary language, while Spanish represented 5%. The remaining 2% identified a primary language other than English or Spanish.

Primary Diagnosis:
RAFSP consumers have been diagnosed with psychosis (42%), bipolar disorders (22%), and depression (19%). RAFSPs also serve consumers that are diagnosed with anxiety (6%) and substance related disorders (5%). The remaining 6% represent those that have a different diagnosis than the others listed above.

Age	
1% Children	**72%** Adult
11% TAY	**16%** Older Adult

Gender Identity	
57% Female	**43%** Male

Race/Ethnicity	
21% African American/Black	**34%** Caucasian/White
1% American Indian/Alaska Native	**37%** Latinx/Hispanic
2% Asian/Pacific Islander	**5%** Other

Primary Language	
93% English	**2%** Other
5% Spanish	

Primary Diagnosis	
6% Anxiety disorders	**42%** Psychosis
22% Bipolar disorders	**5%** Substance Related
19% Depressive disorders	**6%** Other

N=480

*NOTE: This number is an approximation. Some consumers may not have been counted.

MHSA Legislative Goals and Related Key Outcomes

✓ Reduce the subjective suffering from serious mental illness for adults:
- Improve life satisfaction
- Decrease hopelessness/increase hope
- Increase resiliency
- Decrease impairment in general areas of life functions (e.g., health/self-care/housing, occupation/education, legal, managing money, interpersonal/social)

✓ Reduce homelessness and increase safe and permanent housing:
- Decrease rate of homelessness for clients as defined by DCR
- Increase residential stability

✓ Increase access to treatment and services from co-occurring problems; substance abuse and health:
- Increase encounters in specialty co-occurring and substance abuse interventions
- Increase transportation to non-mental health co-occurring appointments (such as substance use disorder, integrated health, primary care, etc.) provided

✓ Reduce the frequency of emergency room visits and unnecessary hospitalizations:
- Reduce number of emergency room visits for mental health concerns
- Increased use of alternative crisis interventions (e.g., CWIC, CCRT, CSU)
- Increase in number of individuals diverted from hospitalization

Positive Results

Consumers are provided the full array of FSP services in order to reduce hospitalizations and hospital bed days. In the chart below, the percent of consumer who avoided hospitalizations in FY 2021/22 are reported by provider.

Provider Name	Unduplicated Consumers Served	% of Consumers Who Avoided Hospitalization Completely in FY 21/22
Barstow Counseling	35	**83%**
Mesa Counseling Services	74	**84%**
Victor Valley Counseling Center	106	**78%**
Phoenix FSP (Clinic Based)	94	**81%**
Valley Star FSP and Valley Star Behavioral Health	174	**89%**
San Bernardino Action Program	144	**85%**
Mariposa Counseling Center	27	**81%**

Success Story

Participant has been involved in a violent relationship and case manager has assisted her in obtaining restraining orders. Participant expressed her gratitude by saying, "You guys saved my life."

Challenges and Solutions

The major challenges for the RAFSP program include the limitations that have continued with the COVID-19 protocol limiting the ability to have group sessions and group outings. Staffing shortages and an increased demand for services have impacted operations for case management services. Housing shortage and locating placement with board and care facilities continue to be a challenge.

During the upcoming Fiscal Years, additional groups will be scheduled. These groups will provide an opportunity for FSP consumers to learn and share experiences with others.

Staff continue to work to find housing solutions for FSP participants. At-risk clients have been able to obtain permanent supportive housing through collaboration with the Homeless and Supportive Services programs. This has greatly improved quality of life, reduced hospitalizations and unnecessary crisis services due to participants having safe shelter.

Program Updates

In Fiscal Year 2023-2024 Regional Adult Full Service Partnership will be renamed Community Full Service Partnerships. Community Full Service Partnership will also receive an increase in funding and will continue to be reported under Community Services and Supports.

Collaborative Partners

- Adult Protective Services/Child Protective Services
- Arrowhead Regional Medical Center
- Barstow College
- Barstow Police Department
- Barstow Unified School District
- Borrego Health

Collaborative Partners (cont.)

- Caring by Nature
- Catleya Day Treatment Program
- Cedar House
- City Link Water of Life Ministries
- Department of Behavioral Health Clubhouses, Crisis Residential Treatment, Crisis Stabilization Units, and MHSA Housing, Recovery Based Engagement Support Teams (RBEST), and Shelter Bed Providers
- Department of Rehabilitation
- Desert Mana
- Desert Sanctuary
- Holistic Campus
- Inland Valley Recovery Services
- Lanterman-Petris-Short Act Designated Facilities
- Lutheran Mission
- Lutheran Social Services
- Mental Health Systems
- OmniTrans
- Resource Oversight & Guidance Incorporated
- Salvation Army
- San Bernardino County, Board and Care Facilities
- San Bernardino County, Transitional Assistance Department (TAD)
- San Bernardino County, YMCA
- Shelter Contract Providers
- South Coast Community Services
- Summit Payee Services
- Tender Hearts
- Valenta Eating Disorder Program
- Valley Star Crisis Walk In Center
- West Side Clinic
- Women, Infants, and Children (WIC) Program

Age Wise

Program Name	Actual Number Served FY 2021-22	Estimated Number Served FY 2023-24	Annual Budgeted Funds FY 2023-24	Estimated Annual Cost per Person FY 2023-24
Age Wise	108*	2,131	$2,187,857	$1,027

*This number includes FSP services only

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, substance use, and case management services throughout San Bernardino County to older adults living with mental illness 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 of San Bernardino County.

Success Story

"Josefina" (she/her) began services with the Age Wise program four years ago. Through connection and partnership with the Age Wise program, Josefina was provided individual therapy, rehabilitation activities of daily living (ADLs), and case management services. She developed coping skills which supported depressive symptom relief and enhanced her ability to practice self-care. She began to utilize local community resources and started keeping routine medical and behavioral health appointments. Josefina is now connected to resources and has frequent contact with friends and family. She has met her personal recovery goals and successfully graduated from the Age Wise program in Spring of 2022.

Program Description and Target Population (cont.)

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.

Outreach and Engagement

For Fiscal Year 2021/22, the Age Wise program conducted the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
Education and Resource Fairs	3	259
Community Outreach	4	192
Total	**7**	**451**

Consumer Demographics Highlights FY 2021/22

The tables to the right show the demographics in various categories for consumers served by the Age Wise program during Fiscal Year 2021/22. The demographic information is also explained below. Age Wise staff were able to successfully reach the target population of older adults living with a serious mental illness.

Age:
All consumers served by the Age Wise program were 60 years or older.

Gender Identity:
Of the 108 consumers served by Age Wise, 80% identified as female and 20% identified as male.

Race and Ethnicity:
Consumers who identify as Caucasian represent 52% of those served by the Age Wise program. Age Wise also served consumers who identify as Latinx or Hispanic (31%) and African American (14%). The remaining consumers identify as American Indian or Alaska Native (1%), or as a different race than those listed above (2%).

Primary Language:
Of the consumers served by Age Wise, 81% identified English as their primary language, while Spanish represented 17%. The remaining 2% identified a primary language other than English or Spanish.

Primary Diagnosis:
Age Wise consumers have been diagnosed with depression (61%), psychosis (18%), bipolar disorders (16%), and anxiety (4%). The remaining 1% represent those that have a different diagnosis from the ones listed above.

Age
100% Older Adult

Gender Identity	
80% Female	**20%** Male

Race/Ethnicity	
14% African American/Black	**52%** Caucasian/White
1% American Indian/Alaska Native	**31%** Latinx/Hispanic
	2% Other

Primary Language	
81% English	**2%** Other
17% Spanish	

Primary Diagnosis	
4% Anxiety disorders	**18%** Psychosis
16% Bipolar disorders	**1%** Other
61% Depressive disorders	

N=108

MHSA Legislative Goals and Related Key Outcomes

✓ Reduce the subjective suffering from serious mental illness for adults:
- Improve life satisfaction
- Decrease hopelessness/increase hope
- Increase resiliency
- Decrease impairment in general areas of life functioning (e.g., health, self-care, housing, occupation/education, legal, money management, interpersonal/social)

✓ Reduce homelessness and increase safe and permanent housing:
- Decrease rate of homelessness for consumers
- Increase residential stability

✓ Increase self-help and consumer/family involvement:
- Increase ration of voluntary mental health services to involuntary mental health services
- Increase number of encounters with collateral contact, such as family members and informal supports

✓ Increase access to treatment and services from co-occurring problems; substance abuse and health:
- Increase encounters in integrated health clinic and/or primary care/health specialist providers

✓ Reduce disparities in racial and ethnic populations:
- Reduce mental health and health care disparities

✓ Reduce the frequency of emergency room visits and unnecessary hospitalizations:
- Increase access to and use of existing community resources (e.g., housing, mental health services, substance use services, medical treatment, education services, etc.)
- Reduce rate of emergency room visits for mental health concerns
- Increase use of alternative crisis interventions (e.g., CWIC, CCRT, CSU)
- Increase number of individuals diverted from hospitalizations

✓ Increase a network of community support services:
- Increase in number of collaborative partners
- Increased coordination of care

Positive Results

The following table represents the measured Age Wise outcome domains and the percentage of consumers who met the criteria in each category:

Outcome Domain	Percentage of consumers
Maintained low or reduced risk of subjective suffering	74%
Maintained safe and stable housing	99%
Are stable and able to seek outside assistance to locate their own resources	70%
Consumers linked to a Primary Care Physician	97%
Diverted from hospitalization for psychiatric care	99%

Challenges and Solutions

The COVID-19 pandemic continues to present challenges for the Age Wise clientele, consisting of older adults aged 59 and older. Although the Center for Disease Control (CDC) has relaxed guidelines (e.g., masking, social distancing, community events), older adults continue to express their fears and anxieties of the unknown and potential long-term effects of both the vaccine(s) and Coronavirus side effects. As one of the most vulnerable populations, personal isolation remains a highly used practice to stay safe, yet it continues to propel higher levels of anxiety, depression, and loneliness.

Additionally, persistent challenges for older adults throughout FY 21/22 included a lack of access to affordable housing, transportation limitations, inaccessible medical care, and food insecurities. Unfortunately, the later months of FY 21/22 also highlighted economical concerns, including the elimination of the Economic Impact Payments. These issues have compounded the distress amongst older adults. For example, basic food essentials have significantly increased in price, affordable housing rents continue to move toward unattainable levels, and more sophisticated scams and fraudulent practices are increasingly targeting older adults. Lastly, triple digit heat days have steadily increased, putting more of an economic strain on the elderly to cool their homes. Optimistically, Community Outreach, Mental/Health Fairs, and local Senior Centers are slowly returning. The older adult population have attended these in-person events, with some marked hesitation, yet conversations with them note their excitement for attending and embracing a new normal.

Reliable transportation continues to be a pronounced challenge. Although social distancing regulations have recently been reduced by the CDC, older adults continue to express concerns with being in close proximity to others outside of their home. This leads to higher demands for single person transportation usage, which is severely impacting the availability of transportation. Age Wise has steadily seen an increase in requests for transportation services. The Age Wise staff spend a significant amount of time coordinating between medical appointments, utility service appointments, and the arrangement of transportation so clients can achieve multiple tasks in one outing.

Alcohol use and other substances continues to be a challenge for a few Age Wise clientele, making treatment efforts complex. The identification of increased co-occurring disorders required an intensification of the Age Wise Program's collaborative efforts with programs like Innovative Remote Onsite Assistance Delivery (InnROADs) and Substance Use Disorder and Recovery Services (SUDRS). The developed partnerships have offered sound guidance on the provision of appropriate care for the Age Wise clientele and older adults impacted.

Throughout the FY 21/22, the Age Wise Program maintained the 24/7 Senior Hotline via clinician staff to serve and provide urgent support to older adults struggling with social isolation and food insecurities, connecting them to behavioral health resources and services. During FY 21/22, the Age Wise 24/7 Senior Hotline responded to 255 calls and more than 563 calls since its inception. The 24/7 Senior Hotline received a 2021 National Association of Counties (NACo) Human Services Achievement Award for the expansion of services offered by the hotline. The 24/7 Senior Hotline will remain as a reliable resource offered by the Age Wise Program and is in practice as the FY 22/23 approaches.



"The Age Wise program really helped me. Age Wise was a great lifeline for me."

Challenges and Solutions (cont.)

The Age Wise Program maintained its use of the Coronavirus Aid, Relief, and Economic Security (CARES) Act Technology award, funded in December 2020, and is committed to indefinitely provide Telehealth services to Age Wise clientele. Age Wise staff providing services are trained as tele-mental health providers, and clinicians complete certification. The higher usage of Telehealth services is by older adults living in remote and rural areas, as well as those experiencing transportation shortages, offering them an opportunity to receive the same high-quality services even at a distance. Age Wise Telehealth services are celebrated as an initiative towards closing the digital divide among older adults.

From April 2021 to June 2022, the Age Wise program was awarded grant funding to help reinforce collaborative care for San Bernardino County older adults experiencing depression. Age Wise partnered with Lifestyle Medical of Redlands to jointly focus on wraparound efforts. The goal of this partnership was to develop a collaborative care team focused on increasing patient awareness and knowledge on the benefits of a holistic and integrated medical-behavioral health model, to promote health, independence and choice. Successes noted through efforts of the collaboration include screening and assisting more older adults with linkage to behavioral health services, therefore lowering the symptoms of depression for those served through the initiative. The partnership and referral process established will remain in practice throughout FY 22/23.

The Department of Aging and Adult Services – Public Guardian along with Public Health and local law enforcement have collaborated to address homeless within the county. Age Wise clinicians have deployed in urgent and emergent situations to provide behavioral health interventions for those experiencing symptoms of anxiety or other noticeable challenges related to being displaced. Additionally, Age Wise clinical staff have assisted the community when natural disasters such as the King Fire in Lancaster, CA displaced older adults from their home. Similarly, Age Wise staff continue to monitor clients during heat advisories issued by the County, regularly providing information on County cooling centers and arranging for transportation, as needed. The clinical staff have taken these opportunities to provide appropriate behavioral health screenings, interventions and wellness support, as well as to educate the community about the Age Wise Program. Age Wise staff have circulated brochures and flyers advertising the Age Wise 24/7 Senior Hotline and program services. In addition to these community services, Age Wise will continue to actively participate in local Health & Wellness Fairs, Senior Community Events, and other community base events to educate and increase awareness of older adult behavioral health services.

Age Wise staff continue to address the rising fraudulent and scam activities targeting the older adult population. Regular communication with Social Security Administration for updates and public information announcements regarding scam alerts will continue in FY 22/23. Clients will be contacted, informed, and educated on how to handle situations in which they may be a target, and will be guided to the appropriate services should they become a victim of fraud.

Challenges and Solutions (cont.)

Age Wise will continue to collaborate with other aging friendly partners to provide complete wraparound care. These efforts include partnerships with the Department of Behavioral Health, Mental Health Services Act (MHSA) housing communities, the Department of Aging and Adult Services – Public Guardian entities such as Adult Protective Services, and the In-Home Supportive Services (IHSS) program, Innovative Remote Onsite Assistance Delivery (InnROADs) and Substance Use Disorder and Recovery Services (SUDRS). Age Wise recognizes and values how these partnerships assist with providing more complete and comprehensive care to address the complex aging needs of the older adult community.

Due to these efforts, Age Wise received National recognition for the second year in a row and was awarded a 2022 National Association of Counties (NACo) award for the initiative titled *Age Wise Home and Community-Based Mental Health Services Expands Access for Seniors*. In addition to this recognition, Age Wise Leadership presented an overview of the program at the 2022 State Conference in Glendale, California.

Age Wise has been recognized by USAging, formally known as the National Association of Area Agencies on Aging, for its fully comprehensive service approach in addressing the complex and specialized needs of older adults. As the recipient of the 2021 *Aging Innovations Award in the Home and Community Based Services Category*, Age Wise leadership had the honor of presenting at the USAging '*Answers of Aging'* 2022 National Conference in Austin, Texas, in a workshop titled *'Integrating Behavioral Health Services in Aging and Adult Services.'*

Program Updates

Age Wise is a County program under the Department of Aging and Adult Services (DAAS). The Memorandum of Understanding (MOU) between DAAS and DBH for Age Wise services is being increased to accommodate the recent County Professional and General MOU agreements for cost of living and other wage increases.

Collaborative Partners

- Barstow Counseling
- Behavioral Health Integrated Complex Care
- Cash Assistant Program for Immigrants (CAPI)
- Catholic Charities
- Community Action Partnership (CAP)
- In Home Supportive Services (IHSS), Adult Protective Services (APS) Programs
- Habitat for Humanity
- Home Energy Assistance Program (HEAP)
- Humane Society
- Loveland Food Pantry
- Mary's Table
- Mission City Psychiatric Care
- Rock Church
- Rolling Start
- Salvation Army
- St. Joan of Arc
- St. John of God
- Tender Hearts
- Victor Valley Behavioral Health

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.

HHSCCP is comprised of:

- **Homeless Outreach Support Team (HOST)**, which offers community outreach and response, as well as housing navigation.
- **Full Service Partnership and Supportive Services**, which include intensive case management, linkage to health services, and assistance with accessing benefits and entitlements.
- **Community Supports**, which include housing transition navigation services, housing deposits, and housing tenancy for clients that have a severe mental illness.
- **Innovative Remote Onsite Assistance Delivery (InnROADs)**, which is a MHSA Innovation project that consists of an engagement team and a mobile treatment team that provide field-based services to consumers. Please refer to the Innovation section of this plan for more details.

The goal of these programs is to provide intensive outreach and engage consumers and families as active participants in their care. The programs also provide resources to increase self-help and linkage to a network of community supports.

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

*SMI = serious mental illness

The table below shows an estimate of how the program expects to perform during the next fiscal year and the associated cost:

Program Name	Actual Number Served FY 2021-22	Estimated Number to be Served FY 2023-24	Annual Budgeted Funds FY 2023-24	Estimated Annual Cost per Person FY 2023-24
HHSCCP	1,756	1,985	$16,193,299	$8,158

Target Populations

The table below identifies the target population of consumers to be served by Housing and Homeless Services Continuum of Care programs for the upcoming three fiscal years (Fiscal Year 2023/2024 – 2025/2026).

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

Number of Consumers to be Served

The table below represents the projected number of consumers to be served by the Housing and Homeless Services Continuum of Care Program (HHSCCP) for the upcoming three fiscal years (Fiscal Year 2023/24 - 2025/26). For each fiscal year, the projected total is broken up into two MHSA categories: age and service category.

Program Name	Fiscal Year	Ages Served	Service Area*	Total Served
Housing and Homeless Services Continuum of Care Programs (HHSCCP)	2023/24	• 9 TAY FSP • 515 Adult FSP • 301 Older Adult FSP	• 6 TAY GSD • 8 TAY O&E • 339 Adult GSD • 492 Adult O&E • 140 Older Adult GSD • 175 Older Adult O&E	1,985
	2024/25	• 11 TAY FSP • 564 Adult FSP • 322 Older Adult FSP	• 6 TAY GSD • 8 TAY O&E • 353 Adult GSD • 492 Adult O&E • 146 Older Adult GSD • 175 Older Adult O&E	2,077
	2025/26	• 12 TAY FSP • 609 Adult FSP • 348 Older Adult FSP	• 6 TAY GSD • 8 TAY O&E • 367 Adult GSD • 492 Adult O&E • 152 Older Adult GSD • 175 Older Adult O&E	2,169

*Service Area

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.

Note: The data above does not include InnROADs. For more information about the InnROADs program, please reference the Innovations section of this plan.

Component Descriptions

Homeless Outreach and Support Team (HOST)

HOST is a field-based program that engages individuals experiencing homelessness with a focus on those that are living with a mental illness and/or substance use disorder.

Services Provided:

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

Full Service Partnership (FSP) and Supportive Services

Full Services Partnership (FSP) provides intensive supportive services for consumers housed in the County's Permanent Supportive Housing (PSH) units with the goal of maintaining housing stability and well-being. Supportive mental health and housing services are also provided to consumers who are in PSH, but not enrolled in a FSP program.

Services Provided:

- FSP and/or mental health services for residents in PSH
- Tenancy supports
- Eviction prevention

Community Supports

The Community Supports element of HHSCCP is newly developed. It focuses on providing housing transition navigation services, housing deposits, and housing tenancy. The target population is clients with severe mental illness and have been linked to a housing voucher or rental subsidy from the Coordinated Entry System (CES).

Services Provided:

- Linkage to mental health services
- Housing navigation
- Tenancy supports

Consumer Demographics Highlights FY 2021/22

The tables to the right show the demographics for the Housing and Homeless Services Continuum of Care Programs (HHSCCP) for Fiscal Year 2021/22. The demographic information is also explained below. The HHSCCP was able to successfully reach the target population of individuals experiencing homelessness or in need of assistance with housing transition, who have a serious mental illness and/or substance use disorder.

Age:
Of the consumers served by the HHSCCP, 59% were adults between the ages of 26 and 59 years old. Of the remaining consumers, 38% were age 60 and older, while 3% were between the ages of 16 and 25.

Gender Identity:
Of the consumers served by the HHSCCP, 65% identified as female and 35% identified as male.

Race and Ethnicity:
The top three groups served by the HHSCCP identify as Caucasian (34%), African American (29%) and as Latinx or Hispanic (29%). Consumers who identify as Asian or Pacific Islander represent 2%, while Native American represents less than 1% of consumers served. The remaining 5% is unknown.

Primary Language:
Of the consumers served by HHSCCP, 90% identified English as their primary language and 6% identified Spanish. Arabic, Filipino dialect such as Tagalog, Korean, Thai, and Vietnamese were also represented at less than 1% each. The remaining 2% of consumers reported a primary language other than those listed above, or chose not to disclose this information.

Primary Diagnosis:
The HHSCCP served consumers that are diagnosed with depression (34%), psychosis (29%), bipolar disorder (19%), anxiety (8%), and substance related (3%). The remaining consumers have a primary diagnosis other than those listed above (5%), deferred diagnosis (2%), or have been diagnosed with disruptive disorder (less than 1%).

Age	
0% Children	**59%** Adult
3% TAY	**38%** Older Adult

Gender Identity	
65% Female	**35%** Male

Race/Ethnicity	
29% African American/Black	**29%** Latinx/Hispanic
2% Asian/Pacific Islander	**<1%** Native American
34% Caucasian/White	**5%** Other/Unknown

Language	
<1% Arabic	**6%** Spanish
90% English	**<1%** Thai
<1% Filipino Dialect	**<1%** Vietnamese
<1% Korean	**2%** Other/Unknown

Primary Diagnosis	
8% Anxiety	**<1%** Disruptive
19% Bipolar	**29%** Psychosis
34% Depression	**3%** Substance related
2% Deferred Diagnosis	**5%** Other

N=552

*NOTE: This number is an approximation. Some consumers may not have been counted. Not all numbers add to 100 due to rounding.

MHSA Legislative Goals and Related Key Outcomes

✓ Reduce homelessness and increase safe and permanent housing:
- Decrease rates of homelessness for clients
- Increase residence stability and safe and permanent housing

✓ Increase network of community support services:
- Increase in number of collaborative partners
- Increase self-help/support/12-step/community/school group or healthcare provider attendance and frequency per consumer
- Increase coordination care

Positive Results

The Homeless Outreach and Support Team is increasing the number of agencies that they "ride along" with to provide outreach and engagement and case management to the County's unhoused population. DBH and DBH contractors currently support 728 clients in Permanent Supportive Housing. This is an increase of 105 clients that have been housed in the past fiscal year.

Developers are also working with the County to build new affordable housing. DBH will provide the supportive services for these additional Permanent Supportive Housing units.

Program Challenges

A primary goal of the HHSCCP is to reduce homelessness and increase safe and permanent housing. However, there is not enough affordable housing for the current homeless population. Housing inventory and resources are increasingly low, making affordable options even more scarce.

Additionally, there are no non-congregate housing options for individuals living on Social Security Income (SSI) as their only form of income. While congregate housing presents a temporary solution, permanent housing for individuals is more difficult to achieve.

Program Solutions

The HHSCCP is pursuing innovative ways to increase housing options, even with the current limited availability. One example, as described in San Bernardino County's 2022 **Homeless Strategic Action Plan**, is to create pop-up or mobile shelters. Another strategy is to decrease barriers, such as allowing pets at shelters.

The Homeless Outreach Support Team (HOST) has hired additional staff to assist the homeless community in obtaining SSI. The goal of this effort is to help more individuals gain access to income and as a result decrease the number of individuals that are unhoused.

The Housing Authority has approved the use of housing vouchers for shared housing. DBH is currently exploring how to leverage this new opportunity to reach and house more individuals in need.

Outreach and Engagement

During Fiscal Year 2021/22, the Homeless Outreach and Support Team reached 324 of San Bernardino County's homeless residents through outreach and engagement activities. HOST provided case management and housing navigation services to transition clients from homelessness to permanent supported housing.

Collaborative Partners

- Community Development and Housing Agency (CDHA)
- Contracted Vendors for Emergency Shelter Beds
- Fontana Police Department
- Housing Authority of the County of San Bernardino
- Inland Housing Solutions
- Knowledge and Education for Your Success (KEYS)
- Lighthouse Social Services
- Mental Health System, Inc.
- Office of Homeless Services
- Redlands Police Department
- Rialto Police Department
- San Bernardino County Homeless Partnership
- San Bernardino County Sheriff's Department Hope Team
- Step-Up on Second
- United Way (*211 Coordinated Entry System)
- US Vets
- Veteran's Affairs

Success Story

"Sara" has a history of domestic violence and experiences mental health and substance use disorder issues. She worked with her case managers to connect with services and community supports. Within 6 months of being housed, she was able to obtain a job in trucking brokerage. This allows her to work for herself. She has plans to continue her education and training to succeed in this line of employment.

Having the stable housing and case managers that are able to meet her where she is has motivated her to move to Salt Lake City, Utah so that she is able to start a brokerage business with her sister. She said "The program gave me back hope and my life, something I will always be grateful for. Never in my life did I believe that a stranger would care about me, but you and the people of HOST never gave up on me, even when I did."

Sara now lives in Salt Lake City. She is independent and continues to work on her dream. She is still engaged in mental health and substance use disorder services. She stated, "The program works if you work it."

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 strength-based approach, promoting the principles of recovery, wellness, and resilience by maximizing the consumer's functioning to help them maintain a more satisfying quality of life.

The Adult Transitional Care program is comprised of:

- Adult Residential Facilities Certified in Social Rehabilitation Services
- Community Reintegration Services
- Enhanced Assisted Living Program
- Enhanced Board and Care Program

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

Program Name	Actual Number Served FY 2021-22	Estimated Number Served FY 2023-24	Annual Budgeted Funds FY 2023-24	Estimated Annual Cost per Person FY 2023-24
Adult Transitional Care Programs	200	422	$27,247,573	$64,568



Artwork by Steven Kruse

Target Populations

The table below identifies the target population of consumers to be served by the Adult Transitional Care programs for the upcoming three fiscal years (Fiscal Year 2023/24 - 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	
Community Reintegration Services (CRS)			X	
Enhanced Assisted Living Program				X
Enhanced Board and Care Program			X	

Number of Consumers to be Served

The tables below represent the projected number of consumers to be served by the Adult Transitional Care Programs for the upcoming three fiscal years (Fiscal Year 2023/24 - 2025/26).

Program Name	Fiscal Year	FSP	GSD	Total Served
Adult Transitional Care Programs • Adult Residential Facilities (ARF) Certified in Social Rehabilitation Services • Community Reintegration Services (CRS) • Enhanced Assisted Living Program • Enhanced Board and Care Program	2023/24	• 300 Adult FSP • 5 Older Adult FSP	• 175 Adult GSD • 4 Older Adult GSD	484
	2024/25	• 300 Adult FSP • 5 Older Adult FSP	• 175 Adult GSD • 4 Older Adult GSD	484
	2025/26	• 300 Adult FSP • 5 Older Adult FSP	• 175 Adult GSD • 4 Older Adult GSD	484

*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.

Adult Residential Facilities Certified in Social Rehabilitation Services

Program Description and Target Population

The Adult Residential Facilities (ARF) are certified through the state to deliver social rehabilitation services. Certified ARFs provide specialized rehabilitative psychiatric mental health treatment 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

Services Provided

- Residential treatment
- Rehabilitative services

Success Story

"Patty" (she/her) presented to the Social Rehabilitation program on conservatorship, struggling with an eating disorder and co-occurring substance use disorder. Once placed in the Social Rehabilitation program and provided with both residential and mental health treatment, Patty was able to stabilize, identify and apply coping skills, and work towards daily hygiene.

By the time Patty graduated the program, she was sober, managing her eating disorder, attending therapy and treatment meetings, and attending community groups such as AA meetings and parenting classes. Patty was also able to work towards a healthy relationship with her daughter. She is no longer on conservatorship and is able to live independently.

Adult Residential Facilities Certified in Social Rehabilitation Services

Consumer Demographics Highlights FY 2021/22

The tables to the right show the demographics in various categories for the ARFs Certified in Social Rehabilitation Services for Fiscal Year 2021/22. The demographic information is also explained below. The ARFs were able to successfully reach the target population of adults who have a serious mental illness and have been discharged from higher level placements.

Age:
Of the 90 consumers served by Adult Residential Facilities, 87% were adults between the ages of 26 and 59 years old. Of the remaining consumers, 8% were between the ages of 16 and 25, while 5% were age 60 and older.

Gender Identity:
Of the consumers served by ARFs, 57% identified as male and 43% identified as female.

Race and Ethnicity:
The top three groups served by ARFs identify as Latinx or Hispanic (33%), Caucasian (30%), and African American (28%). Consumers who identify as Asian or Pacific Islander represent 6% of the ARF population, while Native American represents 1%. The remaining 2% is unknown.

Primary Language:
Of the consumers served by ARFs, 92% identified English as their primary language. Other languages served include Spanish (2%) and Chinese dialect (2%), which includes Mandarin and Cantonese. The primary language for the remaining 4% is unknown.

Primary Diagnosis:
AFRs have served consumers that are diagnosed with psychosis (94%), bipolar disorder (3%), and depression (1%). The remaining 2% represents consumers with other or unknown diagnosis.

Age	
0% Children	**87%** Adult
8% TAY	**5%** Older Adult

Gender Identity	
43% Female	**57%** Male

Race/Ethnicity	
28% African American/Black	**33%** Latinx/Hispanic
6% Asian/Pacific Islander	**1%** Native American
30% Caucasian/White	**2%** Other/Unknown

Primary Language	
2% Chinese dialect	**2%** Spanish
92% English	**4%** Unknown

Primary Diagnosis	
3% Bipolar	**94%** Psychosis
1% Depression	**2%** Other/Unknown

N=90

*NOTE: This number is an approximation. Some consumers may not have been counted.

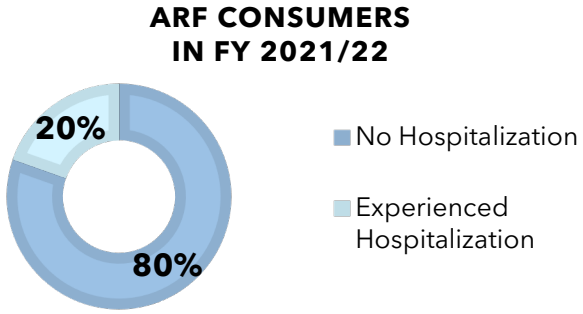
Adult Residential Facilities Certified in Social Rehabilitation Services

MHSA Legislative Goals and Related Key Outcomes

- ✓ Reduce the frequency of emergency room visits and unnecessary hospitalizations:
  - Increase access to and use of existing community resources (e.g. housing, mental health services, substance use services, medical treatment, education services, etc.)
  - Reduce number of emergency room visits for mental health concerns
  - Reduce number of emergency room visits for routine medical concerns
  - Reduce administrative hospital days
  - Increase use of alternative crisis interventions (e.g. CWIC, CCRT, CSU)
  - Increase in number of individuals diverted from hospitalization

Positive Results

In Fiscal Year 2021/22, certified ARFs served a total of 102 consumers. Of these, 20 consumers were hospitalized for varying psychiatric or medical reasons, which means 80% successfully avoided hospitalization due to the stability and interventions provided by this program.



Program Challenges

Due to limited availability and resources, the program's contracted providers have experienced challenges obtaining initial psychiatric appointments from the community mental health clinics, once a consumer was admitted to the program from a locked setting.

Additionally, consumers are often discharged from locked psychiatric hospitals with a limited supply of medications. At times, mental health clinics would not have appointments within 30 days. This would lead to a risk of consumers running out of medications and, subsequently, a potential increase in the severity of their behavioral health symptoms.

Another challenge the program continues to face is limited outreach and engagement activities, due to the ongoing COVID-19 pandemic.

Program Solutions

To address the delays of initial psychiatric appointments, DBH worked collaboratively with contract providers and the hospital staff to ensure appointments were being scheduled in a timely manner. For example, in urgent situations, the Centralized Hospital Aftercare Services Portals clinic is utilized for appointments, when no other options are available. This process assisted with ensuring that clients met with a psychiatrist for initial evaluation prior to the client running out of prescribed psychiatric medication.

Community Reintegration Services

Program Description and Target Population

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

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

Services Provided

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

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

Success Story

"Mark" (he/him) is a 60-year-old with history of significant instability in the community, including contact with the justice system, psychiatric hospitalization, and substance use. He struggled with medication compliance as well. The CRS staff worked with Mark to connect him to the Adult Continuing Care Program's psychiatrist where he receives a higher level of care in a smaller clinic. His goal was to live independently and, eventually, seek out employment.

Since Mark's connection with CRS, Mark's case manager has worked with him on skill building, problem solving, budgeting, accessing resources, and understanding cause and effect. Mark has obtained SSI and food stamps. He was able to successfully move from a board and care into a private room where he pays his own rent. He is able to grocery shop and prepare his own meals. He has learned to manage social interactions and has made new friends with those who also rent private rooms at his location. Mark has also been able to save money to purchase a vehicle.

He is determined and has shown an ability to persevere through hardships. Through the Full-Service Partnership services provided by CRS, Mark has now successfully broken decades-long patterns of self-defeating behaviors, and his quality of life has significantly improved.

Community Reintegration Services

Consumer Demographics Highlights FY 2021/22

The tables to the right show the demographics in various categories for CRS for Fiscal Year 2021/22. The demographic information is also explained below. The CRS program was able to successfully reach the target population of adults with a serious mental illness who are at risk of homelessness, incarceration, or hospitalization.

Age:
Of the consumers served by the CRS program, 79% were adults between the ages of 26 and 59 years old. Of the remaining consumers, 17% were age 60 and older, while 4% were between the ages of 16 and 25.

Gender Identity:
Of the consumers who received services from CRS, 66% identified as male and 34% identified as female.

Race and Ethnicity:
The top two groups served by the CRS program identify as Caucasian (44%) and as Latinx or Hispanic (36%). Consumers who identify as African American represent 13% of consumers served, while Asian or Pacific Islander represent 5%. The remaining 2% is unknown.

Primary Language:
Of the consumers served by CRS, 99% identified English as their primary language, with the remaining 1% unknown.

Primary Diagnosis:
The CRS program served consumers that have a primary diagnosis of psychosis (64%), bipolar disorder (12%), substance related (11%), and depression (8%). Other consumers were diagnosed with a neurodevelopmental or cognitive disorder (1%), or a disorder other than those listed above (4%).

Age	
0% Children	**79%** Adult
4% TAY	**17%** Older Adult

Gender Identity	
34% Female	**66%** Male

Race/Ethnicity	
13% African American/Black	**36%** Latinx/Hispanic
5% Asian/Pacific Islander	**2%** Other/Unknown
44% Caucasian/White	

Primary Language	
99% English	**1%** Unknown

Primary Diagnosis	
12% Bipolar	**64%** Psychosis
8% Depression	**11%** Substance related
1% Neurodevelopmental/ neurocognitive	**4%** Other

N=94

*NOTE: This number is an approximation and includes consumers served and outreach activities.

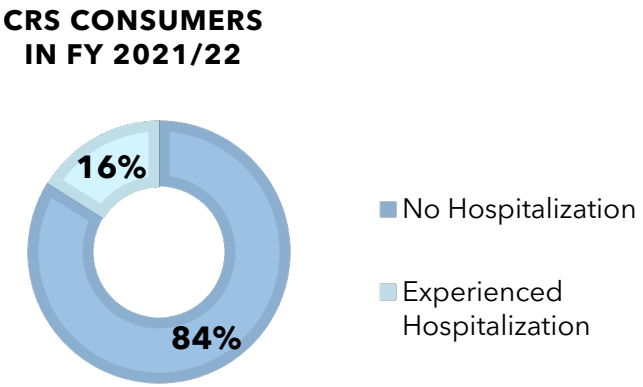
Community Reintegration Services

MHSA Legislative Goals and Related Key Outcomes

- ✓ Reduce the frequency of emergency room visits and unnecessary hospitalizations:
  - Reduce number of emergency room visits for mental health concerns
  - Increase use of alternative crisis interventions (e.g. CWIC, CCRT, CSU)
  - Increase in number of individuals diverted from hospitalization

Positive Results

In Fiscal Year 2021/22, 62 consumers received services from the CRS program. Of these, only 10 experienced psychiatric hospitalization during the year, which means 84% were successfully diverted from hospitalization.



Challenges and Solutions

The number of consumers being referred to the CRS program continues to rise due to the increased number of referrals from State Hospitals. Some consumers could not be housed immediately at the appropriate level of housing due to challenges experienced with available and appropriate options. At times, this resulted in consumers being placed into temporary shelter directly from locked psychiatric and structured care. This causes there to be multiple housing changes before a permanent solution is secured, which is time- and labor-intensive for staff, as well as disruptive for the stability of the consumers served by the program.

DBH has made significant efforts to establish and/or increase contracts with community-based organizations that will provide housing or appropriate placement options for consumers, and programming for this very difficult to serve population. Additional expansions are planned to increase placement options throughout the upcoming years. These options include additional shelter bed days, additional enhanced board and care, additional skilled nursing facility placement, and more.

Outreach and Engagement

The table below provides the outreach and engagement activities by the CRS program for Fiscal Year 2021/22.

Activity Type	Number of Activity Type	Total Number of Participants
Presentations	2	55
Education to Community Stakeholders	15	15
Total	**17**	**70**

Enhanced Assisting Living Program

Program Description and Target Population

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

Services Provided

- 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 consumer care givers

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

*SMI = serious mental illness

Success Story

"Vera" (she/her) was placed in Enhanced Assisted Living and connected with a Full Service Partnership program. She struggled with both mental health and medical concerns. She experienced paranoid thoughts, anxious feelings, and depressive symptoms daily. She would isolate in her room and conduct minimal interactions.

Vera was provided with case management and skill building sessions. Her goals were to remain sober, obtain Social Security Income (SSI), and live independently near her children. With program support, Vera was able to decrease her anxious feelings and manage her symptoms more effectively. The Enhanced Assisted Living offered Zumba classes, to which Vera eventually began to participate in, and she began to follow her recommended diet to assist with her diabetes.

Vera was able to increase her social skills and decrease her symptoms. Vera graduated the program and stepped down to independent living and linked to SSI Advocacy resources. She has maintained all of her follow up medical and mental health appointments and successfully obtained SSI. Vera has successfully met her goals as she has remained sober and is now living independently near her children.

Enhanced Assisting Living Program

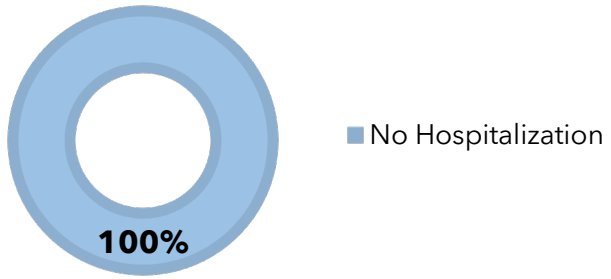
MHSA Legislative Goals and Related Key Outcomes

- ✓ Reduce the frequency of emergency room visits and unnecessary hospitalizations:
  - Reduce number of emergency room visits for mental health concerns
  - Reduce administrative hospital days
  - Increase use of alternative crisis interventions (e.g. CWIC, CCRT, CSU)
  - Increase in number of individuals diverted from hospitalization

Positive Results

In Fiscal Year 2021/22, 8 consumers received services from the Enhanced Assisted Living program. None of these consumers experienced a psychiatric hospitalization during the year, which means 100% were successfully diverted from hospitalization.

ENHANCED ASSISTED LIVING PROGRAM CONSUMERS IN FY 2021/22



Outreach and Engagement

The table below provides the outreach and engagement activities by the Enhanced Assisted Living program for Fiscal Year 2021/22.

Activity Type	Number of Activity Type	Total Number of Participants
Presentations	2	55
Program Education	8	8
Total	**10**	**63**

Challenges and Solutions

The program faced challenges at times with timely placement. COVID-19 pandemic continued to cause delays due to active infection. Additionally, staffing shortages at contracted facilities affect communication and placement.

To address these challenges, the DBH contract providers are actively recruiting staff and working to improve communication.

Enhanced Board and Care Program

Program Description and Target Population

The Enhanced Board & Care Program is an expanded MHSA program to enhance the residential support of complex and challenging adult consumers experiencing chronic behavioral 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 to the community. This level of care provides the consumer with a community step down opportunity, when clinically appropriate, into an unlocked setting with enhanced staffing to ensure a seamless transition back into the community.

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

*SMI = serious mental illness

Services Provided

- Residential services
- Special dietary and medical needs
- Transportation
- Facilitate access to needed services
- Recovery-oriented social education classes/groups
- Crisis intervention
- Medication support

Success Story

"Joe" (he/him) stepped down into Enhanced Board & Care from a locked psychiatric placement. With this program, he was able to work his treatment program to build upon his coping and independent living skills. He successfully terminated his conservatorship after 4.5 years and worked with treatment and Behavioral Health Long Term Care staff to develop a plan to safely return home with family. He was connected to outpatient services near his family home. Since his move, he has been seen monthly by a psychiatrist. He has also worked with a case manager and does not have any psychiatric hospitalizations since his move home.

Enhanced Board and Care Program

MHSA Legislative Goals and Related Key Outcomes

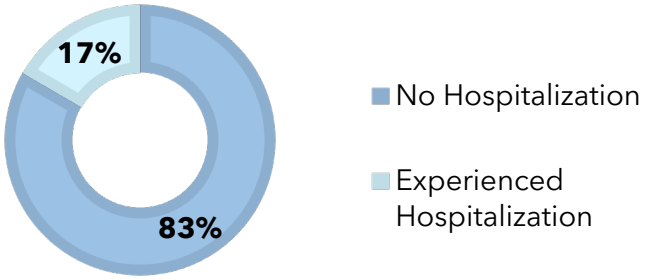
✓ Reduce the frequency of emergency room visits and unnecessary hospitalizations:

- Reduce number of emergency room visits for mental health concerns
- Increase use of alternative crisis interventions (e.g. CWIC, CCRT, CSU)
- Increase in number of individuals diverted from hospitalization

Positive Results

In Fiscal Year 2021/22, the Enhanced Board and Care program served 12 consumers. Of these, two consumers went to the hospital for medical related reasons. This means that 83% avoided hospitalization, and 100% avoided psychiatric hospitalization.

ENHANCED BOARD AND CARE PROGRAM CONSUMERS IN FY 2021/22



Outreach and Engagement

The table below provides the outreach and engagement activities by the Enhanced Board and Care program for Fiscal Year 2021/22.

Activity Type	Number of Activity Type	Total Number of Participants
Presentations	2	55

Program Challenges

COVID-19 exposures continue to be a challenge for residential programs, especially during peak seasons. During quarantine times, limited activities and groups are available at the facility and within the community. Additionally, family and outside visitors are limited, which has a negative impact on treatment and progress in goals to moving to a lower level of care.

Program Solutions

During Fiscal Year 2021/22, the Anne Sippi Clinic (ASC) revitalized the outdoor grounds to provide a more tranquil and community centered atmosphere. The outdoor options allow for future outdoor group activities with spacing options, which will also allow for increased spacing to ensure distancing during any future peak seasons that may occur. The outdoor revitalization will also assist by providing a space where residents are able to visit with family or County staff in a setting that follows CDC social distancing recommendations.

Adult Transitional Care Program Updates

The **Adult Transitional Care** programs will start expanding in Fiscal Year 2022/23 and will continue expanding during the upcoming fiscal years. The funds from this expansion will be used to:

- Address upcoming legislation, such as the Community Assistance, Recovery, and Empowerment (CARE) Court Program
- Increase the amount in social rehabilitation beds available to consumers
- Address the increase in the per day bed rate
- Offer additional services at board and care facilities

In September 2022, Governor Gavin Newsom approved Senate Bill (SB) 1338, also referred to as CARE Court. CARE Court was created with the intention of demonstrating that people with untreated psychosis can be stabilized and housed in community-based care settings. As a result, Centralized Hospital Aftercare Services is working to increase alternative appropriate placement options, including the number of available shelter beds.

One way that this is being accomplished is by increasing the number of contract providers for the **Adult Residential Facilities (ARF) Certified in Social Rehabilitation Services** program and the **Enhanced Board and Care** program. With the new vendors, DBH is expecting to serve an additional 24 consumers at ARFs and an additional 260 consumers at enhanced board and care facilities during each fiscal year. With this expansion, the **Enhanced Board and Care** program target population will shift to now include justice-involved individuals, as well as those who experience co-occurring medical complications who are not being served by other facilities. These enhancements to the **ARF Certified in Social Rehabilitation Services** and **Enhanced Board and Care** programs will start in Fiscal Year 2022/23 and programs will continue expanding during the upcoming Fiscal Years.

The **Community Reintegration Services (CRS)** team is also expanding to include a separate team that will serve those placed at new board and care facilities. The CRS team will ensure transition services are provided as a consumer is placed in the community, including follow up case management and discharge planning.

The **Adult Transitional Care** programs are also anticipating increased costs due to the state of the economy. One of the expected changes is an increase in day bed rate at the contracted facilities, to account for both the cost of living increase and the minimum wage increases that have occurred over the past five years. The minimum wage pay per hour has increased by 55% (from $10.00 to $15.50) between 2017 to 2022. Additionally, inflation has increased costs by approximately 3% for items such as rents, utilities, property taxes, insurance, gas, groceries, etc. This increases overall costs for contractors to continue to run the ARF and enhanced board and care facilities.

One of the existing enhanced board and care contract providers is also proposing to add a health program to increase the physical activity of consumers placed at the enhanced board and care. According to the Centers for Diseases and Control Prevention website, obesity increases the risk of severe illness from COVID and triples the risk of hospitalization. The new proposed program will include inviting health educators to discuss dietary therapy topics, inviting yoga instructors to conduct classes, and purchasing equipment such as stationary bikes. This new program will also include instruction on how to exercise in the community appropriately and purchase healthy foods regularly as part of daily life once transitioned to a lower level of care.

These changes will help the **Adult Transitional Care** programs maintain the infrastructure and resources that are required to serve the community and to continue meeting its MHSA Legislative Goals of reducing emergency room visits and unnecessary hospitalizations.

SAN BERNARDINO COUNTY
Behavioral Health

MHSA Three-Year Program and Expenditure Plan for FYs 23/24-25/26: 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 a primary focus on providing services.

Innovation projects create an environment for the development of new and effective practices and/or approaches in the field of behavioral health. Innovation projects are time-limited, must contribute to learning, and be developed through a process that is inclusive and representative, especially of unserved, underserved, and inappropriately served populations.

Innovation projects are designed to support and learn about new approaches to behavioral health care by doing one of the following:

- Introduce a behavioral health practice or approach that is new to the overall behavioral health system, including, but not limited to, prevention and early intervention.
- Make a change to an existing practice in the field of behavioral heath, including, but no limited to application to a different population.
- Apply to the behavioral health system a promising community-driven practice or an approach that has been successful in a non-behavioral health context or setting.

This component is unique because it focuses on research and learning that can be utilized to improve the overall public behavioral health system. All Innovation projects must be reviewed and approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC).

MHSA Legislative Goals

The overall MHSA goal of the Innovation component is to implement and test novel, creative, time-limited, or ingenious mental health approaches that are expected to contribute to learning, transformation, and integration of the mental health system.

Every Innovation project must identify one of the following primary purposes as part of the project's design:

- Increase access to mental health services to underserved groups.
- Increase the quality of mental health services, including measurable outcomes.
- Increase access to mental health services.
- Promote interagency and community collaboration related to mental health services, supports, or outcomes.



All Innovation projects have been developed through extensive collaboration with DBH partners, stakeholders, consumers, and community members. Innovation projects are subject to approval by the San Bernardino County Board of Supervisors and the MHSOAC, with the local Behavioral Health Commission being responsible for confirming that the stakeholder process was complete.

Innovation

INNOVATIVE PROJECTS

2010

Online Diverse Community Experience (ODCE): **September 2010 – June 2013**
Established the department's presence on social media sites (Facebook and Twitter).

Coalition Against Sexual Exploitation (CASE): **September 2010 – June 2014**
A collaborative partnership to provide a model of interventions and services with the goal of reducing the number of children affected by sexual exploitation.

Community Resiliency Model (CRM): **December 2010 – December 2013**
A community-based model of wellness skills that provides mental health education, including coping skills, trauma response skills, and resiliency techniques.

2011

Holistic Campus: **October 2011 – June 2015**
Brought together a diverse group of individuals, family members, and community providers to create their own individual-focused resources, networks, and strategies, growing out of cultural strengths.

2012

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

TAY Behavioral Health Hostel (The STAY): **July 2012 – March 2017**
Short-term, 14 bed, crisis residential treatment program for the Transitional Age Youth (TAY) population who are experiencing an acute psychiatric episode or crisis, and are in need of a higher level of care than a board and care residential, but lower level than psychiatric hospital.

2014

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

2019

Innovative Remote Onsite Assistance Delivery (InnROADs): **April 2019 – March 2024**
Provides intensive, field-based engagement model that supports multidisciplinary/multiagency teams that meet, engage, and provide treatment to consumers and their families where they live within homeless communities.

2020

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

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

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

Timeline does not include "potential" projects.

Innovative Remote Onsite Assistance Delivery (InnROADs)

Innovation Projects	Actual Number Served FY 2021-22	Estimated Number Served FY 2023-24	Annual Budgeted Funds FY 2023-24	Estimated Annual Cost per Person FY 2023-24
InnROADs INN Project	2,093	2,000	$4,027,762	$2,014

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

Target Population and Project Description

InnROADs is a voluntary, client-centered project which provides field-based services to individuals with untreated mental illness and experiencing homelessness.

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

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

What have we learned during FY 2021-22?

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

Culturally Responsive Engagement: Understanding cultural diversity and the ways in which it impacts decision making is a key requirement for effective and responsive outreach and engagement. Over the course of the last fiscal year, the homeless engagement teams have been restructured to allow the engagement team members flexibility to be responsive to cultural needs of those that they are engaging with. This flexibility has allowed members to address language needs and other cultural needs that may present as barriers to engagement if handled by someone unfamiliar with the culture. This learning has resulted in the merging of two engagement teams making a larger culturally diverse team that is centrally located with team members available to be deployed to where the cultural expertise is needed.

Consumer Demographics Highlights FY 2021-22

Age

5% TAY
77% Adult
18% Older Adult

Sexual Orientation

4% of consumers identified as LGBTQ+

Gender Identity

65% Male
35% Female
UNK **.01%** Other

*Note: >1% of total Declined to State

Race/Ethnicity

13% African-American/ Black
1% Asian/Pacific Islander
54% Caucasian/White
26% Latinx/Hispanic
1% American Indian/ Alaska Native
3% Multiple Races/ Other

Information represented based on data collected in the field and may not be representative of the total number of unique clients served.

InnROADs Collaborative Partners

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

What have we learned during FY 2021-22? (cont.)

2022 Homeless Point in Time Count: The 2022 Homeless Point in Time Count revealed that the seven cities of San Bernardino, Redlands, Colton, Fontana, Ontario, Victorville and Barstow comprised 80% of the County's homeless population. Although still providing services to all regions of the County, there is a focused approach in providing services in these seven cities. InnROADs teams work with locally based organizations to provide assistance and case management for the individuals who need it.



Example of a remote site where the InnROADs team meets with a community member who is experiencing homelessness. Remote site does not receive cell signal and is an eight minute drive to the nearest two-lane road.

Need for a Rapid Response Team(s): Shortly after the InnROADs project fully launched, the COVID-19 pandemic began which required the regional field-based engagement teams to adapt and respond to new needs in the homeless community such as addressing food insecurity, and later providing vaccinations to this population. The service delivery model shifted from being a high frequency/high intensity street-medicine team approach to a "rapid response" model where services and resources were provided through short-term engagements with a higher number of individuals. InnROADs teams were able to adapt to the needs within the community.

Post COVID-19 pandemic, the InnROADs team have identified the need to continue providing both engagement services based on the original plan and target response services based on community needs. Providing engagement services include intensive engagement and street-based behavioral health treatment. Targeted response includes addressing immediate needs of individuals in the community as well as short-term interventions specific to the individuals care needs, linkage to appropriate community resources, and/or referral to Engagement Teams. Data shows that a sampling of 2,004 individuals engaged in the past year 91% were seen five times or less and 77% were engaged only once or twice. Based on these findings InnROADs will implement dedicated "Rapid Response Teams" who will address these immediate community needs. Engagement Teams will continue to provide intensive engagement services. Staffing will be added to these teams without affecting the InnROADs approved funding

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

Consumer Demographics Highlights FY 2021-22

Veterans



4% of consumers identified as a veteran

Language



97% English

3% Spanish

*Note: >1% listed primary language as Other

Information represented based on data collected in the field and may not be representative of the total number of unique clients served.

Project Learning Goals

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

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

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

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

InnROADs Positive Project Outcomes FY 2021-22



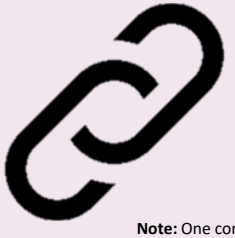
5,049
Records of Engagement for FY 2021 - 22



148
Medical Assessments documented



305
Crisis Activities



1,038
No. of total of Referral/Linkage Activities

Note: One consumer may have more than one linkage.



502
Counseling and/or Therapy Activities



2,093
unduplicated consumers received services during FY 2021 - 22

Program Updates

Creation of Rapid Response Teams: The purpose of the Rapid Response Teams will be to respond to calls from law enforcement and other community stakeholders on individuals who are homeless and are presenting with an immediate need. Service delivery will consist of short-term interventions specific to the individuals care needs, Public Health communicable disease services, linkage to appropriate community resources, referral to a Street Medicine Team, and/or referral to Regional Engagement Teams to provide intensive engagement and behavioral health treatment.

InnROADs is slated to end as an Innovation Project in Fiscal Year 2023/2024. Planning for sustainability is underway and will continue into Fiscal Year 2023/2024. In the next fiscal year a final report with comprehensive evaluation and outcomes in compliance with the regulations set forth for Innovation Reporting by the MHSOAC.

Eating Disorder Collaborative (EDC)

Innovation Projects	Actual Number Served FY 2021-22	Estimated Number Served FY 2023-24	Annual Budgeted Funds FY 2023-24	Estimated Annual Cost per Person FY 2023-24
EDC INN Project	124	134	$2,548,120	$19,016

Estimated number to be served on FY 2024-25: 134; FY 2025-26: 67

Program Serves	Symptom Severity	Location of Services
16+	N/A	CLINIC

Target Population and Project Description

The Eating Disorder Collaborative will focus on increasing the regional understanding of eating disorders (EDOs) to facilitate early identification and access to effective treatments. This project will improve our system of care to better meet the physical and mental health needs of people with EDOs by achieving the following:

- The development and distribution of trainings and informational materials
- Establishing a more robust initial eating disorder assessment tool
- The creation and activation of specialized, multidisciplinary eating disorder treatment teams

Positive Results

- In FY 2021-22 EDC continued to work with managed care partners by coordinating care and ensuring authorizations of services for eating disorder clients. EDC also assisted in linking clients to Higher Level of Care Treatment Programs (i.e. Residential, Partial Hospitalization, Intensive outpatient) when needed and/or to Outpatient Services upon discharge.
- In FY 2021-22 EDC staff participated in the International Association of Eating Disorder Professionals Virtual Symposium which included foundational core courses. The topics included: Overview of Eating Disorders, Psychological Treatment of Eating Disorders, Nutrition Therapy for Eating Disorders and Medical Treatment of Eating Disorders.
- EDC hosted a two-part training series for DBH staff and contracted providers specifically on Dialectical Behavioral Therapy and the skills needed for working with clients with disordered eating.

Consumer Demographics Highlights FY 2021-22

Age



0% Children
73% TAY
32% Adult
0% Older Adult

Sexual Orientation



5% of consumers identified as LGBTQ+

Gender Identity



1% Male
99% Female

Language



86% English
8% Spanish
6% Unknown

Race/Ethnicity

0% African-American/ Black
0% Asian/Pacific Islander
40% Caucasian/White
53% Latinx/Hispanic
7% American Indian/ Alaska Native
0% Multiple Races/ Other

Information represented based on data collected at the time of referral from managed care plan and may not be representative of the total number of unique clients served if client internally referred to program.

Challenges/Solutions

- Staff hiring and retention remained a challenge during FY 2021-22. EDC management continues to work with Human Resources to recruit and onboard necessary staff. See the Workforce, Education, and Training Component for additional information on Departmentwide efforts that address staffing issues.

Program Updates

- EDC will continue to work with managed care plans to provide service authorizations for eating disorder clients, referral to appropriate care, care coordination, linkage to outpatient services, and case management for individuals served by the Eating Disorder Collaborative program.
- Additional coordination with Human Resources staff on recruiting and onboarding necessary staff will occur during the upcoming fiscal year.
- EDC staff will work to identify additional trainings re: eating disorders and treatment options that can be provided to all staff and contracted providers.

Project Learning Goals

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

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

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

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

Multi-County Full Service Partnership (FSP) Project

Innovation Projects	Actual Number Served FY 2019-20	Estimated Number Served FY 2021-22	Annual Budgeted Funds FY 2022-23	Estimated Annual Cost per Person FY 2022 - 21
Multi-County FSP Project	N/A	N/A	$0	N/A

Target Population and Project Description

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

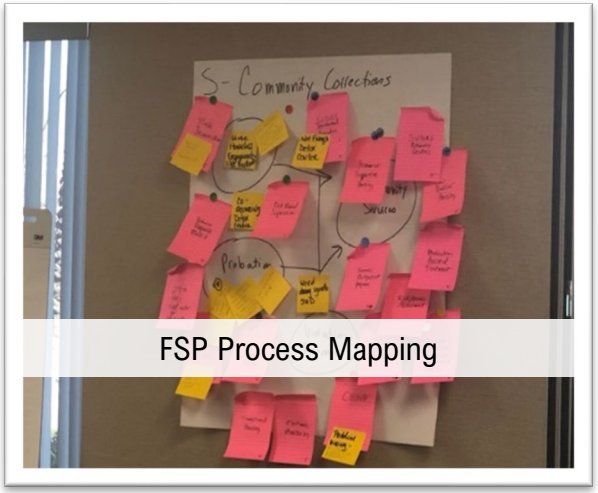
A cohort of six diverse counties — Fresno, Sacramento, San Bernardino, San Mateo, Siskiyou, and Ventura, in partnership with Third Sector, the California Mental Health Services Authority (CalMHSA), the Mental Health Services Oversight and Accountability Commission (MHSOAC), and RAND Corporation, are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

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

Milestones in FY 2021-22

During the last fiscal year, SBC-DBH accomplished the following:

- Standardization of Graduation Guidelines that balance individual services and supports plans and system-wide outcomes in making individual graduation decisions.
- Began the process in developing an electronic referral process and protocols to ensure consistent data collection across FSP programs.
- Improved data reporting by updating existing and/or developing new data reports so that DBH and providers can more effectively, collect, access and utilize FSP Data to inform care decision and understand outcomes.



FSP Process Mapping

Milestones in FY 2021-22, cont.

As part of the larger FSP cohort San Bernardino County and the other five cohort counties built, and finalized, the development of shared population definitions, outcomes, process measures, and statewide data recommendations. As a result, San Bernardino will have more comparable and actionable FSP data that can be used to identify and disseminate FSP best practices. The following activities were developed by the cohort:

- *Population definitions: S*tandardized definitions for the following priority FSP populations: "homeless", "at risk of homelessness", "justice-involved", "at-risk of justice involvement", "high-utilizers of psychiatric emergency facilities", "at-risk high utilizers of using psychiatric emergency facilities."
- *Outcomes & process metrics:* Identified 3-5 outcomes, 3-5 process measures, and associated metrics to track what services individuals enrolled in FSP receive and how successful those services are. In January 2022, San Bernardino, and the other five counties, will began sharing data with RAND for the evaluation portion of the project and to compare outcomes across counties.
- *State reporting recommendations:* Finalized recommendations for revising the statewide Data Collection & Reporting (DCR) system.



23
Workgroup meetings with DBH program leads and support staff during July 2021 – June 2022

Project Learning Goals

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

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

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

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

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

Post Implementation and Sustainability Phase Summary

In the beginning of 2020, counties began the Landscape Assessment phase of the project to learn how each county's FSP programs are structured and identifying program assets and opportunities in service design, populations served, data collection, and eligibility/graduation practices. During this phase the cohort was able to identify the foundational components necessary to begin creating consistency across programs and counties.

These learnings included setting the project goals that could be implemented at the cohort level including:

- Defining population characteristics for the six main populations served (homeless, frequent utilizer of psychiatric or crisis services, justice involved, and the corresponding at risk populations).
- Creating standardized outcomes and process measures to track progress (increased stable housing, reduced justice involvement, reduced utilization of psychiatric facilities, increased social connectedness, and service utilization and location of services).
- Develop state reporting recommendations to address challenges with the Data Collection and Reporting (DCR) system in order to make outcomes data more readily accessible for monitoring program and client success.

Additionally, the cohort learned that some challenges may be better addressed at the local level with each of the six counties determining what areas could be improved for their specific populations. With the input from stakeholders, San Bernardino County used this opportunity to focus on developing a streamlined referral process and guidelines, stepdown guidelines, and new data reports to share with providers on a regular basis.

Stakeholder feedback played an important role in not only determining which activities to pursue but also throughout the implementation process as feedback was solicited throughout in the form of workgroups, surveys, and interviews with staff, providers, peer advocates, and clients.

Stakeholder Engagement Lessons Learned and Best Practices:

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

Cross-County Collaboration Lessons Learned:

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

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

Cracked Eggs

Innovation Projects	Actual Number Served FY 2021-22	Estimated Number Served FY 2023-24	Annual Budgeted Funds FY 2023-24	Estimated Annual Cost per Person FY 2023-24
Cracked Eggs INN Project	18	25	$181,000	$7,240

Estimated number to be served on FY 2024-25: 25; FY 2025-26: 25

Program Serves	Symptom Severity	Location of Services
16+	N/A	Online

Target Population and Project Description

Cracked Eggs is a workshop series is designed around teaching participants to utilize the symptoms from their mental illness as techniques to create art. This workshop empowers peers to not see symptoms as negative but as aspects of themselves that can be used as a creative tool. Using a strength-based approach helps a participant find a form of expression, beyond words, that can be used to describe their lived experiences.

The target population for this project are individuals living with mental illness that are individuals over the age of 18.

Positive Results

- First cohort successfully launched with an initial 18 consumers expressing interest in participating.
- One workshop participant was spotlighted on the virtual stage (i.e., appeared via Zoom), where her performance was viewed by other artists from across the globe.

Age

0% Children
72% TAY
11% Adult
17% Older Adult

Sexual Orientation

0% of consumers identified as LGBTQ+

Gender Identity

28% Male
72% Female

Language

89% English
6% Spanish
5% Cantonese

Race/Ethnicity

11% African-American/ Black
16% Asian/Pacific Islander
39% Caucasian/White
22% Latinx/Hispanic
7% American Indian/ Alaska Native
5% Multiple Races/ Other

Information represented based on data collected at initial workshop meeting and may not be representative of the total number of unique that participated throughout the entire workshop series.

Innovation: Cracked Eggs INN-11

Challenges/Solutions

- Keeping attendance up by conducting cohort workshop classes on a virtual platform has been challenging. The exercises presented were designed and intended to be conducted in-person and have been reworked for the virtual environment for the benefit for workshop participants, but initial feedback from participants indicates a desire to return to in-person programming. Now that the public health emergency has ended programming will return to in-person

Program Updates

- Cohort 2 planning began with an initial interest of 11 participants.



Project Learning Goals

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

Learning Goal #2: Examine if participation in Cracked Eggs leads to improved client 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 clients 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 clients find important from their Cracked Eggs experience. Is there a way to include and centralize art as a leading indicator in an evaluation?

Innovation Proposed Project

Progressive Integrated Care Collaborative (PICC)

Innovation Projects	Actual Number Served FY 2021-22	Estimated Number Served FY 2023-24	Annual Budgeted Funds FY 2023-24	Estimated Annual Cost per Person FY 2023-24
PICC INN Project	N/A	TBD	TBD	TBD

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

Target Population and Project Concept

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. Some of these advances have been driven by primary care providers, while others have been driven by behavioral healthcare practitioners. The field of psychiatry is poised to become a major participant in the new integrated model. But currently there is a lack of best practices that speak to how integrated care should be effectively coordinated between the needed disciplines of behavioral health and physical health.

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 death decades earlier than necessary, often from easily treatable health conditions. Additionally, the lack of consistent, ongoing care forces these individuals to utilize hospital and emergency department services at rates far higher than if a primary care physician provided the care.

Possible Innovative Components

- Delivering limited physical health care services within a behavioral health care setting.
- Delivering integrated behavioral health, physical health, and substance use disorder services to Medi-Cal enrollees at a pilot clinic sites in collaboration with the Inland Empire Health Plan.
- Financial integration of behavioral health, physical health, and substance use disorder services with a single entity with the goal to promote efficiency, eliminate waste, and produce better consumer outcomes.

Project Proposal

San Bernardino County Department of Behavioral Health (SBC-DBH) seeks to address this challenge by introducing *Progressive Integration* that will be based upon a strategy of selection of best practices from a given discipline and applying that uniformly across practice specialties.

- ***Laboratory Studies*:** Physical health, mental health and substance use treatment rely upon the collection of laboratory specimens to evaluate and monitor patients' organ function, sobriety, medication effect, medication levels and other critical parameters. Onsite collection of urine, blood and other body fluids with pickup by a contracted laboratory partner will allow all disciplines to have reliable and timely access to this information. The first goal of the PICC project is to facilitate this either through nursing or through the addition of a trained phlebotomist. Additionally, certifying the integrated care site as a CLIA waived laboratory with Centers for Medicare and Medicaid (CMS) and registering with the California Department of Public Health will facilitate an expanding array of point of care testing options
- ***Electrocardiograms and radiographic studies:*** Electrocardiograms provide critical insight into cardiac function which is frequently altered by psychotropic medications, potentially leading to medical complications. Electrocardiogram results can offer a preliminary interpretation in the clinic but should be verified by a contracted cardiology service for final results. Radiographic studies which include ultrasound studies, X-Ray studies, Computed Tomography and Magnetic Resonance Imaging provide detailed and objective evidence in support of accurate diagnosis of physical health conditions which frequently have implications for both mental health and substance use recovery. In office ultrasound can provide rapid diagnostic information while more advanced imaging studies require a referral system to be established along with a contract for interpretation by skilled physician radiologists.
- ***Data Sharing:*** Health information related to physician and staff notes, outside laboratory studies, radiographic studies, specialist procedures and inpatient psychiatric visits greatly informs 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 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.
- ***Billing:*** Cost data related to laboratory services, electrocardiogram and radiographic studies, 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.

Innovation Proposed Project

Vyvanse in Stimulant Addiction (VISA)

Innovation Projects	Actual Number Served FY 2021-22	Estimated Number Served FY 2023-24	Annual Budgeted Funds FY 2023-24	Estimated Annual Cost per Person FY 2023-24
VISA INN Project	N/A	TBD	TBD	TBD

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

Target Population and Project Concept

Addiction to methamphetamine plagues a significant proportion of consumers in San Bernardino County. Recent changes in illicit drug manufacturing have increased the potency of available methamphetamine contributing to dependence, worsened mental health, significant physical health consequences, and worsened social function. While an extensive body of medical publications describe attempts to *reduce* cravings, **there are no adequately supported Medication Assisted Treatment (MAT) options for individuals seeking treatment for methamphetamine use**.

To address this gap in MAT options, San Bernardino County Behavioral Health seeks to conduct a case control study compliant with an Institutional Review Board approved protocol comparing engagement outcomes an individual receiving Vyvanse plus peer to that of an individual receiving standard care plus peer support. This process would provide an objective evaluation of a promising MAT modality that specifically targets the needs of this patient population.

Possible Innovative Component

- Providing Medication Assisted Treatment (MAT) using Vyvanse for individuals addicted to methamphetamine in a public mental health and substance use setting that addresses withdrawal symptoms not addressed by other treatments

SAN BERNARDINO COUNTY
Behavioral Health

MHSA Three-Year Program and Expenditure Plan for FYs 23/24-25/26: 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 underrepresentation of diversity of professionals with consumer and family member experience. To address challenges faced by the public behavioral health workforce, the MHSA included a component for Mental Health Workforce Education and Training (WET) programs.

WET is a program that provides training opportunities to the Department of Behavioral Health's (DBH) staff and contract agency staff, promotes the recruitment and hiring of a culturally diverse workforce, offers financial incentives to recruit and retain staff, recruits volunteers for the department, facilitates clinical intern programs, supports the inclusion and incorporation of consumers and their family members into the behavioral health workforce, and is committed to addressing the workforce shortage within San Bernardino County through utilization of various strategies to recruit and retain qualified behavioral health employees.

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.



Artwork by Veronica Preciado

MHSA Legislative Goals

Address workforce shortages and deficits identified in the workforce needs assessment:

- Increase in the number of employees hired in identified needs assessment areas
- Increase in pre-licensed to licensed baseline statistics
- Increase in the number of qualified applications received for clinical positions
- Increase in DBH pre-licensed clinicians hired (interns vs. non-interns

Designate a WET Coordinator:

- WET Coordinator designated

Educate the workforce on incorporating the general standards:

- Training documented addressing these standards
- Training evaluations

Increase the number of clients and family members of clients employed in the public mental health system

- Increase number of peer and family advocates (PFAs) hired

Conduct focused outreach and recruitment to provide equal employment opportunities in the public mental health system for individuals who share the racial/ethnic, cultural, and/or linguistic characteristics of clients. Family members of clients, and others in the community who have serious mental illness and/or serious emotional disturbance:

- Documented efforts that target the identified populations
- Adherence to cultural competency training requirement
- Increase in hiring of culturally competent staff
- Increase in the number of bilingual staff, applicants, and interns

Provide financial incentives to recruit or retain employees within the public mental health system:

- Financial incentives implemented
- Tracking for employee scholarship applicants
- License Exam Preparation Program statistics

Incorporate the input of clients and family members of clients, and when possible, utilize them as trainers and consultants in public mental health WET programs and/or activities:

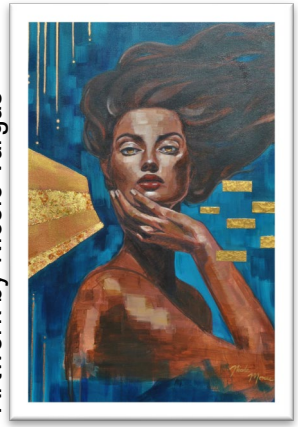
- Documented meetings with clients and family members
- Documented trainings facilitated by clients and family members

Incorporate the input of diverse racial/ethnic populations that reflect California's general population into WET programs and/or activities:

- Documented meetings with diverse racial/ethnic populations

Establish regional partnerships:

- Participate in meetings



Artwork by Nicole Vargas

Workforce Education and Training

Positive Results

To meet the goal of addressing workforce shortages, a needs assessment was completed in July of 2008 and 2013, both 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 Fiscal Year 2021/22, including the Alcohol and Drug Counselor, Licensed Vocational Nurse, Mental Health Nurse II, and Psychiatric Technician I.

There was also a dramatic increase in applications for the Pre-Licensed Clinical Therapist position in Fiscal Year 2021/22.

Job Title	Number of Qualified Applications Received in FY 2021/22	Job Title	Number of Qualified Applications Received in FY 2021/22
Alcohol and Drug Counselor	45	Nurse Manager	N/A
Child Psychiatrist	8	Nurse Supervisor	1
Clinic Assistant	96	Peer and Family Advocate I	N/A
Clinic Supervisor	27	Peer and Family Advocate II	N/A
Clinical Therapist, LCSW	14	Peer and Family Advocate III	N/A
Clinical Therapist, MFT	7	Pre-Licensed Clinical Therapist, LCSW	152
Clinical Therapist, Psychology	3	Pre-Licensed Clinical Therapist, MFT	72
Clinical Therapist II	54	Pre-Licensed Clinical Therapist, Psychology	35
Licensed Vocational Nurse	122	Pre-Licensed Clinical Therapist, LPCC	37
Mental Health Education Consultant	23	Program Manager I	75
Mental Health Nurse II	86	Program Manager II	15
Mental Health Specialist	63	Psychiatric Technician I	49

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 to help staff obtain licensure for their discipline.

For LEPP 1-12, there has been, on average, an approximately **75%** licensure rate among the participants. DBH expects the percentage of pre-licensed to licensed clinicians to continue to increase with the benefit of LEPP as seen below.

Program	Fiscal Year	# of Applicants	# Who Became Licensed	% Licensed
LEPP 1	2009/10	60	41	68%
LEPP 2	2010/11	38	24	63%
LEPP 3	2011/12	32	19	59%
LEPP 4	2012/13	18	16	89%
LEPP 5	2013/14	41	37	90%
LEPP 6	2014/15	59	54	92%
LEPP 7	2015/16	65	58	89%
LEPP 8	2016/17	49	37	76%
LEPP 9	2017/18	41	29	71%
LEPP 10	2019/20	35	26	74%
LEPP 11	2020/21	26	19	73%
LEPP 12	2021/22	31	12	39%
Grand Total		**495**	**372**	**75%**

Through 12 Cohorts of LEPP, Prior to Implementation of Revised LEPP*			
	Clinical Therapist I	**Clinical Therapist I Psychologist**	**Total**
Licensed	50	5	**55**
Pre-Licensed	94	7	**101**
Total	144	12	**156**
Percentage Licensed	34.7%	41.7%	**35.3%**

*DBH has seen a decrease of 8.7% in the percentage of licensed staff in Fiscal Year 2021/22.

"The Marriage, Family and Therapy (MFT) intern program is extremely helpful in providing guidance, experience, supervision and development of skill building and confidence. The program is a valuable tool and resource in fostering key and essential experience to promote growth and motivation."

-Marriage, Family and Therapy Internship Program Intern

Workforce Education and Training

Positive Results (cont.)

With the passage of the MHSA and the creation of WET, DBH was able to consolidate and expand the Internship Program. WET coordinates all aspects of the internships and practicums placed within DBH. Currently, the Internship Program trains students who are enrolled in the following bachelor and graduate programs:

· Social Work

· Marriage and Family Therapy (MFT)

· Psychology

Depending on their discipline, interns participate in the Internship Program for 12 to 18 months. During that time, they learn to provide clinical services in a public community behavioral health setting. In Fiscal Year 2021/22, there were a total of 34 interns in the intern program across the three disciplines.

The program continues to grow and receive positive feedback from participants who report that they received comprehensive training and a valuable experience during their time at DBH. It is hoped that integrating psychiatric residents into the clinical staff and supporting their understanding of the therapeutic process, as well as increasing their clinical skills, will lead to an increase in the retention and hiring of psychiatrists who complete their residency at DBH.

"This intern program was amazing. There isn't anything I would change. Everyone has been supportive, kind, and helpful. I have learned so much! Truly thankful for my experience.

-Marriage, Family and Therapy Internship Program Intern

DBH is committed to hiring applicants that were previously interns. As seen in the following table, 21% of clinical hires in Fiscal Year 2021/22 were DBH interns. Sixteen DBH interns were hired as pre-licensed Clinicians with the department in Fiscal Year 2021/22.

Pre-Licensed Clinicians Hired	FY 2021/22
Total Number of Interns Hired	16
Total Number of Non-Interns Hired	62
% of Interns Hired	21%

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) degrees, 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 76 NP students with eight of those in FY 2021/22.

Workforce Education and Training

Positive Results (cont.)

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

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

Among the trainings provided in Fiscal Year 2021/22, the following are example of trainings that incorporate MHSA standards:

- Law and Ethics for County Healthcare Providers
- Motivational Interviewing
- Objective Arts
- Transformational Collaborative Outcomes Management (TCOM)

The training information table indicates that the evaluation average of the trainings in Fiscal Year 2021/22 is 4.6 out of 5. This rating reflects higher than average trainee satisfaction for the previous eight years. There was a 15% decrease in attendance in Fiscal Year 2021/22, largely due to concentrating on the development of ongoing DBH Electronic Health Record training. WET continued to offer trainings despite the COVID-19 restrictions during Fiscal Year 2021/2022.

Throughout FY 2021/22, WET was unable to offer DBH staff the LEAP® Course (Learn, Empathize, Agree and Partner) , which is a one-day facilitator-led, in person training workshop due to COVID-19 restrictions. LEAP is designed to provide participants the critical research and skillset required to create a therapeutic alliance, and build a collaborative relationship, with persons who have severe mental illness; leading to the acceptance of treatment and services. The training was very successful, as evidenced by the considerable volume of positive trainee feedback.

The table below provides additional information regarding trainings provided by WET in Fiscal Year 2021/22.

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

After completing this rotation, I realized I enjoy working in a community mental health setting, and I hope to work at clinics like this in the future as a psychiatrist. Additionally, being from this county and visiting the different clinic locations in San Bernardino County motivated me to service my community and provide mental health services.

-Medical Educational Program Student Intern

Workforce Education and Training

Positive Results (cont.)

Peer and Family Advocates (PFAs) are behavioral health consumers, or family members of behavioral health consumers who provide crisis response services, peer counseling, linkages to services, and support for consumers of DBH services. They also assist with the implementation, facilitation, and ongoing coordination of activities with the Community Services and Supports (CSS) plan in compliance with MHSA requirements. The Peer and Family Advocate position also fulfills the MHSA Workforce Education and Training goal of increasing the number of clients and family members of clients employed in the public mental health system.

As seen in the table to the right, there has been a significant increase in PFAs hired in DBH over the last several years. This is largely due to increasing knowledge and evidence of the benefits when including Peer and Family Advocates in DBH programs and the positive outcomes it has yielded on the consumers served by these programs. DBH strives to continue to increase the number of PFAs being hired and maintained on staff and hosts an open recruitment for PFA, levels I, II, and III, annually. The recruitment, which includes advertising on social media, flyers, and emails circulated throughout the community, and posting on Jobinsocal.com, is widely popular amongst members of the community and garners between 150 to 200 applications annually. By utilizing different outlets to advertise for the PFA positions, especially social media and word of mouth through current DBH employees, the department increases the public's knowledge of the Peer and Family Advocate position, as well as increases the number of qualified applicants applying for these vacancies each year.

Total Peer and Family Advocates with DBH			
Fiscal Year	Positions	**Fiscal Year**	Positions
FY 2005/2006	4	FY 2014/2015	29
FY 2006/2007	19	FY 2015/2016	28
FY 2007/2008	24	FY 2016/2017	26
FY 2008/2009	24	FY 2017/2018	36
FY 2009/2010	21	FY 2018/2019	28 (Plus 7 Vacancies)
FY 2010/2011	20	FY 2019/2020	35 (Plus 7 Vacancies)
FY 2011/2012	24	FY 2020/2021	35 (Plus 7 vacancies)
FY 2012/2013	25	FY 2021/2022	29 (Plus 20 vacancies)
FY 2013/2014	23		
		Total	**430**

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 2016/2017	3
FY 2011/2012	1	FY 2017/2018	5
FY 2012/2013	1	FY 2018/2019	6
FY 2013/2014	4	FY 2019/2020	11
FY 2014/2015	3	FY 2020/2021	2
FY 2015/2016	4	FY 2021/2022	4

Positive Results (cont.)

The contract agencies that work with DBH are required to employ PFAs as well, although they may be given different working titles. The number of PFAs employed with DBH contract agencies continues to increase as more programs are choosing to utilize the benefits presented by incorporating peer support and advocacy into their practices.

Not all contract agencies use the PFA title. A few other titles they use are:

- Family Partner
- Youth Partner
- Peer Partner
- Parent Partner
- Family Support Partner
- Parent Family Advocate

To meet the goal of conducting focused outreach and recruitment to provide equal employment opportunities in the public mental health system for individuals who share racial/ethnic, cultural and/or linguistic characteristics of clients and family members, the Volunteer Services Coordinator participates in career fairs throughout the County including remote areas such as Barstow and the Morongo Basin. As illustrated in the following table, the coordinator increased the number of participants in outreach efforts every year through FY 2017/18, subsequent years were impacted due to the COVID-19 pandemic which caused the Volunteer Services Coordinator to attend less outreach events than previous years.

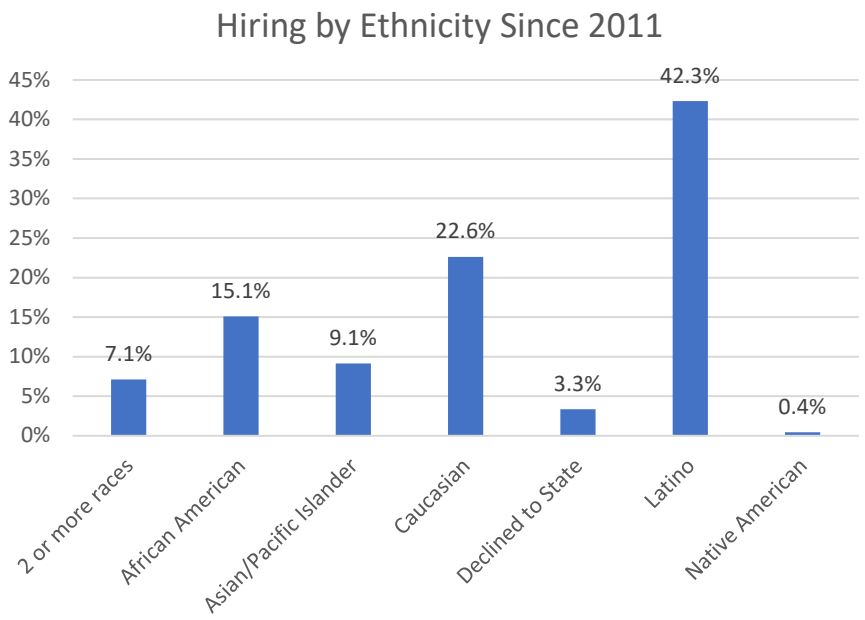
Fiscal Year	Number of Schools Visited	Number of Participants
FY 2011/12	13	2,470
FY 2012/13	16	2,479
FY 2013/14	23	1,706
FY 2014/15	35	2,770
FY 2015/16	35	4,139
FY 2016/17	70	6,958
FY 2017/18	82	9,303
FY 2018/19	63	6,377
FY 2019/20	59	5,818
FY 2020/21	25	2,070
FY 2021/22	32	3093
Total	**453**	**47,183**

To help reach the Spanish speaking community, the coordinator has partnered with a bilingual co-presenter and translated presentations and handouts into Spanish. The co-presenter also helps to explain behavioral health career opportunities to monolingual parents that may not have a full understanding of what kind of career options are available for their children.

Positive Results (cont.)

To meet the goal of recruiting, employing and supporting the employment of individuals in the public mental health system who are culturally and linguistically competent or, at a minimum, are educated and trained in cultural competence, DBH strives to have staff that provide culturally and linguistically competent services to consumers. To ensure that measure is met, all staff are required to take either online or live cultural competency trainings (2 hours for non-clinicians and 4 hours for clinicians), annually.

To help ensure DBH provides culturally and linguistically competent services DBH continually recruits new employees that represent the diverse population of San Bernardino County, as can be seen in the chart below.



To help provide culturally and linguistically competent services to consumers, DBH actively recruits applicants who are bilingual and bicultural. As can be seen below, DBH has continued to maintain the number of bilingual staff employed in Fiscal Year 2021/22. However, it remains a top priority of the department to continue to recruit and retain bilingual staff.

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

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

Positive Results (cont.)

WET has actively recruited bilingual interns to help provide services in other languages. Since Fiscal Year 2008/09, on average **36%** of interns are bilingual. In Fiscal Year 2021/22, **32%** of interns were bilingual. Of the bilingual interns, **100%** are Spanish speakers.

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%
Total	**204**	**569**	**36%**

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

To meet the goal of providing financial incentives to recruit or retain employees within the public mental health system, the Employee Scholarship Program (ESP) was piloted in 2013. 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.



Artwork by Virginia Paleno

Positive Results (cont.)

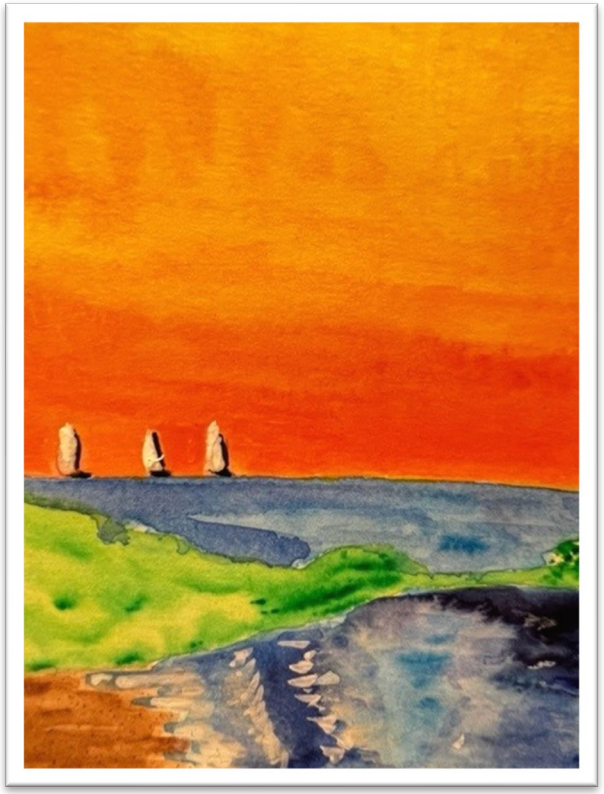
The table below provides a breakdown of which degrees the awardees were pursuing:

Fiscal Year	Certificate	Associate	Bachelors	Masters	Doctorate	Total Recipients
12/13	0	2	5	5	0	12
13/14	0	0	5	6	0	11
14/15	1	0	4	3	0	8
15/16	1	0	5	4	0	10
16/17	1	1	5	2	0	9
17/18	0	0	6	4	0	10
18/19	0	0	2	1	0	3
19/20	0	0	0	0	0	0
20/21	0	0	1	2	1	4
21/22	0	0	2	5	1	8
Total	**3**	**3**	**35**	**32**	**2**	**75**

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

WET was able to add the following DBH sites as approved National Health Service Corps (NHSC) designated sites in FY 2021/22, enabling DBH employees working at those sites to be eligible for NHSC Financial Incentive Programs including the Loan Repayment Programs:

- San Bernardino Department of Behavioral Health – Cottages (9/10/2021)
- San Bernardino Department of Behavioral Health – Fontana Day Reporting Center (9/10/2021)



Artwork by Unknown

Workforce Education and Training

Positive Results (cont.)

Additionally, 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	2017/18	3
2013/14	2	2018/19	10
2014/15	2	2019/20	1
2015/16	0	2020/21	1
2016/17	1	2021/22	3

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

To meet the goal of incorporating the input of consumers and family members, and when possible utilize them as trainers and consultants in public mental health WET programs and/or activities, the Office of Consumer and Family Affairs (OCFA) is invited to the Workforce Development Discussion (WDD) meeting to provide input on the implementation of the MHSA WET Plan component. OCFA is a Peer and Family Advocate office that provides advocacy and support to consumers and family members.

"This rotation had a lasting impact on my career choice by seeing how psychiatrists get to know their patients thoroughly made me inspired to choose a specialty that can provide that kind of environment"

-Medical Services Program Intern

Success Points

- MFT interns successfully completed internship.
- All 3rd year Psychiatric residents promoted to 4th year maintaining service needs with their psychotherapy clients.
- All 4th year Psychiatric Residents successfully terminated with their psychotherapy clients prior to graduation, and transitioned the clients to another provider.



Freedom of the Minds- By Sondra Savage

Workforce Education and Training

Positive Results (cont.)

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 multiple methods. 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
- Cultural Competency Advisory Committee and fourteen culturally specific awareness subcommittees

OEI also works closely with the Workforce Development Discussion (WDD) committee to ensure the needs of the diverse racial/ethnic populations of San Bernardino County are being met.

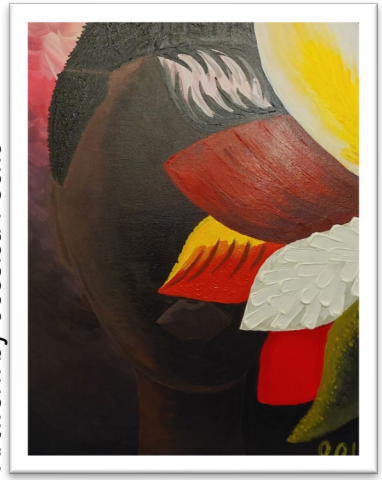
"This rotation confirmed my interest in psychiatry. This is something I want to do for the rest of my life."

-Medical Services Program Intern

To meet the goal of establishing regional partnerships, the Southern Counties Regional Partnership (SCRP) was created in 2009. SCRP is a collaborative effort between ten Southern California counties. The Partnership's goals are to coordinate regional education programs, disseminate information and strategies throughout the region, develop common training opportunities, and share programs that increase diversity of the public behavioral health system workforce when those programs are more easily coordinated at a regional level. The ten member counties include:

- Kern
- Imperial
- Orange
- Riverside
- San Bernardino
- San Diego
- San Luis Obispo
- Santa Barbara
- Tri Cities
- Ventura

San Bernardino County was the fiscal agent of SCRP until June 30, 2014. Santa Barbara County assumed responsibility as the fiscal agent since Fiscal Year 2014/15. San Bernardino County continues to participate in SCRP as a member county.



Artwork by Jessica Poche

Workforce Education and Training

Challenges and Solutions

The WET program experienced the following challenges in FY 2021/22:

- Providing training needs of a growing and diverse workforce such as Continuing Education Units) (CEUs) and certification requirements
- Evaluation of pay rate and lack of advancement opportunities for the PFA series
- Insufficient number of site supervisors and adjusting the current internship programs meet the needs of nontraditional degree programs.
- Increase Nurse Practitioners (NPs) and specialized psychiatrists such as Child and Adolescent Psychiatrists placement opportunities.
- Lack of placement sites for the Volunteer Services Program, Internship Program, NP students, and psychiatric residents/fellows
- Increase in person training for DBH staff

The WET program has taken the following actions to address the challenges:

- Difficulties continue with recruitment and retention efforts, such as high turn-over rates, and increased vacancies.
- Offering Continuing Education Units (CEUs) for more disciplines
- Updating program mission, objectives, policies, and procedures to align with new pipeline development requirements
- Adjustment of intern program dates to align one cohort per year with the schedules of nontraditional schools
- Expansion of financial incentive programs, based on new regional partnership buy in, to loan repayment option
- Creation of career pipelines for nursing staff
- Expansion of medical residency/fellowship programs
- WET continues to develop virtual training models to continue offering training for DBH staff

Program Updates

In December of 2021, DBH opted into participating in the CalMHSA Peer Support Specialist Certification program as a result of Senate Bill (SB) 803. SB 803 defines a peer provider as someone who has self-identified as having lived experience with the process of recovery from mental illness, substance use disorder, or both, either as a consumer of these services or as the parent or family member of the consumer.

Peer providers use their experience to function as advocates, system navigators, or guides, thereby ensuring that consumers receive timely and comprehensive care, and are fully engaged in their treatment.

SB 803 recognizes the benefit of peer support providers, paving the way for Department of Healthcare Services (DHCS) to establish "Peer Support Specialists" as a provider type for both mental health and substance use support services.

DBH has incorporated Peer and Family Advocates (PFAs) into its system of care however, they are not currently certified. DBH is assisting existing PFAs and contract providers in preparing for the examination that will certify them as Peer Support Specialists during this fiscal year. During the next three fiscal years, DBH will continue working towards building their Peer and Family Advocate workforce.

WET will participate in a training collaborative and will provide funding for Reality Based Leadership to provide leadership training, technical assistance and employee leadership development of DBH staff effective FY 2022-23.

Workforce Education and Training

Outreach and Engagement

In Fiscal Year 2021/22, Workforce Education and Training (WET) organized and/or participated in the following outreach and engagement activities:

Activity Type	Number of Activity Type	Total Number of Participants
School College and Career Fairs (Elementary, Middle, High Schools)	0	0
College Career Fairs	19	1,464
Classroom Presentations	10	1,548
Mock Interviews	3	81
Total	**32**	**3,093**

Collaborative Partners

- Alder School of Professional Psychology
- American Career College
- American University of Antigua
- Argosy University
- Arrowhead Regional Medical Center (ARMC)
- Azusa Pacific University
- Brandman University
- Cajon High School, San Bernardino – MIND program (Moving in New Directions
- California Baptist University
- California State University, San Bernardino
- California State University, Fullerton
- Chaffey Joint Union High School District
- Colton-Redlands-Yucaipa Regional Occupational Program (CRY ROP)
- Loma Linda University Medical
- 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
- Serrano High School, Phelan – Get Psyched
- Touro University College of Osteopathic Medicine (TUCCOM)
- University of San Diego
- Western University of Health (WUH)
- Workforce Development Department – Generation Go Student Interns

SAN BERNARDINO COUNTY
Behavioral Health

MHSA Three-Year Program and Expenditure Plan for FYs 23/24-25/26: 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 produce long-term impacts with lasting benefits that support the behavioral health system's movement towards recovery, resiliency, culturally competent, and help first models, as well as opportunities for accessible community-based services for consumers and their families. These efforts include the development of a variety of technological advancements, strategies, and/or community-based facilities that support culturally and linguistically appropriate integrated service experiences. Funds may also be used to support an increase in:

- Peer-support and consumer-run facilities,
- Development of community-based, least restrictive settings that will reduce the need for incarceration or institutionalization, and
- The development of technological infrastructure for the public behavioral health system to facilitate high quality, cost-effective services and supports for consumers and their families

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

Program Description

Capital Facilities

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

Technological Needs

The overarching goal of the technological needs portion of the Capital Facilities and Technological Needs component is to support the modernization of information systems and to increase consumer/family empowerment by providing the tools for secure access to health and wellness information. These projects will result in improvements of the quality and coordination of care, operational efficiency, and cost effectiveness across the Department.

Data Warehouse

Research and Evaluation manages the Data Warehouse which houses data from diverse sources that are then combined to provide consistency in advanced analytics and data mining. This provides the necessary framework for meeting the requirements of Cal-Aim and the foundation for informed program planning across the continuum of care. By combining 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 needed to meet the County's vision for wellness.

Additionally, when incorporating the Data Collection and Reporting System (DCR) information with both the Adult Needs and Strengths Assessment (ANSA) and the Child and Adolescent Needs and Strengths (CANS) assessment outcomes data, the Data Warehouse provides a richer environment for monitoring and enhancing client care through data analysis, dashboard reporting, and predictive modeling.

Program Description (cont.)

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

DBH has implemented a BHMIS that will support the secure access and exchange of health information by providers. The new integrated BHMIS, with EHR, is currently in use by DBH to support consumer care. Internal workflows and processes continue to be reviewed and refined to reflect new and changing requirements. The purpose of the EHR is to provide an efficient system to support information collection, allowing providers to document care in a manner that fosters consumer and family interactions, and enables highly functional reporting and data aggregation, as well as enhances coordination of care between internal and external providers.

Services Provided

Capital Facilities

- Obtains permanent capital assets to deliver behavioral health services

Technological Needs

- Manage, maintain, and improve the Electronic Health Record (EHR) and the delivery modes
- Maintain and utilize the Data Warehouse to generate reports
- Respond to various aspects related to the 1115 Waiver Medi-Cal Program (Medi-Cal 2020)
- Enhancing and maintaining the telehealth and data communications network that is strictly used to support telehealth services
- Support the delivery of services for clinicians onsite and remotely
- Provide 24/7 support to the DBH Call Center and Crisis Response Unit
- Support the connectivity, security, and access to resources for staff working remotely
- Support all deployments of staff in response to emergency incidents
- Support DBH's adherence to County directives in compliance with the COVID-19 pandemic response

Positive Results

Capital Facilities

DBH has successfully created an interactive clinical map for the Children's System of Care that assists providers with informed decisions and ensures access to care.

Technological Needs

To address the goal of increasing access to services, DBH Research and Evaluation is are supporting employee retention initiatives by using the Data Warehouse to provide the necessary data reports medical staff need in order to obtain and retain financial support for repayment of student loans through the CalHealthCares program. Doctors are able to apply for and maintain CalHealthCares eligibility and loan repayment which helps DBH in recruitment efforts and helps to retain medical staff. In FY 2021/22, 18 DBH physicians were awardees of the loan repayment program in exchange for a five-year service commitment.

In order to maintain and utilize the Data Warehouse, DBH underwent a redesign of clinical productivity reporting to develop an executive view of demographic, penetration, and retention reporting. Additionally, the Data Warehouse supports the monitoring and implementation of:

- San Bernardino County's Office of Equity and Inclusion subcommittees
- Development of data reporting for MHSA annual reports
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) reporting of CANS data to the Department of Health Care Services
- Development of robust reporting in compliance with Senate Bill (SB) 1291

DBH's ability to show positive outcomes at discharge assisted the County in qualifying for the Substance Abuse and Mental Health Services Administration (SAMHSA) grants for the juvenile justice programs. Likewise, a three-tier analysis of hospitalizations, crisis, and service data, combined with Crisis Intervention Training (CIT) data, allowed for the successful application for California Health Facilities Financing Authority (CHFFA) grants to benefit the County's Crisis Residential Treatment (CRT) and Crisis Walk-In Clinic (CWIC) programs.

Challenges and Solutions

Technological Needs

The challenges for FY 2021/22 were in the integration of the wide range of data, including new clinical data as a result of implementing the EHR, into the Data Warehouse, and existing reports and processes, after the implementation of the BHMIS (Phase I) in July 2020.

However, data mining and predictive modeling have been integral for the successful discharge of WRAP clients, implementation of clinic-based operations and dashboards, and the fidelity monitoring of client outcomes instruments across time, location, and staff. Additionally, text mining of progress notes and treatment plans assisted in surfacing the data necessary for robust outcomes measurements. DBH is also utilizing the information obtained to develop an interactive provider directory map.

Program Updates

Systems and Operations Support Team Expansion

- Budgetary increase will allow our Information Technology (IT) department to add staffing positions to the Systems and Operation Support Team
- These positions will support the increased, specific technological needs of SBC-DBH staff in support of Healthcare systems and requirements
- DBH will be creating an interactive clinical map for the Adult's and Foster Youth System of Care that will assist with informed decision making and ensures access to care.

Behavioral Health Management Information Systems Expansion

- This expansion is necessary to support claiming and billing functions that allow DBH to receive revenue and increase access and system availability for providers and consumers, and security of data in compliance with evolving requirements (CalAIM, Final Rule, CMS Interoperability Rule, and CalHHS Data Exchange Framework (DxF).
- Budgetary increase will allow IT to add staffing to increase claims submissions to the State twice a month instead of the current once per month

Capital Facilities and Technological Needs

- DBH will be accepting Community Care Expansion (CCE) Preservation Grant and will use MHSA funds from Capital Facilities and Technological Needs component to fund capital facilities projects that are in alignment with the public behavioral health system. Acceptance of a CCR Grant requires the accepting agency to provide 'matching funds' in the amount of 10% of the BHCIP award
- DBH will be accepting a Behavioral Health Continuum Infrastructure Program (BHCIP) grant and will use MHSA funds from Capital Facilities and Technological Needs component to fund capital facilities projects that are in alignment with the public behavioral health system. Acceptance of a BHCIP Grant requires the accepting agency to provide 'matching funds' in the amount of 29% of the BHCIP award.

SAN BERNARDINO COUNTY
Behavioral Health

MHSA Three-Year Program and Expenditure Plan for FYs 23/24-25/26: 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 be in-line with actual anticipated utilization values based on historical trends and anticipated growths. This revision helps ensure more accurate reporting of usages and availabilities of MHSA funds allotted to DBH consistent with County of San Bernardino's continued goal of responsible use of our resources to ensure financial sustainability and does not impact Board of Supervisors approved commitments.

As part of year end reporting, it was found additional Community Support Services (CSS) transfer is required for the Workforce, Education and Training component. This additional transfer is reflected in the balance of unspent funds for CSS.

As part of the expansion of services that are reflected in this current plan, various services expanded in Fiscal Years 2022/23. Those costs are reflected in the budget pages in unspent funds for prior years.



Artwork by L. Lafayett

Funding Summary FY 2023-24

County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
Three-Year Integrated for FY 2023-24 through FY 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
A. Estimated FY 2023/2024 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	$ 162,113,603	$ 42,055,421	$ 16,624,345			$
2. Estimated New FY 2023/2024 Funding	$ 183,081,636	$ 46,166,806	$ 12,209,485			$
3. Transfer in FY 2023/2024	$ (27,395,481)	$	$	$ 6,191,862	$ 21,203,619	$
4. Access Local Prudent Reserve in FY 2023/2024	$	$	$	$	$	$
5. Estimated Available Funding for FY 2023/2024	$ 317,799,758	$ 88,222,227	$ 28,833,830	$ 6,191,862	$ 21,203,619	$
B. Estimated FY 2023/2024 MHSA Expenditures	$ 119,178,540	$ 30,409,776	$ 7,531,869	$ 6,191,862	$ 21,203,619	$
G. FY 2023/2024 Unspent Fund Balance	$ 198,621,218	$ 57,812,451	$ 21,301,961	$ -	$ -	$

1.	Estimated Local Prudent Reserve Balance on June 30, 2023	$ 21,655,429.00
2.	Contributions to the Local Prudent Reserve in FY 2024	$
3.	Distributions from the Local Prudent Reserve in FY 2023/2024	$
4.	Estimated Local Prudent Reserve Balance on June 30, 2024	$ 21,655,429.00

PREVENTION AND EARLY INTERVENTION FY 2023-24

County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
Three-Year Integrated for FY 2023-24 through FY 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	$ 25,881,569	$ 11,707,710	$ 11,143,859			$ 3,030,000
Outreach for Recognition of Early Signs of Mental Illness						
1. PEI CI-1 Promotores de Salud/Community Health Worker	$ 1,260,000	$ 1,260,000				$ -
2. PEI CI-5 Inland Empire Opioid Crisis Coalition (IEOCC)	$ 308,252	$ 154,126	$ 154,126			$ -
Suicide Prevention						
1. PEI SE-8 Office of Suicide Prevention	$ 126,835	$ 126,835				$ -
Stigma and Discrimination Reduction						
1. PEI CI-3 Native American Resource Center	$ 456,851	$ 456,851				$ -
Prevention						
1. PEI SI-2 Preschool PEI Program	$ 380,083	$ 380,083				$ -
2. PEI SI-3 Resilience Promotion in African-American Children	$ 1,700,000	$ 1,700,000				$ -
3. PEI SE-1 Older Adult Community Services	$ 713,935	$ 713,935				$ -
4. PEI SE-5 Lift Program	$ 519,923	$ 519,923				$ -
5. PEI SE-6 Coalition Against Sexual Exploitation (CASE)	$ 309,129	$ 309,129				$ -
Prevention and Early Intervention						
1. PEI CI-2 Family Resource Center	$ 4,603,915	$ 4,603,915				$ -
2. PEI SE-3 Community Wholeness and Enrichment	$ 778,151	$ 778,151				$ -
3. PEI SE-4 Military Services and Family Support	$ 710,967	$ 710,967				$ -
4. PEI SI-1 Student Assistance Program (SAP)	$ 6,794,921	$ 2,333,223	$ 2,925,697			$ 1,536,000
5. PEI SE-7 Improving Detection and Early Access (IDEA)	$ 1,000,000	$ 1,000,000				$ -
PEI Programs	$ 45,544,530	$ 26,754,848	$ 14,223,682	$ -	$ -	$ 4,566,000
PEI Administration	$ 3,093,035	$ 3,093,035				$ -
PEI Assigned Funds	$ 561,894	$ 561,894				$ -
Total PEI Program Estimated Expenditures	$ 49,199,459	$ 30,409,776	$ 14,223,682	$ -	$ -	$ 4,566,000

COMMUNITY SERVICES AND SUPPORTS FY 2023-24

County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
Three-Year Integrated for FY 2023-24 through FY 2025-26

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 Child and Family Support Program (CCFSS)	$ 48,513,217	$ 27,158,919	$ 20,324,577			$ 1,029,721
2.	C-2	Integrated New Family Opportunity Program (INFO)	$ 1,947,326	$ 1,090,162	$ 815,831			$ 41,333
3.	TAY-1	TAY One Stop Centers	$ 6,981,719	$ 3,908,542	$ 2,924,986			$ 148,191
4.	A-2	Forensic Services Continuum of Care	$ 6,723,626	$ 3,098,677	$ 2,816,858			$ 808,091
5.	A-3	Assertive Community Treatment Model FSP Services	$ 2,779,852	$ 1,556,231	$ 1,164,617			$ 59,004
6.	A-7	Housing and Homeless Services Continuum of Care	$ 16,193,299	$ 9,527,806	$ 5,673,020			$ 992,472
7.	OA-1	Age Wise	$ 2,187,857	$ 1,224,818	$ 916,601			$ 46,439
8.	A-11	Regional Adult Full Service Partnership (RAFSP)	$ 14,506,366	$ 7,932,002	$ 6,333,523			$ 240,841
9.	A-15	Recovery Based Engagement Support Teams (RBEST)	$ 3,100,449	$ 1,735,710	$ 1,298,931			$ 65,809
		FSP Programs Total	$ 102,933,712	$ 57,232,866	$ 42,268,945	$ -	$ -	$ 3,431,901
Non-FSP Programs								
1.	A-1	Clubhouse and Community Connections	$ 4,962,549	$ 4,962,549				$ -
2.	A-4	Crisis Stabilization Units (CSU)/Crisis Walk-In Centers (CWIC)	$ 13,085,899	$ 7,325,816	$ 5,482,328			$ 277,756
3.	A-5	Diversion Program	$ 2,462,019	$ 1,149,736	$ 1,031,461			$ 280,822
4.	A-6	Community Crisis Services	$ 9,011,882	$ 3,709,090	$ 3,775,521			$ 1,527,270
5.	A-9	Access, Coordination, and Enhancement (ACE) of Quality Behavioral Health Services	$ 3,515,917	$ 1,968,299	$ 1,472,991			$ 74,627
6.	A-10	Crisis Residential Treatment Program (CRT)	$ 14,111,651	$ 6,867,238	$ 5,912,066			$ 1,332,347
7.	A-13	Adult Transitional Care Programs	$ 27,247,573	$ 21,338,746	$ 5,623,899			$ 284,928
8	A-16	Crisis Intervention Collaborative Programs	$ 6,101,847	$ 3,415,967	$ 2,556,364			$ 129,515
		Non-FSP Programs Total	$ 80,499,337	$ 50,737,441	$ 25,854,630	$ -	$ -	$ 3,907,266
		CSS Programs	$ 183,433,049	$ 107,970,307	$ 68,123,575	$ -	$ -	$ 7,339,167
		CSS Administration	$ 15,636,619	$ 11,208,232	$ 4,428,387			$ -
		CSS MHSA Housing Program Assigned Funds	$					
		Total CSS Program Estimated Expenditures	$ 199,069,668	$ 119,178,540	$ 72,551,961	$ -	$ -	$ 7,339,167
		FSP Programs as Percent of Total	52%					

INNOVATION FY 2023-24

County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
Three-Year Integrated for FY 2023-24 through FY 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)	$ 4,027,762	$ 4,003,401	$ 24,362			$ -
2.	INN-09	Eating Disorder Collaborative	$ 2,548,120	$ 2,548,120	$ -			$ -
3.	INN-10	Multi County Full Service Partnership (FSP)	$ -	$ -				
4.	INN-11	Cracked Eggs	$ 181,000	$ 181,000	$ -			$ -
		INN Programs	$ 6,756,882	$ 6,732,521	$ 24,362	$ -	$ -	$ -
		INN Administration	$ 799,348	$ 799,348	$ -			$ -
		Total INN Program Estimated Expenditures	$ 7,556,230	$ 7,531,869	$ 24,362	$ -	$ -	$ -

WORKFORCE, EDUCATION, AND TRAINING FY 2023-24

County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
Three-Year Integrated for FY 2023-24 through FY 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	$ 778,216	$ 778,216				
2. Internship Program	$ 1,585,594	$ 1,585,594				
3. Psychiatric Residency Program	$ 1,196,508	$ 1,196,508				
4. Financial Incentive Program	$ -					
WET Programs	$ 3,560,318	$ 3,560,318				
WET Administration	$ 2,435,091	$ 2,435,091				
WET Contribution	$ 196,453	$ 196,453				
Total WET Program Estimated Expenditures	$ 6,191,862	$ 6,191,862	$ -	$ -	$ -	$ -

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS FY 2023-24

County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
Three-Year Integrated for FY 2023-24 through FY 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	$ 12,460,446	$ 12,460,446				
2. Community Care Expansion - Facility Preservation	$ 682,762	$ 682,762				
CFTN Programs - Technological Needs Projects						
1. Data Warehouse Continuation Project Empowered Communication/SharePoint Project	$ 471,015	$ 471,015				
2 Behavioral Health Management Information Systems (BHMIS), Electronic Health Record (EHR), Telemedicine Project	$ 4,742,661	$ 4,742,661				
CFTN Projects	$ 18,356,884	$ 18,356,884	$ -	$ -	$ -	$ -
CFTN Administration	$ 2,846,735	$ 2,846,735				
Total CFTN Program Estimated Expenditures	$ 21,203,619	$ 21,203,619	$ -	$ -	$ -	$ -

FUNDING SUMMARY FY 2024-25

County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
Three-Year Integrated for FY 2023-24 through FY 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
A. Estimated FY 2024/2025 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	$ 198,621,218	$ 57,812,451	$ 21,301,961	$ -	$ -	$
2. Estimated New FY 2024/2025 Funding	$ 136,347,403	$ 34,683,724	$ 9,220,942			$
3. Transfer in FY 2024/2025	$ (14,810,258)	$	$	$ 6,271,789	$ 8,538,469	$
4. Access Local Prudent Reserve in FY 2024/2025	$	$	$	$	$	$
5. Estimated Available Funding for FY 2024/2025	$ 320,158,363	$ 92,496,175	$ 30,522,903	$ 6,271,789	$ 8,538,469	$
B. Estimated FY 2024/2025 MHSA Expenditures	$ 129,268,094	$ 32,655,671	$ 3,628,892	$ 6,271,789	$ 8,538,469	$
G. FY 2024/2025 Unspent Fund Balance	$ 190,890,269	$ 59,840,504	$ 26,894,011	$ -	$ -	$

H. Estimated Local Prudent Reserve Balance		
1.	Estimated Local Prudent Reserve Balance on June 30, 2024	$ 21,655,429.00
2.	Contributions to the Local Prudent Reserve in FY 2024/2025	$
3.	Distributions from the Local Prudent Reserve in FY 2024/2025	$
4.	Estimated Local Prudent Reserve Balance on June 30, 2025	$ 21,655,429.00

PREVENTION AND EARLY INTERVENTION FY 2024-25

County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
Three-Year Integrated for FY 2023-24 through FY 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	$ 27,752,107	$ 13,665,264	$ 12,056,843			$ 2,030,000
Outreach for Recognition of Early Signs of Mental Illness						
1. PEI CI-1 Promotores de Salud/Community Health Worker	$ 1,260,000	$ 1,260,000				$ -
2. PEI CI-5 Inland Empire Opioid Crisis Coalition (IEOCC)	$ 317,500	$ 158,750	$ 158,750			$ -
Suicide Prevention						
1. PEI SE-8 Office of Suicide Prevention	$ 380,504	$ 380,504				$ -
Stigma and Discrimination Reduction						
1. PEI CI-3 Native American Resource Center	$ 456,851	$ 456,851				$ -
Prevention						
1. PEI SI-2 Preschool PEI Program	$ 391,485	$ 391,485				$ -
2. PEI SI-3 Resilience Promotion in African-American Children	$ 1,700,000	$ 1,700,000				$ -
3. PEI SE-1 Older Adult Community Services	$ 719,078	$ 719,078				$ -
4. PEI SE-5 Lift Program	$ 535,521	$ 535,521				$ -
5. PEI SE-6 Coalition Against Sexual Exploitation (CASE)	$ 318,403	$ 318,403				$ -
Prevention and Early Intervention						
1. PEI CI-2 Family Resource Center	$ 4,603,915	$ 4,603,915				$ -
2. PEI SE-3 Community Wholeness and Enrichment	$ 778,151	$ 778,151				$ -
3. PEI SE-4 Military Services and Family Support	$ 710,967	$ 710,967				$ -
4. PEI SI-1 Student Assistance Program (SAP)	$ 7,409,892	$ 2,654,680	$ 3,219,212			$ 1,536,000
5. PEI SE-7 Improving Detection and Early Access (IDEA)	$ 1,000,000	$ 1,000,000				$ -
PEI Programs	$ 48,334,373	$ 29,333,568	$ 15,434,805	$ -	$ -	$ 3,566,000
PEI Administration	$ 2,760,209	$ 2,760,209				$ -
PEI Assigned Funds	$ 561,894	$ 561,894				$ -
Total PEI Program Estimated Expenditures	$ 51,656,476	$ 32,655,671	$ 15,434,805	$ -	$ -	$ 3,566,000

COMMUNITY SUPPORT AND SERVICES FY 2024-25

County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
Three-Year Integrated for FY 2023-24 through FY 2025-26

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 Child and Family Support Program (CCFSS)	$ 50,731,882	$ 29,569,506	$ 20,152,728			$ 1,009,648
2.	C-2	Integrated New Family Opportunity Program (INFO)	$ 2,091,943	$ 1,219,306	$ 831,003			$ 41,633
3.	TAY-1	TAY One Stop Centers	$ 7,367,331	$ 4,294,111	$ 2,926,598			$ 146,622
4.	A-2	Forensic Services Continuum of Care	$ 7,073,968	$ 3,457,744	$ 2,810,062			$ 806,162
5.	A-3	Assertive Community Treatment Model FSP Services	$ 2,899,317	$ 1,689,891	$ 1,151,724			$ 57,701
6.	A-7	Housing and Homeless Services Continuum of Care	$ 17,982,725	$ 10,816,152	$ 6,170,737			$ 995,836
7.	OA-1	Age Wise	$ 2,350,337	$ 1,369,914	$ 933,648			$ 46,776
8.	A-11	Regional Adult Full Service Partnership (RAFSP)	$ 15,368,689	$ 8,695,967	$ 6,429,742			$ 242,980
9.	A-15	Recovery Based Engagement Support Teams (RBEST)	$ 3,892,772	$ 2,268,935	$ 1,546,365			$ 77,473
FSP Programs Total			$ 109,758,963	$ 63,381,526	$ 42,952,608	$ -	$ -	$ 3,424,830
Non-FSP Programs								
1.	A-1	Clubhouse and Community Connections	$ 4,911,935	$ 4,911,935				$ -
2.	A-4	Crisis Stabilization Units (CSU)/Crisis Walk-In Centers (CWIC)	$ 13,107,507	$ 7,639,821	$ 5,206,825			$ 260,861
3.	A-5	Diversion Program	$ 2,535,880	$ 1,249,495	$ 1,007,353			$ 279,032
4.	A-6	Community Crisis Services	$ 9,335,368	$ 4,012,001	$ 3,708,381			$ 1,614,986
5.	A-9	Access, Coordination, and Enhancement (ACE) of Quality Behavioral Health Services	$ 3,621,394	$ 2,110,760	$ 1,438,562			$ 72,072
6.	A-10	Crisis Residential Treatment Program (CRT)	$ 13,659,277	$ 6,928,606	$ 5,426,010			$ 1,304,661
7.	A-13	Adult Transitional Care Programs	$ 27,304,582	$ 21,681,169	$ 5,355,122			$ 268,291
8.	A-16	Crisis Intervention Collaborative Programs	$ 6,284,902	$ 3,663,208	$ 2,496,614			$ 125,080
9.	A-17	Innovative Remote Onsite Assistance Delivery (InnROADS)	$ 4,148,595	$ 2,418,044	$ 1,647,988			$ 82,564
Non-FSP Programs Total			$ 84,909,439	$ 54,615,039	$ 26,286,854	$ -	$ -	$ 4,007,546
		CSS Programs	$ 194,668,403	$ 117,996,565	$ 69,239,462	$ -	$ -	$ 7,432,376
		CSS Administration	$ 15,832,767	$ 11,271,529	$ 4,561,238			$ -
		CSS MHSA Housing Program Assigned Funds	$					
		Total CSS Program Estimated Expenditures	$ 210,501,170	$ 129,268,094	$ 73,800,700	$ -	$ -	$ 7,432,376
		FSP Programs as Percent of Total	52%					

INNOVATION FY 2024-25

County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
Three-Year Integrated for FY 2023-24 through FY 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	$ 2,624,564	$ 2,624,564	$ -			$ -
3.	INN-10	Multi County Full Service Partnership (FSP)	$ -					
4.	INN-11	Cracked Eggs	$ 181,000	$ 181,000	$ -			$ -
		INN Programs	$ 2,805,564	$ 2,805,564	$ -	$ -	$ -	$ -
		INN Administration	$ 823,329	$ 823,329	$ -			$ -
		Total INN Program Estimated Expenditures	$ 3,628,892	$ 3,628,892	$ -	$ -	$ -	$ -

WORKFORCE, EDUCATION, AND TRAINING FY 2024-25

County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
Three-Year Integrated for FY 2023-24 through FY 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	$ 484,304	$ 484,304				
2. Internship Program	$ 1,715,161	$ 1,715,161				
3. Psychiatric Residency Program	$ 1,232,403	$ 1,232,403				
4. Financial Incentive Program	$ -					
WET Programs	$ 3,431,868	$ 3,431,868				
WET Administration	$ 2,643,468	$ 2,643,468				
WET Contribution	$ 196,453	$ 196,453				
Total WET Program Estimated Expenditures	$ 6,271,789	$ 6,271,789	$ -	$ -	$ -	$ -

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS FY 2024-25

County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
Three-Year Integrated for FY 2023-24 through FY 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	$ 494,566	$ 494,566				
2 Behavioral Health Management Information Systems (BHMIS), Electronic Health Record	$ 5,111,766	$ 5,111,766				
CFTN Projects	$ 5,606,332	$ 5,606,332	$ -	$ -	$ -	$ -
CFTN Administration	$ 2,932,137	$ 2,932,137				
Total CFTN Program Estimated Expenditures	$ 8,538,469	$ 8,538,469	$ -	$ -	$ -	$ -

FUNDING SUMMMARY FY 2025-26

County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
Three-Year Integrated for FY 2023-24 through FY 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
A. Estimated FY 2025/2026 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	$ 190,890,269	$ 59,840,504	$ 26,894,011	$ -	$ -	$
2. Estimated New FY 2025/2026 Funding	$ 135,950,523	$ 32,747,576	$ 9,337,203			$
3. Transfer in FY 2025/2026	$ (14,717,025)	$	$	$ 6,452,712	$ 8,264,313	$
4. Access Local Prudent Reserve in FY 2025/2026	$	$	$	$	$	$
5. Estimated Available Funding for FY 2025/2026	$ 312,123,766	$ 92,588,080	$ 36,231,214	$ 6,452,712	$ 8,264,313	$
B. Estimated FY 2025/2026 MHSA Expenditures	$ 136,162,886	$ 34,152,475	$ 848,028	$ 6,452,712	$ 8,264,313	$
G. FY 2025/2025 Unspent Fund Balance	$ 175,960,880	$ 58,435,604	$ 35,383,186	$ -	$ -	$

H. 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 2025/2026	$
3.	Distributions from the Local Prudent Reserve in FY 2025/2026	$
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)
Three-Year Integrated for FY 2023-24 through FY 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	$ 27,826,796	$ 14,439,297	$ 12,357,498			$ 1,030,000
Outreach for Recognition of Early Signs of Mental Illness						
1. PEI CI-1 Promotores de Salud/Community Health Worker	$ 1,260,000	$ 1,260,000				$ -
3. PEI CI-5 Inland Empire Opioid Crisis Coalition (IEOCC)	$ 327,025	$ 163,512	$ 163,512			$ -
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	$ 456,851	$ 456,851				$ -
Prevention						
1. PEI SI-2 Preschool PEI Program	$ 403,230	$ 403,230				$ -
2. PEI SI-3 Resilience Promotion in African-American Children	$ 1,700,000	$ 1,700,000				$ -
3. PEI SE-1 Older Adult Community Services	$ 724,375	$ 724,375				$ -
4. PEI SE-5 Lift Program	$ 551,587	$ 551,587				$ -
5. PEI SE-6 Coalition Against Sexual Exploitation (CASE)	$ 327,955	$ 327,955				$ -
Prevention and Early Intervention						
1. PEI CI-2 Family Resource Center	$ 4,603,915	$ 4,603,915				$ -
2. PEI SE-3 Community Wholeness and Enrichment	$ 778,151	$ 778,151				$ -
3. PEI SE-4 Military Services and Family Support	$ 710,967	$ 710,967				$ -
4. PEI SI-1 Student Assistance Program (SAP)	$ 7,892,964	$ 3,235,807	$ 3,505,157			$ 1,152,000
5. PEI SE-7 Improving Detection and Early Access (IDEA)	$ 1,000,000	$ 1,000,000				$ -
PEI Programs	$ 48,955,734	$ 30,747,566	$ 16,026,168	$ -	$ -	$ 2,182,000
PEI Administration	$ 2,843,015	$ 2,843,015				$ -
PEI Assigned Funds	$ 561,894	$ 561,894				$ -
Total PEI Program Estimated Expenditures	$ 52,360,643	$ 34,152,475	$ 16,026,168	$ -	$ -	$ 2,182,000

COMMUNITY SERVICES AND SUPPORT FY 2025-26

County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
Three-Year Integrated for FY 2023-24 through FY 2025-26

		Program Name	A	Estimated CSS Funding B	C	D	E	F
			Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs								$
1.	C-1	Comprehensive Child and Family Support Program (CCFSS)	$ 50,869,703	$ 29,701,232	$ 20,167,678			$ 1,000,792
2.	C-2	Integrated New Family Opportunity Program (INFO)	$ 2,154,701	$ 1,258,063	$ 854,247			$ 42,391
3.	TAY-1	TAY One Stop Centers	$ 7,455,470	$ 4,353,016	$ 2,955,777			$ 146,676
4.	A-2	Forensic Services Continuum of Care	$ 7,229,444	$ 3,555,669	$ 2,866,168			$ 807,607
5.	A-3	Assertive Community Treatment Model FSP Services	$ 2,899,317	$ 1,692,821	$ 1,149,456			$ 57,040
6.	A-7	Housing and Homeless Services Continuum of Care	$ 19,389,975	$ 11,750,213	$ 6,641,579			$ 998,182
7.	OA-1	Age Wise	$ 2,420,847	$ 1,413,457	$ 959,763			$ 47,627
8.	A-11	Regional Adult Full Service Partnership (RAFSP)	$ 15,614,767	$ 8,851,980	$ 6,517,750			$ 245,038
9.	A-15	Recovery Based Engagement Support Teams (RBEST)	$ 4,000,380	$ 2,335,697	$ 1,585,981			$ 78,702
		FSP Programs Total	$ 112,034,603	$ 64,912,148	$ 43,698,400	$ -	$ -	$ 3,424,055
Non-FSP Programs								
1.	A-1	Clubhouse and Community Connections	$ 4,974,198	$ 4,974,198				$ -
2.	A-4	Crisis Stabilization Units (CSU)/Crisis Walk-In Centers (CWIC)	$ 13,129,762	$ 7,666,058	$ 5,205,393			$ 258,310
3.	A-5	Diversion Program	$ 2,611,956	$ 1,296,476	$ 1,035,530			$ 279,951
4.	A-6	Community Crisis Services	$ 9,525,949	$ 5,561,904	$ 3,776,634			$ 187,410
5.	A-9	Access, Coordination, and Enhancement (ACE) of Quality Behavioral Health Services	$ 3,730,036	$ 2,177,852	$ 1,478,801			$ 73,383
6.	A-10	Crisis Residential Treatment Program (CRT)	$ 13,696,254	$ 6,963,996	$ 5,429,983			$ 1,302,274
7.	A-13	Adult Transitional Care Programs	$ 27,363,300	$ 21,729,073	$ 5,367,855			$ 266,372
8	A-16	Crisis Intervention Collaborative Programs	$ 6,473,449	$ 3,779,645	$ 2,566,448			$ 127,356
9.	A-17	Innovative Remote Onsite Assistance Delivery (InnROADS)	$ 4,273,053	$ 2,494,902	$ 1,694,084			$ 84,067
10.	A-18	Eating Disorder Collaborative	$ 2,815,958	$ 2,815,958				$ -
11.	A-19	Cracked Eggs	$ 181,000	$ 181,000				$ -
Non-FSP Programs Total			$ 88,774,915	$ 59,641,063	$ 26,554,729	$ -	$ -	$ 2,579,124
		CSS Programs	$ 200,809,518	$ 124,553,211	$ 70,253,129	$ -	$ -	$ 6,003,179
		CSS Administration	$ 16,307,750	$ 11,609,675	$ 4,698,075			$ -
		CSS MHSA Housing Program Assigned Funds	$					
		Total CSS Program Estimated Expenditures	$ 217,117,269	$ 136,162,886	$ 74,951,204	$ -	$ -	$ 6,003,179
		FSP Programs as Percent of Total	52%					

INNOVATION FY 2025-26

County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
Three-Year Integrated for FY 2023-24 through FY 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	$ -					
		INN Programs	$ -	$ -	$ -	$ -	$ -	$ -
		INN Administration	$ 848,028	$ 848,028	$ -			
		Total INN Program Estimated Expenditures	$ 848,028	$ 848,028	$ -	$ -	$ -	$ -

WORKFORCE, EDUCATION, AND TRAINING FY 2025-26

County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
Three-Year Integrated for FY 2023-24 through FY 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	$ 497,627	$ 497,627				
2. Internship Program	$1,766,616	$1,766,616				
3. Psychiatric Residency Program	$1,269,375	$1,269,375				
4. Financial Incentive Program	$ -					
WET Programs	$3,533,618	$3,533,618				
WET Administration	$2,722,641	$2,722,641				
WET Contribution	$ 196,453	$ 196,453				
Total WET Program Estimated Expenditures	$6,452,712	$6,452,712	$ -	$ -	$ -	$ -

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS FY 2025-26

County of San Bernardino
Department of Behavioral Health
Mental Health Services Act (MHSA)
Three-Year Integrated for FY 2023-24 through FY 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	$ 519,294	$ 519,294				
2 Behavioral Health Management Information Systems (BHMIS), Electronic Health Record (EH	$ 4,724,918	$ 4,724,918				
CFTN Projects	$ 5,244,212	$ 5,244,212	$ -	$ -	$ -	$ -
CFTN Administration	$ 3,020,101	$ 3,020,101				
Total CFTN Program Estimated Expenditures	$ 8,264,313	$ 8,264,313	$ -	$ -	$ -	$ -

SAN BERNARDINO COUNTY
Behavioral Health

MHSA Three-Year Program and Expenditure Plan for FYs 23/24-25/26: 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

Attachment E – CPP Meeting Presentation Spanish

Attachment F – CPP Meeting Stakeholder Comment Form

Attachment G – CPP Meeting Stakeholder Comment Form Spanish

Attachment H – 30 Day Posting Press Release

Attachment I - List of Media Outlets that Published Press Release

Attachment J – IOM Notification of 30 Day Posting to BOS, CAO

Attachment K – 30 day Posting Web Blast

Attachment L – 30 Day Posting Stakeholder Comment Form English

Attachment M – 30 Day Posting Stakeholder Comment Form Spanish

Attachment N – Public Hearing Press Release

Attachment O – Public Hearing Web Blast

Attachment P – Public Hearing Agenda

SAN BERNARDINO COUNTY

Behavioral Health

Community Program Planning Meetings for the MHSA Three Year Plan Fiscal Years 2023-2026

January/February 2023

Please join us at a MHSA Three Year Plan Fiscal Years 2023-2026 stakeholder engagement meeting!
Learn about service data from the last fiscal year and get new information on program planning for the upcoming three fiscal years.

Third District DAC Wednesday, Jan. 4, 2023 3-4 p.m. Join Meeting Call-in: +1-415-655-0002 Meeting number (access code): 146 962 9460 Meeting Password: 2bcGjnSUk23	PEI Quarterly Provider Meeting Thursday Jan. 12, 2023 1-3 p.m. Join Meeting Call-in: +1-415-655-0002 Meeting number (access code): 2485 096 9219 Meeting Password: 68uGmpmdEF4	Asian/Pacific Islander Awareness Subcommittee Friday, Jan. 13, 2023 10-11:30 a.m. Join Meeting Call-in: +1-415-655-0002 Meeting number (access code): 968 187 539 Meeting Password: AP1123	Native American Awareness Subcommittee Tuesday, Jan. 17, 2023 2-3:30 p.m. Join Meeting Call-in: +1-415-655-0002 Meeting number (access code): 146 996 4635 Meeting Password: NAA123
AM WebEx Meeting Tuesday, Jan. 17, 2023 10-11 a.m. Join Meeting Call-in +1-415-655-0002 Meeting number (access code): 2498 257 7683 Meeting Password: BuyjcmbC333	Transitional Age Youth (TAY) Awareness Subcommittee Wednesday, Jan. 18, 2023 11 a.m.-noon Join Meeting Call-in: +1-415-655-0002 Meeting number (access code):960 523 715 Meeting Password: TAY123	Santa Fe Wellness Club Wednesday, Jan. 18, 2023 11 a.m.-noon In-person meeting 56020 Santa Fe Trail, Ste. M Yucca Valley 760-369-4057	Senior Affairs Commission Wednesday, Jan. 18, 2023 1-3 p.m. Join Meeting Call-in: 1-213-306-3065 Meeting number (access code): 146 770 9426#
4th District Advisory Committee Meeting Wednesday, Jan. 18, 2023 6-7 p.m. Join Meeting Call-In: +1-415-655-0002 Meeting number (access code): 2495 776 5577 Meeting Password: fBw5HAvQH23	Cultural Competency Advisory Committee (CCAC) Meeting Thursday, Jan. 19, 2023 1-2:30 p.m. Join Meeting Call-In: +1-415-655-0002 Meeting number (access code): 969 101 891 Meeting Password: CCAC123	A Place to Go Clubhouse (Pacific Clinics) Thursday, January 19, 2023 2-3:30 p.m. In-person meeting 32770 Old Woman Springs Rd., Ste.B Lucerne Valley 760-248-2327	Sky Forest-Rim Family Services with Big Bear Community Healthcare Dist. Thursday, Jan. 19, 2023 10-11 a.m. Join Meeting Call-in: +1-669-900-6833 Meeting ID: 892 0927 4207 Passcode: 371634

Consumer and Family Member Awareness Subcommittee Monday, Jan. 23, 2023 11 a.m.-noon Join Meeting Call-in: +1-669-900-9128 Meeting ID: 951 5082 7516 Passcode: 682466	African American Awareness Subcommittee Meeting Monday, Jan. 23, 2023 2-3:30 p.m. Join Meeting Call-in: +1-415-655-0002 Meeting number (access code): 2484 263 1294 Meeting Password: AAAS123	Victor Community Support Services and IACC in San Bernardino Tuesday, Jan. 24, 2023 9-10 a.m. Join Meeting Call-in: +1-669-444-9171 Meeting ID: 991 7036 3426 Passcode: 513371	LGBTQ Awareness Subcommittee Tuesday, Jan. 24, 2023 12:30-2 p.m. Join Meeting Call-in +1-415-655-0002 Meeting number (access code) 960 570 704 Meeting Password: LGBTQ123
5th District Advisory Committee Meeting Tuesday, Jan. 24, 2023 5-6 p.m. Join Meeting Call-in: +1-415-655-0002 Meeting number (access code): 187 027 1608 Meeting Password: dHmNMUI2v39	Our Place Clubhouse Wednesday, Jan. 25, 2023 In-person meeting 24950 Redlands Blvd., Ste I Loma Linda (909) 557-2145	Women's Awareness Subcommittee Wednesday, Jan. 25, 2023 1-3 p.m. Join Meeting Call-in: +1-415-655-0002 Meeting number (access code): 967 920 279 Meeting Password: WA123	Ontario Montclair School District-Family Solutions Collaborative Wednesday, Jan. 25, 2023 Noon – 1 p.m. Join Meeting Call-in: +1-877-853-5247 Meeting ID: 938 1487 6690 Passcode: 607520
Victor Community Support Services and IACC-Victorville Thursday, Jan. 26, 2023 10-11 a.m. Join Meeting Call-in: +1-669-444-9171 Meeting ID: 935 9099 1003 Passcode: 455463	Latino Awareness Subcommittee Thursday, Jan 26, 2023 10-11:30 a.m. Join Meeting Call-in: +1-415-655-0002 Meeting number (access code): 966 009-041 Meeting Password: LAS123	Yucca Valley Pacific Clinics Family Resource Center with Morongo Basin Healthcare Dist. Friday, Jan. 27, 2023 Join Meeting Call-in: +1-669-444-9171 Meeting ID: 825 6531 3224 Passcode: 402833	NAMI San Bernardino Monday, Jan. 30, 2023 4:30-5:30 p.m. Join Meeting Call-in: +1-669-900-6833 Meeting ID: 894 2025 7075 Passcode: 257801
Serenity Clubhouse Tuesday, Jan. 31, 2023 10:30-11:30 a.m. In-person meeting 12625 Hesperia Rd. Ste.B Victorville (760) 955-6224	PM Webex Meeting Thursday, Feb. 2, 2023 5-6 p.m. Join Meeting Call-in: +1-415-655-0002 Meeting number (access code) 2491 977 0291 Meeting Password: prQ6BYfME75	Veterans Awareness Subcommittee Monday, Feb. 6, 2023 3-4:30 p.m. Join Meeting Call-in: +1-415-655-0002 Meeting number (access code): 2482 788 1413#	Desert Stars Clubhouse Tuesday, Feb. 7, 2023 10:30-11:30 a.m. In-person meeting 1841 E. Main St. Barstow (760) 255-5705
TEAM House Clubhouse Tuesday, Feb. 7, 2023 11:30 a.m. -12:30 p.m. In-person meeting 201 W. Mill St. San Bernardino (909) 388-5640	Co-Occuring and Substance Abuse Subcommittee (COSAC) Wednesday, Feb. 8, 2023 10-11:30 a.m. Join Meeting Call-in: +1-415-655-0002 Meeting number (access code): 961 777 142 Meeting Password: COSAC123	Pathways to Recovery Clubhouse Wednesday, Feb. 8, 2023 11:30 a.m.-12:30 p.m. In-person meeting 17053 E. Foothill Blvd. Fontana (909) 347-1373	Disabilities Awareness Subcommittee Thursday, Feb. 9, 2023 10-11:30 a.m. Join Meeting Call-in: +1-415-655-0002 Meeting number (access code): 146 434 2208 Password: DAS123

2nd District Advisory Committee (DAC) Meeting Thursday, Feb. 9, 2023 3:30-4:30 p.m. Join Meeting Call-in: +1-415-655-0002 Meeting number (access code): 2483 823 7369 Meeting Password: pxYctfry353	Suicide Prevention Awareness Subcommittee Monday, Feb. 13, 2023 10-11:30 a.m. Join Meeting Call-in: +1-415-655-0002 Meeting number (access code): 146 264 6760 Meeting Password: SPA123	Spirituality Awareness Subcommittee Tuesday, Feb. 14, 2023 1-2:30 p.m. Join Meeting Call-in: +1-415-655-0002 Meeting number (access code): 961 357 009 Meeting Password: SA123	1st District Advisory Committee (DAC) Meeting Wednesday, Feb. 15, 2023 11 a.m.-Noon Join Meeting Call-in: +1-415-655-0002 Meeting number (access code): 187 662 3366 Password: u9APaZPXW39
Community Policy Advisory Committee (CPAC) Meeting Thursday, Feb. 16, 2023 10 a.m.-Noon Join Meeting Call-in: +1-415-655-0002 Meeting number (access code): 2486 716 4468 Meeting Password: MnMJKr8yQ22	Amazing Place Clubhouse Friday, Feb. 17, 2023 11 a.m.-Noon In-person meeting 2940 Inland Empire Blvd. Ontario (909) 458-1396	Central Valley Fun Clubhouse Thursday, Feb. 23, 2023 11 a.m.-Noon In-person meeting 1501 S. Riverside Ave. Rialto (909) 877-4889	

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speak English (LEP).

SAN BERNARDINO COUNTY

Salud Mental

Reuniones de planificación del programa comunitario para el plan de tres años de la MHSA, años fiscales 2023-2026

enero/febrero 2023

¡Únase a nosotros en una reunión de participación de las partes interesadas del plan de tres años de la MHSA, años fiscales 2023-2026!
Obtenga información sobre los datos de servicio del último año fiscal y obtenga nueva información sobre la planificación de programas para los próximos tres años fiscales.

Comité Asesor del Distrito del 3ro Distrito Miércoles, 4 ene. 2023 3-4 p.m. Unirse a la reunión 0 llame: +1-415-655-0002 Numero de reunión: 146 962 9460 contraseña: 2bcGjnSUk23	Reunión trimestral de proveedores de PEI Jueves, 12 ene. 2023 1-3 p.m. Unirse a la reunión O llame: +1-415-655-0002 Numero de reunión: 2485 096 9219 contraseña: 68uGmpmdEF4	Subcomité de Concientización de Asiáticos/ Isleños del Pacifico Viernes, 13 ene. 2023 10-11:30 a.m. Unirse a la reunión O llame: +1-415-655-0002 Numero de reunión: 968 187 539 contraseña: AP1123	Subcomité de Concientización de Nativos Americanos Martes, 17 ene. 2023 2-3:30 p.m. Unirse a la reunión O llame: +1-415-655-0002 Numero de reunión: 146 996 4635 contraseña: NAA123
Reunión de WebEx por la mañana Martes, 17 ene. 2023 10-11 a.m. Unirse a la reunión O llame: +1-415-655-0002 numero de reunión: 2498 257 7683 contraseña: BuyjcmbC333	Subcomité de Concientización de Jóvenes en Edad de Transición Miércoles, 18 ene. 2023 11 a.m.-mediodía Unirse a la reunión O llame: +1-415-655-0002 numero de reunión: 960 523 715 contraseña: TAY123	Club de Bienestar Santa Fe Miércoles, 18 ene. 2023 11 a.m.-mediodía Reunión en persona 56020 Santa Fe Trail, Ste. M Yucca Valley 760-369-4057	Comisión de Asuntos de la Tercera Edad Miércoles, 18 ene. 2023 1-3 p.m. Unirse a la reunión O llame: 1-213-306-3065 numero de reunión: 146 770 9426#
Comité Asesor del Distrito del 4to Distrito Miércoles, 18 ene. 2023 6-7 p.m. Unirse a la reunión O llame: +1-415-655-0002 numero de reunión: 2495 776 5577 contraseña: fBw5HAvQH23	Comité Consultivo de Competencia Cultural Jueves, 19 ene. 2023 1-2:30 p.m. Unirse a la reunión O llame: +1-415-655-0002 numero de reunión: 969 101 891 contraseña: CCAC123	A Place to Go Casa club (Pacific Clinics) Jueves, 19 ene. 2023 2-3:30 p.m. Reunión en persona 32770 Old Woman Springs Rd., Ste.B Lucerne Valley 760-248-2327	Sky Forest-Rim Family Services con Big Bear Community Healthcare Distrito Jueves, 19 ene. 2023 10-11 a.m. Unirse a la reunión O llame: +1-669-900-6833 numero de reunión: 892 0927 4207 contraseña: 371634

Subcomité de Concientización de Consumidores y Miembros de Familias Lunes, 23 ene. 2023 11 a.m.-mediodía Unirse a la reunión O llame: +1-669-900-9128 numero de reunión: 951 5082 7516 contraseña: 682466	Subcomité de Concientización de Afroamericanos Lunes, 23 ene. 2023 2-3:30 p.m. Unirse a la reunión O llame: +1-415-655-0002 numero de reunión: 2484 263 1294 contraseña: AAAS123	Servicios de Apoyo Comunitario Victor e IACC - San Bernardino Martes, 24 ene. 2023 9-10 a.m. Unirse a la reunión O llame: +1-669-444-9171 numero de reunión: 991 7036 3426 contraseña: 513371	Subcomité de Concientización de LGBTQ Martes, 24 ene. 2023 12:30-2 p.m. Unirse a la reunión O llame: +1-415-655-0002 numero de reunión: 960 570 704 contraseña: LGBTQ123
Comité Asesor del Distrito del 5to Distrito Martes, 24 ene. 2023 5-6 p.m. Unirse a la reunión O llame: +1-415-655-0002 numero de reunión: 187 027 1608 contraseña: dHmNMUI2v39	Casa club de Our Place Miércoles, 25 ene. 2023 Reunión en persona 24950 Redlands Blvd., Ste I Loma Linda (909) 557-2145	Subcomité de Concientización de Mujeres Miércoles, 25 ene. 2023 1-3 p.m. Unirse a la reunión O llame: +1-415-655-0002 numero de reunión: 967 920 279 contraseña: WA123	Distrito Escolar de Ontario Montclair-Colaboración de Soluciones Familiares Miércoles, 25 ene. 2023 Mediodía – 1 p.m. Unirse a la reunión O llame: +1-877-853-5247 numero de reunión: 938 1487 6690 contraseña: 607520
Servicios de Apoyo Comunitario Victor e IACC - Victorville Jueves, 26 ene. 2023 10-11 a.m. Unirse a la reunión O llame: +1-669-444-9171 numero de reunión: 935 9099 1003 contraseña: 455463	Subcomité de Concientización de Latinos Jueves, 26 ene. 2023 10-11:30 a.m. Unirse a la reunión O llame: +1-415-655-0002 numero de reunión: 966 009-041 contraseña: LAS123	Centro de recursos familiares de Yucca Valley Pacific Clinics con Morongo Basin Healthcare Distrito Viernes, 27 ene. 2023 Unirse a la reunión O llame: +1-669-444-9171 numero de reunión: 825 6531 3224 contraseña: 402833	NAMI San Bernardino Lunes, 30 ene. 2023 4:30-5:30 p.m. Unirse a la reunión O llame: +1-669-900-6833 numero de reunión: 894 2025 7075 contraseña: 257801
Casa club Serenidad Martes, 31 ene. 2023 10:30-11:30 a.m. Reunión en persona 12625 Hesperia Rd. Ste.B Victorville (760) 955-6224	Reunión de Webex por la tarde Jueves, 2 feb. 2023 5-6 p.m. Unirse a la reunión O llame: +1-415-655-0002 numero de reunión: 2491 977 0291 contraseña: prQ6BYfME75	Subcomité de Concientización de Veteranos Lunes, 6 feb. 2023 3-4:30 p.m. Unirse a la reunión O llame: +1-415-655-0002 numero de reunión: 2482 788 1413#	Casa club Desert Stars Martes, 7 feb. 2023 10:30-11:30 a.m. Reunión en persona 1841 E. Main St. Barstow (760) 255-5705
Casa club TEAM House Martes, 7 feb. 2023 11:30 a.m. -12:30 p.m. Reunión en persona 201 W. Mill St. San Bernardino (909) 388-5640	Subcomité de Concientización de Diagnostico Dual y Drogadicción Miércoles, 8 feb. 2023 10-11:30 a.m. Unirse a la reunión O llame: +1-415-655-0002 numero de reunión: 961 777 142	Casa club Pathways to Recovery Miercoles, 8 feb. 2023 11:30 a.m.-12:30 p.m. Reunión en persona 17053 E. Foothill Blvd. Fontana (909) 347-1373	Subcomité de Concientización de Discapacidades Jueves, 9 feb. 2023 10-11:30 a.m. Unirse a la reunión O llame: +1-415-655-0002 numero de reunión: 146 434 2208

	contraseña: COSAC123		contraseña: DAS123
Comité Asesor del Distrito del 2do Distrito Jueves, 9 feb. 2023 3:30-4:30 p.m. Unirse a la reunión O llame: +1-415-655-0002 numero de reunión: 2483 823 7369 contraseña: pxYctfry353	Subcomité de Concientización de Prevención del Suicidio Lunes, 13 feb. 2023 10-11:30 a.m. Unirse a la reunión O llame: +1-415-655-0002 numero de reunión: 146 264 6760 contraseña: SPA123	Subcomité de Concientización de Espiritualidad Martes, 14 feb. 2023 1-2:30 p.m. Unirse a la reunión O llame: +1-415-655-0002 numero de reunión: 961 357 009 contraseña: SA123	Comité Asesor del Distrito del 1º Distrito Mieroles, 15 feb. 2023 11 a.m.-mediodía Unirse a la reunión O llame: +1-415-655-0002 numero de reunión: 187 662 3366 contraseña: u9APaZPXW39
Comité Asesor de Política Comunitaria (CPAC) Jueves, 16 feb. 2023 10 a.m.-mediodía Unirse a la reunión O llame: +1-415-655-0002 numero de reunión: 2486 716 4468 contraseña: MnMJKr8yQ22	Casa club Amazing Place Viernes, 17 feb. 2023 11 a.m.-mediodía Reunión en persona 2940 Inland Empire Blvd. Ontario (909) 458-1396	Casa club Central Valley Fun Jueves, 23 feb. 2023 11 a.m.-mediodía Reunión en persona 1501 S. Riverside Ave. Rialto (909) 877-4889	

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

Department Updates Jan. 23, 2023

DP DBH-PIO
To

Reply | Reply All | Forward | ...
Mon 1/23/2023 1:46 PM



It is that time of year again! Time to think of all the amazing and innovative initiatives and programs developed by your division and submit recommendations for the 2023 NACo Achievement Awards to your leadership team. All ideas need to be submitted by no later than Jan. 31 as the cut off for submissions is April 7.

Let's top our 7 NACo awards from 2022!

Community Program Planning Meetings

Every year Mental Health Services Act (MHSA) Administration holds Community Program Planning Meetings for stakeholders to discuss the MHSA Annual Update, or the MHSA Three Year Integrated Plan (every three years). The January and February 2023 meeting have been scheduled and are posted to the homepage announcements on the DBH website.



View Meeting Information

Attachment D

WebEx Etiquette

Page 1

- PLEASE MUTE YOURSELF ON YOUR COMPUTER AND/OR PHONE.
- **Do not** put this call on **"Hold"** at any time during this meeting.
- Please "announce" yourself by typing your name in the **"Chat."**
- Use **"Chat"** to ask questions.
- **"Raise Hand"** if you would like to be unmuted to ask questions *out loud*. We will have question breaks throughout the meeting.
- If you are using a computer AND a telephone connection, please **turn off the volume** on your **computer** to avoid an echo.
- Meeting is being recorded for internal audit purposes.



1

Poll Question: Getting to Know You

Page 2

We want to know more about you!

We will be launching a WebEx poll to get a better understanding of 'who' is in the audience today. A QR code has also been provided if you would like to complete the survey via a mobile device.

This information will also be used as part of the post-presentation analysis on stakeholder engagement.

2

SAN BERNARDINO COUNTY

Behavioral Health
MHSA Administration

MHSA Three Year Integrated Plan
Fiscal Years FY 2023/24 thru FY 2025/26
Community Planning Process (CPP)



Artwork by Tracy Hutchinson

www.SBCounty.gov

3

Meeting Overview

Page 4

- MHSA Three-Year Plan Purpose
- MHSA Components
- Community Program Planning (CPP) Meeting Schedule
  - January through February 2023
- Program Changes and Updates
- CPP Meeting Overview
- Questions and Answers

4

MHSA Three-Year Plan Overview

Page 5

Why do we do an MHSA Three-Year Plan?

- The MHSA Three-Year Integrated Plan is required by MHSA regulations (WIC § 5847)
- An Integrated Plan provides service data for the prior fiscal year and provides information on program planning for the upcoming three fiscal years

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MHSA Three-Year Plan Purpose

Page 6

The purpose of the MHSA Three-Year Plan is to:

- Provide information of MHSA funded programs in San Bernardino County to our stakeholders
- Include any proposed changes or updates to programs that might be made to the MHSA Plan
- Evaluate short-term and long-term impacts of MHSA programs
- Use as evidence to demonstrate that we are meeting the regulatory requirements

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MHSA - Components

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The MHSA Three-Year Plan and Annual Updates, like the Act itself, is constructed out of MHSA's six components, as well as a budget summary and component detail:

- Community Services and Supports **(CSS)** - Programs and services intended for SMI populations, focusing on individuals at risk of psychiatric hospitalization and/or homelessness due to the severity of the illness they are living with
  - 76% of MHSA funds
- Prevention and Early Intervention **(PEI)** - 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, symptoms, or risk factors of mental illness
  - 19% of MHSA funds

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MHSA - Components

Page 8

- Innovation **(INN)** - 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% of MHSA funds
- Workforce Education and Training **(WET)** - 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 **(CFTN)** - 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 (CPP)



9

MHSA - Components

Page 10

- Community Program Planning **(CPP)** - As part of the continuous feedback and improvement process, we meet with our stakeholders every month in many ways
  - Allows continuous communication between the department and our stakeholders regarding our services, outcomes, and other information related to the public behavioral health system
  - CPP stakeholder meetings emphasize the importance of consumer and family member involvement and attendance, as they are one of our major stakeholder populations

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Community Program Planning - Stakeholders

Page 11

Who are the Stakeholders for DBH?

WIC §5848 identifies the following as stakeholders:

- Adults and seniors with severe mental illness
- Families of children, adults, and seniors with severe mental illness
- Providers of services
- Law Enforcement agencies
- Education and social services agencies
- Veterans and representatives from Veteran organizations
- Providers of alcohol and drug services
- Healthcare organizations
- Any other interested parties



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Community Program Planning Meetings

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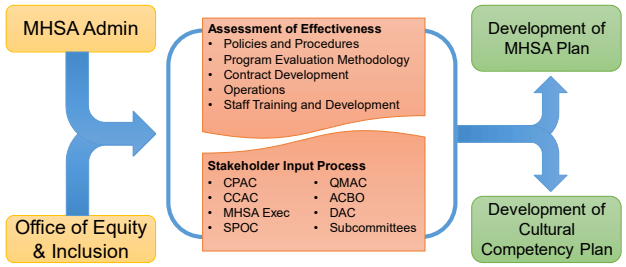
Examples of stakeholder meetings include:

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



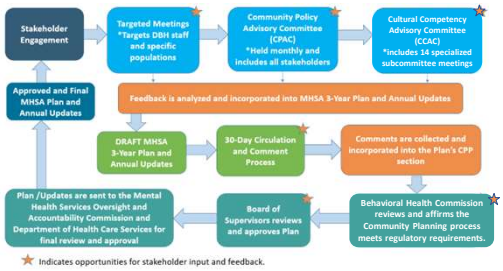
12

Stakeholder Engagement Process Overview



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Community Program Planning Process for MHSA Plan



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MHSA Three Year Plan – FY 2023/24 thru FY 2025/26 Proposed Timeline



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Stakeholder Participation

- Over the last three fiscal years 2,356 people have participated in CPAC.
  - Of those participants, the groups represented included:
    - Family Members or Loved Ones (32%)
    - Federal, State, County, or City Government (15%)
    - Healthcare – Behavioral/Mental Health & Physical Heath (12%)
    - Social or Human Services Agency (9%)
    - Consumer of Behavioral/Mental Health Services (7%)
    - Consumer of Substance Use Disorder Services (5%)
  - This number does not include the regular CCAC and sub-committee meetings
- Each meeting includes an opportunity to review MHSA component and program data and information
- Stakeholders are encouraged to provide feedback to support improvements, modification, or to support establishing new MHSA programs at each meeting

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Capacity Assessment: Trends in Stakeholder Feedback



Outreach and Education
- Use new technology
- Outreach to underserved
- More training
- Know current issues
- Virtual outreach events

Housing and Homelessness
- Increase collaboration
- Increase shelter infrastructure
- Partner with other agencies

Geographical Needs
- Services in all regions
- Build capacity in remote areas
- Host events in rural areas
- Greater appreciation given to regional specific barriers to access

Substance Use Disorder Recovery Services
- Increase collaboration
- Integrate with MH Services
- Additional education
- Improve access
- Integrate with other programs

Clubhouses
- More locations
- Help navigating programs
- SUDRS at clubhouses
- PFAs conduct outreach
- Attend community events

Transportation
- Expand options
- Collaborate with providers
- Access to UBER/LIFT
- Mobile therapy
- Decrease barriers

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MHSA Programs Updates

- DBH continuously reviews current expenditures, utilization, and availability of funding for stakeholder supported program updates and development
- DBH will continue using existing MHSA funds to support existing programs
- The review of feedback and stakeholder engagement is a continuous process that allows DBH to learn what programs/services best meet the needs of community
- Due to ongoing public health concerns, DBH has implemented the use of a virtual platform for most stakeholder engagement

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Page 19

Program Changes and Updates



Artwork by B. Lopez

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Page 20

Prevention and Early Intervention (PEI) Updates

Early Psychosis Program – Name Change

- The Early Psychosis Program will now be called the Improving Detection and Early Access (IDEA) program

Screening, Assessment, Referral, and Treatment (SART) & Early Identification and Intervention Services (EIIS) – Funding Increase

- SART provides mental health and adjunct services (e.g. occupational therapy, speech therapy) to children ages 0 through 5 yrs. old; EIIS provides mental health services, without the adjunct services, to children aged 0 through 8 yrs. old
- Both the SART and EIIS contracts will be increased by 20% to adjust for inflation since 2018

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Page 21

Prevention and Early Intervention (PEI) Updates

Behavioral Health Ministries – Pilot Project Ending

- This pilot project will be ending in FY 2022/23
- Data will be reviewed and evaluated to determine sustainability

Resilience Promotion in African American Children

- This program will receive an increase of $727,523 per fiscal year
- Increase will serve an additional 3,135 children per year
- Program will expand to additional areas of the county that include San Bernardino, Victorville, Adelanto, Barstow, Fontana, Rancho Cucamonga and Rialto.

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Page 22

Prevention and Early Intervention (PEI) Updates

Office of Suicide Prevention

- New program administered under Prevention and Early Intervention
- Strengthen the infrastructure surrounding suicide prevention in San Bernardino County
- Provide ongoing community education and supports for suicide prevention

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Page 23

Community Services and Support (CSS) Updates

Adult Transitional Care Programs – Program Expansion

DBH is contracting with a new vendor to provide appropriate placement options with onsite medical and psychiatric services, which can accommodate admittance 24/7

- This facility and program will offer a step-down level of community placement, with services for both medical and behavioral health on-site to provide the wrap-around care ensuring stability in the community
- This expansion will provide an additional 150 enhanced board and care beds
- This expansion will also reduce recidivism and extended stays in locked psychiatric settings

23

Page 24

Community Services and Support (CSS) Updates

Diversion Programs – Name Change

- Diversion Programs will now be called Triage Transitional Services

Crisis Intervention Collaborative Programs– Name Change

- Crisis Intervention Training (CIT) and Triage, Engagement, and Support Teams (TEST) are now being consolidated under the program name Crisis Intervention Collaborative Programs.

24

Community Services and Support (CSS) Updates

Page 25

Adult Full Service Partnerships: Community FSP and Permanent Supportive Housing FSP– Name Change and Expansion

- "Full-Service/FSP Permanent Support Housing" will be renamed to "Adult Full Service Partnerships: Community FSP and Permanent Supportive Housing FSP"
- Review of current cases in community clinics where the client is not enrolled in an FSP determined an additional 91 clients need to be served through an FSP per year
  - Increased funding would allow for an expansion of the C-FSP contract to serve these 91 additional consumers
- Upcoming permanent supportive housing projects require FSP programs to serve an additional 125 consumers
  - Increased funding would provide the capacity to provide FSP services to an additional 125 consumers during FY 2023-2024, and another 50 consumers per year through FY 2027-2028

25

Community Services and Support (CSS) Updates

Page 26

Shelter Beds for all FSPs – Program Expansion

- Increase in funding will allow the expansion of contract shelter beds for those consumers who need placement in emergency shelters
- The increase in bed days per year will provide consumers with additional time and case management while placed in emergency shelters, and allow for an appropriate and successful transition to stable housing

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Community Services and Support (CSS) Updates

Page 27

RBEST AOT Program – Program Expansion

- Assisted Outpatient Treatment (AOT) is court-ordered outpatient treatment for individuals who have a history of untreated mental illness and meet criteria:
  - 18 yrs. or older
  - Person suffering from a mental illness
  - Clinical determination that, in the view of patient history, AOT is needed in order to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to the person or to others
  - Person has a history of lack of compliance with treatment
- The program is intended to interrupt the cycle of hospitalization, incarceration and homelessness for adults ages 18 and older who are living with serious mental illness and have been unable and/or unwilling to participate in mental health services on a voluntary basis.

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Community Services and Support (CSS) Updates

Page 28

RBEST AOT Program – Program Expansion

- The Recovery Based Engagement Support Team (RBEST) AOT program will provide assertive community treatment model full service partnership services to consumers meeting criteria after they have been referred by the RBEST Engagement team.
- Services will include intensive treatment, case management and rehabilitation services provided in the field by a multidisciplinary team.
- Staffing will include a 1:10 ratio and utilize a "whatever it takes" approach to providing services focused on building therapeutic relationships that facilitate trust, linkage to services and, ultimately, treatment adherence.

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Innovation (INN) Updates

Page 29

Progressive Integrated Care Collaborative – NEW Potential Project

Progressive Integration will be based upon a strategy of the selection of best practices from a given discipline and applying those practices uniformly across the following specialties:

- Laboratory Studies
- Electrocardiograms and Radiographic Studies
- Data Sharing
- Physical Health Specialist Consultation and Referrals
- Billing

29

Innovation (INN) Updates

Page 30

Vyvanse in Stimulant Addiction (VISA) – New Potential Project

Evaluate if the use of Vyvanse, a stimulant medication, as a Medication Assisted Treatment (MAT) for individuals addicted to methamphetamine

- Addiction to methamphetamine plagues a significant proportion of consumers in San Bernardino County
- Changes in illicit drug manufacturing have increased the potency of available methamphetamine contributing to dependence, worsened mental health, and causing significant physical health consequences that worsened social function
- There are no adequately supported MAT options for individuals with this condition

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Workforce Education and Training (WET) Updates

Page 31

Peer Workforce – NEW Program

San Bernardino County will renew the agreement with CalMHSA as the county's Peer Support Specialist certifying entity

- Current agreement with CalMHSA is non-financial; the new agreement will allow DBH to pay for the application, training, and exam for the Peer Support Specialist
- New agreement is for 2 years
- Includes 2 new WET positions (Staff Analyst II and Training Development Specialist/Mental Health Education Consultant) dedicated to Peer Workforce

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Workforce Education and Training (WET) Updates

Page 32

Training and Technical Assistance – Funding Increase

- Increase in WET funding that will allow trainings, technical assistance, and leadership development for staff

32

Capital Facilities and Technological Needs (CFTN) Updates

Page 33

Behavioral Health Continuum Infrastructure Program (BHCIP) – Funding Provided

- Acceptance of a BHCIP Grant requires the accepting agency to provide 'matching funds' in the amount of 29% of the BHCIP award
- DBH will be accepting the grant and will use MHSA funds from Capital Facilities and Technological Needs component to fund capital facilities projects that are in alignment with the public behavioral health system

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Capital Facilities and Technological Needs (CFTN) Updates

Page 34

Community Care Expansion (CCE) Preservation Funds Grant – Funding Provided

- Funds from this grant will be used for the immediate preservation of existing licensed residential adult and senior care facilities
- Acceptance of a CCR Grant requires the accepting agency to provide 'matching funds' in the amount of 10% of the BHCIP award
- DBH will be accepting this grant and will use MHSA funds from Capital Facilities and Technological Needs component to fund capital facilities projects that are in alignment with the public behavioral health system

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Fiscal Update

Page 35

As part of Department of Behavioral Health's (DBH) continued fiscal accountability, management, and transparency of MHSA funds, DBH has revised the reporting of program expenditures and revenues for this State Plan Update to be in-line with actual anticipated utilization values based on historical trends and anticipated growths. This revision helps ensure more accurate reporting of usages and availabilities of MHSA funds allotted to DBH consistent with County of San Bernardino's continued goal of responsible use of our resources to ensure financial sustainability and does not impact Board of Supervisors approved commitments. As part of year end reporting, it was found additional Community Support Services (CSS) transfer is required for the Workforce, Education and Training component. This additional transfer is reflected in the balance of unspent funds for CSS.

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CPP Summary

Page 36

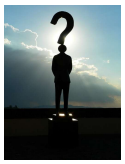
MHSA Three-Year Integrated Plan

- Draft MHSA Plan will be posted and available for review from February 13, 2023 through March 15, 2023
- 41 meetings held in all geographic regions of the county
  - Includes standing CPP Stakeholder meetings (CPAC, DACs, CCAC, and subcommittees, etc.)
  - Includes the clubhouses in all regions
- Public Hearing is tentatively set to be conducted at the regular Behavioral Health Commission Meeting on **April 6, 2023**
- Presentation of the Plan to the Board of Supervisors for approval is tentatively scheduled May-June 2023

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Page 37

Questions?

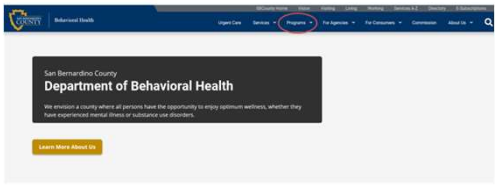


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How to find the MHSA Three-Year Plan

Page 38

1. Website: https://wp.sbcounty.gov/dbh/

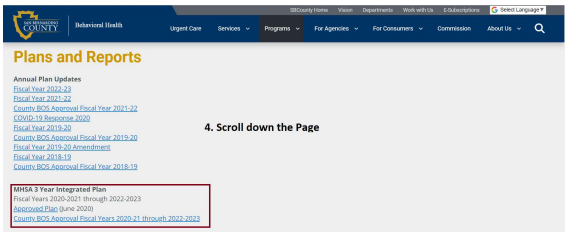


2. Click on Programs
3. Select Mental Health Services Act (MHSA) from the drop down menu

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How to find the MHSA Three-Year Plan

Page 39



4. Scroll down the Page

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Closing

Page 40

Thank you for your thoughtful participation!

Your feedback is important to us.

Please ensure that you have completed your comment forms.

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Contact

Page 41

For additional help in accessing Behavioral Health Services please call 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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Concerns

Page 42

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/2021/08/COM0947.pdf

To report concerns related to receipt of behavioral health services, please contact the DBH Access Unit at:

(909) 386-8256
Toll Free 1 (888) 743-1478
or 7-1-1 for TTY users.

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Questions

For questions or comments, please contact:

Maribel Gutierrez
Senior Program Manager
MHSA@dbh.sbcounty.gov
(909) 252-4017

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Normas de etiqueta para WebEx

- SILENCIE EL MICRÓFONO DE SU COMPUTADORA Y/O TELÉFONO.
- **No** ponga esta llamada **"en espera"** en ningún momento durante esta reunión.
- "Anúnciese" escribiendo su nombre en el **"Chat".**
- Utilice el **"Chat"** si tiene preguntas.
- **"Levante la mano"** si desea que reactiven su micrófono para hacer preguntas en voz alta. Tendremos pausas para hacer preguntas a lo largo de la reunión.
- Si está usando conexión por computadora Y por teléfono, **apague el volumen** de su **computadora** para evitar el eco.
- La reunión será grabada para fines de auditoría interna.



1

Pregunta de sondeo: Queremos conocerlo

¡Queremos conocer mejor quién es usted!

Estaremos llevando a cabo un sondeo por WebEx para comprender mejor 'quién' forma parte de la audiencia hoy. También se ha proporcionado un código QR si desea responder a la encuesta usando un dispositivo móvil.

Esta información también se utilizará como parte del análisis posterior a la presentación sobre la participación de los interesados.

2

SAN BERNARDINO COUNTY

Behavioral Health
MHSA Administration

Plan Integrado de Tres Años de la MHSA
Años Fiscales del 2023/24 al 2025/26
Proceso de Planificación Comunitaria (CPP)



Arte por Tracy Hutchinson

www.SBCounty.gov

3

Resumen de la reunión

- Propósito del plan de tres años de la MHSA
- Componentes de la MHSA
- Calendario de reuniones de Planificación de Programas Comunitarios (CPP)
  - Enero a febrero de 2023
- Cambios y actualizaciones del Programa
- Resumen de la reunión de CPP
- Preguntas y respuestas

4

Resumen del plan de tres años de la MHSA

¿Por qué hacemos un plan de tres años de la MHSA?

- El Plan integrado de tres años de la MHSA es requerido por los reglamentos de la MHSA (WIC § 5847)
- Un plan integrado proporciona datos sobre el servicio del año fiscal anterior e información acerca de la planificación del programa para los siguientes tres años fiscales

5

Propósito del plan de tres años de la MHSA

El propósito del plan es:

- Informar a los interesados sobre los programas financiados por la MHSA en el Condado de San Bernardino.
- Incluir todos los cambios o actualizaciones propuestos para los programas que pudieran hacerse al Plan de la MHSA.
- Evaluar el impacto a corto y largo plazo de los programas de la MHSA.
- Demostrar fehacientemente que cumplimos con los requisitos reglamentarios.

6

Componentes de la Actualización Anual de la MHSA

Page 7

El Plan de tres años de la MHSA y las actualizaciones anuales, como la ley misma, se basan en seis componentes de la MHSA, así como en el detalle del componente y resumen del Presupuesto:

- Community Services and Supports **(Servicios y Apoyo Comunitarios, CSS)** - Programas y servicios para personas que sufren de Enfermedades Mentales Graves (SMI), enfocados en personas que corren el riesgo de hospitalización psiquiátrica y/o de quedar sin hogar debido a la gravedad de la enfermedad que padecen.
  - 76% de fondos de la MHSA
- Prevention and Early Intervention **(Prevención e Intervención Temprana, PEI)** - Servicios que tienen como fin evitar que una enfermedad mental se convierta en grave e incluso, de ser posible, evitar que ésta se desarrolle. Las poblaciones objetivo son las personas que experimentan señales, síntomas o factores de riesgo de enfermedad mental.
  - 19% de fondos de la MHSA

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Componentes de la Actualización Anual de la MHSA

Page 8

- Innovation **(Innovación, INN)** - Proyectos de tiempo limitado cuyo fin es llevar a cabo investigaciones a corto plazo que ayuden a mejorar el sistema público de salud mental. Estos programas realizan pruebas con diferentes estrategias y nos permiten incorporar a los servicios públicos de salud mental, aquellas que tienen éxito.
  - 5% de fondos de la MHSA
- Workforce Education and Training **(Educación y Capacitación de la Fuerza Laboral, WET)** - Nos permite capacitar y reclutar personal en todos los niveles para proveer servicios ininterrumpidos
  - Asignación única, sostenida a través de la transferencia de fondos de CSS.
- Capital Facilities and Technological Needs **(Infraestructura y Necesidades Tecnológicas, CFTN)** - Espacio para proveer servicios y tecnología para asistir en la recopilación y almacenamiento de la información de los usuarios y asistir en la planificación de tratamientos
  - Asignación única, sostenida a través de transferencia de fondos de CSS.

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Page 9

Community Program Planning (Planificación de Programas Comunitarios, CPP)



9

Plan de tres años de la MHSA (Cont.)

Page 10

- Planificación de Programas Comunitarios **(CPP)**: Como parte del proceso continuo de retroalimentación y mejoras, nos reunimos con los interesados cada mes de diversas formas
  - Permite la comunicación continua entre el departamento y los interesados con respecto a nuestros servicios, resultados y otra información relacionada con el sistema público de salud mental
  - En las reuniones con los interesados, enfatizamos la importancia de la participación y asistencia de los usuarios y sus familias a las reuniones de CPP ya que ellos pertenecen a uno de los grupos interesados principales

10

Partes Interesadas en la Planificación de Programas Comunitarios

Page 11

¿Quiénes son los interesados en el DBH?

WIC §5848 identifica a los siguientes interesados:

- Adultos y adultos mayores con enfermedades mentales graves,
- Familias de niños, adultos y adultos mayores con enfermedades mentales graves,
- Proveedores de servicios,
- Entidades del orden público,
- Entidades educativas y de servicios sociales,
- Veteranos y representantes de organizaciones de veteranos de las fuerzas armadas,
- Proveedores de servicios por consumo de alcohol y drogas,
- Organizaciones de atención de la salud y
- Otros interesados importantes.



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Reuniones de Planificación de Programas Comunitarios

Page 12

Entre los ejemplos de reuniones de interesados se encuentran:

- Comité de Asesoría de Competencia Cultural
- Subcomités de Asesoría de Competencia Cultural
- Comité de Asesoría de Políticas Comunitarias (CPAC)
- Reunión de la Comisión de Salud Mental
- Reuniones del Comité de Asesoría del Distrito (DAC)
- Juntas de Asesoría de Casas Club para usuarios
- Asociación de Organizaciones Basadas en la Comunidad (ACBO)



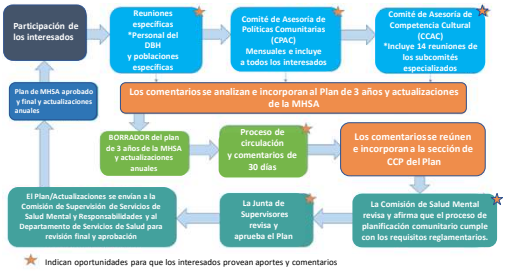
12

Resumen del proceso de participación de los interesados



13

Proceso de Planificación de Programas Comunitarios para el plan de la MHSA



14

Plan de tres años de la MHSA – Calendario propuesto para los Años Fiscales 2023/24 a 2025/26



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Participación de los interesados

- Durante los últimos tres años fiscales, 2,356 personas han participado en CPAC.
  - De esos participantes, los grupos representados incluyeron:
    - Miembros de la familia o persona amada (32%)
    - Gobierno federal, estatal, del condado o de la ciudad (15%)
    - Atención de la salud - Salud mental/conductual y física (12%)
    - Agencia social o de servicios humanos (9%)
    - Usuario de los servicios de salud conductuales/mentales (7%)
    - Usuarios de Servicios para trastornos por uso de sustancias (5%)
  - Esta cifra no incluye las reuniones ordinarias de CCAC y de subcomités.
- Cada reunión incluye la oportunidad de revisar un componente de la MHSA y datos e información de programas.
- Se exhorta a los interesados para que proporcionen comentarios para respaldar las mejoras, modificaciones o para respaldar el establecimiento de nuevos programas de MHSA en cada reunión.

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Evaluación de la capacidad: Tendencias en los comentarios de los interesados



Proyección y educación
- Uso de nueva tecnología
- Proyección hacia los menos atendidos
- Más capacitación
- Conocer los problemas actuales
- Eventos virtuales de proyección

Viviendas y carencia de vivienda
- Aumento en la colaboración
- Aumento de la infraestructura de los refugios
- Asociación con otras agencias

Necesidades geográficas
- Servicios en todas las regiones
- Desarrollar la capacidad en áreas remotas
- Realizar eventos en áreas rurales
- Reconocer mejor las barreras al acceso regionales específicas

Servicios de recuperación por trastornos causados por el uso de sustancias
- Aumento en la colaboración
- Integración con servicios de salud mental
- Educación adicional
- Mejorar el acceso
- Integración con otros programas

Casas club
- Más localidades
- Ayuda en la navegación de los programas
- Servicios de Recuperación por Trastornos y Uso de Sustancias (SUDRS) en casas club
- Defensa de Pares y la Familia (PFA)
- Asistencia a eventos de la comunidad

Transporte
- Expansión de opciones
- Colaboración con proveedores
- Acceso a UBER/LIFT
- Terapia móvil
- Disminuir barreras

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Actualizaciones de los Programas de la MHSA

- El DBH evalúa continuamente los gastos, la utilización y la disponibilidad de fondos actuales para actualizaciones y desarrollo de programas respaldados por los interesados
- El DBH continuará usando fondos existentes de la MHSA para respaldar programas existentes
- La evaluación de la retroalimentación y participación de los interesados es un proceso continuo que permite al DBH informarse acerca de qué programas y servicios satisfacen mejor las necesidades de la comunidad
- Debido a las inquietudes actuales de la salud pública, el DBH ha implementado el uso de una plataforma virtual para la participación de la mayoría de los interesados

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Page 19

Cambios y actualizaciones del Programa



Arte por B. Lopez

19

Actualizaciones a la Prevención e Intervención Temprana

Page 20

Early Psychosis Program (Programa de psicosis temprana) – Cambio de nombre

- El Programa Early Psychosis, en adelante se llamará Improving Detection and Early Access, IDEA (Programa de Mejora en la Detección y Acceso Temprano)

Screening, Assessment, Referral, and Treatment (Colaboración para la Detección, Evaluación, Remisión y Tratamiento, SART) y Early Identification and Intervention Services (Servicios de Identificación e Intervención Temprana Infantil, EIIS) – Aumento en el financiamiento

- SART proporciona servicios de salud mental y servicios anexos (ej. terapia ocupacional, terapia del habla) a los niños de edades de 0 hasta 5 años; EIIS proporciona servicios de salud mental, sin servicios anexos, a niños de edades de los 0 hasta los 8 años.
- Ambos contratos de SART y EIIS tendrán un aumento del 20% como ajuste por la inflación desde 2018.

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Actualizaciones a la Prevención e Intervención Temprana

Page 21

Ministerios de Salud del Comportamiento – Fin del Proyecto Piloto

- Este proyecto piloto finalizará en el año fiscal 2022/23
- Los datos serán revisados y evaluados para determinar la sostenibilidad.

Promoción de la resiliencia en niños afroamericanos

- Este programa recibirá un aumento de $727,523 por año fiscal
- El aumento servirá a 3,135 niños adicionales por año
- El programa se expandirá a áreas adicionales del condado que incluyen San Bernardino, Victorville, Adelanto, Barstow, Fontana, Rancho Cucamonga y Rialto.

21

Actualizaciones a la Prevención e Intervención Temprana

Page 22

Oficina de Prevención del Suicidio

- Nuevo programa administrado bajo Prevención e Intervención Temprana
- Fortalecer la infraestructura que rodea la prevención del suicidio en el condado de San Bernardino
- Brindar educación comunitaria continua y apoyo para la prevención del suicidio.

22

Actualización de los Servicios y Apoyo Comunitarios (CSS)

Page 23

Programas de atención de transición para adultos - Expansión del programa

El DBH está contratando a un nuevo proveedor que ofrezca opciones de ubicación apropiadas para servicios médicos y psiquiátricos dentro de las mismas instalaciones, el cual pueda acomodar la admisión 24 horas al día, los 7 días a la semana.

- Estas instalaciones y el programa ofrecerán un nivel descendiente de atención a nivel de la comunidad, con servicios médicos y de salud mental en las mismas instalaciones para proporcionar atención integral garantizando la estabilidad en la comunidad.
- Esto reducirá la reincidencia y estadías prolongadas en entornos psiquiátricos restrictivos.

23

Actualización de los Servicios y Apoyo Comunitarios (CSS)

Page 24

Diversion Programs (Programas de Reencauzamiento) – Cambio de nombre

- Los Diversion Programs se llamarán Triage Transitional Services (Servicios Transicionales de Priorización)

Programas Colaborativos de Intervención en Crisis: Cambio de Nombre

- Entrenamiento en la Intervención de Crisis (CIT) y los Equipos de Clasificación, Compromiso y Apoyo (TEST) ahora se están consolidando bajo el nombre del programa Programas Colaborativos de Intervención en Crisis.

24

Actualización de los Servicios y Apoyo Comunitarios (CSS)

Page 25

Adult Full Service Partnerships: Community FSP y Permanent Supportive Housing FSP (Alianzas de Servicio Integral para adultos: Servicio Integral Comunitario y Apoyo permanente para vivienda) – Cambio de nombre y expansión

- "Full-Service/FSP Permanent Support Housing" tendrá el nuevo nombre de "Adult Full Service Partnerships: Community FSP and Permanent Supportive Housing FSP" (Alianzas de servicio integral para adultos: Servicio Integral Comunitario y Apoyo permanente para vivienda")
- Una revisión de casos actuales en clínicas comunitarias donde el cliente no está inscrito en una FSP determinó que cada año, 91 clientes adicionales necesitan atención a través de una FSP.
  - El aumento en el financiamiento permitirá una expansión del contrato C-FSP para atender a estos 91 consumidores adicionales.
- Los próximos proyectos de apoyo de vivienda permanente requieren que los programas FSP atiendan 125 consumidores adicionales.
  - El aumento en el financiamiento proporcionaría la capacidad de proveer servicios FSP a 125 consumidores adicionales durante el año fiscal 2023-2024, y otros 50 consumidores al año a través de los años fiscales 2027-2028

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Actualización de los Servicios y Apoyo Comunitarios (CSS)

Page 26

Camas de refugio para todas las Asociaciones de Servicio Completo(FSP por sus siglas en ingles): Expansión del Programa

- El aumento de la financiación permitirá la expansión de camas de refugio por contrato para aquellos consumidores que necesitan ubicación en refugios de emergencia
- El aumento en los días de cama por año brindará a los consumidores tiempo adicional y administración de casos mientras se encuentran en refugios de emergencia, y permitirá una transición adecuada y exitosa a una vivienda estable.

26

Actualización de los Servicios y Apoyo Comunitarios (CSS)

Page 27

Equipo de Soporte de Compromiso Basado en la Recuperación, Tratamiento Ambulatorio Asistido (RBEST AOT por sus siglas en ingles) - Ampliación del programa

- El Tratamiento Ambulatorio Asistido (AOT, por sus siglas en inglés) es un tratamiento ambulatorio ordenado por un tribunal para personas que tienen antecedentes de enfermedad mental no tratada y cumplen con los siguientes criterios:
  - 18 años o mayor
  - Persona que sufre de una enfermedad mental
  - Determinación clínica de que, en vista del historial del paciente, se necesita AOT para prevenir una recaída o deterioro que probablemente resulte en una discapacidad grave o un daño grave a la persona o a otros.
  - La persona tiene antecedentes de falta de cumplimiento del tratamiento.
- El programa tiene como objetivo interrumpir el ciclo de hospitalización, encarcelamiento y falta de vivienda para adultos mayores de 18 años que viven con una enfermedad mental grave y no han podido o no han querido participar en los servicios de salud mental de forma voluntaria.

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Actualización de los Servicios y Apoyo Comunitarios (CSS)

Page 28

Equipo de Soporte de Compromiso Basado en la Recuperación, Tratamiento Ambulatorio Asistido (RBEST AOT por sus siglas en ingles) - Ampliación del programa

- El programa AOT del Equipo de Apoyo de Compromiso Basado en la Recuperación (RBEST) proporcionará un modelo de tratamiento comunitario asertivo con servicios de asociación de servicio completo para los consumidores que cumplan con los criterios después de que hayan sido referidos por el equipo RBEST.
- Los servicios incluirán tratamiento intensivo, manejo de casos y servicios de rehabilitación proporcionados en el campo por un equipo multidisciplinario.
- La dotación de personal incluirá una proporción de 1:10 y utilizará un enfoque de "lo que sea necesario" para brindar servicios enfocados en construir relaciones terapéuticas que faciliten la confianza, el vínculo con los servicios y, en última instancia, la adherencia al tratamiento.

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Actualizaciones a Proyectos de Innovación (INN)

Page 29

Progressive Integrated Care Collaborative (Colaboración de la atención integrada progresiva) – NUEVO proyecto potencial

Integración progresiva que estará basada en una estrategia de seleccionar las mejores prácticas de una disciplina determinada y aplicarlas de manera uniforme a lo largo de las especializaciones dentro de dicha práctica. Estas especializaciones son:

- Estudios de laboratorio
- Electrocardiogramas y estudios radiográficos
- Datos compartidos
- Consultas y derivaciones a especialistas en salud física
- Facturación

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Actualizaciones a Proyectos de Innovación (INN)

Page 30

Vyvanse in Stimulant Addiction (El Vyvanse en la adicción estimulante, VISA) – Nuevo proyecto potencial

Evaluar el uso del Vyvanse, una medicina estimulante, como Tratamiento asistido por medicamentos (MAT) para individuos con adicción a la metanfetamina.

- La adicción a la metanfetamina abarca una proporción significativa de consumidores en el Condado de San Bernardino
- Los cambios en la fabricación ilícita de drogas han aumentado la potencia de la metanfetamina disponible lo cual contribuye a la dependencia, empeoramiento de la salud mental y tienen consecuencias de salud física significativas que empeoran el desempeño social
- No existen opciones de MAT con respaldo adecuado para individuos con esta condición

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Actualizaciones a Educación y Capacitación de la Fuerza Laboral (WET)

Page 31

Peer Workforce (Fuerza laboral de Pares) – NUEVO programa

El condado de San Bernardino renovará el contrato con CalMHSA como entidad certificadora especialista de soporte entre pares.

- El contrato actual con CalMHSA no es financiero; el nuevo acuerdo permitirá al DBH pagar por la solicitud, capacitación y examen para el Especialista de soporte entre pares
- El nuevo contrato es de 2 años
- Incluye 2 nuevos puestos dentro de WET (Analista de personal II y Especialista de desarrollo de capacitación/Consultor en educación de salud mental) dedicados a la Fuerza laboral entre pares

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Actualizaciones a Educación y Capacitación de la Fuerza Laboral (WET)

Page 32

Capacitación y Asistencia Técnica – Aumento de Financiamiento

- Aumento de los fondos WET que permitirán capacitaciones, asistencia técnica y desarrollo de liderazgo para el personal

32

Actualización a Infraestructura y Necesidades Tecnológicas

Page 33

Behavioral Health Continuum Infrastructure Program, BHCIP (Programa continuo de infraestructuras de salud mental) – Se proporcionó financiamiento

- La aceptación de una subvención de BHCIP requiere que la agencia receptora proporcione 'fondos comparables' por el monto igual a un 29% de la concesión de BHCIP.
- El DBH estará aceptando la subvención y utilizará fondos de los componentes de Infraestructura y Necesidades Tecnológicas de la MHSA para financiar proyectos de infraestructura que estén alineados con el sistema de salud mental pública.

33

Actualización a Infraestructura y Necesidades Tecnológicas

Page 34

Subsidio de Fondos de Preservación de Expansión de Atención Comunitaria (CCE) - Financiamiento Provisto

- Los fondos de esta subvención se utilizarán para la preservación inmediata de las instalaciones residenciales de atención para adultos y personas mayores con licencia existentes.
- La aceptación de una subvención de CCE requiere que la agencia que la acepta proporcione "fondos de contrapartida" por un monto del 10 % de la subvención de BHCIP
- DBH aceptará esta subvención y utilizará los fondos de la MHSA del componente de necesidades tecnológicas y de instalaciones de capital para financiar proyectos de instalaciones de capital que estén alineados con el sistema público de salud conductual.

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Actualización Fiscal

Page 35

Como parte de la responsabilidad fiscal, la gestión y la transparencia continuas de los fondos de la MHSA del Departamento de Salud del Comportamiento (DBH por sus siglas en inglés), DBH ha revisado los informes de gastos e ingresos del programa para esta Actualización del Plan Estatal. Ahora están en línea con los valores de utilización anticipados reales (basados en tendencias históricas) y los crecimientos anticipados. Esta revisión ayuda a garantizar un informe más preciso de los usos y disponibilidades de los fondos de la MHSA asignados a DBH. La revisión es coherente con el objetivo continuo del Condado de San Bernardino de uso responsable de nuestros recursos para garantizar la sostenibilidad financiera. No afecta los compromisos aprobados por la Junta de Supervisores. Como parte de nuestro informe de fin de año, se encontró que se requiere una transferencia adicional de Servicios de Apoyo Comunitario (CSS por sus siglas en inglés) para el componente de Fuerza Laboral, Educación y Capacitación. Esta transferencia adicional se refleja en el saldo de fondos no utilizados para CSS.

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Resumen del CPP

Page 36

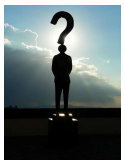
Plan Integrado de Tres Años de la MHSA

- El Plan en forma de borrador de la MHSA será publicado y estará disponible para revisión del 13 de febrero de 2023 al 15 de marzo de 2023.
- 41 reuniones celebradas en todas las regiones geográficas del condado
  - Incluidas reuniones permanentes de interesados en la Planificación de Programas Comunitarios, CPP (CPAC, DAC, CCAC y subcomités, etc.)
- Incluye las casas club de todas las regiones
- Se tiene programado que la Audiencia Pública se lleve a cabo durante la Reunión de la Comisión de Salud Mental el **6 de abril de 2023**
- Programada tentativamente para la presentación del Plan para aprobación de la Junta de Supervisores en mayo-junio de 2023

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Page 37

¿Preguntas?

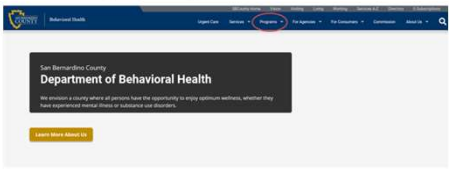


37

Cómo encontrar el Plan de tres años de la MHSA

Page 38

1. **Sitio Web:** https://wp.sbcounty.gov/dbh/

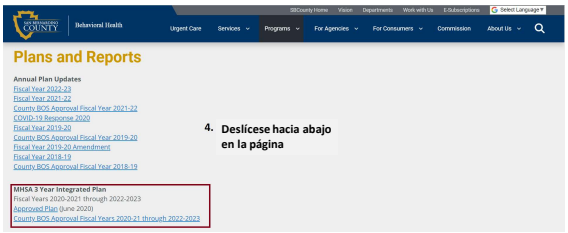


2. Haga clic en Programas
3. Seleccione Ley de Servicios de Salud Mental (Mental Health Services Act, MHSA) del menú desplegable

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Cómo encontrar el Plan de tres años de la MHSA

Page 39



4. **Deslícese hacia abajo en la página**

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Cierre

Page 40

¡Gracias por su participación reflexiva!

¡Nos interesan sus comentarios!

Por favor asegúrese de completar sus formularios de comentarios.

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Contacto

Page 41

Para obtener ayuda adicional para acceder a los Servicios de Salud Mental, por favor llame a la Unidad de Acceso del DBH al:

(909) 386-8256

Teléfono sin cargos: 1 (888) 743-1478

o 7-1-1 para usuarios de TTY.

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Inquietudes

Page 42

Para reportar inquietudes relacionadas con la Planificación de Programas Comunitarios de la MHSA, consulte el Proceso de Resolución de Problemas de la MHSA en:

https://wp.sbcounty.gov/dbh/wp-content/uploads/2021/08/COM0947.pdf

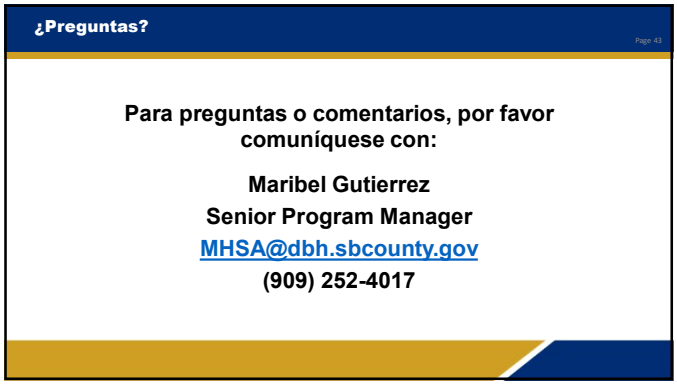
Para reportar sus inquietudes relacionadas con la recepción de servicios de salud mental, comuníquese con la Unidad de Acceso del DBH al:

(909) 386-8256

Teléfono sin cargos: 1 (888) 743-1478

o 7-1-1 para usuarios de TTY.

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¿Preguntas?
Page 43
Para preguntas o comentarios, por favor comuníquese con:
Maribel Gutierrez
Senior Program Manager
MHSA@dbh.sbcounty.gov
(909) 252-4017

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SAN BERNARDINO COUNTY | Behavioral Health

MENTAL HEALTH SERVICES ACT (MHSA)

Stakeholder Survey Form

MHSA Three Year Integrated Plan
Fiscal Years 2023/24 - 2025/26
Community Program Planning Meeting

1. What is your age?

☐ 0-15 yrs ☐ 26-59 yrs
☐ 16-25 yrs ☐ 60+ yrs

2. What sex were you assigned at birth?

☐ Female ☐ Male

3. How do you describe yourself?

☐ Female ☐ Male
☐ Trans Female/Woman ☐ Trans Male/Man
☐ Genderqueer ☐ Nonbinary
☐ Questioning or Unsure of Gender Identity
☐ Not Listed:_____
☐ Decline to State

4. Do you consider yourself:

☐ Straight/Heterosexual ☐ Gay/Lesbian
☐ Queer ☐ Bisexual
☐ Questioning or Unsure about Orientation
☐ Not Listed:_____
☐ Decline to Answer

5. What is the primary language spoken in your home?

☐ English ☐ Spanish
☐ Not Listed: _____

6. Are you a consumer of mental health services?

☐ YES (currently) ☐ NO
☐ YES (previously) ☐ Decline to State

7. Are you a consumer of alcohol and/or drug services?

☐ YES (currently) ☐ NO
☐ YES (previously) ☐ Decline to State

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

9. Have you ever served in the military?

☐ YES (currently) ☐ NO
☐ YES (previously) ☐ Decline to State

10. Which category best describes your race (i.e. physical/ancestral characteristics)?

☐ American Indian or Alaskan Native
☐ Asian
☐ African American/Black
☐ Native Hawaiian or other Pacific Islander
☐ Hispanic/Latino
☐ Caucasian/White
☐ More than One Race
☐ Decline to State

11. Which best describes your employer:

☐ Self
☐ Private Business
☐ Community Based Service Provider
☐ Federal, State, County, or City Government
☐ Nonprofit
☐ Student/Intern
☐ Other:_____

12. Do you work in any of the following areas/fields? (check all that apply)

☐ Law Enforcement
☐ Education
☐ Social or Human Service Program/Agency
☐ Healthcare
  ☐ Physical Health ☐ Behavioral/Mental Health
☐ Alcohol and Drug Service Program
☐ Veterans Organization
☐ Faith Based Organization
☐ Not Listed:_____

Stakeholder Survey Form

MHSA Three Year Integrated Plan
Fiscal Years 2023/24 - 2025/26
Community Program Planning Meeting

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
☐ Decline to Answer

14. Do you live or work in San Bernardino County, if both list the region you live in:

☐ YES
- ☐ Central Valley Region
  e.g. Bloomington, Fontana, Grand Terrace, Rialto
- ☐ Desert/Mountain Region
  e.g. Adelanto, Amboy, Apple Valley, Baker, Big Bear City, Cima, Earp, Fort Irwin, Hesperia, Hinkley, Joshua Tree, Landers, Ludlow, Morongo Valley, Mountain Pass, Needles, Nipton, Parker Dam, Phelan, Pioneertown, Sky Forest, Sugarloaf, 29 Palms, Wrightwood, Yermo, Yucca Valley
- ☐ East Valley
  e.g. Green Valley Lake, Highland, Lake Arrowhead, Loma Linda, Lytle Creek, Mentone, Patton, Redlands, Rimforest, Running Springs, San Bernardino, Yucapia
- ☐ West Valley
  e.g. Chino Hills, Chino, Guasti, Mt. Baldy, Montclair, Rancho Cucamonga

☐ No, I live and work in a neighboring California County

Zip Code:_____

15. Were you satisfied that this meeting met its goals and/or objectives?

☐ Very Satisfied
☐ Satisfied
☐ Neutral
☐ Unsatisfied
☐ Very Unsatisfied

16. In the future how would you like to receive MHSA updates? (check all the apply)

☐ Community Policy Advisory Committee Meetings
☐ Webinar
☐ Email (Provide email address below)
☐ Social Media
☐ Special meeting in your community
☐ Other:_

SAN BERNARDINO COUNTY | Behavioral Health

Stakeholder Survey Form

MHSA Three Year Integrated Plan
Fiscal Years 2023/24 - 2025/26
Community Program Planning Meeting

1. **What did you learn about the MHSA Three Year Integrated Plan FY 2023/24 – 2025/26?**

2. **Do you support the Innovation Project *Progressive Integrated Care Collaborative (PICC)*?**
   ☐ Strongly Support ☐ Support ☐ Neutral ☐ Opposed ☐ Strongly Opposed

3. **Do you support the Innovation *Project Vyvanse in Stimulant Addiction (VISA)*?**
   ☐ Strongly Support ☐ Support ☐ Neutral ☐ Opposed ☐ Strongly Opposed

4. **Do you have any ideas on how to make proposed Innovation Projects *Progressive Integrated Care Collaborative (PICC)* and/or *Vyvanse in Stimulant Addiction (VISA)* more innovative?**

5. **What else would you like to learn about the MHSA process?**

6. **Do you have other concerns not addressed in this discussion?**

Thank you again for taking the time to review and provide feedback.

Behavioral Health

MENTAL HEALTH SERVICES ACT (MHSA)

Formulario de Encuesta de Partes Interesadas

Plan Integrado de Tres Años
Años Fiscales 2023/24 hasta 2025/26
Reunión de Planificación de Programas Comunitarios

1. ¿Cuál es tu edad?

☐ 0-15 años ☐ 26-59 años
☐ 16-25 años ☐ 60+ años

2. ¿Qué sexo te asignaron al nacer?

☐ Femenino ☐ Masculino

3. ¿Cómo te describes a ti mismo?

☐ Femenino ☐ Masculino
☐ Trans Mujer ☐ Trans Hombre
☐ Genero queer ☐ No Binario
☐ Cuestionándome o Inseguro de identidad de Género
☐ No aparece:_____
☐ Declinar a declarar

4. . ¿Te consideras a ti mismo?

☐ Heterosexual ☐ Gay/Lesbiana
☐ Queer ☐ Bisexual
☐ Cuestionándome o Inseguro sobre Orientación
☐ No aparece:_____
☐ Declinar a declarar

5. ¿Cuál es el idioma principal que se habla en su hogar?

☐ Inglés ☐ Español
☐ No aparece: _____

6. ¿Es usted consumidor de servicios de salud mental?

☐ SI (actualmente) ☐ NO
☐ SI (previamente) ☐ Declinar a declarar

7. ¿Es usted un consumidor de servicios de alcohol y/o drogas?

☐ SI (actualmente) ☐ NO
☐ SI (previamente) ☐ Declinar a declarar

8. ¿Es usted amigo, familiar o ser querido de un consumidor de servicios de salud mental y/o de servicios alcohol y drogas?

☐ SI ☐ NO

9. ¿Ha servido en el ejército?

☐ SI (actualmente) ☐ NO
☐ SI (previamente) ☐ Declinar a declarar

10. ¿Qué categoría describe mejor su raza (es decir, características físicas / ancestrales)?

☐ Indio Americano o Nativo de Alaska
☐ Asiático
☐ Afroamericano/Negro
☐ Nativo de Hawái u otro isleño del Pacífico
☐ Hispano/Latino
☐ Caucásico/Blanco
☐ Más de una raza
☐ Declinar a declarar

11. ¿Qué mejor describe a su empleador?:

☐ Propio
☐ Empresa Privada
☐ Proveedor De Servicios Basados En La Comunidad
☐ Gobierno Federal, Estatal, Condado o de Ciudad
☐ No Lucrativa
☐ Estudiante / Interno
☐ Otro:_____

12. ¿Trabaja en alguna de las siguientes áreas / campos? (marque todas las que apliquen)

☐ Aplicación De La Ley
☐ Educación
☐ Programa de Servicio Social o Humano/Agencia
☐ Salud
  ☐ Salud Física ☐ Comportamiento/Salud Mental
☐ Programa de Servicio de Alcohol y Drogas
☐ Organización De Veteranos
☐ Organización Basada En La Fe
☐ No aparece:_____

13. ¿Tiene usted una discapacidad u otro impedimento que se espera que dure más de 6 meses y sustancialmente limita una actividad importante de la vida, que no es el resultado de una enfermedad mental de servicio?

☐ SI ☐ NO
☐ Negarse a Responder

14. ¿Vive o trabaja en el Condado de San Bernardino, si ambos enumeran la región en la que vive?:

☐ SI
- ☐ Región Del Valle Central
  e.g. Bloomington, Fontana, Grand Terrace, Rialto
- ☐ Región Montañosa/Del Deserto
  e.g. Adelanto, Amboy, Apple Valley, Baker, Big Bear City, Cima, Earp, Fort Irwin, Hesperia, Hinkley, Joshua Tree, Landers, Ludlow, Morongo Valley, Mountain Pass, Needles, Nipton, Parker Dam, Phelan, Pioneertown, Sky Forest, Sugarloaf, 29 Palms, Wrightwood, Yermo, Yucca Valley
- ☐ Valle Del Este
  e.g. Green Valley Lake, Highland, Lake Arrowhead, Loma Linda, Lytle Creek, Mentone, Patton, Redlands, Rimforest, Running Springs, San Bernardino, Yucapia
- ☐ Valle Del Oeste
  e.g. Chino Hills, Chino, Guasti, Mt. Baldy, Montclair, Rancho Cucamonga

☐ No, vivo y trabajo en un Condado vecino de California

Código Postal :_____

15. ¿Está satisfecho de que esta reunión cumplió con sus metas y/o objetivos?

☐ Muy Satisfecho
☐ Satisfecho
☐ Neutral
☐ Insatisfecho
☐ Muy Insatisfecho

16. En el futuro, ¿cómo le gustaría recibir las actualizaciones de MHSA? (marque todas las que apliquen)

☐ Reuniones del Comité Asesor de Planificación Comunitaria
☐ Seminario Web
☐ Correo electrónico (Proporcione la dirección abajo)
☐ Redes Sociales
☐ Reunión especial en su comunidad
☐ Otro:_____

Formulario de Encuesta de Partes Interesadas

Plan Integrado de Tres Años
Años Fiscales 2023/24 hasta 2025/26
Reunión de Planificación de Programas Comunitarios

1. **¿Qué aprendió sobre el Plan Integrado de Tres Años de la MHSA (por sus siglas en inglés)?**

2. **¿Apoya el Proyecto de Innovación *Colaboración de Atención Integrada Progresiva (PICC por sus siglas en inglés)?***
   ☐ Fuerte Apoyo ☐ Apoyo ☐ Neutral ☐ Opuesto ☐ Fuertemente Opuesto

3. **¿Apoya el Proyecto de Innovación *Vyvanse en la Adicción a los Estimulantes (VISA por sus siglas en inglés)*?**
   ☐ Fuerte Apoyo ☐ Apoyo ☐ Neutral ☐ Opuesto ☐ Fuertemente Opuesto

4. **¿Tienes alguna idea sobre cómo hacer los projectos propuestos *Colaboración de Atención Integrada Progresiva (PICC por sus siglas en inglés) y/o Vyvanse en la Adicción a los Estimulantes (VISA por sus siglas en inglés)* sean más innovadores?**

5. **¿ Qué más le gustaría saber sobre los programas de la MHSA (por sus siglas en inglés)?**

6. **¿ Tiene alguna inquietud que no se haya abordado?**

Gracias por tomarse el tiempo para revisar y proporcionar comentarios.

From: San Bernardino County
To: McAdam, Cheryl DBH
Subject: Behavioral Health Seeks Public Input on MHSA Three-Year Plan
Date: Monday, February 13, 2023 5:17:18 PM

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County of San Bernardino

Media Release

Contact

Miranda Canseco
Public Relations and Community
Outreach Coordinator
(909) 386-8202
miranda.canseco@dbh.sbcounty.gov

For Immediate Release
February 13, 2023

Behavioral Health Seeks Public Input on MHSA Three-Year Plan

The San Bernardino County Department of Behavioral Health (DBH) invites community members to review and comment on the draft Mental Health Services Act (MHSA) Three-Year Integrated Plan, which includes fiscal years 2023/24 through 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 programing for the upcoming fiscal years. View and comment on the draft plan by visiting https://wp.sbcounty.gov/dbh/programs/mhsa/ now until March 15, 2023. 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.

“The draft plan demonstrates the expansion of the public behavioral health system of care, promoting wellness, recovery and resilience for our county,” said DBH Director Dr. Georgina Yoshioka. “Community is at the center of what we do, therefore it is important that you share feedback for DBH to plan on further developing our services.”

The MHSA was passed by California voters in November 2004 and is funded by a one percent tax surcharge on personal income over $1 million per year. DBH, through the MHSA, is supporting the Countywide Vision by providing behavioral health services and ensuring residents have the resources they need to promote wellness, recovery, and resilience in the community. Information on the Countywide Vision and on DBH can be found at www.sbcounty.gov.

About San Bernardino County Department of Behavioral Health: San Bernardino County Department of Behavioral Health provides mental health and substance use disorder services to county residents who are experiencing major mental illnesses and/or substance abuse issues and are uninsured or on Medi-Cal, and individuals experiencing a behavioral health crisis. Learn more by visiting sbcounty.gov/dbh.

About San Bernardino County: San Bernardino County is a diverse public service organization serving America's largest county. 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 as outlined in the Countywide Vision. It is comprised of 42 departments and agencies, which are staffed by more than 25,000 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. San Bernardino County's organizational culture is defined by the four pillars of value, innovation, service, and vision. For more information, visit sbcounty.gov.

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From:	Canseco, Miranda DBH
To:	Cervantes, Karen DBH; Gutierrez, Maribel DBH; Scott Young, Rebecca DBH
Cc:	McAdam, Cheryl DBH; Morrow, Gayle DBH; Rice, Nicole DBH
Subject:	FW: Behavioral Health Seeks Public Input on MHSA Three-Year Plan
Date:	Thursday, February 23, 2023 4:18:56 PM

FYI

Miranda Canseco, MPA
Public Relations and Community Outreach Coordinator
Department of Behavioral Health
Direct: (909) 386-8202

From: City News <news@citynewsgroup.com>
Sent: Thursday, February 23, 2023 4:15 PM
To: Canseco, Miranda DBH <Miranda.Canseco@dbh.sbcounty.gov>
Subject: RE: Behavioral Health Seeks Public Input on MHSA Three-Year Plan

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Behavioral Health Seeks Public Input on MHSA Three-Year Plan

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Sincerely,

Claudia Zepeda
Assistant Editor | City News Group
22797 Barton Rd

Grand Terrace, CA 92313
909-370-1200

From: San Bernardino County <sbcounty@public.govdelivery.com>
Sent: Monday, February 13, 2023 5:17 PM
To: City News <news@citynewsgroup.com>
Subject: Behavioral Health Seeks Public Input on MHSA Three-Year Plan

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County of San Bernardino

Media Release

Contact

Miranda Canseco
Public Relations and Community
Outreach Coordinator
(909) 386-8202
miranda.canseco@dbh.sbcounty.gov

For Immediate Release
February 13, 2023

Behavioral Health Seeks Public Input on MHSA Three-Year Plan

The San Bernardino County Department of Behavioral Health (DBH) invites community members to review and comment on the draft Mental Health Services Act (MHSA) Three-Year Integrated Plan, which includes fiscal years 2023/24 through 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 programing for the upcoming fiscal years. View and comment on the draft plan by visiting https://wp.sbcounty.gov/dbh/programs/mhsa/ now until March 15, 2023. 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.

“The draft plan demonstrates the expansion of the public behavioral health system of care, promoting wellness, recovery and resilience for our county,” said DBH Director Dr. Georgina Yoshioka. “Community is at the center of what we do, therefore it is important that you share feedback for DBH to plan on further developing our services.”

The MHSA was passed by California voters in November 2004 and is funded by a one percent tax surcharge on personal income over $1 million per year. DBH, through the MHSA, is supporting the Countywide Vision by providing behavioral health services and ensuring residents have the resources they need to promote wellness, recovery, and resilience in the community. Information on the Countywide Vision and on DBH can be found at www.sbcounty.gov.

About San Bernardino County Department of Behavioral Health: San Bernardino County Department of Behavioral Health provides mental health and substance use disorder services to county residents who are experiencing major mental illnesses and/or substance abuse issues and are uninsured or on Medi-Cal, and individuals experiencing a behavioral health crisis. Learn more by visiting sbcounty.gov/dbh.

About San Bernardino County: San Bernardino County is a diverse public service organization serving America's largest county. 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 as outlined in the Countywide Vision. It is comprised of 42 departments and agencies, which are staffed by more than 25,000 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. San Bernardino County's organizational culture is defined by the four pillars of value, innovation, service, and vision. For more information, visit sbcounty.gov.

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SAN BERNARDINO COUNTY

Interoffice Memo

DATE: February 24, 2023 **PHONE:** 909-388-0801

FROM: **DR. GEORGINA YOSHIOKA,** Director
Behavioral Health

TO: **MEMBERS**
Board of Supervisors

LEONARD X. HERNANDEZ, Executive Officer
County Administrative Office

DIANE RUNDLES, Assistant Executive Officer
County Administrative Office

SUBJECT: **POSTING OF THE DRAFT MENTAL HEALTH SERVICES ACT THREE YEAR INTEGRATED PLAN FY'S 2023/24 THROUGH 2025/26**

The purpose of this memo is to provide information regarding the posting of the Draft Mental Health Services Act (MHSA) Three Year Integrated Plan for Fiscal Years 2023/24 through 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 the Mental Health Services Act. 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 www.sbcounty.gov/dbh.

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 before July 1st each fiscal year. 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. Based on input, DBH is conducting special stakeholder engagement meetings concurrent with the posting of the draft plan. 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 list serves, websites, and through use of social media tools such as Instagram, Facebook, and Twitter.
- Conducting forty special stakeholder engagement meetings in all regions (i.e., supervisory districts) to review proposed programmatic changes and new programs.
- Utilizing webinar technology to allow stakeholders to participate from home or a satellite location.
- Facilitating a meeting in Spanish for monolingual community members hosted in collaboration with the Consulate of Mexico in San Bernardino County, in addition to providing translation services, as needed, at the other scheduled meetings.

STATUS / IMPLEMENTATION

Per Welfare and Institutions Code 5848, the MHSA Three Year Integrated Plan FY's 2023/24 through 2025/26 will be available for a minimum 30-day public review and comment period on the DBH website from February 13, 2023, through March 15, 2023. 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 6, 2023 at the regularly scheduled Behavioral Health Commission for a formal review of the community program planning process. The MHSA Three Year Integrated Plan is tentatively scheduled for Board approval in May 2023. Should you have any questions or need further information regarding the submission of the MHSA Three Year Integrated Plan for San Bernardino County, please contact my office. Thank you for your continued support!

GY:RSY:mv

C: Leonard X. Hernandez, County Chief Executive Officer
Diane Rundles, Assistant Executive Officer
Diana Alexander, Assistant Executive Officer
Luther Snoke, County Chief Operating Officer
Christopher Lange, Administrative Analyst III, Human Services
Members, Behavioral Health Commission
MHSA Community Policy Advisory Committee
Executive Management Team, Department of Behavioral Health
Paul Quijano, President, Association of Community Based Organizations
Dr. Rebecca Scott Young, Department of Behavioral Health, MHSA Administrative Manager

Department Updates Feb. 21, 2023

DP DBH-PIO
To

Visit the DBH Now blog to view appreciation gram templates and to see how you can win a prize for wearing blue on March 2!

Learn More

DBH Seeks Public Input on MHSA Three-Year Plan



DBH invites community members to review and comment on the draft Mental Health Services Act (MHSA) Three-Year Integrated Plan, which includes fiscal years 2023/24 through 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 programing for the upcoming fiscal years. For complete information on the MHSA Three-Year Plan visit https://wp.sbcounty.gov/dbh/programs/mhsa/ now until March 15, 2023.

Learn More

SAN BERNARDINO COUNTY | Behavioral Health

MENTAL HEALTH SERVICES ACT (MHSA)

Stakeholder Survey Form

MHSA Three Year Integrated Plan
Fiscal Years 2023/24 - 2025/26
30-Day Public Posting

1. What is your age?

☐ 0-15 yrs ☐ 26-59 yrs
☐ 16-25 yrs ☐ 60+ yrs

2. What sex were you assigned at birth?

☐ Female ☐ Male

3. How do you describe yourself?

☐ Female ☐ Male
☐ Trans Female/Woman ☐ Trans Male/Man
☐ Genderqueer ☐ Nonbinary
☐ Questioning or Unsure of Gender Identity
☐ Not Listed:_____
☐ Decline to State

4. Do you consider yourself:

☐ Straight/Heterosexual ☐ Gay/Lesbian
☐ Queer ☐ Bisexual
☐ Questioning or Unsure about Orientation
☐ Not Listed:_____
☐ Decline to Answer

5. What is the primary language spoken in your home?

☐ English ☐ Spanish
☐ Not Listed: _____

6. Are you a consumer of mental health services?

☐ YES (currently) ☐ NO
☐ YES (previously) ☐ Decline to State

7. Are you a consumer of alcohol and/or drug services?

☐ YES (currently) ☐ NO
☐ YES (previously) ☐ Decline to State

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

9. Have you ever served in the military?

☐ YES (currently) ☐ NO
☐ YES (previously) ☐ Decline to State

10. Which category best describes your race (i.e. physical/ancestral characteristics)?

☐ American Indian or Alaskan Native
☐ Asian
☐ African American/Black
☐ Native Hawaiian or other Pacific Islander
☐ Hispanic/Latino
☐ Caucasian/White
☐ More than One Race
☐ Decline to State

11. Which best describes your employer:

☐ Self
☐ Private Business
☐ Community Based Service Provider
☐ Federal, State, County, or City Government
☐ Nonprofit
☐ Student/Intern
☐ Other:_____

12. Do you work in any of the following areas/fields? (check all that apply)

☐ Law Enforcement
☐ Education
☐ Social or Human Service Program/Agency
☐ Healthcare
  ☐ Physical Health ☐ Behavioral/Mental Health
☐ Alcohol and Drug Service Program
☐ Veterans Organization
☐ Faith Based Organization
☐ Not Listed:_____

Stakeholder Survey Form

MHSA Three Year Integrated Plan
Fiscal Years 2023/24 - 2025/26
30-Day Public Posting

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
☐ Decline to Answer

14. Do you live or work in San Bernardino County, if both list the region you live in:

☐ YES
- ☐ Central Valley Region
  e.g. Bloomington, Fontana, Grand Terrace, Rialto
- ☐ Desert/Mountain Region
  e.g. Adelanto, Amboy, Apple Valley, Baker, Big Bear City, Cima, Earp, Fort Irwin, Hesperia, Hinkley, Joshua Tree, Landers, Ludlow, Morongo Valley, Mountain Pass, Needles, Nipton, Parker Dam, Phelan, Pioneertown, Sky Forest, Sugarloaf, 29 Palms, Wrightwood, Yermo, Yucca Valley
- ☐ East Valley
  e.g. Green Valley Lake, Highland, Lake Arrowhead, Loma Linda, Lytle Creek, Mentone, Patton, Redlands, Rimforest, Running Springs, San Bernardino, Yucapia
- ☐ West Valley
  e.g. Chino Hills, Chino, Guasti, Mt. Baldy, Montclair, Rancho Cucamonga

☐ No, I live and work in a neighboring California County

Zip Code:_____

15. Were you satisfied that this meeting met its goals and/or objectives?

☐ Very Satisfied
☐ Satisfied
☐ Neutral
☐ Unsatisfied
☐ Very Unsatisfied

16. In the future how would you like to receive MHSA updates? (check all the apply)

☐ Community Policy Advisory Committee Meetings
☐ Webinar
☐ Email (Provide email address below)
☐ Social Media
☐ Special meeting in your community
☐ Other:_

Behavioral Health

Stakeholder Survey Form

MHSA Three Year Integrated Plan
Fiscal Years 2023/24 - 2025/26
30-Day Public Posting

1. **What did you learn about the MHSA Three Year Integrated Plan FY 2023/24 – 2025/26?**

2. **What else would you like to learn about the MHSA process?**

3. **Do you have other concerns not addressed in this discussion?**

Thank you again for taking the time to review and provide feedback.

SAN BERNARDINO COUNTY | Behavioral Health

MENTAL HEALTH SERVICES ACT (MHSA)

Formulario de Encuesta de Partes Interesadas

Plan Integrado de Tres Años
Años Fiscales 2023/24 hasta 2025/26

Publicación pública de 30 días

1. ¿Cuál es tu edad?

☐ 0-15 años ☐ 26-59 años
☐ 16-25 años ☐ 60+ años

2. ¿Qué sexo te asignaron al nacer?

☐ Femenino ☐ Masculino

3. ¿Cómo te describes a ti mismo?

☐ Femenino ☐ Masculino
☐ Trans Mujer ☐ Trans Hombre
☐ Genero queer ☐ No Binario
☐ Cuestionándome o Inseguro de identidad de Género
☐ No aparece:_____
☐ Declinar a declarar

4. . ¿Te consideras a ti mismo?

☐ Heterosexual ☐ Gay/Lesbiana
☐ Queer ☐ Bisexual
☐ Cuestionándome o Inseguro sobre Orientación
☐ No aparece:_____
☐ Declinar a declarar

5. ¿Cuál es el idioma principal que se habla en su hogar?

☐ Inglés ☐ Español
☐ No aparece: _____

6. ¿Es usted consumidor de servicios de salud mental?

☐ SI (actualmente) ☐ NO
☐ SI (previamente) ☐ Declinar a declarar

7. ¿Es usted un consumidor de servicios de alcohol y/o drogas?

☐ SI (actualmente) ☐ NO
☐ SI (previamente) ☐ Declinar a declarar

8. ¿Es usted amigo, familiar o ser querido de un consumidor de servicios de salud mental y/o de servicios alcohol y drogas?

☐ SI ☐ NO

9. ¿Ha servido en el ejército?

☐ SI (actualmente) ☐ NO
☐ SI (previamente) ☐ Declinar a declarar

10. ¿Qué categoría describe mejor su raza (es decir, características físicas / ancestrales)?

☐ Indio Americano o Nativo de Alaska
☐ Asiático
☐ Afroamericano/Negro
☐ Nativo de Hawái u otro isleño del Pacífico
☐ Hispano/Latino
☐ Caucásico/Blanco
☐ Más de una raza
☐ Declinar a declarar

11. ¿Qué mejor describe a su empleador?:

☐ Propio
☐ Empresa Privada
☐ Proveedor De Servicios Basados En La Comunidad
☐ Gobierno Federal, Estatal, Condado o de Ciudad
☐ No Lucrativa
☐ Estudiante / Interno
☐ Otro:_____

12. ¿Trabaja en alguna de las siguientes áreas / campos? (marque todas las que apliquen)

☐ Aplicación De La Ley
☐ Educación
☐ Programa de Servicio Social o Humano/Agencia
☐ Salud
  ☐ Salud Física ☐ Comportamiento/Salud Mental
☐ Programa de Servicio de Alcohol y Drogas
☐ Organización De Veteranos
☐ Organización Basada En La Fe
☐ No aparece:_____

13. ¿Tiene usted una discapacidad u otro impedimento que se espera que dure más de 6 meses y sustancialmente limita una actividad importante de la vida, que no es el resultado de una enfermedad mental de servicio?

☐ SI ☐ NO
☐ Negarse a Responder

14. ¿Vive o trabaja en el Condado de San Bernardino, si ambos enumeran la región en la que vive?:

☐ SI
- ☐ Región Del Valle Central
  e.g. Bloomington, Fontana, Grand Terrace, Rialto
- ☐ Región Montañosa/Del Deserto
  e.g. Adelanto, Amboy, Apple Valley, Baker, Big Bear City, Cima, Earp, Fort Irwin, Hesperia, Hinkley, Joshua Tree, Landers, Ludlow, Morongo Valley, Mountain Pass, Needles, Nipton, Parker Dam, Phelan, Pioneertown, Sky Forest, Sugarloaf, 29 Palms, Wrightwood, Yermo, Yucca Valley
- ☐ Valle Del Este
  e.g. Green Valley Lake, Highland, Lake Arrowhead, Loma Linda, Lytle Creek, Mentone, Patton, Redlands, Rimforest, Running Springs, San Bernardino, Yucapia
- ☐ Valle Del Oeste
  e.g. Chino Hills, Chino, Guasti, Mt. Baldy, Montclair, Rancho Cucamonga

☐ No, vivo y trabajo en un Condado vecino de California

Código Postal :_____

15. ¿Está satisfecho de que esta reunión cumplió con sus metas y/o objetivos?

☐ Muy Satisfecho
☐ Satisfecho
☐ Neutral
☐ Insatisfecho
☐ Muy Insatisfecho

16. En el futuro, ¿cómo le gustaría recibir las actualizaciones de MHSA? (marque todas las que apliquen)

☐ Reuniones del Comité Asesor de Planificación Comunitaria
☐ Seminario Web
☐ Correo electrónico (Proporcione la dirección abajo)
☐ Redes Sociales
☐ Reunión especial en su comunidad
☐ Otro:_____

Formulario de Encuesta de Partes Interesadas

Plan Integrado de Tres Años
Años Fiscales 2023/24 hasta 2025/26

Publicación pública de 30 días

1. **¿Qué aprendió sobre el Plan Integrado de Tres Años de la MHSA (por sus siglas en inglés)?**

2. **¿ Qué más le gustaría saber sobre los programas de la MHSA (por sus siglas en inglés)?**

3. **¿ Tiene alguna inquietud que no se haya abordado?**

Gracias por tomarse el tiempo para revisar y proporcionar comentarios.

From: San Bernardino County
To: McAdam, Cheryl DBH
Subject: Public Hearing to be Held for Mental Health Services
Date: Monday, April 3, 2023 8:25:13 AM

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County of San Bernardino

Media Release

Contact

Miranda Canseco
Public Relations and Community Outreach Coordinator
miranda.canseco@dbh.sbcounty.gov
(909) 386-8202

For Immediate Release
April 3, 2023

Public Hearing to be Held for Mental Health Services

San Bernardino County Department of Behavioral Health (DBH) invites members of the community to attend an upcoming public hearing regarding the draft Mental Health Services Act (MHSA) Three-Year Integrated Plan, which includes fiscal years 2023/24 through 2025/26.

The public hearing will be held during the regularly scheduled Behavioral Health Commission Meeting on Thursday, April 6, 2023, from noon to 2 p.m. via WebEx pursuant to the provisions in the Governor's Executive Order N-25-20 dated March 17, 2020. The meeting will also be held in-person in San Bernardino, Ontario, Chino and Apple Valley. To view the Webex meeting info and all in-person locations, visit https://wp.sbcounty.gov/dbh/bhc/.

The Three-Year Integrated Plan is a report highlighting achievements and progress of MHSA programs for fiscal year 2021/22 and the plan for using the funds in the upcoming three years.

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.

DBH, through the MHSA, is supporting the Countywide Vision by providing behavioral

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

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MHSA Public Hearing



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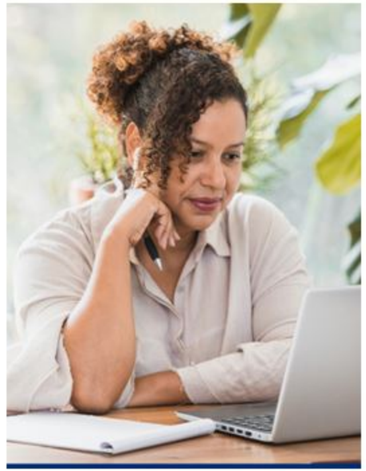


Department Updates - April 3, 2023

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Mon 4/3/2023 3:45 PM

Register Here



Public Hearing to be Held for Mental Health Services

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The public hearing will be held during the regularly scheduled Behavioral Health Commission Meeting on Thursday, April 6, 2023, from noon to 2 p.m. via WebEx and will also be held in-person in San Bernardino, Ontario, Chino and Apple Valley. To view the Webex meeting info and all in-person locations, click below.

View Meeting Info

From: DBH-PIO
Subject: Behavioral Health Commission Meeting | April 6, 2023
Date: Tuesday, March 28, 2023 8:45:54 AM
Attachments: image018.png
image019.png
image024.png

SAN BERNARDINO COUNTY | Behavioral Health

Behavioral Health Commission

BEHAVIORAL HEALTH COMMISSION MEETING

Thursday, April 6, 2023
Noon - 2:00 p.m.

Virtual Option via WebEx: Join meeting

The meeting link is also available at https://wp.sbcounty.gov/dbh/bhc/)
Or Call: 1-415-655-0002 | Meeting number (access code): 146 265 5870
Meeting password: D4Wn9PE2ZxD

In-person/Remote Teleconference Locations with Public Access:

1st District Commissioner, Pastor Mark Graham	12920 Topsham Bay, Apple Valley, CA 92308
4th District Chair, Dr. Monica Caffey	3200 Guasti Road, Ontario, CA 91730
4th District Commissioner, Jennifer Spence	4681 Revere Court, Chino, CA 91710
5th District Vice Chair, Gil Navarro	303 E. Vanderbilt Way, San Bernardino, CA 92415, Conference Room 116
5th District Commissioner Veatrice Jews	303 E. Vanderbilt Way, San Bernardino, CA 92415, Conference Room 116
5th District Commissioner Lynn Summers	303 E. Vanderbilt Way, San Bernardino, CA 92415, Conference Room 116
Clerk of the Commission, Sheena Felix	303 E. Vanderbilt Way, San Bernardino, CA 92415, Conference Room 116

Click here for the Agenda

SUBJECT MATTER PRESENTATION:
Mental Health Services Act (MHSA) Three Year Integrated Plan
FY2023-24 Through 2025-26

Executive Session will be held from 10 – 11:30 a.m.
Meetings are open to the public.

Department of Behavioral Health - WEBMASTER
(909) 386-9730

SAN BERNARDINO COUNTY

Our job is to create a county in which those who reside and invest can prosper and achieve well-being.
www.SBCounty.gov/DBH | Sign up for our newsletter



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